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Reconstruction and Reorientation: Changing Disability Policies in the Netherlands and Norway

Abstract. The Netherlands and Norway are among the many countries that have faced serious challenges to the sustainability of their social security systems in recent years. In this article we examine the growth in benefit schemes related to illness and disability since they have been one source of particular concern in both countries. The Netherlands came to face more serious and persistent problems earlier than Norway in this policy area. Our analysis reveals significant differences with respect to the underlying assumptions in the social protection systems for the long-term sick and disabled as they were originally constructed in the 1960s. We identify a general emphasis on 'integration' in the Norwegian social policy discourse and legislation up until the late 1980s, whereas the Dutch legislation in the same period tended to focus on autonomy and individual 'choice'. In the article we compare the reforms introduced in both countries to control the growth in sickness and disability schemes, by means of a common analytical and conceptual framework. 'Incentives' have occupied an increasingly prominent position in the policy discourse in both countries. While the Norwegian development may largely be seen as a return to and revival of partly forgotten, partly eroded assumptions behind the original social protection scheme, the Dutch policy shift amounts to a more fundamental reconstruction of the whole social security system.

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1. INTRODUCTION

Since the first oil crisis of the early 1970s, most European countries have experienced more turbulence in the labour market than in previous decades. Higher as well as fluctuating levels of unemployment and accelerated processes of restructuring the labour force have put public income maintenance schemes under heavy pressure. The number of people claiming cash benefits has remained high and more people have received financial support for longer periods.

European governments have adopted various responses to these challenges, for instance tightening eligibility criteria, shortening the maximum period of entitlement and reducing the generosity of benefits, or introducing closer links between benefits and measures to help people become self-sufficient through work. These responses can serve to illuminate the more or less taken for granted rationale of existing social protection systems, and indicate how the underlying assumptions behind these systems are modified. Some of the responses may imply *de facto* changes of priorities, for instance in conceptions of equity and efficiency or in new ways of striking the balance between individual welfare and 'societal interests'.

In this article we examine changes in cash benefits to compensate for the risks of illness and disability. These benefits have come to play a key role within the income transfer systems for people of employable age. In financial terms they are, for instance, even more important than unemployment benefit and social assistance provisions in many countries (e.g., OECD 1996). It seems unlikely that the increased expenditure on benefits relating to illness and disability reflects a general worsening of the population's health in these countries. Governments have therefore put their social protection schemes in this area under scrutiny. Our aim is to contribute to a better understanding of the concerns and assumptions behind the reforms that have been introduced. We apply a theoretical framework of relationships between policy assumptions and institutional arrangements for benefits and services aimed at disabled people, as developed by Bolderson and Hvinden (1994) and Drøpping and Hvinden (1996).

We compare the responses of governments in the Netherlands and Norway to challenges in the area of illness and disability. As modern welfare states in two affluent Western societies, these two countries have a great deal in common. Their provisions have been fairly generous and universal, offering their citizens basic income security, and less dependence on the market and kinship in periods of economic hardship (e.g., Esping-Andersen, 1990). As we will see, they have in some respects experienced parallel changes in their labour markets and in spending on cash benefits.

At the same time, their public income maintenance schemes have had different structures, reflecting somewhat different principles and forms of reasoning. Moreover, the Netherlands has been faced with graver, more pressing and persistent problems of labour market restructuring and financial adjustment than Norway. We would therefore expect to find more substantial changes in the Dutch than in the Norwegian social protection schemes. On the other hand, the Netherlands has, in some respects, been some years ahead of Norway in that it has made adjustments that, in the near future, will be seen to be necessary in Norway. All in all, the Netherlands and Norway appear sufficiently similar as well as significantly dissimilar to make a comparative analysis of changes in disability policies interesting and worthwhile.

2. The Challenges

The Netherlands has been adversely affected by the turbulence in the international economy earlier and for a longer period than Norway has, as a look at the two countries shows.

2.1 Registered unemployment

The Netherlands experienced higher levels of unemployment than Norway from the 1970s and this continued until the 1990s when the two countries had roughly matching levels (see table 1).

Table 1: Levels of unemployment in the Netherlands and Norway, 1970-97 Five-year averages of standardized unemployment rates (per cent)

5 year period	The Netherlands	Norway
1970-74	2	2
1975-79	5	2
1980-84	8	3
1985-89	8	3
1990-94	6	6
1995-97	6	5

Source: OECD (1989; 1998a).

Statistics on the incidence of *long-term unemployment* – defined as being unemployed for more than six months – are more uncertain and less directly comparable. However, figures collected by the OECD (1997; 1999) suggest that the Netherlands experienced higher levels of long-term unemployment than Norway both in the 1980s and in the 1990s, but that the differences decreased in the early 1990s, particularly for men.

2.2 *Labour market participation*

More striking contrasts emerge when we look at the rates for labour market participation in the two countries. The overall participation rate has been consistently lower in the Netherlands from the early 1970s (see table 2).

Table 2: Labour market participation rates by age and sex in the Netherlands and Norway. Five-year averages (per cent)

	Men					
Age	15-24		25-54		55-64	
Period	NL	NO	NL	NO	NL	NO
1970-74	61	52	95	93	78	83
1975-79	51	54	94	92	70	82
1980-84	52	65	92	94	56	80
1985-89	57	67	93	94	46	77
1990-94	62	60	93	91	43	72
1995-97	67	62	91	92	43	74

	Women					
Age	15-24		25-54		55-64	
Period	NL	NO	NL	NO	NL	NO
1970-74	51	46	25	53	15	42
1975-79	47	51	31	61	14	47
1980-84	50	54	40	72	14	51
1985-89	54	61	55	79	14	54
1990-94	62	54	62	79	17	54
1995-97	66	56	67	82	20	59

	All	
Age	All	
Period	NL	NO
1970-74	58	69
1975-79	57	73
1980-84	59	78
1985-89	62	81
1990-94	68	79
1995-97	72	81

Source: OECD (1991; 1999).

Yet this overall participation rate has increased in both countries. Behind these overall trends we find a complex restructuring of the labour force. The participation rate of women, especially of middle aged women, has grown strongly in the period under consideration. At the same time, the participation rate of elderly men has decreased, most sharply for elderly men in the Netherlands. While some of these economically inactive persons have gone on to general early retirement schemes, there are several reasons to expect that decreasing participation rates for the elderly sections of the labour force also exert strong pressure on health-related benefits schemes. Among the elderly members of any labour force there will probably always be a reservoir of illness, disablement or injury, which may be used as a basis for claiming such benefits if a need for exit arises. Leaving the labour

market to go on to a disability benefit may be seen as more compatible with the individual's dignity and self-respect than becoming unemployed, redundant and 'unwanted' after many years in work. Finally, to be in receipt of a disability benefit may be financially more advantageous, secure and attractive for the individual than claiming unemployment benefit or social assistance.

2.3 Expenditure related to sickness and disability benefits

As one might expect, a more difficult labour market situation and a higher incidence of labour market exit in the Netherlands meant that the relative expenditure on cash benefits relating to illness and disability was higher in the Netherlands in the early 1980s (table 3). However, in the course of the 1980s and early 1990s, the inter-country differences in expenditure on these benefits diminished as Norway also came to experience higher levels of unemployment and labour market exit for elderly men.

Table 3: Levels of expenditure sickness and disability cash benefits (five-year averages of expenditure as percentage of the gross domestic product).

	Sickness cash benefits		Disability cash benefits	
Period	The Netherlands	Norway	The Netherlands	Norway
1980-84	2.8	1.7	4.7	2.0
1985-89	2.4	1.9	4.3	2.4
1990-(93)	2.6	2.2	4.7	2.9

Source: OECD (1996a).

2.4 Disability benefit rate

The proportion of the population of working age in receipt of disability benefit – the disability benefit rate – increased substantially in both countries and has remained strikingly similar since the early 1970s (table 4). The disability rate has not only been consistently higher in the elderly sections of the labour force, but it is also here that there has been the greatest interest. Again, it seems unlikely that a general deterioration of the health of people over fifty years can explain this – even if we take into account modern 'lifestyle illnesses' related to stress, smoking, rich food, and/or too little physical exercise. This points to the role of disability schemes in facilitating exit from the labour market.

Table 4: Disability benefit rates, five-year intervals, by age and sex (per cent) in the Netherlands and Norway, 1970-97.*

Year	Total		Men		Women		Men 25-54		Men 55-64		Women 25-54		Women 55-64	
	NL	NO	NL	NO	NL	NO	NL	NO	NL	NO	NL	NO	NL	NO
1970	3	5	4	5	1	5	3	2	15	10	1	3	4	10
1975	4	6	6	6	2	6	5	3	21	16	2	3	5	15
1980	7	6	10	6	4	6	9	3	35	18	4	4	9	17
1985	8	7	11	6	4	7	9	3	37	21	4	4	11	22
1990	9	8	11	7	6	9	10	4	36	26	6	6	13	29
1995	8	8	10	7	6	9	8	4	33	25	6	6	14	30
1997	8	9	10	8	6	11	8	5	31	25	6	7	14	32

* Proportion of disability benefit recipients – partial and full – of total population in the same age group.

Sources: LISV (1998), RTV (1971-84, 1985-99).

As well as the similarities in overall trends, two specific inter-country differences are worth noting:

i. The increase in the disability benefit rate for elderly women has been much greater in Norway than in the Netherlands. This is related to an earlier growth and higher level of female labour market participation in

Norway (table 2), since higher labour market participation meant that more women qualified for disability benefits.

ii. Given that the labour force participation of elderly men in the Netherlands has decreased more dramatically and remained lower than in Norway (table 2), it is striking that the difference in the disability rate for elderly men between the two countries has diminished since the second half of the 1980s. This suggests that the Netherlands, to a greater extent than Norway, has been able to modify the tendency of people who make an early exit from the labour market to become recipients of disability benefits.

Since the 1970s, the governments of both countries have been faced with the challenge that an increasing proportion of the population of working age has been claiming cash benefits related to illness and disability. This trend has resulted in a growing financial burden on public budgets. The burden has, at least partially, been reinforced by two factors: more people have become entitled to higher benefits as schemes mature; and the duration of the benefit period has increased as the average age of new entrants into disability benefit schemes has decreased. This raises the following questions:

i. What concerns have driven the responses of the two governments to these challenges?
ii. Have the two governments chosen similar responses, or have more substantial changes been introduced in the Netherlands?
iii. To what extent have the underlying assumptions of the two social protection systems been modified as a result of these changes?

In order to answer these questions, we present an outline of the history and structure of the social protection systems for the long-term sick and disabled in the two countries. Although we include short-term benefits (sickness benefit/sick pay) in this account, the emphasis is on problems and initiatives related to long-term benefits (disability benefit/pensions).

3. The Social Protection Systems in the Netherlands and Norway

In both countries, the ongoing of the modern social security system dates back to the end of the nineteenth century. From a situation where the dominant social protection system was means-tested assistance of a 'Poor Law' type, a number of social insurance benefits were introduced before the Second World War. These benefits mainly covered the risks of work

injury, old age and sickness, but in Norway they also covered the risk of unemployment. After the Second World War, social insurance schemes were expanded to cover a broader section of the population of working age and a broader range of risks, including disablement in general.

3.1 The Netherlands

The Van Rhijn Commission presented its blueprint for a new social security system in 1945. Significantly, the legitimizing principle for social security was now to be the idea that 'society, organized in the state, is liable for the social security and protection against want of all its members, on the condition that citizens themselves do all that can be reasonably expected in order to acquire such security and protection' (Van Rhijn, 1945, p. 4). This principle opened the door for a system that included all citizens, not just waged employees (as in the existing schemes). In the years after the Van Rhijn Commission's report, a number of so-called 'national insurances' were introduced, which for all citizens covered old age, loss of provider (survivors) and disability. These schemes were highly collective in the sense that they were designed and controlled by the state, and highly solidaristic as 'bad risks' were not excluded and contributions were proportional to income rather than risk. In specific cases, people could claim benefits even if they had never paid any contributions. A new national safety net or social assistance scheme replaced the inadequate Poor Law. A national unemployment scheme for waged workers was introduced, and schemes covering the risks of work injury, invalidity and sickness were made more collective and solidaristic.

These processes got a strong boost in the 1960s when the Minister for Social Affairs, Veldkamp, formulated a new and broader legitimizing principle for social security, holding that 'every citizen has a right to self-realization and to equality of chances' (TK, 1962/63). This principle had its strongest effect on the new disability schemes that were under construction during this period. Basically, Dutch social security in the late 1970s contained three types of schemes, whose main structure is still present today, despite all the revisions of the last decade:

i. The so-called *national insurances* cover the risks of old age, death of the spouse and having a child, as well as long-term disablement. These are all compulsory, contributary, non-means-tested schemes to which all citizens are entitled.[1] Waged workers and the self-employed pay contributions that are proportional to income, while benefits are flat-

1 Means-testing was introduced in survivors' pensions in 1997.

rate and at subsistence level (which is, in effect, the level of the statutory minimum wage).

ii. The so-called *employees' insurances* cover unemployment, long-term disablement and sickness. These schemes are also compulsory, contributary and non-means-tested, but are confined to employees, with the exception of civil servants, for whom there are separate schemes (although in 2002 they will be brought under the regular employees' insurances – for disability benefits this has already been realized). Contributions are paid as a percentage of wages, while benefits are wage-related.

iii. There is a safety net of *social assistance* for all citizens. Social assistance is non-contributary and paid for out of general taxes. It is means-tested, with tests on the income and assets of claimants and their partners. Benefits are up to subsistence level.

With the implementation of the revized disability insurance for all citizens in the 1976 AAW act (General Disability Act), the period of expansion, collectivization and 'solidarization' of the Dutch system came to an end. Veldkamp's principle had already started to lose its appeal after the effects of the first oil crisis were felt. The economic optimism of the 1960s was replaced by caution, followed by pessimism and ultimately a deep crisis by the end of the 1970s and early 1980s. One government response to the crisis was to reconstruct the social security system.

As we have seen there was a steady increase in the proportion of the adult population claiming disability benefits from the mid-1970s onwards (table 4). Due to the broad definition of disability, based on Veldkamp's universal principle, the schemes had low access thresholds and attracted many older workers who would otherwise have been laid off as unemployed. In other words, the number of beneficiaries of the disability benefit scheme reflected substantial 'hidden' unemployment. The number of recipients rose from 214,000 in 1970 to 707,000 in 1982. This led to the perception that the system was facing overload and could eventually collapse. The initial reaction was to try to keep social expenditure on the employees' insurances under control by reducing the duration and level of benefits. This reaction was known as 'price' policy because it was mainly directed at keeping the system affordable. However, by 1990 the number of beneficiaries of the employees' insurances had increased by a further 300,000 since 1982, more than offsetting the decline in the number of social assistance beneficiaries during this period. Subsequently, the emphasis was put on 'volume' policies that were aimed at reducing the accessibility of schemes and gaining control over the inflow of beneficiaries.

There is no doubt that the 'price' and 'volume' measures contributed to halting the trend towards increasing numbers of beneficiaries and growing expenditure. On the other hand, they did not result in any substantial decrease in demand or expenditure. The government realized that its initial 'price' and subsequent 'volume' policies were insufficient to reduce social security expenditure substantially or to solve the problem of economic inactivity among a large part of the working-age population. The Dutch government therefore gradually developed a new concept of social protection, the core of which implies a fundamental criticism of the model of collective solidarity itself. The main objection of politicians and policy-makers to this model is its anonymity. The national and collective nature of the system is believed to undermine individual responsibility and to promote self-interested adjustments by all the actors involved, be they citizens, workers, employers, unions or companies. The prevention of unemployment, sickness and disability, as well as the reinsertion or integration of disabled and unemployed workers, have all been neglected because they have not been seen to be in anyone's interest. This 'modern carelessness' (Schuyt, 1995) means that moral hazard, broadly defined, is seen as the core problem of the model of collective solidarity.

Based on this diagnosis, market elements, e.g. freedom of choice and risk differentiation, are introduced which, in essence, are aimed at reintroducing individual responsibility by way of confronting all the actors more directly with the costs of social protection. More specifically, the diagnosis has also been the starting point for efforts aimed at 'activation'. These comprise policies promoting the (re-)insertion of all types of beneficiary, including disabled people, into paid and even unpaid work. It was increasingly felt, in the 1980s, that Dutch social security administration focused too exclusively on paying benefits and neglected the re-insertion of beneficiaries into the labour market. Veldkamp's broad principle of equality of opportunity and the right to self-realization had obscured the other side of Van Rhijn's coin of social solidarity, i.e. the responsibility of citizens to maximize self-reliance and to minimize their claims for support in exchange for the right to be protected by society. With regard to the re-insertion of (partly) disabled people, in particular, administrative bodies were perceived as passive and as leaving the initiative mostly to claimants themselves. With respect to Dutch social political discourse more generally, Van Oorschot (1998b, p. 190) concludes that it 'is no longer dominated by Veldkamp's universal and unconditional principle, but by notions of individual responsibility, conditionality, minimum protection and the logic of market-led private insurance'.

A clear example of the implementation of these new ideas can be found in the changes in the sickness benefit scheme, ZW. The earnings replacement ratio for this benefit was reduced from 80 to 70 per cent in

1987.[2] However, the main revision of the ZW started in 1994. Before that, benefits for workers who were ill – for less than a year after which the disability scheme comes into force – were paid from the collective sickness fund for the full period. The fund was financed by contributions from employers and employees. The relation between the extent of absenteeism and the costs of insurance was not strong as contributions were only differentiated between sections of industry. Incentives to prevent sickness were thus lacking at the level of the individual firm. This changed with the 1994 TZ (Act on Reducing Sickness Absence). Under this law, employers were obliged to pay sick employees at least 70 per cent of their wage for the first six weeks of absence (two weeks for companies with less than fifteen employees). The first weeks of sickness benefit were thus privatized and ceased to be a burden on the national sickness fund. Either employers paid wages for sick employees directly, or, as most of them did, they reinsured the risk with private insurance companies. Reducing sickness absenteeism was further promoted by a second obligation, which held that every firm had to develop a sickness absence prevention and control policy. In 1994, another revision took place as a result of the 1992 TAV (Act on Reducing the Disability Volume). This law introduced a further differentiation of contributions for sickness benefit between different sectors of industry. Firms with a higher absenteeism than the average for their sector pay higher contributions. (See below for an analysis of the TAV). More recently a further privatization was introduced in a measure known as the WULBZ (Act on Extension of Obligation to Pay Wages in Case of Sickness) that came into effect in 1997. To the majority of the Dutch labour force this implies the abolition of the ZW.[3]

3.2 Norway

After the Second World War, all political parties expressed a joint commitment to develop a comprehensive legislative framework to cover important life contingencies (sickness, disability, old age and unemployment). This started a 25-year process of planning, design and implementation of an encompassing scheme. The legislators of the early post-war years were unified in their concern about the perceived constrains posed by the economic situation in a period of national reconstruction. In effect, the Norwegian case represents a complex story of welfare state

2 This modification corresponds to a revision of the replacement rate under the WAO (Act on Disability Insurance) of the same year.

3 ZW still covers the sickness risks of specified categories (estimated at 15 per cent of the previously covered population), such as pregnant women, (partly) disabled workers, people on temporary contracts and apprentices.

development, marked by piecemeal expansion and gradual progress rather than radical, overnight expansion.

The major gap in the social insurance system – a general scheme to cover the risk of disablement for people of working age – was not filled until 1960.[4] This involved two inter-linked acts, known as the 'twin acts', providing a universal Disability Pension (with a replacement rate identical to the flat-rate Old Age Pension) and an accompanying scheme of Rehabilitation Assistance (including a Rehabilitation Allowance meant as an income replacement for participants in medical or vocational rehabilitation). The 'twin acts' are further discussed below. A universal benefit covering loss of provider (aimed at surviving and unmarried mothers) was introduced in 1964, and a new and modernized Social Assistance Act replaced the antiquated Poor Law in the same year.

The most important milestone in the development of a modern income maintenance system in Norway was the National Insurance Scheme, NIS (*Folketrygdloven*), introduced in 1966. NIS had two major features. First, it incorporated most of the separate schemes already referred to above,[5] thus creating a comprehensive and unified scheme – excluding only family allowance, pensions for war veterans and some specific occupational categories and social assistance. Second, it introduced a system of earnings-related supplements to all the long-term benefits ('pensions'). Even before this, sickness and unemployment benefits had varied with previous earnings. These characteristics reflect two general objectives in Norwegian income maintenance policy: first, citizens ought to maintain their accustomed standard of living during temporary spells out of work and when leaving employment permanently; second, there ought to be a relationship – if not a proportional one – between individual contributions and returns from the scheme. More generally, the scheme was meant to combine and balance an element of basic income security for all citizens with an element providing standard security for those with a history of incomes from work.

A generous sick pay scheme, SP (*Sykelønnsordningen*), was enacted in 1978, a period otherwise marked by caution in terms of social policy expansion. The SP scheme partly replaced the sickness benefit scheme of the NIS. Under the SP scheme – still largely intact today – employees are entitled to a wage replacement rate of 100 per cent from the first day of sickness (with no waiting days), and no medical certificate is required until

4 A small but significant amendment in the Provisional Act regarding Help to the Blind and Crippled of 1936 had been introduced in 1956.

5 Old age pension, disability benefit, rehabilitation assistance, benefit for surviving spouses and single mothers were incorporated in 1967; and the benefits related to occupational injury, sickness and unemployment were included from the early 1970s.

the fourth day of absence from work.[6] Both the high replacement rate and the abolition of waiting days represent liberalization compared with the previous arrangements of sickness benefits.[7] Furthermore, the scheme obligated employers to finance the benefits during the first two weeks of absence (from 1998, the first three weeks).

Sickness absence rates increased steadily in the 1970s, but the start of the growth period preceded the introduction of the SP scheme. The absence rate displayed a general tendency of growth throughout the 1970s, a development also observed throughout the 1980s (Hagen and Hippe, 1991). Despite a quite dramatic rise in the cost of benefits from 1984 to 1988, SP expenditure in 1995 was a modest five per cent above the level in 1980 in fixed prices. By contrast, the cost of disability pensions exceeded the 1980 level by 80 per cent (Pedersen, 1997, pp. 37-8). Developments in the SP scheme nevertheless caused major public concern in the late 1980s, mainly because a breakdown of these figures indicated a substantial growth in the long-term absence rate (NOU 1990/23, pp. 47-4). As a response to these trends, a medical certificate (*Sykmelding II*) was introduced in 1988.[8]

These developments in the Norwegian disability pension and sick pay schemes were the main background for the reorientation of social policy from the late 1980s on. More specifically, what was assumed to be a growing 'expulsion' (*utstøting*) from the labour market gave rise to a critical evaluation of the whole income maintenance system for people of working age, especially the schemes related to sickness and disability. Thus, in the opening paragraph of the 1992 White Paper on Rehabilitation, the government asserted that: 'a predominant feature of these schemes is that they only to a limited extent pave the way for activities leading back to the labour market' (St. meld. nr. 39, 1991-92, p. 7).

The same White Paper also launched a strategy to promote a turn from 'passive benefits' to 'active efforts' under the heading 'Work Approach'.[9] The objectives of the 'Work Approach' were to promote self-sufficiency through work for as many as possible, and to help persons with social and health problems to manage their daily activities themselves. The National

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6 A personal sick note (*egenmelding*) is sufficient for the first three days of absence.

7 The replacement rate was previously 90 per cent, and granting of SP was subject to three waiting days.

8 In order to emphasize early intervention as a means of preventing permanent labour market exit, *Sykmelding II* made eligibility for sick pay after eight weeks contingent on reassessment. The formal authority to make this reassessment was eventually transferred to the National Insurance Administration.

9 The ideas behind this approach were not new, as they only reiterated the principles of rehabilitation and 'help-to-self-help' that had served as the ideological underpinning of the legislation of the 1950s and 1960s. However, most observers appeared to have forgotten or were unaware of this.

Insurance Scheme continues to be the main source of income replacement for those unable to participate in the labour market. At the same time, it is increasingly emphasized that social protection schemes should be designed so as to motivate persons of working age to engage in gainful employment rather than become long-term recipients of social security benefits.[10] Reforms introduced with reference to the Work Approach in the early 1990s included:

i. adoption of stricter qualifying medical criteria for health-related benefits;
ii. more stringent requirements regarding occupational and geographical mobility for people claiming disability or unemployment benefit;
iii. stricter enforcement of the rehabilitation requirement before assessing claims for disability pension;
iv. more frequent routine reassessments of disability pensions already granted;
v. more extensive use of work requirements in social assistance ('workfare');
vi. reduction of the maximum duration of income replacement benefits for people under medical rehabilitation (one year), lone parents (three years) and the unemployed (three years);
vii. increased resource input and reorganization of vocational rehabilitation services;
viii. more systematic attempts to facilitate early intervention and return to work for people on sick leave; and
ix. encouraging the utilization of remaining work capacity by increasing the possibilities of combining work and benefits.

As in the Netherlands, health-related benefits in Norway used to be more financially advantageous than unemployment benefit. When unemployment grew around 1990 this led to concern and the regulations were changed in 1991 in order to adjust the replacement rate of sick pay for the unemployed to the level of unemployment benefit. The main purpose of this revision was to avoid a situation in which *de facto* 'able-bodied' unemployed persons managed to avoid the requirements otherwise placed on the unemployed, while at the same time enjoying a more generous benefit. As noted above, a medical certificate was introduced in 1988 in order to

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10 This also applies to the beneficiaries of the social assistance scheme (funded and administered by the municipalities) of the national insurance schemes for lone parents, the transitional allowance, and, not the least, for the unemployed.

emphasize early intervention for people on sick leave. In a similar vein, a second 'checkpoint' was introduced in 1993, when sick pay exceeding twelve weeks became contingent on confirmation from the national insurance authorities in addition to the medical doctor's assessment.

While important legislative initiatives in the Netherlands have been targeted towards the employer, few examples of this can be found in Norway. In 1992, however, the Norwegian government proposed a doubling – from two to four weeks – of the sick pay period financed by the employer. This proposal was motivated by a perceived need to stimulate employers to take a greater responsibility for prevention through improvements in the work environment. The proposal was eventually rejected by parliament but the period covered by the employer was extended to three weeks in 1998. Another reform, which sought to promote the responsibility of employers, was introduced through parallel changes in the NIS and the Work Environment Act. This obligated employers to provide – at the request of the National Insurance Administration – a written statement on the possibilities for return to work for employees who had been off sick for a considerable period.

4. A Framework for Analyzing Differences in Policy Responses

Following Bolderson and Hvinden (1994), and drawing on our general knowledge of existing disability policies, we maintain that it is possible to identify some characteristic sets of assumptions implied in the institutional arrangements in this field. These arrangements tend to reflect propositions about empirical reality as well as normative assumptions about:

i. the meanings and consequences of disability;
ii. the responsibilities and obligations of the actors involved;
iii. the role and significance of financial incentives; and
iv. different concepts of integration, choice and rights.

In principle, assumptions may obviously be combined in a great number of ways. But on the basis of our general knowledge of existing disability policies, we argue that five combinations of assumptions are particularly relevant for analytical purposes. Each of these combinations can be summarized as a distinct configuration of institutional arrangements for benefits, services and work (table 6). We claim that each configuration represents an internally meaningful set of characteristics. However, none of these configurations will have any direct empirical counterpart. Rather, they are to be understood as 'ideal-types', that is, theoretical constructs against which the singularity of individual countries' empirical

configuration may be compared (see Weber, 1949, p. 90). These five ideal-type models may thus serve as a frame of reference for a dynamic, cross-national analysis of policy assumptions.

Table 6: Five sets of policy assumptions, institutional arrangements for benefits and services, and expectations about labour market participation for disabled people.

Ideal-type model of policy assumptions	**Benefits**	**Services**	**Work**
Market-led	May be provided in preference to services	None	None
Incentive-led	Low/restricted	Minimal	Expected to work
Integration-led	Adequate/linked	Adequate, linked and coordinated	Expected and linked to services
Choice-led	Adequate	Adequate but may/may not be linked and/or coordinated	Not expected
Rights-led	Minimal emphasis	Minimal: non-discrimination emphasized	Demanded

Source: Bolderson and Hvinden (1994)

The basic ideas behind each of the five models of disability policy are as follows:

i. In the *market-led model*, the relative lack of competitiveness and productivity of people with disabilities is perceived as disqualifying them from participation in the labour market. Rather than creating disequilibrium in the labour market, granting of financial benefits may be preferred.
ii. Within the *incentive-led model*, inducements are seen to promote participation in the labour market. Notwithstanding similarities with the market-led model, the principal distinguishing feature of this model is that the social value of work is recognized, both in its own right and as an independent objective of social policy.
iii. The *integration-led model* holds maximum participation in the economic sphere of society as a primary objective, which also applies

to disabled people. Thus, rather than granting 'passive' benefits, resources should be geared towards bringing individuals (back) into the labour market.

iv. According to the *choice-led model* individuals ought to be able to choose whether or not to work, that is, income benefits should allow a decent standard of living outside work and jobs should be available for those who want to work.

v. Finally, the *rights-led model* questions the very grounds on which separate measures for people with disabilities are founded. This radical model maintains instead that 'disability' is a relative concept; a product of a disabling society.

These models are presented as static, but they are subject to processes of erosion through internal conflicts and extraneous factors. For example, the market-led model is internally threatened by the fear that those who enjoy benefits may 'malinger' and become dependent, and thus cuts in benefits may follow. The incentive-led model cannot function as expected unless work is available. In the integration-led model, problems of stratification in society may be mirrored insofar as it will be relatively easier to 'integrate' some people than others, and likely successes may be creamed off whilst others fail.

At any particular point in time, the empirical configuration of policies in a country may be seen as a mixture of elements from these models. Although the character and relative weight of each element is likely to change over time, we expect one or two of the models to dominate over the others in the overall configuration within a particular country. This framework thus helps us in detecting and identifying various kinds of policy shifts.

A key premise for our analysis is that governments are faced with the challenge of providing a rationale (reasons and justifications) for any remotely controversial policy proposal. This rationale will in practice amount to what Scott and Lyman (1968, p. 1) have called an account: 'a [...] linguistic device employed whenever an action is subjected to valuative inquiry.' These accounts – and the reassurance they may convey – are particularly important when policy shifts are undertaken. We thus expect, for instance, to find a markedly different policy discourse in periods of expansion and contraction in both countries. We emphasize, however, that this particular analysis concentrates on typifying assumptions behind policy formulation; we, to a less extent, examine the implementation of policies.

Our primary sources of data are public documents relating to this area of social policy. The major intake of information is provided by the 'explanatory notes' offered with proposals for new laws in the Netherlands;

the Norwegian analysis relies – in addition to the proposals for new laws – on the preparatory documents (Green Papers and White Papers) preceding most changes in Norwegian legislation. Among other entries, these written sources (in both countries) commonly contain references to the socio-economic background and the rationale informing the initiative, i.e. the perception of the problem, as well as accounts of the government's position on alternative responses to the problem. In the following section we offer a review of the legislative developments pertaining directly to disability and vocational rehabilitation. Unlike the situation in the Netherlands – where new regulations are presented as new laws, even though they are amendments to existing laws – most Norwegian reforms are introduced as amendments and modifications of the existing legislative framework, mainly within the National Insurance Scheme.

5. The Changing Policy Assumptions in Dutch and Norwegian Disability Policies[11]

As we have already indicated, there is evidence to suggest that some sort of policy shift has occurred in both countries and that this reorientation has proceeded along different paths. The main objective of the present analysis is to give a more systematic picture of the similarities and differences in the assumptions underlying Dutch and Norwegian policy, as discerned from applying our analytical framework. We examine the findings with reference to whether they can be attributed to incremental accumulation and *ad hoc* problem perception, or to more fundamental adjustments resulting from assumptions regarding the productivity and appropriate 'social roles' of people with disabilities. Although focusing mainly on the 1980s and 1990s, we also take account of the existing legislative contexts in order to interpret more recent developments. While the 1960 'twin acts' on disability pension and vocational rehabilitation can be seen as the bedrock of Norwegian disability policy up to the present day, the 1967 WAO (Act on Worker's Disability Insurance) and a few other key acts occupy a similar position in the Netherlands.

11 The analysis presented in this section is based on the Dutch case study (Van Oorschot, 1998a) and the Norwegian pilot/case-study (Drøpping and Hvinden, 1996).

5.1 Comparison of national policies in the period of construction

A number of formulations in the Dutch WAO (TK 1962/63) portray training for disabled workers as an investment in working capabilities, and the act relies on two guiding principles: 'Equality of life chances' and the 'right to self-realization'. Despite this stance, there are few references in the act to the relevant means of investment. Instead, the WAO explicitly maintained that its primary intention was provision of a financial benefit. The range of more active measures was quite limited, as vocational rehabilitation was seen as a secondary aim.[12] The original WAO was mainly a 'benefit scheme' and was quite generous as such. The replacement rate was 80 per cent throughout the duration of the disability (until replaced by old-age pension at the age of 65). Based on its training perception (investment), concerns with issues of equity and individual well-being, and, in particular, the fact that the limited training measures were open on demand, our conclusion is that the underlying assumptions of the WAO amounts to a *choice-led* model.

This conclusion is substantiated by an analysis of the 1976 AAW (General Disability Act), which represents a continuation of the WAO for all residents, with respect to the policy dimensions listed above. Providing flat-rate benefits at the level of the minimum wage, the AAW extended the range of disability insurance to all citizens ('national insurance'). The WAO supplemented this benefit to 70 per cent of the former wage for workers. The similarities between the AAW and the WAO are also striking with respect to the limited role attributed to measures of (re-)integration.

Conversely, the 1969 WSW (Act on Sheltered Workplaces) attempted to balance these two 'benefit schemes' with a specific emphasis on active measures. The WSW did offer work in a sheltered environment – organized by the municipalities, with a wage corresponding to or marginally exceeding the minimum wage – but its ambitions never extended to promoting integration into the mainstream labour market. Instead it provided permanently sheltered jobs in a segregated labour market for disabled people. Participation in sheltered work was voluntary and not linked with eligibility for benefits under the WAO/AAW schemes.

The analysis of these three central acts suggests that Dutch legislation relating to sickness and disability in the 1960s and 1970s was based on underlying assumptions congruent with a *choice-led* model. The observed absence of formal rehabilitation requirements as a condition for claiming rights to cash benefits is strong evidence for this conclusion, but the most

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12 The most important active measures were workplace accommodations and a benefit to top up low earnings when participating in training or accepting paid work.

striking support is probably the explicitly stated purpose of the WAO as being almost exclusively aimed at income maintenance – at the expense of active measures aimed at (re-)integration.

This stands in clear contrast to the Norwegian 1960 disability regime, in which we can identify underpinnings congruent with an integration-led model. The 1960 legislation introduced a right to income support for those unable to provide for themselves due to permanent and objectively defined symptoms of sickness, injury or defect. While benefits might in principle be reviewed after some time, they were, in practice, granted on a permanent basis and constituted a *de facto* disability-related early retirement pension.[13] In this respect, it is probably worth noting that, for most of the post-war period, Norway has had no general early retirement scheme.[14]

On the other hand, the 1960 legislation also reflects a great concern with measures of rehabilitation. The legislators feared that a right to a disability pension might give rise to an unrestrained influx of claimants – unless the granting of this right was countered by other measures (Hvinden, 1994a; p. 52, Pettersen, 1991, p. 80). The 1960 framework – which still constitutes the bedrock of the current legislation – thus came to include both benefits and services. While the claimants' remaining earnings capacity (as defined by the National Insurance Administration) is a key concept in determining eligibility for benefit, the emphasis on vocational rehabilitation implies that a disability pension is not to be granted unless all possibilities for rehabilitation have been exhausted. The main concept is thus vocational disability; medical disablement *per se* is not a sufficient criterion for granting disability benefit.

The flavour of an integration-led Norwegian disability policy was not changed when the twin acts were incorporated into the National Insurance Scheme in 1967 (Ot. prp. nr. 17, 1965-66). The most interesting adjustments concerned how much earnings capacity had to be reduced in order to qualify for benefit and the grading of disability benefit in accordance with the degree of reduced earnings capacity. The former adjustment materialized as a significant reduction from two-thirds to one half minimum loss of earnings capacity; and the latter implied a closer relationship between benefit level and actual reduction in earnings capacity. Still, the lack of discussion of the possibility of combining a graded disability benefit with income from work is quite striking. We would expect an integration-led policy to highlight this issue, but this lack of

13 The terms 'disability benefit' and 'disability pension' are still used interchangeably in Norway.

14 The social partners have only in recent years agreed on a limited scheme for early retirement for labour market reasons (*'avtalefestet pensjon'*).

reference may testify to the status of 'integration' as a self-evident and implicit part of the Norwegian political discourse by the late 1960s.

In sum, the conclusion of our analysis of disability policies before the 1980s is as follows: in the Netherlands, there was a *choice-led* policy which, with the benefit of hindsight, was bound eventually to generate overload in social expenditure budgets; in Norway, there was, in theory, an *integration-led* policy which, for various reasons, failed in practice to live up to its ambitions. A particularly important source of expansion in Norway was probably deficient implementation (see, for example, Hvinden, 1991; 1994b; Kjønstad, 1992).

5.2 Paths of reconstruction and reorientation

A general observation is that Dutch efforts to modify their disability scheme since the mid-1980s constitutes a clear break with the past. Indeed, in tandem with matching initiatives in other social security schemes – e.g., their unemployment, sickness and social assistance schemes – these efforts amount to a reconstruction of the entire Dutch social security system (Van Oorschot, 1998b). The Dutch system in general, and the disability scheme in particular, arrived at a point of crisis when its collective nature was challenged by turbulence in the international economy. In Norway, where some of the same modifications were introduced a few years after the Dutch initiatives, developments over the last decade are best conceived of as a reorientation of the social security system (Drøpping and Hvinden, 1996). Norway encountered less severe cyclical problems than those experienced in the Netherlands, but a continued steep increase in the number of recipients, and therefore in expenditure, was defined as unacceptable in the late 1980s. The recession in the mid-1980s may have contributed to this but arguably the roots of the problems went back much earlier. For instance, we have noted how the rehabilitation requirement remained a dead letter in Norwegian disability legislation throughout the 1970s and 1980s. This represented an erosion from an *integration-led* policy in theory to a *choice-led* policy in practice.

In the Netherlands, the first major call for change came in 1986 with the WAGW (Act on Work for Disabled Workers). Aiming to reduce the extent of disability through labour market intervention, e.g. workplace accommodation, the WAGW was the first Dutch act which attempted to deal with the growing number of disabled workers and claimants of disability benefits as its primary concern. The WAGW did not contain much in the way of new reintegration measures, but the perceived importance of labour market intervention as a means of promoting the chances of disabled people clearly reflects a commitment to this end. The WAGW highlighted the responsibility of society as a whole to increase

labour market participation among the disabled. Training was seen as an investment leading to lower costs through more efficient resource allocation. Adding a range of measures which sought to persuade employers to assume greater responsibility for disabled workers, the resulting picture is a mix between integration-led and incentive-led policies. Despite the lack of innovation in the area of reintegration (and the lack of commitment to implementation), the most interesting observation is that the WAGW represents a farewell to the choice-led model that had characterized Dutch disability policy.

Similarly, the 1992 TAV (Act on Reducing the Disability Volume) and the 1993 TBA (Act on Reducing Disability Claims) were also primarily 'volume' measures. Presented as elements of a new broader policy aimed at stimulating employers and administrative bodies, the main financial 'stick' and 'carrot' introduced in the TAV was the *bonus-malus* (subsidy and fine) system.[15] At the same time, administrative bodies were presented with more generous budgets to be spent on training and schooling of the disabled. In contrast to the TAV, the TBA was more explicitly directed at claimants of disability benefits. The main 'volume' initiatives were more restricted access to the WAO benefit and a reduced eligibility period for the wage-related benefit.[16] The act clearly reflects policy-makers' belief in a substantial amount of 'hidden unemployment' in the disability scheme (cf. also OECD, 1998b, p. 82). The (re-)integration measures introduced by the TBA are primarily concerned with making disability benefit less accessible and less attractive for workers.

The government's intention to fine employers for failing to retain disabled workers met with strong resistance from the federations of employers. Administrative agencies faced considerable difficulties in implementing the measure. As the fine was found by the Court to be

15 The *bonus-malus* system awarded a once-off subsidy to employers hiring a disabled worker for at least one year, together with an additional 20 per cent wage subsidy. The 'malus', on the other hand, would come into consideration if an employee was fired as a result of acquiring a disability at work.

16 A number of specific measures were implemented in this strategy. First, the reference standard for the degree of (vocational) disability was changed from 'suitable' to 'generally accepted' work (a change in phrasing strikingly similar to the change in Norway two years before); the immediate results of which were an extension of the range of jobs available to the disabled, as well as rendering (re-)training and (re-) schooling more important as means of acquiring the skills necessary to obtain and hold a job. Second, re-assessment (according to the new reference standard) of every existing claimant of the WAO benefit younger than fifty years, and routine five-year re-assessment of all new cases. Third, certain categories of the disabled became eligible for a substantial personal subsidy (maximum three years) if accepting a job or extending their work-hours.

contrary to the principles of the Convention on Political and Civil Rights, it was abolished in the 1995 AMBER (Act on the Abolishment of the Malus and Stimulation of Re-integration). Partly to compensate for the loss of this particular policy instrument – but also as a means of furthering the attack on the volume of disability, which was still perceived as unacceptably high – AMBER introduced a number of new financial measures. Directed at employers as well as employees, these new initiatives were all designed as positive incentives. Among the measures were an extension of the wage subsidy provided to employers under the TAV and the introduction of a wage supplement for disabled workers facing reduced income as a result of accepting work. They also included a guarantee to disabled workers over the age of 50 of retaining their old benefit level if they had to stop working again; as well as the possibility of working in a 'test-job' without loss of benefit eligibility.

All in all, the TAV, the TBA and the AMBER represent a continuation of the WAGW in their measures to reduce the volume of disability, but a few observations nevertheless serve to distinguish the legislation of the 1990s from that that went before. First, (re-)training of the disabled (as a means of investment) obtained a much more prominent position in the TAV than it previously had. Second, particularly apparent in the TBA and the AMBER, individual responsibility for increased labour market participation was promoted by means of incentives; most notably by reducing the attractiveness and accessibility of disability benefit. Incentives were also brought to the forefront in the 'bonus' and 'malus' system targeted at employers. In both cases, the accounts by means of which the initiatives were promoted highlighted societal interests. Third, we find a clear intention to achieve more efficient resource allocation in disability policy – especially in terms of the costs associated with an imbalance between 'actives' and 'inactives'. This all suggests that important elements of the TAV, the TBA and the AMBER point towards an incentive-led policy, which accentuated the reconstruction process initiated by the WAGW in 1986.

This impression of a turn towards an incentive-led model in the 1990s is underscored by the 1998 REA (Act on Reintegration of Handicapped Persons on the Labour Market), which replaced the WAGW as the legal framework for (re-)integration policies. This recent initiative contrasts with its 1990s predecessors, in displaying a somewhat more explicit concern with the interests of disabled people. Employers and unions were expected to take on a general responsibility for raising the labour market participation rate among people with disabilities. The REA contained

several new incentives for employers and employees,[17] but the government emphasized that it would be up to the social partners to make use of the new measures and no institutional pressures can be identified in the act. With its emphasis on the interests of the disabled, the REA represents a mix between incentive- and integration-led models. Nevertheless, the fact that it relies on financial incentives as the primary means of promoting integration suggests a bias towards the former orientation.

In Norway, the 1992 White Paper on Rehabilitation (St. meld. nr. 39, 1991-92 – WPR) marked the beginning of the government's reorientation of social policy. Following two 1990 Green Papers on the Sick Wage Scheme and Disability Pension (NOU, 1990, pp.17/23), the WPR signals the advent of a government offensive to deal with the tendency of increasing exclusion from the labour market that had become notable throughout the 1980s. The complexity of this problem inspired a strategy comprizing a number of initiatives along several paths in most social policy areas. The common denominator was the strong belief in paid employment as a condition for individual welfare. In disability policy, this 'Work Approach' refers, above all, to reducing the influx of new claimants through an escalation of rehabilitation and other 'active' measures.[18]

The 1990 Green Papers on the Sick Wage Scheme and the Disability Pension, on which the recommendations in the WPR were largely based, had contained the first signs of a new direction in Norwegian social policy. Both papers included discussions regarding the potentially negative work incentives embedded in the income maintenance schemes.[19] After this issue had been given attention in preparatory documents for the 1960s reforms, it remained more or less dormant for a long period. When both committees

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17 On the demand-side, one measure was to award a fixed budget with which the employer could implement any workplace adaptations necessary to hire a disabled worker. Furthermore, any employer spending more than five per cent of the wage costs on disabled employees would be liable for a reduction in WAO contributions. Finally, sick pay for any disabled employee would be paid from the national sickness fund rather than the employer, thus persuading risk-aversive employers to hire.

18 The WPR reserved the term 'rehabilitation' for initiatives aimed at helping people with reduced earnings capacity and limitations in occupational choice (back) into employment. On the administrative level, this implied that a sharper separation was made between vocational rehabilitation and medical treatment. The most tangible result of this separation was the transfer of the budgetary and administrative responsibility for vocational rehabilitation services from the National Insurance Administration to the Labour Market Service in 1994 (see Ford and Hvinden (1997) for an evaluation of the reform).

19 An issue later addressed more thoroughly by the 1992 Green Paper on 'A National Strategy for Increased Employment in the 1990s' (NOU, 1992, p. 26). Although the replacement rates of Norwegian social security benefits have remained largely intact throughout the 1990s, this green paper proposed a number of curtailments.

started to accentuate how benefit arrangements might create disincentives, the issue gained greater prominence in the social policy discourse. The discussion of the two papers also emphasized issues of efficiency. For instance, the Green Paper on Disability Pensions stressed that rehabilitative resources should be targeted towards those groups who were most likely to benefit from such efforts. These concerns are perhaps best illustrated by the proposal, later enacted in the Green Paper on the Disability Pension, to introduce more binding requirements of professional and geographical mobility in the assessment of claims for disability benefit.

When comparing the Norwegian and Dutch cases, it is interesting to note how the 1992 WPR explicitly expressed a desire to supplement the rather one-sided reliance on financial instruments to encourage employers to hire disabled job-seekers (mainly through wage subsidies).[20] Instead, it was argued, the state should provide more information and guidance on good practice in order to promote employers' active involvement in, and responsibility for, rehabilitation. Nevertheless, the primary reason for concluding that the WPR signals the advent of an *incentive-led* policy is the way in which the Work Approach of the 1950s and 1960s was relaunched as a guiding principle for the policy reforms of the 1990s. According to the WPR (p. 8): 'the basic premise of a social insurance system is that individual rights are not exclusively tied to cash benefits; each individual has [...] a right and a duty to work, participate in rehabilitation programs or enter education [...].'

While the White Paper on Rehabilitation was concerned specifically with health-related benefits, the 1995 Welfare White Paper (St. meld. nr. 35, 1994-95 – WWP) reviewed the entire system of social protection. Clearly adopting the Work Approach, the WWP focused on a number of objectives: to achieve a more equitable redistribution of welfare, to reduce the need for cash transfers from the economically active to the non-active, and to increase the number of persons in a position to contribute to the financing of social security. Inasmuch as the WWP represented a confirmation and reinforcement of the Work Approach, the impression of a shift towards an incentive-led policy is strengthened.

The 1998 Plan of Action for the Disabled 1998-2001 (St. meld. nr. 6, 1998-99 – PAD) follows up this emphasis on the role of financial incentives, but it also contains significant elements of a rights-led policy. The PAD relies on a conception of disability as a 'mismatch between

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20 Among other reasons for shifting the emphasis, the government suggested that wage subsidies could cause a focus on the authorities' financial support rather than employers' individual responsibilities, and that the effects of the existing financial inducements were dubious (*see also* discussion by Vik, 1999).

individual abilities and society's requirements in areas instrumental to establishing and maintaining an independent social life.' This definition is noteworthy, both as a contrast to the more limited functional or 'medical' concept that had previously dominated, as well as a quite explicit recognition of the 'social model' of disability (Oliver, 1990). The PAD also signaled the establishment of a Public Commission to explore issues related to disabled people's rights, a subject which is discussed in a human rights context. Although such 'Action Plans' as a rule abound with good intentions and references to somewhat idealistic goals, an emerging discussion on the prospects of a more rights-based approach in Norway lends some credibility to the signals of the PAD.

The 1999 White Paper on Income and Living Conditions (St. meld. nr. 50, 1998-99 – WPILC) is only partly concerned with disability, but is included here because it launched the concept of a 'Softer Work Approach'. The normative principle informing the WPILC is that 'contributing to high participation rates is the best distributive initiative.' It presents an assessment of the Norwegian Work Approach in the 1990s, and concludes that a more demanding labour market might have become less accessible to people with long-term health problems. Against this background, it is argued, the Work Approach may have contributed to sending people back and forth in the welfare bureaucracy until they finally end up on disability pension. The Softer Work Approach is outlined in order to avoid a situation in which a disabled person obtains neither permanent employment nor a stable income replacement, e.g. disability pension.[21] In the accounts of this modified Work Approach, the prominence of individual concerns is worth noting. While the government declares its support for the principles of the Work Approach – inasmuch as it signals a right to work also for vulnerable groups in the labour market – it also brings the experience of the individual disabled person to the forefront. The fact that almost all the components of the Softer Work Approach are related to health-related schemes suggests that the issues of gaps and of falling between stools have come to occupy a prominent place in the Norwegian social policy agenda.

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21 The main components of this work approach will be experiments with a five-year wage subsidy to people with reduced earnings capacity (increased from a maximum of three years); eligibility for disability pension from 30 per cent disability (reduced from 50 per cent); and increased efforts at re-activating the disability pensioners through 'networks of motivation'. A fourth suggestion pertains to the activation of long-term claimants of social assistance.

6. Conclusion

The first part of the paper illustrated how turbulence in the labour market posed serious challenges for social protection systems in general and for disability policies in particular. In both the Netherlands and in Norway, these systems have – in the words of Esping-Andersen (1990, p. 28) – been 'genuinely committed to a full-employment guarantee, and entirely dependent on its attainment'. The pressure on social protection systems became a matter of concern in both countries, although earlier in the Netherlands than in Norway. In both countries, health-related benefit schemes became prime targets for reform initiatives, partly due to the assumption that behind the increasing number of beneficiaries of these schemes, was a growing amount of 'hidden unemployment'.

Two strategies – or a combination of them – have been available to the governments of the two countries: introducing cuts in benefit levels and duration, and modifying or enforcing more systematically the rules of conditionality. The Norwegian Work Approach of the 1990s has so far primarily subscribed to the latter strategy: stricter qualifying criteria, shorter maximum duration for some benefits and an increased emphasis on rehabilitation and re-insertion. To the extent that the 'generosity' of benefits has been affected, it has mainly been expressed through changes in the duration of the eligibility period. This characteristic has so far distinguished the Norwegian strategy from its Dutch counterpart, and it also singles Norway out in comparison with the other Nordic countries (Stephens, 1997, p. 52). This preference for a 'soft' and 'socially acceptable' strategy of public cost-control (Drøpping *et al.*, 1999) may have been facilitated, at least in part, by a broad national consensus reflecting a compromise between the social partners. Another important factor has probably been the fact that Norway experienced a more favourable economic situation than the Netherlands, due to its substantial oil revenues, even through the recession of the early 1990s.

The Netherlands, on the other hand, has subscribed to a diverse mix of measures. In addition to the curtailments of disability benefit and sick pay replacement rates, put into effect from 1987 and onwards, successive Dutch movements towards a complete privatization of sick pay have not been matched by the modest alterations discussed and implemented in the Norwegian scheme. The OECD (1998b, pp. 78-79) asserts that while the Dutch reform proposals of the 1980s were driven mainly by budgetary considerations and the need for fiscal consolidation, the main objective of reforms in the 1990s has been to redesign the social security system itself. Our analysis supports this reading and suggests that the paralyzing notion of 'crisis' in the 1980s eventually paved the way for a more coherent strategy in the 1990s. The legislation relating to disability has become far

more specific with respect to the prescribed measures of (re-)integration, and although the actual implementation of measures may so far have failed to produce the desired results, issues relating to disability benefits have certainly been placed high on the agenda. Moreover, the social partners – especially the employer associations – have come to be recognized as active participants and stakeholders in the process of reconstruction.

Our main objective in this article has been to identify the particularities of the assumptions informing the related turns of social policy in the two countries. We have identified some notable changes in these underlying assumptions: first, training (widely defined) has been attributed a greater role in the (re-)integration of disabled people over the last decades, a development particularly discernible in the Netherlands, where such supply-side measures have traditionally been relatively modest. Moreover, training of the disabled is incorporated as an essential part of general active labour market policy (ALMP) in both countries. In both Norway and the Netherlands, the rationale behind this shift appears to be a renewed emphasis on investment, i.e. on human capital. While this highlights the 'collective' benefits of integration, concerns with the opportunities and responsibilities of the individual appear to have played an increasingly important role in the political discourse as well.

The relative role of training cannot be assessed, however, without a closer look at cash benefits. While not trivializing the benefit curtailments that have occurred both in Norway and (especially) the Netherlands, it remains clear that neither of the countries has attempted to pursue the radical strategies adopted elsewhere (see, for example, Pierson, 1994, p. 139 ff.). Changes in benefits, in the Dutch and Norwegian contexts, have primarily served to highlight notions of conditionality and responsibility. Cuts in benefit levels have ranged from limited to moderate and appear mainly to have been introduced as incentives to increase labour market participation, rather than as direct cost-saving measures. Despite these similarities, it is clear that behavioural incentives have been targeted towards distinctively different actors in our two countries. While Norwegian policy-makers in the early 1990s decided to reduce the financial inducements for employers and extend the guidance role of the authorities, their Dutch counterparts actively opted for a sticks and carrots strategy *vis-à-vis* employers. Conversely, modification in individual benefits has been given a far more prominent role in Norway than in the Netherlands.

It is beyond doubt that both countries today pay more attention to efficient resource allocation and societal interests in this area than was previously the case. Simultaneously, however, in the Norwegian discourse attempts to achieve the best of both worlds can be found. Recent initiatives point towards incentive-led policy assumptions; yet it is striking to observe the extent to which successive initiatives have also been justified with

reference to equity concerns and individual welfare. Part of this Norwegian rhetorical mix may be attributed to the fact that claims for investment in human capital and improved opportunities for those concerned permit more verbal leeway than initiatives informed by financial concerns *per se*. We may speculate that such accounts serve to convey reassurance to the supporters of a welfare system which enjoys widespread public support. In the Dutch case, it was not until the 1998 REA that equity and individual concerns became prominent ingredients in disability policy accounts.

The main conclusion of this comparison of the changing assumptions behind disability policies in the two countries is that the Norwegian development may largely be seen as a return to, and revival of, the partly forgotten, partly eroded assumptions behind its original social protection scheme, whereas the Dutch policy shift amounts to a more fundamental reconstruction of the whole social security system.

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