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Neo-liberal Convergence of European Welfare State Policies?

The Case of Sickness Benefit Schemes

BACHELOR THESIS

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Abstract

The debate on welfare state change, its scope and its direction, is far from settled. This thesis aims at contributing to the debate and does so by providing a description and analysis of the development of the sickness benefit schemes in three European countries (the United Kingdom, the Netherlands and Sweden) over a period of 35 years (from 1975 to 2009) to see whether a process of (neo-liberal) convergence of policy goals (that is, paradigm convergence) can be observed. An answer to the central research question is sought through a qualitative longitudinal cross-country comparison that is executed on the basis of legal texts, of (accompanying) governmental documents, and of scientific literature. Sub-questions that are guiding the research project are as follows: How have the English respectively Dutch respectively Swedish sickness benefits schemes developed over a period of 35 years? Can common trends be detected in (paradigms underlying) these developments? In which direction(s) do these common trends point? And how do these common trends relate to the current theoretical and conceptual framework? On the basis of the descriptions and analyses provided, it is found that some paradigm convergence has indeed taken place in the field of sickness benefits and that this convergence has clustered foremost around the neo-liberal ideals of activation and individualisation. It is also stressed, however, that it is traces of (neo-liberal) convergence that are identified rather than an 'absolute' process of ideational convergence, thus questioning the 'true' applicability of the concept of neo-liberalism.

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1 Introduction

While the European Union has reached significant results with regard to the development of shared economic institutions, the creation of a common framework for social policy has appeared to be a much more difficult task (e.g. Moreno & Palier, 2004). Consequently, direct influence of European social policy at the national level is still rather contested (e.g. Pochet, 2006; Jacqot, 2008). Discussing European social integration, Threlfall (2003) has distinguished a fourfold typology of social integration processes present in the European Union. Social security (benefit) schemes, the social policy area with which this research, broadly speaking, is concerned, is placed by Threlfall into the category representing the lowest level of integration, that of convergence, implying that the nation-state is still the principle level at which welfare generosity is dealt with.

This research concerns such a process of (possible) convergence. The past decennia, characterised by economic globalisation, demographic ageing, and growing unemployment rates (e.g. Heidenreich & Zeitlin, 2009; Taylor-Gooby, 2002), have challenged the European welfare states, putting national governments "under pressure to reform their social and labour market policies" (Heidenreich & Zeitlin, 2009, p. 1). Although a significant part of the scientific literature has stressed that "the European welfare settlement is (so far) surprisingly resilient in the face of the[se] current challenges" (Taylor-Gooby, 2002, p. 597), a more recent wave of literature has come to point at the weaknesses of such institutionalist approaches and has opted instead for the visibility of change. This thesis aims at contributing to the debate (and accordingly to the available theory) by testing *whether* the pattern that might be expected on the basis of current theory also occurs empirically in a specific area of the welfare state and even of social security (i.e. a deductive inquiry). More specifically, by executing a longitudinal cross-country comparison of the development of sickness benefit schemes, this research aims at analysing whether common (ideational) trends can be detected when this specific part of three countries' social security systems is studied empirically (these three countries – the United Kingdom, the Netherlands and Sweden – being selected on the basis of their traditionally different welfare state policies). It should be added that the debate has turned to be even more interesting since the introduction of soft law mechanisms on the European scene. As it has been more than a decade since the European Employment Strategy has been institutionalised, the efforts should have started to pay off by now, leading indeed to converging results (on the level of policy goals). Based on the ideas promoted within in this framework and on other pressures resulting from European cooperation, such convergence is likely to revolve around the neo-liberal theory. Consequently, the central question of this thesis reads as follows:

When comparing the development of the sickness benefit schemes of the Netherlands, Sweden and the United Kingdom, can a process of convergence of policy goals be traced, and if so, does this convergence point in a neo-liberal direction?

An answer to this main question will be sought through the following sub-questions:

- *How have the English respectively Dutch respectively Swedish sickness benefits schemes developed over a period of 35 years?*
- *Can common trends be detected in (paradigms underlying) these developments?*
- *In which direction(s) do these common trends point?*
- *How do these common trends relate to the current theoretical and conceptual framework?*

In the following attention will first be paid to the theoretical framework underlying the hypotheses that will be tested throughout this thesis. The third section, subsequently, will focus on the methodological

choices that have been made in order to test these hypotheses. Descriptions of the development of the national sickness benefit schemes are provided in section four, five and six, as is a first indication of the neo-liberal character of the changes implemented over the years. The different paths of development will be compared in the seventh part of this thesis and, accordingly, the validity of the hypotheses will be assessed. Finally, in the concluding eighth section, an answer will be provided to the central research question, the theoretical relevance of the study will be highlighted and the limitations of the study will be discussed.

2 Theoretical Framework

2.1. Welfare state change: Converging paradigms

The period ranging from 1945 to 1975 has been labelled the 'Golden Age of the welfare state'. During these early post-war decades, nation states were still "able to control their own economic boundaries and the conditions under which transnational economic transactions would take place" (Scharpf, 2000, p. 191). Consequently, they were also able to use their "capacity for market-correction action", amongst other things, to deliver "social insurance against the risks of sickness, invalidity, unemployment, and old age" (2000, p. 192). However, in the 1970s, changes in the international environment brought the "virtuous dialectic between economic growth and social policy development […] to an end" (Ferrera, Hemerijck, & Rhodes, 2001, p.166), indicating the erosion into a 'Silver Age'. As those circumstances favouring the expansion of welfare in the Golden Age were reversed (Taylor-Gooby, 2002), constraints were introduced to the pursuit of the welfare goals, making it "increasingly difficult for advanced welfare states to deliver on their core commitments of full employment, social protection, and reduced inequality" (Ferrera *et al*., 2001, p. 166). Still, according to Pierson (1996, p. 149), such "tendencies toward fragility [had to] be weighed against the considerable sources of welfare state stability", thus pointing at a process of resistance (i.e. institutional inertia). Accordingly, institutionalists, like Pierson, have continuously described European welfare settlements as being "surprisingly resilient" (Taylor-Gooby, 2002, p. 597). For them, "[p]ath dependency is certainly the theoretical key word, enhancing continuity over change" – that is to say, they argue that current reforms are reinforcing each model's logic (Jacqot, 2008, p. 11). However, according to Streeck and Thelen (2005, p. 1), such an account includes a "conservative bias" and is "ill-equipped to capture significant developments underway", as it fails to recognise the possibility of "gradual transformation" (2005, p. 9; see also Heidenreich, 2009, p. 10)[1]. Bannink and Hoogenboom (2007, p. 31) have, conclusively, argued that "[c]ontrary to what institutionalists think, the welfare state is not necessarily stagnant and development is not necessarily path-dependent. Instead there is continuous change".

This thesis is concerned with identifying *change* at the level of policy goals and outputs, rather than at the level of benefit recipients (so the actual level of social protection or the 'outcomes'). To assess the amount of change – i.e. its scope – I will, in principle, make use of and refer to Hall's work, in which policy-making is described "as a process that usually involves three central variables: the overarching goals that guide policy in a particular field, the techniques or policy instruments used to attain those

[1] It fails to recognise such a cumulative effect of incremental changes, amongst others, because of its regime approach (e.g. Moreno & Palier, 2004; Bannink & Hoogenboom, 2007) and because of its underestimation of the capacity of external forces, such as European economic integration (see Sainsbury, 2001, p. 261)

goals, and the precise settings of these instrument" (1993, p. 278). It is the former that, according to Hall, is "marked by the radical changes in the overarching terms of policy discourse associated with a 'paradigm shift'", whereas the latter two can generally be considered instances of "normal policy[-]making" (1993, p. 279)[2]. Though acknowledging the value of Hall's categorisation (and, specifically, its inclusion of ideational change), van Gerven and Beckers (2009) have criticised the hierarchy inherent in the classification. Rather, recognising "a reverse sequence of learning" (2009, p. 79), they propose not to engage in making assumptions about the order of change. Accordingly, for the purposes of this thesis, change will be associated with a shift in policy goals, also when occurring in 'isolation' – a claim that appears quite reasonable given that international, and more specifically European, benchmarking procedures (such as the Open Method of Coordination (OMC)) are "used to determine the policy priorities and goals, rather than their detailed implementation" (van Gerven & Beckers, 2009, p. 62). Indeed, Jacqot (2008, p. 18) has argued that "influence is not necessarily to be found in the imposition of a common solution, but rather in common trends", referring to the concept of "ideational convergence".

The debate on whether change reflects such a process of convergence – or rather divergence – has, so far, remained unsettled (e.g. Haupt, 2010). Whereas Jessop (2006, p. 157), for instance, has concluded that "we can expect continuing divergences in economic and social policy regimes, reflecting the path-dependent legacies of different models of capitalism, different balances of forces and different accumulation strategies and hegemonic projects", Moreno and Palier (2004, p. 6) have found that "a degree of convergence in output and outcomes produced by the European welfare states is undeniable if one compares the present situation with that thirty years ago". As appears from these two contradicting findings, what is to be expected is again very much dependent on the conceptualisation of convergence as opposed to divergence. If change is occurring, I consider this change to be of a converging nature when, following Knill (as quoted by van Gerven & Beckers, 2009, p. 69), there is "any increase in the similarity between one or more characteristics of a certain policy across a given set of political jurisdictions over a given period of time". More concretely, although it is true that, for instance, "similar reforms implemented in different national policy and institutional contexts obviously do not have the same outcomes" (Sainsbury, 2001, p.258), this does not allow to conclude that no convergence has arisen *per se*. Indeed, for the concept of convergence to be relevant and applicable, the different welfare state regimes do not have to become alike or identical. Rather, it allows for "the national 'ways of doing things'" (van Gerven & Beckers, 2009, p. 65), thus not challenging the claims about path-dependent reforms as such.

In line with such a conceptualisation, the 'kind of convergence' with which this thesis is primarily concerned is *paradigm convergence*, that is, "convergence in the policy paradigms and cognitive filters in and through which [...] pressures and challenges are identified and understood" (Hay, 2004, p. 245). It should be stressed that this type of convergence is only concerned with a specific stage in the process of policy-making. Accordingly, other "referents of convergence" that have been identified by Hay (2004, p. 245-246) are input convergence, policy convergence, convergence in legitimatory rhetoric, outcome convergence, and process convergence. Although the focus of this research is on convergence of the underlying paradigm, the processes of input and policy convergences are also relevant, since the hypothesis on the direction of change is mainly derived on the basis of the common (EU) pressures to which the welfare states are exposed (*input convergence*), and since the analysis will

[2] It should be emphasised that this approach is, for instance, very similar to Paliers' framework (2000) in which fundamental change is linked to the rise of a new political logic (as described by Sainsbury, 2001, p. 261).

be conducted at the level of policy output or policies pursued (*policy convergence*). With regard to paradigm convergence, it is interesting to note that the influence which the European Union is seeking to exercise in the area of social policy through the OMC is indeed "less aimed at harmonising [...] than at bringing into line ideas, visions, conceptions, knowledge and norms of action, in order to have policy goals converging towards a common political vision of social protection in the European Union" (Moreno & Palier, 2004, p. 14). Based on these considerations, the following hypothesis can be derived:

Hypothesis one: On the level of policy objectives, different national systems of social security are expected to converge.

2.2. A neo-liberal trend

In the previously identified Silver Age, European welfare states are confronted with multiple challenges. Ferrera *et al*. (2001, p. 171) have used the term "quicksand effect", to indicate "the phenomenon whereby welfare structures designed for a different era become bogged down [...], generating negative effects, destroying incentives, and making redistributive policies inefficient, while the productivity of welfare services themselves declines and their cost increases", hence the pressure to reform. To start with a more general remark on the direction in which such reforms are likely to take place, I would like to refer to Offe (2003, p. 446), who has suggested that Continental European capitalism and Anglo-Saxon capitalism "are tied to each other in an asymmetrical relation of entropy […, as] it is much more likely that a European-style capitalism transforms itself into a liberal model than that the Anglo-Saxon model becomes 'Europeanised'". Freely 'translated', this implies that it is harder to move away from a neo-liberal paradigm than to move towards it (indicating the existence of relatively neo-liberal-friendly context). A comparable conclusion, albeit implicitly, has been reached by Scharpf (2000, p. 219), arguing that for Anglo-Saxon welfare states, "[i]n comparative perspective, [...] neither employment nor the financing of the welfare state appears to be an acute problem", while the latter is considered to be a problem confronting the Scandinavian (social-democratic) welfare states, and the former challenging the Continental (conservative-corporatist) welfare states.

One of the main neo-liberal starting points is that "labo[u]r market rigidities are at the root of employment problems [...] and that deregulation is the solution", as these rigidities, such as welfare state generosity, "prevent the labo[u]r market from producing optimal outcomes" (Bradley & Stephens, 2007, p. 1488). Indeed, "antagonism to the welfare state" has been described as "one of the most distinctive neo[-]liberal traits" (Giddens, 1998, p. 13). Clarke has distinguished "two privatisations in the process of neo-liberal remaking of the public realm" (2004, p. 32), namely "the shift of activities, resources and the provision of goods and services from the public sector to the private sector" (2004, p. 32) and "the shift of social responsibilities from the public sphere [...] to the private sphere" (2004, p. 33). Whereas the former type of privatisation is particularly relevant for the question of which actor is to be responsible for the provision of social security benefits (this responsibility referring to both financial and managerial aspects), the latter refers mainly to the process of individualisation and increased self-responsibility on the level of the benefit recipient. From this perspective, it is argued that a higher level of passive benefits and a longer duration of receipt may reduce people's incentives to get 'inside' the labour market again. The legacy of neo-liberalism, then, seems to be very much related to what has been coined 'Work First' by Bruttel and Sol (2006, p. 70), focussing on "putting participants into jobs as quickly as possible" and, thus, "prioritising labour market attachment" (2006, p. 71). The term 'activation', to be defined as "increasing labour market entry and participation, and phasing out temporary labour market exit options for working age

claimants" (Clasen & Clegg, 2006, p. 528), seems a relevant one in this respect. However, although the increasing levels of self-responsibility and individualisation through activation are to be found at the core of the neo-liberal debate, it should be emphasised that neo-liberalists have been argued to have taken a rather sceptical stance towards active labour market policies (e.g. Bradley & Stephens, 2007). Indeed, what seems to distinguish neo-liberalism from the so-called 'Third Way' (Green-Pedersen, van Kersbergen & Hemerijck, 2001) is that those supporting the 'Third Way' approach "are not laissez-faire neo[-]liberals". Rather, they tend to argue that "sweeping deregulation is not the answer" (Giddens, 1998, p. 122) and that "[f]lexible markets must [therefore] be combined with a newly defined role for an *active state*" (Green-Pedersen *et al*., 2001, p. 312, emphasis added), particularly in the form of a "social investment state" (Giddens, 1998, p. 117).

If neo-liberal convergence really is to take place, socio-economic policies and institutions are expected to cluster around "market-friendly practices which favour smaller governments, reduced provision of social services and lower levels of taxation and deregulation" (Haupt, 2010, p. 8). It is in this respect that Clarke has labelled the neo-liberal strategy "anti-welfarism" and "anti-statism" (2004, p. 30). In terms of economic policy, neo-liberalism is, amongst others, to be associated with liberalisation of markets and monetary policy committed to low inflation (e.g. Haupt, 2010). As will be shown in the following, European (economic) integration, has 'forced' the member states to adopt neo-liberal economic policies, this way, in my opinion, paving the way for the adoption of more neo-liberal social policies as well.

Neo-liberal policies in the European Union

As has been recognised by van Gerven and Beckers (2009, p. 61), "[a]lthough the main driving forces behind welfare reform in today's European welfare states remain predominantly national, such processes of reform no longer take place in 'splendid isolation'". Although Ferrera *et al*. (2001, p. 174) have reasoned that "convergence on a neo[-]liberal set of values and solutions" is not inevitable, in the following, I will argue, by referring to relevant literature, that these external forces *do* increase the potential for neo-liberal transformations. The focus will be on the influence of European integration, which has been described as "an 'intense' case of globali[s]ation" (Haupt, 2010, p. 7).

Although the role of the European Union within these (possible) processes of change and convergence is only scarcely taken into account, it has been found that "[i]nfluencing national ideas in welfare policies has become one of the main targets of the EU" (Moreno & Palier, 2004, p. 13). This influence takes place in two main ways, namely indirectly and 'voluntarily' (Pochet, 2006) (although no consensus exists on the actual degree of voluntariness (e.g. Kröger, 2009)), and has stimulated the European welfare states to transform "into semi-sovereign entities with a pro-market bias" (Moreno & Palier, 2004, p. 11). Indirectly, European "economic integration has largely contributed to the evolution of the general economic context in which social policies are implemented" (Jacqot, 2008, p. 13-14), this context being "already biased in favour of liberalism and [... representing] an ideological climate dominated by neo-liberalism" (Jessop, 2006, p. 148). Especially the establishment of the European Monetary Union (EMU) (and its accompanying Maastricht criteria) and the Growth and Stability Pact have reduced the available options for national governments to regulate and take action, "exacerbat[ing] pressures in favo[u]r of austerity" (Ferrera *et al*., 2001, p. 167) and thus making it harder for member states "to escape the neo-liberal framework" (Jessop, 2006, p. 148). Accordingly, Jacqot (2008, p. 13) has noted that "one can trace a direct link between the Maastricht criteria [...,] the reali[s]ation of the EMU, and the content, or at least the orientation, of contemporary welfare state reforms". Referring to Pierson's (1996) arguments on blame avoidance, one could also argue that these restrictions allowed for the possibility of reform as "changes and policy reforms [could be and]

were justified by most governments as required in order to meet the Maastricht criteria" (Moreno & Palier, 2004, p. 8; see also Visser, 2000, p. 442).

To compensate (at least symbolically) for the European Monetary Union, a process of 'horizontal Europeanisation' (e.g. Jacqot, 2008) has developed. The so-called Open Method of Coordination is based on the "iterative benchmarking of national progress towards common European objectives" (Heidenreich & Zeitlin, 2009, p.1). Subsequently, it "should be a means of spreading best practice and achieving greater convergence towards the main EU goals" (Kröger, 2009, p. 2). Although the effectiveness of this method of 'soft law' is still very much debated, recent literature has also become quite 'critical' with regard to its 'message'. Far from being a neutral policy instrument, the OMC is found to be "supportive of a neo-liberal discourse [– as it "is seen to transport a neo[-]liberal understanding of competence-sharing between state, market and individual, privileging the market over social rights and the individuali[s]ation of social risks" (2009, p. 5) –] and supply-side policies" (2009, p. 12) – "encourag[ing] to 'un-learn' the traditional continental welfare model" (2009, p. 5). Consequently, it has been argued that "the OMC may not only be largely ineffective in preventing welfare state retrenchment; in fact, it may even contribute to it" (2009, p. 11). This is not surprising when taking into account Jessop's remark (2006, p. 150) that the EU has made a "general commitment to the reorientation of economic and social policy [... on the basis of] post-national 'embedded neo-liberalism'". That there has been an ideological shift towards neo-liberalism within the European Union (see also Haupt, 2010, p. 6) already becomes quite clear from one of the 1992 recommendations by the European Commission's General Directorate, promoting "the decrease of 'social burdens' [...] on firms [and proposing] to render social protection more employment-friendly and switch from a passive to an active social policy framework" (Moreno & Palier, 2004, p. 16). In 1997, moreover, as a (less radical) follow-up, the European Employment Strategy (EES) was launched by the Council to change the 'mental map' of policy-makers (see Heidenreich & Zeitlin, 2009, p. 3), to initiate "a 'radical policy reorientation [by] replacing the old 'wait and see' attitude – the politics of passivity – with a new active, preventive policy'" (Larsson, 1998, as quoted by Visser, 2009, p. 37), this way defending equal opportunity instead of (the traditional social-democratic) equal outcomes (e.g. Visser, 2000, p. 450).

These theoretical considerations are backed up by the general empirical finding that "we are witnessing how a reduction in the traditionally high protecting intensity of welfare benefits, together with a hardening of the criteria of access and eligibility to welfare entitlements, has taken place in Continental Europe" (Moreno & Palier, 2004, p. 6-7). Accordingly, the second hypothesis to be tested for the purposes of this research can be formulated as follows:

Hypothesis two: Ideational convergence of sickness benefit schemes is expected to take place in a neo-liberalist direction.

3 Methodological Choices

3.1. Case selections (and consequences for generalisability)

Selection of countries

The three countries selected for my thesis are chosen on the basis of the regime theory developed by Esping-Anderson (1990), as they are said to represent the three main welfare state regimes present in the European Union. Esping-Anderson's classification is based primarily on the different levels of de-

commodification, where de-commodification is occurring "when a service is rendered as a matter of right, and when a person can maintain a livelihood without reliance on the market" (1990, p. 22). De-commodification, thus, is a principle that runs contrary to the legacy of neo-liberalism "with its rock solid confidence in the 'free' market" (Green-Pedersen *et al*., 2001, p. 310). Translated to the specific topic of sickness benefit schemes, this means that for a welfare state to be considered 'perfectly' de-commodifying "a sickness insurance that individuals be guaranteed benefits equal to normal earnings, and the right to absence with minimal proof of medical impairment and for the duration that the individual deems necessary" would be required (Esping-Anderson, 1990, p. 23), whereas neo-liberal pressures would push in exactly the opposite direction. This level of de-commodification, then, is supposed to be highest in social-democratic Sweden, lowest in the liberal United Kingdom, and the conservative-corporatist Netherlands is to be located in the middle. It should be emphasised though that these different regimes are to be considered ideal types. That is to say, they "will never have a perfect fit with existing realities, and such typologies may obscure the actual variations among countries" (Korpi & Palme, 1998, p. 665). Indeed, keeping in mind the observation by Bannink and Hoogenboom (2007) that welfare state regimes are often hybrid (consisting of various risk approaches), this implies that the possibilities for generalisations (to other countries located within the same regimes) are rather limited. Still, this should not be a major problem. In case the results will indeed point at convergence of paradigm(s) underlying the benefit systems in all three countries, this might provide some incentives for future research to see whether these findings also hold when other countries are studied (possibly allowing for the drawing of more general conclusions). In case no convergence will be found, this does not imply that convergence is not occurring in other countries; however, it would allow for the conclusion that ideational convergence in the field of sickness benefits is not an EU-wide process.

With regard to this classification in terms of Esping-Anderson's welfare state regimes, it should also be mentioned that Kangas (2004, p. 191) has found this concept "too crude a measure", as "such labels as 'social democratic', 'liberal' or 'conservative' do not necessarily tell that much about the actual construction of single programmes" (see also Bannink & Hoogenboom, 2007). Rather, he prefers to use the "typology of social insurance institutions" provided by Korpi and Palme (1998, p. 665 ff.), a typology that is based on the "bases of entitlement", the "benefit-level principle" and the "forms for governing a social insurance program[me]". It is interesting to note that the three countries selected for the study also represent the three different models present in Europe. The United Kingdom is argued to represent a basic security model of social insurance, that is to say, its security system, "at least in principle, covers all people on the basis of their citizenship and guarantees a basic livelihood to everybody" (flat-rate) (Kangas, 2004, p. 192). The Netherlands – at least as far as sickness insurance is concerned – is thought to represent the corporatist model, characterised by income-related benefits and entitlements "based on contributions and the claimant's membership" (Kangas, 2004, p. 192). Finally, Sweden is said to belong to the encompassing 'group', in which elements of the other two models are combined. It should be noted that, although this additional classification does not allow for the drawing of solid generalisations either, it could provide some additional body to future findings, since any process of convergence cannot be explained by the sole argument that the regime classification used covers up the fact that the countries under study actually have been said to be based on comparable models of social insurance.

Selection of benefit scheme

Considering the choice for the sickness benefit scheme, I would like to start by referring to Taylor-Gooby's observation (2002, p. 598) that a "growth in groups outside the labour market" (including sick people) is one of the main developments amplifying the demand for social services. Indeed,

Esping-Anderson (1990, p. 49) has argued that sickness benefit schemes ranks in the top three of "most important social-welfare program[me]s" and Wikeley, Ogus and Barendt (2002, p. 526) have put forward that "[t]he income maintenance of those who are unable to work because they are sick remains one of the cardinal purposes of social security". Sickness benefit schemes deal with income replacement during illness (i.e. short-term incapacities). Such schemes are often very much related or closely connected to disability benefit schemes. In the Netherlands, for instance – as will also be elaborated upon in the fifth section –, the duration of sickness benefit provision has been extended "in order to restrict access to long-term disability benefits" (van Oorschot, 2006, p. 68). Although the restrictions attached to the writing of this bachelor thesis do not allow for the analysis of both schemes, in cases like these references *will* have to be made to the national disability benefit schemes to put the changes introduced in the sickness benefit schemes into perspective.

What is particularly interesting about sickness benefit schemes is that illness, in principle, is a basic concern for *all* citizens (e.g. Kangas, 2004). Since, as has been argued by Pierson (1996), the new politics of the welfare state can, to a large extent, be equated with blame avoidance, it is interesting to see whether fundamental change, nevertheless, has occurred *even* in these 'popular programmes'. It should be stressed, again, that both welfare state regimes and social security regimes are hybrid (e.g. when considering the organisation of pension insurance in the Netherlands, Korpi & Palme (1998) give the country the label of social security rather than corporatist). Thus, the possibility to generalise is again limited.

Selection of time-frame

Finally, I have chosen to include a relatively long period of time to base my analysis on, namely ranging from 1975[3] to 2009. The main advantage of such a longitudinal trend study is that it allows for both the study of separate fundamental reforms and for the identification of processes of gradual transformation, as "many small reforms, when going in the same direction and changing the parameters for adjacent policy fields, may add up to radical departures from the past" (Visser, 2009, p. 48). Considering the importance attached to European integration in the process of identifying the hypotheses central to this research, it is interesting to note that 1975 also represents the year in which the first in a series of four "European Tripartite Employment Conferences took place", indicating one of the earliest attempts of the European Communities "to tackle employment issues" (Goetsche, 1999, p. 118). It should also be emphasised that at this time the process of European economic integration, initiated by the Treaty of Rome (1957), had already taken off. Nevertheless, issues like the institutional architecture of the European Monetary Union, the incentives inherent in the Stability and Growth Pact and the messages promoted through the Open Method of Coordination have only become relevant at a later stage (i.e. from the 1990s onwards). In this respect, it might be interesting to see whether the different national sickness benefit schemes have been converging more in a neo-liberal direction since the early 1990s.

3.2. Data-collection and -analysis

General research approach

It should be emphasised that, following the research question(s) and hypotheses identified above, the goal of the research is descriptive. My aim is to draw a picture of what happened over a significant time period with regard to the sickness benefit schemes in three different countries, paving the way,

[3] The year that has been said to represent the end of the Golden Age of the welfare state (e.g. Moreno & Palier, 2004, p. 3).

eventually, for a comparative analysis (i.e. describing whether (and how) the different processes of change are related to each other). Reasons for choosing this descriptive purpose, or rather, for not choosing an explanatory purpose, are elaborated upon in the concluding section.

As Palier has rightfully pointed out, "[t]he measurement of change should not be quantitative" (as quoted by Pochet, 2005, p. 11), if only because "quantitative methods tend to produce findings which place greater emphasis on continuity and resilience" (Taylor-Gooby, 2002, p. 597). Indeed, I have chosen to conduct a qualitative research in the form of multiple (i.e. three) case studies to identify (the direction of) changes. These case studies are executed on the basis of content analysis. Under consideration are, first of all, the different national legal texts. It should be stressed in this respect that attention is paid both to the concrete terms contained in the communication (i.e. manifest) and to the underlying meaning of the legal texts (i.e. latent). To detect such underlying meanings, reference is also made to texts accompanying the introduction of new legal text, such as explanatory memoranda, the initial proposals for the piece of legislation and the discussions conducted in the national parliaments. Scientific literature is considered as well, not at the least because of some of the additional insights it provides, thus allowing for a more complete analysis. As a final source of information, I have also retrieved information from documents issued by organisations such as the European Union itself, the Mutual Information System on Social Protection (MISSOC) and the Organisation for Economic Co-operation and Development (OECD).

Operationalisation

Although attention has been paid quite extensively so far to the meaning of the concepts central to the thesis and the documents from which the data are retrieved, in order to be able to conduct the final analysis, that is to be able to see whether traces of neo-liberal convergence can be found, it is yet to be explained how the policy outputs derived are going to be assessed, how change and (neo-)liberal convergence are going to be measured. As emphasised before, the main focus of this paper is on change at the level of overarching policy goals (see Hall, 1993), on paradigm convergence (see Hay, 2004). Change, then, can be considered fundamental and relevant for my research, if a specific legal change is or a combination of several changes are found to be (clearly) dominated by neo-liberalistic thinking or by non-neo-liberalistic thinking. In the following, I will describe how such neo-liberalistic thinking is to be measured (with non-neo-liberalistic thinking being characterised by exactly the opposite reasoning).

Again, for the topic of social security two questions are of the utmost importance, namely who is to be responsible for its provision – according to neo-liberals, here, a shift from the public to the *private sector* is to take place – and what are the characteristics and requirements of social security benefits receipt – with neo-liberals emphasising self-responsibility and individualisation (i.e. a shift to the *private sphere*). Concerning this latter 'pillar', following Bradley and Stephens (2007, p. 1491), the key measures of benefit generosity are considered to be the *replacement rate, benefit duration, and conditionality*. From a neo-liberal point of view, then, it is argued that higher levels of benefits, a longer duration of receipt and fewer conditions imposed on the continuation of benefits are a 'bad' thing as they increase the incentives to remain outside the labour market. In this respect, it seems plausible to stress once more the centrality of personal (that is to say, individual) responsibility – as opposed to a collective one – in the neo-liberal theory. As has been nicely described by Clarke (2004, p. 33), "the shift to *meaner and more conditional forms* of income support 'privatise[...]' the task of 'getting by'" (emphasis added). In this respect, thus, a neo-liberal-minded government could, for instance, make the continuance of sickness benefit supply dependent upon the employee's efforts to return to the workforce. Korpi and Palme (1998) have distinguished two dimensions on which

policymakers of social policies are divided. Whereas the 'flat-rate versus earnings-related levels of benefit' discussion can be linked to the replacement rate referred to above, the 'targeted versus universalism' division introduces a new dimension, which reminds us of the importance of *access or eligibility to benefits* as well (see also Castles, 2002, p. 614). Here, the same neo-liberal reasoning applies (i.e. the stricter, the better, thus favouring targeting). Examples of neo-liberal policy changes, then, include the introduction or extension of the number of waiting days, or the requirement of medical certificates. Finally, with regard to the first 'pillar' mentioned, a change in *delivery mechanism*, though not indicating a (direct) change in the degree of social protection per se, can also be seen as indicating change (in a specific direction). The two neo-liberal key words to be referred to are, of course, *privatisation and deregulation*. Here, the transformation of responsibility for the financing or managing of sickness benefit from the public to the private sphere (e.g. to the employers (a process that, indeed, as will appear from the following sections, has taken place in all selected countries)) is the obvious example.

The lengthiness of the chosen time period, as justified in the previous paragraph, does not only allow for the identification of gradual transformation, it also provides the possibility to see whether changes are sustained over time. For instance, if benefit levels are lowered at a certain point in time but increased again (shortly) afterwards, although the former change could be considered of a neo-liberal nature, this initial conclusion can and should be balanced by the second finding.

4 The Case of the United Kingdom

4.1. Longitudinal development of the British sickness benefit scheme

Since the *National Insurance Act 1911* has introduced sickness benefits for insured persons as "[p]eriodical payments whilst rendered incapable of work by some specific disease or by bodily or mental disablement" (c. 55/1911, Art. 8), "[p]rovision against sickness has ranked alongside provision for unemployment and old age as one of the central pillars of the British social insurance system" (Creedy & Disney, 1989, p. 121). In 1975, National Insurance sickness benefits were "contributory" [4] (e.g. Brewer, Clarke & Wakefield, 2002, p. 520) – i.e. entitlement was dependent upon (credited) National Insurance contributions. As has been laid down in the *Social Security Act 1975* (c. 14/1975), sickness benefit was not paid during the first three days of "interruption of employment" (Art. 14) and was paid for a maximum period of six months – after which the claimant became entitled to invalidity benefit. The level of compensation was flat-rate and could be increased for adult and child dependants and with an earnings-related supplement. Moreover, additional occupational sick pay was "relatively widespread" (Dean & Taylor-Gooby, 1990, p. 50).

Thatcherism: Less generous benefit levels and the gradual privatisation of sickness benefits
The first major reform to the British sickness benefit scheme, within the considered timeframe, took place through the *Social Security (No. 2) Act 1980* (c. 39/1980). Forming an example of the "Thatcherism mould" to cut benefits (Mesher, 1981, p. 125), the Act allowed for cuts to or limited increases – through a process of de-indexation – of the level of national insurance sickness benefit and

[4] As the non-contributory benefits – such as the Non-Contributory Invalidity Pension and the Non-Contributory Housewives' Invalidity Pension (Social Security Act 1975 (c.14/1975)), and Severe Disablement Allowance (Health and Social Security Act 1984 (c. 48/1984)) – became relevant and applicable only after six months, a description of their development will not be included in this thesis.

paved the way for an abolishment of an earnings-related supplement to sickness benefits in 1982. On the other hand, in June 1982, "to reduce costs and the burden on general practitioners who ha[d] always regarded the work as interfering with the doctor-patient relationship" (Wikeley *et al*., 2002, p. 540; see also House of Commons, 22 December 1981, 372), "short-term certificates" were abolished and self-certification was introduced "for sickness or injury lasting less than eight days" (Kearns, 1982, p. 1132), thus facilitating initial access to the sickness benefit scheme.

Reflecting the government's aim to "disengage itself from activities which firms and individuals can perform perfectly well for themselves" (DHSS, 1980, as quoted by Dean & Taylor-Gooby, 1990, p. 48), one of the main reasons behind the introduction of the *Social Security and Housing Benefit Act 1982* was "to make provision for the payment of [S]tatutory [S]ick [P]ay [(SSP)] by employers" (c. 24/1982), "to encourage the development of occupational sick pay schemes at the expense of public provision" (Disney, 1987, p. 60). As a general starting point it was laid down in Article 1 that "[w]here an employee has a day of incapacity for work in relation to his contract of service with an employer, that employer [– *instead of* the state –] shall [...] be liable to make to him [...] a payment [– i.e. 'Statutory Sick Pay' –] in respect of that day" (c. 24/1982). However, this employer's duty did not apply to "the first three qualifying days in any period of entitlement" (Art. 5) – thus maintaining the three-days waiting period – and was limited to the first eight weeks of sickness absence only. Three rates of payment were established, related to different income categories – the 'lowest' category being applicable from an included lower-earnings limit (i.e. threshold) onwards[5]. At the same time, sick pay was made subject to income taxation, such a measure being considered "essential as one of the steps to deal with the 'why work' syndrome" (House of Commons, 15 April 1980, 1030). Interestingly, the Act allowed for "any employer who ha[d] made a payment of [S]tatutory [S]ick [P]ay to recover the amount so paid by making one or more deductions from his contributions payments" (Art. 9). Indeed, "one of the most important innovations stemming from SSP [was] that the onus of *operating* the state scheme for the short-term sickness ha[d] been transferred to the private sector" (Disney, 1987, p. 70). The process of privatisation initiated by this piece of legislation was, thus, directed (mainly) at the transfer of administrative responsibilities to the private sector, rather than financial ones (see also Taylor-Gooby (1988, p. 3): "state-financed employer-administered [...] sick pay"). Although this new construction allowed for a lower level of "observed" government expenditure (Creedy & Disney, 1989, p. 121), as correctly noted by Dean and Taylor-Gooby (1990, p. 59), it added "little additional financial incentive for employers to clamp down on sickness absences"[6]. From the employee's perspective, however, "the replacement ratios [were] significantly reduced" in the early 1980s, because "some employees previously received [both National Insurance sickness benefits and occupational sick pay] benefits" (Creedy & Disney, 1989, p. 121) and because, as indicated above, short-term sickness support had been made liable to income tax simultaneously with the introduction of the Statutory Sick Pay scheme (e.g. Taylor-Gooby & Lakeman, 1988, p. 24).

As will be shown in the following, this privatisation process has been furthered and extended through subsequent reforms. First, defining social security as "a partnership between the individual and the state [...], a system built on twin pillars" (UK, 1985, as quoted by Creedy & Disney, 1989, p. 113), the

5 In other words, as also emphasised by Disney (1987, p. 62), "[e]ligibility for [Statutory Sick Pay came to] depend[...] on employment status whereas eligibility for [National Insurance sickness benefit and] invalidity benefit depend[ed] on contributory status". Moreover, by linking the rate structure to earnings, possibilities for claiming dependants' allowances were not included, reflecting another contrast with the public schemes (e.g. Disney, 1987, p. 60).

6 Several authors (e.g. Taylor-Gooby & Lakeman, 1988; Creedy & Disney, 1989) have even claimed that the scheme actually provided an incentive for (some) employers "to use the scheme to their advantage" (1989, p. 122), describing the new arrangements as a "direct windfall to employers" (1998, p. 24).

British government extended the entitlement limit for Statutory Sick Pay from eight to 28 weeks (*Social Security Act 1985* (c. 53/1985), this way "virtually abolishing short-term [National Insurance sickness benefit]" (Dean & Taylor-Gooby, 1990, p. 50)[7]. In 1987, the number of rates of payment was reduced to two (*Statutory Sick Pay (Rate of Payment) Regulations 1987*), a cut in line with the abolition of the reduced rate of the National Insurance sickness benefit scheme (c. 50/1986) that had made access to the public programme stricter – after all, this rate was payable "on partial satisfaction of contribution conditions". More importantly, through the *Statutory Sick Pay Act 1991*, the government started "to reduce the amount of [S]tatutory [S]ick [P]ay which employers are entitled to recover" (to 80 percent) (c. 3/1991). Three years later this process of privatisation was finalised when the *Statutory Sick Pay Act 1994* was adopted "to remove the right of employers other than small employers to recover sums paid by them by way of [SSP]" (c. 2/1994)[8]. Such a measure was deemed necessary by the British government "to make sure that benefits concentrate help on those whom Parliament wishes to help" (House of Commons, 1 December 1993, 1040). It was argued that the varying levels of sick leave "between companies even in the same business" reflected an employer's "success or failure in motivating employees, caring for their health and monitoring absence", thus pointing at the importance of focussing on increasing rather than "remov[ing]" employers' incentives to reduce sick leave (House of Commons, 1 December 1993, 1040). Also, as a matter of simplification (House of Commons, 1 December 1993, 1041), the lower rate of Statutory Sick Pay was abolished, leaving one (weekly) rate that was to be applied to all (sick) employees (c. 18/1994).

Incapacity benefit: Stricter medical requirements

In 1994, the public sickness benefit scheme was also drastically revised when the National Insurance sickness benefit and invalidity benefit were merged, resulting in the construction of *one* incapacity benefit scheme, which was founded on and designed according to the idea of "the longer the period of sickness, the higher the benefit" (House of Commons, 24 January 1994, 45). Sickness benefit was replaced by the lower rate of short-term incapacity benefits (see c. 18/1994, Art. 2(2)). As correctly emphasised by Wikeley (1995, p. 528), this replacement entailed, in practice, mainly "a change of name". More radical changes were introduced with regard to a claimant's position after this initial period of six months. Whereas, before the *Social Security (Incapacity for Work) Act 1994* entered into force, claimants used to be 'transferred' directly to the invalidity scheme once the six months-period had expired, such claimants were now assigned to "an intermediate level of benefit" (Wikeley, 1995, p. 528), that is, the "higher rate" of short-term incapacity benefit[9], for another six months (c. 18/1994, Art. 2) before the highest rate would become payable. In other words, claimants were subjected to less generous benefit levels for a longer period of time as the duration of the sickness benefit scheme – although no longer officially labelled this way, as it was now called short-term incapacity benefit – was extended and access to disability benefits – now coined long-term incapacity benefit – was postponed. Also, entitlement to sickness (or incapacity) benefit was made more conditional upon stricter medical inspection, as the old system was considered "to fail[...] to act as effective

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7 Only "relatively few" (Wikeley *et al*., 2002, p. 523) employees, such as those satisfying the National Insurance contribution requirements but not having earnings above the lower-earnings limit or being employed for a period of less than three months (at least, until the coming into force of the *Fixed-term Employees (Prevention of Less Favourable Treatment) Regulations 2002* (No. 2034/2002)), remained eligible for the National Insurance sickness benefit scheme.

8 In 1995, through the *Statutory Sick Pay Percentage Threshold Order 1995* (No. 512/1995), the exemption for small employers has been changed in one for those employers whose payments of Statutory Sick Pay exceed thirteen percent of their national insurance contributions liability (Art. 2).

9 This middle rate of incapacity benefit was to be payable "at the same rate as statutory sick pay" (House of Commons, 24 January 1994, 46) and was, like statutory sick pay, subjected to income taxation (as was the long-term incapacity benefit).

'gatekeeper[...]'" to invalidity benefit (Wikeley, 1995, p. 527). The scheme distinguished two tests of incapacity for work: The "own occupation test" during the first six month of work incapacity (c. 18/1994, Art. 171B) and the "all work test" for all other occasions (Art. 171C). Whereas the former tested whether the claimant was incapable "of doing work which he could reasonably be expected to do in the course of the occupation in which he was so engaged" (Art. 171B), the latter was concerned with the claimant's capability for work in general or, in Wikeley's words (1995, p. 530), with "medical incapacity alone"[10] (and was, thus, considered "more objective" (Wikeley *et al*., 2002, p. 525).

The era of 'New Labour': Work for those who can and benefits for those who cannot

From 1997 onwards the British government "has emphasised the aim of getting people back into paid employment" (Brewer *et al*., 2002, p. 513). Accordingly, in 1999, in line with the New Deal's "central principle of work for those who can, and security for those who cannot" (Explanatory notes, accompanying the *Welfare Reform and Pensions Act 1999* (c. 30/1999)[11]), the all work test was re-labelled the "personal capability assessment" (Art. 61) to "correct the false impression that those who reach the threshold for benefit are incapable of any work" (MISSOC, 2001, p. 56). This new label reflected the government's new approach of focussing on people's capabilities – rather than incapabilities – as the new test was intended to assess "the extent to which a person's condition affects their ability to do a range of everyday work-related activities" (Mitra, Corden & Thornton, 2005, p. 146). Committed to the target of "increas[ing] the employment rate" for all (House of Commons, 13 January 2003, 394), since 2003, piloting measures such as the *Social Security (Incapacity Benefit Work-focused Interviews) Regulations 2003* (No. 2439/2003) have been put forward within the framework of the Pathways to Work reforms (e.g. Brewer, 2009, p. 20). Eventually, the whole incapacity benefit system was reformed in 2008, when, to express the attachment of the British government to the "values of opportunity" (House of Commons, 9 January 2007, 244), incapacity benefit was replaced by Employment and Support Allowance. The main motive supporting this replacement was that "[a]lthough the state has a duty to help people back to work and to provide support [...], all who can do so have a duty to take up the support that is offered to them to make progress in preparing for, and gaining, work" (House of Commons, 9 January 2007, 245).

Accordingly, the *Employment and Support Allowance Regulations 2008* (No. 794/2008) introduced an assessment phase (of thirteen weeks) during which the claimant was "placed on a holding benefit" (Kemp & Davidson, 2010, p. 204) and, upon its 'successful' completion, a benefit consisting of a basic (flat-rate) compensation that was to be supplemented by a support component for those assessed to have a limitation that "is such that it is not reasonable to require the claimant to work" (Art. 19) or by a (less generous) work-related activity component for those assessed not to have such a limitation. To "activate the [claimants'] aspirations" (Kemp & Davidson, 2010, p. 204), this latter component was made conditional upon the attendance of work-focused interviews and health-related assessments, this way emphasising the intended 'temporary' character of the benefit. Contrary to its predecessor, the new benefit scheme introduced "an integrated contributory and income[-]based allowance"[12]

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10 Whereas fulfillment of this 'first' test remained conditional upon "self-certification for a week and a doctor's note thereafter" (Wikeley, 1995, p. 529), the gatekeepers appointed to determine access to the higher short-term – i.e. the second half year of 'sickness benefit' – and long-term incapacity benefit were "doctors working on behalf of the employment services" (Beatty & Fothergill, 2005, p. 838).

11 This Act also strengthened the link between recent work activities and entitlement with regard to the (short-term) incapacity benefit scheme (see Art. 62).

12 Under the previous incapacity benefit scheme, those with an insufficient national insurance contributions record were 'left' to claim means-tested Income Support (e.g. Brewer, 2009, p. 22; Beatty & Fothergill, 2005, p. 838).

(MISSOC, 2008, p. 3), although different rates were established. Even more interestingly, however, where the introduction of the incapacity benefit scheme had already abolished the label 'sickness benefit', the British *public* sickness and disability benefit schemes seem to have been fused with the coming into force of the employment and support allowance scheme.

4.2. Analysis of change

In the previous paragraph, a quite extensive description of the development of the English sickness benefit scheme between 1975 and 2009 has been provided. The question that remains, and will be leading in this paragraph, is how these identified changes relate to the (non-)neo-liberal dichotomy distinguished earlier.

It has been found that the ambitions of the Thatcher-government (from 1979) were very much in line with the neo-liberal aims to increase "individual and private forms of social protection" (e.g. Clasen, 2003, p. 573). Indeed, with regard to the delivery mechanism, a clear neo-liberal trend has been visible within the United Kingdom since 1982. Although the Statutory Sick Pay scheme initially did not transfer financial obligations to the private sector (and did, thus, allow only for a reduction in *observed* government expenditure), the measures taken with regard to the administrative duties did allow for an increasing "acceptance of welfare provision based on market principles" (Dean &Taylor-Gooby, 1989, p. 51) – not at the least because it 'forced' companies to establish an administrative 'infrastructure', thus facilitating the provision of occupational sick pay – paving the way for a 'true' privatisation of the sick pay scheme in 1994. Accordingly, the British government has come to limit its involvement with regard to the sick pay scheme to the setting of minimum 'basic pay' compensation rates, this way not only adhering to the neo-liberal principle of *privatisation* but also of *deregulation* by allowing the market forces to play their part (especially in the form of occupational sick pay). This phenomenon of deregulation has manifested itself during the 1980s with the reduction of the number of compensation rates from three to two (in 1987) and, eventually, to one (in 1994). However, contrary to what might be expected on basis of the neo-liberal legacy, in the latter case it was the lower compensation rate that was abolished.

With regard to the public scheme that has remained in place for those not eligible to sick pay some neo-liberal tendencies can be distinguished as well. To recall, neo-liberalism is also concerned with the individualisation of social welfare and the accompanying focus on self-responsibility. Indeed, in the English context, the neo-liberal concept of *activation* has gained a very prominent position. The most evident example of the firm establishment of this concept in the British sickness benefit scheme is provided by the increase in strictness of medical requirements. Whereas the incapacity benefit scheme had already introduced the 'all work test', this test was re-labelled five years later to emphasise the focus on the claimant's remaining capabilities to get back to the work floor. Such measures represent a clear example of the growing importance attached to *individualisation* within social security policies, as the provision of benefits became increasingly linked to the personal, individual position of the claimant. With the introduction of the employment and support allowance in 2008, the focus on a (quick) return to the work force was put to the fore even more. The new scheme differentiated the amount of benefit paid, to some extent, according to the claimant's incapacity to work and, moreover, made part of the benefit provision (for those who still could be reasonable expected to work) conditional upon the attendance of work-focused interviews and health-assessments (i.e. a "stick" rather than a "carrot" was provided here (e.g. Brewer, 2009, p. 3)). To fight the 'work-off' syndrome, moreover, following the neo-liberal logic, compensation rates have been made *less*

generous, for instance through the abolishment of the earnings-related supplement and the subjection of some of the sickness benefits to income taxation.

As appears from the description provided in the first paragraph of this section, the maximum duration of the sickness benefit scheme has been changed twice. With the introduction of the sickness benefit scheme, it was extended to a year, although the compensation rate for the second half year was set at a higher level. Although one might consider such an extension to oppose the neo-liberal theory, based on the operationalisation of neo-liberalism provided in this paper, it should be noted that even the higher level provided during the second half year was less generous than the amount of compensation that was provided under the previous (invalidity benefit) scheme. Such a lower compensation rate can, of course, be justified from the neo-liberal perspective. The abolishment of the dividing line between the sickness and the invalidity benefit scheme in 2008 is difficult to locate in the (non-)neo-liberal spectrum. However, as indicated before, these new arrangements allowed for the differentiation of benefits and this differentiation forms an interesting example of *targeting* benefits on the most needy (that is, on those who are really incapable of working) that has become one of the spearheads of the British policy over the years.

This is not to say that all developments that have taken place in the United Kingdom are in line with the neo-liberal hypotheses. The most obvious example of a policy change that is to be marked non-neo-liberal, is the introduction of *self-certification* for the first seven days of sickness and the accompanying abolishment of the requirement for a medical certificate for these initial days of the sick spell. It should be stressed, though, that the motives underlying this reform, as described above, were not conflicting with the neo-liberal ideals. Indeed, the effects of the reform have been subject to monitoring processes to make sure that the introduction of self-certification would not have lead to the non-neo-liberal effect of encouraging people to call in sick (e.g. House of Commons, 19 November 1982, 313).

Leaving such (small) exceptions or, rather, ambiguities, out of consideration, all in all, most reforms to the British sickness benefit schemes during the period ranging from 1975 to 2009 have, thus, followed the neo-liberal way of thinking, both with regard to the instruments used and with regard to the motives expressed.

5 The Case of the Netherlands

5.1. Longitudinal development of the Dutch sickness benefit scheme

Sickness benefits have been provided in the Netherlands since the coming into force of the *Sickness Benefit Act* in 1930 (Stb. 1929, 375). In 1975, a sick employee (working on the basis of an employment agreement), was, after two waiting days, entitled to 80 percent of his (previous) wage (or the maximum or minimum daily wage) for a maximum period of 52 weeks. Due to amendments to the Act in 1967, no distinction was made with regard to the cause of incapacity to work – that is to say, both the "risque professionel" and the "risque social" were covered (Koopmans, 2007, p. 75) – and no minimum earnings limit was required.

Lowering social security expenditure: The decrease of compensation rates
During the 1980s the debate on the future of the Dutch social security system took off, focussing initially "on the expenses for social security" (Van der Veen & Trommel, 1999, p. 293). The debate

resulted, at first, in a suspension of indexation of social benefits to wage development (e.g. Caminada & Goudswaard, 2001, p. 406) and culminated in a process of cutting the levels of social security benefits. According to the government (Tweede Kamer, 1984-1985, p. 9), the sickness benefit scheme could not be exempted from this trend and, consequently, through the *Act on Lowering the Benefit Percentage of the Sickness Benefit Act and Collection of National Insurance for Sickness Benefits* (Stb. 1985, 201)[13], Article 29 of the *Sickness Benefit Act* was amended. The new provisions allowed for the reduction of the level of sickness benefits in two stages. Whereas in 1985, this level of income replacement was first lowered from 80 to 75 percent, in 1986, another reduction of five percent was implemented, thus setting the rate of sickness benefits at 70 percent (Stb. 1985, 201). It should be stressed, however, that although such measures aimed at making benefit regimes less attractive for employees (Hartog, 1999, p. 27), this incentive was often offset through collective agreements on extra-statutory supplemental benefits (e.g. Bovenberg, 2000, 346), though, as also recognised by the Dutch government in its explanatory memorandum (Tweede Kamer, 1984-1985, p. 22), (often) "at the expense of the employer" (Hartog, 1999, p. 27).

Focussing on the employers' incentives: The privatisation of the sickness benefit scheme

It is this same employer that has been *directly* targeted by subsequent reforms in the following decades. Indeed, as has been noted with regard to the Dutch welfare state policies more broadly by Van Oorschot (2006, p. 60), "[w]hile initially, in the 1980s, policies were mostly aimed at curtailing benefits for citizens and workers, the focus was moved to employers and administrative bodies in the 1990s" (see also MISSOC, 2000, p. 41: "common theme"). As will be shown below, since 1993, "several measures have been taken which have raised the 'own risk' of employers with regard to salary payment in the event of sickness" (Geurts, Kompier & Gründemann, 2000, p. 89), this way making the reduction of sickness absenteeism "in the employer's interest" (Van Oorschot, 2006, p. 68). Whereas the *Act on Reducing the Disability Volume* (Stb. 1992, 82) – representing a first "element[...] of marketisation" (Muffels & Dirven, 1999, p. 5) – paved the way for the application of differential sickness premiums, the main revision of the sickness benefit scheme started with the adoption of the *Sickness Absence Reduction Act* (Stb. 1993, 750), introducing "a private responsibility for employers" (Van der Veen & Trommel, 1999, p. 301). By amending the *Civil Code*, the responsibility for sick pay during the first six weeks of incapacity to work[14] was transferred to the employers – the amount of 'obligatory' sick pay being equal to at least 70 percent of the normal wage and/or the applicable minimum wage – thus "ceas[ing] to be a burden" (Drøpping, Hvinden & Van Oorschot, 2000, p. 46) on the Dutch state. It should be noted that "[r]ather than bearing the risks themselves, firms [were given] the option of taking out insurance with private insurance companies, which differentiate[d] premiums according to their risk assessment" (Bovenberg, 2000, p. 357). Through such a measure – providing a clear financial incentive – the government anticipated to stimulate employers to both increase prevention and to shorten the length of sickness absence, thus improving re-integration (Tweede Kamer, 1992-1993b, p. 19) and fighting the 'Dutch disease' of the high number of disability benefit recipients (e.g. van Gerven, 2010, p. 11).

The privatisation of sick pay was taken a step further in 1996 with the introduction of the *Act on Enlargement of Wage Payment during Sickness* (Stb. 1996, 134), extending "the compulsory wage payment period to 52 consecutive weeks of work incapacity" (Van der Veen & Trommel, 1999, p.

[13] As indicated by its title, this Act also made sickness benefits liable to social insurance premiums. Indeed, until 1985, sick employees often even *gained* in net income (Hartog, 1999, p. 27) (thus making the sickness benefits 'attractive' and actually 'supporting' moral hazard).

[14] For companies employing up to fifteen persons, the own risk period was limited to two weeks (instead of six).

203). In the view of the Dutch government, such an arrangement would diminish the possibilities of shifting problems to the collective (Tweede Kamer, 1995-1996, p. 3). Indeed, as this period of 52 weeks "is the formal period of sickness before one may qualify for a work disability benefit" (Geurts *et al.*, 2000, p. 89), the introduction of this act indirectly implied the abolition of the public *Sickness Benefit Act* to "the majority of the Dutch labour force"[15] (Drøpping *et al.*, 2000, p. 46). As has been nicely put by Van Oorschot and *Boos* (2000, p. 7), "from a full-fledged national insurance the [*Sickness Benefit Act*] has been turned into a safety net for specifically vulnerable groups". The private responsibility for sickness absence was increased even more with the adoption of the *Act Extending the Wage Payment Obligation* (Stb. 2003, 555) by doubling the duration of the wage payment obligation (to 104 weeks), this way postponing entitlements to the disability benefit scheme. To balance the financial incentives between employers and employees, the possibilities for topping up the compensation level were limited as the maximum total compensation rate for two years of sickness was set at 170 percent of the annual wage (Tweede Kamer, 2003-2004, p. 9; see also Koopmans, 2007, p. 115). Furthermore, the legal right to a guaranteed minimum wage during sickness was not extended to the second year of sick pay[16].

Several authors (e.g. Geurts *et al.*, 2000; Van Oorschot & *Boos*, 2000) have pointed at the "less ethical side effects" of this process of privatisation, claiming that "employers seem to have started to undertake procedural measures" (Geurts *et al.*, 2000, p. 93), thus identifying "a remarkable tension between the intended activation impact of the[...] measure[...] and [its] actual effect" (Van Oorschot & Abrahamson, 2003, p. 298). Already during the process of getting the *Sickness Absence Reduction Act* approved, the Dutch government recognised the risk of employers basing their recruitment and selection policies, to a large extent, on the potential employee's health status (Tweede Kamer, 1992-1993b, p. 20), leading, eventually, to the adoption of the *Act on Medical Examinations* (Stb. 1997, 365)[17].

Additional reforms: Triggering prevention and activation

To obtain the aforementioned goals of increased prevention and reintegration, several additional, non- or indirect financial incentives or, rather, obligations have been established as well. In 1993, to accompany the introduction of the *Sickness Absence Reduction Act*, the Dutch government added Article 4a to the *Working Conditions Act* (Stb. 1993, 757) to express its view that the employer should be considered as the actor who is "primarily responsible" for the prevention and reduction of sickness absence (Tweede Kamer, 1992-1993a, p. 7; 1992-1993b, p. 23) and to oblige the employer to adjust his enterprise policy accordingly. Arguing that subsequent reforms with regard to the sickness and disability benefit schemes had made the requirements of this provision "self-evident" (Tweede Kamer, 2005-2006, p. 32), the Article was abolished in January 2007 (Stb. 2006, 673). A particularly important reform in this respect has been the adoption of the *Act on Improving the Gatekeeper* (Stb.

[15] The Sickness Benefit Acts has remained in force to cover the sickness risk of certain specified categories of *workers*, such as pregnant women – who are, if their condition can be traced back to their pregnancy, entitled to 100 percent of their wage – and people on temporary contracts.

[16] As emphasised by the government in the explanatory memorandum accompanying the *Act Extending the Wage Payment Obligation*, an extension of this legal right to the second year of sickness would have improved the claimant's situation – as the invalidity benefit scheme, previously applicable to those who were incapable of work for more than a year, did not include such a minimum wage-guarantee – and, thus, would have conflicted with the underlying goal of activation (Tweede Kamer, 2003-2004, p. 10).

[17] Following this Act, employers are allowed to perform health checks – that is, to ask questions regarding the applicant's health status or to conduct a medical examination – *only if* certain health requirements are considered to be a prerequisite in the exercise of the function *and* the employer, based on all other assessments of the capabilities of the candidate-employee, already intends to appoint the applicant.

2001, 628), which aimed at creating a more "active attitude" to get the worker back to work as soon as possible (Tweede Kamer, 2000-2001, p. 6), this way "limit[ing] the number of people moving on to invalidity benefit" (MISSOC, 2002, p. 2). On the basis of this Act, both the employer *and* the employee have been required to construct a plan of action and re-integration report in which their efforts to have the employee returning to and participating on the labour market are to be laid down. With regard to such efforts, on the basis of the *Implementation Structure for Work and Income Act* (Stb. 2001, 625), the employer is expected to find "appropriate labour" for the employee, either within the firm or within a 'third' company[18]. The employee, on the other hand, is required to engage in any appropriate labour or participate in measures which are intended to enable the employee to work. If the employee does not contribute adequately to his reintegration into the labour market, his right to wage payment during sickness (temporarily) expires. If, on the other hand, the employer falls short of promoting the reintegration of his employee or if both parties fail to do their parts, the employer's wage payment obligation is extended, thus postponing the claimant's entrance to the disability benefit scheme.

5.2. Analysis of change

Having described the evolution of the Dutch sickness benefit scheme, in this paragraph the (non)-neo-liberal character of these developments will be discussed. As appears from the first paragraph, most of the reforms that have taken place in the past 35 years with regard to the Dutch sickness benefit scheme have been concerned with a redistribution of responsibility for sickness absence between the state and the market, with the *privatisation* of most of the public scheme. Over a period of ten years, employers have been made fully financially responsible for sickness absences of their employees that last up to two years. However, it should be mentioned that, contrary to what neo-liberals would advocate, the Dutch government has been hesitant to transfer all power to the forces of the market. In this respect, in consultation with the social partners, a limit has been put to the maximum compensation level of sickness benefits. Accordingly, as also noted by van der Veen and Trommel (1999, p. 302), "one should not overestimate the degree of liberali[s]ation". Still, this interference by the government aimed at decreasing the incentives of claimants to remain passive benefit recipients, and this aim *is* in line with the neo-liberal legacy. Indeed, the motive pronounced most often as a justification for the privatising reforms has been that such a transfer to the private sector would increase the incentives of especially employers to prevent sickness and to speed up the re-integration process, thus limiting access to the disability benefit scheme – this way, representing one of the attempts to cure the 'Dutch disease' (see also van Gerven, 2010). Accordingly, although the privatisation process seems to represent an example of the centrality of the advancement of *labour participation* in the Dutch context (e.g. MISSOC, 2007, p. 1), one should bear in mind that these neo-liberal coloured reforms of privatisation have not been initiated on the basis of 'pure' neo-liberal objectives.

This emphasis on labour participation has also formed the basis for some additional reforms. Whereas the 1993 amendment to the *Working Conditions Act* already imposed some obligations on employers with regard to conducting a sickness absence policy, in 2001, duties concerning the re-integration of sick employees were actually related to the provision of sickness benefits, making these benefits *active* rather than passive. Interestingly, both employees and employers were expected (and required, under penalty of a temporary loss of entitlement (for employees) or of an extension of wage payment

[18] This obligation is also referred to as "second-track re-integration" (Loonstra, 2009, p. 60). When the employee comes to work for a third party within this framework, the initial employment contract remains intact, as has been laid down in Article 7:629 of the *Civil Code*.

obligations (for employers)) to show such an active attitude. In this respect, the following comment made by the Dutch government is very illustrative: "A system itself is not activating, but *can* support the actors involved to engage in activating efforts; and so the supporting system should be adequate" (Tweede Kamer, 2003-2004, p. 2). As has been nicely put by van der Veen and Trommel (1999, p. 303), "[i]ndividual employers and workers [we]re now confronted much more with the real costs of social security". Indeed, *individual responsibility* – rather than collective responsibility – has become leading (see also van Oorschot, 2006, p. 72).

Not only have sickness benefits become more conditional upon efforts to return to work, they have also been made *less generous*. As indicated above already, limits have been put on the amount of contractual top-ups allowed. Also, the compensation rate as such has been lowered by ten percent, but has remained earnings-related. Such a decrease in generosity is, in principle, in line with the neo-liberal body of thought – although the high amount of regulation surrounding this decrease, as pointed out before, is not. The holding on to *earnings-related* compensation levels, however, does not fit this body (neo-liberals preferring a flat-rate). The extension of the period covered by the sickness benefit scheme to two years, at first sight, also appears to be in contrast with neo-liberalism. However, this reform was implemented to postpone entrance to the disability benefit scheme and, thus, to extend the period during which the employer and employee remained responsible for the re-integration of the sick employee.

To sum up, the Dutch government has implemented several neo-liberal coloured measures to fight sickness absence. Whereas it directed its 'activating arrows' initially primarily at the employers, more recently the 'individual' employee has been targeted as well. Although self-responsibility has, thus, come to the fore, the Dutch government has been shown to have been hesitant to take its hands off completely.

6 The Case of Sweden

6.1. Longitudinal development of the Swedish sickness benefit scheme

The Swedish sickness insurance scheme has been "public and compulsory" (Alexanderson & Norlund, 2004, p. 16) or "mandatory and universal" (Ståhlberg, 1997, p. 41) since 1955. In 1975, based on the *National Insurance Act* (1962:381), sickness benefits were, after one waiting-day, provided "in the event of illness which reduce[d] working capacity by at least one-half" (Chapter 3, Art. 7) – for which a medical certificate was often only required from the eighth day of the sick spell onwards – to people of whom the qualifying income exceeded the lower-earnings limit. The compensation rate was set at 90 percent and the benefits received were subject to income taxation. In principle, no time limit applied to the period of time that was covered by the sickness benefit scheme.

Increasing generosity

During the first years of the period under study, some of the yet generous provisions of the Swedish sickness benefit scheme were made even more generous. In 1977, the *Work Injuries Insurance Act* (1976:380) was enacted, allowing for full compensation in cases of loss of income due to work injury from the 90th day of incapability to work onwards[19]. Following a decade of stability, in December

[19] The development of this Work Injuries Insurance Act will not be discussed in the remaining part of this description of the Swedish sickness benefit scheme. It should however be noted that the period of 90

1987, the one remaining (unpaid) waiting day[20] was abolished (*Act (1987:223) Amending the National Insurance Act (1962:381)*). At the same time, the sickness benefit scheme came to cover only scheduled work days during the first two weeks of sickness absence (see e.g. Alexanderson & Norlund, 2004, p. 13; Andrén, 2005, p. 329).

The turbulent 1990s and early 2000s

Whereas the 1970s and 1980s represented a 'quiet' – but all in all 'generous' – era, "the big economic downturn in the early 1990s opened a window of opportunity for reform" (OECD Directorate for Employment, Labour and Social Affairs, 2009, p. 12). Indeed, Henrekson and Persson, attempting to measure the effects of changes in the sickness insurance system on sick leave, have found that in the 1990s "reforms were so frequent that their effects cannot be accurately distinguished" (2004, p. 96). According to Kuhnle (2000, p. 214), "[t]he sickness cash benefit scheme [was] the most frequently and extensively reformed area of the Swedish social security system in the 1990s". This reformative process took off with the introduction of two additional levels of sickness or working incapability and related compensation into the scheme, namely of one-fourth and three-fourth (*Act (1990:157) Amending the National Insurance Act (1962:381)*), to make it easier for claimants to return to work after a long(er) period of sick leave (Prop. 1989/90:62)[21]. In March 1991 (*Act (1990:1519) Amending the National Insurance Act (1962:381)*), reflecting the government's intention to limit social security spending in order to "regain an economic balance in the system" (Prop. 1990/91:59, p. 15), for the first time since the introduction of the public sickness insurance scheme, a reduction of the compensation rate was implemented. That is to say, the compensation level was reduced from 90 percent to 65 percent for the first three days of sickness and to 80 percent for the subsequent days until the 90th day of sickness. The sickness benefit rate payable from day 91 onwards was (initially) kept at 90 percent, "to avoid disadvantageous effects of the reform on income distribution" (Johansson & Palme, 2004, p. 4). Also, to reassure that this decrease in the level of compensation "affects everyone as equally as possible" (Prop. 1990/91:59, p. 21; see also Ståhlberg, 1997, p. 53), the Act introduced a ceiling to the total amount of sickness benefit – i.e. both statutory *and* contractual – by ensuring that those amounts exceeding the levels of 75 respectively 90 percent of lost earnings – i.e. those amounts including an addition of more than ten percent. Such 'excessive' complements would be adjusted through "a corresponding decline in the sickness benefit paid out of the national sickness insurance" (Edebalk, 2009, p. 56). Moreover, after 90 days of sickness absence negotiated complementary benefits were no longer permitted at all.

In order to provide incentives for both "preventive investments in the working environment and for rehabilitative measures" (Ståhlberg, 1997, p. 53; see also Prop. 1990/91:181, p. 27-28), "to encourage better policing of the system" (Swank, 2001, p. 227) and to ensure "a more equitable compensation" for loss of income due to sickness (Prop. 1995/96:209; see also Edebalk, 2009, p. 57: "uniformity"), a system of obligatory sick pay[22] came into force in 1992. The *Sick Pay Act (1991:1047)* introduced a two-week "employer period" (e.g. Andrén, 2003, p. 56), requiring employers to compensate 75

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days was extended to 180 in 1992 (*Act (1991:1978) Amending the Work Injuries Insurance Act (1976:380)*) and that the right to the more generous work injury sickness benefits was dropped in July 1993 (*Act (1993:357) Amending the Work Injuries Insurance Act (1976:380)*).

20 Indeed, as emphasised by Burtless (1987, p. 200) and Henrekson and Persson (2004, p. 93), the sickness benefit programme was less generous during the early 1960s, when, for instance, the waiting period counted three days (instead of one).

21 As pointed at by Andrén (2003, p. 56), such partial sickness benefits were to be provided "in connection with rehabilitation for persons returning to work after a long period of sickness".

22 It should be noted here that some authors (e.g. Hytti, 2006, p. 132) have described contractual benefits as (non-obligatory) instances of sick pay as well.

percent of the employee's earnings during the first three days of sickness absence and 90 percent thereafter[23]. A waiting day was *re*introduced in 1993 (*Act (1992:1701) Amending the Sick Pay Act (1991:1047)* and *Act (1992:1702) Amending the National Insurance Act (1962:381)*), implying that no sick pay respectively sickness benefit was to be paid on the first day of sickness and that the applicability of the rate of allowance of 75 respectively 65 percent was now limited to the second and third day of the sick spell only. Also, the benefit rate covering the period from the 91st to the 365th day of sickness was lowered to 80 percent and the compensation level applicable from the 366th day of sickness onwards was reduced to 70 percent[24]. The compensation rate was again subject to change in 1996, when the rate was set at 75 percent for the entire sickness period – with the exception of the waiting day (*Act (1995:1478) Amending the National Insurance Act (1962:381)* and *Act (1995:1480) Amending the Sick Pay Act (1991:1047)*). Arguing that the incentives behind the introduction of sick pay had "not worked as intended" and that a longer employer period would make the employer's costs "more mobile and therefore avoidable" (Prop. 1995/96:209), in 1997, the government extended the sick pay period and, thus, the financial responsibility of employers to 28 calendar days (*(Act (1996:1062) Amending the Sick Pay Act (1991:1047)*). However, this decision was reversed again only fourteen months later (*(Act (1997:311) Amending the Sick Pay Act (1991:1047)*), following criticism voiced by the social partners (Prop. 1997/98:1). Sick pay and sickness benefits were – in contrast with the developments that had taken place during the preceding decennium – made more generous in January 1998, when the compensation rate was raised to 80 percent (*Act (1997:562) Amending the Social Security Act* and *Act (1997:569) Amending the Sick Pay Act (1991:1047)*). Moreover, the reduction rule – as implemented in 1991 – was amended, so that the receipt of additional compensation after the 90th day of a sick spell became allowed as well, thus setting "the maximum compensation for the long-term ill" at 90 percent from 1 January 1998 (Edebalk, 2009, p. 58).

In 2003, the employer period came to cover the first three weeks of a sick spell (*Act (2003:424) Amending the Sick Pay Act (1991:1047)*). Also, the compensation rate was, once again, subject to change, as it was decreased to 77.6 percent (*Act (2003:423) Amending the National Insurance Act (1962:381)*). Moreover, a "compensation ceiling" was established for the "sick unemployed" at the level of the highest unemployment benefit (see Andrén, 2003, p. 55). Whereas the latter measure has remained in force, the compensation rate was re-set at 80 percent again in 2004 (*Act (2004:1238) Amending the National Insurance Act (1962:381)*).

Emphasising re-integration: A work-first policy approach

In 2002, the government had expressed the aim to have halved the amount of sick leave by 2008. Although in 2004 the number of 'sick pay' days was reduced to fourteen once more (*Act (2004:1240) Amending the Sick Pay Act (1991:1047)*), in this same year employers were made responsible for the co-financing of sickness benefits after this initial period of time. Through the *Special Sick Pay Act (2004:1237)*, the share of the employer's contribution to the costs of sickness benefits was set at fifteen percent[25]. Again, the introduction of this Act was motivated by the argument that such a

[23] Those who were not covered by this Sick Pay Act (such as the unemployed) remained subjected to the National Insurance Act for the first fourteen days of sickness as well.

[24] Concerning the latter, however, through *Act (1993:355) Amending the National Insurance Act (1962:381)*, the Swedish government arranged that the compensation rate of 80 percent could, as an "exception" (Prop. 1992/93:78, p. 33), be maintained after day 365 in (certain) cases of medical treatment or rehabilitation.

[25] That is to say, employers were now supposed to financially account for twelve percent – fifteen percent of 80 percent – of the wage of their sick employees from the fifteenth day of a sick spell onwards. Through reductions in the employers' health insurance contributions, the new system aimed at creating

measure would "encourage a greater commitment on the part of employers to a good working environment and to give employers an interest in ensuring that people on sick leave can return to work quickly" (Prop. 2003/04:100, p. 18). However, this Act was repealed again in 2007 (*Act (2006:1428) on the Annulment of the Special Sick Pay Act (2004:1237)*) as the government's focus shifted towards the aim to "increas[e] and clarify[...] the responsibility of the individual to cooperate in making it possible to return to work" (Prop. 2003/04:100, p. 20). Recognising the necessity of reform (Swedish Government, 2006, p. 56), for the first time since the system's inception in 1955, a limit (of one year) was set on the length of sickness benefit provision through *Act (2008:480) Amending the National Insurance Act (1962:381)* (although the possibility of obtaining "extended sickness benefit" was introduced at the same time). This Act, moreover, established what has been coined a "rehabilitation chain", allowing for the review of a person's capacity – rather than *in*capacity – to work at several fixed checkpoints (e.g. Swedish Ministry of Finance, 20 September 2007). During the first three months of absence sickness benefit is to be paid to those who cannot return to their existing job. Between the 90th and 180th day, recipients are expected "[t]o cooperate with their employer to find another job in that business" (OECD Directorate for Employment, Labour and Social Affairs, 2009, p. 24) and sickness benefit is paid only if a person cannot perform any job for his current employer. After day 180, sickness benefit is only provided if the claimant is incapable of performing any job in the labour market. Also, "to increase employers' ability to control cases of short-term [sick]ness" (Swedish Government, 2006, p. 56), provisions have been made to allow an employer to require a doctor's certificate from the first day of sickness (instead of the eighth).

6.2. Analysis of change

Although the description of the development of the sickness benefit scheme provided in the previous paragraph has shown that reforms have been numerous in the Swedish context, the question that remains is whether or how these changes can be linked to the theory of neo-liberalism. Before conducting such an analysis, however, it is interesting to note that the Swedish government itself has repeatedly stressed its commitment to a '*Work First*' approach (e.g. Prop. 2003/2004:100, p. 3; 2006, p. 56). Indeed, the Swedish governments have always been dedicated to the goal of a high employment level (Hytti, 2006, p. 131). Nevertheless, the changes made with regard to the sickness benefit scheme cannot always be easily aligned with these objectives. One clear example of a non-neo-liberal initiative was the abolishment of the waiting day in 1987, as such a development could be expected to provide incentives for employees *not* to go to work. However, as mentioned above, a waiting day was re-introduced in 1993, thus making it difficult to detect a clear (non-)neo-liberal trend overall. It is because of changes like these, that Lindbom (2001, p. 178) has been able to conclude that "[t]he rules for sickness cash benefit [in 2001 we]re similar to those in 1980". The Swedish government, as also stressed by the OECD Directorate for Employment, Labour and Social Affairs (2009, p. 14), appears to be very sensitive to the current economic situation.

The same reasoning applies, to a large extent, to the changes to sickness benefit compensation levels that have been very numerous in the 1990s (and early 2000s). Although most of these changes implied a *decrease* in the level of compensation, overall the benefit level decreased with 'only' ten percent over the years. Indeed, "their magnitude [...] was small" (Palme, Bergmark, Backman, Estrada, Fritzell, Lundberg, Sjöberg & Szebehely, 2002, p. 341) (and thus is the Swedish sickness benefit scheme currently still characterised by a relatively generous compensation rate). During the 1990s the

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the situation in which "employers with a high incidence of sickness absence w[ould] pay more than they previously did, whilst employers with a low incidence [would] pay less" (MISSOC, 2005, p. 1).

Swedish government has made attempts to differentiate the allowance rate according to the length of the sick spell by reducing the rate for the first part of a sick spell, this way making access to the scheme less attractive (and work more attractive). However, the current system is based on one rate again. Still in place is the legislation that allows for the reduction of the sickness benefit provided in case of contractual additions of more than ten percent. Although such a limit on the benefit level in principle coincides with the legacy of neo-liberalism, it forms an example of regulation rather than neo-liberal deregulation or a politics of laissez-faire. The setting of a *limit on the duration* of sickness benefit provision, on the other hand, does provide a good example of the neo-liberal theory translated into practice, as does the introduction of the possibility to require a doctor's certificate from the first day of sickness onwards. The same applies to the introduction of more *partial benefits* into the scheme in 1990, as this allows people to go back to work if they are not fully capable of work again, whilst still receiving benefits for their remaining incapacity. The activating effect of such measure is obvious, however, it does touches upon the area of *active labour market policies*, pointing at an active rather than passive state.

The neo-liberal process of *privatisation* has also found its way into the Swedish sickness benefit scheme, though to a different extent than in the other two countries studied. Although the length of the employer period has been changed several times, it currently equals the two weeks that were also originally introduced by the *Sick Pay Act (1991:1047)* in 1992. The private scheme, thus, only represents a very modest part of the Swedish sickness benefit scheme. Indeed, following more recent reforms, it seems as if the government's wishes to direct its arrows at the incentives of employees rather than of employers. With the introduction of the rehabilitation chain, emphasis has been put on getting those on sick leave back to work (see e.g. Swedish government, 2008, p. 46) by making the eligibility to the benefit *conditional upon stricter medical testing requirements*. Not only does the introduction of this rehabilitation chain point at the increasing important attached to the neo-liberal concept of activation, it is also illustrative for the emphasis that is, nowadays, put on individuals and their *self-responsibility*.

Conclusively, it can, thus, be argued that although the majority of changes to the sickness benefit scheme have for a long time seemed to offset one another, more recent reforms introduced a more radical shift towards the neo-liberal objectives of activation and targeting. The part that is to be played by the private sector, however, has not been significantly extended and a strong and active public sector has remained.

7 Assessment of Findings: Relating Theory to Practice

7.1. Common trends and variations

The descriptions provided in the previous sections have clearly demonstrated that the different sickness benefit schemes have been subject to various reforms since 1975. Moreover, the analyses that have been derived in the second paragraphs of sections four to six have pointed at the (non-)neo-liberal character inherent in most of these reforms. This paragraph aims at comparing these changes which have been implemented in the three selected countries by identifying common trends (i.e. traces of *convergence*), but also by showing variations in the (motivations for the) paths that have been taken.

With regard to the first neo-liberal pillar of shifting responsibilities from the public to the private sector, it has become evident from the developments described before that the public sickness benefit scheme has been supplemented by a 'private' scheme in all three countries. That is to say, employers have become responsible for (part of) the provision of sickness benefit. However, whereas the British government has initiated this process of privatisation to decrease the amount of government involvement in matters that can also be dealt with by the private sector, the Dutch and Swedish government have emphasised the incentives (with regard to prevention and rehabilitation) inherent in such a measure. It should be stressed that such incentives are likely to play a more important part in the Netherlands, given the differences in the duration of the so-called employer period. While the Dutch and British sick pay provisions have to a large extent replaced the public scheme, the reach of the Swedish sick pay programme has remained very modest. Although employers in the United Kingdom have become financially responsible for sick pay only twelve years after the transfer of administrative duties to the private sector, once this transfer was established, the British government did limit itself to the setting of a minimum sick pay rate and refrained from taking any further actions, this way actually supporting additions to the benefit through occupational sick pay. In the Netherlands and Sweden, on the other hand, the concept of 'managed liberalisation' (van der Veen & Trommel, 1999) rather than deregulation seems to have played a very relevant part, as both countries have attempted to limit the possibilities for contractual top-ups, though for different reasons: Whereas the Swedish government stressed the concept of equality, the Dutch government's main aim was to increase the claimant's incentives to return to work.

With regard to these 'pillar one-reforms', it can then be concluded that as far as the neo-liberal notion of deregulation is concerned, both the Netherlands and Sweden have been very cautious to make commitments, allowing for the conclusion that neither *policy convergence* nor *paradigm convergence* seem to have taken place. The degree of convergence surrounding the neo-liberal concept of privatisation should be assessed differently, as in all three countries some form of privatisation of sickness benefit has been implemented (indicating the presence of a certain extent of *policy or output convergence*). Nevertheless, the ideas supporting these processes of privatisation have differed and have not always coincided with the neo-liberal objective of a privatisation of responsibilities *as such* (thus pointing at a lack of *paradigm convergence*). Interestingly enough, the transfer of responsibilities from the public to the private sector has in certain cases been justified on the basis of arguments referring, albeit indirectly, to the principle of activation, a prominent principle within the 'second neo-liberal pillar'.

With regard to this second pillar, it should be mentioned first of all that in all three countries studied, the concepts of self-responsibility and individualisation have increasingly come to the fore, as rights have been increasingly linked to responsibilities. The principle of need (e.g. Clasen & van Oorschot, 2002, p. 96) – reflecting a "targeting and selective" (i.e. neo-liberal) approach – has been gradually translated into policies, though not in the form of a means-test, but rather through the introduction of stricter medical tests or re-integration obligations. In other words, although only the Swedish government has allowed for stricter medical requirements for initial access to the benefit scheme, governments of all three countries have, by providing 'sticks', attempted to focus the provision of sickness benefits at those who are really incapable of working and to encourage those who are not to get back to work as soon as possible (i.e. to activate). Still, some differences have remained within this respect as well, for instance, because the Swedish government has extended the possibilities for the provision of partial sickness benefits, while the Dutch and British systems are still based on the 'all-or-nothing' principle. This statement should be balanced, however, as *in practice* employers, because of the considerable financial incentives provided through the Dutch and English scheme, have been

encouraged to support their employees to return to work as soon as possible, thus, if considered necessary or more appropriate, also – at least initially – on a partial basis. Still, whereas the state plays a rather passive part in this latter process, the Swedish system requires a relatively active state – a requirement that illustrates a deviation from the neo-liberal principle of laissez-faire.

Concerning the duration of the sickness benefit, the three countries have followed three different paths. For instance, whereas the Dutch government has lengthened the duration of the sickness benefit scheme, the Swedish government has recently – for the first time in history – put a time limit on the provision of sickness benefit, and the British government has abolished first the label of 'sickness benefit' and later the whole public scheme as such (by fusing it with the disability benefit scheme). This does not imply, however, that not all three systems can be justified in terms of the neo-liberal theory, as has been illustrated through the analyses provided in the country sections. Indeed, all three governments have, to a large extent, justified the reforms with references to the concept of activation (or related terms). In other words, activation has become a common ideal, however, the countries studied have taken different paths or measures to achieve this goal, at least as far as the duration of the sickness benefit provision is concerned. Policy convergence has, on the other hand, at least partly, arisen in the context of compensation rates, as the replacement rate has become less generous in all three countries. While the percentages have been lowered in both Sweden and the Netherlands, in the United Kingdom, at first, the duration of the less generous short-term benefit was extended and from 2008 onwards, the benefit level has been based, to some extent, on the degree of incapacity[26]. Still, a considerable contrast should not be overlooked: Whereas the United Kingdom has abolished earnings-related supplements and has opted for a flat-rate, both Sweden and the Netherlands have hold on to an earnings-related rate and, thus, have not entirely surrendered to the neo-liberal ideal of low(er) compensation rates. Moreover, the lowering of compensation rates has often been justified in terms of the economic situation rather than in neo-liberal terms (except for in the United Kingdom).

To sum up, with respect to 'pillar two-changes', although *policy convergence* has only incidentally occurred, a certain degree of *paradigm convergence* has been initiated. The concept of activation has gained prominence in the three countries studied and so has the targeting focus, thus emphasising the importance increasingly attached to individual responsibility. The provision of sickness benefits, and especially the conditionality upon which this provision is based, appears to represent a good example of the individualisation of social welfare. Still, as has been the case with regard to the first pillar more evidently, the Swedish and Dutch governments have been shown to have been hesitant to allow for a complete triumph of the pure neo-liberal body of thought. Accordingly, as has also been recognised by Palier (2007, p. 9), it appears that, in spite of the fundamental changes that have been and are executed on the scene of the welfare state, "integrating phenomena of path dependency in welfare state analysis [remains] essential". Obvious examples of such processes of path dependency with regard to this second neo-liberal pillar form the continuing attachment of the Dutch government to the reproduction of income differences in the pattern of sickness benefits (Kleinman, 2002, p. 36; see also Clasen & van Oorschot's (2002) principle of reciprocity) and the Swedish remaining focus on universalism (e.g. Lindbom, 2001; Clasen & van Oorschot, 2002) of the scheme (that is to say, conditions such as the British National Insurance contribution requirement have not been implemented and, thus, at least in principle, all residents have remained eligible for the (public) scheme).

[26] It should be noted that such a process of differentiation ("between permanent disability and partial[…] capability" (van Gerven, 2010, p. 14) has also found its way in the Netherlands, but only in the context of the disability benefit scheme (through the *Act on Work and Income According to Work Capacity* (Stb. 2005, 619)). However, since the sickness and disability benefit schemes have been merged in the United Kingdom, the resemblance is worth mentioning here.

To provide a clear and more concise overview, the findings of this paragraph have been symbolised and summarised in 'Table one' (see 'Appendix'). The impact of these findings for the validity of the hypotheses established in the second section of this thesis will be discussed in the following paragraph.

7.2. Hypotheses revisited

The three sickness benefit schemes studied in this thesis differed in 1975, the starting point of the analysis, and were still far from identical in 2009 (although some policy convergence has been identified). Nevertheless, all three systems have been subject to significant neo-liberal-coloured reforms. Following what has been argued in the first paragraph of this section, it seems reasonable to point out – in line with the first hypothesis (to recall, that on the level of policy objectives, different national systems of social security are expected to converge) – that *at least some paradigm convergence has taken place*, and – following the line of expectation expressed by the second hypothesis (i.e. that ideational convergence of sickness benefit schemes is expected to take place in a neo-liberalist direction) – that this convergence has *generally tended to point in a neo-liberal direction rather than in a non-neo-liberal direction*.

It appears that especially the concepts of activation and targeting have been some of the main driving forces of reforms to sickness benefit schemes in the past 35 years, although they seem to have gained importance primarily in the second part of this period (an issue I will return to in the final section). Other (more concrete) elements of neo-liberalism that have been visible, in one way or another, in the sickness benefit policies of the three countries are the lowering of benefit levels and the transfer of (some of the) responsibilities to the private sector. With regard to the latter it should, however, be stressed that although a process of privatisation clearly fits the neo-liberal theory, in several instances privatisation has been used mainly as a means, thus indicating a lack of true ideational convergence on this point. Even more significantly is the lack of ideational convergence with regard to the neo-liberal objective of deregulation, as in most instances an active rather than a passive state is still preferred (i.e. adhering instead to the 'Third Way' approach). Accordingly, it should be added to the comments made on the validity of the second hypothesis earlier in this paragraph (in italics) that this neo-liberal ideational convergence has occurred *mainly in relation to the 'second neo-liberal pillar'* established in the theoretical framework (i.e. the pillar containing the transfer of responsibilities from the public to the private *sphere*).

8 Concluding Remarks

This study has described the reforms which have been implemented to the sickness benefit schemes of the United Kingdom, the Netherlands and Sweden over a period of 35 years. It has analysed the (non-) neo-liberal character of these reforms and has, accordingly, provided an assessment of whether a process of convergence upon such (non)-neo-liberal objectives was initiated. Based on the conducted research several concluding remarks can be formulated which add to the current theoretical framework in various ways.

First of all, the study aligns with the more recent stream of literature on welfare state change in which it is stressed that welfare state policies can indeed be subject to fundamental reforms as it *finds* that paradigm convergence with regard to social security provisions does actually occur. It also *confirms*

that such a process of ideational convergence is not necessarily preceded by or accompanied with convergence of policy outputs (although such convergence occasionally has arisen as well), thus pointing at the potential merits of attempts to (merely) coordinate the paradigm(s) guiding welfare state policies. More significantly, the study *shows* that, at least in the field of sickness benefits, this process of ideational convergence has clustered foremost around the neo-liberal *ideals* of activation and individualisation. Accordingly, it is worth mentioning that, at first sight, the research offers a quite 'positive' answer to the research question on which this thesis is primarily based. It should also be emphasised, however, that it is *traces of* (neo-liberal) convergence that have been identified through this research rather than an 'absolute' process of ideational convergence. Referring back to the conceptualisation of 'neo-liberalism' provided in the 'Theoretical Framework' this implies, more concretely, that although all three countries have made attempts to remove or, at least, reduce the rigidities or "perverse consequences" (Giddens, 1998, p. 113) which follow from welfare state generosity, they have done so mostly by increasing the incentives to activate and by targeting claimants rather than by initiating a true process of deregulation. It is, thus, only *part of* the neo-liberal paradigm (i.e. that part represented by those notions forming the second neo-liberal pillar) that has 'conquered'. The question that arises accordingly is, then, whether it truly is 'neo-liberalism' that has gained the ideological upper hand, or whether there is another paradigm that better fits the identified developments. In the 'Theoretical Framework' reference was already made to the 'Third Way' approach, that is also "about turning welfare into work", but "involves both a positive view of the ability of the market to provide certain outcomes *and* a strong emphasis on the active 'social investment state'" (Green-Pederson *et al*., 2001, p. 309, emphasis added), as it "aims to bring together the inherited neo-liberal design and incentive structure with elements of Scandinavian-style active labour market policy" (Crouch, 2000, as put forward by Ferrera, Hemerijck & Rhodes, 2000, p. 33). Although such a paradigm better suits better to the Swedish and, to a lesser extent, to the Dutch realities, it does not coincide with the traditionally deregulatory bias on the British scene. In other words, no ideational convergence appears to have yet arisen with regard to the question of who is to arrange the provision of sickness benefits. Such paradigm convergence has, on the other hand, been initiated in respect of the ideas underlying the characteristics and requirements of (sickness) benefit receipt, and this paradigm is in line with both the neo-liberal legacy and the Third Way approach (as it is this part that those expressing the latter body of thought have 'copied' from the former).

The time and resources available for this research project only allowed for the study of one specific part of the countries' social security system of no more than three European Union member states. Further research should, therefore, indicate whether the *initial* findings as described above can be proven to hold when generalised over other countries and other parts of the social security system. In particular, it will be interesting to see whether, first of all, convergence on the second-pillar objectives of activation and individualisation can be considered a process that has been spread more broadly over the past decennia. And, secondly, whether such ideational convergence has again *not* occurred in the light of the first-pillar goals of regulation and privatisation[27]. If the former appears to be the case, the possibility of a Europe heading towards one social model, that is to say, at least as far as a significant part of the overall social (security) paradigm is concerned, might actually appear to be a realistic prospect. In case the latter is shown to represent a general development, attention should be directed to the question of whether a process of dualisation is taking place in this regard (with countries following

[27] With regard to this notion of privatisation, it would be interesting to see whether there are more instances in which this neo-liberal *instrument* is used to achieve goals that are not so much related to the idea of privatisation itself (also outside the direct framework of social security).

the Third Way approach and countries following the neo-liberal body of thought) or whether a clear demarcation between more than two different welfare state regimes is still visible.

Constraints have not only come to the fore with regard to the number of countries and benefit schemes that could be selected for the study. Another limitation has arisen from the purpose of this research that has been identified as solely descriptive. In other words, the research design chosen did not allow me to identify the factor(s) accounting for the ideational convergence that has been shown to have taken place (nor to explain why such convergence did not come into being in relation to the first-pillar objectives). This implies that, although the hypotheses have, to a large extent, been established on the basis of developments at the European Union level, the explanatory force of these developments with regard to the traces of convergence retrieved has not been established. I have chosen not to engage in explanatory research as, in my opinion, causal relationships would be hard to detect since there was no feasible possibility to work with a control group, which in turn implies that the effect of third variables could not have been ruled out. Following this line of reasoning, Kröger (2009, p. 8) has, for instance, argued that "[t]he influence of the [Open Method of Coordination] is indeed very difficult to establish".

Still, it is interesting to consider the developments described above in the light of the time frame chosen. Although all three countries started to privatise (parts of their) sickness benefit scheme long before the European Employment Strategy was adopted, the concept of activation (that has, as indicated before, always been a central one in the context of the Strategy) seems to have gained most of its prominence after 1997. Although the United Kingdom was the first country to implement this neo-liberal turn in the early 1990s (see also Crouch & Keune, 2005, p. 87; Walker & Wiseman, 2003, p. 22), the Netherlands and Sweden followed this path in the first respectively second part of the 2000s. Moreover, unlike activation, deregulation is not an objective that has been explicitly promoted through the Strategy. These findings could pave the way for subsequent research with an aim to find out 'the true motives' of policy-makers behind the neo-liberal-coloured reforms implemented. For instance, by conducting a large number of qualitative in-depth interviews with the relevant actors, attempts could be made to find out whether it has indeed been the introduction of the European Employment Strategy that has allowed for neo-liberal convergence upon the objectives of activation and individualisation to occur, or whether there have been other variables that have played a significant part in this development. Although the weaknesses of such a research (aiming at explanation) in terms of validity are obvious, it might provide some (more concrete) ideas on the question of what has caused policymakers to carry out reforms in spite of the unpopularity these reforms have usually been associated with.

Appendix

Table one – Summary of 'Common trends and variations': Neo-liberal influences

	First neo-liberal pillar		***Second neo-liberal pillar***	
	Privatisation	*Deregulation*	*Individualisation: Targeting*	*Self-responsibility: Activation*
United Kingdom	**+ + +** In several phases both the managerial and financial responsibility for a significant part of the provision of sickness benefits has been transferred to the private sector. Moreover, this shift has mainly been justified in terms of decreasing the degree of government involvement in matters which can be dealt with 'privately'.	**+ +** The transfer of these responsibilities for the provision of sickness benefits to the private sector has not been accompanied by attempts of the British government to guide this provision in a specific direction (i.e. to regulate). Rather, the government has generally only engaged in the process of laying down certain (basic) minimum requirements, while stimulating the provision of private or occupational sick pay.	**+ + +** The medical requirements underlying sickness benefit provision have been altered or, rather, tightened several times to emphasise the importance attached to 'true' need and this attachment has been reinforced by the introduction of possibilities to differentiate according to the remaining work-capacity. Moreover, the National Insurance contribution requirements to allow access to the public scheme have been sharpened.	**+ + +** Reforms to the medical tests which are to determine eligibility for sickness benefit provision have been directed more and more at the remaining capacity (rather than *in*capacity) of the claimant to return to the work floor. Ever since the problem of the 'why work' syndrome was put to the fore in the early 1980s, the notion of activation has remained and even gained importance on the social security reform agenda.
The Netherlands	**+** Although the main part of sickness benefit provision has been privatised over the years, this process was stimulated to a large extent by the aim to increase the incentives (of employers) to increase prevention and rehabilitation efforts (and not so much by the objective of transferring responsibilities to the private sector as such).	**0 / +** The process of privatisation initiated in the Netherlands has largely been supplemented with 'public action'. However, certain aspects have remain rather unregulated (such as the provision of partial benefits) and social partners (i.e. the private sector) have quite often been consulted during regulatory processes.	**+ +** Next to a decreasing generosity of sickness benefits, eligibility to the provision of sickness benefits has also become stricter due to an increase in re-integration requirements. This way, obvious 'sticks' are provided. Still, the Dutch government has refrained from initiating reforms in respect of the earnings-related character of the replacement rate.	**+ + +** The right to sickness benefit (or sick pay) has been made increasingly conditional upon certain re-integration *responsibilities* of the claimant. The employees are also addressed through measures that 'oblige' them to smoothen and speed up the claimant's return to the work force.
Sweden	**0 / +** Only a small part of the sickness benefit scheme has been privatised. Also, the process of privatisation was initiated more as a	**0** Although a process of deregulation has not been initiated, the opposite process of regulation has not taken place either. For instance, the	**+ +** The Swedish government has tightened access to the sickness benefit scheme by the introduction of stricter medical requirements	**+ + +** Although changes to the Swedish benefit scheme for a long time seemed to cancel each other out, more recent reforms have made the concept of

	means to stimulate employers to deal with sickness absence rather than as a means for transferring responsibilities from the public sector to the market (see the Netherlands).	privatisation of part of the sickness benefit scheme (generally pointing at some sort of deregulation) has been *counterbalanced* by the introduction of some accompanying rules (e.g. with respect to the determination of a maximum total compensation rate).	(both with regard to initial access to the scheme and with regard to continuing eligibility) and by introducing a 'time limit'. However, a universalistic trend is still visible, as is an earnings-related element in the compensation rate.	activation a key one. Particularly with the introduction of a rehabilitation chain, the government has come to emphasise the process of getting those on sick leave back to work as soon as possible, thus confirming its self-assigned status of being committed to a 'Work First' approach.
	⇩	⇩	⇩	
	First and foremost convergence of means (i.e. policy convergence rather than convergence of paradigms), as the Netherlands and Sweden have used privatisation mainly as a means to achieve something else (i.e. lower levels of sickness absence).	Neither paradigm convergence, nor policy convergence.	Convergence of paradigms has to a very large extent taken place (and convergence of instruments occasionally). The notions of activation and individualisation are the driving forces behind the large majority of the reforms enforced in the different countries in relation to the sickness benefit schemes, such as the lowering of compensation rates and the tendency to increase conditionality . The objective has even been used to 'justify' the first-pillar process of privatisation in the Netherlands and Sweden.	

Key to symbols

The scale applied in 'Table one' ranges from '- - -' to '+ + +', with the latter indicating a strong neo-liberal influence and the former a strong *non*-neo-liberal influence. A '0' indicates a neutral effect over a period of 35 years with regard to the (non-)neo-liberal dichotomy.

Additional notes

First of all, it is interesting to see that in none of the three countries under study a clear non-neo-liberal route has been taken (neither with regard to the objectives central to the first neo-liberal pillar, nor with regard to those central to the second one). This finding does not, however, immediately allow for the conclusion that neo-liberal convergence has indeed occurred. As far as the first neo-liberal pillar is concerned, the table shows that the pace of neo-liberal adherence differs greatly between the different countries (as only the British developments seem to be in line the neo-liberal paradigm) and that it is mainly policy convergence that has occurred. This research, however, is primarily concerned with paradigm convergence. In this respect, the results with regard to second pillar changes are very promising. Although the selected countries have not always opted for the same measures, the objectives stimulating the measures *have* very often been of the same neo-liberal nature. Especially the concept of activation has become a very dominant one in all countries involved, but targeting has also come to play a very prominent part in both the United Kingdom, the Netherlands and Sweden.

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