

Sickness, Disability and Work: Breaking the Barriers

**VOL. 2: AUSTRALIA, LUXEMBOURG,
SPAIN AND THE UNITED KINGDOM**



Sickness, Disability and Work

BREAKING THE BARRIERS

Australia, Luxembourg, Spain
and the United Kingdom

Vol. 2



ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

The OECD is a unique forum where the governments of 30 democracies work together to address the economic, social and environmental challenges of globalisation. The OECD is also at the forefront of efforts to understand and to help governments respond to new developments and concerns, such as corporate governance, the information economy and the challenges of an ageing population. The Organisation provides a setting where governments can compare policy experiences, seek answers to common problems, identify good practice and work to co-ordinate domestic and international policies.

The OECD member countries are: Australia, Austria, Belgium, Canada, the Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Korea, Luxembourg, Mexico, the Netherlands, New Zealand, Norway, Poland, Portugal, the Slovak Republic, Spain, Sweden, Switzerland, Turkey, the United Kingdom and the United States. The Commission of the European Communities takes part in the work of the OECD.

OECD Publishing disseminates widely the results of the Organisation's statistics gathering and research on economic, social and environmental issues, as well as the conventions, guidelines and standards agreed by its members.

This work is published on the responsibility of the Secretary-General of the OECD. The opinions expressed and arguments employed herein do not necessarily reflect the official views of the Organisation or of the governments of its member countries.

Also available in French under the title:

Maladie, invalidité et travail

SURMONTER LES OBSTACLES

Australie, Espagne, Luxembourg et Royaume-Uni

Vol. 2

Corrigenda to OECD publications may be found on line at: www.oecd.org/publishing/corrigenda.

© OECD 2007

No reproduction, copy, transmission or translation of this publication may be made without written permission. Applications should be sent to OECD Publishing rights@oecd.org or by fax 33 1 45 24 99 30. Permission to photocopy a portion of this work should be addressed to the Centre français d'exploitation du droit de copie (CFC), 20, rue des Grands-Augustins, 75006 Paris, France, fax 33 1 46 34 67 19, contact@cfcopies.com or (for US only) to Copyright Clearance Center (CCC), 222 Rosewood Drive, Danvers, MA 01923, USA, fax 1 978 646 8600, info@copyright.com.

Foreword

Sickness and disability policy should be a key economic policy concern in all OECD countries, but tends to receive less attention than it deserves. Medical conditions, or problems labelled as such by societies and policy systems, are increasingly proving an obstacle to raising labour force participation rates and keeping public expenditures under control. More and more people of working age rely on sickness and disability benefits as their main source of income, and the employment rates of those reporting disabling conditions are low. Unemployment has fallen in recent years in the OECD area, yet almost nowhere has this drop translated into more jobs for people with disability. With increasingly stricter work requirements in unemployment and social assistance programmes, and gradual retrenchment of early retirement systems, the pressure on long-term sickness and disability benefit schemes has increased. This, in turn, has led to rising numbers of people of working-age drawing these benefits and more public spending on them. There is now an urgent need to address this “medicalisation” of labour market problems.

This new thematic review looks at how abilities can be matched with opportunities. It examines national policies to control and reduce the inflow into sickness and disability benefit programmes, and to assist those beneficiaries who are able to work reintegrate the labour market. It attempts to discover what leads a person with a health problem to withdraw from the labour market or remain outside of it, and to identify areas for further policy improvement. Along these lines, this is a review of the employment prospects of persons with health problems or disability, not of their wider position and chances in society. This is why the report has a strong focus on benefit systems and employment policies while saying little about, for instance, broader issues of accessibility, which can be important pre-conditions for some of those people. Similarly, the main concern of the review is people who could work but do not work. Many people with health problems can work and want to work, so any policy based on the assumption that they cannot work is fundamentally flawed. Helping people to work is potentially a “win-win” policy: it helps people avoid exclusion and have higher incomes while raising the prospect of more effective labour supply and higher economic output in the long term.

The second report in this series examines the challenges and obstacles facing Australia, Luxembourg, Spain and the United Kingdom. In particular, it looks at promising steps in those four countries toward transforming sickness and disability schemes from passive benefits to active support systems that promote work. The report consists of five chapters and an Executive Summary of main challenges and lessons with a number of specific recommendations for further reforms for each country. Chapter 1 sets the scale of the problems looking at current key outcomes in the four countries. Chapter 2 evaluates past and ongoing sickness and disability policy reforms. Chapter 3 discusses how better sickness management and disability assessment can help reduce the inflow into long-term benefits. Chapter 4 analyses how replacement rates and work incentives are affected by the countries’ tax and benefit systems. Chapter 5, finally, looks at the roles of employers, public authorities and people with reduced work capacity in the delivery of employment policies and rehabilitation programmes and at recent developments and new challenges in this field.

This publication is the second in a series of three comparative reports on sickness and disability policies in selected OECD countries. The first report, which was published in 2006, covered Norway, Poland and Switzerland, and the third one, to be published in 2008, will cover Denmark, Finland, Ireland and the Netherlands. The three comparative reports will be followed by a synthesis report that will summarise the lessons learned in the course of the review for all OECD countries.

Work on this review was a collaborative effort, carried out jointly by the Employment Analysis and Policy Division and the Social Policy Division at the Directorate for Employment, Labour and Social Affairs. The report was prepared by Patrik Andersson, Michael Förster and Christopher Prinz (team leader). Tax-benefit models were prepared by Dominique Paturet, statistical assistance was provided by Dana Blumin and Maxime Ladaique, and administrative support by Marie-Line Noonan. Important inputs for the report were supplied by the Australian Department of Employment and Workplace Relations (DEWR), Luxembourg's General Inspectorate of Social Security (IGSS), the Spanish Ministry of Employment and Social Affairs (MTAS) and the United Kingdom's Department for Work and Pensions (DWP). These institutions prepared background documents, provided empirical evidence (together with the National Statistical Institutes), organised fact-finding missions and commented on a draft of this report. The draft text was also discussed at a seminar in Luxembourg in June 2007.

Table of Contents

Executive Summary and Policy Recommendations	11
Chapter 1. Key Trends and Outcomes	37
1.1. Employment and unemployment of people with disability	38
A. Macroeconomic environment and labour market trends	38
B. Employment among people with disability	39
C. Unemployment and inactivity among people with disability	41
1.2. Financial resources of people with disability: income and poverty	44
A. Relative income levels	44
B. Incidence of low incomes and poverty risks	45
1.3. Costs of disability benefit schemes: public spending and benefit dependence ...	47
A. Amount and composition of public spending	47
B. Trends in benefit reciprocity	48
C. Average benefit levels	50
1.4. Exclusion and inclusion errors: disability benefit reciprocity and disability prevalence	51
A. Understanding the concept of “disability”	51
B. Exclusion and inclusion errors	52
1.5. Demographic challenges: population ageing and future labour supply shortages.	54
A. Effects of ageing on recent trends among disability beneficiaries	54
B. Demographic challenges on disability policies over the coming decades	54
1.6. Impact of labour market requirements: work and health	57
A. Disability and health trends in the population	57
B. Labour market requirements and health	58
1.7. Conclusion	62
Notes	63
Chapter 2. Evaluating Recent and Ongoing Reforms	65
2.1. Australia: new participation requirements through welfare reform	68
A. Expansion of services and new funding mechanisms	68
B. Increasing workforce participation and reducing welfare dependency	70
2.2. Luxembourg: managing partial work capacity in a different way	71
A. Reducing the inflow into disability benefits	71
B. Helping people with partial work capacity getting into work	72
2.3. Spain: decentralising and concentrating decision powers	73
A. Devolution of responsibilities to the regional level	73
B. Concentration of benefit matters at one single authority	74
2.4. The United Kingdom: rebalancing rights and opportunities	75
A. Switching to a more active policy approach	75

B. Redefining rights and responsibilities	76
C. Improving assessments and work incentives	77
2.5. The likely impact of recent and ongoing reform	78
Notes	80
Chapter 3. Absence Monitoring and Assessment of Disability	81
3.1. Inflow into disability: what do we know?	82
A. Evidence on inflows into disability	82
B. Evidence on sickness absence	85
C. Pathways into disability benefits	87
3.2. Preventing disability early on	88
A. Early identification and early intervention	88
B. The role of employers	90
C. Monitoring absences of sick workers	92
D. Health status monitoring of the unemployed	94
3.3. Disability benefit for those who need it	95
A. Assessing disability	95
B. Health conditions and disability benefits	98
C. Addressing partial work capacity	101
3.4. Future policy directions	104
Notes	105
Chapter 4. Financial Incentives and Disincentives for People with Disability	107
4.1. The “attractiveness” of disability benefits	108
A. The relative importance of disability benefits	108
B. The tax/benefit position of persons with disability	110
C. Adequacy and generosity of replacement rates	112
4.2. Disability benefits as an early retirement pathway	115
A. Age bias in disability benefit reciprocity	115
B. Accounting for disability prevalence	115
C. Benefit system design and reform	116
D. Different pathways into retirement	118
4.3. Work incentives and disincentives for disability benefit recipients	120
A. Does it pay to work?	120
B. The impact of increasing work efforts	122
4.4. The impact of recent and planned benefit reforms on work incentives	123
A. Australia	123
B. Luxembourg	125
C. Spain	126
D. United Kingdom	128
4.5. Conclusions	129
Notes	131
Annex 4.A1. Background Tables for Different Household Types	132
Chapter 5. Employment Policy – New Challenges and Directions	137
5.1. Employment and disability: where do we stand?	138
5.2. More and better targeted employment services	142
A. What support is suitable for people with disability	142

B. What support is available for people with disability	143
C. Participation in activation measures	147
D. Access to employment activation services	149
5.3. A new balance of rights and responsibilities	152
A. New directions for the state to help people with health problems back to work ..	152
B. Increasing responsibilities for individuals with health problems	158
C. New ways to better involve employers	161
5.4. Future policy directions	167
Notes	169
Bibliography	171
List of Acronyms	175

List of Boxes

0.1. Scope of the report	11
0.2. Policy recommendations for Australia	21
0.3. Policy recommendations for Luxembourg	25
0.4. Policy recommendations for Spain	28
0.5. Policy recommendations for the United Kingdom	32
2.1. Structure of the countries' sickness and disability schemes – An overview	66
2.2. Illustration of countries' policy stances and trends	79
3.1. Early identification and co-operation between main actors in Norway	89
3.2. Harmonisation of sickness benefit regulations in Luxembourg	91
3.3. Ways to re assess and monitor sickness absence in Luxembourg and Spain ...	93
3.4. Innovative Job Capacity Assessment in Australia	96
5.1. Personalised employment service of Work Directions United Kingdom	144
5.2. Specialised employment measures in Australia and the United Kingdom	145
5.3. Australia's Job Network Disability Support Pension Pilot	151
5.4. Benbro Electronics: A recurrent best-practice price winner in Australia	167

List of Tables

0.1. Magnitude of the problem in Australia, Luxembourg, Spain and the United Kingdom	13
0.2. Selected key outcomes in Australia, Luxembourg, Spain and the United Kingdom	14
1.1. Favourable economic and labour market trends in the past five years	39
1.2. Employment differentials are higher for older and less educated persons	41
1.3. Higher shares of inactivity among total non-employment for people with disability, especially among men	43
1.4. Many inactive persons with disability want to work	43
1.5. More persons with disability among the lowest income deciles, especially in Australia	45
1.6. Being employed reduces otherwise higher poverty risks among persons with disability	46
1.7. Average disability benefits grew faster than wages in Luxembourg and Spain, but lagged behind in Australia and especially in the United Kingdom	50

1.8. Benefit receipt and disability prevalence: comparing different disability definitions	51
1.9. Exclusion errors are higher in continental European countries.	53
1.10. Population ageing will have a larger impact on future beneficiary trends in Australia and Luxembourg	56
1.11. Disability prevalence increases with age and lower education	58
1.12. Increasing levels of perceived work intensity in European countries.	61
1.13. Levels of perceived work-related stress vary greatly with work intensity and work satisfaction	61
3.1. The time people spend on disability benefits is increasing	84
3.2. Long-term absence in Luxembourg is much higher for blue-collar workers ...	86
3.3. Pathways into disability benefits are poorly documented	87
3.4. Employment rates drop rapidly after the onset of a disability.	88
3.5. Employment rates for people with mental health conditions are extremely low	100
4.1. Earnings are the most important income source for persons with disability ..	109
4.2. Gross and net replacement rates for main disability benefit schemes are higher in continental European countries	111
4.3. Disability benefits are more prominent among older men in Australia and the United Kingdom	120
4.4. Increasing working hours is not always very attractive for workers with disability	123
4.5. Lower benefit rates but higher withdrawal rates for persons with partially-reduced work capacity in Australia since July 2006	124
4.A1.1. Main characteristics of disability benefit and taxation systems, as at 1st July 2005	133
5.1. Employment characteristics of people with disability are different from those of people without disability.	139
5.2. Qualification levels of people with disability are lagging far behind everywhere.	141
5.3. Participation in employment measures in Australia and the United Kingdom	148
5.4. Per capita spending on activation measures is similar in Australia and the United Kingdom	149
5.5. Employment outcomes from activation programmes in the United Kingdom are promising	155
5.6. Employment outcomes for jobseekers with disability in Australia are slightly worse than for those without disability	155
5.7. Outflows from disability benefits are relatively low everywhere	159
5.8. The majority of recipients in Australia and the United Kingdom leave disability benefits involuntarily	160
5.9. Share of disability benefit recipients in receipt of a benefit for less than two years	160
5.10. Fulfilment of the employment quota is weak in Luxembourg.	163

List of Figures

1.1. Employment rates of persons with disability are only half the level of those without disability, except in Luxembourg	40
1.2. Higher and longer unemployment among the population with disability	42
1.3. Relative income levels of persons with disability are higher in continental European countries	44
1.4. Falling trend in spending on disability benefits in recent years	47
1.5. Incapacity-related spending exceeds unemployment-related spending, except in Spain	48
1.6. Disability benefit reciprocity rates have increased in Australia and the United Kingdom but have fallen in Luxembourg	49
1.7. Most persons with disability do not receive disability benefits, and many recipients do not claim to have a disability	52
1.8. Recent trends in beneficiary numbers result only partly from population ageing	55
1.9. Projected population and labour force 2005-2050	57
1.10. Steadily improving health status in all four countries	59
1.11. Inconclusive evidence on selected changes in the working environment	60
2.1. Comparing sickness and disability policies across time and countries	80
3.1. Inflows into disability benefits are falling and the gender gap is closing	83
3.2. Disability inflow rates and unemployment-population ratios are highly correlated	84
3.3. Evolution of sickness absence in the European countries	85
3.4. Major health conditions of disability benefit recipients vary considerably	99
3.5. Employment rates of disability benefit recipients are highest in Spain and lowest in the United Kingdom	102
3.6. Unemployment in Luxembourg increased more than disability fell	103
4.1. Lower-rate disability and unemployment schemes provide similar net replacement income	113
4.2. Disability beneficiaries significantly biased toward older age groups, in particular in Luxembourg and Spain	116
4.3. United Kingdom: interdependency between age-specific disability reciprocity and prevalence rates	117
4.4. Reciprocity age bias in Australia and the United Kingdom is explained by the age structure of disability prevalence	117
4.5. Age top-up to disability benefits in Spain moves net replacement rates above those of unemployment benefits	118
4.6. Australia: changes in old-age pension rules influenced disability inflow	119
4.7. Taking up work can be very costly, but not so in Spain	121
4.8. Australia: moving from DSP to NSA increases work disincentives for lower-earning singles and inactive couples	125
4.9. Luxembourg: being on unemployment rather than disability benefit can imply doubling of average effective taxation when taking up work	126
4.10. Spain: reform of non-contributory benefits significantly increased work incentives in the lower earnings range	127
4.11. United Kingdom: net replacement income from new Employment and Support Allowance is likely to be similar to incapacity benefit	128

4.12.	United Kingdom: taking up work becomes slightly more attractive with the new Employment and Support Allowance	129
4.A1.1.	Net replacement rates for disability benefits, unemployment benefits and social assistance, couple households, 2005	135
4.A1.2.	Average effective tax rates for persons with disability in different household situations, 2005	136
5.1.	Spending on activation measures for people with disability is low in all countries.	149

Executive Summary and Policy Recommendations

Too many workers leave the labour market permanently in the course of a growing health problem, and too few people with reduced work capacity are working. This is a social as well as economic tragedy that is common to virtually all OECD countries, including Australia, Luxembourg, Spain and the United Kingdom. Health-related problems, or problems labelled as such because of societies' inability to accommodate individual differences, are increasingly proving an obstacle to raising labour force participation rates and keeping public expenditures under control. Yet throughout the OECD area there is a shared paradox that needs explaining. Why it is that average health status is improving, yet more and more people of working-age leave the workforce and rely on health-related income support? This report explores the possible factors behind this paradox, highlights the role played by institutions and policies, and puts forward a range of recommendations aimed at improving the situation (see Box 0.1 for more details on the scope of the report).

Box 0.1. Scope of the report

Focus of the report

The focus of the report is on how countries' benefit and employment policy systems could be enhanced so as to better match people's work capacities with their employment prospects. Therefore, the main target group of the report is people who could work but do not work, or work less than they could and often would like to. This is why emphasis is put on sickness absence monitoring and the assessment of disability; financial incentives and disincentives offered by the benefit system; and the rights and responsibilities of beneficiaries and workers with health problems, their employers and the state in delivering and structuring employment policy. Many other aspects of policy important for the integration of people with disability into society at large are outside the scope of the report. This includes, for instance, broader issues of physical barriers and accessible transport and of attitudes of the society towards people with disability. For some groups of people with reduced work capacities these issues can be important for their labour market integration as well. Politically, these issues are much less contested than benefit and employment policies. Transportation, public buildings and private workplaces ought to be accessible for everybody, and available technical aids (e.g. for vision or hearing-impaired workers) be made available whenever needed, and OECD countries ought to move into this direction quickly. Non-discrimination legislation is a necessary but by no means sufficient step.

Box 0.1. **Scope of the report** (cont.)**Definition of disability and reduced work capacity**

Identifying the target group of the report, i.e. working-age people with a health problem or disability, is not straightforward (working age is defined as the age group 20-64). Disability and impaired health is not a dichotomous category but instead a complex concept influenced as much by personal characteristics as by “environmental” factors and barriers. Depending on the latter, a person with a health problem or disability may or may not be confronted with a reduced work capacity. The report uses two different sets of definitions, one determined by administrative procedures and the other through self-assessment. The latter and broader one is used to identify all people whose activities of daily living are to some degree, moderately or severely, hampered by their health situation, or commonly as people with disability. This is referred to as (self-assessed) *disability prevalence* in the working-age population, or commonly as people with disability. Different population surveys in the countries under review allow the identification of this group, noting that resulting prevalence rates are not fully comparable across countries and sometimes even across surveys within the same country. Administrative definitions of disability, on the contrary, are based on often complex and more or less objective assessment procedures, always comprising medical and to some extent also vocational elements. The main one used in the report is the definition used by the disability benefit system (or systems, if there is more than one such scheme with different assessment procedures), with the resulting figure referred to as *disability benefit reciprocity*. Another definition used only occasionally is *legal disability* as determined by administrative procedures for other than benefit purposes (more precisely, this concept is used in both Luxembourg and Spain in the context of these countries’ employment quotas). Due to the nature and purpose of these different definitions of working-age disability, resulting figures overlap only partially.

Terminology

Finally, throughout the report a uniform terminology is used. Unless noted otherwise, the term *disability benefit* refers to the Disability Support Pension for Australia; temporary and permanent disability pensions and the special minimum income for persons with severe disability for Luxembourg; invalidity pension for total, absolute and severe incapacity and non-contributory invalidity benefit for Spain; and Incapacity Benefit (short-term lower rate excluded), Income Support with a disability premium and, for older data, Severe Disablement Allowance for the United Kingdom.

Key lessons from the report*Main challenges in Australia, Luxembourg, Spain and the United Kingdom*

The general problem is similar in all four countries under review: large-scale labour market exclusion of people with health problems and widespread dependence on health-related benefits putting pressure on the social protection system. A closer look at country-specific outcomes, however, shows that the countries are facing different key challenges, as summarised in Tables 0.1 and 0.2.

A major finding for **Australia** is the low and falling level of income of people with disability (measured as total income of all household members adjusted for household size), which is more than one-third lower than for those without disability, in turn leading

Table 0.1. **Magnitude of the problem in Australia, Luxembourg, Spain and the United Kingdom**

Selected key policy issues	Australia	Luxembourg	Spain	United Kingdom
Controlling incapacity-related public spending	++	+++	++	++
Raising employment rates for people with health problems	+++	+	++++	++
Tackling lower incomes of households with people with disability	+++	+	++	+++
Reducing the inflow into sickness and disability benefits	++	++	++	++++
Addressing the increase in mental health conditions	++	++	+	+++
Raising the outflow from usually permanent disability benefits	+++	+++	++	++
Strengthening co-ordination across different benefit schemes	++	+++	+++	++

Note: The scales should be interpreted as follows:

+ ... minor challenge; ++ ... moderate challenge; +++ ... substantial challenge; and ++++ ... formidable challenge.

Source: Authors' assessment.

to a high poverty risk. This problem partly results from the equally low and falling rate of employment of people with disability, of only 40%, despite a tight labour market. Added to this is the very strong increase over the past 15 years in the number of people receiving disability benefits, only partly explained by increases in the retirement age for women and the closing of other non-activity tested income support payments. This increase has predominantly affected workers under age 50. Even if the increase has halted recently, the problem will persist because of the low rate of outflow from disability benefits.

In **Luxembourg**, disability benefits are predominantly used as an early retirement pathway, with more than 80% of all recipients being older than 50. In turn, the share of people without disability on disability benefit is the highest in the four countries (the “inclusion error”) and outflows from those benefits are low. At the same time more people with disability are found to have neither a job nor a benefit (the “exclusion error”). Also of concern is the high level of public spending on disability benefits, at 1.7% of GDP in 2005, despite a fall from 2.2% in the past decade. Another challenge in Luxembourg is the weak co-operation between various actors responsible for rehabilitation and employment support, which is one of the reasons for the recent increase in unemployment of people with disability.

In **Spain**, the decentralisation of large parts of disability benefit and employment policies to the autonomous regions has raised significant co-ordination issues. In particular, problems arise from the complexity of the indispensable co-operation between the decentralised employment service and the centralised social insurance institution. The second fundamental challenge in Spain is the very high level of unemployment of people with a disability (over 18%) and their low rate of employment (less than 35%). While employment rates have increased recently, and incomes risen in return, the sharp drop in overall unemployment has not reached people with disability. This is partly related to the lower average level of educational attainment and the higher average age of this population group.

In the **United Kingdom**, the main challenge is the very large number of disability benefit recipients. At 8%, the share of the working-age population on such benefits is much higher than on average across the OECD (though including people which in other countries would receive a separate long-term sickness benefit), and almost twice the country's rate

Table 0.2. **Selected key outcomes in Australia, Luxembourg, Spain and the United Kingdom**

Selected key outcomes	Australia	Luxembourg	Spain	United Kingdom ^a
Spending on sickness benefits (in % of GDP)	0.5 (falling)	0.8 (constant)	1.0 (constant)	0.6 (falling)
Spending on disability benefits (in % of GDP)	1.1 (constant)	1.7 (falling)	1.1 (constant)	1.5 (falling)
Employment rate of people with disability (%)	39.8 (falling)	50. (constant)	34.9 (rising)	45.3 (rising)
Unemployment rate of people with disability (%)	7.8 (falling)	7.3 (rising)	18.4 (rising)	7.4 (constant)
People with disability and below upper secondary education (%)	49 (constant)	55 (falling)	81 (falling)	72 (falling)
Workers with disability and below upper secondary education (%)	34 (constant)	43 (constant)	69 (falling)	61 (falling)
People with disability below 50% of the median income (%)	36 (rising)	9 (. .)	18 (constant)	14 (constant)
Income of people with disability relative to those without disability (%)	65 (falling)	89 (. .)	86 (rising)	73 (falling)
Workers on sickness absence in the entire past week (%)	[0.7] ^b (constant)	1.7 (rising)	2.8 (rising)	2.0 (constant)
Disability benefit recipients in % of the working-age population	5.7 (rising)	4.9 (falling)	3.5 (constant)	8.1 (constant)
Disability benefit recipients with mental health problem (%)	29 (rising)	[18] ^c (. .)	10 (constant)	40 ^d (rising)
Disability benefit recipients over age 50 (%)	56 (constant)	82 (constant)	65 (falling)	47 (falling)
Annual outflow from disability benefits in % of current recipients ^e	4.6 (constant)	6.1 (rising)	. .	7.3 (constant)
Inclusion error: people without disability on disability benefit (%)	29	56	34	8
Exclusion error: people with disability without benefit or work (%)	11	20	16	11

Note: Information in parentheses refers to the trend in the respective indicator in the past few years (if available).

a) Except for spending data, information refers to Great Britain only.

b) The figure for Australia refers to workers absent during the entire past two weeks. Other data suggest that sickness absence rates in Australia are similar to those recorded for the United Kingdom.

c) The figure for Luxembourg is a crude estimate that is not really comparable with the data for the other countries.

d) The figure for the United Kingdom includes behavioural disorders.

e) Data for Spain are not available. Outflows exclude deaths and transfers into retirement. Nevertheless, only between 12% (Australia) and 22% (United Kingdom) of all outflows shown are outflows into employment.

Source: Details on the outcome indicators are available from the analytical chapters of this report.

of unemployment. The prevalence of mental and behavioural illness has increased sharply to reach 40% of all disability benefit recipients in 2005. Another important issue in the United Kingdom is the low level of income of people with disability. Given their comparatively high rate of employment, this suggests that people with disability tend to work in low-paid jobs.

Recent policy responses

Poor outcomes like those illustrated above may to some extent reflect changing labour market requirements. For instance, some have argued that workplaces are increasingly stressful and working conditions surveys find that work intensity has indeed increased. However, one important factor at work in all OECD countries is inadequate policies. Disability assessment procedures and benefit systems have long pushed people with

reduced work capacity out of work and into long-term benefit dependency. Recognising the key role of policy in this field, the four countries under review have engaged recently in reform processes which go in the right direction.

First, in all four countries assessment procedures have been reformed. In Australia, what is now assessed is the *remaining work capacity* of the individual, instead of the functional disability or limitation, as was the case before the reform. In the United Kingdom, the assessment procedure is also being reformed along these lines, and in Spain increasing efforts are being made to identify better the remaining work capacity of an individual. Luxembourg and Spain have put greater emphasis on monitoring sickness absence, so as to better control inflows into disability benefits. Secondly, the four countries are making greater use of employment and rehabilitation measures for those already on benefits but also to avoid inflows into long-term benefits. Australia and the United Kingdom are now funding employment services on the basis of employment outcomes and they make intensive use of individualised case management. More fundamentally, the four countries are also in the process of creating a new balance of rights and responsibilities for the authorities, for people with health problems or disability and, to a lesser extent, for employers.

There are some interesting differences across the four countries in the sequence of reform. In Australia, employment policy change preceded benefit reform, while Luxembourg went through the reverse pattern, with employment policy expansion coming after changes in the benefit system. In Spain and the United Kingdom, employment and benefit policy reform went largely hand-in-hand. Reforms in the past twenty years are likely to help improve the effectiveness of activation and integration measures, so that outcomes can be expected to improve as well. Nevertheless, this report shows that much more needs to be done to curtail flows from work to sickness and disability benefits, and to raise participation rates of those people with disability who wish to work.

Work needs to be put at the heart of sickness and disability policies, for two reasons. First, in the face of an ageing population it will be important to maintain effective labour supply. People with reduced work capacity who are highly underrepresented in today's labour markets will be an important resource in this regard. To mobilise this labour resource will be particularly challenging in view of the much higher disability prevalence and benefit recipiency among older workers. However, improving work opportunities is also the best way to ensure that long-term sick people and people with disability have a chance to play the role in society to which they aspire. Current policies often serve such people badly: they are trapped at the margins of society, excluded from work or marginalised into special employment categories. Helping people with disability stay or return to work should increase overall employment rates and reduce public spending, which further justifies dedicating resources and public expenditures to achieving this end.

Causes behind the trend rise in disability

The four countries offer some interesting lessons about trends in disability benefit recipiency, and the driving forces behind them. First, these trends are strongly influenced by the rate of unemployment and by reforms of the unemployment benefit scheme. In both Australia and the United Kingdom, in the early 1990s unemployment was high and increasing, and this translated into gradually increasing disability benefit receipt. In the

second half of the 1990s, however, when unemployment fell due to a strong economy, disability benefit reciprocity continued to increase at the same pace. By now, unemployment has fallen to historically low levels while disability benefit receipt has reached historical maxima. The mechanisms behind these opposing trends are complex, but surely include the tighter participation requirements introduced for the unemployed. Disability benefit reciprocity growth only started to level off and then even halt when reforms of the disability benefit system started to bite.

Conversely, recent evidence for Luxembourg suggests that tighter access to disability benefit has translated into higher structural unemployment. This raises an interesting political economy issue, because policy makers tend to put more importance on low unemployment rates than total non-employment rates. Spain offers yet another interesting aspect to this story, because in this country rapidly falling unemployment has not translated into higher disability benefit receipt. Partly this may be because the fall in unemployment in Spain is more cyclical than in Australia and the United Kingdom where it is structural. However, part of the explanation is that unemployment has not fallen among people with disability; on the contrary, it has risen for this group.

These country experiences also show that the number of people having difficulties in the labour market has not declined, that today more of those difficulties are associated with or labelled as health problems, and that reducing non-employment is therefore very difficult. This finding is particularly interesting in view of the rapid economic growth which all four countries have enjoyed in the past decade. This further confirms that disability benefit reciprocity tends to react asymmetrically, i.e. rising in periods of economic weakness and staying high (unless reforms are being implemented) in periods of high growth.¹

Analysis for the four countries also offers some lessons about the impact of benefit levels, which were found to be one of the two key factors (together with benefit coverage) explaining cross-country differences in disability benefit reciprocity rates (OECD, 2003). Low benefit levels tend to lead to lower incomes and, in turn, higher poverty risks. Yet, they do not necessarily lead to either lower inflows into disability benefit or higher transitions from disability benefit into work. Average disability benefit levels are much lower in Australia and the United Kingdom than in the other two countries, yet disability reciprocity rates are lower in Luxembourg and, especially, Spain.

The main explanation for this is that people with disability tend to have comparatively low levels of skills and low-wage jobs. In turn, for most (potential) recipients net replacement rates are relatively high even in countries with seemingly low flat-rate benefits – such as those in Australia and the United Kingdom. This is further accentuated by the larger role of secondary cash or in-kind benefits in those countries, such as the Disability Living Allowance in the United Kingdom and various concession cards in Australia. Moreover, replacement rates and benefit withdrawal rates of disability benefits *relative* to those of other non-employment benefits need to be taken into account in assessing the work disincentives of the disability benefit system.

All these findings point to the need for, first, coherent policies which take all different benefit schemes into account, secondly, employment-oriented policies which help people overcome their labour market obstacles, and thirdly, policies which address the interests and incentives of all players involved.

Reducing the inflows into sickness and disability

Experiences in the four countries also offer some lessons in terms of how best to reduce inflows into sickness and disability benefits. Good sickness management is the key to disability prevention and work retention. There are several elements to this. First-class medical assessment of sickness is crucial. Strict and frequent controls by independent medical experts, as increasingly done in Spain and Luxembourg, are needed to enable early identification and avoid unnecessary delays of action. Systematic monitoring of longer or repeated absences is also important. This should be done by those who carry the costs of shorter as well as longer-term absences and disability, i.e. the employer as well as private or public insurances or benefit authorities.

Employers play an instrumental role in this context. There are three main components for a suitable involvement of employers. First, they need to be responsible *e.g.* for monitoring absences, for seeking occupational health advice and for developing, together with the employee, a rehabilitation and work retention strategy. Secondly, they need to have the right financial incentives to fulfil their responsibilities, *e.g.* by carrying substantial costs of not managing sickness matters adequately, as is the case in the United Kingdom and in Luxembourg. And thirdly, they need to get early and easily accessible support to help their sick workers. This includes good information for employers about their role and the available supports, as is since recently provided by Australia's JobAccess tool.

There are all kinds of practical difficulties in this regard, especially as regards confidentiality of a medical dossier. The goal is not to violate confidentiality, of course, but to find ways to tackle problems as soon as they arise. What is needed for this is confidential advice at an early stage. Such advice should be provided by occupational health services, which should have the medical and vocational expertise to identify appropriate workplace adaptation and rehabilitation needs, especially also for mental health problems. Advice from such services should be available for employers, general practitioners and employees.

Health status monitoring and health management is equally important for the unemployed and people on other types of income support payments, because the share of such people moving into disability benefits is very high. For those people, the public authorities have to take over the role of the non-existing employer. Australia offers a good-practice example in this regard because unemployment benefit recipients with health problems who are activity-exempt for 26 weeks or more within one year, due to a temporary incapacity, have to undertake a comprehensive work-capacity assessment.

Finally, greater focus needs to be given to the connection between sickness and disability. The seemingly inevitable, almost automatic transfer from long-term sickness into disability should be broken. In the first place, this requires proper assessment at a pre-disability stage of what a person is able to do. Australia's Job Seeker Classification Instrument, which is applied upon registration with the employment service, fulfils this role by triggering a Job Capacity Assessment for disadvantaged jobseekers. However, this also implies that long-term sick people should be treated as long-term benefit recipients needing help to return to employment. Luxembourg has developed a model structure for this, even though the supports put in place to achieve the objectives are insufficient.

Promoting transitions from benefits to employment

The strong “reaction” to reform of the disability benefit inflow rate and the comparatively inert disability benefit outflow rate suggests that limited resources are best directed towards the inflow side of the problem. Some countries, like Switzerland, have decided to go down this route (OECD, 2006b). Indeed it is very difficult to activate people who have been out of the labour force for many years, often more than a decade. However, trials in both Australia and the United Kingdom have shown that this is not impossible, and that the same elements determine success for the integration of long-term and new recipients.

Again, experiences from the four countries point towards policy elements needed to best promote the transition from benefits into employment. *Timing* of intervention is obviously key. Work motivation and personal aspirations decline rapidly with the duration of inactivity and disability benefit receipt, and so do qualifications. With its redeployment procedure, Luxembourg addresses the issue of late identification and (where needed) intervention most rigorously.

What is most important is to target services to the very needs of people who are sick or have a disability, taking into account that needs differ enormously. The personal adviser approach is most developed in the United Kingdom and has been shown to be effective (and recent and emerging evidence shows that there can be a net cost-benefit). In the context of well-targeted services, it is essential that all people who can benefit from such services can get them. This is not always the case in the four countries. Not in Spain, where due to resource constraints mainstreamed services have so far failed to reach people with disability in sufficiently large numbers, not in Luxembourg, where available services are insufficient, and not in Australia either, where people not entitled to income support payments have access to only a more limited set of services. To a lesser extent, the latter argument also holds for the United Kingdom. Therefore, access to effective services should be eased in all four countries.

This is not to say that employment services should be offered without limits. All countries to a varying degree suffer from a lack of knowledge about which of their programmes works for whom and, even more so, the cost-effectiveness of various types of interventions. Developing the evidence base further is an important intermediary step to develop more effective programmes. This requires better governance and monitoring of employment services and their regional offices. The innovative outcome-based funding of services in Australia and the United Kingdom seems to be a step in the right direction because it ensures that the system rewards success. It will be important to evaluate these initiatives rigorously to see if they work.

Incentives for benefit recipients to seek work and to seek help in finding work are other important factors. Work must pay under all circumstances. This is certainly the case in Spain, where benefits can be cumulated with earnings from another occupation. Gradual benefit withdrawal rates, like in Australia, are one aspect of this. In-work payments, as available in the United Kingdom, are another element. To the extent that the work capacity loss is permanent, the in-work benefit should be permanent as well. The impact of these benefits would be greater if take-up were higher and the earnings range at which they are paid broader.

Equally important as an incentive to seek work are benefit suspension rules, i.e. a possibility for longer-term benefit recipients looking for work voluntarily to put their benefit entitlement on hold and return to disability benefit if working turned out to be impossible. Australia and in a more restrictive manner also the United Kingdom have benefit suspension (linking) rules which seem generous in an international context, yet there are time limits of two years, which seem to act as a major deterrent. Given the almost non-existent benefit off-flow of long-term beneficiaries, it is worth considering to make these rules more flexible and unconditional and allow individuals, whose condition is unlikely to improve and who have been on a disability benefit for, say, more than three years, to return to benefit at any time.

In-work benefits and suspension rules are only part of the work incentives picture. Stringent job-search requirements are also important, and these have been almost inexistent until recently for people with partially-reduced work capacity claiming disability benefits. In this regard, the recent reform in Australia through which those people are regarded as having some capacity to work and expected to seek suitable part-time work is promising, provided the supports given to those people adequately match their support needs.²

Challenges and policy options for Australia

The current situation

The Australian economy has enjoyed high rates of economic growth for more than a decade. During the past five years, the overall employment rate has increased by over 2 percentage points, the unemployment rate has dropped to 4.3% and the proportion of long-term unemployment in total unemployment has also fallen, from one-quarter to one-sixth. And yet, the living conditions of people with disability have not improved. Their employment rate stands at around 40%, which is lower than five years ago and only half the rate of their counterparts without disability. The income of people with disability has fallen further behind and is now more than one-third lower than that of those without disability, compared with 30% five years ago.

Low incomes are also partly a consequence of the low level of benefits in Australia, which are non-contributory (tax-funded), flat-rate and household means-tested, i.e. targeted at those most in need. This implies that certain groups of people with disability, i.e. those living in middle- and higher-income households, are not entitled to a disability benefit (and most other income support payments as well). Due to the fact that publicly-funded activation measures have benefit recipients as their primary target group, some of these people can only access a certain set of activation measures. Little is known about the socio-economic pathways of these people, i.e. the extent to which the economic burden of long-standing health problems and disability may push a number of former middle-income people down the income ladder, eventually ending up on income support.

Despite these coverage issues, which are very special to Australia, at around 6% of the working-age population the disability benefit reciprocity rate is very similar to the OECD average. This rate has doubled since around 1990, but growth in reciprocity rates has slowed down in the past three years and halted in the second half of 2005. During the past decade, reciprocity grew fastest for people aged 20-49.

Importantly, there is a very high inflow into disability benefit from a non-employment status. More than every third new claimant transfers from unemployment benefit. Among them, a large proportion experience multiple spells of income support prior to the

transition, and the average pre-transition unemployment duration is more than one year. This is partly related to institutional problems, but also suggests that long-term unemployment tends to be associated with a work-capacity loss. There is also a considerable flow into disability benefit from other income-support payments, such as parenting payment, or inactivity without income-support payment.

People with mental illness have been identified as a major group of people with disability needing significant additional support in order to build their workforce capacity and actively participate in employment and in the community. Nearly one in five, or more than three million Australians are affected by a mental illness in any one year. It is estimated that the annual cost of mental illness in Australia is approximately AUD 20 billion, which includes the costs from loss of productivity and participation in the workforce.

Key policy recommendations

The rapid increase in the disability beneficiary rate over the 1990s, reinforced by the economic downturn in the early 1990s, partly resulted from changes in the system itself, including easier access to benefits for people with a mental health condition. However, this trend increase in the number of people on disability benefit was also driven by reforms in the unemployment benefit scheme that have led to stricter compliance rules and participation requirements.

Likewise, the recent halt in reciprocity growth rates can probably be seen as a first effect of the recent *Welfare to Work* reform. The reform has three important features. First, the assessment was changed to evaluating a person's remaining work capacity rather than disability. Secondly, the focus on individually-tailored activation and employment support was extended. Thirdly, a new balance was put in place between responsibilities and support, as people with a partially-reduced work capacity (who can work between 15 and 29 hours a week) are no longer entitled to disability benefit but only to unemployment benefit, with much stricter compliance rules. In short, Australia is in the process of transforming its hitherto passive disability benefit system into an active labour market programme – even though, so far, only for new benefit claimants who are assessed to be able to work 15 or more hours per week.

The timing for the ongoing *Welfare to Work* reform could not be better. Due to the record low rate of unemployment, the Australian labour market is very tight at present. This is a promising pre-condition for the implementation of the welfare reforms which have the primary focus of increasing employment and reducing welfare dependence, as one of the solutions to increase household incomes in general and of people with disability in particular. There also appears to be very strong support for the government's reform agenda from most public and private stakeholders. However, certain areas are not yet given the attention they deserve. Three problems, in particular, should be addressed in future reforms:

- The limited involvement of employers in the early phase of a health condition.
- Insufficient efforts to reach all people who could benefit from employment services.
- Poor encouragement to seek work for people on benefit, contributing to low incomes.

More can be done to improve the implementation of the *Welfare to Work* reform with the aim of ensuring better outcomes. To bolster ongoing and future reforms, the Australian government should consider the following policy recommendations, as summarised in Box 0.2.

Box 0.2. Policy recommendations for Australia

Strengthen employer involvement in the early phase of a health condition

Current policy pays little attention to the issue of early identification of health problems and the role of employers in this initial period, thereby missing an opportunity to intervene early. Sickness absence is generally not regarded as a major issue, and any paid sick leave provided beyond the legislated minimum of ten days per year is a matter of negotiation between employers and employees. Employers therefore generally only make wage payments for sick workers for a relatively short period and have no obligation to do anything for their employees beyond this period. Similarly, income maintenance insurance taken out by several employers merely functions as a means to compensate their costs. Recently, a free one-stop-information website and hotline was put in place for employers (but also workers, co-workers and service providers) to improve employers' access to available government supports and subsidies. This is a first step which should be complemented by other changes so to promote better absence management, thereby preventing people from losing part of their work capacity. The following measures could be considered:

- *Intensify employer responsibilities and supports.* Employers should be responsible for monitoring their workers' sickness absences lasting more than around one month as well as repeated absences, and they should inform the authorities about dismissals following a prolonged sick leave. They should have access to occupational health services and advice to be able to identify adequate responses to arising health issues, including e.g. workplace accommodations and job adjustments. Employees and general practitioners should have access to the same type of confidential support.
- *Match responsibilities with corresponding incentives.* This obligation should be matched by financial incentives for employers to increase prevention and job-retention efforts. Other countries, including Luxembourg, are doing this by lengthening the period during which employers have to continue wage payments for sick workers. Consider a minimum sick-leave coverage for casual workers as part of a prevention and early identification strategy, recognising the higher wage (casual loading) these workers currently receive to compensate for their non-coverage of paid leave.
- *Back up these changes from the medical and procedural side.* As a rule, sickness certificates should be provided for no more than a few weeks. Moreover, there should be a mandatory referral to a Job Capacity Assessment for all people on sick leave for three to six months (not only those on Sickness Allowance). General practitioners and health professionals should get training on how to manage returns to work.
- *Improve the functioning of private income maintenance insurance.* Make efforts to develop the prevention and retention focus of private income maintenance insurance and promote experience-rated employer premiums for these insurances. In a second step, increase awareness of such reformed insurance and promote take-up.

Make sure everybody who could benefit from employment services can get them

Australia has taken important steps in terms of expanding its employment and vocational rehabilitation services and improving the quality of these services. What remains to be done is to ensure that services better reach those clients who are currently inactive. For instance, certain groups like people who are not entitled to income support payments are only entitled to a basic set of services or face considerable waiting lists. Furthermore, some of the inherited structures – such as the separation of employment and rehabilitation services – are creating unnecessary inefficiencies e.g. when a person who completed rehabilitation would need ongoing on-the-job employment support (even

Box 0.2. Policy recommendations for Australia (cont.)

though some interventions are already available through both service streams). The following measures could help improve employment outcomes:

- *Increase resources for employment services.* The fixed appropriation of services (so-called capping) should be abolished to avoid parking people on waiting lists for too long or referring them to the wrong or second-best service. People with health problems should have full and equal access to all publicly-funded employment supports according to their needs and employment disadvantage, irrespective of their benefit status. Capacity constraints seem particularly problematic for the very effective and low-cost Personal Support Programme. To prevent an explosion of ineffective interventions, means to target services better might need to be developed.
- *Change funding rules to avoid creaming.* For employment services, a stronger focus should be put on longer-term employment outcomes beyond the first 13 or 26 weeks, with some focus on career paths. The focus on positive outcomes in funding of the Personal Support Programme should also be raised, with outcome measures in this case including e.g. transfers to more employment-focused services, study or vocational training but also agreed social outcomes. Similarly, the funding of disability assessment services should move away from the current output approach and seek ways to reward the quality of assessments and the adequacy of referrals.
- *Further streamline service provision.* The distinction between Disability Employment services and Vocational Rehabilitation services should be further reduced. Providers of either of the two services should get full access to all possible types of interventions to avoid suboptimal referrals.

Benefit reform to improve work incentives and increase incomes

Disability benefits are low in an international comparison because of the non-contributory nature of the social protection system. Nevertheless, despite a free earnings zone and a low benefit taper rate, few benefit recipients work. In addition, transferring from unemployment benefit to disability benefit is attractive, because the latter comes with all the advantages of a pension – untaxed, higher free zone, lower taper rate, more generous indexation, higher supplements – that do not apply to allowances. The Welfare to Work reform addresses some of these issues but also creates new problems, because workers with partially-reduced work capacity are now facing *higher* tax rates upon moving into work up to average earnings. This situation could be improved by the following changes:

- *Improve work incentives for people with partial work capacity.* Strong work incentives are particularly important for those with a partially-reduced work capacity who are now treated as unemployed and expected to seek part-time work. Should the ongoing evaluation of the effects of Welfare to Work reform show that this group is not staying in or moving into work in sufficient numbers, applying the more generous free earnings zone and taper rates of a disability benefit for this group should be considered. In-work payments would further help improve work incentives and job-search efforts for people with partial work capacity.
- *Harmonise unemployment and disability benefit.* More generally, there is a case for a single working-age benefit (as was already recommended in the 2000 McClure Report on social welfare reform) to simplify the system and avoid undesirable incentives to move from one benefit to another.

Box 0.2. Policy recommendations for Australia (cont.)

- *Increase incentives for disability benefit recipients to move off benefit.* To the extent possible, the new Welfare to Work approach, i.e. part-time participation requirements in exchange for better employment support, should be applied to current disability benefit recipients as well (in a first step only to younger recipients with shorter durations of benefit receipt). For current beneficiaries without participation requirements, work incentives could be increased by relaxing benefit suspension rules: the current two-year time limit could be extended, with the number of years for this limit being related to the length of previous disability benefit receipt (for those with prior benefit receipt of, say, 15 or more years, abolishing the time limit could be considered).
- *Evaluate payments intended to compensate additional costs of disability.* Sufficient extra payments should be made to cover the extra costs of a disability. Like the existing Mobility Allowance, these payments should not be means-tested and they might even be higher for those in work to the extent that they face higher costs of working. Evaluate the impact of the array of existing payments of this kind to identify reform needs. Promote the take-up of existing cost-of-disability payments.
- *Consider further steps to raise incomes of people with disability who cannot work.* Higher employment is the best strategy to raise incomes. People who are unable to work could be helped by better and consistently-regulated disability coverage in private superannuation schemes.

Challenges and policy options for Luxembourg*The current situation*

At around USD 70 000, Luxembourg's GDP per capita is considerably higher than for most other OECD countries.³ This relative wealth, together with a substantial share of cross-border workers, implies that the country can afford its relatively low overall employment rate. This rate is almost 10 percentage points lower than in Australia and the United Kingdom, owing to low employment of young workers, older workers and mothers. Employment rates of people with disability in Luxembourg, however, are higher than in the other three countries, and particularly relative to their peers without disability. In 2004, every second person with a disability was employed.

The high rates of employment of people with disability, coupled with a generous benefit system, imply that people with disability in Luxembourg have comparatively high incomes and a lower level of relative income poverty (below 10% earn less than 50% of median income). Another consequence of their relatively high employment is an unusually low proportion of inactive people with permanent disability who indicate that they wish to work: one in seven of those under age 35, and 2% of those over age 50. This is a major challenge for a government planning to bring more people with disability into work.

The disability benefit reciprocity rate in Luxembourg has been falling steadily since 1997, when access to disability benefits became much more stringent. Since 2000, the annual inflow into disability benefits is roughly constant at 4-5 per 1 000 of the working-age population, which is half the level ten years ago and below the current OECD average. On the other hand, at around 1.7% of GDP, disability benefit spending is still relatively high, largely because of the extremely widespread use of disability benefits in the

mid-1990s. Disability benefits are often used as an early retirement instrument; and as the fall in the beneficiary rate affected younger workers more than older ones, the age structure has become even more skewed towards the early retirement age.

Hand-in-hand with falling beneficiary numbers in the past decade went a rapid increase in unemployment rates, from 2.4% in 2000 to 4.5% in 2005. There is a great risk that much of this additional unemployment could become structural, with some groups of people with disability permanently parked on long-term benefits which are topped-up to the level of disability benefits. This is confirmed by disability-specific unemployment trends: while unemployment for people without disability has only increased by 1 percentage point in the past five years, the increase for people with disability was 5 percentage points. In turn, there has been a rapid increase in the share of new disability benefit recipients coming from an unemployment status – leading to new policy challenges.

Key policy recommendations

In recent years, policy has attempted to address the unsatisfactory situation of people with a partially-reduced work capacity, for whom access to disability benefits was *de facto* closed in 1997, in turn leading to a rapid increase in long-term sickness. The main change, introduced in 2002, was a combination of stricter absence monitoring on the one hand and new employment or *redeployment*-oriented procedures on the other, directed towards those with remaining work capacity but unable to return to their jobs. So far, the new procedure has predominantly produced a new category of “unemployed with disability”, with unsatisfactory transition of these workers back into employment.

An important and still ongoing reform plan, likely to be implemented as of 2009, is the *statut unique*, i.e. the abolition of the current difference between blue-collar and white-collar worker status. Harmonisation of currently very different sick-leave regulations in the course of this reform could contribute to disability prevention by increasing the financial incentives for employers in the blue-collar sector to avoid or reduce sickness absence.

This alone, however, will not be sufficient to improve outcomes of the new redeployment procedure. Every effort will have to be made to better understand the obstacles for redeployment, be it a lack of interest on the part of employers, inadequate PES intervention, lack of motivation of workers, or a combination of all three. To improve the outcomes from redeployment of workers with partially-reduced work capacity, the following three aspects will have to be tackled:

- Ineffective and poorly-enforced responsibilities and financial incentives for employers.
- Insufficient work incentives which contribute to the low work motivation of people with disability.
- Too little rehabilitation and placement efforts by the Public Employment Service.

Measures in those areas could be helped by further improving the redeployment procedure itself, including procedural and assessment issues but also aspects of co-ordination across the main actors. In this respect, the government of Luxembourg should consider the following policy recommendations, as summarised in Box 0.3.

Box 0.3. Policy recommendations for Luxembourg

Make responsibilities and incentives stronger for employers

Employers can easily circumvent the intentions of the new redeployment procedure. Incentives should, as much as possible, encourage employers to prevent health problems and to retain workers with health problems. Early quantitative evidence shows that internal redeployment (i.e. job retention) has improved while external redeployment (i.e. integration into a new job) is rare. This suggests that every effort should be made to make internal redeployment possible. To this end, the following proposals should be considered:

- *Raise financial incentives for employers to prevent sickness.* In harmonising sick-pay regulations, make sure that incentives are strengthened for the blue-collar sector without weakening those for the white-collar sector. This should be done by matching the regulations for the former to those of the latter.
- *Strengthen internal redeployment.* To make internal redeployment more likely, 1) tighten rules for approved non-compliance and extend the redeployment obligation to workers ending a temporary disability benefit claim; 2) involve employers in the rehabilitation and retraining of their sick or disabled employees; and 3) speed up the process to avoid unnecessary loss of skills, work motivation and, in particular, jobs before the procedure starts.
- *Disassociate internal redeployment from the employment quota.* An employer who fulfils the quota for hiring workers with disability is not obliged to redeploy another sick or disabled worker. This link should be cut to make sure that every worker can benefit from internal redeployment responsibilities and supports.

Strengthen responsibilities and incentives for workers

Similarly, workers should have strong incentives to remain in work or return to the labour market, to help improve the outcomes of internal and external redeployment. This is currently not the case because sickness and disability benefits are comparatively high. The same applies to unemployed people waiting to be redeployed who are entitled to a waiting allowance (i.e. a long-term benefit which is paid at the higher level of a disability benefit). On the other hand, workers (and their employers) may be inclined to seek partial wage compensation through internal redeployment albeit having full or fully-recovered work capacity. The following proposals should be considered to support the new procedure:

- *Improve work incentives for people with disability not in work.* High disability benefits help to reduce poverty rates but pose obstacles in bringing people with disability back to work. Making work pay in all circumstances will require lowering the level of out-of-work benefits in exchange for introducing permanent in-work payments to stimulate the return to work.
- *Strengthen job-search requirements.* Strict job-search requirements and compliance rules should be introduced for unemployed people with partially-reduced work capacity who receive a waiting allowance. Otherwise, this new allowance could easily turn into just another type of long-term disability benefit.
- *Re-evaluate work capacity of people who are internally redeployed with a wage compensation.* Introduce an automatic and repeated re-evaluation of the situation of an internally redeployed person, e.g. once a year, and reduce subsidies when work capacity has improved. This is important to avoid that employers and employees use the new procedure to permanently and unfoundedly save parts of the wage costs. This also requires that the post-redeployment job conditions are being controlled.

Box 0.3. Policy recommendations for Luxembourg (cont.)**Improve rehabilitation and placement efforts**

The redeployment procedure involves a large number of independent actors at different stages. It is unclear to what extent the complexity of the procedure itself and its inflexibility contributes to the current mediocre outcomes. The Public Employment Service (PES) bears the main responsibility for the new procedure as well as for activation support in the form of *e.g.* employment subsidies and vocational rehabilitation. The availability of the latter is rather limited and many people have to go abroad (usually to Germany) for adequate service. Moreover, rehabilitation is still primarily medically-oriented. Given the poor outcomes of the external redeployment process, the efficiency of the process will have to be increased and PES intervention strengthened in various ways, including by the following measures:

- *Research the reasons for the failure of the redeployment process.* External redeployment has not delivered the desired employment outcome, implying that further changes are needed. To be sure to make the right changes, it is of utmost importance to fully understand what has happened and which elements of the process have failed. This requires concerted efforts to evaluate the situation of the past five years.
- *Put more emphasis on vocational rehabilitation and training.* Increase the focus on work-related rehabilitation and training, by fostering the work-related activities offered by the only rehabilitation centre. The impact of vocational training would be raised by introducing a system of recognition of such training, which is currently not the case.
- *Develop a rigorous evaluation strategy.* The PES needs to evaluate its labour market programmes to better understand what works, and for whom. For instance, while the PES believes that wage subsidies are a very effective tool, employer organisations argue that these subsidies will not create any jobs. Only sound scientific evidence on the impact of different programmes can ensure effective and efficient use of available resources.
- *Increase the flexibility of the system.* An internally redeployed worker who is fired after the first year should also become eligible for external redeployment or, at a minimum, have access to the same activation support. Enable repeated reassessments of the integration potential beyond the current 10-week cut-off point, to account for the volatility and instability over time of various health problems, especially mental health conditions. Facilitate earlier intervention to avoid an unnecessary loss of motivation and the decay of qualification; *e.g.* introduce the possibility to assess a worker's potential before a long-term sickness absence phase.
- *Strengthen the work capacity focus of the procedure.* The entire assessment of disability is heavily medically-oriented. There is a need to involve vocational experts earlier in the decision-making process, not only if and after the independent medical assessors decide to initiate the redeployment procedure.

Challenges and policy options for Spain

The current situation

The situation in Spain is in many ways different from that in the other three countries. Most importantly, Spain has never suffered from a particularly widespread use of the disability benefit scheme. Inflows into this system have been stable in the past 15 years

and so has the reciprocity rate which stood at 3.5% of the working-age population in 2005 – significantly below the OECD average of around 6%. Moreover, very few people claim disability benefits for mental health reasons. Like in Luxembourg, however, disability benefits tend to be used as an early retirement pathway, especially by men of whom almost one-third in the age group 55-59 receive such benefit.

Importantly, contrary to what has happened in many other OECD countries some ten years ago, even the sharp drop in the overall unemployment rate in the past decade, from almost 20% in the mid-1990s to 9.2% in 2005, has not translated into an increase in the disability benefit reciprocity rate – even though a disability benefit for people with no remaining work capacity is more generous than other social benefits for the working-age population. Part of the explanation is that the fall in unemployment has only affected people without disability, while the unemployment rate of people with disability remained unchanged at over 15% and even increased recently.

The high rate of unemployment among people with disability in Spain, which is in part a result of the larger share of older workers in this sub-population, went for a long time hand-in-hand with extremely low rates of employment, of less than 30%, for this group, and as low as 15% for those people with disability with a mental health problem. Reasons for this are a low work motivation partly caused by the high incidence of temporary contracts; a widespread stigma concerning the work ability of people with disability; and the ineffectiveness of employment regulations and supports. Only since very recently has the overall employment growth, which is driven by a steady rate of economic growth of over 3% annually, started to affect the employment of people with disability as well. In turn, incomes of people with disability have increased and poverty rates fallen. Nonetheless, at around 35%, their employment rate is still below the OECD average.

Key policy recommendations

Because of stringent disability assessment and improved sickness absence monitoring by the social security authority, Spain has been successful in keeping long-term dependency on health-related benefits at a low level. Employment measures, on the other hand, had much less success so far, although integration of workers with disability in the open labour market has been a policy target for the past 25 years. Many regulations and obligations for workers and employers exist, but these are not enforced, and take-up of available instruments is low. Moreover, collective agreements which have a strong binding character for Spanish employers make little reference to disability issues. With the decentralisation of labour market institutions in the course of the devolution of powers to the autonomous communities, new opportunities have arisen. An increasing problem is that very little is known about the extent to which state laws are followed on a regional and local level.

The key issue for Spain for the coming years is to reduce unemployment and increase employment of people with disability. Given the strong economy, which was able to create some 700 000 additional jobs annually in the past five years, some of which for people with disability, the timing for further reform is good. The recently strengthened focus of the European Union on raising employment in general, and that of older workers and people with disability in particular, has helped in increasing the funds available for employment support. This in turn has helped Spain to establish a policy framework based on non-discrimination, participation and universal accessibility.

In 2006, a new Agreement on Social Security Measures was signed between the government and the social partners, which aims to make the social protection system more viable while at the same time favouring employment and competitiveness. With respect to disability, the agreement aims to discourage fraudulent use of disability benefits.

To reduce unemployment and increase employment of people with disability, the government has recently introduced further improved incentives for enterprises to hire workers with disability, new programmes to support workers in the open labour market, and more supports for self-employment. Special attention is given to women with disability to address the double discrimination they are often facing. To harvest the fruits of this new approach, four issues in particular will have to be addressed in the future:

- The little attention given by the Public Employment Service to people with health problems.
- Limited monitoring and evaluation efforts of policies delivered by regional governments.
- Insufficient incentives for employers to hire workers with disability.
- Obsolete features of the benefit system posing an obstacle to the new active approach.

Measures in these areas would be greatly helped by further developing the evidence base to facilitate policy making. Along these lines, the following policy recommendations should be considered by the Spanish government, as summarised in Box 0.4.

Box 0.4. Policy recommendations for Spain

Boost the quality of employment support for people with disability

The regional headquarters of the Public Employment Service (PES) are, since a few years, the main players in disability employment policy design and implementation. Many of them have developed programmes with training and work experience elements. Yet, take-up of these programmes by people with disability is low and, because of the mainstreaming approach, largely unknown. Another aspect is the complexity of the institutional structure and challenges arising from the need of co-operation between a number of entities: the decentralised PES (responsible for employment matters), the centralised Institute of Social Security, INSS (responsible for benefit matters and controls), the Mutual Benefit Societies (responsible for work injury matters but also general sickness matters for more than 50% of the workforce) and the decentralised National Health System, NHS (responsible for diagnosis and treatment of illness but also for medical rehabilitation for those workers not covered by a Mutual Benefit Society). The following structural and procedural changes could help improve this situation:

- *Target support to jobseekers with disability.* Reconsider the current strong focus on mainstreaming, which has not sufficiently helped people with disability into work, and increase targeting in offering PES programme places. Make sure that all groups of people with disability – those with a legal disability certificate, those on disability benefit and those with neither a certificate nor a benefit – receive the support they need.
- *Refocus PES spending.* Reduce subsidies for sheltered work and use this money for an upgrading of skills and the employability of people with disability. Put a stronger focus on vocational rehabilitation and training to prevent health problems or disability. Make special efforts to find work in new occupations for people with partially-reduced work capacity (i.e. people with incapacity for their usual occupation). Where needed, increase the available funding while keeping an eye on the cost-efficiency of supports.

Box 0.4. Policy recommendations for Spain (cont.)

- *Improve the co-operation between institutions responsible for employment, vocational rehabilitation and training, and benefit matters.* The current fragmentation of the institutional framework in relation to the management of benefit matters on the one hand and employment and vocational rehabilitation and training on the other, partly across different government levels, is likely to hinder optimal employment outcomes. Strengthening the collaboration between the key institutions responsible for these fields of policy would be a major building block in improving the situation. Bilateral and multilateral agreements (like those between INSS and NHS on controlling sickness absence) would be a promising step towards a more integrated approach with better-coordinated interventions by all actors. In the longer term, further streamlining of responsibilities should be considered.

Increase monitoring and evaluation of regional government policies

With the devolution of significant powers to regional labour market institutions, a number of new policy issues have arisen. There is a need for better governance of institutions operating at different government levels, and for better data and information collection at the regional level for evidence-based policy making. The following adjustments should be considered to make the system more effective and efficient:

- *Improve the governance of the PES.* Introduce target agreements with regional PES offices concerning the outcomes for jobseekers with disability (including, for instance, targets on placements into stable jobs). Individual action plans for jobseekers with disability should be made in an earlier stage, not only after 12 months of unemployment as is common for the “standard” unemployed.
- *Generate additional evidence.* Systematic monitoring should be introduced for institutions responsible for policy implementation. For this, the national government will need systematic evidence from the autonomous regions on both policy implementation and policy effectiveness. Regional PES headquarters, in particular, should be obliged to produce regular evidence, including programme evaluations and, if possible, cost-benefit analyses. Good practices should be shared between the regional PES offices.
- *Make better use of available evidence.* The IMSERSO database on people with a *legal* disability certificate, though not originally designed for this purpose, should be developed into a dynamic evidence base by systematically collecting employment and benefit status as well as disability status dynamics. Alternatively, the IMSERSO database should be better linked with information collected by other administrations and institutions.

Improve financial incentives and enforce responsibilities for employers

The Spanish labour law contains a series of obligations for employers, including the requirement for large companies to employ 2% of people with disability. In reality, however, regulations have little impact because they are not enforced stringently enough. Added to this is the unawareness of most employers about existing subsidies and programmes to retain or hire workers with disability. Moreover, current regulations provide meagre incentives for employers to improve working conditions so as to keep absence low. The following changes could contribute to a better involvement of employers in the policy process:

- *Help employers to obtain support.* Awareness campaigns on available workplace adaptation subsidies and hiring supports should be launched, with the involvement of the social partners, to ensure that employers know what they could do. Strengthening the position of disability policy in collective agreements by writing existing rules into sector-wide and individual agreements would raise the not sufficiently binding character of employer actions.

Box 0.4. Policy recommendations for Spain (cont.)

- *Enforce employer responsibilities.* Employer responsibilities need to be controlled and sanctions should be used in cases of non-compliance. In this context, more responsibility should be given to the Labour Inspectorate which is better placed than the regional authority to take a neutral decision. It may also be necessary to turn the appeals process around, i.e. to let employers appeal only if and after they have paid the established fine.
- *Strengthen financial incentives for employers.* Stronger elements of employer co-payments should be considered to increase the economic rational of prevention and job-retention activities (Luxembourg's effort to lengthen the employer's wage-payment period for sick workers is one example of this type of reform). Such change is supported by a recent labour tribunal ruling in Spain, which concluded that employers should share the costs of (temporary) work incapacity.

Modernise the disability benefit system

Stringent disability assessment has kept disability benefit inflows under control, and recently strengthened sickness monitoring has helped to halt the increase in long-term absence. However, some elements of the disability benefit system need to be adjusted to today's medical, economic and labour market realities. In particular, benefits tend to be granted permanently, and 53% of all beneficiaries receive a benefit for being unable to continue in their own job, albeit being able to work in another occupation. The following measures should be considered:

- *Review the adequacy of the disability definition.* The current granting of incapacity benefits on the grounds of incapacity for the usual occupation is outdated for an increasingly mobile labour market with an increasingly better and more-continuously trained workforce. Inspired by reforms such as those undertaken in Luxembourg, for example, workers with a disability unable to carry on their current job could be classified and treated as unemployed, expected to accept work in another occupation that is feasible on health grounds, and be offered (if necessary, permanent) in-work top-up payments to avoid sharp post-disability income losses.
- *Reassess entitlements at regular intervals.* Currently, disability benefits are *de facto* permanent two years after the benefit was granted. This practice does not take into account that some people's health situation might improve and, even more importantly, that the impact on work capacity might change (also e.g. due to the availability of new technologies). In many OECD countries, regular and repeated reassessment has become common for the majority of disability benefit recipients.
- *Improve work incentives for older workers with partial incapacity.* The 20% supplement to the current "partial" disability benefit (i.e. incapacity for the usual occupation) for people aged 55 and over who are not working is a strong incentive not to seek work. Significantly improved employment support for this group of people (see corresponding recommendations above) would be a better alternative to improve those people's social and economic integration.

Challenges and policy options for the United Kingdom*The current situation*

The United Kingdom offers perhaps the best illustration of an OECD-wide trend, starting in the 1980s: falling unemployment and increasing use of disability benefits. With

a strong economy and increasingly tighter compliance rules in the unemployment benefit scheme, the United Kingdom's unemployment rate has fallen from above 10% in 1993 to around 5% today, while disability benefit receipt doubled to around 8% of the working-age population. In the past few years, however, both rates have stabilised and, in 2005, the overall disability benefit reciprocity rate fell for the first time since more than thirty years.

The structure of the disability benefit population has changed substantially during the past decade. More often than 10-15 years ago, the average recipient today is a young person, a woman, a recipient of a non-contributory benefit with a limited work history, and, most importantly, a person with a mental or behavioural health condition. The latter already make up for 40% of the beneficiary population, and their share continues to increase.

Mental health problems are an obstacle to employment: less than 20% of people with mental conditions are employed, which is less than half of the rate of people with muscular-skeletal conditions, for example. The overall employment rate of people with disability in the United Kingdom is now slightly above the OECD average, both in absolute terms (at 45%) and relative to people without disability. Moreover, employment rates of people with disability have increased by 7 percentage points in the past eight years, suggesting that disability discrimination legislation might have helped harvesting the opportunities of a strong labour market. The rate of unemployment is still higher for people with disability than for their peers without disability, but it has fallen even faster for people with disability.

Despite these encouraging employment and unemployment trends, incomes of people with disability are more than a quarter below those of people without disability. This partly reflects the low level of flat-rate public disability benefits, which often only lift incomes very slightly above the poverty line, especially for single people. On top of this, only one-fifth of the workforce has private disability insurance to top-up public claims.

Key policy recommendations

The long-run shift from unemployment to disability is at the heart of recent and ongoing reform, which aims to establish a new balance of rights and responsibilities for incapacity benefit recipients. The *Pathways to Work* process that is currently being rolled out nationwide requires new benefit claimants to go through a series of mandatory work-focused interviews with their personal adviser. Any action proposed in response to these interviews is still non-compulsory, but there are ongoing attempts to develop mandatory activities further to bring new claimants closer to the labour market.

These changes are complementing prior reforms in the past few years, which consisted of two main elements: first, a merger of the Benefits Agency and the Employment Service, which has created a single point of delivery for job-search support and benefits advice; and secondly, a new focus on *individualised* service delivery steered by personal advisers in this new agency and provided more profoundly by Job Brokers.

Forthcoming benefit reform aims to add to these changes by improving work incentives for recipients of incapacity-related benefits. Financial incentives were shown to be insufficient in so far as of those leaving incapacity benefits for work of 16 hours per week, at the minimum wage, only one-third gain financially unless they claim the disability element of the Working Tax Credit. However, take-up of this credit is known to be

low and even among those claiming the credit almost one in five would not gain financially. The additional temporary Return-to-work Credit, which is part of the *Pathways to Work* programme, will improve the situation, albeit only for the first year. Through benefit reform a new allowance will be introduced which will replace the currently existing incapacity benefit and will, among other things, have a top-up for those fulfilling their activity requirements.

In the course of this forthcoming reform, disability assessment will also be transformed to take better account of both mental health problems and the actual range of jobs a person could possibly engage in. Nevertheless, in view of the government's objective to reduce the incapacity benefit caseload by one million people by 2010, recent and ongoing reforms are likely to be insufficient. Further change should address four areas in particular:

- The neglect of the sickness phase that results in late identification of the need for help.
- The high inflow into disability benefits from unemployment and inactivity.
- The low number of people with disability, especially those with mental health problems, who are effectively (re)integrated into the labour market.
- Insufficient incentives to seek work for people on disability-related benefits.

Measures in these areas should be complemented by effective benefit reform to address work incentives of (potential) beneficiaries and the low incomes of people with disability. Further steps are also needed to ensure that the intentions of recent and ongoing reform are achieved more effectively. To this effect, the United Kingdom's government should consider the following policy recommendations, as summarised in Box 0.5.

Box 0.5. Policy recommendations for the United Kingdom

Accelerate the identification of health problems

Since the privatisation of sickness benefits, which are under the responsibility of the employer for a period of 28 weeks, little is known by the public authorities about what is happening in the early stages of sickness. Added to this, after exhaustion of sick pay, workers unable to return to their job are automatically transferred to a disability benefit (if they fulfil the contribution requirements); the disability assessment to determine continued eligibility for such benefit is only initiated a few months later. Social insurance, albeit taking over the costs of sickness and disability after the first 28 weeks, is not involved in controls or supports during the employer-paid absence period. This situation, which leads to a high number of new disability benefit claims, could be improved through the following measures:

- *Intensify employer responsibilities and supports.* Employers should be obliged to monitor sickness absences lasting more than around one month as well as repeated absences and to inform Jobcentre Plus about such cases. Failure to do so should have a direct impact on the costs the employer has to carry. Employers should have access to occupational health services and advice to be able to identify adequate responses to the arising health issues, including e.g. workplace accommodations and job adjustments. Employees and general practitioners should have access to the same type of confidential support.

Box 0.5. Policy recommendations for the United Kingdom (cont.)

- *Strengthen early medical controls.* Medical control of a worker's health status should come earlier and be more frequent. Independent second opinions by specialists, e.g. psychiatrists, and medical controls of the decision of the general practitioner by public authorities (initiated by Jobcentre Plus) are needed during the employer-paid sickness phase to avoid delayed identification of longer-term health problems. Technically this would become possible through the above-mentioned obligation of employers to monitor longer-term and repeated absences. General practitioners and health professionals should also get training on how to manage returns to work.
- *Advance eligibility assessment for a disability benefit.* The comprehensive Personal Capability Assessment should come *before* granting a disability benefit, thereby avoiding the quasi-automatic transfer from sickness to disability, and it should be a requirement for most claimants. Replace the functionality test by a work-capacity test and check what activities a person can do. Involve more mental health experts, or expertise, in the assessment procedure.

Address the circumstances of unemployed and inactive people

Many new disability benefit claimants have lost their job prior to claiming the benefit: one in four new claimants receives unemployment benefit at the time of the claim, and one in eight receives income support. Similarly, a considerable share of those leaving disability benefits, voluntarily or not, moves onto unemployment benefit. This suggests that they have continued problems in accessing the labour market. To address this group of people and the issue of carouselling between unemployment and disability benefits, the following measures could be considered:

- *Improve absence monitoring of the non-employed.* Put more emphasis on sickness prevention, health status monitoring and health management for people on unemployment and lone-parent benefits. Most importantly, try to identify people who would need more support early on to be able to return to employment. Following the example of Australia, the unemployed who are sick should go through a mandatory capacity assessment.
- *Address the group of people moving between unemployment and disability.* Disability benefit recipients losing their entitlement but not moving into work are at high risk of long-term benefit dependence. These people should be followed-up systematically and offered the support needed to return to employment.

Raise the number of people helped by work integration programmes

The work integration approach has changed markedly over the past decade, as can be seen from the changes in the organisation of services as well as the introduction of new, hitherto unknown programmes. A new element in disability employment policy is the shift towards outcome-based funding of services. Added to this are the new compliance responsibilities for new claimants of a disability benefit. A key weakness of these changes is that they have not sufficiently helped people with mental health problems. All of these areas could be developed further to ensure better outcomes and more efficient use of resources. The following adaptations could be considered:

- *Foster employment service delivery.* Introduce special targets related to people with health issues in monitoring regional Jobcentre Plus offices to ensure that jobseekers with disability qualified for a vacancy are identified and placed into jobs rapidly. Develop more extensive retraining opportunities in addition to the currently existing fast-placement approach. Make additional efforts to help jobseekers with mental health problems.

Box 0.5. Policy recommendations for the United Kingdom (cont.)

- *Underpin the new conditionality approach.* Strengthen participation requirements beyond the current mandatory interviews. For instance, make actions identified during these interviews increasingly compulsory. Consider introducing similar requirements for current recipients as well.
- *Further improve the condition management programmes (CMP).* Ensure integration of these programmes, which aim to help people deal with their health conditions, with employment services and help improve the co-operation of CMP health professionals with the clients' general practitioners. Develop CMP services targeted to people with mental health conditions. Change the current bulk-funding of CMP into a more outcome-driven system.
- *Strengthen the focus on sustainable employment outcomes.* Further refine funding rates by: 1) reducing the payment rate for very short hours work (permitted work); 2) changing the definition of sustained employment from 13 to at least 26 weeks and adding a component for long-term sustained employment; and 3) including a reward for continued provision of in-work support leading to higher earnings (career component).
- *Ensure that more disadvantaged people have access to services.* Differentiate funding rates by the degree of work limitation to ensure that more disadvantaged people, especially those with mental health conditions who face stronger labour market barriers, also receive appropriate services. A target accelerator, i.e. funding increasing with the number of successful placements, could improve outcomes: providers would have an incentive to invest more to get more "difficult" clients into work rather than screening them out too early.

Benefit reform to improve work incentives and increase incomes

Poor work incentives for people with disability are mirrored by the high share of beneficiaries who would not improve their incomes by moving into work at 16 hours a week. This is related to the low take-up of in-work benefits, especially the disability element of the permanent Working Tax Credit, as well as the short earnings range at which people would benefit from in-work payments. Forthcoming benefit reform aims to correct this situation partly. The following issues will be important:

- *Increase incentives for beneficiaries to seek work.* Replace the 16 hours cut-off point for permitted work by a smoothly phased-out permitted earnings criterion. Reduce the risk of benefit entitlement loss for long-term beneficiaries seeking work voluntarily by broadening the benefit suspension (i.e. linking) rules for those with stable conditions and on disability benefits for at least three years; changes could include 1) more systematic promotion of the suspension rules, 2) automatic re-establishment of benefit payments when people stop working within a certain number of years, with the number of years depending on the previous length of disability benefit receipt, and 3) design of a similar rule for Housing Benefit as well.
- *Raise the impact of in-work payments.* Raise the take-up of the Working Tax Credit by informing clients about the impact on their future earnings as systematically and early as possible. Consider extending the income range at which this permanent in-work benefit is paid.
- *Improve incomes of people with disability.* Reconsider the level of existing cost-of-disability benefits, such as the Disability Living Allowance, to ensure that these benefits cover the actual additional costs of a person with a disability. Better private disability insurance coverage, ideally with case-managed insurance contracts, would contribute to higher incomes of people no longer able to work.

Notes

1. Similar benefit substitution effects might be found between disability and early retirement schemes. There is less evidence on this hypothesis from the four countries, be it because they do not have any early retirement scheme (United Kingdom) or because they have not changed their schemes (Spain, Luxembourg). However, in Australia the phasing-out of special options through the unemployment benefit scheme and the gradual increase in the old-age pension age for women, from 60 to 65 years, has led to a significant increase in the inflow of women aged 60-64 into the disability benefit scheme. OECD (2006b) suggested that such substitution also took place in Norway and Poland.
2. The lack of participation requirements until 2006 probably explains the disappointing impact of the relatively strong work incentives for beneficiaries that have existed in Australia for some time.
3. GDP per capita is a slightly misleading statistic in the case of Luxembourg, because of large amounts of foreign investment and output of non-resident cross-border workers. However, when adjusting for foreign factor income Luxembourg remains the richest country of the OECD.

Chapter 1

Key Trends and Outcomes

What are the main sickness and disability policy challenges that Australia, Luxembourg, Spain and the United Kingdom will need to address in the future? This chapter highlights the key outcomes and trends in these countries during the past 10-15 years in four areas: labour market integration of workers with disability and reduced work capacity; financial resources of those people; costs of sickness and disability benefit schemes; and exclusion and inclusion errors of benefit schemes. In addition, it addresses two macroeconomic challenges: population ageing and future labour supply shortages, and the impact of changing labour market requirements on workers' health. These challenges need to be taken into account if sickness and disability policy systems are to be reformed successfully.

This first chapter provides a summary of the most important sickness and disability trends in Australia, Luxembourg, Spain and the United Kingdom during the past 10-15 years.¹ Outcomes in the following six areas are discussed:

- Labour market integration of people with disability: employment and unemployment.
- Financial resources of people with disability: income and poverty.
- Costs of disability benefit schemes: public spending and benefit dependence.
- Exclusion and inclusion errors: disability benefit reciprocity and disability prevalence.
- Demographic challenges: population ageing and future labour supply shortages.
- Impact of labour market requirements: work and health.

These key trends indicate where structural reforms in the sickness and disability area will be most needed. It will be seen that the challenges arising from these trends are not the same in the four countries. However, in addressing these challenges, reforms in all countries will need to be designed so as to improve outcomes in a given area (e.g. increasing outflows from disability benefits) without worsening other areas (e.g. increasing financial insecurity, or increasing flows into alternative exit routes such as early retirement).

1.1. Employment and unemployment of people with disability

A. Macroeconomic environment and labour market trends

The four countries reviewed share a number of common “starting points” and features but diverge in others (Table 1.1). The share of persons among the working-age population describing themselves as having a disability is around 10-12% in Australia, Luxembourg and Spain but 18% in the United Kingdom.² A considerable number is also drawing disability benefits, namely 3% of the working-age population in Spain, 4-5% in Australia and Luxembourg and 8% in the United Kingdom, compared to an OECD average of around 6% (OECD, 2003).

All four countries are undertaking major disability policy reforms against the background of a favourable economic situation at the beginning of the 2000s. During the past five years, real GDP grew continuously, employment rates increased and unemployment decreased, except in Luxembourg where unemployment remained, however, still at the lowest level across the four countries.

At slightly over 3%, annual growth of real GDP in Australia, Luxembourg and Spain was significantly higher than the OECD average (2.5%). Growth in the United Kingdom was about average – mainly due to a slow-down in 2005 and, to a lesser degree, in 2002. That said, growth is projected to remain strong in all four countries over the next two years: 2.5-3% in the United Kingdom, above 3% in Australia and Spain, and around 5% in Luxembourg (OECD, 2007a).

Table 1.1. Favourable economic and labour market trends in the past five years
GDP and labour market indicators, 2000-2005

	Australia	Luxembourg	Spain	United Kingdom ^a	OECD average ^b
<i>Population (in thousands)</i>					
Working-age population 2005	12 075	344	29 308	32 435	
Disabled persons (self-assessed), circa 2005	1 488	34	3 119	6 018	
Disability benefit recipients, 2005	683	17	1 011	2 615	
<i>Macroeconomic indicators</i>					
GDP per capita 2005 in USD PPPs	34 240	70 245	27 400	32 860	30 062
Annual GDP growth 2000-2005 (%)	3.2	3.1	3.2	2.4	2.5
<i>Labour market indicators (age 15-64)</i>					
<i>Employment ratio</i>					
2000	69.3	62.7	57.4	72.2	65.7
2005	71.6	63.6	64.3	72.6	65.5
<i>Unemployment rate</i>					
2000	6.4	2.4	13.9	5.5	6.2
2005	5.2	4.5	9.2	4.6	6.8
<i>Long-term unemployment^c</i>					
2000	25.5	22.4	47.6	27.9	30.6
2005	17.7	26.3	32.5	22.2	31.6

a) The number of disability benefit recipients and of self-assessed disabled persons refers to Great Britain, while the remaining figures are for the United Kingdom.

b) Unweighted average.

c) Long-term unemployment is the percentage of the total unemployed who have been out of work continuously for more than a year.

Source: Figure 1.8; Table 1.9; OECD.Stat reference series; and OECD database on Labour Force Statistics.

Employment rates increased in all four countries in the past five years but particularly in Spain, namely by 7 percentage points. The increase was less marked in the other three countries (between half and 2½ percentage points). The levels of the overall employment rate are close to the OECD average (65%) in the two continental European countries and significantly higher in the two English-speaking countries (72%).

Unemployment rates of 4-5% are below the OECD average in Australia, Luxembourg and the United Kingdom. In Spain, unemployment has declined by one-third since 2000, but still concerns almost 9% of the labour force. About one unemployed out of five are long-term unemployed in Australia and the United Kingdom, one out of four in Luxembourg, and one out of three in Spain. In all countries except Luxembourg, this share decreased during the past five years.

Most recent OECD projections for the years up to 2008 expect the labour force participation rate to grow further in Luxembourg, Spain and the United Kingdom (by 1½-3 percentage points) and to remain stable at a high level in Australia, while the OECD average is projected to fall slightly (OECD, 2006a). Overall, the macro-economic frame and the labour market situation in the first decade of the 2000s are encouraging in all four countries, setting a good basis for further reforms.

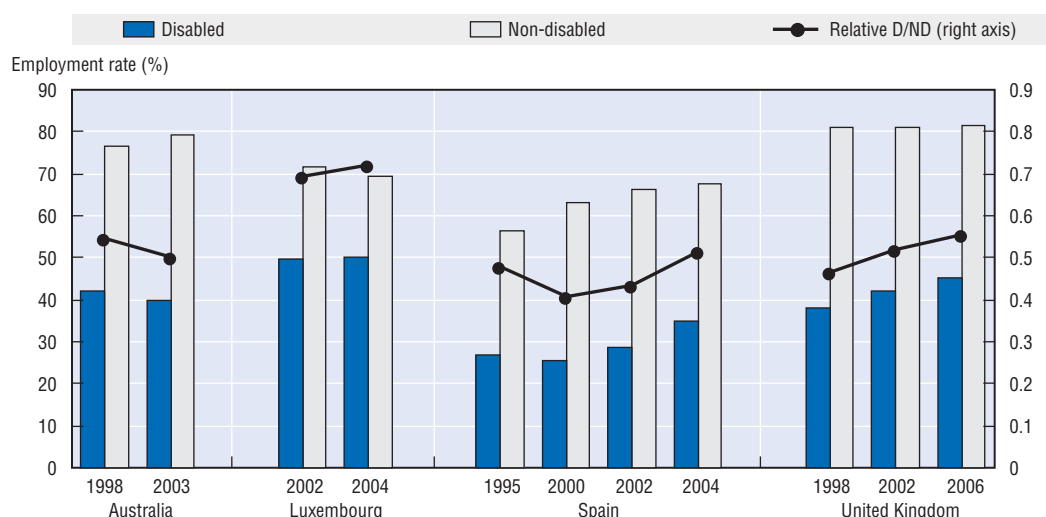
B. Employment among people with disability

General labour market and macro-economic performances are likely to have “spill-over” effects on the employment integration of people with disability. It can be expected that, in a situation of rapid growth, high overall employment and low unemployment, persons with reduced work capacities will have greater opportunities to find a job.

Against the backdrop of the favourable macro-economic indicators in the four countries highlighted above, employment outcomes for people with disability are somewhat disappointing. Nonetheless, the most recent trends are more promising, except in Australia. People with disability have consistently lower employment rates than their peers without disability, especially in Spain where only one-third of them have a job. For comparison, 40% of people with disability have a job in Australia, 45% in the United Kingdom and 50% in Luxembourg (Figure 1.1).³ This compares to employment rates of about 45% in Norway, 52% in Switzerland and less than 20% in Poland, for the three countries reviewed in OECD (2006b). In relative terms – employment rates of people with over those without disability – the ratio is about 0.5-0.6 in Australia, Spain and the United Kingdom, but 0.7 in Luxembourg.

Figure 1.1. Employment rates of persons with disability are only half the level of those without disability, except in Luxembourg

Employment rates of working-age people with and without disability, latest available years (percentage)^a



a) Definition of disability on self-assessment basis: existence of chronic health problem and long-term limitations in daily life activities.

Source: SDAC (Australia); national labour force surveys (Luxembourg and Spain, 2002; United Kingdom); ECHP (Spain, 1995, 2000); and EU-SILC (Luxembourg and Spain, 2004).

Employment rates tend to fall with severity of disability – though less so in Luxembourg. In Australia and Spain, about 42% to 46% of people with moderate disability have a job but only about 25% to 28% of those with severe disability (Chapter 5). In contrast, in Luxembourg the respective shares are 55% and 41% (no comparable data available for the United Kingdom).

That said, employment rates of people with disability have been increasing in recent years in Spain, the United Kingdom and, to a lesser extent, also in Luxembourg, and even faster than those of the population without disability. The exception is Australia, where employment rates of people with disability stagnated between 1998 and 2003 (the latest year for which comparable data is available) while overall employment continued to increase, leading to a fall in the relative employment rate of people with disability.

In general, age and education but not gender determines employment differentials between persons with and without disability (Table 1.2). There is a strong correlation

Table 1.2. Employment differentials are higher for older and less educated persons
Relative employment rate of people with, over those without disability, by gender, age and education, 2000-2005^a

		All	Gender		Age group			Educational attainment		
			Men	Women	20-34	35-49	50-64	Below secondary	Upper secondary	Tertiary
Australia ^b	1998	0.55	0.54	0.56	0.70	0.63	0.45	0.50	0.76	0.82
	2003	0.50	0.50	0.51	0.62	0.58	0.44	0.40	0.58	0.67
Luxembourg	2002	0.69	0.68	0.66	1.06	0.82	0.61	0.61	0.80	0.99
Spain	1995	0.48	0.46	0.54	0.51	0.59	0.50	..	..	..
	2000	0.41	0.39	0.44	0.52	0.52	0.36	..	..	..
	2002	0.43	0.42	0.44	0.57	0.48	0.40	0.40	0.66	0.65
	2004	0.52	0.48	0.58	0.67	0.62	0.45	..	..	..
United Kingdom	1998	0.47	0.44	0.50	0.59	0.51	0.38	0.41	0.62	0.75
	2002	0.52	0.51	0.54	0.62	0.58	0.46	0.46	0.67	0.76
	2006	0.56	0.56	0.56	0.62	0.61	0.51	0.48	0.72	0.79

a) Definition of disability on self-assessment basis: existence of chronic health problem and long-term limitations in daily life activities.

b) The definition of the education variable has changed between 1998 and 2003 so that trends shown for educational groups may overestimate the true trends.

Source: SDAC (Australia); national labour force surveys (Luxembourg, Spain and the United Kingdom); EU-SILC (Spain, 2004).

between the relative employment rates of persons with disability and age. In Luxembourg, younger people with disability even have a slightly higher employment rate than their peers without disability while employment of older people is 40% lower. The same pattern, though less pronounced, appears in Australia. In this respect, the performance of the United Kingdom is noteworthy: the relative employment rate of older workers with disability increased by 13 percentage points. Lower educational attainment is also associated with lower relative employment rates of people with disability, in particular in Australia where these fell by 10 percentage points between 1998 and 2003 and are below those of the other countries. On the other hand, employment rates of persons with disability with higher education still lag behind those of their peers without disability except in Luxembourg.

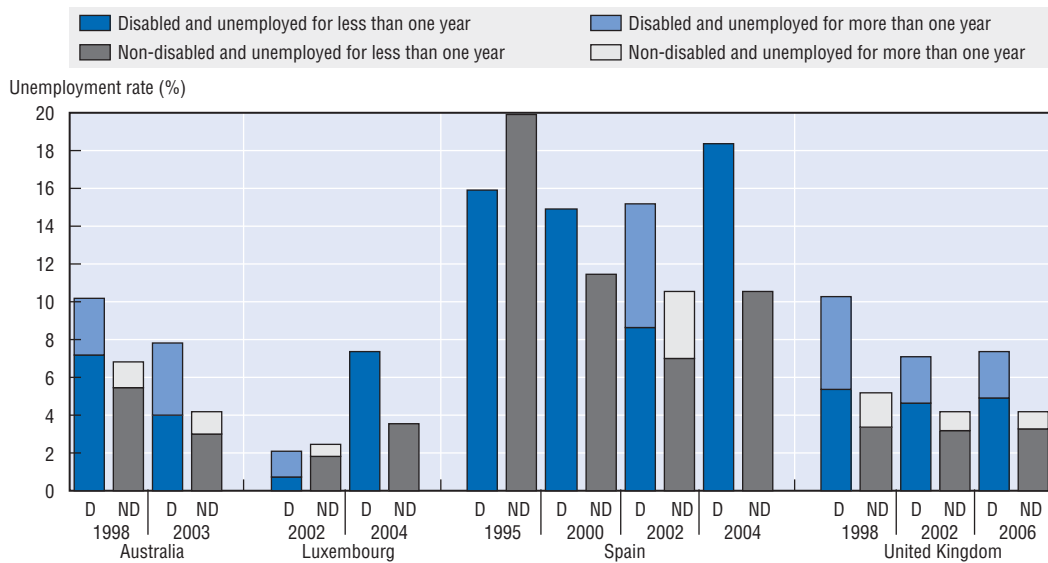
C. Unemployment and inactivity among people with disability

Unemployment rates of persons with disability are higher than those of persons without disability in all four countries (Figure 1.2).⁴ The difference is particularly pronounced in Spain, where unemployment rates of people with disability are almost twice as high as those of persons without disability; although they were lower one decade ago. The recent substantial fall in unemployment rates in Spain benefited exclusively people without disability. The other country where unemployment among people with disability recently increased is Luxembourg: although the rate more than tripled (from 2% to 7%) the absolute level is still slightly below that of the other countries. On the contrary, unemployment rates of persons with disability decreased in line with overall unemployment in Australia, and even faster, in the United Kingdom.

Long-term unemployment is much more common among people with disability; it concerns about half of all unemployed persons with disability in Australia and Spain. In the United Kingdom, the share of long-term unemployed people with disability fell from about half to one-third – in line with the fall of this share among people without disability, from one-third to one-fifth.

Figure 1.2. **Higher and longer unemployment among the population with disability**

Unemployment rates of persons with and without disability, 2000-2005 (percentage)^a



a) Definition of self-assessed disability: existence of chronic health problem and long-term limitations in daily life activities. No data by unemployment duration for Luxembourg 2004 and Spain 1995, 2000 and 2004.

Source: SDAC (Australia); national labour force surveys (Luxembourg and Spain, 2002; United Kingdom); ECHP (Spain; 1995, 2000); and EU-SILC (Luxembourg and Spain; 2004).

Despite a higher risk of unemployment for people with disability, they also consistently have higher shares of inactives among the non-employed population in all four countries. The inactivity shares are some 5-12 percentage points higher than for people without disability (Table 1.3). This differential concerns men much more than women. In turn, there is not much of a variation across age groups.

Employment policies for people with disability are targeted mostly at those who would wish to work – unemployed but also inactive persons. Some indication of the share of inactive people with disability who, despite their disadvantage, wish to take up a job is available for the European countries from the EU Labour Force Survey. Table 1.4 shows that the share of people with “permanent” disability reporting a wish to work differs substantially across the three countries. It ranges from a low of 5% in Luxembourg to 14% in Spain and up to 45% in the United Kingdom, compared with an EU average of 21%.⁵

Based on the Australian HILDA survey, the Productivity Commission found that 55% of inactive men who are ill or have a disability did not want to work, while 38% would wish to work; another 6% were unsure (Lattimore, 2007). In a different survey of disability beneficiaries, around half of all men and women indicated they were likely or hoping to work in the future (FaCS, 2004). Hence, the Australian figures appear to be fairly close to those in the United Kingdom.

The percentage of inactive persons with disability wishing to work further depends on age and decreases sharply for the older age group (50-64). In Luxembourg, for instance, the share of older inactive people with disability who would like to work is negligible. In

Table 1.3. Higher shares of inactivity among total non-employment for people with disability, especially among men

Share of inactive in percentage of non-employed population, by gender and age, 2005^a

All	Gender		Age group		
	Men	Women	20-34	35-49	50-64
Australia					
Disabled	94.4	92.8	85.0	92.3	97.3
Non-disabled	83.1	66.6	75.6	81.7	93.1
<i>D/ND</i>	<i>1.14</i>	<i>1.39</i>	<i>1.12</i>	<i>1.13</i>	<i>1.05</i>
Luxembourg					
Disabled	97.9	98.5	90.7	96.6	98.9
Non-disabled	93.5	88.7	88.4	90.3	99.5
<i>D/ND</i>	<i>1.05</i>	<i>1.11</i>	<i>1.03</i>	<i>1.07</i>	<i>0.99</i>
Spain					
Disabled	87.9	86.0	67.5	84.6	94.7
Non-disabled	75.3	64.9	64.8	72.1	91.5
<i>D/ND</i>	<i>1.17</i>	<i>1.33</i>	<i>1.04</i>	<i>1.17</i>	<i>1.03</i>
United Kingdom					
Disabled	93.4	91.2	87.5	90.1	96.6
Non-disabled	81.0	65.2	75.7	75.8	91.2
<i>D/ND</i>	<i>1.15</i>	<i>1.40</i>	<i>1.16</i>	<i>1.19</i>	<i>1.06</i>

a) Definition of disability on self-assessment basis: existence of chronic health problem and long-term limitations in daily life activities. Data refer to 2002 (Luxembourg), 2003 (Australia), 2004 (Spain) and 2006 (United Kingdom), respectively.

Source: SDAC (Australia); national labour force surveys (Luxembourg, United Kingdom); EU-SILC (Spain).

Table 1.4. Many inactive persons with disability want to work

Percentage of inactive persons with permanent disability who say they want to work, by age group, 2004/2005^a

		Total	20-34	35-49	50-64
Luxembourg	Men	6.2	24.9	13.8	2.4
	Women	3.7	6.3	11.1	1.3
	Total	5.1	14.5	12.8	1.9
Spain	Men	13.1	21.3	15.9	9.2
	Women	15.8	23.0	20.0	12.4
	Total	14.4	22.0	17.8	10.8
United Kingdom	Men	49.1	56.4	56.6	43.0
	Women	40.7	49.8	50.6	32.1
	Total	45.1	53.5	53.5	37.9
OECD Europe ^b	Men	21.8	29.7	27.5	17.3
	Women	20.0	30.7	27.7	14.4
	Total	20.9	30.1	27.6	15.8

a) Figures refer to the average of 2004 and 2005.

b) Data are the weighted average of EU19 (excluding Ireland and the Netherlands), Iceland, Norway and Switzerland.

Source: EU Labour Force Survey 2004 and 2005.

contrast, more than a third of inactive people with disability in the United Kingdom aged 50-64 would wish to work. Questionnaire wording, cultural differences, labour market conditions and household income levels all have their say in explaining these huge differences, but it is likely that institutional factors play an important role: replacement rate levels and possibilities to transfer to (early) retirement.

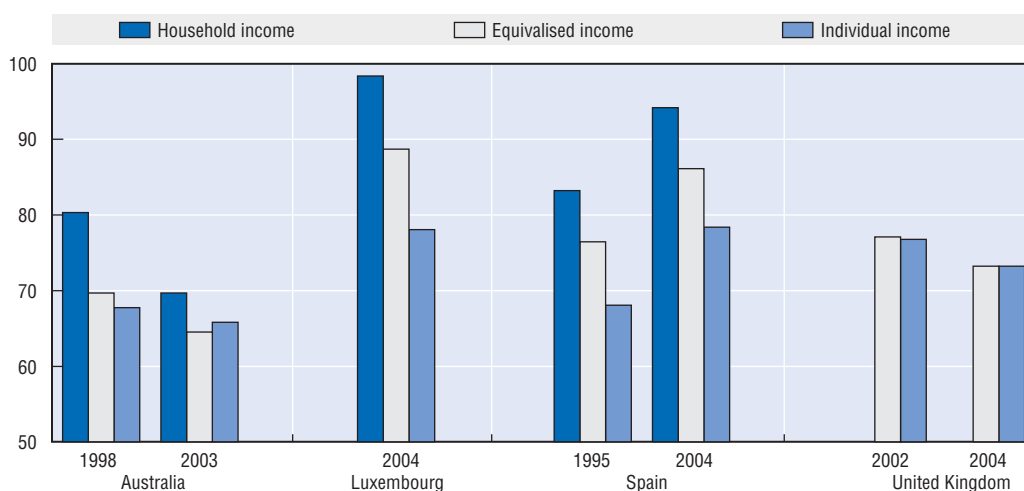
1.2. Financial resources of people with disability: income and poverty

A. Relative income levels

On average, people with disability have less financial resources than others in society in all four countries. But income levels are much closer to the average working-age population in the two continental European countries. Figure 1.3 shows three average yardsticks for financial resources, presented in relative terms: i) total unadjusted incomes of households with at least one person with a disability; ii) equivalised incomes of persons with disability;⁶ and iii) individual incomes of persons with disability. Average incomes of households with people with disability are some 10 percentage points higher than equivalised incomes of persons with disability in those households. In Luxembourg, the former are virtually identical to the average income of households without persons with disability. Equivalised incomes are, in turn, higher than individual incomes, although this difference is less pronounced in Australia and the United Kingdom.

Figure 1.3. **Relative income levels of persons with disability are higher in continental European countries**

Average incomes of persons of working age with disability over those without disability (percentage), three income definitions^a



a) Total income of households with at least one member with a disability; equivalised adjusted income of persons with disability; individual income of persons with disability. Income concept: disposable income, except Australia: gross income.

Source: SDAC (Australia); ECHP (Spain, 1995, 2000); FRS (United Kingdom); and EU-SILC (Luxembourg and Spain, 2004).

Equivalised household income (the medium indicator) is best suited for international comparison, because it takes into account all household incomes (income from work, capital and social benefits) but corrects for differences in household size and refers only to persons with disability. On that basis, average income levels of persons with disability are around 70% of those of persons without disability in Australia⁷ and the United Kingdom, but 85-90% in Luxembourg and Spain. For comparison, relative incomes stood at almost 90% in Norway and Switzerland and around 80% in Poland (OECD 2006b). In Spain, relative incomes of people with disability increased by as much as 10 percentage points over the period 1995 to 2004, while relative incomes stagnated or fell slightly in Australia and the United Kingdom in the early 2000s.⁸

How do these income levels compare to those of other economically vulnerable groups in the countries? For example, for single parents they are at about OECD average (66%) in Luxembourg and Spain but below that in Australia and the United Kingdom (57-58%). For persons aged 75 years and over, they are above the OECD average in Luxembourg (91%) and Spain (84%) and again below that in Australia (64%) and the United Kingdom (71%) (Förster and Mira d'Ercole, 2005). Levels of relative incomes of persons with disability are, therefore, comparable to those of senior citizens. Further, relative income levels of all economically vulnerable groups seem to be lower in the two English-speaking countries, indicating a higher degree of overall income inequality.

It should be noted that the traditional income concepts such as the one used here do not adjust for specific additional costs associated with disability, *e.g.* for transport or particular equipment. Empirical evidence on such costs is available for the United Kingdom. Jones and O'Donnell (1995) report that physical disability has a significant effect on household fuel expenditures (plus 64%) and transport expenditures (plus 45%). More recently, Zaidi and Burchardt (2005) find that disability generates substantial additional costs of living, especially for people with disability living alone, and that these rise with severity of disability.⁹

B. Incidence of low incomes and poverty risks

To which extent do the lower income levels coupled with distributive patterns of earnings, transfers and other incomes lead to increased poverty risks among the population with disability? First, and foremost, a higher percentage of people with disability fall in the lower income deciles and a correspondingly lower percentage in the richer deciles, and this picture is particularly pronounced in Australia (Table 1.5). While, by definition, one tenth of the total working-age population falls in the lowest decile, this concerns 22% of Australians with disability, compared to 14% of persons with disability in Luxembourg, Spain and the United Kingdom. These percentages increase to 57% among the poorest three deciles in Australia,¹⁰ 41% in the United Kingdom and 38% in Luxembourg and Spain. In turn, just 13% of people with disability in Australia are part of the richest 30% of the working-age population, compared to 21-22% in the other three countries.

Table 1.5. More persons with disability among the lowest income deciles, especially in Australia

Cumulative percentages of persons with disability in lower and higher income deciles
(based on household incomes of working-age population)^a

		Lowest decile	Two lowest deciles	Three lowest deciles	Three highest deciles	Two highest deciles	Highest decile
Australia	1998	21	42	55	14	9	4
	2003	22	45	57	13	8	4
Luxembourg	2004	14	27	38	22	13	7
Spain	1995	14	29	43	16	10	3
	2000	15	30	41	18	11	4
United Kingdom	2004	14	26	38	22	13	5
	2005	14	29	41	21	13	6

a) Income refers to disposable household income per equivalent person, except for Australia where it is gross household income per equivalent person (equivalence elasticity = 0.5).

Source: SDAC (Australia); ECHP (Spain, 1995, 2000); FRS (United Kingdom); and EU-SILC (Luxembourg and Spain, 2004).

As concerns trends, the relative income position has not improved for persons with disability in Australia between 1998 and 2003. In Spain, on the other hand, the share of people with disability in lower income segments has slowly but continuously decreased in the decade between 1995 and 2004, with a corresponding increase of the share in higher income deciles.

Table 1.6 details the incidence as well as the profile of the population with disability in the lower income segments. By convention, two low-income thresholds are shown: 50% and 60% of the median income of the total working-age population.¹¹ Poverty rates, defined in these terms, are lowest in Luxembourg: 9% of people with disability have incomes below 50% of median income, and 16% below 60% of median income. These rates are higher in Spain and the United Kingdom, with 14-18% of persons with disability falling below the lower income cut-off, and 24% below the higher income cut-off. And they are substantially higher in Australia, with more than a third of people with disability having incomes less than 50% of the median and almost half of them less than 60%. With regard to the total working-age population, this means that disability increases the poverty risk by a factor of 1.3-1.4 in Luxembourg and Spain, by 1.7-1.8 in the United Kingdom, and by more than two in Australia.¹²

The share of persons clustered between the two low-income cut-off lines of 50% and 60% median income gives some hint on the severity of the low-income situation. Indeed, a higher percentage of people falling between these two benchmarks indicates that smaller increases in income are needed to push these people above the 60% poverty line. In Luxembourg and the United Kingdom, this concerns more than 40% of people with disability with low incomes, in Spain around 30% and in Australia only some 20%.

Table 1.6. Being employed reduces otherwise higher poverty risks among persons with disability

Poverty rates and relative poverty risks for persons with disability, by degree of disability and labour force status^a

	Australia		Luxembourg	Spain			United Kingdom	
	1998	2003	2004	1995	2000	2004	2002	2004
A. Low-income threshold 50% of total median income								
Poverty rate of disabled persons	32	36	9	17	16	18	13	14
Total relative risk rate	2.23	2.41	1.28	1.43	1.54	1.44	1.52	1.69
Risk rates by labour force status								
Employed	0.69	0.81	0.70	1.47	0.95	0.75	0.76	0.77
Unemployed	3.06	3.53	7.52	2.42	1.58	2.59	4.50	4.29
Inactive	3.32	3.44	1.37	1.34	1.75	1.70	1.92	2.19
B. Low-income threshold 60% of total median income								
Poverty rate of disabled persons	42	45	16	26	26	24	23	24
Total relative risk rate	2.12	2.23	1.40	1.45	1.56	1.33	1.65	1.77
Risk rates by labour force status								
Employed	0.72	0.88	0.82	1.18	1.23	0.79	0.80	0.76
Unemployed	3.00	3.08	4.87	2.03	1.73	2.19	3.98	3.74
Inactive	3.10	3.12	1.74	1.51	1.66	1.53	2.15	2.36

a) Poverty rates: percentages of persons with disability in households with less than 50% and 60% of median income.

Relative poverty risk: group-specific poverty rate divided by overall poverty rate for the working-age population.

Source: SDAC (Australia); ECHP (Spain, 1995, 2000); FRS (United Kingdom); and EU-SILC (Luxembourg and Spain, 2004).

Employment is the most important factor for reducing poverty risks. In all four countries, employed persons with disability have poverty rates which are 20-30% below the average of the total working-age population. It should be noted that employment substantially reduces poverty risks among people without disability, too. However, the counter-factual – inactivity and in particular unemployment – has a much more detrimental effect on the income position of persons with disability.

Over time, relative poverty risks slightly increased for all population groups with disability in Australia and most groups in the United Kingdom. In Spain, people with moderate disability and, in particular, those who are employed could reduce their poverty risk, but not the other groups.

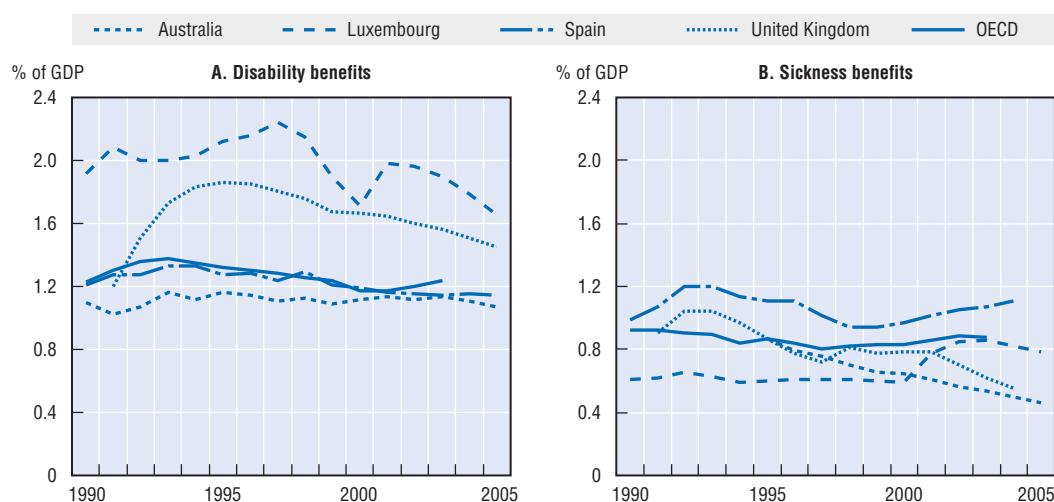
1.3. Costs of disability benefit schemes: public spending and benefit dependence

A. Amount and composition of public spending

Moderating the high costs of sickness and disability is one of the key policy concerns – in some countries, however, more than in others. By 2005, in Luxembourg and the United Kingdom spending on disability benefits was higher than in the other countries, at 1.7% and 1.5% of GDP, respectively. This compares to spending of around 1.1-1.2% in Australia and Spain, a figure which corresponds to the OECD average (Figure 1.4). That said, in all four countries disability spending is lower than in the three countries reviewed in OECD (2006b). Moreover, and more importantly, there was a trend toward lower spending, in particular in the two “higher spending” countries: in the United Kingdom since the middle

Figure 1.4. **Falling trend in spending on disability benefits in recent years**

Annual spending on disability^a and sickness benefits,^b percentage of GDP, 1990-2005



a) Data include income-replacement benefits and key benefits compensating the extra costs of a disability (Luxembourg and Spain do not have separate benefits for this purpose). Australia: Disability Support Pension, Mobility Allowance, Wife Pension (DSP) and benefits for incapacitated veterans; Luxembourg: disability pensions; Spain: disability benefits for employees, self-employed, civil servants, military personnel and local government employees; United Kingdom: Incapacity Benefit, Severe Disablement Allowance, Income Support with a disability premium and Disability Living Allowance.

b) Australia: Sickness Allowance and employer-provided sickness payments (OECD Secretariat's estimate); Luxembourg: employer-provided sickness payments (only from 2001 onwards) and sickness benefits; Spain: sickness benefits for employees, self-employed, civil servants, military personnel and local government employees; United Kingdom: Statutory Sick Pay and employer-provided sickness payments.

Source: OECD Social Expenditure database and data supplied by national authorities.

of the 1990s and in Luxembourg since the late 1990s, although there was an interruption of this trend during 2001-2003 in the latter country.¹³

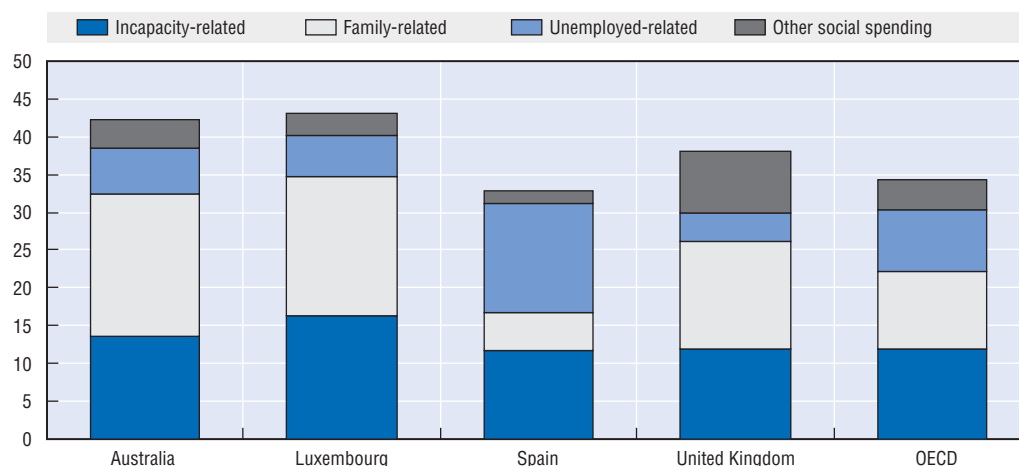
Spending on sickness benefits constitutes less than half that on disability, with the notable exception of Spain where it is almost equal to that on disability. In all four countries, sickness spending is rather similar to the OECD average. There is no clear trend in the two continental European countries, while spending continuously decreased in Australia since 1995, and during two periods in the United Kingdom: in the early to mid-1990s and since the early 2000s.

Adding expenditures on occupational injury benefits and services to those on disability and sickness benefits raises total public spending on incapacity-related schemes to 2.5% of GDP in Australia, Spain and the United Kingdom (a figure that is also close to the OECD average), and to 3.6% in Luxembourg. This is a considerable commitment of resources – especially when compared with other working-age related public social expenditure.

Moreover, incapacity-related spending is higher than unemployment-related expenditures: on average across the OECD, the two categories of spending amount to 12% and 8% of total social expenditures, respectively (Figure 1.5). Also in Australia, Luxembourg and the United Kingdom, incapacity-related spending is much higher than unemployment-related spending: three times higher in Luxembourg and the United Kingdom, and two times higher in Australia. Spain stands out with the highest share of unemployment-related spending in social expenditures, due to the higher incidence of unemployment and related expenditures on unemployment compensation (though expenditures on active programmes are just OECD average).

Figure 1.5. Incapacity-related spending exceeds unemployment-related spending, except in Spain

Annual non-health working-age spending,^a by type, percentage of total public social expenditures, 2003



a) Unemployment-related spending includes unemployment benefits and active labour market programmes for the unemployed; family-related spending includes family allowances, parental leave benefits and child and childcare services; and other spending mainly includes social assistance and housing benefits.

Source: OECD Social Expenditure database and data supplied by national authorities.

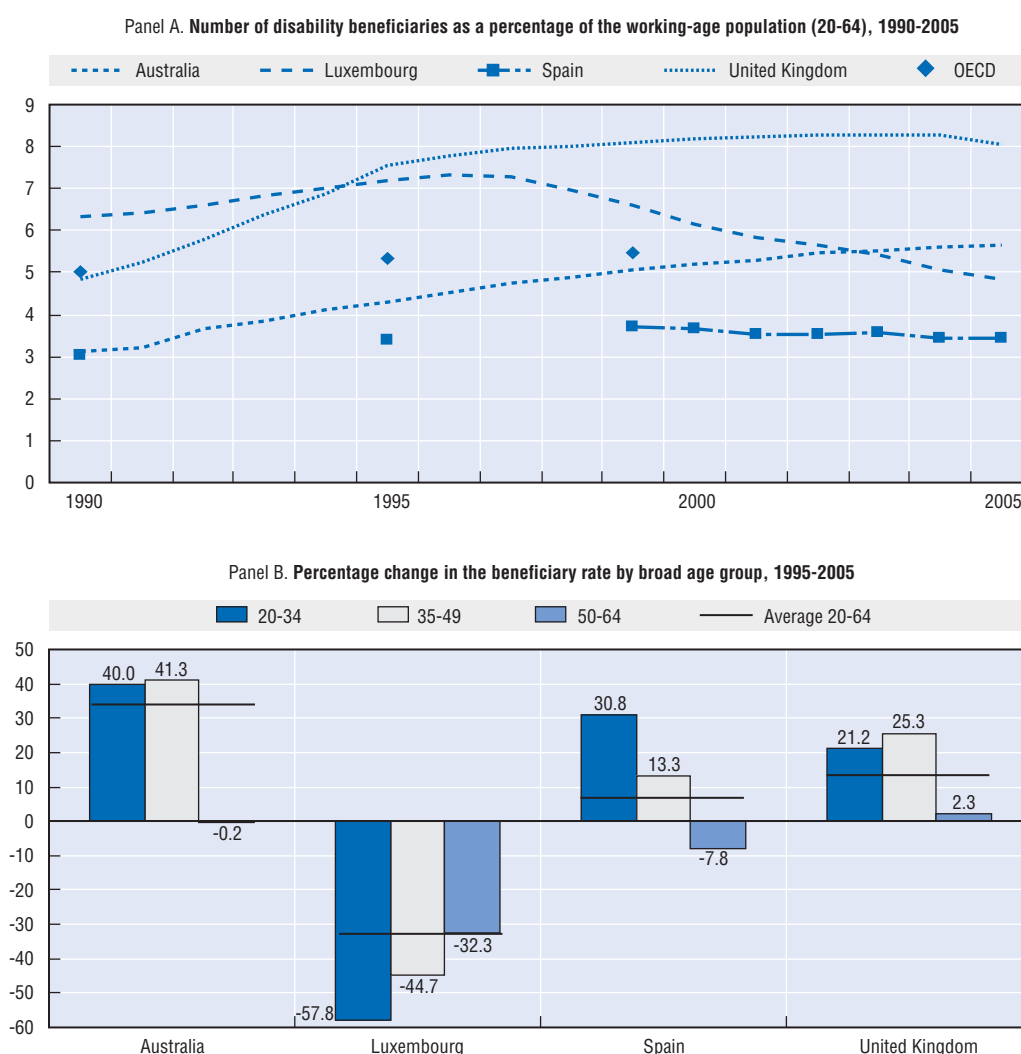
B. Trends in benefit reciprocity

In contrast to the more generalised fall or, at least, stability in disability benefit spending, the trends in benefit reciprocity rates among the working-age population vary

considerably across the four countries (Figure 1.6, Panel A). In the two English-speaking countries, beneficiary rates increased considerably between 1990 and 2005 – by as much as 70 to 80% – although there were signs of a turn-around in the most recent years in the United Kingdom and, in 2006, also in Australia. On the other hand, beneficiary rates decreased substantially in Luxembourg from 1997, while they remained stable in Spain. By 2005, the rate was lowest in Spain, with 3.5% of the working-age population. It stood at 5-6% in Australia and Luxembourg – roughly the level found across twenty OECD countries at the end of the 1990s (OECD, 2003) – and at 8% in the United Kingdom.

Figure 1.6. Disability benefit recipiency rates have increased in Australia and the United Kingdom but have fallen in Luxembourg

Benefit recipiency rates 1990-2005 and change in the beneficiary rate by broad age group (percentage)^a



a) Beneficiaries: DSP customers (Australia); permanent and temporary disability pension recipients (Luxembourg); contributory and non-contributory invalidity pensions (Spain); Incapacity Benefit and Severe Disablement Allowance claimants, excluding IB short-term lower rate (United Kingdom). Data for working-age population for Australia have been adjusted for changes in female retirement age. Data for Spain refer to persons aged 16 to 64 in Panel A and age group 20-34 refers to 15-34 in Panel B. Age groups for the United Kingdom are 20-34, 35-44 and 45-64 in Panel B.

Source: Data supplied by national authorities: DEWR (Australia), IGSS (Luxembourg), Ministerio de Trabajo y Asuntos Sociales, Subdirección General de Estudios (Spain), DWP (United Kingdom).

Changes in beneficiary rates during the past ten years have been driven mainly by the younger age groups. In Australia and the United Kingdom, for instance, all of the increase during this period is due to younger and prime-age persons, while the beneficiary rate of people aged 50-64 hardly changed. In Spain, the beneficiary rate of the youngest increased by almost one-third, while that of older people fell by 10%. Finally, in Luxembourg the fall in the beneficiary rate among young workers was almost double that for those over age 50 (Figure 1.6, Panel B).

C. Average benefit levels

The second key factor in explaining spending trends is trends in average benefit levels. It appears that trends in beneficiary rates are not related to trends in levels of average disability benefits. Table 1.7 summarises the development of the latter over the period 2000 to 2005. On the one hand, in the two continental European countries – which experienced a fall in rates of beneficiaries (especially Luxembourg) – the real average value of disability benefits increased much faster than corresponding wage indicators. On the other hand, in Australia – which experienced a considerable increase in beneficiary rates – and the United Kingdom, the annual average growth rate of disability benefits lagged behind that of net and gross wages. In the United Kingdom, the real value of the long-term incapacity benefit even fell, while net and gross wages increased by more than 2% annually between 2000 and 2005. This fall in benefit levels reflects changes in both benefit rates and the composition of beneficiaries.

Table 1.7. Average disability benefits grew faster than wages in Luxembourg and Spain, but lagged behind in Australia and especially in the United Kingdom

Annual average growth rates of average disability benefit, gross wage and take-home pay (in real values), 2000-2005^a

	Annual average growth real values, ^b 2000-2005			Disability benefit, 2005		
	Disability benefit	Gross earnings	Take-home pay	% of minimum wage	% of gross earnings	% of take-home pay
Australia	2.5	2.6	3.2	45	22	28
Luxembourg	2.2	1.1	1.9	99	42	57
Spain	2.0	0.3	0.2	118	41	52
United Kingdom	-1.2	2.4	2.1	45	16	21

a) Benefits covered: DSP (Australia); temporary and permanent disability pension (Luxembourg); permanent disability pension (Spain); Incapacity Benefit (long-term) (United Kingdom); gross earnings refer to the Average Worker earnings, take-home pay to net earnings of an average worker (OECD, 2007a).

b) Deflated with private consumer price index.

Source: Data supplied by national authorities; *Taxing Wages* 2005/06; OECD *Economic Outlook*.

There are also considerable differences as to the relative value of the average disability benefit across countries. In Luxembourg and Spain, the average benefit is worth more than half of average net earnings and around the level of the national minimum wage. By contrast, the relative level of the average disability benefit is much lower in the two English-speaking countries: it is worth less than half the national minimum wage, and 28% and 22% of net earnings in Australia and the United Kingdom, respectively. This suggests that barriers for taking up work for people with disability who rely only on disability benefits are most likely not rooted in benefit levels being set too close to earnings (“benefit traps”) in these two countries, unless other benefits – such as housing benefit or costs-of-living benefits – are considered as well (Chapter 4).

1.4. Exclusion and inclusion errors: disability benefit reciprocity and disability prevalence

A. Understanding the concept of “disability”

The number and composition of people describing themselves as “disabled” due to a health condition is far from being identical to those who claim and receive an incapacity-related benefit. Estimating the extent of disability is therefore not straightforward. In contrast to the contingency “unemployment” for instance (having a job or not; searching and being available for work or not), disability status is rarely dichotomous and much more a matter of degree. Disability can be defined as a self-assessed or self-perceived status or else as a legal status based on administrative sources, *e.g.* benefit receipt or holding a legal disability certificate. Often, and perhaps inaccurately so, these two definitions are referred to as “subjective” versus “objective” disability. All four countries under review use data and indicators derived from both self-assessed and administrative definitions. None of these definitions is “superior” to the others; rather, they measure different though related phenomena.

Household surveys estimate a similar number of disability benefit recipients as do administrative registers (United Kingdom excepted):¹⁴ around 3-3.5% in Spain, and 5-8% in the remaining countries (Table 1.8). On the other hand, “subjective” definitions on the basis of own-assessed health lead to much higher disability rates: around 18% in the United Kingdom, and around 12% in the other three countries. That said, due to variations in actual questions asked, even among the self-assessed category using very similar definitions, estimates may vary between surveys, as can be seen when comparing results for the United Kingdom in Columns C (based on the national LFS) and D (based on EULFS). Finally, estimates of the number of people not looking for work because of illness or disability range between 3% in Luxembourg and 7% in the United Kingdom.

Table 1.8. Benefit receipt and disability prevalence: comparing different disability definitions

Number of working-age persons with a disability as a percentage of the working-age population, 2005 (or closest year)^a

	Administrative disability status		Self-assessed disability status		
	Beneficiaries (registers)	Beneficiaries (national survey)	Health definition (national survey)	Health definition (EU-LFS 2002)	Search for work definition (EU-LFS)
	(A)	(B)	(C)	(D)	(E)
Australia	5.7	5.8	12.0 (17.5)	–	–
Luxembourg	4.9	5.0	12.3 (21.3)	12.2	3.0
Spain	3.5	3.1	11.7 (18.3)	9.1	4.6
United Kingdom	8.1	5.5	17.6	28.4	7.0

a) Sources and definitions are as follows: Col. (A) Australia: DSP recipients (DEWR); Luxembourg: disability pension recipients (IGSS); Spain: contributory and non-contributory invalidity pensions (Ministerio de Trabajo y Asuntos Sociales, Subdirección General de Estudios); United Kingdom: IB and SDA claimants, excluding IB short-term lower rate (DWP, Work and Pensions Longitudinal Study). Col. (B) Australia: ABS, Disability, Ageing and Carers 2003, Disability pension; Luxembourg: EU-SILC 2004, sickness, disability and work injury benefit; Spain: SILC 2004, invalidity benefit; United Kingdom: 2006 LFS, claiming IB, SDA or IS a disability premium. Col. (C) Australia: ABS, Disability, Ageing and Carers 2003, profound/severe + moderate/mild core activity restriction (figure in bracket: national definition, includes non-core schooling and employment disabilities); Luxembourg and Spain: SILC 2004, chronic health problem and limited daily activities for at least six months (figures in brackets: limited daily activities for at least six months); United Kingdom: LFS 2006 (Persons with reduced capacity due to a long-lasting health problem of more than a year). Col. (D) EULFS 2002 Ad-hoc module on employment of people with disability: existence of a longstanding health problem or disability. Col. (E) EULFS 2005 (2004 for Luxembourg, United Kingdom): Persons who are not looking for work because of illness/disability.

B. Exclusion and inclusion errors

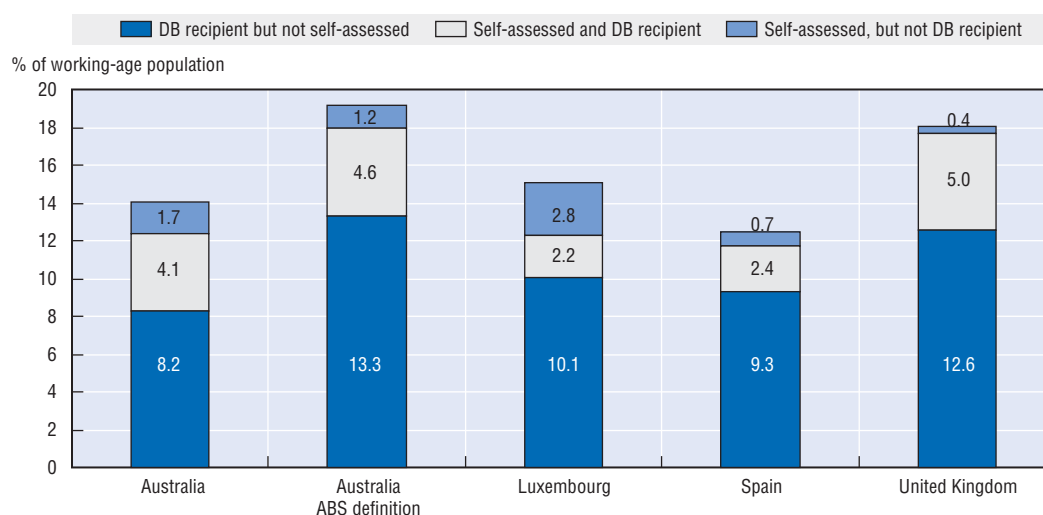
Among those who assess themselves as “disabled”, many will not claim or receive disability benefits. They remain “excluded” from the benefit system, either because they are working and/or they have otherwise sufficient economic resources, *e.g.* via other household members (a central issue in family means-tested systems such as in Australia or the United Kingdom), or else because of quasi or “true” exclusion errors – be it that they may not in fact be sufficiently disabled or impaired as to qualify for a disability benefit or that they have never applied for a disability benefit *e.g.* because of insufficient benefit information or stigmatisation. At the same time, there may be a number of persons “included” in the benefit system who do not consider themselves as “disabled” although apparently fulfilling benefit eligibility criteria.

Figure 1.7 explores the overlap between these population groups in more detail. The total height of the bars indicates the possible extent of disability – *i.e.* self-assessed people with disability or disability benefit recipients, or both. This amounts to around 12-15% of the working-age population in Australia, Luxembourg and Spain, and 18% in the United Kingdom. Using the national disability definition for Australia, which includes not only core disabilities but also non-core disabilities related to schooling and employment, the share would also increase to 19% in this country.¹⁵ The middle bars show the overlap between the different disability definitions, *i.e.* people who assess themselves as disabled^a and who are also on disability benefit rolls. These are between 2% (Luxembourg and Spain) and 4-5% (Australia and the United Kingdom) of the working-age population and they constitute a minor share – less than one-third – of the total disability potential.

Figure 1.7 gives some first hints on the size of “inclusion” and “exclusion” errors: people on benefit registers who do not have self-assessed disabilities on the one hand (upper bars), and people who do have disabilities but do not receive benefits on the other (lower bars). At first sight, inclusion errors seem to be much lower than exclusion errors in

Figure 1.7. Most persons with disability do not receive disability benefits, and many recipients do not claim to have a disability

Overlap between self-assessed and benefit recipient disability,^a 2005 (or close)



a) DB recipients refer to DSP (Australia); sickness, disability and work injury benefit (Luxembourg); invalidity benefits (Spain); IB, SDA or IS with a disability premium (United Kingdom).

Source: SDAC 2003 (Australia); LFS 2006 (United Kingdom); and EU-SILC 2004 (Luxembourg and Spain).

all four countries. The extent of such inclusion errors differs, however, largely across countries: less than one-tenth of persons on a disability benefit have no self-assessed disability in the United Kingdom, but 24-29% of beneficiaries in Australia and Spain and over half in Luxembourg. On the contrary, the possible exclusion error amounts to some 70% in Australia and the United Kingdom and to 80% in Luxembourg and Spain, i.e. a large majority of self-assessed people with disability do not receive a disability benefit.

These results are confirmed by alternative data sources and definitions for Spain, namely for persons who applied for a “legal disability certificate” in 2004: 77% of those with a legal certificate do not receive a disability benefit while just 3% without a certificate do have access to disability benefits (special tabulations by the University of Madrid, based on linked INSS and IMSERSO data).

These summary indicators capture the extent of exclusion from disability benefits at large, but not necessarily “exclusion errors”. People with disability may be covered by other social protection benefits or may have own earnings preventing them from drawing disability benefits. Table 1.9 therefore presents two additional estimates of exclusion errors, namely the share of persons with disability without any public social benefits, and, among those, people not being employed.¹⁶

Table 1.9. Exclusion errors are higher in continental European countries

Different estimates of exclusion errors, by gender and age group, percentage shares, around 2005

Disability status			Percentage distribution				
			Men	Women	20-34	35-49	50-64
Australia	Total self-assessed disabled population	100	48	52	16	31	53
	<i>of which:</i>						
	– without disability benefit	68	43	57	17	34	49
	– without any benefit	43	49	51	16	36	47
Luxembourg	– without any benefit and not employed	11	34	66	12	29	59
	Total self-assessed disabled population	100	..	..	..	..	..
	<i>of which:</i>						
	– without disability benefit	82	..	..	..	..	..
Spain	– without any benefit	66	..	..	..	..	..
	– without any benefit and not employed	20	..	..	..	..	..
	Total self-assessed disabled population	100	48	52	18	31	51
	<i>of which:</i>						
United Kingdom	– without disability benefit	80	43	57	19	31	50
	– without any benefit	44	36	64	22	31	47
	– without any benefit and not employed	16	..	..	..	..	..
	Total self-assessed disabled population	100	46	54	16	33	51
	<i>of which:</i>						
	– without disability benefit	71	42	58	17	33	50
	– without any benefit	51	49	51	17	36	46
	– without any benefit and not employed	11	38	62	17	24	59

Source: SDAC 2003 (Australia); LFS 2006 (United Kingdom); and EU-SILC 2004 (Luxembourg and Spain).

The share of people with disability without access to any public social benefit is 43-51% in Australia, Spain and the United Kingdom but 66% in Luxembourg. When turning to the strictest definition – those without any benefits or employment – the exclusion error falls to 11% in the two English-speaking countries, 16% in Spain and 20% in Luxembourg. In general, when applying the strictest definitions of exclusion error, those excluded are primarily women and older people.

1.5. Demographic challenges: population ageing and future labour supply shortages

Both the number of self-assessed persons with disability and disability benefit recipients increase strongly with age in all four countries. The process of population ageing will, therefore, “automatically” translate into higher disability rates, without any behavioural changes and other things being equal. Related to this fact are concerns about declining labour supply in the forthcoming decades due to population ageing; mobilising under-utilised labour potential among older workers and workers with disability is sometimes seen as one policy answer to this challenge.

A. Effects of ageing on recent trends among disability beneficiaries

To what extent are recent trends in disability beneficiary numbers explained by changes in the population structure? The “pure” effect of ageing can be explored by producing an estimated historical series of disability beneficiaries for the past decade for each country, multiplying 1995 age- and gender-specific beneficiary rates by population numbers in each age and gender group. The difference between the estimated results and the actual beneficiary numbers is the part of the trend resulting from changes in benefit reciprocity rates and therefore not explained by changes in the size of the population “at risk” but by behavioural changes, effects of policies or both.

Demographic changes alone (dotted lines in Figure 1.8) would have continuously increased disability beneficiary rates in the past ten years in all countries: by roughly 10% in the United Kingdom, 20% in Spain, 30% in Australia and 40% in Luxembourg. Actual developments, however, diverged largely across countries (straight lines in Figure 1.8). In Australia, about half of the increase in beneficiary numbers during the period 1995-2005 was due to changes in the population age structure, i.e. the relatively larger increase in the number of older workers who have a higher risk of developing a disability. The other half is explained by changes in the beneficiary rates themselves.

In the United Kingdom, practically the totality of the increase is due to population ageing, although this is a result of a stronger actual increase in the first seven years and a reduction of the differential since 2001. The pattern is quite different in Spain and, in particular Luxembourg, where population ageing would have increased the number of disability beneficiaries by more than the actual numbers show. In Luxembourg, the actual numbers even fell by 6%, which means that the already sizeable reduction would have been even larger in the absence of population ageing.

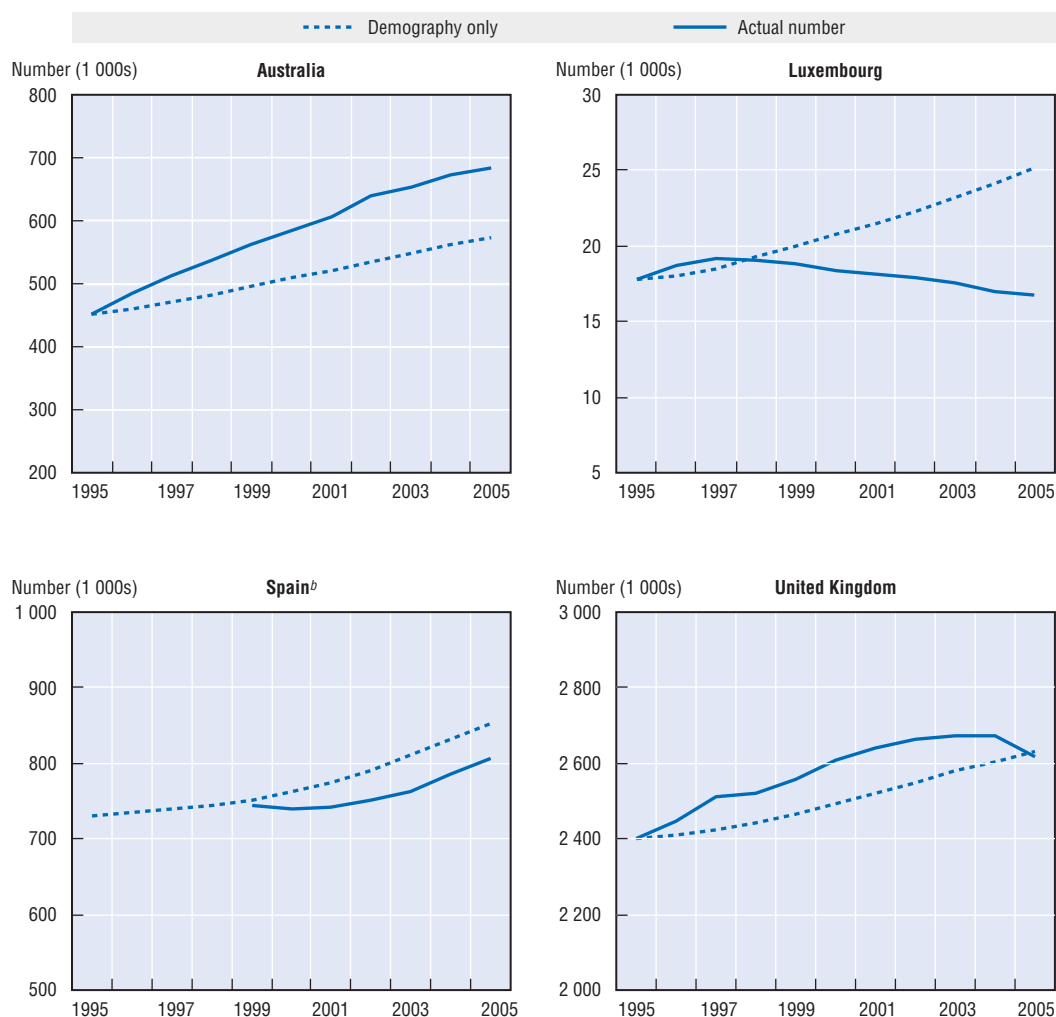
B. Demographic challenges on disability policies over the coming decades

Yet another question is how disability beneficiary rates and numbers will evolve over the coming decades as a consequence of future population ageing, all other things being equal. By using national population projections,¹⁷ future trends in disability beneficiary numbers are estimated, again assuming for illustrative purposes that beneficiary rates by age and gender remain constant from 2005 onward.

Results from these projections are summarised in Table 1.10. The number of beneficiaries is projected to increase by one-third in Australia and by half in Luxembourg in the very long run, i.e. by 2050, but to remain at about the same level in Spain and the United Kingdom.¹⁸ Likewise, the size of the self-assessed population with disability is projected to increase by one-third in both Australia and Luxembourg and by 10% in the

Figure 1.8. Recent trends in beneficiary numbers result only partly from population ageing

Number of disability beneficiaries 1995-2005, actual and estimated, on the basis of 1995 beneficiary rates^a



a) The dotted lines labelled “demography” show estimated numbers of beneficiaries under the assumption of constant age- and gender-specific beneficiary rates of 1995; the solid lines show the actual numbers of beneficiaries. All data refer to the age group 20-64.

b) Data refer to the contributory pension only.

Source: OECD Population database and beneficiary data from national insurance administrations.

United Kingdom but to decrease in Spain. Overall, therefore, the demographic pressure on disability policies could well be much higher in Australia and Luxembourg than in Spain and the United Kingdom.

The pure demographic impact on disability numbers differs according to different time periods in each of the four countries. In Australia, numbers of both beneficiaries and self-assessed persons with disability increase continuously and steadily over the whole period. In Luxembourg, they increase much more substantially over the coming two decades, but then remain constant for the subsequent 15 years or so. However, a further increase of disability numbers is projected from around 2040 onwards.

Population projections draw a similarly dramatic picture for Spain, but only for the next two decades. Numbers of beneficiaries are projected to increase considerably and to

Table 1.10. Population ageing will have a larger impact on future beneficiary trends in Australia and Luxembourg

Projected number of disability benefit recipients and self-assessed persons with disability, 2005-2050^a
(in thousand)

	Australia		Luxembourg		Spain		United Kingdom ^b	
	Disability benefit recipients	Self-assessed disabled population	Disability benefit recipients	Self-assessed disabled population	Disability benefit recipients	Self-assessed disabled population	Disability benefit recipients	Self-assessed disabled population
2005	683	1 508	17.1	34.7	808	5 057	2 755	6 236
2010	749	1 639	19.4	37.5	899	5 378	2 848	6 490
2015	785	1 717	21.5	39.7	974	5 575	2 890	6 552
2020	820	1 779	23.6	41.4	1 059	5 714	2 961	6 741
2025	841	1 827	24.8	42.1	1 113	5 747	2 976	6 819
2030	853	1 848	24.4	41.9	1 123	5 657	2 922	6 707
2035	873	1 890	23.2	41.7	1 088	5 375	2 880	6 577
2040	883	1 914	23.0	42.5	996	4 946	2 906	6 613
2045	909	1 962	24.1	44.2	869	4 501	2 959	6 767
2050	920	1 982	25.6	45.9	800	4 242	2 952	6 790

a) The results refer to the age group 20-64 for all four countries.

b) The data refer to the United Kingdom which is why beneficiary numbers deviate slightly from those shown elsewhere.

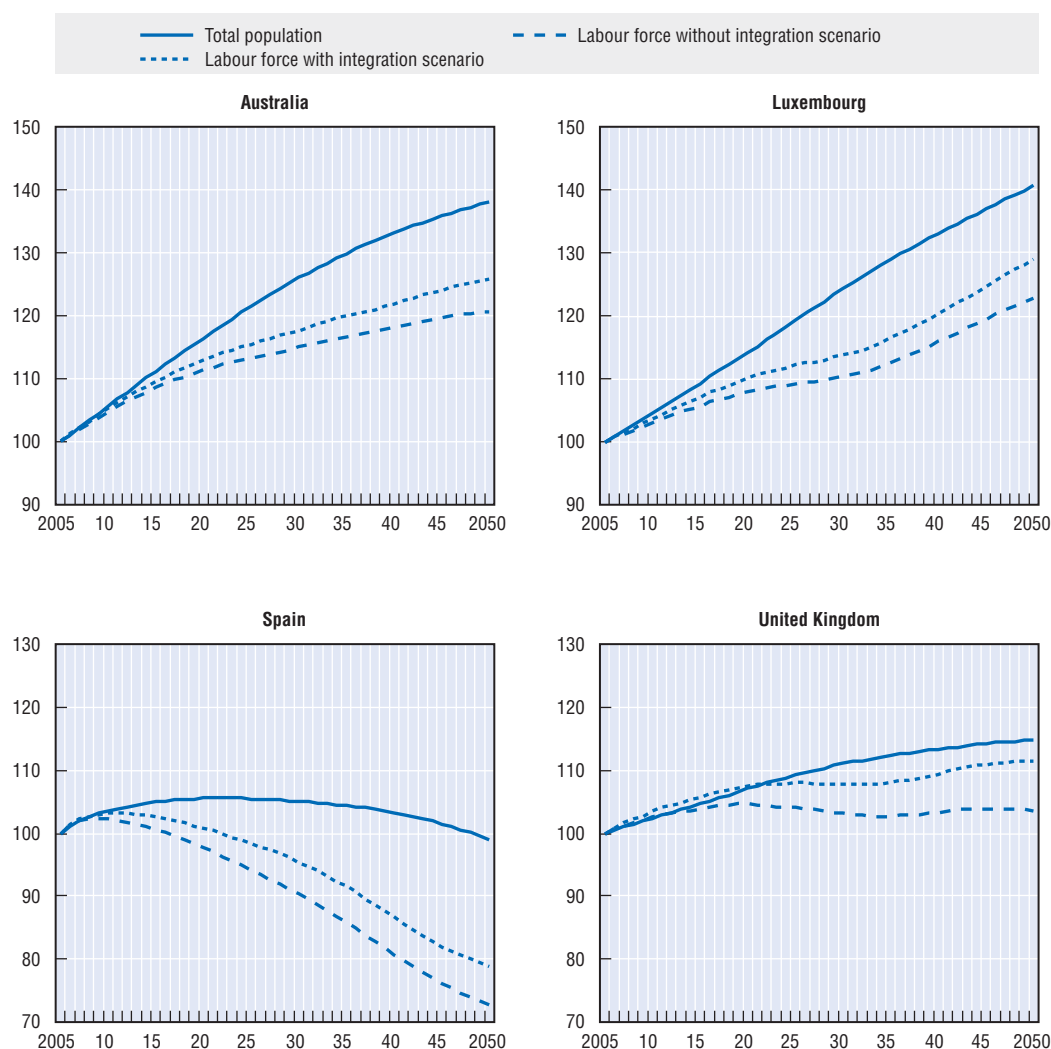
Source: OECD projections based on OECD Population database and beneficiary data from national insurance administrations.

exceed one million in the 2020s. However, and in contrast to Luxembourg, as from 2030, in line with demographic trends, beneficiary numbers decline continuously. The pattern is again different for the United Kingdom; in this country, both beneficiary and prevalence rates increase at a much slower path over the coming ten to twenty years and then remain broadly stable.

Applying specific labour market integration targets to population and labour force projections can shed some light on the possible impact of mobilising the labour potential among persons with disability. This is done in Figure 1.9 which compares projections of the total labour force (long-dotted lines, on the basis of the above population projections) with projections of the labour force augmented by estimates of persons with disability taking up work (short-dotted lines). The scenario assumes for illustrative purposes that, by 2025, all four countries will have succeeded in integrating inactive persons with disability into the labour force by an age- and gender-specific percentage which corresponds to the average percentage of persons with disability wishing to work (Table 1.4), and to double this percentage by 2050. Because of the large country differences in the wishing-to-work proportions, the scenario takes the European average for each age- and gender group as a basis for all four countries. For example, it is assumed that by 2025, in each country 29.7% of the 20-34 year old inactive men with disability will enter the labour force and another 29.7% between 2025 and 2050. This is assumed to be phased in annually from 2005 onward.

Figure 1.9 shows that the labour market integration of all those who would wish to work would have sizeable effects on projected labour supply, although the overall effects would remain by no means sufficient to cope with possible labour shortages. By 2050, in Australia, Luxembourg and Spain, the optimistic labour force scenario would result in projections of some 5 percentage points higher than the constant labour force scenario. This would, however, close the gap to the projected overall population growth only by between one-quarter and one-third. Only in the United Kingdom – where the projected

Figure 1.9. Projected population and labour force 2005-2050
 Labour force under pure demographic and policy reform scenario^a (2005 = 100)



a) The long dotted lines assume constant age- and gender-specific disability prevalence rates as at 2005. The short dotted lines assume an annual reduction of beneficiaries until 2050 corresponding to the average European percentages of persons with disability who say they want to work, by age and gender.

Source: OECD (2006a), data supplied by national authorities; OECD Population database; Table 1.4.

labour force growth is only 10 percentage points below population growth – would the labour market integration scenario close the gap considerably.

1.6. Impact of labour market requirements: work and health

A. Disability and health trends in the population

As shown above, disability based on self-assessment (“disability prevalence”) concerned as much as 18% of the working-age population in the United Kingdom and about 12% in the other three countries. While this percentage remained practically unchanged in Australia and Spain over the most recent period, disability prevalence in the United Kingdom increased by 3 percentage points between 1998 and 2006 (Table 1.11). (No trend data are available for Luxembourg.)

Table 1.11. Disability prevalence increases with age and lower education
Trends in self-assessed disability prevalence by gender, age group and educational attainment, various years

			All (20-64)	Gender		Age group			Educational attainment		
				Male	Female	20-34	35-49	50-64	Below secondary	Upper secondary	Tertiary
			Prevalence rate	Relative prevalence (overall prevalence rate = 100)							
Australia	1998	12.8		101	100	49	92	191	163	77	50
	2003	12.0		96	104	43	87	194	159	82	64
Luxembourg	2004	12.3		117	83	42	96	175	142	91	50
Spain	1995	12.1		94	106	33	77	229	..	..	..
	2004	11.7		94	106	47	87	199	147	58	49
United Kingdom	1998	14.6		100	100	53	91	183	128	69	44
	2006	17.6		94	106	50	88	167	134	76	49

Source: See Table 1.10, Column C.

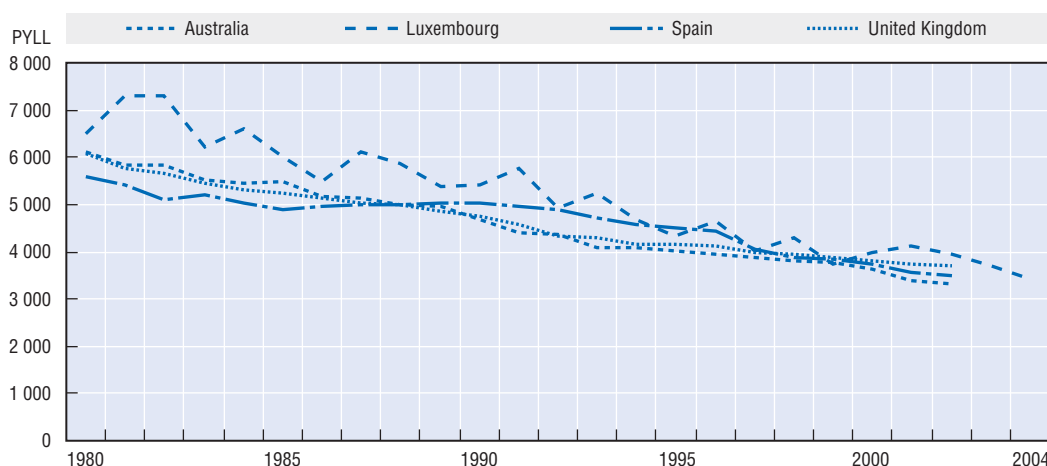
Gender differences in self-reported disability are relatively small. At the most recent date, disabilities are slightly more prevalent among women in Australia, Spain and the United Kingdom – as in a majority of OECD countries (OECD, 2003) – but much more common among men in Luxembourg. There is much more of a differential across age, with disability prevalence gradually increasing by age in all four countries, especially in Australia and Spain. Educational attainment is also negatively linked with disability prevalence, though it appears that the age factor has somewhat more importance than the educational attainment factor in all four countries.

These large and persistent numbers of people with a self-assessed disability have to be seen against the background of the improving “objective” health status of the population. One such indicator of this improvement is the “potential years of life lost”. This is a summary measure of premature mortality, which provides an explicit way of weighting deaths occurring at younger ages that are, *a priori*, preventable. In all four countries this measure has fallen substantially, by as much as 40 to 50% since 1980 and by 20 to 30% since 1990 (Figure 1.10).

This means that subjective health or disability indicators provide quite a different trend picture of the health status than objective ones. Furthermore, developments in disability benefit receipt over time (Section 1.3.B) are not related to trends in either objective or subjective health indicators. This suggests that these latter trends are to a considerable extent influenced by factors beyond health.

B. Labour market requirements and health

The current restructuring of the labour market in post-industrialised societies has profoundly changed labour market requirements. In the context of continuously increasing efficiency and competitiveness, continuous core employment is said to be shrinking and workloads, work pressure and job insecurity increasing. All these pressures can affect sickness and disability prevalence via two channels: first, so-called “niche jobs” become rarer, leaving less employment opportunities for people with reduced work ability because of health problems and disability. Second, increased work pressure and falling work satisfaction themselves can create health problems of employees and lead to disability.

Figure 1.10. **Steadily improving health status in all four countries**Potential years of life lost until age 70, per 100 000 of population, 1980-2004^a

a) The calculation of potential years of life lost (PYLL) involves summing up deaths occurring at each age and multiplying this by the number of remaining years to live up to a selected age limit. The limit of 70 years has been chosen for the calculations.

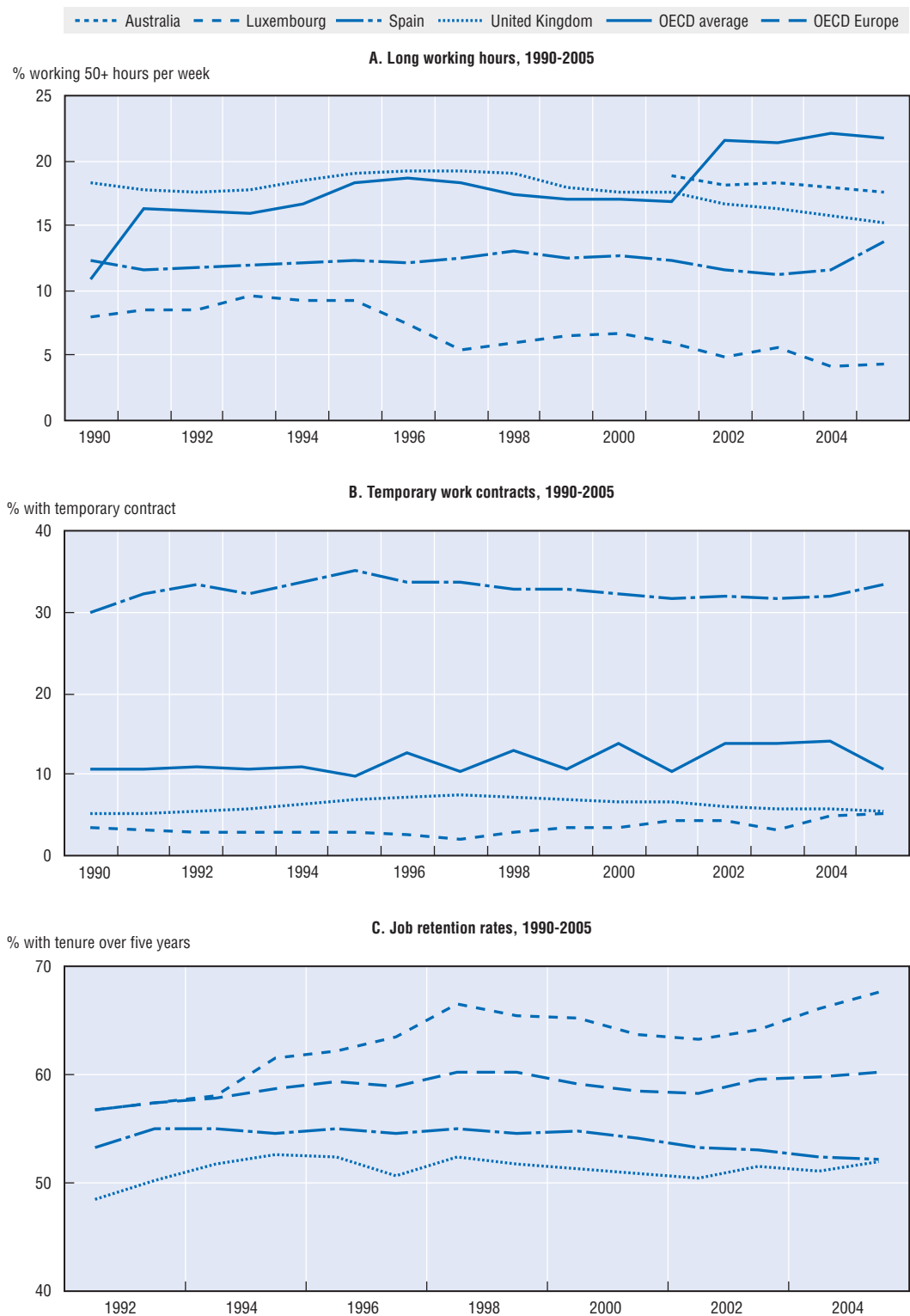
Source: OECD Health Data 2006.

The impact of labour market restructuring on the actual work pressure for employees is difficult to measure, and available objective indicators are inconclusive (Figure 1.11). Changes in long working hours (as an indicator of workloads), for instance, were rather small in the four countries. The share of temporary work contracts as a proxy for atypical work and job insecurity has also remained fairly stable in all countries, as in the OECD area as a whole. Job stability, measured through five-year job retention rates, has been increasing in Luxembourg and remained very stable in Spain and the United Kingdom – though the levels are below OECD Europe in the latter two countries.

Comparative evidence on levels and trends in *perceived* working conditions and demands of work in EU countries suggests that the work intensity may indeed have increased. Table 1.12 shows several indicators of perceived working conditions: cognitive demands of work (items 1.a and 1.b), autonomy in the workplace (items 2.a and 2.b), work intensity (items 3.a and 3.b) and work satisfaction (item 4). Neither demands of work in terms of the complexity of tasks nor autonomy in the workplace as regards the order of tasks and the speed of work have changed very much. On the other hand, work intensity increased strongly in Luxembourg and Spain, in line with the EU average. This is less the case in the United Kingdom, where working to tight deadlines (item 3.b) appears to be far more widespread already than in the other two countries and the EU as a whole.

This finding is important in view of the fact that work intensity appears to be one of the key factors for stress at work. Persons who work under conditions of high work intensity report stress levels almost twice as high as those reported by people who do not have to work at high speed or to tight deadlines (Table 1.13). The only other element that appears to be as important or even more important for the perceived level of stress resulting from work is work satisfaction: across the European Union, one in two workers who are not satisfied with the working conditions in their main job report stress at work, with results for the three countries ranging from 30% in Spain to 60% in Luxembourg.¹⁹

Figure 1.11. **Inconclusive evidence on selected changes in the working environment**



Source: Panel A: OECD database on Usual Hours Worked; Panel B: OECD database on Temporary Work; Panel C: OECD database on Job Tenure.

Table 1.12. Increasing levels of perceived work intensity in European countries
Percentage of employed persons reporting specific working conditions, 2005 and changes since 1995^a

	Luxembourg		Spain		United Kingdom		EU15	
	Level	Trend	Level	Trend	Level	Trend	Level	Trend
1.a Main job involves complex tasks	64	=	39	=	56	–	60	=
1.b Main job involves learning new things	76	=	59	–	69	–	74	=
2.a Able to choose/change order of tasks	70	=	64	=	66	–	69	=
2.b Able to choose/change speed of work	75	+	65	=	69	–	71	=
3.a Job involves working at very high speed	23	+++	23	+++	19	=	26	+++
3.b Job involves working to tight deadlines	25	+++	23	+++	36	+	28	+++
4. Satisfied with working conditions in the job	86	–	81	=	92	+	84	=

a) Levels refer to year 2005. Trends refer to percentage changes 1995-2000: “+++” denotes an increase of more than 20%; “+” denotes an increase of between 5% and 20%; “=” denotes changes between –5% and +5%; “–” denotes a decrease of more than 5%; “---” denotes a decrease of more than 20%.

Source: OECD Secretariat calculations based on various waves of the European Working Conditions Surveys from the European Foundation for the Improvement of Living and Working Conditions (2007a).

Table 1.13. Levels of perceived work-related stress vary greatly with work intensity and work satisfaction

Share of respondents reporting stress at work, according to various working conditions, 2005^a

	Luxembourg	Spain	United Kingdom	EU15
Overall	30	19	12	25
Whether main paid job involves complex tasks				
Yes	30	28	16	29
No	28	13	7	19
Whether main paid job involves learning new things				
Yes	28	24	15	26
No	34	12	6	21
Whether respondent can choose or change the order of tasks				
Yes	26	19	12	24
No	38	18	13	27
Whether respondent can choose or change the speed or rate of work				
Yes	27	20	12	24
No	39	17	12	28
Whether the job involves working at very high speed				
Yes	44	33	18	36
No	25	15	10	21
Whether the job involves working to tight deadlines				
Yes	42	31	20	37
No	25	15	8	20
Whether respondent is satisfied with working conditions in main paid job				
Yes	25	16	9	20
No	60	31	44	51

a) Don't knows/refusals are omitted from calculations.

Source: OECD Secretariat calculations based on 4th wave (2005) of the European Working Conditions Surveys from the European Foundation for the Improvement of Living and Working Conditions.

In sum, available objective evidence on changes in work requirements is somewhat inconclusive. The changes are not big enough to explain sickness and disability trends, nor are the directions of change always in line with those trends. Subjective evidence suggests that work intensity has been increasing recently, and that work intensity is positively

correlated with work-related stress. Policy makers are facing a vicious circle. Heightened requirements on the labour market seem to lead to more pressure and increasing work intensity, which in turn may lead to health problems, sickness absence, disability and, eventually, dropping out of the labour market. Once out of the labour market, however, the absence of a job adversely affects health. Policies need to address this vicious circle.

1.7. Conclusion

The following facts emerge from the picture drawn in this chapter:

Economic and labour market status of people with disability

- Against the backdrop of very favourable macro-economic indicators in the four countries under review, employment outcomes for people with disability are somewhat disappointing. Just between one-third (Spain) and half of persons with disability (Luxembourg) have a job.
- Employment rates of people with disability, however, have been increasing faster than those of the total working-age population in the past years in three countries: Luxembourg, Spain and the United Kingdom.
- Unemployment is higher among people with disability, and their unemployment rate increased in Luxembourg and Spain.
- In the past five years, average disability benefits increased faster than average earnings in Luxembourg and Spain, but lagged behind in Australia and the United Kingdom. By 2005, average benefits stood at 50-60% of average net wages in Luxembourg and Spain but at only around 20-30% in Australia and the United Kingdom.
- Taking income sources from employment, public benefits and other household members together, average income levels of persons with disability are around 70% of those of persons without disability in Australia and the United Kingdom, but close to 90% in Luxembourg and Spain.
- Relative poverty risks of persons with disability – defined in terms of low-income incidence – are comparatively moderate in Luxembourg, high in Spain and the United Kingdom, and extremely high in Australia. Moreover, these risks increased in Australia and the United Kingdom in recent years.
- Employment is the single most important factor for reducing poverty risks for persons with disability. In contrast, unemployment – much more than inactivity – multiplies the poverty risk among persons with disability.

Costs of disability

- By 2005, spending on disability benefits stood at 1.1-1.2% of GDP in Australia and Spain and 1.5-1.7% in Luxembourg and the United Kingdom and there was a trend toward lower spending.
- Adding expenditures on sickness and occupational injury benefits as well as services raises total public spending on incapacity-related schemes to 2.5% of GDP in Australia, Spain and the United Kingdom, and to 3.6% in Luxembourg. Incapacity-related spending is thus much higher than unemployment-related expenditures (except in Spain).
- The rate of disability beneficiaries among the working-age population is 3.5% in Spain, 5-6% in Australia and Luxembourg (roughly the OECD average of the late 1990s) and 8% in the United Kingdom. Sickness absence is highest in Spain and lowest in Australia.

- In Australia and the United Kingdom, beneficiary rates have been increasing considerably, especially during the 1990s. On the other hand, they decreased substantially in Luxembourg since 1997, while they remained stable in Spain. Changes in beneficiary rates during the past ten years have been mainly driven by younger age groups in all four countries.
- Less than one in ten persons on a disability benefit assess themselves as not having a disability in the United Kingdom, compared to a third of beneficiaries in Australia and Spain and over half in Luxembourg. In turn, 70-80% of self-assessed people with disability do not receive a disability benefit in all four countries.
- The share of people without any benefit or employment is 11% of all self-assessed persons with disability in Australia and the United Kingdom, 16% in Spain and 20% in Luxembourg. This concerns mainly women and older people.

The impact of exogenous factors

- During the past decade, trends in disability beneficiary numbers in the United Kingdom were strongly influenced by population ageing, while in Australia ageing accounted for only half of the increase in those numbers. In Luxembourg and Spain, despite similar demographic pressures, actual beneficiary trends diverged downwards.
- Assuming constant age- and gender-specific beneficiary and prevalence rates, population projections for the next four decades suggest a much higher demographic pressure to disability policies in Australia and Luxembourg than in Spain and the United Kingdom.
- If 42% of inactive persons with disability were to be integrated into employment over the next 45 years (i.e. double the percentage for the European Union as a whole of those who say they would wish to work), this would close the gap between the projected labour force and total population growth by only up to one-third, except in the United Kingdom where such a scenario would close the gap considerably.
- Increased labour market requirements may contribute to raising disability. But the evidence on this as being a significant factor behind rising disability benefit rates is mixed. During the past ten years, perceived work intensity increased significantly in Luxembourg and Spain, with work intensity being a key determinant of perceived work-related stress.

Notes

1. Most figures in this report refer to Great Britain only and do not include Northern Ireland.
2. The higher figure for the United Kingdom is likely to be partly explained by cultural differences or, possibly, a difference in the way the underlying survey questions are interpreted by the respondents. Similarly high disability prevalence rates are, e.g., also found in the Scandinavian countries.
3. These employment outcomes refer to persons who self-assess their disability status via household surveys, according to standardised questions on health conditions. Not all of these people – in fact, only a minority (Section 1.4) – claim and receive disability benefits. Employment rates of disability benefit recipients are much lower, ranging from 5% in the United Kingdom, to 18% in Australia and Luxembourg, and 25% in Spain (Chapter 3).
4. Generally the increasing unemployment rate of people with disability is an indicator of their larger disadvantages in the labour market. However, it can also indicate that more people with disability who are out of work are becoming economically active by seeking work.

5. The large differences in these percentages across countries partly reflect the cross-country difference in the age structure of disability benefit recipients, with relatively young beneficiaries in the United Kingdom and much older beneficiaries – who are closer to the retirement age and therefore less likely to be wishing to work – especially in Luxembourg.
6. That is, household income per person with a disability where income is adjusted for household size with an equivalence elasticity of 0.5. This means that total household income is divided by the square root of the household size, implying that, for instance, the income position of a four-person household is considered “equivalent” to that of two single-person households.
7. Unlike the other three countries and those reviewed in OECD (2006b), official Australian data have been made available only on a gross rather than disposable (net) income concept, restricting cross-country comparison. Analyses on Luxembourg data for 2004, which are available on both gross and net income bases, show that this affects absolute rather than relative indicators. Based on gross income, the total average income of persons with disability would be 28% higher but the relative income levels (i.e. with regard to persons without disability) would remain practically unchanged, and this holds for sub-groups by labour force status and severity of disability. Additional evidence on net incomes for Australia is also available from the 2005 HILDA survey: these data suggest a relative income level of persons with over those without disability of 78% (calculations provided by Mark Pearson, OECD).
8. For those countries for which data are available (Australia, Luxembourg, Spain), incomes of persons with severe disability are 5-10 percentage points below those with moderate disability.
9. Adjusting the income concept for these additional costs, they find that the low-income incidence among people with disability of working age (those below 60% of median income) would be significantly higher, i.e. more like 45% rather than the 30% derived with the “traditional” measure.
10. The cut-off points for the 1st, 2nd and 3rd deciles in Australia correspond to about one-quarter, one-third and half of the average wage, respectively. The corresponding figures for Luxembourg are 43%, 55% and 65% of the average wage (OECD, 2007a).
11. The threshold of 50% of median income is often used in OECD and other international comparisons as a yardstick for relative income poverty. The threshold of 60% is used by the European Union as a comparative yardstick for “at-risk-of-poverty”.
12. Available evidence for Australia on a net income basis suggests that 27% of people with disability fell short of 50% median income and 35% of the 60% median threshold (HILDA 2005, calculations provided by Mark Pearson, OECD). This implies relative risk rates of 1.95 and 1.71 for the two thresholds, respectively. Results for risk rates by labour force status are almost identical to those reported on the basis of gross incomes in Table 1.8.
13. Disability spending data include both income-replacement benefits and the main benefits designed to compensate the extra costs of a disability (Mobility Allowance for Australia and Disability Living Allowance for the United Kingdom). Luxembourg and Spain do not have separate benefits for this purpose but they have much higher income-replacement benefits and Spain also has a significant top-up payment for those who are severely disabled and in need of attendance.
14. The non-matching beneficiary rates in the United Kingdom can probably be explained by people on Income Support with a disability premium not classifying themselves as disability benefit recipients.
15. Note that the five percentage points increase in disability prevalence in Australia under this broader definition is almost entirely due to an increase of self-assessed persons with disability who do not draw disability benefits.
16. Only inactive persons in the case of Spain.
17. The long-run demographic assumptions are as follows. Total fertility rates (children per woman): Australia 1.7 (currently 1.72), Luxembourg 1.8 (1.65), Spain 1.4 (1.3), United Kingdom 1.74 (1.77); Female life expectancy at birth (years): Australia 88 (currently 77.03), Luxembourg 86.7 (81.4), Spain 87.9 (83.4), United Kingdom 87 (81.1); Net immigration (annual numbers): Australia 110 000, Luxembourg 2 800, Spain 101 600 (currently 507 500), United Kingdom 145 000 (currently 223 000).
18. National projections for the United Kingdom, based on a more sophisticated yet less comparable model of flows into and out of benefits, yield slightly different results.
19. National data in the United Kingdom suggest that, on average, each stress-related absence involves 29 working days lost, making work-related stress the single most relevant cause of working days lost through occupational injury and ill-health (Health and Safety Executive, 2006). A national survey for Luxembourg indicates a level of work-related stress of 25%; about half of the surveyed population believes that the stress level is likely to increase in the coming years, and one-third that it will remain constant (Confédération syndicale indépendante du Luxembourg, 2006).

Chapter 2

Evaluating Recent and Ongoing Reforms

All four countries have gone through comprehensive sickness and disability policy reform in the past decade. In the United Kingdom and Spain, employment and benefit policy reform went largely hand-in-hand. In Australia, employment policy change preceded the more recent reform of the benefit system, while Luxembourg went through the reverse sequence, with employment policies only being adjusted and expanded after significant changes in the benefit system.

In Australia and Luxembourg, reform has primarily affected people with a partial reduction of their work capacity, who are now expected to remain in or enter the workforce and who are given more help to achieve this. In Australia and the United Kingdom, the array of employment and rehabilitation programmes was extended considerably and new funding mechanisms were introduced. The United Kingdom, in particular, is also instituting new rights and responsibilities for the government and for new disability benefit claimants. Reforms in Spain were largely about decentralisation and concentration of responsibilities to improve service delivery and benefit eligibility management.

Sickness and disability policy in Australia, Luxembourg, Spain and the United Kingdom has seen many comprehensive changes in recent years. In all four countries changes relate to the assessment procedure and include a range of structural and administrative modifications. In some of the countries, reforms also involve a new way of dealing with people with a partially-reduced work capacity (Australia, Luxembourg), creating a new balance of rights and responsibilities for the authorities, as well as sick workers and people with disability themselves (Australia, United Kingdom) and, to a lesser extent, also for employers (especially Luxembourg). This chapter summarises and evaluates the key elements of recent and ongoing reforms. Box 2.1 gives an overview of the countries' sickness and disability schemes to help readers understand recent reform processes better.

Box 2.1. Structure of the countries' sickness and disability schemes – An overview

Sickness and disability benefit systems as well as rehabilitation and employment support schemes differ across the four countries in many ways, reflecting different social protection traditions. The key characteristics are as follows:

How are disability benefits paid?

In Australia and the United Kingdom, disability benefits are flat-rate payments set at around 25% of average earnings. In Australia, these payments are household means and asset-tested (unless a person is blind). In the United Kingdom, contributory disability benefits are not means-tested, while non-contributory payments for those who do not fulfil the contribution requirements are. Both payments, however, are flat-rate and very similar in amounts and they both hinge on the same personal capacity assessment test. Luxembourg and Spain have social insurance-type disability benefits and a complementary but minor non-contributory programme for those not entitled to insurance benefits. The latter are administered by a different authority and using different medical criteria. Insurance payments in Luxembourg consist of a flat-rate and an earnings-related component. The first is paid in full for all eligible workers while the second depends on the contribution record with additional increments for the period between the date of onset of disability and age 55 (if the disability occurs before age 55). Insurance benefits in Spain are earnings-related but, provided contribution-criteria are fulfilled, the length of the contribution period has no impact on the benefit level (i.e. benefits do not depend on the age of onset of a disability). The systems of Spain and Luxembourg both specify minimum and maximum monthly benefit amounts, with average benefit levels around 50-60% of the average wage. Contrary to the other countries, the Spanish system also offers a partial disability benefit (for people unable to work in their usual occupation, i.e. "total" incapacity) which pays around 55% of a full disability benefit ("absolute" incapacity). In addition, Spain has a 20% top-up to a partial disability benefit for people over age 55 who are not employed.

Box 2.1. **Structure of the countries' sickness and disability schemes – An overview** (cont.)

Who is covered by a disability benefit?

In Australia, residents between age 16 and the statutory age-pension age are eligible for a disability benefit. If the assessed disability began before residing in Australia, the person must have ten years of residence in the country. Contributory disability benefits in Luxembourg, Spain and the United Kingdom are paid to all workers fulfilling the contribution criteria and with earnings above a minimum threshold. Criteria range from less than six months of covered earnings in recent years in the United Kingdom, to 12 months of covered earnings in the past three years in Luxembourg, and at least five years of contributions in Spain. Self-employed persons are covered in all three countries, and there are special systems for public-sector employees in Luxembourg and also for several other economic sectors (*e.g.* seamen, miners, armed forces) in Spain. Non-contributory schemes are residency based.

Who is covered by a sickness benefit?

In Australia, employees are entitled to ten days of continued wage payment per year, and in many cases these days can be accumulated over years as long as a worker stays with the same employer. Casual employees, who comprise around one-quarter of the workforce, are not entitled to employer payments in case of sickness. In addition, there is a public, flat-rate and means-tested sickness allowance for residents over age 21 who have a sickness or injury preventing work, provided they have a job to return to. The United Kingdom has privatised its statutory sick pay scheme during the 1990s. Today, following a three-day waiting period, employers are responsible for sickness payments for the first six months of work incapacity for all workers above a lower earnings limit, after which people transfer onto disability benefit. Statutory payments are flat-rate, but many employers top-up this payment during a varying period (three months is quite common) and often to the level of the past wage. People not fulfilling the contribution and earnings requirements for statutory sick pay are entitled to a disability benefit from early on (so-called short-term incapacity benefit). In Spain, sickness cash benefits are paid to employed persons with 180 days of contribution in the past five years and amount to 60% of insured earnings (75% from the 21st day). The benefit is paid from the 4th day and for up to 12 months, a period which can be extended to 18 months. Benefits are paid by the employer through the 15th day, and employers normally also pay a full wage in the first three days. In Luxembourg, all active persons are covered by sickness benefits without a minimum qualifying or work period. Benefits are paid up to 52 weeks and reimburse the full salary which the insured person would have earned. Blue-collar workers receive a publicly paid sickness cash benefit from the first day, while for white-collar workers in the private sector the employer has to continue the wage payment for the month in which the disease occurs and for the following three months.

How are disability schemes financed?

In Australia, the entire social protection system is financed from general tax revenues, with an income tax system that is less progressive than that of the other three countries and the OECD as a whole (OECD, 2007a). In the other three countries, non-contributory disability benefits are also tax financed. Contributory disability benefits, on the other hand, are predominantly financed from employer and employee contributions, at (roughly) equal shares in the United Kingdom and Luxembourg but with a much larger share for employers in Spain. The government contributes with an annual subsidy in Spain and a treasury grant to cover benefit expenditure shortfalls in the United Kingdom, while

Box 2.1. Structure of the countries' sickness and disability schemes – An overview (cont.)

government revenues cover one-third of total contributory benefit spending in Luxembourg. None of the three countries has a contribution rate targeted at contributory disability benefits alone; instead, contributions cover all kinds of contributory benefit programmes, including old-age, survivor, sickness and maternity benefits.

How are rehabilitation and employment supports organised?

Rehabilitation and employment support is organised differently in the four countries. Medical rehabilitation falls under the remit of health insurance in all countries and has little work focus. However, the United Kingdom has recently introduced work-focused Condition Management Programmes outside the health insurance to bridge this gap and in Luxembourg vocational elements are increasingly used in the medical rehabilitation process. Vocational rehabilitation as such is largely inexistent in Spain and Luxembourg, while there are special structures in place for this in Australia and the United Kingdom. Similarly, there are special employment services available for workers with disability in Australia and the United Kingdom, whereas in Spain and Luxembourg those people are helped by the Public Employment Service. The financing differs accordingly. Vocational rehabilitation and employment services in Australia and the United Kingdom are financed through general taxation, and providers are partly reimbursed on the basis of outcomes. In Luxembourg and Spain most available services are financed via unemployment insurance contributions, topped-up by regional and ESF funds in the case of Spain.

More details on the countries' benefit and tax systems can be found in the Annex of Chapter 4 (Table 4.A1.1).

2.1. Australia: new participation requirements through welfare reform

Australia has undergone major changes in its disability policy over the past twenty years. The system developed gradually from a passive benefit scheme to an active labour market programme. With the most recent *Welfare to Work* reform, a further big step was taken, leading to much the same treatment for all (newly) unemployed people regardless of whether or not their work capacity is reduced. The strong support of most stakeholders for the government's reform agenda in combination with the currently very tight labour market is a promising pre-condition for effective implementation of recent and ongoing reforms.

A. Expansion of services and new funding mechanisms

Twenty years ago, Australia's disability policy relied largely on passive instruments, with a range of permanent benefits and very limited employment support for people with health problems or disability. Rehabilitation services were established soon after World War II, but the number of people serviced remained very low. With the Disability Services Act in 1986, which outlined new rules regarding disability service provision and vocational rehabilitation, the approach started to change. Due to opposition from the large service providers, however, this act remained largely unimplemented (OECD, 2001). The 1991 Disability Reform Package and later reforms provided new labour market programmes and additional targeted places for people with disability in existing programmes. Anti-discrimination legislation set new standards in 1992 for both employers and public agencies. This was complemented by Commonwealth-State-Territory Disability

Agreements (the first in 1991) to delineate the roles of the Australian government and state and territory governments in respect of the planning, policy setting and management of specialist disability services.

More recently, the focus switched from programme expansion and increasing the number of places available to improving the quality and outcomes of services. In this regard, Australia is setting new standards for other OECD countries. In 1996, the government announced reforms to disability employment assistance to enhance opportunities for people with disability to take part in quality employment, more closely match funding to support needs, link funding to employment outcomes and address historical funding inequities. The key elements of the reforms were a legislated quality assurance system and a case-based funding model. The quality assurance system, introduced in 2002, implies that providers are audited and certified against prescribed disability service standards, covering employment conditions, governance and prevention of neglect and abuse. There is no funding for providers without respective certification.

General employment services for the unemployed were changed completely as from 1998, in the course of the first Job Network contract. These general services are now supplied by private (be it for-profit or non-profit) providers, and some Job Network providers are specialised in providing services to people with disability. Before reform, payments to providers were dominated by fixed per-client fees, but today funding is mostly outcome-based – with outcomes judged in terms of 13 and 26 weeks of continuous employment. Fees increase with the level of disadvantage and the duration of unemployment of the jobseeker. After various start-up problems, the placement record of Job Network providers has improved significantly in recent years (Grubb, 2006). This is explained by the survival of the best providers in a newly established market, promoted by final performance management through a star-rating system; increasing stability for providers in the course of a progressively refined strategy; and the shift to predominantly outcome-based funding.

The principles ruling the Job Network are currently being expanded to specialist employment services for people with disability. Since mid-2005, the Disability Employment Network (DEN) also operates on the basis of case-based rather than block-grant funding. Fees are based on jobseekers' support needs, as assessed by the Job Seeker Classification Instrument (the larger the needs, the higher the fees), and their employment outcomes. Similarly, from mid-2006, Disability Business Services providing employment assistance to people with more severe disability have been funded under a case-based funding model.¹ Again, funding is linked to the person's support needs, as in this case assessed by the Disability Maintenance Instrument, and employment outcomes. Vocational Rehabilitation services (VR) are still predominantly provided by one public agency, but, as of mid-2006, a proportion of these services is delivered through case-based funding contracts with non-governmental organisations.

Finally, Australia is increasingly moving away from fixed or supply-driven appropriation of employment services which substantially limited the scope for improved labour market integration of people with labour market disadvantage. In the course of the *Welfare to Work* reform, as of mid-2006 demand-driven DEN and VR services were introduced for jobseekers with a part-time participation requirement. These are people who have an assessed work capacity of 15 to 29 hours per week who are able to become independent in the workplace with no more than two years of assistance. For this group,

the employment services no longer have a cap on the number of places available at one point in time.² This new uncapped stream complements the existing capped stream in DEN and VR services, which continues to provide assistance to those people with disability who are assessed as likely to require ongoing support to retain employment after they have found a job.

B. Increasing workforce participation and reducing welfare dependency

The recent developments in service provision must be seen in combination with ongoing welfare reform aimed at increased workforce participation and lower welfare dependency of four targets groups, including people with disability. For older workers and long-term unemployed, participation requirements were tightened to improve work outcomes. For people with disability (and for lone parents), better employment outcomes are sought through a restructuring of income support. Recipients who are in a position to look for work, including part-time work, are no longer entitled to the higher disability benefit but only to a normal unemployment benefit with its stricter compliance rules.

The key elements of the *Welfare to Work* reform affecting people with a disability are the following:

- There is no change for current recipients of a Disability Support Pension (DSP). They do not lose their benefit nor are any obligations imposed. All support services are accessible on a voluntary basis, subject to availability, but in this case a current and valid work capacity assessment is required.
- New applicants are only entitled to a DSP if their work capacity is less than 15 hours per week (rather than 30 hours pre-reform). *Welfare to Work* reform does not entail any changes for this group with such a low work capacity.
- New applicants with a partial work capacity of 15-29 hours per week are only entitled to the lower unemployment benefit. They have to look for suitable part-time work, consistent with their remaining work capacity, and/or to participate in appropriate services offered to them.
- All DSP applicants, except for those considered as “manifestly disabled”, have to undergo a new Job Capacity Assessment (JCA). The JCA has a dual role: to establish the individual’s work capacity and ongoing support requirements, and to identify barriers to work and interventions needed to overcome those barriers. The assessor will refer and in most cases book the applicant into their first appointment with a service provider within a few days.
- Services to which jobseekers are referred can include Disability Employment Network or Vocational Rehabilitation services, but also specialist or generalist services offered by a Job Network provider as well as the Personal Support Programme (for those with special non-vocational barriers). Within the service type, the jobseeker can choose the provider.

It is too early to tell what the impact of the *Welfare to Work* reform and of the demand-driven provision of job-search and training support for those with a work capacity of 15 to 29 hours a week will be.³ One direct impact is a lower benefit payment – because these people are now on unemployment rather than disability benefit – and higher tax rates for those moving off benefit into low-paid work (Chapter 4). However, the new comprehensive JCA is a promising step as an integrated assessment aimed at earlier intervention, and the last step in a shift from a medical to a functional view of disability (Chapter 3). The dual assessment and referral role could develop into its key strength. Success of recent reforms

will rely heavily on the quality of the JCA, which is contracted out to a number of public and private agencies, and the quality of services provided after that.

JCA is also a step towards a more similar treatment of unemployed with disability and “standard” unemployed people with labour market disadvantage. This is mirrored by the fact that there are several ways to get to a JCA. The new assessment is compulsory for DSP applicants but also for unemployed persons who apply for a longer-term activity-test exemption because of temporary work incapacity. As such, this may prove to be a useful tool to identify and tackle health problems earlier. In addition, a JCA is an option in two other instances: first, during the profiling process for normal jobseekers (which is done through the Job Seeker Classification Instrument), and secondly, when clients indicate to either Centrelink or an employment service provider that they have a medical condition or disability that impacts on their work capacity or employment assistance needs.

2.2. Luxembourg: managing partial work capacity in a different way

Sickness and disability policy reform in Luxembourg during the past decade was characterised by a changing approach towards people no longer able to perform their last job but still potentially able to work in another occupation. A pessimistic assessment of these changes will conclude that this has simply resulted in shifts between programmes. People were first “parked” on disability benefits, then on long-term sickness benefits, and are now on topped-up unemployment benefits. Indeed, people with partially-reduced work capacity have not been able to move into, or stay in, work in significant numbers. The latest change, however, has the potential to improve the situation.

A. Reducing the inflow into disability benefits

After unification of the pension system for blue-collar, white-collar and self-employed workers in 1987, disability benefit rolls increased very rapidly. This was essentially the consequence of a generous administrative practice. The 1987 law defined disability as the inability to carry on the occupation of the last post or another occupation suited to the person’s capacity. In practice, however, this was interpreted as including all individuals unable to carry on in the occupation of the last post, so that people no longer able to do their current job were systematically granted a disability benefit. As a consequence, by the mid-1990s, Luxembourg had one of the highest beneficiary rates in the OECD.

Several court rulings in the mid-1990s criticised the lenient interpretation of the eligibility criteria and firmly established that disability has to be defined as described in the law. In 1997, the implementation of legislation eventually became much stricter. People with partially-reduced work capacity were no longer granted disability benefits. Benefit rolls started to fall again and public spending on disability dropped from 2.6% of GDP (1995) to 1.8% (2001). However, those people with partially-reduced work capacity were not given any real support to remain employed. This had two consequences: first, long-term sickness absence grew, and secondly, after exhaustion of sickness benefit entitlement of one year, those who were unable to find a new job were at risk of falling out of the social security safety net.

The first plan, several years back, was to remedy this situation by introducing a partial disability benefit for those with an occupational but no general disability – similar to the current partial benefit system in Spain, France and Poland (OECD, 1999). This partial or occupational benefit, paying 50% of a full disability benefit, should have been compatible

with professional activities in another occupation up to a ceiling. This plan, however, never materialised, mainly because the main trade unions disagreed, fearing that this would not avoid the poverty trap for workers entitled to the new reduced benefit (Wagener, 2003). Instead, based on the ideas developed by a tripartite working group, a new proposal was prepared which was approved by parliament in 2002 and is in force since October of that year.

B. Helping people with partial work capacity getting into work

The new law has two main objectives: to prevent misuse of disability benefits by tighter medical control procedures, and to improve employment integration of those with a partially-reduced work capacity unable to continue working in their current job through a new redeployment procedure.

Tighter medical control and health status monitoring comes in at several points. Under the new law, which applies to both new and current beneficiaries, a prolonged sickness leave leads to a compulsory medical examination by the medical control service of the social security authority. This examination, which takes place within the first four months of sick leave, can have three outcomes. If the worker is found able to return to work, benefit payments are stopped. If the worker is still found unable to work, sickness benefit payment continues and another medical exam is scheduled for a later date. If the worker is found likely to permanently remain unable to work, application for a disability benefit is launched.

A second more comprehensive medical examination is carried out when the worker applies for a disability benefit. At this stage, only two outcomes are possible, i.e. acceptance or rejection. If the worker is found to be unable to work according to the 1987 definition, the work contract is dissolved and disability benefit payment is started. In case of benefit rejection, another medical assessment by the occupational medical service of the Ministry of Health determines whether or not the person can return to the last job. If not, or if the person has no valid employment contract, the new redeployment procedure is launched. Companies with more than 25 employees are obliged to find an appropriate job for their worker, be it a different job in the same company or the same job at reduced working hours (internal redeployment). If employers can prove that this is impossible or would come at an excessive cost, external redeployment is sought.

Employers and employees involved in an internal redeployment process are given financial incentives. If the new job pays less than the previous one, the Labour Fund pays a compensatory benefit to the worker which covers the difference (up to five times the social minimum wage). In addition, the redeployed worker is protected from dismissal during one year. The employer is entitled to special support (e.g. reimbursement of the outlays for additional training and accommodation of the workplace), as well as special tax credits. Furthermore, internally redeployed workers count against the company's employment quota for handicapped persons. On the other hand, another penalty equivalent to 50% of the statutory minimum wage (payable for up to 24 months) may be imposed on employers who fail to comply with their obligation to internally redeploy an employee with a disability.

If internal redeployment is not possible, the worker is registered as unemployed with the labour office and entitled to unemployment benefit while the search for suitable employment continues. If such employment is found, workers with disability and their

employers are entitled to the same benefits as in the case of internally redeployed workers. Compensatory benefits are calculated according to the previous wage regardless of the level of unemployment benefit paid in the interim. If the person could not be placed in alternative employment during the legal duration of unemployment benefit payments (of between one and, at most, two years), the worker is entitled to a waiting allowance, which is paid at the level of a regular disability benefit. The worker has to remain available for any placement attempts, and payment is stopped once a suitable occupation is found. This new waiting allowance is not paid by the Labour Fund, but by the pension insurance.

Early evidence suggests that the number of sick workers returning to their previous company has increased, while external redeployment has failed – noting that around two-thirds of all cases going through the process fall in the latter category. In turn, unemployment has increased and there is a great risk that structural unemployment will permanently remain at a higher level. The longer-term effect of the reform is yet to be seen, in terms of both employment integration and benefit applications. Being redeployed within the same enterprise with fewer working hours, while maintaining one's previous income, could make application for a disability benefit even more attractive than in the past. This is why the first element of the reform, the tightening of medical controls, is an important complement to the new procedure. The anticipation of external redeployment into another company and the uncertainty surrounding the entire process, on the other hand, might make it less attractive for workers to go through the hassle of applying for a disability benefit.

For the society and the social security system as a whole, the key question for success of the reform is the extent to which the currently poor outcomes of external redeployment can be improved. The new policy entails a number of permanent additional expenses. These could be more than offset by considerably lower spending on sickness benefits and especially disability benefits, but only if work integration of people with partially-reduced work capacity becomes more frequent.

2.3. Spain: decentralising and concentrating decision powers

Spanish disability policy changed markedly in 1982, when integration of workers with disability in the open labour market became a target for policy. Twenty-five years later, however, the actual implementation of active policies is still lagging far behind and integration in the open labour market remains the exception. On the benefit side, policy implementation was more successful; long-term benefit dependency was reduced and poverty levels have fallen. Both these outcomes are related to the accomplishment of two administrative reforms starting some ten years ago and completed only recently, which changed the disability policy setting considerably.

A. Devolution of responsibilities to the regional level

The decentralisation of responsibilities from the central level to the 17 autonomous communities is perhaps the single most important change in Spanish policy making over the past two decades. After a long period of asymmetric federalism, today all regions have broadly the same responsibilities as regards the delivery of public goods and services. The Spanish Constitution enumerates the powers that may be taken up by the regions, those that are an exclusive competence of the central government, those that may be implemented in tandem and those that may be delegated, in full or in part, to the regions (OECD, 2005a). Many of those tasks that are key for a better labour market integration of people with disability fall into the latter two groups, including labour market policies, social security, and training

programmes for both the unemployed and the working-age population more generally. For those shared or partially-delegated responsibilities to be executed as intended, considerable co-ordination efforts across government levels are needed.

Decentralisation of labour market policies was completed only a few years ago. Most of the powers of the national Public Employment Service (PES) were transferred to the regional headquarters. These regional head offices now manage all employment programmes that are delivered by their local agencies. Apart from payment of unemployment benefits, the responsibilities left to the national PES are to develop and disseminate overall strategies and guidelines to ensure coherent policies across Spain and to distribute funds to the regional offices. Regional strategies and any more specific regulations and measures have to be developed by the regional PES headquarters. Actual policy implementation is thus an exclusive responsibility of the autonomous communities. Presumably, laws are implemented quite differently across regions, but as regional implementation is not monitored systematically, little is known country-wide about the extent to which state laws are enforced.

The decentralisation of employment policy contrasts with the central management of the National Social Security Institute (INSS) (see below). Through the different policy execution levels, indispensable collaboration between these two institutions has become even more difficult. While a special Working Group (with representatives from the regional PES offices) has been established to mediate problems across different PES levels, an institutional interface between the PES and the INSS is lacking. More particularly, the INSS is not responsible for activation measures or vocational rehabilitation and people are not referred to the PES, nor does the PES refer people with health problems to the INSS. This makes the Spanish situation quite different from that in many other countries which are in the process of merging these two institutions.

The decentralisation of responsibilities was accompanied by a reform of financing which aimed to increase the regions' self-sufficiency and fiscal responsibility. However, the devolution of spending and revenue powers remains asymmetric. In 2002, for instance, some 45% of total public expenditure was managed at the sub-national government level, but only about 30% of all government revenues were collected at this level (OECD, 2004a). This funding mismatch is most evident in one area of disability policy: non-contributory disability benefits are financed by the central government but managed at the regional level. Reviewing the invalidity status to determine eligibility for such a benefit is carried out by the health authorities of the autonomous communities (Chapter 3). Theoretically, this is an incentive for the regions to shift beneficiaries with low employment potential from social assistance rolls (which are costly for the regional administration) to non-contributory disability benefits (the costs of which are covered by the central government), although available data do not support this. Similarly, financing structures imply that the fiscal consequences of failure of regional labour market policies are to a large extent borne by the central government.

B. Concentration of benefit matters at one single authority

On the benefit side, recent policy was driven by attempts to reduce the wide use of sickness and disability benefit schemes. With a major organisational reform, back in 1997, all disability benefit matters were transferred to the INSS. Since then, disability is no longer assessed by general practitioners but by a group of experts from the disability assessment team, a newly founded INSS body. This team assesses the person's work ability on the

basis of the available medical files and a special medical assessment by one of the (currently) 400 INSS doctors. Ultimate benefit decisions are taken by benefit administrators in the 52 provincial branches of the INSS, usually following the advice of the national assessment team.

But the responsibility of the INSS goes much further than this. The stricter assessment process, coupled with a reduction in benefit levels and a change in the eligibility criterion for a partial disability benefit, has indeed helped to avoid an increase in beneficiary numbers in times of rapidly declining unemployment. However, it could not stop sickness absences from increasing, although stricter sick leave controls were also enacted in 1997. Today, INSS also has exclusive responsibility for sickness absence controls, and this function is nowadays carried out very rigorously. In 2004, a new sub-department at INSS was established with the sole purpose of better monitoring and reducing absence rates. A new INSS monitoring tool (ATRIUM), with daily updated complete individual sickness absence histories, allows online selection of cases for reviews on the basis of “longer-than-expected” recovery phases (Chapter 3). In addition, in 2005 a general absence control was put in place when the duration of absence was greater than six months.

In order to reduce sickness absence rates more effectively, INSS increasingly operates on the basis of bilateral agreements with autonomous communities, big employers, hospitals and other actors. For instance, recently INSS has signed pilot agreements with three autonomous communities (Extremadura, Castille-La Mancha and Castille-León) to pay special attention to the 14 most frequent sickness absence causes. INSS is setting aside a certain budget to ensure that the regions tackle these pathologies more forcefully. Through those funds, special primary health care is being offered by the regional public health service, with financial rewards for general practitioners putting this programme into operation.

Available data suggest that these efforts are having some impact. The annual rate of growth in total sickness benefit spending, which peaked in the year 2003/2004, has dropped continuously since (spending increased by almost 15% in 2003/2004, but by only 6% in 2006/2007).

2.4. The United Kingdom: rebalancing rights and opportunities

Sickness and disability policy in the United Kingdom has been changing rapidly. In the past decade, the country has made a big step away from what used to be a very passive system mainly designed to pay benefits to people out of work. Change was initiated in the mid-1990s, with new elements on both the benefit system side (incapacity benefit replacing the old invalidity and sickness benefit) and the employment policy side (anti-discrimination legislation replacing the never-enforced employment quota scheme). Since then, the government has initiated a range of policies with good-practice elements of various kinds and ongoing reform will add yet more of these elements.

A. Switching to a more active policy approach

The employment part of the Disability Discrimination Act (DDA) came into force in 1996. The new focus of policy is to enable persons with disability to function fully in the regular labour market. Initially the DDA only applied to employers with 20 or more employees, but it was gradually extended and now covers all companies irrespective of their size. In parallel to this, the New Deal for Disabled People (NDDP) was developed, the

first attempt to provide a national network of Job Brokers to help people with health conditions and disability move from disability benefits into sustained employment. The NDDP was piloted in 1998 and extended nationally as of 2001. By mid-2004, nearly 100 000 people had registered with the entirely voluntary NDDP programme.

Within NDDP, brokers have used a variety of approaches, including unpaid work trials and temporary job-match payments for part-time work. A strong focus was put on individual case management, sometimes with unusually low caseloads of less than 50 jobseekers per caseworker. This tailoring and case-management approach is currently further extended in the course of the *Pathways to Work* reform (see below), through which each claimant is looked after by a specially-trained Incapacity Benefit Personal Adviser. The advisers follow their clients through the whole process and help them find the best possible service and Job Broker. A second key element of the NDDP system is the outcome-based funding of job-brokering services, with service providers receiving basic fees for placements and additional fees for more sustainable job outcomes (Chapter 5).

Merging the Benefits Agency and the Employment Service, starting in 2002, was another step towards a streamlined and more integration-oriented approach. This new agency, Jobcentre Plus, operates on a far more customer-oriented basis and provides a single point of delivery for jobs, benefits advice and support for people of working-age. As a result, the practice of shifting people around – e.g. from unemployment to incapacity benefit and *vice versa* – has become less common.

The overall impact of these employment-focused measures is difficult to assess, but available evidence shows that employment rates of people with disability have increased during the past few years. A major impact of the reforms is the change in signal for people with disability willing and able to work. More detailed programme evaluation suggests that of those who participated in the NDDP programme, 35% had moved into work, and that of those who did, the majority has done so within three months of registration with NDDP (Orr *et al.*, 2007). However, these results should be seen in context: no more than around 2% of the eligible population registered for the NDDP programme. Activation spending would therefore have to be increased considerably in the future to make a real difference through this route.

B. Redefining rights and responsibilities

Many people with disability can and wish to work, in the United Kingdom more than elsewhere. With the government offering new, highly individualised and better streamlined support, it becomes more reasonable to reconsider participation requirements for people on disability benefits. Requirements of this kind and work tests have been strengthened considerably in the past 15 years for unemployment benefit recipients. This has contributed to a fall in unemployment but, possibly and plausibly, also the continued increase in disability benefit numbers. The most recent and still ongoing *Pathways to Work* incapacity benefit reform is a first step towards establishing a new balance of rights and responsibilities also for incapacity benefit claimants.

The main feature of *Pathways to Work* at this stage is a series of six monthly and mandatory work-focused interviews starting eight weeks after the benefit claim. These interviews are led by the incapacity benefit adviser in the Jobcentre Plus office and result in a personal action plan.⁴ In the course of *Pathways*, a range of programmes can be accessed known as the *Choices* package of interventions to support return to work. Choices

include the existing NDDP programmes but also new instruments such as work-focused Condition Management Programmes which are developed jointly with the local National Health Service. *Pathways* started as a pilot in late-2003 and is currently being rolled out nationwide, a process which will be complete by April 2008.

So far, *Pathways to Work* primarily targets new disability benefit customers, and the six interviews are the only mandatory element of the process. Any action taken in response to this work-focused dialogue is still non-compulsory. However, people already receiving a disability benefit can volunteer to go through the *Pathways* process and would have access to the whole range of interventions available through the Choices package. In additional pilots, *Pathways to Work* has been extended, on a mandatory basis, to some existing incapacity benefit customers; in a first stage to people whose benefit claim started in the two years immediately prior to the rollout of *Pathways* and later on including those whose claim started up to six years before as well. For these pilots, only three mandatory interviews are foreseen.

Quantitative evidence on the impact of *Pathways* suggests that for those participating in the pilots, the chances of being in employment 18 months after starting the benefit claim are increased by 7 percentage points (Bewley *et al.*, 2007). This confirms earlier evidence from the first *Pathways* cohorts (Adam *et al.*, 2006). The main question now is the extent to which the *Pathways* process should be extended by further strengthening the mandatory elements. There is a good chance that forthcoming welfare reform will go one step further by introducing a requirement for most new customers to undertake some form of work-related activity (this is planned to be introduced as resources permit). Yet another question is the extent to which mandatory elements should be introduced for all or some existing recipients as well. Currently, there are no definite plans to migrate existing customers to the new scheme.

C. Improving assessments and work incentives

Making work pay is an important element of the potential success of the new approach. The Disabled Person's Tax Credit, a wage top-up for people with disability in low-paid employment, was introduced in 1999 and merged into the Working Tax Credit in 2002. However, take-up of the disability element of the Working Tax Credit is very low. Without claiming the credit, only an estimated one-third of all incapacity benefit claimants would gain financially from moving into work at 16 hours per week, at the minimum wage (Blackman, 2006). But even one in five of those claiming the credit would not be better off upon starting to work, showing that there is further room for improving work incentives.

Alongside *Pathways to Work*, a new and better-promoted though temporary earnings supplement was introduced for incapacity benefit recipients who move into paid work. This Return-to-Work Credit (RTWC) is available for a maximum of 52 weeks for those who have been receiving benefits for at least 13 weeks and have found a job of no less than 16 hours a week earning no more than GBP 15 000 a year. RTWC has been introduced stepwise since 2003 and currently covers one-third of the country. Early evidence suggests that the take-up of this credit is not large but that workers at least do not seem to return to benefit in large numbers after exhaustion of the entitlement, i.e. after one year (Corden and Nice, 2006).

Ongoing reform is likely to change the incentives structure for incapacity benefit recipients more drastically. A comprehensive welfare reform proposal presented in early 2006 has now been passed into law through the Welfare Reform Act 2007 (see also DWP, 2006). It includes a broad range of measures in several areas. In terms of sickness and disability policy, the key proposal is the introduction of a new Employment and Support Allowance, which will replace both incapacity benefit and means-tested Income Support on grounds of disability from 2008 on. The new allowance will consist of three elements: i) a basic rate, equal to Jobseekers Allowance; ii) a top-up for those fulfilling their activity requirements; and iii) a top-up for severely hampered persons who are exempt from activity requirements (these are estimated to account for 10-20% of all customers). The level of these top-ups, which are mutually exclusive, is yet to be determined. Moving from unemployment to disability benefit will be less attractive and engaging in work and work-related activity will pay more than it does today.

A complementary key element of the forthcoming welfare reform is a change in the assessment procedure. The United Kingdom's well-structured Personal Capability Assessment (which was introduced in its current form in 1999) is seen as good practice by many OECD countries. However, it is no longer adequate for the range of issues it ought to address. It is a standardised objective assessment of functional limitations resulting from physical and/or mental health conditions and disability, but it does not measure inability to work. The main features of the new assessment will be a substantially revised assessment of mental health, together with some changes to the assessment of physical conditions, and a new work-focused assessment which will focus on individual's capabilities and the interventions which may help them to return to work.

2.5. The likely impact of recent and ongoing reform

Sickness and disability policy reforms during the past twenty years are essential explanatory factors for the current outcomes in each country. OECD (2003) developed two indices of policy – one on *integration policy* and the other on *compensation policy* – in order to illustrate and compare countries' policy stances and to assess broad trends in policy development (Box 2.2).

According to this policy typology, compared with the OECD average in 2000, Luxembourg had a relatively less developed integration policy, with Australia, Spain and the United Kingdom all being close to the OECD average on this parameter (Figure 2.1, Panel B). Australia, Luxembourg and Spain had a relatively more generous and/or accessible disability benefit system than the average, while the opposite held for the United Kingdom.

For three of the four countries, Australia, Luxembourg and the United Kingdom, Figure 2.1 (Panel A) shows a spectacular policy trend, both before and after the year 2000, as regards the direction and the level of change. Luxembourg and Australia have gone through a rather different sequence of policy transformation. In Australia, employment policy change preceded benefit reform. Integration policy was broadened considerably in the 1985-2000 period, with an estimated 17-point increase on the 50-point integration policy dimension. Compensation policies remained largely unchanged in this fifteen-year period but changed significantly in the past seven years. Luxembourg went through the reverse sequence, with employment policies only being adjusted and expanded after significant changes on the benefit system side. The latter consisted of changes in the implementation of regulations as well as in regulations themselves.

Box 2.2. Illustration of countries' policy stances and trends

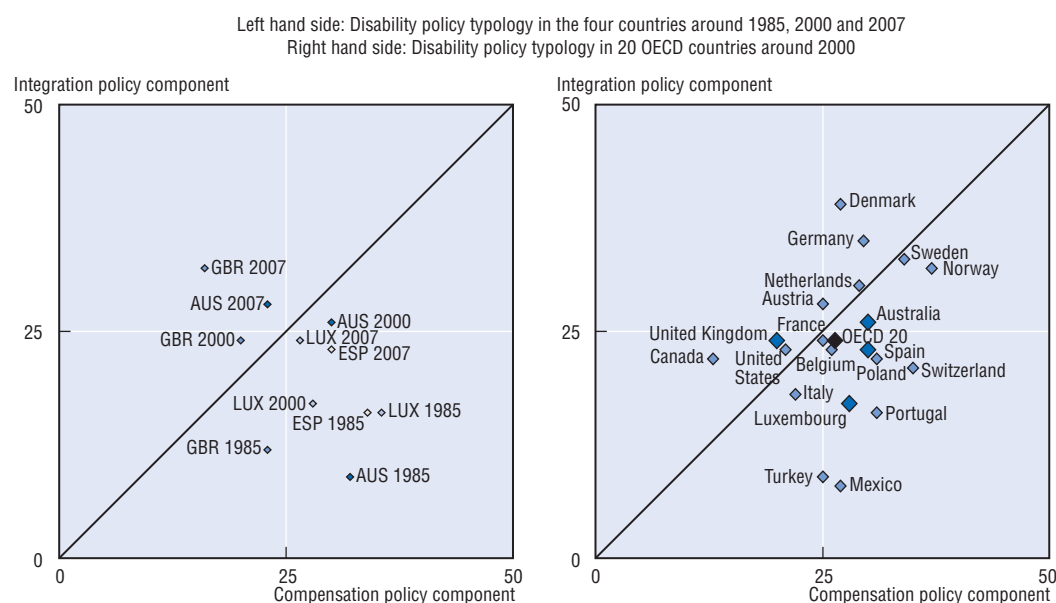
So many different dimensions of policy matter when assessing the overall stance of a system that it is easy to get swamped in details. This is particularly the case when looking at trends over time. In order to get a reasonable overview of what is happening in policy both over time and across countries, an index of the various policy parameters can be useful.

Indices in two dimensions have been developed in OECD (2003). The first is the level of compensation. The index of compensation takes into account ten policy parameters: i) coverage of the benefit system; ii) the minimum disability level; iii) the disability level needed to get a full disability benefit; iv) the maximum benefit level at average earnings; v) the permanence of benefits; vi) the medical assessment; vii) the vocational assessment; viii) the sickness benefit level; ix) the sickness benefit duration; and x) the unemployment benefit level and duration in comparison with disability benefits. Each country is ranked on a scale of zero to five on each of these categories. No attempt is made to assess which of these categories is most important; all have equal weight. A country which has a high total score in the compensation dimension is "generous" in supporting people with disability who are not working.

The second dimension is that of integration. Again, ten sub-dimensions are taken into account: i) access to different programmes; ii) the consistency of the assessment structure; iii) employer responsibility; iv) supported employment programmes; v) subsidised employment programmes; vi) the sheltered employment sector; vii) vocational rehabilitation programmes; viii) the timing of rehabilitation; ix) benefit suspension regulations; and x) work incentives. As with the compensation dimension, each of these sub-dimensions is rated from zero to five and assigned equal weight. A country which has a higher integration score is one which has a more active policy in ensuring that people with disability can find work. (Details of the points attached to each aspect of policy and the policy stance of 20 OECD countries in 1985 and 2000 can be found in OECD, 2003).

In the United Kingdom and Spain, employment and benefit policy reform went largely hand-in-hand. This is unusual in the OECD context, with reforms in many countries being characterised by a clear strengthening of integration policy elements and a relative lack of reform on the compensation policy dimension (OECD, 2003). All four countries seem to have gone through much more change in benefit programmes in the form of stricter and better-controlled access than the typical OECD country. This should help taking advantage of new employment policies and procedures and to avoid that, in response to restricted access to other benefits (such as unemployment, social assistance or early retirement), disability benefits are used as a last-resort income support. This bolsters the positive work focus which governments have been trying to follow and which is in the interests of the majority of those on the benefit.

Despite recent reforms, however, Luxembourg and Spain still belong to those OECD countries where the compensation policy score exceeds the integration policy score – noting that this typology says little about both the implementation of regulations and the effectiveness of policies. Such a situation was characteristic for almost all OECD countries in 1985, but ever fewer of them today. This suggests that there is room for further policy change in those two countries in particular. The United Kingdom has recently become an

Figure 2.1. **Comparing sickness and disability policies across time and countries**

Source: Secretariat update based on OECD (2003), *Transforming Disability into Ability*, Paris.

opposite example, with a *much* higher integration than compensation score, i.e. a strong employment orientation coupled with a stringent benefit system. Such setup bears considerable potential for much better employment outcomes in the future.

Notes

1. In Australia, Disability Business Services provide “supported employment” (referred to as sheltered employment in most other OECD countries) to people with disability in an environment that matches the open labour market as much as possible.
2. However, employment services are constrained or indirectly capped in Australia by the level of the fee per client: providers, who are subject to Star Rating, have incentives to not provide assistance that will have no impact on the client’s employment prospects.
3. The Australian government is currently evaluating the effects of the *Welfare to Work* reforms on people with disability, including the question if more of them are assisted into employment, thus reducing their reliance on income support and, thereby, raising their incomes and improving well-being and self confidence. Early analysis indicates that there has been a significant increase in the proportion of people with partial capacity to work leaving income support since requirements to look for part-time work were introduced through the *Welfare to Work* reforms in July 2006.
4. At the initial *Pathways* interview in the United Kingdom, a screening tool is applied to screen out those who are more likely to leave benefit without additional help. These people do not have to attend further interviews. Similarly, people with more severe health problems are not required to undergo the full assessment and process (Chapter 3). However, all claimants are entitled to participate in the programmes on offer or to have further interviews on a voluntary basis.

Chapter 3

Absence Monitoring and Assessment of Disability

Disability benefit recipiency in most cases is a permanent status from which there is little movement back into employment. This is why policies aim, and should aim, to reduce the inflow into such benefits. For this to be effective, it is important to intervene in the early phase of a health condition to avoid that it develops into a more serious problem, eventually leading to a disability benefit claim. This in turn requires comprehensive evidence on the pathways into disability, but such evidence is scarce and partial. It is vital to better identify and assist people with health problems, be it at work, during a sickness absence spell or during unemployment.

Spain and Luxembourg are two good-practice examples with regard to sickness absence monitoring. Such early monitoring is lacking in Australia and the United Kingdom, but these two countries are in the process of developing their disability assessment into a strong work capacity assessment tool. In addition, Australia is now better able to discover health-related work barriers of the unemployed, a key issue when so many people are switching from unemployment onto disability. This is also important because the recent tightening of eligibility criteria for people with partially-reduced work capacity, who are now pushed onto unemployment benefits, can only help achieving better outcomes if good services and support systems are in place. The example of Luxembourg shows that such an approach can indeed reduce disability benefit dependency and improve work retention, but also that structural unemployment is likely to increase as well.

Disability beneficiary rates are high in Luxembourg, Australia and the United Kingdom, much higher than these countries' rates of unemployment, and they have continued to increase until recently in the latter two countries (Chapter 1). This is because, first, people tend to remain on these benefits once they get them, and secondly, the inflow into disability benefits continues to be high. This chapter addresses policies in place or needed to curb the inflow into disability benefits so as to obtain a sustainable reduction in the number of people receiving such benefits.

The structure of the chapter is as follows. Section 3.1 gives an overview on how sickness absence and the inflow into disability benefits has developed during the past decade, and identifies the most frequent pathways into these benefits. Based on this evidence, Section 3.2 emphasises ways of, and the need for, early identification of health problems and, where needed, early intervention. It distinguishes policies targeting sick workers and those aimed at unemployed people with health problems. Section 3.3 looks at ways of assessing the right to disability benefits and emphasises the importance of a sound medical and vocational process to deal with emerging health conditions such as mental illness. The section ends by discussing how countries are dealing with people with partially-reduced work capacity.

3.1. Inflow into disability: what do we know?

A. Evidence on inflows into disability

The take-up of disability benefits over the past five to ten years varies substantially across the four countries (Figure 3.1, Panel A). Inflow rates to contributory disability benefits have been low and constant in Spain, while they have been falling slightly in the other three countries (more substantially in Luxembourg over 1996-99), but from higher levels. Despite this fall in inflow rates in Australia, Luxembourg and the United Kingdom, however, levels continue to be much higher than in Spain.¹ On the other hand, Spanish unemployment rates are substantially higher compared to the other countries and may therefore include people eligible for disability benefits in other countries.

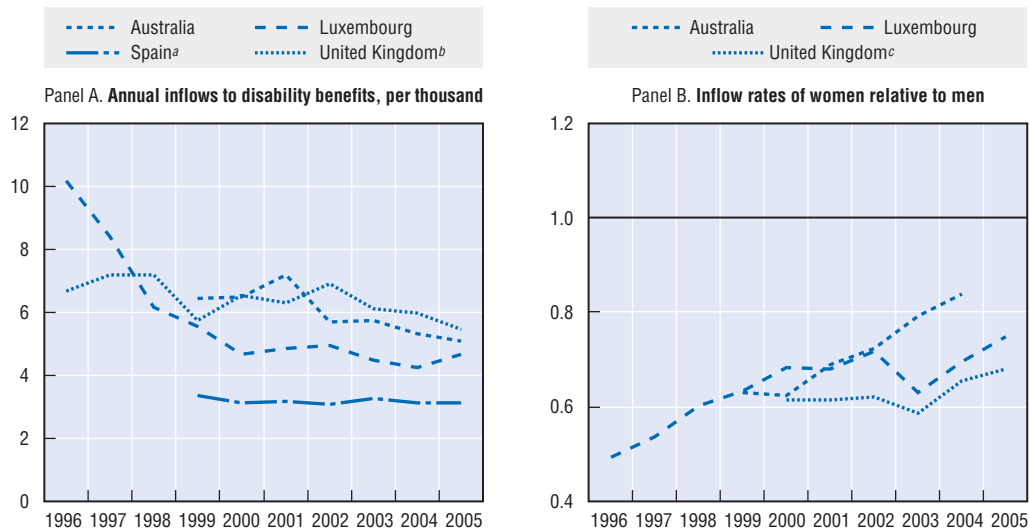
Inflow rates of women are consistently lower than those of men (Figure 3.1, Panel B). This gender gap has narrowed over time in the three countries for which gender-specific information is available, but is still wide, especially in the United Kingdom.

The impact of disability benefit reforms

Reforms in some of the countries may have helped to reduce the inflow rates. The *Australians Working Together* package, introduced in 2002, provided a better assessment of benefit claims. The announcement of stricter eligibility criteria in 2001 most certainly resulted in a larger number of claims (and grants) the same year.² Since 2002, the number of newly-granted benefits has fallen. Inflows are expected to continue to fall as an effect of the 2006 *Welfare to Work* reform.

Figure 3.1. Inflows into disability benefits are falling and the gender gap is closing

Inflows into disability benefit per thousand of the working-age population, 1996-2005



a) Data refer to contributory pensions only but include some people over age 65. This is because a right to claim disability pensions persists for those older people who do not fulfil the retirement pension eligibility criteria (this group accounts for about 1% of the total inflow).

b) Data refer to the (contributory) Long-term Incapacity Benefit only.

c) Data refer to Incapacity Benefit, Severe Disablement Allowance and Income Support.

Source: DEWR for Australia, IGSS for Luxembourg, INSS for Spain, and DWP Work and Pensions Longitudinal Study for the United Kingdom.

Changes in Luxembourg started in 1996 when a series of court rulings eventually lead to a stricter implementation of legislation. However, it was not until 2002 that the disability benefit system itself was changed. Developments after 1996 meant that people able to work, even if not in their previous job, were no longer granted a disability benefit. This change cut inflow numbers in half over the following three years and these have ever since remained stable at around five per thousand.

Spain and the United Kingdom have not yet made any major changes to their benefit schemes. However, the assessment process in the United Kingdom has undergone several changes since its introduction in 1990. The country is also in the process of introducing a differentiation between people who are severely disabled and those with severe limitations but only partially-reduced work ability (see Chapter 2 for a detailed description of the reform process in the four countries).

Benefit recipiency numbers have so far only fallen in Luxembourg (Chapter 1, Figure 1.8). The much smaller inflow drop in Australia and the United Kingdom has been more than compensated by the increasing time people spend on disability benefits. Currently, people are, on average, in receipt of disability benefits between six and eight years, depending on the country (Table 3.1). Around one-third of all disability beneficiaries have been recipients for more than ten years.

The recent trend of a growing share of young people moving into disability benefits has over the past five years extended the average duration of benefit dependency by one to two years. If this trend continues, average duration will increase further in the future because people tend to stay on disability benefits until the age at which they transfer to an old-age pension (Chapter 5).³

Table 3.1. The time people spend on disability benefits is increasing
Average duration of disability benefit receipt in years, 2000 and 2005

	Australia		Luxembourg	United Kingdom	
	Men	Women	Total	Men	Women
2000	6.9	7.1	6.6	4.1	4.0
2005	8.3	7.9	7.6	6.0	6.0
<i>Share of disability benefit recipients with benefit duration of ten years or more (in %)</i>					
2005	32.4	30.9	41.2	28.9	28.1

Source: DEWR for Australia; IGSS for Luxembourg; and DWP Work and Pensions Longitudinal Study for the United Kingdom.

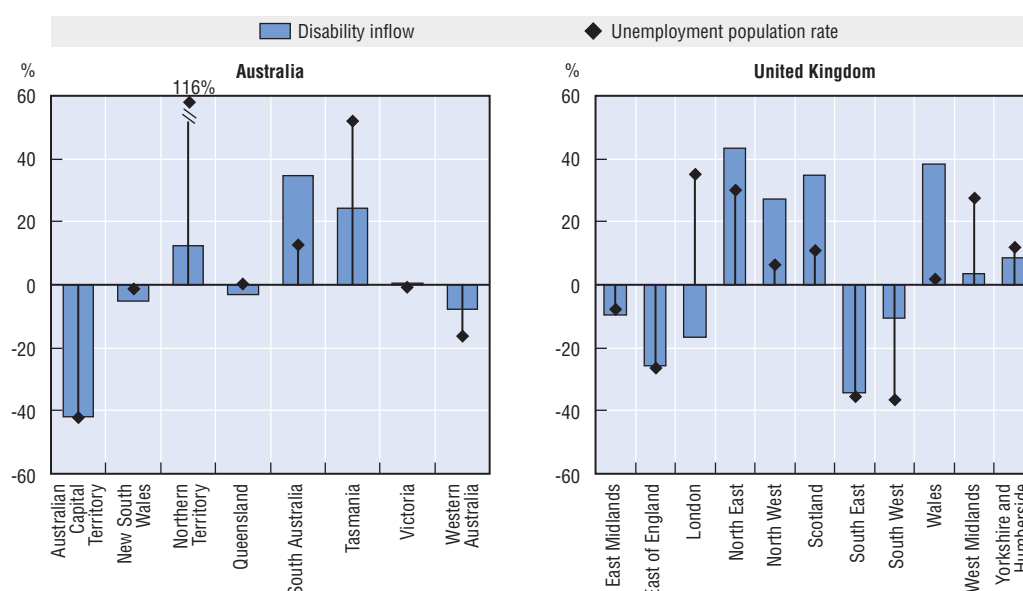
Regional variation in disability

Significant regional variation in inflow rates into disability benefits is found in many OECD countries, including Australia and the United Kingdom. At least to some extent, this results from the discretion of the officer in the local or regional office of the responsible authority. However, regional labour market conditions also play an important role for the inflow into disability benefits, as can be seen from comparing variations in unemployment-population rates with those in disability inflow rates (Figure 3.2): regions with high unemployment tend to have more disability beneficiaries.

Weak economic performance of a region appears to raise inflows into disability benefits. Health differentials, however, may not be the main driving factor behind this empirical correlation. The situation in the United Kingdom, beginning in the mid-1980s, is a good example of this. During this period, when coal mines started to close down, people

Figure 3.2. Disability inflow rates and unemployment-population ratios are highly correlated

Differences in percentage from the overall rate in the country, 2005^a



a) The correlation coefficients of the regional deviations from the overall mean between disability inflow rates and unemployment-population ratios are close to 0.8 in both Australia and the United Kingdom (in the latter case only if the very special region "London" is excluded).

Source: DEWR for Australia and DWP for the United Kingdom.

did not move to unemployment benefits but rather to sickness or disability benefits. One explanation was that people may have had health problems prior to the close down of the mine, but it was not until their job disappeared that the condition became a relevant health issue.

B. Evidence on sickness absence

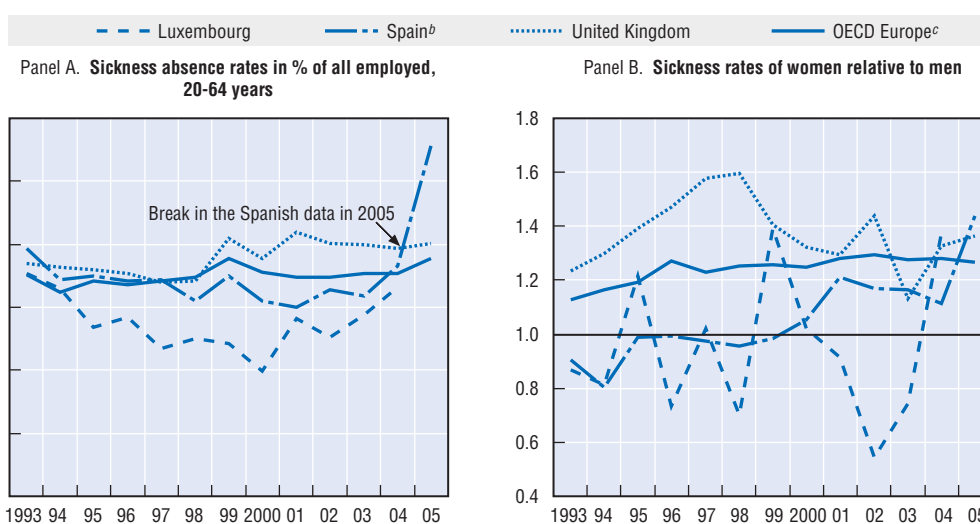
Trends in sickness absence over the past decade

Levels of sickness absence, measured as the share of employees absent for a whole week, are also quite different across the four countries. In the United Kingdom, at close to 2%, for most of the period absence rates appear to be higher than in the other countries (Figure 3.3, Panel A). Absence rates in Australia are below 1%, but refer to total absence during two full weeks (rather than one week as in the other countries). Australian sickness figures may, in fact, be quite similar to those in, for example, the United Kingdom (see below). The steep increase in Spanish absence rates in 2005 is the result of a new question to respondents, which is understood to better reflect the “true” situation. This would suggest that Spain has by far the highest sickness absence rate among the four countries.

Contrary to inflow rates into disability benefits, absence rates are higher for women than men (Figure 3.3, Panel B). Women in the United Kingdom have always had a 20-60% higher sickness rate than men. Fluctuations during the period are mainly caused by variation in sickness behaviour of men. In Spain, women’s sickness rates were below those of men ten years ago, but are now substantially higher. The gender ratio in Luxembourg has fluctuated over the period, reflecting large variation in male and female absence rates. Gender patterns in absence rates largely mirror what is found in the rest of Europe: roughly 30% higher rates for women.⁴

Figure 3.3. **Evolution of sickness absence in the European countries**

Share of employees absent from work, 1993-2005^a



- Employed persons reporting not having worked at all during the week prior to the survey, due to illness, injury or temporary disability.
- Because of a change in the question in the Active Population Survey in 2005, there is a break in the series between 2004 and 2005. Figures for 2005 are a better reflection of the actual situation.
- Unweighted average of EU19, Iceland, Norway and Switzerland.

Source: EULFS, 2006.

An in-depth survey conducted in 2003 in Australia found that the average permanent employee used six days of sick leave, which corresponded, at that time, to 80% of their annual sickness leave entitlement (Hallis, 2003). Further, employees on average classified less than 60% of their absence days as “genuine” sickness, with the majority of the remaining days being taken for family-related reasons.

Lost working days due to sickness in the United Kingdom added up to 6.6 days per worker in 2005, a figure very similar to the one found in Australia (CBI, 2006). There is a large variation across economic sectors, ranging from 2.6 work days lost per employee to 11.4 days. Manual employees’ record higher absence rates than professionals, and absence in the public sector (8.5 days) is higher than the overall average in the private sector (6.5 days). The employers in the United Kingdom further believe that less than 15% of all absence is “non-genuine”, a much lower figure than the 40% reported by employees themselves in the Australian survey.

Long-term sickness absence

Around 15% of all sickness cases in Spain are absences of more than 60 days. This figure is close to the overall share of long-term sickness absence in Luxembourg, of 17%, in this case defined as longer than 30 days. Blue-collar workers in Luxembourg are more absent than white-collar workers, and this difference becomes much more pronounced for long-term absence (Table 3.2). Overall, almost one-quarter of all sickness absences for blue-collar workers turns into long-term absence compared to only one-tenth for white-collar workers – and this difference is found for all age groups and for men and women alike.

Table 3.2. Long-term absence in Luxembourg is much higher for blue-collar workers

Long-term absence in percentage of all employed persons on sickness absences, 2005

	Blue-collar workers	White-collar workers	All workers
<i>Share of employed absent due to sickness at any time during the year</i>			
Total	52.3	46.3	49.3
<i>Long-term absence (> 30 days) as a share of all sickness absence</i>			
Total	23.9	10.3	17.4
<i>Age</i>			
20-34	18.6	8.0	13.3
35-49	24.5	10.3	17.9
50-64	36.9	19.5	29.8
<i>Gender</i>			
Men	22.7	8.4	17.6
Women	26.7	11.7	17.1

Source: Data submitted by the General Inspectorate of Social Security (IGSS).

In the United Kingdom, only 5% of all sickness cases are long-term, with the latter defined as 20 days or more. However, these cases account for 36% of all working days lost, and even for more than 50% in the public sector where absence duration is much longer (CBI, 2006). In Australia, data on long-term sickness absence are not available. What is known is that public sickness benefit (Sickness Allowance) is, on average, received for almost 200 days. Given the very small number of recipients of such benefits which is explained by the particular eligibility criteria,⁵ however, this does not adequately reflect the problem of long-term sickness absence in this country.

C. Pathways into disability benefits

To devise adequate policy responses to lower the inflow into disability benefits, it is important to know more about how people enter these benefits. Unfortunately, pathways into disability benefits are weakly documented. Spain has no information about the origin of a disability-benefit claimant, while partial information on pathways exists in Australia, Luxembourg and the United Kingdom.⁶ However, countries make little use of this information, either as a monitoring tool or as a tool to intervene early and thereby prevent unnecessary inflow into disability benefits.

Sickness benefits do not appear to be the main route into disability benefits in any of the three countries, but the data do not allow for a firm conclusion on this (Table 3.3). In Luxembourg, up to 2005, workers receiving wage payments while being sick could not be separated from people working. Similarly, also in Australia, the category “employed or no income support” includes people who receive continued wage payments from their employer due to sickness. The low share of people (of less than 2%) transferring from a public sickness benefit onto disability, therefore, is not a true reflection of the role of sickness as a passage into disability.⁷ Only data for the United Kingdom allow for an evaluation of the role of sickness as an intermediary stage: in this country, one in six of all transfers into disability go through a long-term sickness phase (usually in the form of continued wage payment by the employer for six months).

Table 3.3. Pathways into disability benefits are poorly documented
Origin of new disability benefit claimants as a percentage of all inflows, most recent available year

Australia ^a		Luxembourg ^b		United Kingdom ^c	
Employed or no income support	45.3	Employed or sickness benefits	67.4	Employed	40.0
Sickness allowance	1.8	Unemployed/Redeployed	23.4	Statutory sick pay	17.0
Unemployed	37.0	Social assistance	1.9	Unemployed	26.0
Parenting payment	6.3	Other inactives	7.3	Income support	12.0
Other payments	9.6			Other inactives	5.0
Total	100.0	Total	100.0	Total	100.0

a) Based on people entering onto Disability support pension between June 2004 and June 2005.

b) Based on people entering into either temporary disability benefit, permanent disability benefit or the tide-over allowance in 2005.

c) Data refer to 2001/2002. Previous benefit status is defined as SSP receipt immediately before commencing an IB claim but refers to a 90-day period before starting an IB claim in case of Jobseeker Allowance and Income Support.

Source: Data provided by DEWR for Australia; IGSS for Luxembourg; and a 1% sample of annual benefit administration data for the United Kingdom.

Unemployment is another and maybe even more important passage into disability in all three countries and in Australia in particular. Unemployment accounts for around one-quarter of all transfers to disability benefits in Luxembourg and the United Kingdom and 37% in Australia (Table 3.3). This suggests that unemployment benefit schemes include a significant share of people with health conditions or partial disability, people who in other countries might be receiving sickness benefits. This may also be the case in Spain where the unemployment rate is markedly higher than the disability beneficiary rate (an opposite situation to most other OECD countries).

The sizable share of people in Australia and the United Kingdom moving from unemployment benefits into disability could be related to the fact that sick employees can be fired relatively easily (Chapter 5), but there are no studies available on this subject. In

Australia, for instance, after the mandatory ten days of continued wage payment in case of sickness, people can be laid off and, without a valid employment contract, they will not be entitled to public sickness benefit.⁸ Instead, they will be directed to the unemployment benefit scheme.

In conclusion, evidence suggests that Australia, Luxembourg and the United Kingdom all suffer from high disability benefit reciprocity rates, that people enter these benefits through employment, sickness or unemployment, and that the latter group, i.e. people who have lost their job already, is very significant in all three countries. Spain seems to be in a different situation. Disability beneficiary rates are much lower, and both unemployment and sickness absence rates much higher, suggesting a different composition of pathways (but no data is available for Spain).

3.2. Preventing disability early on

A. Early identification and early intervention

The timing of identification of health problems and subsequent intervention is crucial to achieve better outcomes in terms of lower benefit dependence and higher economic activity of people with disability. People at risk of becoming long-term sick should be a priority target group because they often lose their jobs and face considerable obstacles in regaining a job, and often end up on disability benefits. In the United Kingdom, for instance, nine to twelve months after people move onto sickness or disability benefits almost half have lost their job (Burchardt, 2003).

This finding is supported by data from the 2002 LFS module on disability. For people who acquire a new disability, employment rates drop by some 10 percentage points within a year and another 10 percentage points in the subsequent two years (Table 3.4). In Spain, the impact of a new disability on the employment rate is even more pronounced. Only Luxembourg seems to deviate from this pattern: in this country, employment rates only start to fall more than three years after the onset of a disability. In all four countries, employment rates do not fall further in the very long run; after more than ten years they are at the same level as after 3-10 years of disability.

In certain cases, it will be possible to judge whether a sickness case will turn into a long-term problem. The critical issue here is to identify the right group of people early enough with sufficient accuracy without incurring huge deadweight costs for people who would have returned to work without any intervention. Employers, who are usually the first confronted with a health problem, may choose to ignore the issue until it becomes the

Table 3.4. Employment rates drop rapidly after the onset of a disability

Employment rates by disability status and duration of disability, percentages, 2002

	Luxembourg	Spain	United Kingdom	EU19
Non-disabled people	71.5	66.2	82.0	75.1
Disabled people	49.7	28.6	54.8	46.4
Disabled for less than 1 year	70.3	49.3	71.7	64.7
Disabled for 1-3 years	69.2	34.5	64.0	55.2
Disabled for 3-10 years	46.4	24.2	53.4	44.6
Disabled for more than 10 years	45.6	24.8	54.7	42.7

Source: 2002 EULFS *ad hoc* module on disabled people.

responsibility of the public authorities, and doctors may prefer to encourage their patients to stay away from work. The impact of such behaviour on the side of doctors and employers is that the state may have to carry the costs for expensive rehabilitation programmes and other employment activation measures that, at the end of the day, may not be able to avoid a disability benefit claim because action has been initiated too late.

Co-ordination between a number of actors – including occupational health specialists, the employment service, the employee's general practitioner, the employer and employees themselves – is critical for better solutions to these problems. Steps recently taken in Norway towards early identification and better co-operation between the main actors provide an example of the difficulty of tackling this problem. The main objective of the measures taken by the Norwegian government is to find solutions at each workplace (Box 3.1). So far, however, outcomes from these measures are not very encouraging; for instance, absence rates which are extraordinarily high have not fallen (OECD, 2006b). An important lesson from the Norwegian example is that soft improvements of this type can only work when they are stringently enforced.

Box 3.1. Early identification and co-operation between main actors in Norway

The new early identification measures rely on the co-operation of the National Insurance Office, the employee, the employer and the general practitioner. Each of these actors has a number of new rights and responsibilities to fulfil:

The duties of the general practitioner: If an employee is sick for more than eight weeks, an extended medical certificate must be completed by the general practitioner (GP). The GP should guide employees in a manner that strengthens their work motivation and assess whether there are significant medical grounds for a person to be absent from work. GPs who fail to follow the regulations may lose their entitlement to issue medical certificates that form the basis for social security benefits.

The duties of the employee: During the first eight weeks of sickness absence, the employee and the employer must draw up a plan that describes the return to work. The employee must contribute information about his/her own functional capacity, so that necessary measures can be implemented quickly. The employee must also agree to a dialogue with the employer on the possible reorganisation of the workplace. If an employee refuses collaboration, sickness benefit payments could be reduced or even stopped.

The duties of the employer: Testing of an employee's functional ability must be carried out at the workplace. After 12 weeks of sick leave, if the employee is not in a work-related activity, the National insurance office requests a follow-up plan from the employer. This plan should include important documentation to help further monitoring of those on sick leave in preparation for returning to work. The employer is obliged to submit the follow-up plan to the National insurance office on request.

The duties of the National insurance office: In case of non-compliance, the office can impose enforcement penalties and sanctions on employers, employees and GPs. Moreover, every company can sign a contract with its local social security office and get advice from a regular contact person at the newly-established local Workplace Centres to assist them in taking necessary actions and to follow up employees on sick leave.

B. The role of employers

Early identification and early intervention mean different things for different groups of people. For workers with health problems who still hold a job, irrespective of whether they are on sick leave or not, preventive measures at work will help to retain employment and avoid transfers onto disability benefits. Employers play an instrumental role in this context. The range of involvement of employers in the sickness and rehabilitation phase, their responsibilities towards their workers, and the support given to them to fulfil these differ widely across countries. Supports and responsibilities of employers are discussed in more detail in Chapter 5. Their financial incentives towards sick employees are discussed in the following.

The longer employers have the financial responsibility for sick workers, the larger their interest should be in keeping workplaces and working conditions healthy and safe. Helping a sick employee return to work quickly keeps the costs of absenteeism low. Improving the health of the workforce should also have a positive impact on the company's productivity. On the other hand, when the employer has the full responsibility for the sick worker over a longer period, public authorities are often left uninformed about problematic sickness cases. If employers fail to take their role as early actor seriously, for instance because they do not believe in the cost-effectiveness of prevention or early intervention measures, there is a risk that such a system will instead generate an increasing share of inactive people and a higher inflow to disability benefits.

The United Kingdom is an interesting case in this regard, because the sickness benefit system was privatised in several steps over the 1980s and 1990s. In 1983, employers became responsible for sick pay for the first eight weeks of sickness absence per year, a period which was extended to 28 weeks in 1986. However, until then this remained a virtual liability because employer costs were fully reimbursable. Reimbursement was reduced to 80% in 1991 and eventually abolished in 1994 (with exceptions for very large sickness costs). Unfortunately, employers do not have to keep sick leave records, which is one reason for the lack of evaluation of these reforms. Data collected by the employer federation suggest that shifting the responsibility to employers in the 1980s had no impact but that absence rates dropped in 1991, by over 10%, when employers had to cover parts of the costs (CBI, 2006). Most of this was due to a decline in short-term absences. On the other hand, shifting the costs fully to the employer in 1994 had no significant additional effect.

The same CBI study of sickness absence among 10 000 private sector companies and public sector organisation in the United Kingdom concluded that around 90% of all employers monitor long-term absence, defined as 20 days or longer (CBI, 2006). In 70% of all companies this was the responsibility of the line manager and only in 14% a human resource manager was involved. In cases where the responsibility lies on the latter, annual sickness absence was, on average, two days shorter. Employers use a range of practices to manage sickness absence, including discipline procedures, return-to-work interviews, giving absence statistics to supervisors, and rehabilitation (including e.g. flexible working hours and counselling). Interestingly, absence was found to be higher in companies that were taking actions (seven days per year) than in those that did not (five days). This may suggest that measures taken by employers are still insufficient. However, it may also indicate that companies with higher absence rates show more concern for these issues.⁹

Outcomes in the other three countries covered in this review partly confirm the existence of a relationship between observed absence rates and the length of continued wage payment by the employer for a sick worker. Spain has the shortest employer period of only two weeks and the highest absence rates. Luxembourg has a relatively long wage-payment period for white-collar workers (3.5 months) but no employer involvement for blue-collar workers, with absence rates being much higher for the latter group (see above). The picture in Australia is blurred by the fact that the actual wage-payment period varies from worker to worker, depending on tenure.

To reduce long-term sickness absence of blue-collar workers, the Tripartite Co-ordinating Committee in Luxembourg decided, in early 2006, that more financial responsibility should be placed on enterprises employing these workers. This will be made possible by a broader reform that will remove all differences in regulations between blue-collar and white-collar workers, the so-called *statut unique*. Unifying sickness benefit rules is expected to improve sickness absence management for blue-collar workers and ease the financial burden on the sickness fund. The government's plan is to implement the new rules as from January 2009 (Box 3.2).

Box 3.2. Harmonisation of sickness benefit regulations in Luxembourg

Currently, the Sickness Insurance is responsible for paying sickness benefits for blue-collar workers from the first day of absence, but only after a period of three and a half months for white-collar workers (with employers being responsible for the payment of benefits for this initial period). Abolishing the distinction between blue-collar and white-collar status requires harmonisation of the two regimes, preferably on the basis of the regulations for white-collar workers. This would imply that employers' labour costs for blue-collar workers will increase. At the same time, it is expected that the culture of work absenteeism (*e.g.* in the construction sector) will change with improved sickness management.

The changes in regulations are at this stage under negotiation. It does not seem politically feasible to simply apply the white-collar regulations on blue-collar workers. Ongoing discussions are exploring, for example, the possibility to change the rules in such a way that the financial impact on employers will be neutral, with no disadvantage for either blue-collar or white-collar sector employers – an equation that seems extremely difficult to solve.

A possible solution is that employers of blue-collar workers will benefit from a reduction in social security contribution rates along with the responsibility to pay sickness benefits from day one. Employers of white-collar workers will have to pay higher social security contributions, but in turn have a shorter wage-payment period. How long the wage-payment period will be, whether gross wages will have to be reduced for blue-collar workers (to keep net salaries equal), and how social security contribution rates will change is yet to be decided.

Harmonising the status of blue and white-collar workers would be a step in the right direction since the classification of occupations (or jobs) becomes more and more arbitrary. In addition to changes in sickness rules, regulations for overtime and redundancy payments along with broader changes in the labour law also have to be solved during this reform process.

C. Monitoring absences of sick workers

In all four countries the costs of disability benefits are fully externalised, while costs during the sickness phase, to different extents, are carried by the employer. It is therefore to the advantage of governments to identify potential disability cases early so as to avoid transfers into permanent public benefits. Governments have an interest in monitoring and reassessing both medical conditions and functional capacity of people on sickness benefits. Monitoring should also include requesting employers to supply information on ongoing sickness cases longer than, for example, one month.

A first step to avoid that people fall out of the labour market because of health problems is to encourage them to stay in work, possibly on more flexible terms or with new work tasks. In this respect, the role of general practitioners (GPs) is vital since they are usually the first ones to meet the sick person. But GPs are often trapped in their traditional caring role and unaware of work-related matters. Evidently, too much work pressure can result in sickness and deteriorate health. However, the absence of work may also be unhealthy. Based on both clinical and disability literature, Waddell and Burton (2006) concluded that having a job is generally good for the physical and mental well-being of healthy people, many people with disability and most people with common health problems. Joblessness can have significant adverse effects on health.

In all four countries, temporary work incapacity i.e. sickness absence is in the first instance certified by GPs. However, in Luxembourg and Spain, GPs have no formal gate-keeping role as in the United Kingdom and Australia. Luxembourg and Spain have in place thorough systems for monitoring and reassessing sickness benefit entitlements in order to avoid long-term absence and subsequent flows onto disability benefits (Box 3.3). Such absence control by the public authorities could and should also be used in countries where wage-payment periods are longer. A good-practice country example in this regard is Austria, where GPs absence certificates are frequently controlled by the Social Security Authority early on (randomly as well as systematically) despite a wage payment period by employers that is similar to that for white-collar workers in Luxembourg.

In Spain, work accidents and work-related illnesses are at the full responsibility of so-called mutual benefit societies, or mutualities.¹⁰ However, they are also responsible for general sickness absence of employees whose employers are covered by a mutuality (this concerns more than half of all workers). Check-ups, monitoring and reports to GPs are common practice, and this has also helped to reduced sickness absence growth. Prevention and medical rehabilitation are also among the responsibilities of these mutualities, which often have close relationships with employers and an interest to promote a fast return to work.¹¹ Mutualities have their own doctors who, however, can only recommend a sickness benefit suspension while the ultimate decision to extend or discontinue a valid absence certificate rests with the patient's GP.

Monitoring and reassessing alone is not sufficient to avoid that people return to sickness benefits or even claim disability benefits at a later stage. Good monitoring systems like the ones in Luxembourg and Spain should therefore go hand-in-hand with additional help and assistance to those people who are otherwise likely to stay on (or return to) long-term sick leave. One way forward is to develop individual action strategies that involve all the stakeholders, similar to the individual action and follow-up plans in Norway. Such a process also requires extensive information about people's health situation and their employment history, which is already collected in Luxembourg and Spain.¹²

Box 3.3. **Ways to re assess and monitor sickness absence in Luxembourg and Spain**

Spain: To better monitor and reduce sickness absence, the National Social Security Institute (INSS) established, in 2004, a new executive directorate. The institute has currently 400 doctors but will soon hire another 200 to better monitor and reassess ongoing sickness cases. These medical inspectors are superior hierarchically to GPs and can terminate a sickness benefit when appropriate.

For this purpose, INSS operates a very rich individual-based administrative database with complete sickness absence histories, including information on the employee, the employer, the cause for the absence, and the full medical history. Information is automatically registered through mandatory reporting of employers on every sickness case as well as all sickness certificates issued by GPs. The INSS then controls people with absences longer than the average for a specific sickness, specified by very detailed lists for all possible diseases.

INSS is paying for the sickness benefits, but the decision to grant a benefit is taken on a regional level. To maintain the control over spending on sickness benefits, the INSS head office is setting up agreements with its 52 regional offices which specify goals and objectives, such as the number of reassessments per INSS doctor and year. These objectives are then related to costs, duration of absences, and training of GPs to better assess sickness and work ability. If objectives are not reached, half of the grant to the region will be withheld. The INSS regional offices send daily reports including detailed diagnosis on new and terminated sickness cases.

Luxembourg: Since 2005, in case of sickness of at least six weeks within the last 16 weeks, the sick person receives a 4-page form (known as R4) from the Sickness Insurance. The person has to forward this form to the attending GP, who in turn has to forward the completed form to the Administration of Medical Control (AMC), the public control unit for social security institutions. If the form has not been returned within two weeks, a reminder is sent out to the sick person. After another two weeks, benefit payments would be stopped. However, 92% of all forms are returned within the given time frame.

AMC immediately evaluates all the information and makes a statement regarding the person's work ability. This statement is sent back to the Sickness Insurance to make a decision. The statement can lead to the following outcomes: i) application for a disability benefit; ii) initiation of the redeployment procedure (see Chapter 2 for more details); iii) extension of the sickness benefit until reassessment at a future date; or iv) termination of the sickness benefit.

What is said above mainly concerns blue-collar workers. White-collar workers are usually reassessed after four months (i.e. after the employer's payment period has ended) so that the whole procedure is initiated much later. With the forthcoming harmonisation of sickness benefit rules for blue and white-collar workers, it is foreseen that the AMC will be monitoring and controlling sick leaves already during the employer payment period.

There are various practical difficulties involved with sickness absence controls and the drawing of early actions plans, especially in regard to the confidentiality of a medical file. Confidential advice at this stage, to employers and employees alike, would be one promising solution. Such advice should be provided by occupational health services, which should have the expertise to identify appropriate workplace adaptation and rehabilitation needs, also for mental health problems.¹³

Occupational health advice should also be available to GPs, who often lack such expertise and have little knowledge of their patients' working conditions and the reasons for work-related health problems. This is confirmed by a survey by Meager et al. (1998) who found that 40% of currently inactive people with a disability left their employment after advice to do so from their health professional. A second opinion by an occupational therapist or a doctor, as in Luxembourg, is of critical importance for assessing correctly the work capacity during an ongoing sickness case.¹⁴ In the United Kingdom, for instance, the vast majority of employees in the private sector have no access to an occupational therapist (Sawney and Challenor, 2003).

D. Health status monitoring of the unemployed

With so many workers transferring to disability via unemployment, it is also vital to improve the health status monitoring of jobless people and especially those receiving unemployment benefits. This is the only way of detecting health problems early enough to avoid "unnecessary" shifts onto disability. Contrary to the group of people who have a job and are temporarily sick and receiving some form of sick pay, for which employers play a key role, health screening and monitoring of the unemployed is a responsibility of the public authorities.

Ongoing research in the United Kingdom on the history of disability benefit claimants suggests that most of those coming onto benefit through unemployment have lost their job for reasons not related to their health problem, which is an indication that unemployment contributes to creating disability. Long-term unemployment clearly increases the likelihood of a transfer to disability benefits. In the United Kingdom, in 2001, 22% of people coming from unemployment to disability benefits had been on unemployment benefits for two years or more. Although this group had applied for as many jobs as other jobseekers, only 5% had received job offers – compared to 15% for the other unemployed (Bacon, 2002). For Australia, people coming through unemployment were shown to have the highest likelihood of long disability benefit durations (Cai, 2004).

All countries have a large and sometimes growing number of people with health problems on their unemployment benefit rolls. In Australia, for instance, in 2005 one in ten jobseekers were formally classified as incapacitated unemployment benefit recipients. This share has fallen somewhat since 2000, but is expected to increase considerably as an effect of the *Welfare to Work* reform through which people with partially-reduced work capacity will be shifted onto the unemployment benefit scheme.

Countries are increasingly addressing the issue of early identification of jobseekers at risk of transferring onto disability. Since 2006, health problems of the long-term unemployed in Australia have a higher chance of being detected early on through a requirement for some groups of unemployed – e.g. jobseekers who ask to be exempt from job-search activities due to temporary but longer-term sickness – to undergo a Job Capacity Assessment (see below). New procedures in Luxembourg also aim to prevent transfers from unemployment onto disability. People, whose sickness benefit is terminated although they are unable to continue in their current job and whose work capacity reduction is not serious enough to generate entitlement for a disability benefit, are classified as a special group of unemployed with detected health problems in need of special support.¹⁵ Health problems developing while being unemployed, however, would often remain undetected.

Despite these efforts, in all countries health problems among the unemployed could pass undetected for too long, leading to further worsening health while chances of finding employment continue to fall. This is particularly important in Spain, where mainstreamed employment programmes contain no measures to ensure participation of unemployed people with health problems or lighter disability. Health problems of jobseekers are only formally identified in Spain if a person has successfully applied for a legal disability certificate; in this case a number of subsidies are available to encourage employers to hire these workers (Chapter 5).

Chances of detection of health problems by caseworkers are probably higher in Australia and the United Kingdom, for several reasons. First, placement agencies and service providers receive a higher payment for disadvantaged jobseekers, including people with health problems. This increases the incentive of the employment officer to identify health problems of their customers. Secondly, in both countries the unemployed have personal advisers, which is not the case in Luxembourg and Spain. In addition, caseloads are much lower in the United Kingdom and in Australia.

3.3. Disability benefit for those who need it

Early identification will help to prevent and minimise some but not all health problems. Therefore, comprehensive disability assessment is equally important for a strategy to lower long-term benefit dependence by raising economic activity. What is particularly important is to link eligibility for a disability benefit primarily to the remaining work capacity, not the person's health problem as such. In assessing the right to a disability benefit, there is no uniform approach across countries, but looking at the remaining work capacity is winning ground over the traditional way of assessing the health problem itself. This will help keeping disability benefit inflow rates low. Too strict eligibility criteria, however, can lead to exclusions of people in need of such benefit (Chapter 1).

A. Assessing disability

Countries use different approaches to assess eligibility for a disability benefit. Common to all four countries is that general practitioners are no longer acting as gatekeepers to disability benefits, or at least only partially. In Australia, GPs' judgements and independent medical examinations are used only as one of several inputs in the decision to grant a benefit. The assessment is also based on a face-to-face meeting of the personal assessor with the disability benefit claimant. As such, Job Capacity Assessments (JCAs), which were introduced in 2006, focus on identifying people's capacity to work and any barriers or impediments that prevent them from getting a job (Box 3.4). This is a more comprehensive approach than in the other countries.

However, the other countries have also gone through changes in their assessment procedures. In 1997, the Spanish National Social Security Institute (INSS) took over responsibility from GPs for the disability benefit assessment. Since then, the benefit claimant's work ability is assessed by INSS doctors who make their own medical examination.¹⁶ After this assessment, the INSS doctor sends a summary statement to a committee consisting of doctors, labour inspectors and managers of INSS. This committee proposes whether the person is able to work and, if so, how much.¹⁷ The final decision to grant a benefit is taken by INSS.

Box 3.4. Innovative Job Capacity Assessment in Australia

The Job Capacity Assessment (JCA) was introduced in 2006 as a key part of the Australian Government's *Welfare to Work* package. At the same time, the eligibility to disability benefits was changed: such benefit is now only granted if a person is assessed as unable to work at least 15 hours per week with up to two years of assistance from employment services (lowered from 30 hours prior to reform). Moreover, the disability must be permanent, fully diagnosed, treated (i.e. all reasonable treatment explored) and stabilised (i.e. significant functional improvement unlikely).

All disability benefit applicants, except those considered as "manifestly disabled", have to undergo a JCA. JCA has a dual role: to assess the individual's work capacity and barriers to find work, and to refer the person to appropriate assistance when needed. For this purpose, the assessor collects medical files, employment-history information and other relevant information about the person. The assessment includes a face-to-face meeting between the assessor and the person (typically lasting one to two hours).

After the assessment has taken place (generally, within ten working days from the referral), the assessor prepares a report about the claimant's ability to work and the possible activation support needed to find a job. This report is sent to Centrelink (a one-stop-shop agency responsible for benefit payments and the delivering of a range of Commonwealth services) and, if appropriate, also to a service provider. The decision to grant a disability (or, if appropriate, unemployment) benefit is taken by Centrelink, not the assessor.

Currently, 80% of all assessments are done by government providers such as Centrelink, CRS Australia, and Health Services Australia. However, in 2008, all providers of JCA will be selected through a competitive tender process. Assessors are and will be mostly health professionals such as psychologists, rehabilitation counsellors, occupational therapists and physiotherapists. Assessors will have to follow training courses and service guidelines to ensure that assessments are delivered consistently across the country. For this purpose, assessments will be closely monitored by the staff of the Department of Human Services.

Since 1997, the responsible authorities in Luxembourg no longer grant disability benefits for people who are able to work, albeit not in their current occupation. Hence, contrary to Spain, access to disability benefits was closed for people with only partially-reduced work capacity. The process of examining the right to a disability benefit in Luxembourg is currently initiated by either a longer period of sickness absence as described in Box 3.3, or by a personal claim. When a person applies for a disability benefit, a process very similar to that for long-term sickness absence is started. Once the claimant has gone through the long-term sickness absence assessment, a second assessment is done by the Administration of Medical Control (AMC).¹⁸ The final decision is taken by the Pension Insurance.

For 70% of all disability benefit claimants in the United Kingdom the first-entry assessment is based on the GPs medical examination, while the remainder have to undergo a Personal Capability Assessment (PCA). After six months on incapacity benefits, the PCA is applied to the majority of claimants.¹⁹ Contrary to the Australian assessment, the main purpose of the PCA is to determine benefit entitlement, not the remaining work capacity. This is slowly being changed in the context of broader welfare reform (Chapter 2), which will introduce a stronger focus on what work people can do despite their health limitation.²⁰ The decision to grant a benefit is taken at the Jobcentre Plus office, based on

information provided by the applicant's questionnaire, the information provided by the claimant's GP and the PCA. A remaining weakness is the almost automatic granting of provisional disability benefits, often after exhaustion of sick pay, upon calling the contact centre. Very often, the PCA will only take place several months later. While this helps bridging any possible periods without earnings, it sends a wrong signal to claimants.²¹

As for sickness benefits, some countries also monitor health improvements of disability beneficiaries. In Australia, such a reassessment can take place at any time and people who volunteer for working are almost certainly reassessed under the JCA. In Spain, disability beneficiaries are rarely reassessed. If they are, this happens only during the first two-year period (during which the person has a right to return to the former employer). Most reassessments are done if the person takes up a job shortly after the granting of the benefit. Benefit recipients in the United Kingdom can be reassessed under the PCA to ensure that they still meet the entitlement conditions. These reviews appear to be less random than in other countries because the doctor who carries out the PCA also has to give an indication if and when a next reassessment should be conducted. Overall, however, health monitoring once on disability benefits for a while is fairly sporadic in all four countries and much less common than, for example, the monitoring of sickness absence in Luxembourg and Spain.

Some countries use additional types of disability assessments for various purposes. One is for assessing eligibility for *non-contributory* disability benefits for people with insufficient contribution records. Such benefit exists in Spain and the United Kingdom. In Spain, the level of this benefit is much lower than that of the insurance-based benefit, while there is little difference in benefit levels in the United Kingdom (Chapter 4). In the United Kingdom, people claiming a non-contributory benefit (Income Support with a disability premium) are assessed in exactly the same way as those claiming a contributory benefit. In Spain, non-contributory disability benefits are managed by authorities of the autonomous communities (IMSERSO assessment teams), not the National Social Security Institute.²² Eligibility for these benefits requires a minimum assessed disability of 65%, without any reference to the remaining work capacity.

Yet another disability assessment is used to determine a *legal disability status* in Spain and Luxembourg, mainly for purposes related to these countries' employment-quota systems (Chapter 5). To qualify for a legal disability certificate, both countries require a disability that hampers daily activities by an amount of around one-third (and thus, in the case of Spain, substantially lower than the limit for non-contributory disability benefit). In Luxembourg, individuals have to apply for a legal certificate to qualify for the status of disabled worker. Moreover, the claimant needs to be employed or a registered jobseeker. The status is granted to those with an assessed disability level of at least 30%. The assessment is done by the Medical Commission and is in most cases based on the opinion of the GP. In Spain, a person unable, to a certain degree, to participate in daily life activities can be granted a legal disability status (irrespective of labour force status). The assessment is done by IMSERSO assessment teams (as for the non-contributory benefit), based on standardised WHO classification scales of impairments. To be classified as legally disabled, the impairment must be at least 25%.

A setup similar to legal disability is used in the United Kingdom for granting a Disability Living Allowance (DLA). People are eligible if they have care or mobility needs during at least three months prior to the application and a disability that will last, and not

improve significantly, for at least the following six months. The eligibility does, however, not depend on an inability to work. Claims are based on a self-assessment form and decision makers at the benefit-processing centres are not required to diagnose medical conditions of claimants (often based on a GP's certificate).²³ Around half of all Incapacity Benefit (IB) recipients but only one-fifth of all new IB entrants receive DLA. In turn, 80% of DLA recipients are IB recipients.

B. Health conditions and disability benefits

Disability assessment has come under pressure in the recent past, not the least because of the very rapid increase in mental illness. Mental health problems account for almost 40% of all disability benefit recipients in the United Kingdom, including behavioural disorders, and close to one-third in Australia (Figure 3.4). In all four countries, shares of mental illness are systematically higher for younger and prime-age people, but particularly so in the age group 20-34 in the United Kingdom where almost six in ten have a disability benefit due to mental health problems.

In Spain, mental health problems as a reason for disability benefits are far less widespread than in the other three countries but also in comparison to most other OECD countries. Explanations probably include a higher stigma towards mental health problems, lower acceptance for these conditions among assessors, fewer doctors and specialists within these disciplines and, hence, lower recognition in general but also, maybe, that this OECD-wide trend has not yet reached Spain.

In most OECD countries, mental health problems (such as depression, stress and anxiety) have grown rapidly over the past one to two decades and are currently the fastest growing health problem – in particular among younger and prime-age people (OECD, 2003; and OECD, 2006b). Data for the United Kingdom show that the share of all people on disability benefits with mental health problems is around 15 percentage points higher today compared to 1995. In Australia, mental illness has increased even more dramatically from 2% in 1990 to almost 30% in 2005.²⁴

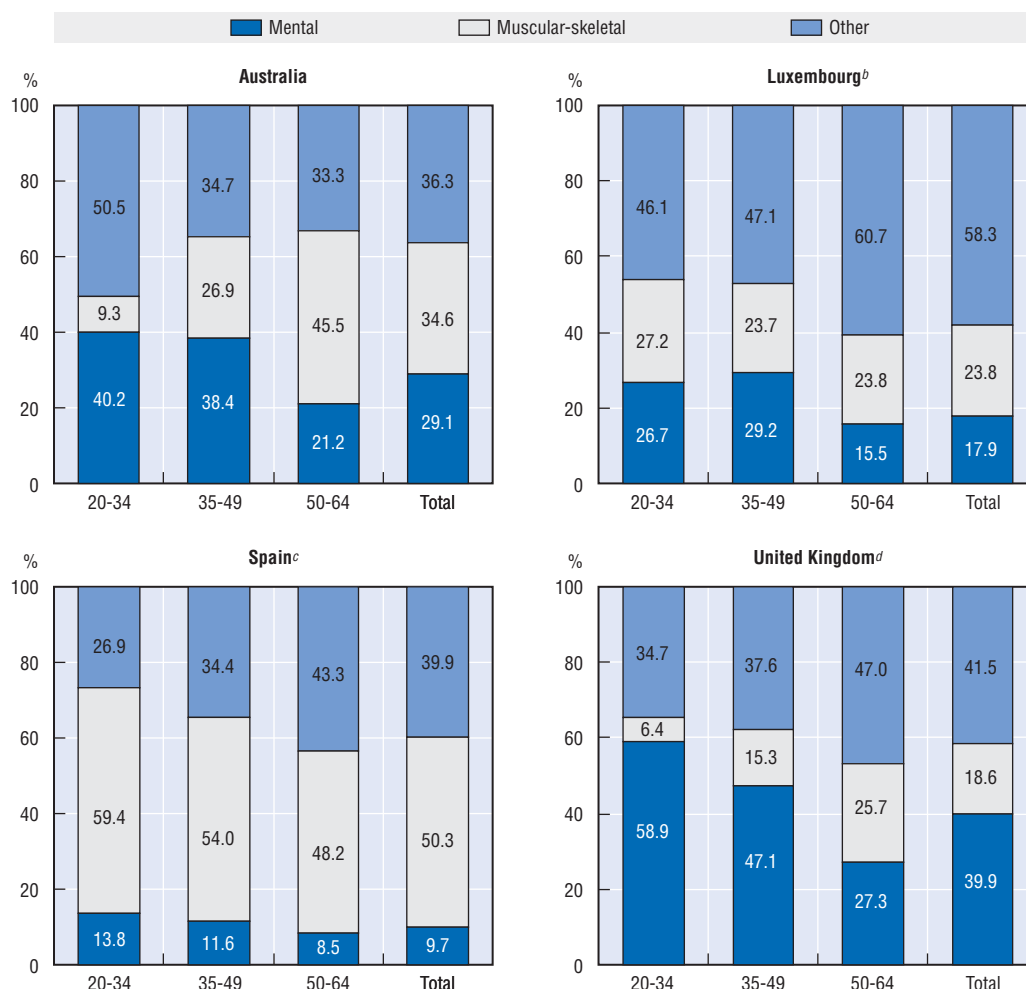
The increasing prevalence of mental health problems necessitates changes in assessment methods. The reform proposal in the United Kingdom to further improve the health assessment component of the PCA certainly is a step in the right direction. More generally, assessments usually focus on current health situations rather than needs emerging over future months and years. Yet, mental conditions may not always last a lifetime and, therefore, not require life-long disability benefit entitlement. The Australian JCA takes persistence of a health condition into account by using the criterion of being unable to work at least 15 hours per week *within the next two years*. This may have a lowering impact on the inflow to disability benefits of people with mental health conditions. On the other hand, people's health conditions may *improve* beyond this two-years period, implying that they could be pushed into disability benefits unnecessarily.

Mental health problems and the labour market

Reforms of the assessment process in Australia and the United Kingdom will only have an impact on the employment situation of people with mental illness and partial work capacity if claimants receive adequate support to remain in, or return to, work. Otherwise, there is a considerable chance that the number of unemployed people with mental health problems will increase. This is likely to happen, or have happened already,

Figure 3.4. Major health conditions of disability benefit recipients vary considerably

Percentage distribution of total benefit recipients, by age group, most recent available year^a



a) 2004 for Luxembourg and Spain, 2005 for Australia and 2006 for the United Kingdom.

b) For Luxembourg, data on health reasons for people on disability benefits do not exist. Instead, data are based on ambulatory treatments and shares are calculated according to the number of visits to a specialist among people with a disability benefit. Data cover the resident population only.

c) Data for Spain refer to a sample of people with legal disability.

d) Data on mental disability include learning disabilities which account for approximately 6% of all mental disabilities.

Source: DEWR for Australia; IGSS for Luxembourg; special tabulations for Spain provided by the University of Madrid, based on linked INSS and IMSERSO data; and DWP Work and Pensions Longitudinal Study for the United Kingdom.

in Luxembourg where an increasing number of people with health problems, in many cases mental health issues, are transferred to unemployment benefits. In Spain, where mental health problems seem to remain undetected more often than elsewhere, these people would most certainly end up on unemployment benefits as well.

Unemployed people with mental health problems have much larger difficulties getting back into work once they lost their job everywhere. Data from the special module of the 2002 EULFS show that employment rates of people with mental conditions are below 30% in all three European countries, and even as low as 15% in Spain (Table 3.5).

Table 3.5. Employment rates for people with mental health conditions are extremely low

Employment rates of people with disability by type of health problem, percentages, 2002

	Luxembourg	Spain	United Kingdom	EU19
All working-age persons	68.9	62.8	74.3	70.6
Non-disabled people	71.5	66.2	82.0	75.1
All disabled people	49.7	28.6	54.8	46.4
Muscular-skeletal disability	53.2	31.1	50.2	48.0
Mental disability	30.5	14.6	22.5	28.2
Other disabilities	46.8	31.0	62.0	48.2

Source: 2002 EULFS *ad hoc* module on disabled people.

Discrimination legislation will only help to the extent that employers are able to identify suitable reasonable work adjustments for workers with mental health problems, and willing to put these into practice. Data from the United Kingdom are disappointing in this respect: one-third of all people with mental health problems report being laid-off or forced to resign because of their health conditions and another 40% say they have been denied a job because of psychiatric treatments (BBC News, 2006). It is therefore even more critical that these people are identified at an early stage – preferably *before* they lose their job – and supported in and into work with appropriate services and rehabilitation programmes.

Unemployment has a clear negative impact on mental wellbeing. In the United Kingdom, for instance, 27% of those moving from unemployment to disability benefits had mental health problems. With 15% of all cases, depression was the single most common category (Bacon, 2002). Figures from the Health and Safety Executive in the United Kingdom show that, in 2001, 2.3 million Britons had a health condition that was either caused or made worse by their work. Of these illnesses, close to one-quarter were related to stress, depression and anxiety (Trade Union Congress, 2005). However, for Australia the difference in mental well-being between those in “good” and “bad” jobs was found to be even larger than the difference between those in employment and those unemployed (Dockery, 2005).²⁵

Recognition and treatment of mental health problems

A critical question is how mental health problems are recognised, treated and managed by general and mental health care. Sometimes it is claimed that the problem has always been there and that old taboos concerning mental illness made it possible to keep disability benefit inflow numbers relatively low. This could also be an explanation for the very low numbers reported in Spain. Various mental diseases (as well as muscular-skeletal diseases) that are now increasing in importance were almost unknown two decades ago. Many of them are treatable now, and more may be in the future.

Common mental health problems are treated almost entirely within primary care in the United Kingdom. These health conditions may be better addressed by psychologists, occupational health therapists or other specialists but these professions are in short supply (British Occupational Health Research Foundation, 2005). This is confirmed by patients, whose biggest complaint is the lack of psychological therapy. Among people with depression around one in two receive treatment, only 8% have met a psychiatrist, and 3% have seen a psychologist. For those who managed to be referred to a psychologist, the average waiting time was often more than half a year (Layard, 2004).

In Australia, the *National Action Plan on Mental Health* (2006-2011) aims to address these issues. This action plan involves a joint package of measures and significant new investment by all governments that will promote better mental health and provide additional support to people with mental illness and their families (Council of Australian Government, 2006). The value of measures for all jurisdictions totals around AUD 4 billion over five years, almost half of which coming from the federal government. Key measures include: i) a major increase in clinical and health services available in the community and new teamwork arrangements for psychiatrists, GPs, psychologists and mental health nurses; ii) new non-clinical and respite services; iii) an increase in the mental health workforce; and iv) new programmes for community awareness. These measures complement a range of existing programmes and initiatives at all government levels through earlier mental health strategies.

In the United Kingdom, pilot projects on increasing access to psychological therapies are testing the feasibility of substantially increased provision of these services, and the extent to which this can improve well-being and employment.

C. Addressing partial work capacity

Most of the changes in sickness monitoring and disability assessment aim to improve identification of people who are able to work despite a health problem or disability. A tendency in many OECD countries is to treat those people with a partially-reduced work capacity like “standard” unemployed. Australia and Luxembourg belong to this group of countries. Others, including Spain, use a partial disability benefit to encourage people with partially-reduced work capacity to remain in, or return to, employment. Across the OECD, there is inconclusive evidence as to whether such partial benefits help reduce or instead increase benefit recipiency rates, and how they impact on employment rates. This section recapitulates the main changes in the four countries from the point of view of people with partially-reduced work capacity.

Partial disability benefit for partial work capacity in Spain

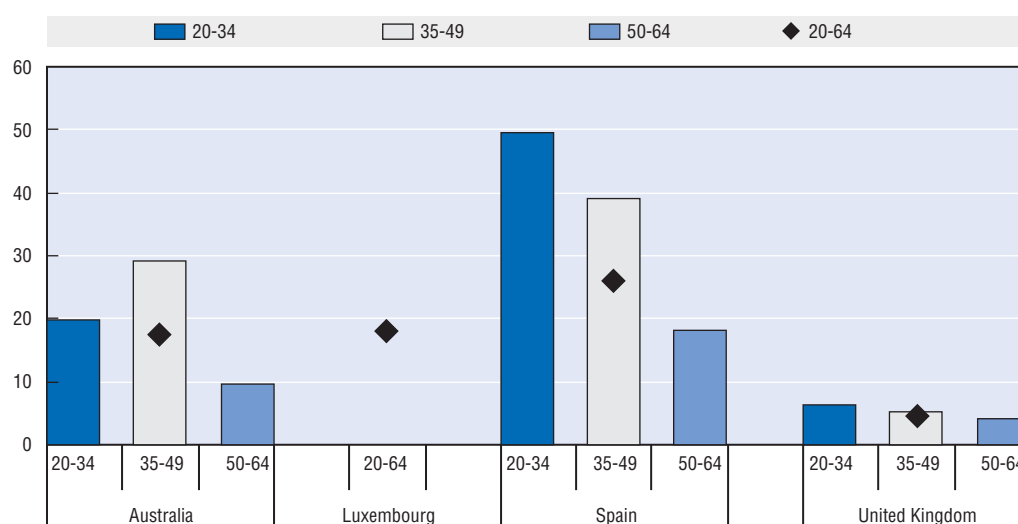
A potential problem with partial disability benefit schemes is that people with minor disability rather than those with substantially-reduced work capacity leave the labour market. Another risk is that people tend to apply for the highest possible benefit rate, which means that more people may end up on full benefits than would otherwise be justified. In this respect, Norway is a telling example. Not only does this country have one of the highest disability benefit recipiency rates in the OECD, but also one of the most detailed partial disability benefit grids starting at 25% reduction of work capacity. Despite the fine grid of benefit levels, almost three-quarters claim a full benefit (requiring 100% work capacity loss) and only 3.5% a benefit in the range of 75-99% reduced work capacity (OECD, 2006b).

Among the four countries in this review, only Spain has a partial disability benefit scheme. The Spanish system is much less detailed than the Norwegian one and very similar to the system in Poland (OECD, 2006b), with the big difference of not generating a massive inflow into these benefits. The system offers two kinds of benefits: full benefits to people no longer able to carry out *any* job and a reduced (i.e. partial) benefit of 55% of the full benefit to those unable to perform their *usual* work. The partial benefit can be combined with unlimited income from work in another occupation.

Partial benefits in Spain account for more than half of all contributory disability benefits. The employment rate of disability benefit recipients, however, is only 26% (Figure 3.5). This may seem to be a high proportion the other countries, but it also means that every second recipient of a partial disability benefit in Spain does not work. Confirming age patterns of labour market participation and discrimination found earlier, the proportion of recipients who are employed is by far lowest for people over age 50. This is probably also a consequence of the 20% supplement those people can get in Spain provided they are over age 55 and not working (Chapter 4).

Figure 3.5. **Employment rates of disability benefit recipients are highest in Spain and lowest in the United Kingdom**

In percentage of all disability benefit recipients, by age group, latest available year^a



a) Data includes the following groups: in Australia, disability benefit recipients (DSP) in 2003; in Luxembourg, recipients of sickness, disability and work injury benefits in 2004; in Spain, disability benefit recipients in 2004; in the United Kingdom, claimants of Incapacity Benefit, Severe Disablement Allowance or Income Support on the basis of sickness/disability in 2006.

Source: SDAC (Australia); EU-SILC (Luxembourg); special tabulations by the University of Madrid, based on linked INSS and IMSERSO data (Spain); national LFS (United Kingdom).

The extremely low proportion of employed disability benefit recipients in the United Kingdom, only about 5%, results from restrictive rules for combining work and benefit income. For most recipients, the maximum one can earn indefinitely without losing at least some benefit entitlement is GBP 20 a week, i.e. less than four hours a week at the minimum wage. For those on contributory benefits only, it is possible to earn up to GBP 85 a week while working for up to 16 hours, without loss of benefit, for up to 12 months, and in some cases longer.²⁶

The free earnings zone in Australia is considerably higher than this and the taper rate more generous, as is reflected in the higher employment rate of recipients (around 18%), which almost doubled from 1998 to 2003. Data for Luxembourg show a share of working recipients very similar to Australia. This is explained by relatively high earnings disregards: a disability benefit can be combined with income from work up to pre-disability earnings (Chapter 4).

Unemployment benefit for partial work capacity in Australia and Luxembourg

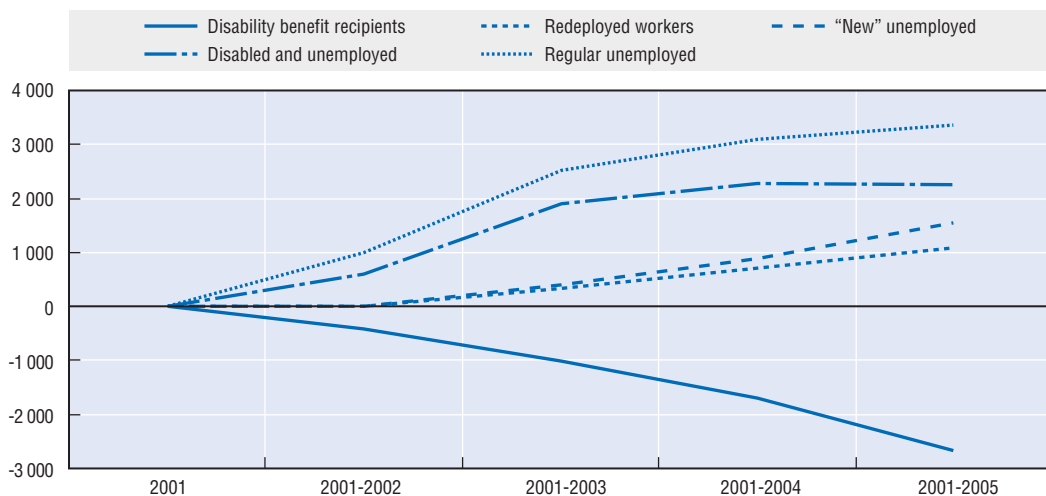
Until recently, Australia and Luxembourg also granted (in this case full) disability benefits to people with minor reduction of their work capacity. To improve workforce participation of people with reduced work capacity, through different types of changes both countries chose to close their disability benefit schemes for this group of people. Instead, people with only partially-reduced work capacity are now referred to the unemployment benefit scheme, with similar participation requirements as for other recipients of unemployment benefits. In Luxembourg, this change was achieved through more stringent administrative practice following a series of court rulings, without a formal change in regulations, while in Australia this was done in the course of the 2006 *Welfare to Work* reform package (Chapter 2).

The impact of this change in Luxembourg is illustrated in Figure 3.6. The number of people on disability benefits fell continuously, by more than 600 people annually, adding up to 12% of the entire 2001 number of recipients over a four-year period. Almost 60% of this decline, however, was compensated by a corresponding growth in “new” forms of unemployment, i.e. people unemployed due to partial incapacity to work at the last workplace and those in this status for more than one year who also receive a top-up payment or waiting allowance. Some 40% of the fall in disability recipients has translated into more employment, i.e. “redeployed” workers with or without extra compensation.

Whether this result can be interpreted as a success remains to be seen. First, these data are very preliminary and long-run effects still unknown. Secondly, these data do not result from a proper evaluation exercise and they are not corrected for any changes, e.g. in age structures. And thirdly, and most importantly, as the figures also show, in the same period regular unemployment has increased very fast (by more than 70% in four years) so that the total number of people on either disability or unemployment benefit has increased as well. It is unknown to what extent this development is related to the 2002 reform and to what extent other factors, especially macro-economic developments, have driven this change. One outcome of the 2002 benefit reform in Luxembourg is that, today, one-third of

Figure 3.6. **Unemployment in Luxembourg increased more than disability fell**

Total number of people in various statuses, changes since reform in 2001



Source: Social Security Administration.

all disability and unemployment benefit recipients are unemployed, compared to only one-sixth four years ago. Potentially this will increase the chances for a reduction of benefit recipiency in times of labour shortages. However, structural unemployment is likely to remain higher more permanently.

For Australia, no data is available at this stage to assess the impact of reform simply because reforms are too recent. However, judging from the results for Luxembourg, structural unemployment is also at risk of increasing unless labour demand rises significantly. The United Kingdom is also in the process of introducing a differentiation between people who are severely disabled and those with severe limitations but only partially-reduced work ability (Chapter 2). The latter group will, in principle, receive a lower benefit but with a top-up for those who participate in employment-activation programmes. Details of this reform are yet to be fixed. However, since in this case reform will take place within the disability benefit scheme itself, unemployment is unlikely to be effected by this change very much.²⁷

3.4. Future policy directions

Once people obtain disability benefits they tend to remain on them for very long. Since people enter these benefits at an increasingly younger age, average benefit duration is increasing. As a result, disability beneficiary rates are persistently high. These findings call for a change in disability benefit inflow policies. Health monitoring of employees and the unemployed and stringent disability assessment will be crucial to reduce the number of people moving into these benefits.

Improve health monitoring during the sickness phase...

It is vital to detect a health problem before it develops into a more serious condition. For workers, good sickness management is the key to disability prevention and work retention. Employers are key players in this regard, and they should be given as much support as possible. Absence management should also include systematic controls by independent medical experts, as in Luxembourg and Spain.

One way to better involve employers during the early sickness and rehabilitation phase is to increase their financial responsibility by extending the wage-payment period. This has proven quite effective in a number of countries. Confidential occupational health advice for employers and employees alike is equally important. Such advice is also needed for general practitioners who lack the work-related expertise needed to encourage sick workers to return to work.

... but also of people on unemployment benefits

In all four countries, unemployment benefits are one of the main pathway into disability benefits. This means that it is extremely important to monitor the health status of the unemployed and especially the long-term unemployed. Such monitoring is particularly important for people who are developing mental health problems which pose particularly severe obstacles to find and keep jobs. Australia in particular has taken important steps recently in this regard.

Improve the assessment of rights to disability benefits for mental illness

With the exception of Spain, mental illness accounts for 20-40% of all disability benefit claims. These shares are particularly high for people aged 20-34. This is worrying because

it is in these age groups that inflow rates are increasing fastest. Added to this, employment rates of people with mental conditions are only around half of the overall employment rate of people with disability. This situation calls for better ways of taking mental health problems into account in the assessment of disability and work incapacity.

Moreover, not enough has been done to understand the reasons behind this shift in health problems. A good start is to recognise these diseases and to make efforts to provide the right treatment in primary and mental health care. This is often not the case. In all countries, better co-operation is needed between the social insurance authority, employers and the health care sector.

Notes

1. The average inflow rate in OECD in 1999 (latest year with data for a sufficiently large number of countries) was around six per thousand (OECD, 2003) and, hence, almost twice as high as the Spanish rate. The rates in the other three countries were around the OECD average.
2. The reform proposal in Australia was to lower the requirement of not being able to work more than 30 hours per week to 15 hours per week. This reform was in the end postponed to 2006 (Chapter 2).
3. Longer benefit duration may also result from a more restrictive inflow management where benefits are only made available to people with severe disability with relatively lower chances of finding jobs.
4. In Australia, absence rates are also slightly higher for women compared to men (The Australian Bureau of Statistics, National Health Survey 2004/5).
5. Employees in Australia unable to perform their usual work due to a temporary incapacity caused by an injury or illness, who have a job to return to, can receive Sickness Allowance (SA). For a person to be eligible for SA, their temporary incapacity must be (virtually) wholly caused by a medical condition, and it must be likely that the person will be able to return to work within two years (but people may remain on SA for up to four years if they are undergoing an approved vocational rehabilitation programme). The commencement date for SA is affected by the payment of sick leave, annual leave and other leave payments made by the employer. SA is a non-contributory, means-tested and flat-rate payment at the same rate as unemployment benefit.
6. The United Kingdom is currently running a large quantitative survey of new disability benefit claimants to improve the evidence base in this field. This is following-up on a recent qualitative study on new recipients and their pathways into, as well as off, disability benefits (Sainsbury and Davidson, 2006), which concluded that health dominated most people's accounts of their route on and either their route off or their continued receipt of a disability benefit.
7. There are other explanations for the infrequent transfer from sickness into disability in Australia as well. First, since 1996, unemployment benefit recipients with temporary work incapacity are no longer transferred to sickness benefit. This alone has led to a drop in transfers from sickness to disability benefit from 20% to 6% of the inflow (Cai et al., 2006). Secondly, casual workers, who make up for one-fourth of the workforce and one-third of all workers with a disability (Chapter 5), are not covered by sickness benefits. Thirdly, eligibility criteria are very narrow (see note 31).
8. If the stipulated ten days of continued wage payment in Australia are not used they can, since recently (i.e. since the introduction of Work Choices), be accumulated over the years as long as the worker stays with the same employer or within the public sector. People who change jobs lose these days.
9. This mirrors a finding for Norway, where companies with the highest absence rates were those which responded most actively to the recent government initiatives to curb sickness absence (OECD, 2006b).
10. There are around 30 mutualities (Mutuelles des Accidents de Travail et Maladies Professionnelles) across Spain. These are independent not-for-profit institutions, but supervised and audited by INSS.
11. Like in most other OECD countries, however, much of the responsibility for medical rehabilitation in Spain rests with the health care system, which in turn is administered at the level of the autonomous regions, with counselling and supervision from the national level.

12. A very special problem in Luxembourg, not further elaborated here, is that cross-border workers can use sickness certificates of a GP in their home country and the control of these certificates is not in the hands of the IGSS. For further cross-border related policy issues, see Grubb (2007).
13. A recent randomised controlled trial in the United Kingdom tested various interventions (workplace and/or health interventions) aimed at increasing the return-to-work rate of people who were off sick (Purdon *et al.*, 2006). Surprisingly, the control group had almost the same return rate as the different intervention groups, even though some impact was found for certain subgroups. It is important to better understand why this experiment showed so little success; the factors identified in this study included inappropriateness of the interventions, more pro-activity among people in the control group and non-cooperative employers.
14. In Luxembourg, employers can seek a second opinion from an occupational doctor. If the employer decides to do so, the employee is obliged to see this doctor, who albeit not being able to control the validity of a sick leave certificate can criticise the absence duration and may be able to identify problems at the workplace. In the United Kingdom, employers also may choose to refer employees to their own doctors or to doctors under contract with the public authorities in cases where their workers' temporary work incapacity seems in doubt.
15. The new group of unemployed with detected health problems in Luxembourg remain on the unemployment benefit scheme and receive special support to find another job. After the introduction of this procedure in 2002, total unemployment rose rapidly and, by 2006, the share of unemployed people with detected health problems had increased to 17% of total unemployment (ADEM, 2006).
16. The assessment of the INSS in Spain is usually taking place during the first 12 months after onset of a health problem. The average duration is 50-60 days from the applicant's visit to the decision taken by the assessment team, a fall from around 300 days a few years ago.
17. Spain has two disability benefit levels: a full benefit for those assessed as not being able to work at all and a partial benefit for those assessed as not being able to perform their previous job.
18. Luxembourg's AMC is a public control unit (consisting of medical doctors with different specialties) under the Ministry of Social Affairs, but independent of the Social Insurance Administration.
19. The PCA in the United Kingdom is required for people who have not worked during the last two months or have previously been on public sickness benefits, or on sickness or short-term disability benefits for six months.
20. A similarity with Australia is that the medical service performing the PCA in the United Kingdom is contracted to a private company consisting of PCA-trained medical services doctors.
21. Forthcoming benefit reform in the United Kingdom will do away with this problem in so far as claimants will, during the initial three months, only receive an amount of benefit equivalent to unemployment benefit and they will only receive the higher rate on completion of the PCA.
22. IMSERSO is an agency in responsible for benefit policies directed towards elderly and dependents, operating at the level of the Spanish autonomous communities.
23. These benefit-processing centres in the United Kingdom deal with all kinds of benefits, including dealings with the PCA and the companies responsible for PCA assessments.
24. One reason for this rapid growth in mental illness in Australia is a change in the definition of disability in 1991, opening the door to people with mental conditions. Prior to this reform, these people tended to be counted towards the long-term unemployed.
25. "Bad" jobs are often defined as jobs with, for example, high job insecurity, unsatisfactory work environment and too high work loads.
26. The rules on permitted work also reflect the policy approach in the United Kingdom. Those capable of work should be encouraged to leave benefits, so that the low proportion working while on benefits is to be expected. The risk of increasing this number through more relaxed regulations is that it might not only concern those currently on benefits and not working, but also some of those currently working and not on benefits returning to benefits, *e.g.* by reducing their hours of work.
27. In this context it is worth noting that within the United Kingdom's unemployment benefit scheme there is provision for disabled people to have restrictions on their job search requirements.

Chapter 4

Financial Incentives and Disincentives for People with Disability

One of the main objectives of current disability benefit reforms in all four countries is to increase incentives for persons with disability to take up, or to remain in, work. Disability and other public benefits are an important source of income for people with disability, especially in lower income groups. Nonetheless, the design of these benefits in combination with income taxation can create work disincentives. For instance, in a number of cases (Australia, United Kingdom and above-average income in Spain) disability benefits appear to be more attractive than unemployment benefits, which partly explains the frequent transitions from unemployment into disability. Disability benefits are also being used as a pathway into early retirement, particularly in Luxembourg and Spain. Finally, returning to work may be linked to high effective taxation: such “inactivity trap” exists in the United Kingdom. The other three countries are rather facing “low-wage traps”, as increasing working hours sometimes does not significantly increase incomes of workers with partially-reduced capacity.

Recent and on-going benefit reforms reduce slightly the levels of benefit but do not necessarily decrease disincentive features embedded in the system. This is important in view of the low incomes of people with disability, especially in Australia and the United Kingdom, which are partly the result of comparatively low disability benefits in these countries.

The prime aims of disability benefit policies are to prevent large financial losses and to reduce poverty risks for people with disability. At the same time, governments need to ensure that these policies are balanced enough so as to avoid “benefit traps”, i.e. situations in which a possible take-up of work actually penalises the people concerned. This chapter looks at the income adequacy *versus* work incentives dilemma. It shows that, in a number of cases, benefit systems fail to achieve one or the other of these objectives and highlights examples how this could be avoided. Section 4.1 looks at the “attractiveness” and adequacy of disability benefits *versus* other working-age benefits, in particular unemployment and social assistance benefits. Section 4.2 examines the extent to which disability benefits are used as a pathway to early retirement. Section 4.3 analyses the financial consequences for people with disability who take up work. Section 4.4 discusses the impact of recent and planned reforms to the benefit scheme in the four countries.

4.1. The “attractiveness” of disability benefits

A. The relative importance of disability benefits

Average disability benefits are set at 22-28% of average national net earnings in Australia and the United Kingdom, and at 52-58% in Luxembourg and Spain (Chapter 1). Persons with disability rely, however, on a multitude of income sources. Other public benefits often play a major role, but other income sources also include own earnings, capital income, and income from savings and private transfers. Furthermore, the resources of other household members with whom the person with a disability is living contribute to (or, in their absence, put a burden on) their economic well-being.

This “income package” differs, however, between countries. In all countries, labour income plays the most important role, contributing as much as between 64% (Spain) and 71% (Australia and the United Kingdom) to the income of persons with disability (note 4.1). Moreover, the share of labour income in total incomes increased in the past ten years in Spain, more so for people with disability (plus 10 percentage points) than for people without (plus 6 percentage points), reflecting increasing employment rates in that country.

Second, public social transfers are an important source of income; their share in total income of persons with disability is about twice that for persons without disability. Levels differ, however: while they make up for 18-19% of all income of people with disability in Australia and the United Kingdom,¹ they constitute 28% in Luxembourg and 34% in Spain, and these percentages are higher for persons with severe disability. It should be noted that old-age pensions (including early retirement pensions) are a more important income source than disability benefits in Luxembourg and Spain, especially when disabilities are moderate. Third, other income sources such as capital income or private transfers top up the financial resources of persons with disability. While they play a negligible role on average in Luxembourg and Spain, they amount to a significant 10-12% in Australia and the United Kingdom.

Table 4.1. **Earnings are the most important income source for persons with disability**Income composition by disability status, 2004^a

	Moderate disability	Severe disability	All people with disability	No disability
Australia				
Labour income	..	..	71	85
Capital income, private transfers	..	..	10	8
Public social transfers	..	..	19	7
Luxembourg				
Labour income	72	64	69	83
Capital income, private transfers	2	2	2	2
Public social transfers	26	34	28	15
Disability and sickness benefit	6	14	8	2
Unemployment benefit	1	2	2	1
Social assistance	1	3	2	0
Old-age pension	11	9	10	6
Other benefits	6	5	6	6
Spain				
Labour income	69	57	64	84
Capital income, private transfers	2	2	2	2
Public social transfers	29	41	34	14
Disability and sickness benefit	8	19	13	2
Unemployment benefit	3	3	3	2
Social assistance	0	0	0	0
Old-age pension	14	16	15	7
Other benefits	4	3	3	2
United Kingdom				
Labour income	..	..	71	88
Capital income, private transfers	..	..	12	7
Public social transfers	..	..	18	5
Disability benefit	..	..	6	1
Old-age pension	..	..	3	1
Other benefits	..	..	9	4

a) Income concept used is equivalised disposable household income per person. Old-age pension includes early retirement pension. Other benefits include family benefits and, in the United Kingdom, unemployment benefits and tax credits.

Source: HILDA 2005 for Australia (calculations were provided by Mark Pearson, OECD); EU-SILC 2004 for Luxembourg and Spain; FRS 2005/06 for the United Kingdom.

The fact that labour income constitutes about two-thirds of all disposable household income of people with disability in all four countries underlines the crucial importance of employment. While public policy often focuses on benefits, succeeding in increasing employment seems the best way to economic security for most people with disability. That said, these results refer to persons who assess themselves as “disabled” and who are to a large majority (70% to 80%, see Chapter 1) not receiving disability benefit, either because they are employed or for other reasons.

Given the sizeable share of public transfers and, in particular, disability benefits in the income package of people with disability, an important question concerns their redistributive features and the extent to which they provide income security for persons at the lower end of the income scale. Due to their flat-rate and (partly) means-tested nature, disability and other social benefits have a much higher redistributive impact in the United Kingdom and, in particular, in Australia than in the other two countries where they are more equally distributed – i.e. people in all income deciles receiving more or less the same

share of benefits.² In Spain, this concerns both disability and other social benefits while, in Luxembourg, benefits other than for disability are more progressively distributed. That said, even if less progressively distributed, social benefits alleviate inequalities of other income sources in all countries (Förster and Mira d’Ercole, 2005).

B. The tax/benefit position of persons with disability

The disability benefit and tax systems differ considerably across the four countries (Annex Table 4.A1.1 and Box 2.1 in Chapter 2). This has to do with different social protection traditions. The two continental European countries both rely on contributory benefits for employed persons, complemented by minor non-contributory schemes for people not fulfilling the contribution requirements. The contributory benefits are earnings-related but specify minima and maxima. The United Kingdom, too, relies on a contributory disability scheme; benefits are, however, flat-rate amounts. As in Spain and Luxembourg, this is complemented by a non-contributory scheme. Also in Australia disability benefits are flat-rate payments but the benefit system is non-contributory, universal and household means and asset-tested.

Table 4.2 compares the tax/benefit position of a 40-year-old single person with average earnings when working and after going on full disability benefit. The first column for each country describes the steps from gross to net earnings for a working person. In all three countries, between one-fifth and one-fourth of gross income is “taxed away”: in Australia this is done entirely through income taxation, while in Luxembourg and the United Kingdom social security contributions contribute one-third to the total tax burden. In Spain, the share between taxes and social security contributions is about balanced.

The second column for each country in Table 4.2 looks at the tax/benefit position of a single person after having moved from work to a full disability benefit entitlement (main scheme). The third and fourth columns show the position of a person who moved from work to other types of disability benefits. The tax weight on benefits is much lower than for workers, and zero in many cases due to non-taxation of benefits or sufficiently high tax allowances. Gross replacement rates, i.e. gross benefit levels with regard to former gross earnings, are therefore generally lower than net replacement rates.

Net replacement rates for single persons who were formerly on average earnings vary largely across countries but also within countries, depending on the benefit regime and type. In Luxembourg and Spain, for instance, replacement rates for people on non-contributory benefits are much lower than for those on contributory disability benefits (the latter constitute the vast majority of beneficiaries: 96% in Luxembourg, 80% in Spain). By contrast, in the United Kingdom there is almost no difference in benefit levels (and therefore replacement rates) between persons with disability on non-contributory Income Support with a disability premium and those on a contributory Incapacity Benefit.

On the other hand, there appears to be quite a significant difference in the United Kingdom between short-term and long-term incapacity benefit payments. However, this difference is mainly explained by the specific model assumptions, i.e. results being very sensitive to the inclusion of Disability Living allowance (DLA). Reflecting a “typical” case, it is assumed that a beneficiary will only claim DLA some 1-2 years after claiming disability benefit (contributory or non-contributory). If this top-up allowance, which is received by about half of all disability benefit recipients, were to be excluded from the model calculations, the replacement rate for long-term beneficiaries – be they on Income Support or on Incapacity Benefit – would fall from 60% to 47%.³

Table 4.2. **Gross and net replacement rates for main disability benefit schemes are higher in continental European countries**Tax-benefit position of a single person at average earnings and when out of work on disability benefits, USD Purchasing Power Parities (PPP), 2005^a

	Australia		Luxembourg			Spain				United Kingdom			
	Working single person	Disability Support Pension	Working single person	Disability benefit	Non-contributory benefit	Working single person	Partial ("total") incapacity benefit	Full ("absolute") incapacity benefit	Non-contributory benefit	Working single person	Short-term incapacity benefit after 28 weeks	Long-term incapacity benefit after 52 weeks	Income support disability premium
A.1 Gross earnings	37 069		44 441			26 729				46 832			
A.2 Taxable benefits													
Disability/incapacity benefits				27 222	13 224		14 159		5 287		5 486	6 796	
Housing benefits				0	1 569								
B. Income tax and social security contributions													
Income tax allowances			7 926	1 558	1 222	9 282	10 852		11 639	7 807	7 807	7 807	
Taxable income	37 069		36 515	25 665	13 570	17 446	3 307		0	39 025	0	0	
Income tax and local taxes ^b	8 904		6 072	2 552	307	3 707	496		0	8 185	0	0	
Social Security Contributions			6 198	961	501	1 697	0		0	4 294	0	0	
Total income tax and social security contributions	8 904		12 125	3 452	800	5 404	496		0	12 479	0	0	
C. Non-taxable benefits													
Disability benefits		8 971						25 743					
Disability related benefits ^c		167										4 553	4 553
Income support													6 647
Housing benefits		1 846									9 366	9 269	9 366
Total non-taxable benefits		10 984						25 743			9 366	13 822	20 566
D. Net income out of work (A – B + C)	10 984		23 771	13 992		13 663	25 743	5 287		14 852	20 619	20 566	
E. Net income in work (A1 – B)	28 165	32 316			21 324				34 352				
F. Gross replacement rate [(A2 + C)/A1]		30%		61%	33%		53%	96%	20%		32%	44%	44%
G. Net replacement rate (D/E)		39%		74%	43%		64%	121%	25%		43%	60%	60%

Note: Gross (net) replacement rates: ratio of household gross (net) income after becoming inactive and receiving disability benefit to household gross (net) income.

a) Average earnings refer to average worker (AW): AUD 51 169 in Australia, EUR 40 500 in Luxembourg, EUR 20 439 in Spain and GBP 29 364 in the United Kingdom. Estimates refer to a 40-year old single person with an earnings history of 22 years at average earnings. Figures assume no waiting period between employment and the benefit situation.

b) Includes surtax in Luxembourg.

c) Pharmaceutical allowance and telephone allowance in Australia, Disability Living Allowance in the United Kingdom.

Source: Special module of OECD tax-benefit model. Information provided by national authorities.

Across contributory disability regimes, net replacement rates for average earners are lower in Australia (39%) and the United Kingdom (43-60%) than in Luxembourg (74%) and in Spain where they are estimated at 64% in the case of partial disability (“total incapacity benefit”) and at 121% in the case of full disability (“absolute incapacity benefit”).

Finally, in terms of *absolute* benefit levels of the main disability scheme, expressed in USD in purchasing power parities, these are highest in Luxembourg and lowest in Australia.

C. Adequacy and generosity of replacement rates

Net replacement rates (NRRs) compare the income situation when moving from paid work to inactivity. They thus provide indicators of both the adequacy and generosity of disability benefit schemes. Low NRRs for people who become totally incapacitated for work in the midst of their professional career may raise concerns about poverty and social exclusion, especially if the persons have caring obligations towards children. However, a majority of persons with disability are not fully incapacitated for work but experience problems of staying in the labour market. In the case of NRRs approaching or exceeding 100%, such schemes may become an attractive alternative to employment (for employees but also for employers looking to adjust workforce size without causing labour discontent). Indeed, past OECD work suggests a positive correlation between scores on a synthetic “benefit generosity indicator” and both beneficiary rates and disability benefit inflows (OECD, 2003).

Apart from Australia, with its entirely non-contributory social protection system, all countries have different disability schemes in place, differentiated either by degree of work incapacity (Spain) or duration of disability (United Kingdom). In addition, there are special schemes for persons not covered otherwise (a new special social assistance payment in Luxembourg, non-contributory benefit in Spain and Income Support with disability premium in the United Kingdom). A first issue is how these disability schemes compare to each other in terms of replacing earned income.

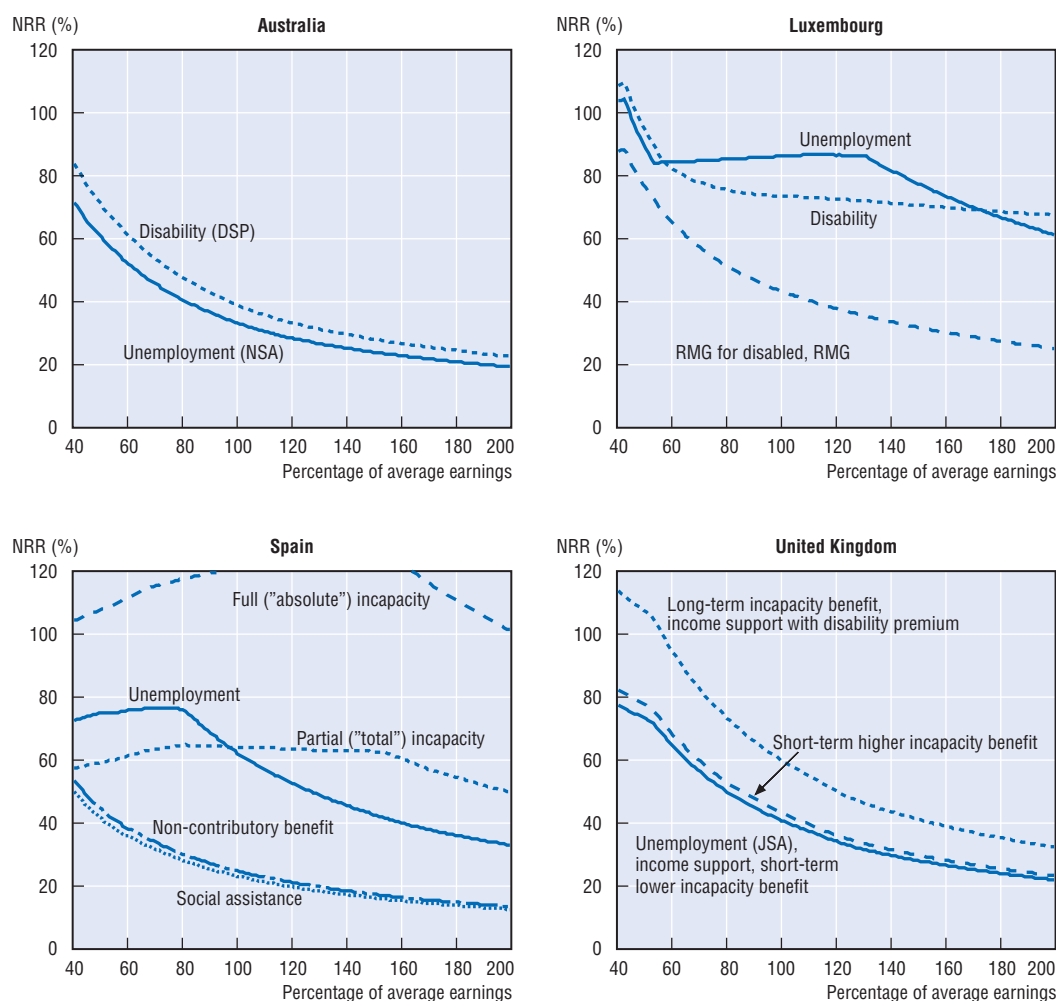
A second issue is how disability benefits compare, again in terms of replacing earned income, with other main income support schemes for those of working-age in case of inactivity: unemployment benefit and social assistance. In theory, these schemes have been distinct, serving different groups of people. However, there is some evidence that many persons with health problems – to which social and employment problems often are added – are being shifted around and, in the end, trapped between increasingly tightened schemes. Figure 4.1 compares NRRs for different disability, unemployment and social assistance benefit schemes for single persons (results for other household types are shown in Annex Figure 4.A1.1). Key findings are summarised in the following.

How do different disability schemes compare within countries?

In general, NRRs are higher for persons and households who receive longer-term or more severe disability benefits. This is particularly pronounced in the case of Spain where NRRs in the case of full (“absolute”) incapacity benefits are between 100% and 125% for the entire range up to twice average earnings, and for all family types. This is mainly due to non-taxation of these benefits. NRRs in the case of long-term incapacity benefit in the United Kingdom are also some 20-30 percentage points higher than those for short-term benefits, due to inclusion of Disability Living Allowance (see above and especially note 3) in

Figure 4.1. **Lower-rate disability and unemployment schemes provide similar net replacement income**

Net replacement rates for disability benefits, unemployment benefits and social assistance, single person, 2005^a



a) Net replacement rates: ratio of household net income after becoming inactive and receiving disability benefit or unemployment benefit or social assistance to household net income when earning 40% through 200% of average earnings. Estimates refer to a 40-year-old single person with a full earnings history since age 18.

Source: Special module of OECD tax-benefit model. Information provided by national authorities.

the latter case; however, the level of the NRR decreases continuously with higher earnings and falls below 60% beyond average earnings (except for couples with children).

On the other hand, non-contributory and minimum income schemes for persons with disability provide lower NRRs than contributory schemes in Luxembourg and Spain – in general their NRRs are quite close to general social assistance schemes for the working-age population. The exception is the case of couples with active spouses in Luxembourg, because the special social assistance payment is not means-tested in this country. In such cases, NRRs for the whole family are closer to contributory disability (and unemployment) schemes than to the regular social assistance. The situation with non-contributory benefits is different in the United Kingdom: the disability premium top-up to Income

Support, together with housing benefits, raises the level of NRRs for persons with disability on this scheme to those on contributory long-term benefits throughout the earnings range.

How do disability benefits compare with other working-age benefits?

In general, unemployment and disability benefits have relatively similar replacement features. NRRs for disability benefits are slightly higher than for unemployment benefits in Australia, though this difference increases for couples with children where the partner is working (Figure 4.1 and Figure 4.A1.1). Both curves, however, reflect the flat-rate nature of Australia's social protection payments: NRRs fall from 60-70% at half average earnings to around 20% at twice average earnings. Like in Australia, NRRs for unemployment benefits are lower than for long-term incapacity benefits in the United Kingdom practically throughout the whole earnings range. However, for people not eligible to DLA the difference between the two benefits is very small, and smaller than in Australia.

On the other hand, in Luxembourg unemployment benefits provide higher NRRs than disability benefits but only around average earnings (80% to 130% of average earnings), and this holds for different household constellations. In Spain, NRRs for unemployment benefits are higher than for partial ("total") incapacity benefits in the lower-income range but significantly lower above average earnings. Benefits for full ("absolute") incapacity are much higher than this at all earnings levels.

Both unemployment and disability benefits provide higher NRRs than regular social assistance, especially in Luxembourg and Spain, and also for lower income ranges. In the United Kingdom, short-term incapacity benefits provide about the same NRRs than regular social assistance (Income Support) while long-term incapacity as well as Income Support with a disability premium appear to be significantly above this level. This is, again, almost entirely due to the Disability Living Allowance supplement (see above). Without eligibility to DLA payments, NRRs would fall to a level similar to that of short-term incapacity benefits.

How does family structure affect benefit entitlements?

Especially in Australia and the United Kingdom, NRRs for disability benefits are considerably higher when there are children present in the household – for example, at former average earnings, they are 25-30 percentage points higher than for singles in both countries. This is a typical feature for flat-rate income support payments, due to general child benefits and family allowances but also special child supplements within the disability benefit system in the case of the United Kingdom. NRRs for couples with children are also higher than for singles in Luxembourg and Spain, but differences are much less pronounced (plus 10-15 percentage points at previous average earnings).

NRRs for disability benefits for inactive childless couples are very similar to those for singles. The major exception is Spain where NRRs for partial ("total") incapacity benefits are significantly higher for inactive couples than for singles in the lower earnings range until about half average earnings. This is due to the particular regulation that a *minimum* disability benefit is paid only for persons with dependent (i.e. inactive) spouses.

The interplay of different benefits, minima and maxima, income-test thresholds and taxation may cause several "notches" in the NRRs for disability beneficiaries as former earnings increase. Withdrawal of means-tested benefits (social assistance payments, housing allowance) and differences in tax rules at specific income levels can drive NRRs up

at some earnings levels and down at others. This seems, however, to be much less the case for the disability schemes in the four countries under review, compared to those reviewed by OECD in 2006 (Norway, Poland, Switzerland).

A few exceptions are noteworthy. For example, in Luxembourg, a first “notch” appears in the lower earnings range (42% of average earnings for singles and 63% for inactive couples) because only at that stage tax/benefit regulations permit net incomes of working people to increase. From that point, NRRs for disability beneficiaries fall rather steeply until a second “notch” when housing benefits and social assistance top-up is phased out as regular disability benefit is high enough that net incomes of disability beneficiaries start increasing. In Spain, NRRs for full (“absolute”) incapacity benefits increase steadily from about 100% to 120% (and above) over the earnings range until about one and a half times previous average earnings, because they are not taxed. They then start decreasing as this is the point where the maximum disability benefit is reached.

To sum up, income from work dominates the household income package of people with disability. For those among them who are inactive and on benefit, regulations on taxes and transfers determine net replacement rates. The latter tend to be lower in Australia and the United Kingdom than in Luxembourg and Spain but can, under certain conditions, be topped up by extra allowances, *e.g.* for daily living expenses, children and inactive spouses. Moreover, disability benefits provide generally higher net replacement income than unemployment benefits in Australia and the United Kingdom, but only for previous earnings above average in Spain and above twice average in Luxembourg.

4.2. Disability benefits as an early retirement pathway

A majority of disability benefit recipients is above age 50, and in some countries high disability take-up is an early retirement phenomenon more than anything else (*e.g.* for Luxembourg, Hartmann-Hirsch 2006). This section looks at the age bias in disability benefit recipiency and the extent to which such a bias may be explained by either demographic or policy design features.

A. Age bias in disability benefit recipiency

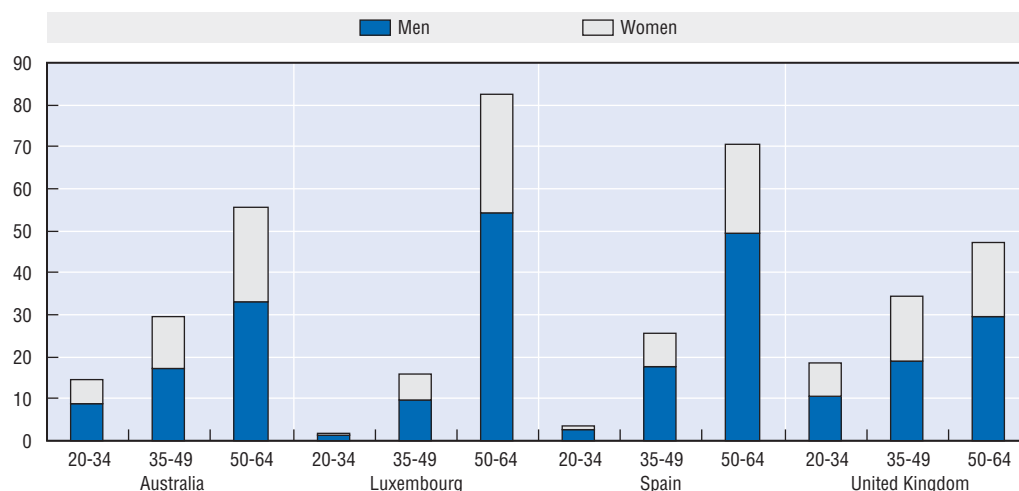
The age distribution of disability benefit recipiency is indeed biased towards older age groups, with 50 to 55% of all beneficiaries being aged 50 to 64 in Australia and the United Kingdom, 65% in Spain and as much as 82% in Luxembourg (Figure 4.2). This means that a strong age bias exists in all countries, but that there are also large differences across countries. That said, men dominate the disability benefit rolls everywhere, and the age bias is larger for men than for women, including in countries where the legal retirement age is 65 for both men and women.

B. Accounting for disability prevalence

A first explanation for this age bias in disability benefit recipiency is basically demographic in nature and related to the age structure of disability prevalence: more older workers have health problems or a disability (or perceive themselves as disabled), hence presumably more of them should apply for and receive a disability benefit. Such a pattern may be expected when juxtaposing age-specific recipiency with disability prevalence rates (Chapter 1, Table 1.11). Indeed, disability prevalence is biased towards older age groups, too: almost twice as high at age 50-64 as on average in all four countries. Again, the age bias is larger for men than for women.

Figure 4.2. **Disability beneficiaries significantly biased toward older age groups, in particular in Luxembourg and Spain**

Disability recipients by age and gender, as a share of total disability recipients, 2005^a



a) Beneficiaries: DSP customers (Australia); permanent and temporary disability pension recipients (Luxembourg); contributory and non-contributory incapacity benefits (Spain); Incapacity Benefit and Severe Disablement Allowance claimants, excluding IB short-term lower rate (United Kingdom).

Source: DEWR (Australia); IGSS (Luxembourg); MTAS (Spain); DWP (United Kingdom).

There exists an interdependency between these two phenomena and indicators: people on disability benefit will have a higher likelihood of considering themselves as being disabled. Such a pattern is suggested by the fall in disability prevalence for women in the age group 60-64 in the United Kingdom (Figure 4.3) – a group of people who are entitled to regular old-age pensions because the legal retirement ages are still 60 years for women and 65 for men (even though the former will gradually be increased to 65 years as well until 2017).

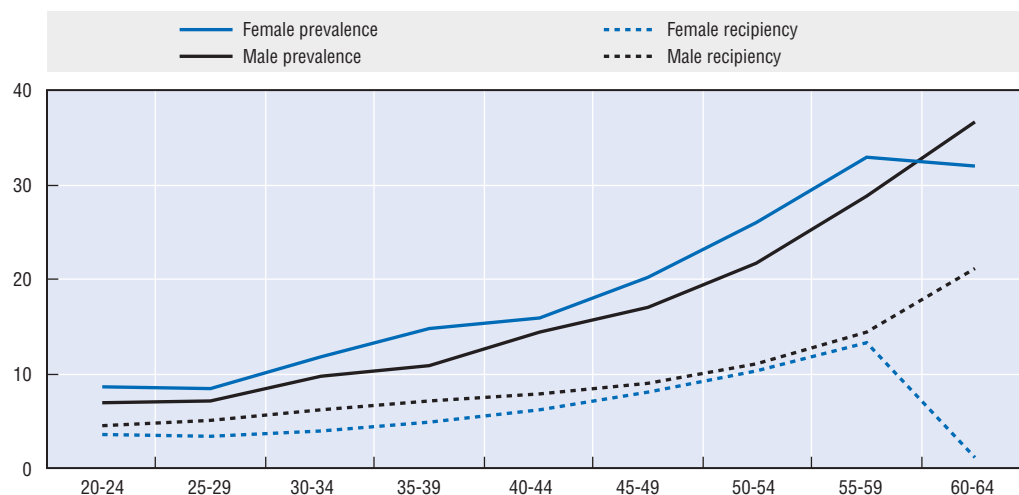
A simple way to account for the age structure of disability prevalence is to look at prevalence-adjusted disability benefit reciprocity rates, i.e. relating the number of recipients in each age-gender group to the respective number of people with self-assessed disability. Results are very telling (Figure 4.4): for men and women in the United Kingdom and in Australia – and to a lesser extent also for women in Spain – the age bias of disability benefit reciprocity largely disappears. This is not the case for men in Spain and both genders (men more than women) in Luxembourg. For these countries and population groups, explanations for the age bias other than demography are needed.

C. Benefit system design and reform

Another explanation for the age bias can be the design features in the disability benefit system. This may especially be the case for partial disability benefits (“total incapacity”, i.e. incapacity for the usual occupation) in Spain. This scheme includes a special top-up of the calculation basis for beneficiaries aged over 55 and out of work (Annex Table 4.A1.1). This can constitute incentives for some persons to apply for such a benefit. Figure 4.4 above suggests that this may be one factor driving the adjusted reciprocity rate upwards for those over age 55 and more so for men than for women.

Figure 4.3. **United Kingdom: interdependency between age-specific disability reciprocity and prevalence rates**

Disability reciprocity and prevalence by age and gender, 2005^a

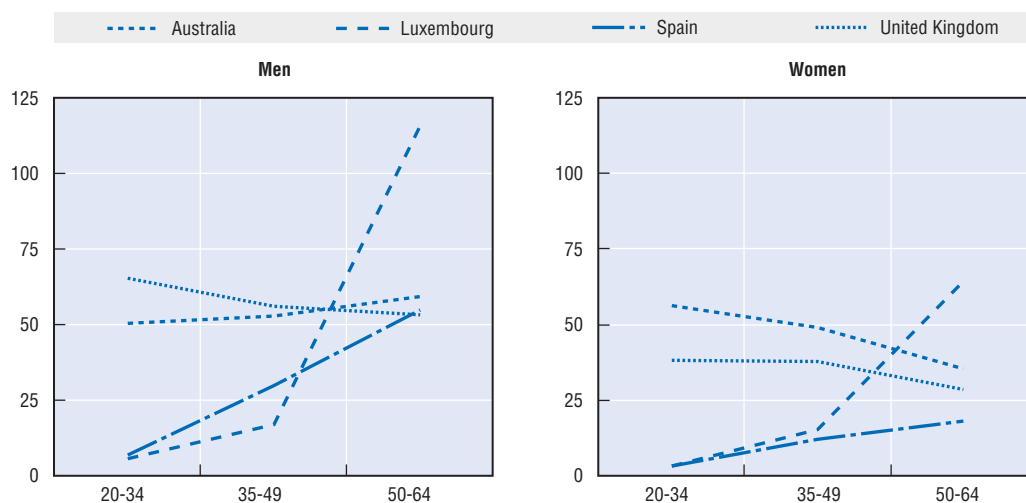


a) Beneficiaries: Incapacity Benefit and Severe Disablement Allowance claimants, excluding IB short-term lower rate.

Source: DWP; LFS 2006.

Figure 4.4. **Reciprocity age bias in Australia and the United Kingdom is explained by the age structure of disability prevalence**

Disability adjusted age and gender specific benefit reciprocity rates, 2005^a



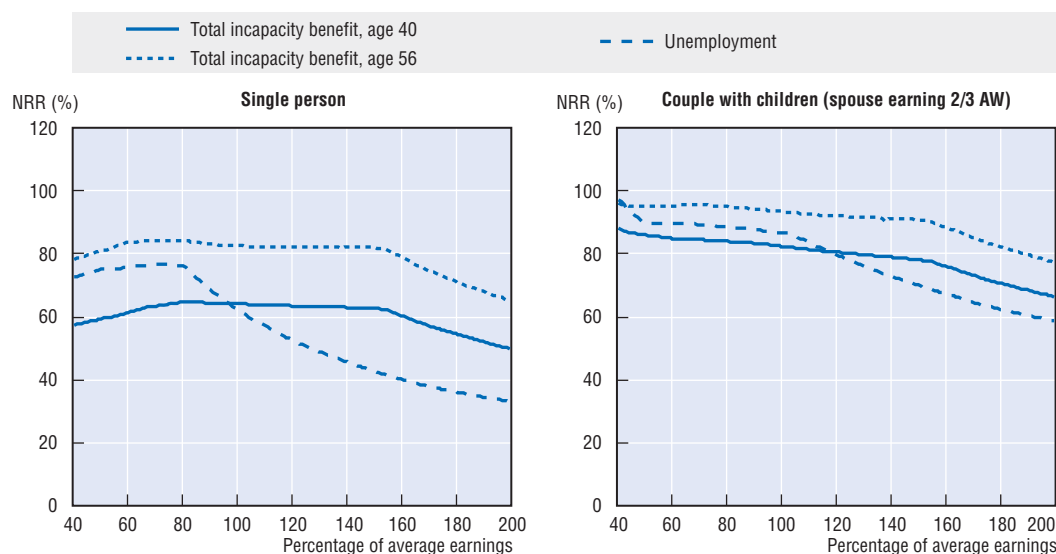
a) See Figure 4.2.

Source: Beneficiary data: DEWR (Australia); IGSS (Luxembourg); MTAS (Spain); DWP (United Kingdom). Prevalence data: SDAC 2003 (Australia), EU-SILC 2004 (Luxembourg, Spain), LFS 2006 (United Kingdom).

Indeed, net replacement rates for disability benefits above age 55 in Spain are significantly higher than below that age: 15-20 percentage points higher in the case of a single person, and 8-12 percentage points in the case of a disability beneficiary living with an active spouse and two children, depending on the level of prior earnings (Figure 4.5). More importantly, the replacement level of the topped-up benefit is higher than the unemployment benefit in the earnings range below average wage.⁴ This creates incentives

Figure 4.5. **Age top-up to disability benefits in Spain moves net replacement rates above those of unemployment benefits**

Net replacement rates of partial ("total") incapacity benefits at ages 40 and 56 and unemployment benefits, Spain 2005^a



a) Net replacement rates: ratio of household net income after becoming inactive and receiving disability benefit or unemployment benefit to household net income when earning 40% through 200% of average earnings. Estimates refer to a 40-year-old person (56-year-old in case of top-up IB) with a full earnings history since age 18.

Source: Special module of OECD tax-benefit model. Information provided by national authorities.

for older persons with weaker labour market attachment to move onto disability benefit and, moreover, to remain out of work as the supplement would get lost otherwise (while a partial disability benefit without this supplement can be combined with work).

The higher the age, the higher the level of disability benefit in the other countries as well, with the exception of Australia. In the United Kingdom, the long-term incapacity benefit includes age supplements if benefit receipt started before age 35 and 44, respectively. In Luxembourg, the earnings-related part of the disability benefit formula refers to total wages earned and, therefore, increases substantially for older workers.

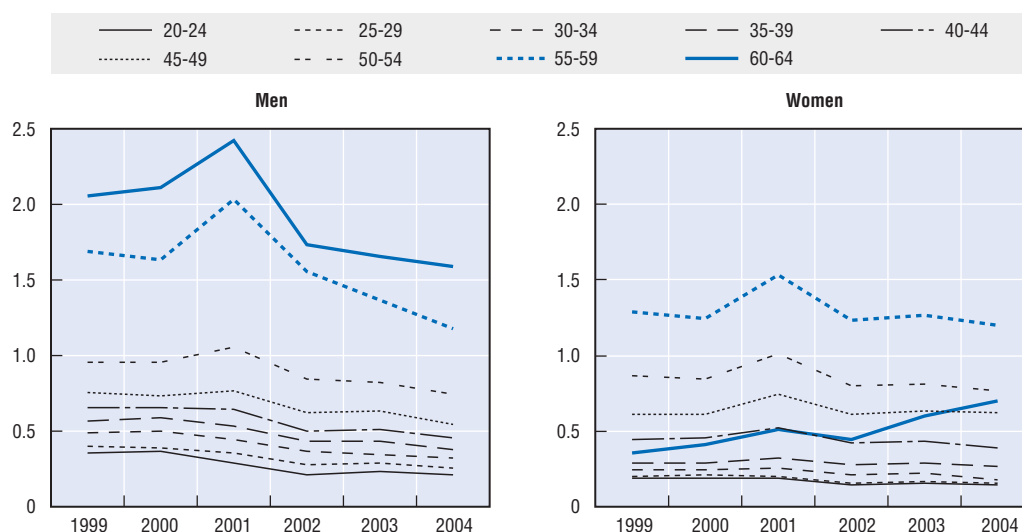
A third possible explanation for the age bias in disability benefit reciprocity is features of and changes in the old-age pension system. In Australia, the minimum age-pension age for women is currently being increased gradually from 60 to 65 years (it was 61 years in 1999 and 62.5 years in 2004). Moreover, mature age allowance and partner allowance, two special unemployment allowances for people (*de facto* mostly women) over age 60 with no work experience, were both closed to new entrants as of 2003. Figure 4.6 suggests that these changes lead to a gradually increasing inflow into disability benefits among women aged 60-64, which runs counter to the trend in other age groups or for men in the 60-64 age group.

D. Different pathways into retirement

None of the possible explanations described above sufficiently explain the substantial age bias of disability benefit reciprocity in Luxembourg. The most important factor here is likely to be related to a different way of treating older applicants for a disability benefit, for example a higher likelihood that the labour market disadvantage of older people with

Figure 4.6. **Australia: changes in old-age pension rules influenced disability inflow**

Inflow rates into disability benefits (DSP) by age and gender, 2005



Source: Department of Employment and Workplace Relations (DEWR).

disability is taken into account by gatekeepers – even if this should formally not be the case – or a continuation of the pre-1997 application of benefit regulations, i.e. a continued granting of disability benefits to workers over age 55 with partially-reduced work capacities. Therefore the number of disability beneficiaries aged 50 and over exceeds by ten times the number of persons on formal early retirement in Luxembourg (Hartmann-Hirsch, 2006).

Nonetheless, disability benefits are often used as early retirement pathways also in the other three countries. Blanco (2000), for instance, finds that in Spain the exit to early retirement via disability insurance is particularly favoured in the public sector and for self-employed individuals. This is not to say that disability benefits are the only or even the main instrument to anticipate retirement. All four countries have retirement options before the legal retirement age in place, such as early retirement, advance retirement with adjusted benefits, quasi-retirement through the unemployment benefit system, or retirement through second-pillar pension schemes. Therefore, rather than 65 years, the earliest possible retirement age is 55 years in Australia,⁵ 57 years in Luxembourg, and 60 years in Spain and the United Kingdom (OECD, 2006c).

Disability benefit is a major pathway to retirement, but not the only one. Table 4.3 looks at the frequency of disability and other benefits among persons with disability aged 50 to 64. The data suggest that disability benefits are the main early exit pathway for men in Australia and the United Kingdom and women in Luxembourg, while they are only one of several options for women in Australia and the United Kingdom, men in Luxembourg and for men and women in Spain.

In sum, both demographic and benefit design features explain much of the age bias in disability benefit systems. These seem partly be used as a pathway into early retirement, especially in Luxembourg. Disability benefit is, however, not necessarily a “surrogate” for early retirement. On the contrary, its use as an early retirement tool is frequent in countries with an established and widespread early retirement culture.

Table 4.3. Disability benefits are more prominent among older men in Australia and the United Kingdom

Benefit distribution of persons with disability aged 50 to 64, 2005 (or closest), percentages

	Disability benefit ^a	Other benefit ^b	No benefit
Australia			
Men	50	17	33
Women	27	33	40
Total	38	25	37
Luxembourg			
Men	21	23	56
Women	16	9	75
Total	19	17	64
Spain			
Men	33	40	27
Women	7	17	76
Total	22	37	41
United Kingdom			
Men	37	10	53
Women	24	37	40
Total	30	24	46

a) Disability Support Pension (Australia), disability pension (Luxembourg), incapacity benefit (Spain), Incapacity Benefit, Severe Disablement Allowance and Income Support with disability premium (United Kingdom).

b) Australia: Age pension, Newstart allowance, Mature age allowance, Service pension, Wife pension, Carer payment, Sickness allowance, Widow allowance, Special benefit, Partner allowance, Youth allowance, War widow's pension, Overseas pension and Parenting payment; Luxembourg: Early old age pensions and pre-retirement, waiting allowance, unemployment benefit and supplementary unemployment benefits; Spain: Old-age pension, Survivor benefits, Unemployment benefit, Social assistance, Family benefits and Other benefits; United Kingdom: Invalid Care Allowance, Disability Living Allowance, Attendance Allowance, Industrial Injuries Disablement Benefit, Mobility Allowance, Income Support, Job Seekers Allowance, Guardian's Allowance, Maternity Allowance, Statutory Maternity Pay, State Pension, Housing Benefit, Council Tax Benefit (United Kingdom)

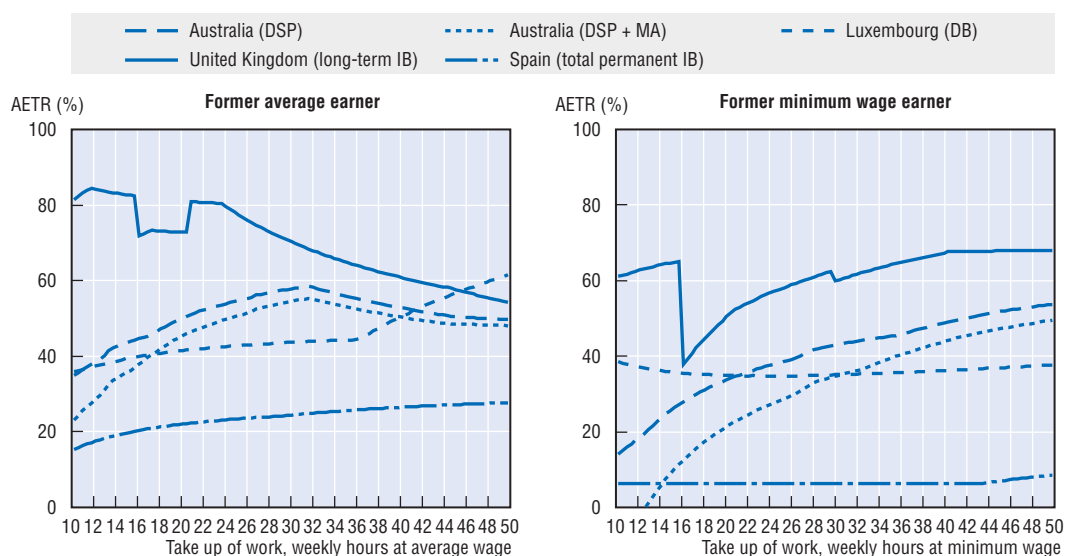
Source: SDAC 2003 for Australia; IGSS for Luxembourg; EU-SILC 2004 for Spain; LFS 2006 for United Kingdom.

4.3. Work incentives and disincentives for disability benefit recipients

This section looks at *financial* work incentives and disincentives for persons with disability through the tax/benefit scheme. Non-financial incentives – *e.g.* stemming from eligibility and duration criteria for various benefits and programmes and the extent of follow-up and activation policies towards persons on such schemes – are discussed in Chapters 3 and 5. Here, the net income effects of transitions from inactivity into work and further on into work at more hours are considered. That is, the extent to which gains in earnings are “taxed away” through a combination of reduced benefits and higher taxes, when taking up work – expressed as average effective tax rates (AETR) – or when increasing hours of work – measured through marginal effective tax rates (METR).

A. Does it pay to work?

Once inactive and on disability benefit, what are the financial consequences of a return to work? This question will be particularly relevant for the population with partially-reduced work capacity, in particular those on temporary or partial benefits. Taking up work should be financially attractive for those considering this step, but this is not always the case. Figure 4.7 shows average effective tax rates embedded in the countries' main disability schemes, for single persons with two different earnings histories: those who were on average wage prior to becoming disabled, and those who were on minimum wage.⁶

Figure 4.7. Taking up work can be very costly, but not so in SpainAverage effective tax rates for a 40-year-old single person on disability benefit, 2005^{a, b}

a) Average effective tax rate (AETR) is the percentage of earnings that is taxed away via increased taxes and reduced benefits when taking up work. Take-up of work at 10 and 50 hours weekly work, at average wage AW (Panel A) or national minimum wage (Panel B). The person is assumed to be on disability benefit after having worked at 100% of AW (Panel A) or at minimum wage (Panel B) (48%, 42%, 35% and 35% of AW in Australia, Luxembourg, Spain and the United Kingdom, respectively). Estimates refer to a 40-year-old person with a full earnings history since age 18.

b) DB = Disability Benefit; DSP = Disability Support Pension; IB = Incapacity Benefit; MA = Mobility Allowance. Persons are assumed to keep pharmaceutical and telephone allowance in Australia and Disability Living Allowance in the United Kingdom when taking up work.

Source: Special module of OECD tax-benefit model. Information provided by national authorities.

It is assumed that persons return to a job at the same wage rate but for varying working hours. The following key findings emerge.

In Australia, effective taxation is relatively low when working few hours: below 40% when returning to work up to about 13 hours on average wage or 27 hours on minimum wage. The AETR then increases further until about 32 hours work at average earnings. At this level, both disability and housing benefits are completely phased out, and effective taxation starts falling towards a rate of about 50%.⁷ The effect of the Mobility Allowance in reducing effective taxation is particularly significant for lower-wage earners. This allowance is paid to DSP recipients if they undertake work or training for at least eight hours a week. However, just 6.1% of DSP beneficiaries received mobility allowance in 2005, in majority younger people aged 16 to 39 (DEWR, 2006).

Effective taxation is in general relatively low in Luxembourg, too; just below 40% for minimum wage earners, irrespective of the number of hours worked; and around 40% for average earners almost up to full-time work: reflecting the fact that earnings can be accumulated with benefits. AETRs then increase as disability benefit is gradually reduced, up to a level of 150% of the average wage (this range is not shown in the figure) when the benefit is phased out completely.

Spain has the lowest AETRs throughout the entire earnings range, at around 20% for average earners and 6% for minimum wage earners. This is because earnings can be accumulated with disability benefit without limit or phasing out, and taxation on this combined income is at a low rate.

Average effective taxation for single average earners is high in the United Kingdom: around 80% when taking up work up to three days per week, and still around 60% when in full-time work. The two in-work benefits (WTC, RTWC)⁸ designed to motivate sizeable take-up of work come into play only between 16 and 21 hours of work at average earnings. This is because both tax credits are phased out rather quickly and are terminated at low earnings limits – around half the average wage level. The effective taxation features are somewhat more favourable for persons with disability taking up minimum wage jobs. In particular, the two in-work benefits are now available starting from 16 hours across the whole earnings range shown in Panel B. Still, AETRs for minimum wage earners at full-time 40 hour work are higher in the United Kingdom than in the other three countries.

Household composition can influence financial work incentives for disability beneficiaries, especially in case of withdrawal of child or family-related benefits, or different earnings disregards depending on the activity of the partner. In Australia, for instance, AETRs are much lower for persons with disability who live with an inactive spouse because disability benefit is higher and can be combined with earnings slightly above average earnings (Annex Figure 4.A1.2). In turn, in the United Kingdom, two-earner couples (with and without children) face lower AETRs than other household groups. There are no great differences across households in Luxembourg and Spain.

Additional non-contributory disability schemes exist in Luxembourg, Spain and the United Kingdom. Recipients of these benefits face lower AETRs than contributory benefit recipients in the former two countries, but higher ones in the United Kingdom, due to lower earnings disregards.

B. The impact of increasing work efforts

The discussion above has focused on *inactive* disability benefit recipients and the consequences when taking up work. A different yet important question arises for those persons with disability who are *in work* already drawing a (partial) disability benefit and considering working more hours. Table 4.4 considers the financial consequences of increasing working hours for a person with a disability, in four steps: from 0 to 10 hours (marginal work), from 10 to 20 hours (part-time work), from 20 to 30 hours (considerable part-time work) and from 30 to 40 hours (full-time work). Again, two cases are considered: the person is assumed to have worked at average or minimum wage earnings before having become disabled, and again to be taking up work at this earnings level and receiving a partial disability benefit, if eligible.

There are a few “zones” of increases in working hours with only limited financial awards from working more, i.e. with marginal effective tax rates close to 100%. In such cases, persons are encouraged to stay in their current benefit position despite their wish to become more active due to, for instance, improvements in their health condition. Such “zones” often occur when a disability benefit is suspended – taking account of other benefit reductions and taxation.

First, increasing working hours seems to be more attractive – in that less of additional earnings are “taxed away” – for minimum than average wage earners. Two exceptions are noteworthy and they occur in Australia and the United Kingdom: for minimum wage earners with disability it is less attractive to increase work to full-time hours than is the case of average earners. In the United Kingdom, as much as 90% of the earnings increase from 30 to 40 hours is taxed away.⁹

Table 4.4. Increasing working hours is not always very attractive for workers with disability

Marginal effective tax rates for those receiving full or partial disability benefits, percentage of earnings, 2005^a

		Increase in working time			
		0 >> 10 hours	10 >>> 20 hours	20 >>> 30 hours	30 >>> 40 hours
Australia	Average earner	35	65	73	<i>38</i>
	Minimum wage earner	14	53	61	66
Luxembourg	Average earner	36	47	48	70
	Minimum wage earner	39	31	35	39
Spain	Average earner	15	29	29	33
	Minimum wage earner	6	6	6	6
United Kingdom	Average earner	81	64	<i>65</i>	<i>33</i>
	Minimum wage earner	61	40	79	<i>90</i>

a) Average earnings refer to average wage (AW). Marginal effective tax rate (METR) is the percentage of earnings that is taxed away via increased taxes and reduced benefits when increasing working hours. The hourly wage is at the AW level (first line) or national minimum wage level (second line). The person is assumed to be on (partial) disability benefit, provided such benefit exists. Estimates refer to a 40-year-old single person with an earnings history of 22 years at AW respectively minimum wage earnings. Figures in italics refer to situations where no more disability benefits are granted.

Source: Special module of OECD tax-benefit model. Information provided by national authorities.

Second, for average earners in Australia, Luxembourg and Spain engaging in work entails lower METRs than increasing the number of hours worked; hence the issue seems to be more one of a low-wage (poverty) trap than that of an inactivity trap.¹⁰ In the United Kingdom, however, the opposite situation is found, a diagnosis which is confirmed in a recent policy study on work incentives for disability benefit claimants (Blackman, 2006).

Third, a few country-specific features emerge. In Spain, METRs are impressively low throughout the working hours range, again reflecting the unlimited possibility to combine benefits with earnings from another occupation. In Luxembourg, the level of effective taxation also seems to be more stable across the earnings range than in the two English-speaking countries. Finally, for average earners with disability in Australia and the United Kingdom, a move from part-time to full-time work seems much more attractive than marginally increasing part-time work.

4.4. The impact of recent and planned benefit reforms on work incentives

All four countries are in the process of reforming parts of their disability benefit schemes, focusing in particular on people with partially-reduced work capacities (Chapters 2 and 3). While these reforms are much broader in scope than simple changes to benefit parameters, the financial implications of these changes are important for the attraction of these benefits. This section considers the financial effects of benefit reforms on replacement incomes and work incentives.¹¹

A. Australia

Since 1st July 2006, persons who are assessed as being able to work for 15 to 29 hours per week at award wages in the open labour market are no longer entitled to disability benefit (DSP) but are placed on the Australian unemployment scheme, Newstart Allowance (NSA). As a financial consequence, these persons receive lower income support payment rates. Further, and equally important for employment considerations, a lower amount of earnings can be accumulated with NSA than with DSP, and benefit withdrawal rates ("taper

Table 4.5. Lower benefit rates but higher withdrawal rates for persons with partially-reduced work capacity in Australia since July 2006

Payment rates and earnings disregards of Disability Support Pension and Newstart Allowance, single person aged 21 to 60, 2006-07^a

	DSP		NSA		Difference
	AUD/week	Percentage of average wage	AUD/week	Percentage of average wage	AUD/week
Payment rate	257	25	211	21	-46
Amount of income that can be earned before payment is reduced	64	6	31	3	-33
Withdrawal rate above this threshold	40%		50%		
Second income test threshold	None		125	12	
Withdrawal rate above second threshold	40%		60%		
Income threshold where income support cuts out	706	69	398	39	-308

a) Includes pharmaceutical allowance but excludes telephone allowance and mobility allowance.

Source: Harding *et al.* (2005, p. 3); special module of OECD tax-benefit model. Information provided by national authorities.

rates”) are higher. Table 4.5 summarises the pre-and post-reform situation for a single person with assessed partially-reduced work capacity.

The new payment rate is about 20% lower than that which previous claimants would have received, and this entails lower net replacement rates for NSA as compared to DSP recipients discussed above in Section 4.1. The difference is slightly higher for persons with disability living with a working partner and when there are children present (Figure 4.A1.1). Two features may further adversely affect the benefit status of persons with disability receiving NSA: First, NSA is taxable while DSP is not. However, the current design of the “beneficiary tax offset” actually makes receipt of NSA tax-free if there are no additional private earnings. Second, NSA is indexed to prices while DSP is indexed to earnings – this difference in indexation is expected to increase the gap in future years (Harding *et al.*, 2005).

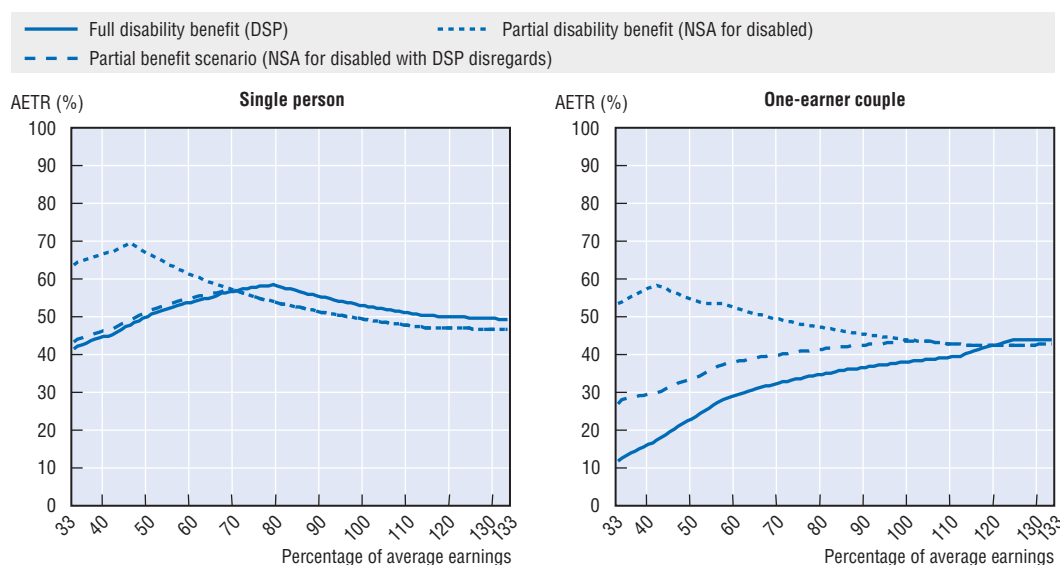
The prime aim of the reform is to increase workforce participation among people with partially-reduced work capacity. How, then, are effective tax rates affected when moving from the former DSP to the current NSA regime? For single persons (with and without children) as well as persons with disability living with inactive spouses, average effective tax rates in the lower earnings range are much higher – by 10-40 percentage points (Figure 4.8). This is because earnings disregards are lower and benefit withdrawal rates are higher under the NSA regime. This move, therefore, creates new financial disincentives to take up work, up to earnings at about two-thirds of the average wage for singles and average wage for couples.¹²

Figure 4.8 also presents a hypothetical scenario, in which DSP rules for earnings disregards (higher free zones and lower taper rates) are applied to NSA recipients. In this case, average effective tax rates for people with partially-reduced work capacity on NSA would deviate much less from before and financial barriers to take up part-time or low-wage work would not increase very much.

Careful design and fine-tuning of regulations on earnings disregards is therefore needed. For persons and households on benefits which do not already have some earnings, lowering withdrawal rates and increasing “free earnings” zones might have to be considered.

Figure 4.8. Australia: moving from DSP to NSA increases work disincentives for lower-earning singles and inactive couples

Average effective tax rates for people with partially-reduced work capacity in Australia under three scenarios: former full disability benefit (DSP), new benefit (NSA) and new benefit with former earnings disregards^{a, b}



a) Average effective tax rate (AETR) is the percentage of earnings that is taxed away via increased taxes and reduced benefits when taking up work. Take up of work at 33-133% of average wage (AW). The person is assumed to be on benefit after having worked at 100% of AW.

b) The figures apply 2006/07 rules to 2005 data. Includes pharmaceutical and telephone allowance but not mobility allowance. NSA and DSP rules for earnings disregards and withdrawal rates as in Table 4.5.

Source: Special module of OECD tax-benefit model. Information provided by national authorities.

B. Luxembourg

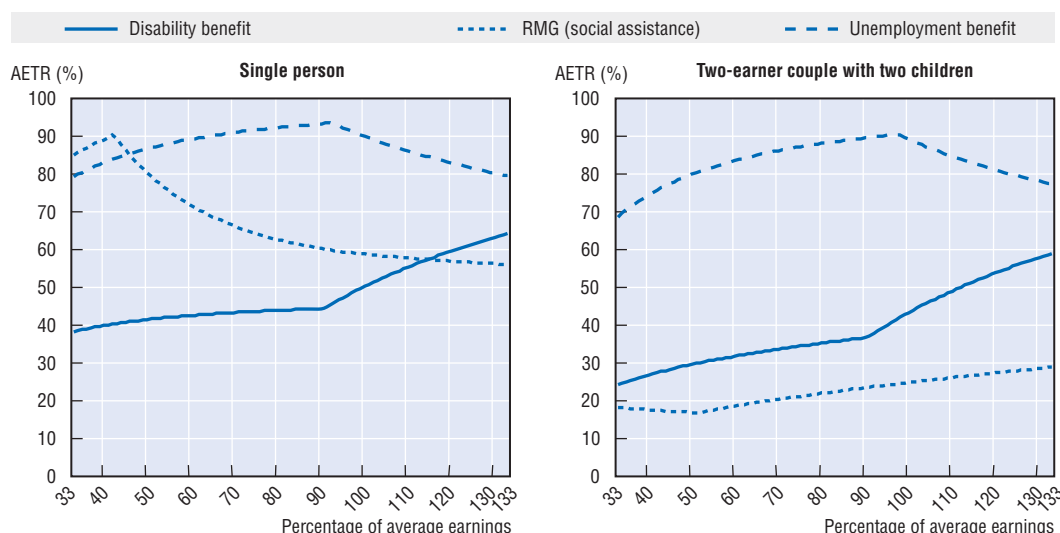
In the course of the new redeployment procedure, persons with partially-reduced work capacity in Luxembourg who cannot be redeployed within their former firm are registered as unemployed and entitled to unemployment benefits as well as labour market programmes (external redeployment). At expiration of unemployment benefit after one year, the person is entitled to a waiting allowance, paid at the level of a regular disability benefit.

When being on unemployment benefit, however, taking up paid work is connected with much higher effective tax rates than when being on disability benefit. A single person and former average earner on disability benefit who takes up work between one-third and 100% of the average wage loses EUR 4-5 for a gain in gross earnings of EUR 10. The same person on unemployment benefit loses EUR 8-9 (Figure 4.9). The difference is even higher for persons with disability living with a partner and children, as the unemployment benefit in Luxembourg has a top-up for dependent children.

In this respect, the situation in Luxembourg for people with partial work capacities resembles the one in Australia: they face higher effective tax rates when being on unemployment rolls and taking up work at certain levels. However, while in Australia this increased effective taxation is mainly due to lower earnings disregards and higher withdrawal rates under unemployment, in Luxembourg these are only one part of the explanation. The other reason is the higher rate of unemployment benefit during the first year.¹³

Figure 4.9. Luxembourg: being on unemployment rather than disability benefit can imply doubling of average effective taxation when taking up work

Average effective tax rates for persons on disability and unemployment benefit and social assistance, Luxembourg, 2005^a



a) Average effective tax rate (AETR) is the percentage of earnings that is taxed away via increased taxes and reduced benefits when taking up work. Take up of work at between 33-133% of average wage (AW). Second earner in the two-earner couple assumed to work at 67% of AW, children aged four and six.

Source: Special module of OECD tax-benefit model. Information provided by national authorities.

After one year, unemployment benefit payments stop and an unemployed person is entitled to social assistance (RMG), as there is no unemployment assistance scheme in Luxembourg. AETRs of single social assistance beneficiaries are also very high at the lower-earnings range because social assistance is phased out much quicker when taking up work. AETRs for persons with disability living with active partners and without access to either unemployment or disability benefit are lower because the earnings of the partner (assumed here at two-thirds of average wage) are incompatible with social assistance eligibility.

These results underline the importance of availability of in-work benefits for those persons with disability who move from unemployment rolls into work and become externally redeployed – the compensatory benefits which cover the earnings difference between the new and the old job (up to five times the social minimum wage) are designed to fulfil this role. The results also suggest that the relatively high net replacement level of unemployment benefits may penalise work efforts which could contribute to explaining the relative failure of the redeployment process in Luxembourg to date.

C. Spain

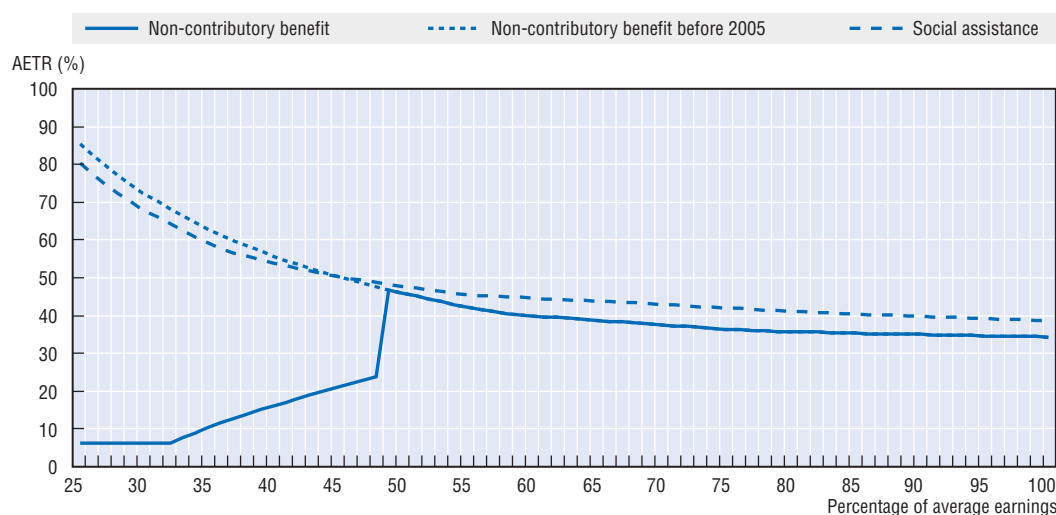
While there are a number of parametric reforms to the contributory disability benefit formula under discussion, none of these has so far been implemented. Discussions concern possible reductions in the insurance period for younger ages; extension of minima for younger age groups; equivalency of the calculation procedure with that of retirement; and a new system of calculation of the disability complements in order to improve the lowest benefits. More generally, an “Agreement on Social Security” reached, in July 2006, between the government and social partners is expected to lead to an overall reform of invalidity and other working-age benefits.

At the same time, important changes were recently made to earnings conditions for people on *non-contributory* disability benefit. This scheme has been established in 1990 as a pure subsistence scheme for uncovered persons with disability. Until 1997, take up of work for these people meant automatic loss of eligibility to this benefit. In that year, unlimited linking rules were introduced and the persons concerned had a right to return to the benefit once they stopped working. Finally, in 2005 disregards were introduced, allowing the combination of benefits with earnings up to the level of the benefit indicator IPREM¹⁴ (about EUR 6 600 per year), and at a reduced rate up to 1.5 times this indicator level.

This change led to a consequent fall in average effective tax rates in the lower earnings range as shown in Figure 4.10. When taking up work up to one-third the average wage, non-contributory beneficiaries now lose less than EUR 1 on every EUR 10 gross earnings gain, while it was EUR 7-9 prior to the reform (working for a marginal amount was even penalising). When increasing work from one-third to half the average wage, average effective taxation increases to about 20% but still remains considerably lower than the 50-70% AETRs before the reform.

Figure 4.10. Spain: reform of non-contributory benefits significantly increased work incentives in the lower earnings range

Average effective tax rates for a single person on non-contributory benefits, 2005^{a, b}



a) Average effective tax rate (AETR) is the percentage of earnings that is taxed away via increased taxes and reduced benefits when taking up work. Take up of work at between 25-100% of average wage (AW).

b) The figures apply pre- and post-2005 rules to 2005 data.

Source: Special module of OECD tax-benefit model. Information provided by national authorities.

This new regulation has increased work incentives at low income levels considerably. For it to be more effective in increasing employment, the new rules need to be advertised to a much larger extent. Currently, of the 200 000 people on non-contributory disability benefits, only 2.5% are taking advantage of the new earnings disregard (information provided by IMSERSO). Moreover, an increase of the earnings disregard, as well as extending the period of possible accumulation with benefits would further increase the motivating effects of this measure. In case of permanent disability, the possibility of accumulating benefits with a certain amount of earnings could be given on a permanent basis.

D. United Kingdom

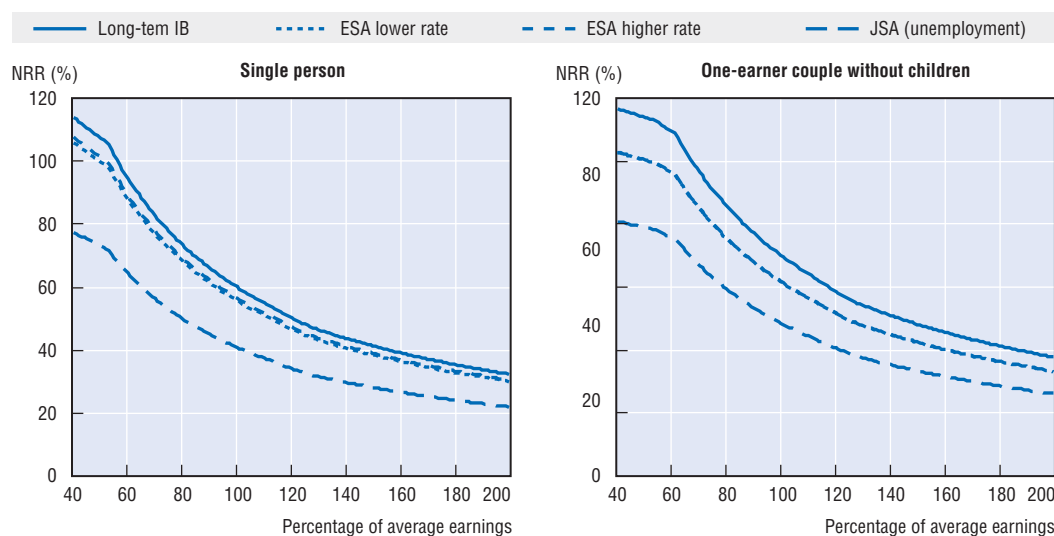
A number of structural reforms have been undertaken in the past years. On the tax/benefit side, these efforts have been supported by the availability of a disability element and a severe disability element to the basic rate of the Working Tax Credit (WTC), as well as the introduction of an additional Return to Work Credit (RTWC). It has been estimated that, without the disability elements of WTC, one-tenth of disability beneficiaries taking up part-time work at minimum wage would lose out significantly but this falls to 3% when these elements are considered, and 0% if RTWC is available in addition (Blackman, 2006). However, take-up of the disability elements of WTC is low.

A major benefit reform is in preparation which will replace the current disability benefit including supplements by a new Employment and Support Allowance (ESA). This will also replace current disability premia to social assistance (income support), but not Disability Living Allowance. ESA will consist of a basic rate which equals the current unemployment benefit (GBP 56.20 a week in 2005) complemented by an Employment Component for persons with partially-reduced work capacity which rewards those people who take steps to make a return to work.

In the following, the OECD model is extended to look at possible effects of such a benefit change on net replacement and average effective tax rates. Two scenarios for the level of the employment component are considered: GBP 20 and GBP 30, so that the assumed levels of total ESA amount to GBP 76.20 and GBP 86.20, respectively, a range often put forward in policy debates (e.g. Blackman, 2006). It can be seen from Figure 4.11 that both levels of ESA result in net replacement rates relatively close to those obtained from long-term incapacity benefit, more so for singles than one-earner couples. Further, the

Figure 4.11. United Kingdom: net replacement income from new Employment and Support Allowance is likely to be similar to incapacity benefit

Net replacement rates for incapacity benefit, possible Employment and Support Allowance (low and high hypothesis) and unemployment benefit, 2005^{a, b}



- a) Net replacement rates: ratio of household net income after becoming inactive and receiving disability benefit or unemployment benefit or social assistance to household net income when earning 40-200% of average earnings. Estimates refer to a 40-year-old person with an earnings history of 22 years at average earnings
- b) Includes Disability Living Allowance for persons on IB or ESA.

Source: Special module of OECD tax-benefit model. Information provided by national authorities.

differences between the lower and higher ESA rate in terms of net replacement are often negligible: 1-2 percentage points for single persons, and nil for one-earner couples. This has to do with the interaction with other benefits; in particular, housing benefits and the (standard) top-up to social assistance may lead to identical replacement rates.

The effects of a possible introduction of the Employment and Support Allowance on financial incentives to work are clear-cut: average effective tax rates are slightly lower – around 1-3 percentage points for singles, and around 5-8 percentage points for one-earner couples, across the whole earnings range considered, i.e. taking up work becomes slightly more attractive (Figure 4.12). Interestingly, the higher assumed ESA rate does not entail higher effective tax rates.

Figure 4.12. United Kingdom: taking up work becomes slightly more attractive with the new Employment and Support Allowance

Average effective tax rates for incapacity benefit and a possible Employment and Support Allowance (low and high hypothesis) and unemployment benefit, 2005^{a, b}



a) Average effective tax rate: percentage of earnings that is taxed away via increased taxes and reduced benefits when taking up work. Take-up of work at between 33-133% of average earnings (AW). Estimates refer to a 40-year-old person with an earnings history of 22 years at average earnings.

b) It is assumed that (IB and ESA) beneficiaries keep their Disability Living Allowance upon moving into work.

Source: Special module of OECD tax-benefit model. Information provided by national authorities.

Nonetheless, average effective tax rates in the United Kingdom for ESA recipients would remain at a comparatively high level. Former average earners would still lose more than 70% of their gains when entering work, except if they earn more than before or if they earn between 40 and 50% of average wages in order to benefit from the tax credits. Even in those cases, more than half of additional gross earnings are taxed away.

4.5. Conclusions

Taxes and benefits determine the adequacy of public net transfers provided to people with disability but also the financial awards for those who take up work, in particular those with partial work capacities. Across main disability benefit regimes, net replacement rates are lower in Australia and the United Kingdom than in Luxembourg and Spain: for single former average earners they amount to some 40 to 50% in the former two countries, and to

65 to 75% in the latter. However, under certain circumstances and conditions, top-up payments can significantly increase the net replacement rate: this is the case for persons with disability who receive a supplement for daily living expenses (DLA in the United Kingdom), for advanced age (Luxembourg and Spain), for dependent spouses (Spain and the United Kingdom) and those with children.

In the short run, i.e. upon leaving the labour market, disability benefits appear to be only slightly more “attractive” than unemployment benefits in the two English speaking countries and in the higher-incomes part in Spain (above average earnings) and Luxembourg (above twice average earnings). However, disability benefits are expected to provide a much more “permanent” source of replacement income than unemployment benefits.

Even when account is taken for the ageing of populations, disability benefits are heavily biased toward elder population groups and often used as a pathway into early retirement. This is particularly the case in Spain and even more so in Luxembourg. In Spain, this has partly to do with a significant age top-up to the disability benefit from the age of 56 which is combined with an inactivity condition. In Luxembourg, a widespread and established “early retirement culture” leads to a take-up of disability benefit after age 50 which is ten times higher than that of the formal early retirement benefit.

The step to paid work can be costly for a person with a disability (“inactivity trap”), as can be the decision to increase working hours or earnings (“low-wage trap”). Depending on the country, between 40% and 65% of the gains in gross earnings are taxed away when taking up full-time work at either minimum or average earnings. The inactivity trap appears to be more of an issue in the United Kingdom, despite availability of in-work benefits: people who formerly earned the average wage returning to part-time (or lower wage) jobs face effective tax rates of 70% to 80%. In all four countries, marginal effective tax rates can increase significantly depending on the (additional) work efforts a person with a disability is undertaking.

Recent and planned policy reforms have only partly responded to these concerns, if at all. More consideration is needed, in three areas. First, current regulations for combining disability benefit with earnings need to be redesigned and adapted to the new employment integration focus. In some cases, the amount of permitted earnings simply seems too low to make work in excess of marginal work attractive (Australia, United Kingdom). In other cases, take up of otherwise carefully designed regulations needs to be promoted (non-contributory benefit in Spain).

Second, benefits paid conditional to employment may prove a powerful tool to increase work incentives but need to be extended or implemented. There are again problems of coverage and take-up (Mobility Allowance in Australia, compensatory allowance for externally redeployed workers in Luxembourg). There are also problems of design where tax credits to take up work concern only a small part of the possible earnings range (United Kingdom). No such payments or allowances exist specifically for persons with disability in Spain.

Third, a better co-ordination of the different benefit schemes is needed. The fact that the recent move of people with partial work capacities from disability to unemployment benefit in Australia leads to higher marginal tax rates needs to be given careful attention. Age specific top-ups to contributory disability benefit (Spain) and early retirement cultures (Luxembourg) which lead to withdrawal from the labour market need to be reconsidered.

Notes

1. The lower average figures for Australia and the United Kingdom are explained by the characteristics of these schemes. For persons with disability in the lowest two income deciles in Australia, for instance, public transfers constitute some 70% of total income.
2. This general conclusion refers to the overall impact of these benefits among the total working-age population in 2000 (Förster and Mira d'Ercole, 2005).
3. In 2005, 41% of all disability benefit recipients in the United Kingdom also received DLA, and the large majority of all DLA recipients received a disability benefit. The models assumes that they receive the lower-rate mobility component and the middle-rate care component of DLA, because this is the single most frequent DLA case (concerning 17% of all DLA recipients in 2005). DLA rates range from GBP 15.6 to GBP 99.9 a week in 2005. With higher or lower DLA entitlements, results could look quite different. Finally, further down in the chapter it is assumed that, upon moving into work, long-term disability benefit recipients keep their DLA entitlement.
4. Note that unemployment benefit too has age-specific regulations in Spain in that unemployed persons aged 52 and above are eligible for unlimited benefit duration. This does, however, not change the level of the benefit and, thus, the net replacement rate.
5. The possibility to retire at age 55 in Australia refers to mandatory occupational pensions (through the superannuation scheme), while age 57 in Luxembourg requires 40 years of actual contributions.
6. These two earnings groups are considered “typical” and thus most relevant for policy considerations. For the United Kingdom, there is some evidence that the majority of those moving from disability rolls into work earn around the minimum wage (Blackman, 2006). Note that in earnings-related benefit systems (Luxembourg, Spain), assuming lower past earnings will lead to lower disability benefits. On the other hand, in the United Kingdom, work incentive indicators will be influenced by the fact that lower limits for working tax credits are specified in terms of *hours* (13 and 30, respectively) rather than earnings levels while upper limits are expressed in terms of income. Therefore, tax credits predominantly cover lower-wage earners.
7. The Australian Disability Support Pension is completely phased out at the level of 67% of AW and rent allowance at 79% of AW.
8. For the United Kingdom, the model assumes full take-up of both the basic and the disability element of Working Tax Credit (WTC) and of RTWC (Return to Work Credit) as well.
9. METRs in this case are equally high for other household constellations, between 70% (two-earner couples) and 95% (one-earner couple with children).
10. It is commonly believed that elasticities are much higher at the extensive margin (the decision whether to work at all or not) than at the intensive margin (once working, whether to increase or decrease hours). Therefore, there is a good theoretic case for structuring income tests to encourage people at the margins of the labour market to take some work.
11. For that, the OECD tax-benefit models for the benchmark year 2005 have been modified to take account of (possible) reforms. The resulting indicators therefore reflect 2005 values under reform assumptions.
12. However, it is worth noting that the situation can be inverse, namely in the case of persons with disability living with partners who are working (assuming that the spouse works at two-thirds of the average wage). In that case, AETRs under the Australian NSA regime are actually lower. This is because earnings disregards are counted at the household level.
13. For a single former average earner in Luxembourg with a full employment record, the gross unemployment benefit amounts to EUR 33 708 and the disability benefit to EUR 25 810 (the net values are EUR 26 413 and EUR 22 537, respectively).
14. IPREM (*Indicador Público de Renta de Efectos Múltiples*) is the reference indicator to determine different social benefit amounts in Spain. It is approved each year in the Law of General Budgets of the State and corresponded to 32% of the average wage in 2005.

ANNEX 4.A1

Background Tables for Different Household Types

Income positions when persons are in work and when they are out of work are strongly influenced by the level and design of taxation and available benefits and their interaction with personal and household incomes. The analysis in Chapter 4 is based on estimations from an additional module to the OECD tax-benefit model (OECD, 2005b), for different groups of people with disability: those living alone, those living with inactive spouses and those living with working spouses (with and without children for all three constellations).

Table 4.A1.1 summarises the main features of the three countries' disability benefit systems, their taxation and the rules for combining benefits with labour earnings.* Figure 4.A1.1 complements the results for single persons shown in Figure 4.1, with estimates on net replacement rates for disability benefits, unemployment benefits and social assistance for two other household types: a person with a disability living with an inactive spouse and one living with a lower-wage earning spouse and two children. Figure 4.A1.2 presents average effective tax rates for different household types.

It should be noted that the incentive indicators presented in Chapter 4 do not take into account a range of disability-related monetary and non-monetary policy instruments to support living expenses which are available in all four countries. This concerns, in particular, allowances or vouchers for public transport and preferential prices for special equipment. The system of indirect support measures is perhaps most generalised in Australia where all disability beneficiaries receive a "pensioner concession card" which entitles them to a number of benefits, such as reductions in property and water rates, reductions in energy bills, reduced fares on public transport or reductions on motor vehicle registration. This concession card is linked to the benefit status while in the United Kingdom the Disability Living Allowance, which fulfils a similar purpose, is not discontinued should a person with a disability get off benefit rolls.

* A detailed description of the country-specific parameters of the disability systems that have been used for the models is available at www.oecd.org/els/disability.

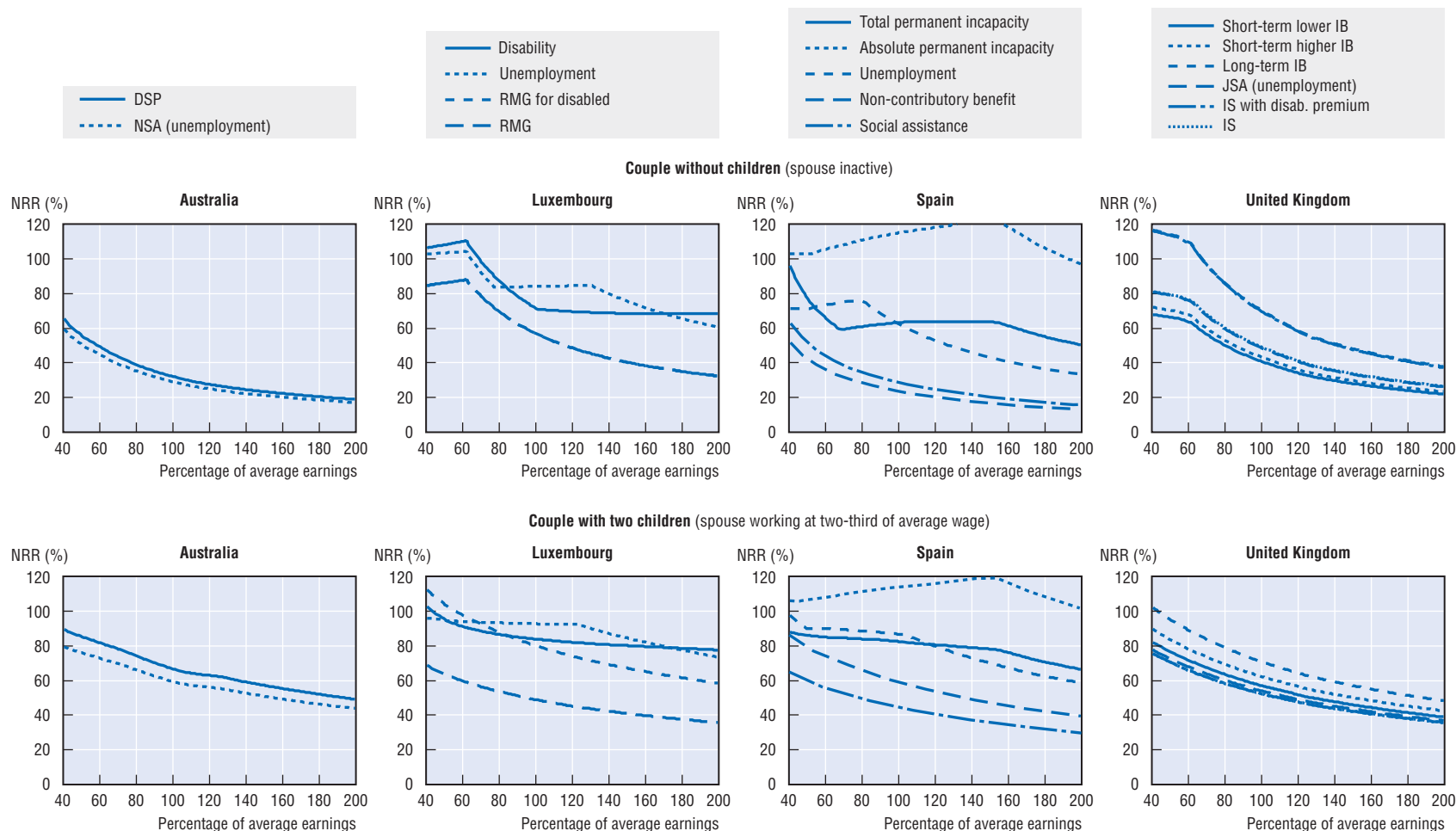
Table 4.A1.1. **Main characteristics of disability benefit and taxation systems, as at 1st July 2005**

	Australia	Luxembourg	Spain	United Kingdom
<i>Benefit schemes (covered in model)</i>	1. DSP (disability support pension): universal flat-rate benefit, means and asset-tested unless blind.	1. Contributory DB for employees and self-employed; benefits depending on the duration of the affiliation (flat-rate) and on contributions (earnings-related). 2. Special minimum income scheme for severely disabled persons (revenu pour personnes gravement handicapées).	Four types of contributory DB in case of permanent incapacity: 1a. Partial permanent incapacity for the usual occupation: lump sum. 1b. Total permanent incapacity for the usual occupation: 55% of calculation basis (75% if over 55 and out of work). 1c. Absolute permanent incapacity: 100% of calculation basis. 1d. Severe incapacity: 150% of calculation basis. 2. Non-contributory flat-rate benefit: EUR 4 043.06/year for 65% disability; EUR 6 064.59/year for 75% disability.	Two types of contributory incapacity benefit (IB) for those not or no longer eligible to statutory sick pay: 1aa. Short-term IB, lower rate: GBP 55.90/week (first 28 weeks). 1ab. Short-term IB, higher rate: GBP 66.15/week (weeks 29-52); eligibility subject to personal capability assessment. 1b. Long-term IB: GBP 74.15/week after week 52 2. Income Support (IS) including premia for low-income people not eligible for IB, or as a top-up to IB.
<i>Benefit formula</i>	Single, 21 or older: AUD 476.30/fortnight; Couple: AUD 397.70/fortnight each.	Flat-rate part: EUR 344.75 per month for 40 years insurance; income-related part: 1.85% of total wage. Special RMG: same rates as RMG but not means-tested	DB paid monthly 14 times/year. Calculation basis is the quotient resulting from dividing the bases of contribution during the 96 months prior to the one in which the event occurs by 112. Bases corresponding to the 24 months prior to the event are calculated at their value, the remaining are updated with the CPI.	1. Flat rate amounts (see above). 2. Amounts until resources reach "applicable amount" which includes premia in case of disability, severe disability or enhanced disability.
<i>Minima and maxima</i>	– Flat rate, no minimum. – Flat rate, no maximum.	– Minimum: 90% of the reference amount (EUR 1 320). If insured does not qualify for full DB, reduced proportionately. – Maximum: of five times the reference amount (EUR 6 111).	– Minima: EUR 438 (EUR 524 with spouse) for absolute incapacity; EUR 658 (EUR 786 with spouse) for severe incapacity. – Maximum DB: EUR 2 159.12.	– Flat rate, no minimum. – Flat rate, no maximum.
<i>Special supplements (covered)</i>	– Pharmaceutical allowance: Single AUD 5.80/fortnight; Couple: AUD 2.90/fortnight each. – Telephone allowance: AUD 19.80 per quarter. – Mobility allowance if undertaking paid or voluntary work or vocational training for 32 hours every four weeks: AUD 69.40/fortnight. – Rent assistance, depending on rent paid and family situation.	– Flat-rate age supplements of 1/40 for each year between commencement and age 65. – Income-related age supplement for each year from commencement until age 55 (1.85% of salary). – End-of-year allowance of EUR 564 (in case of a complete career; otherwise proportional reduction).	Only in case of minimum DB: for dependent spouses.	– Child increase (long-term IB): GBP 9.55 for 1st child, GBP 11.35 for each additional child. – Adult dependency increase: GBP 34.60 (short-term IB), GBP 44.35 (long-term IB). – Disability Living Allowance (DLA): three rates for care needs (GBP 15.55/39.35/58.80); two rates for mobility needs (GBP 15.55/41.05). Model uses GBP 39.35 + 15.55. – Age supplements: GBP 15.55 (GBP 7.80) if incapacity began before age 35 (age 35-44).
<i>Graduation of benefits</i>	No graduation. Minimum condition for receipt is being unable to work for 15 or more hours.	No graduation.	Minimum condition for receipt of DB is 33% incapacity. Degree of severity determines DB amount.	No graduation.
<i>Benefit schemes (not covered)</i>			1a and 1d above are not modeled.	

Table 4.A1.1. **Main characteristics of disability benefit and taxation systems, as at 1st July 2005 (cont.)**

	Australia	Luxembourg	Spain	United Kingdom
<i>Special supplements (not covered)</i>	– Concessional prices for services linked to Pensioner Concession Card. – Pensioner education supplement. – Remote Area Allowance. – Eligibility for maximum rate of child care benefit.	– Six days additional holidays for disabled workers. – Mobility allowance for job seekers.	Various subsidies and tax reductions (<i>e.g.</i> vehicle tax and water/electricity/gas tariffs).	– Help towards cost of equipment; VAT relief. – Vouchers for public transport. – Council tax reductions. – IS recipients are exempt from prescription charges.
<i>Taxation of benefits</i>	Not taxed (except if at pension age).	General taxation rules, no special relief for benefits.	Partial and total incapacity DB is taxed; absolute and severe incapacity DB is not taxed.	Lower-rate short-term IB not taxed; higher-rate short-term IB and long-term IB are subject to normal taxation; IS not taxed; DLA neither taxed nor means-tested.
<i>Social security contributions</i>	None.	Contributions for health care and long-term care insurance.	No contributions on incapacity benefits.	No contributions on incapacity benefits.
<i>Accumulation of benefits with earnings</i>	Income test: fortnightly income over below amounts reduces the DSP rate by AUD 0.40 for every dollar (single person) or by AUD 0.20 for every dollar (each partner). Figures in brackets: income level at which pension ceases to be paid: – Single: AUD 20.00 (AUD 1 266.50) – Single + 1 child: AUD 144.60 (AUD 1 291.10) – Couple (combined) : AUD 212.00 (AUD 2 116.50) – Additional children: Add AUD 24.60 per child	– Earnings may be cumulated with DB up to a ceiling comprising the average of the five highest annual salaries during the period of insurance. DB is reduced by the amount of income exceeding this ceiling.	– No limit. For total permanent incapacity: working in another occupation allowed. – For non-contributory beneficiary (> 65% disabled) total earnings up to IPREM (EUR 469.8 in 2005) up to four years. Pension reduced by 50% of exceeding amount for earnings up to highest limit: 1.5 times IPREM.	– Under permitted work rules up to GBP 81/week (1.1.2006) or GBP 86 (1.10.2006), when working less than 16 hours, for one year. – Up to GBP 20/week indefinitely.
<i>Tax credits</i>	– Employment Entry Payment: one-off payment of AUD 312 if earnings disqualify from payment. – Low-Income Tax Offset.			– Working Tax Credit: basic element GBP 30.17, second adult element GBP 29.68, disability supplement GBP 40.32, severe disability supplement GBP 17.08. Need to work at least 16 hours/week. – Return to Work Credit: GBP 40/week, payable for 52 weeks provided earnings are below GBP 15 000/year and works 16 hours/week.
<i>Return-to-benefit (linking rules)</i>	Two years for grandfathered beneficiaries, except if they undergo a new assessment.		Four years for non-contributory beneficiaries.	Eight weeks for lower-rate short-term IB; 104 weeks for higher-rate and long-term IB.
<i>Combination with other benefits</i>	Only possible in conjunction with family benefits.	With injury pension up to ceiling (average of five highest annual earnings, or earnings on which injury pension is based).	No combination with other benefits and pensions except widow's pensions.	IB unaffected by DLA, Attendance Allowance, basic war or industrial injuries disablement pension.

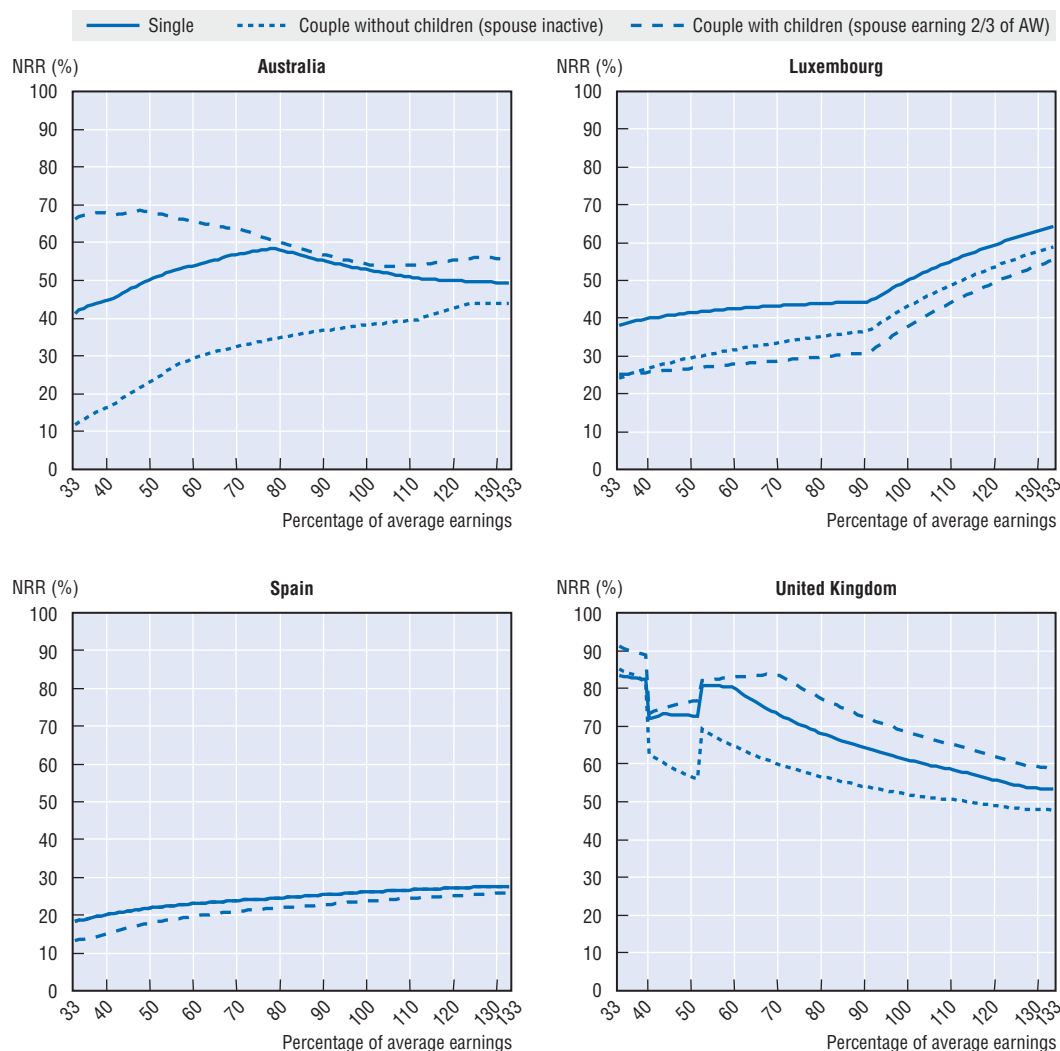
Source: OECD (2005b), MISSOC, MISSCEO and information provided by national authorities.

Figure 4.A1.1. **Net replacement rates for disability benefits, unemployment benefits and social assistance, couple households, 2005^a**

a) Net replacement rates: ratio of household net income after becoming inactive and receiving disability benefit or unemployment benefit or social assistance to household net income when earning 40-200% of average earnings. Estimates refer to a 40-year-old person with an earnings history of 22 years at average earnings. Percentage of average earnings refers to pre-disability earnings of the first earner.

Source: Special module of OECD tax-benefit model. Information provided by national authorities.

Figure 4.A1.2. **Average effective tax rates for persons with disability in different household situations, 2005^a**



a) Average effective tax rate: percentage of earnings that is taxed away via increased taxes and reduced benefits when taking up work. Take-up of work at 33-133% of average earnings (AW). Estimates refer to a 40-year-old person with an earnings history of 22 years at average earnings. Disability schemes considered: DSP (Australia), disability pension (Luxembourg), total permanent incapacity benefit (Spain), long-term incapacity benefit (United Kingdom).

Source: Special module of OECD tax-benefit model. Information provided by national authorities.

Chapter 5

Employment Policy – New Challenges and Directions

Employment rates of people with disability are far below those of persons without disability. Partly this is because severe health impairments prevent people from working. However, there are many other factors including a lack of appropriate skills, discrimination, weak incentives to look for work and accept a job offer, and ineffective re-integration measures. Anti-discrimination legislation (Australia, United Kingdom), employment quotas (Luxembourg, Spain) and other forms of employer responsibilities and supports have proven to be insufficient. Measures to improve the employability of people with reduced work capacity and to help those workers stay in and find employment are needed.

Spain and Luxembourg have only just started to acknowledge the need for such change. Australia and the United Kingdom have recently made big steps away from what used to be extremely passive benefit systems, and they are both setting new standards in outcome-based funding of services, individual case management and streamlined service delivery. Yet, overall investments in these areas are still lagging behind and, despite very welcome advances in the United Kingdom, there is a general lack of rigorous evaluation and cost-benefit analysis of employment programmes. To improve the situation, a range of steps have been taken recently in all countries with the aim to raise the involvement and responsibilities of the main actors: workers with disability, their employers and the public authorities supporting them.

In all countries, employment rates of people with a disability are low. This is disappointing because work has been found to be good for people's health and re-entering work associated with improvements in income, socio-economic status and well-being. Higher employment rates of people with reduced work capacity are also vital to boost economic growth and to lower public spending. This chapter focuses on how employment rates could be increased.

The chapter starts by describing employment and education characteristics of people with disability, and the extent to which they differ from those of people without disability. Section 5.2 considers suitable activation measures for people with reduced work capacity in relation to their needs and skill levels. It compares available support measures across countries, the possibilities to access them and their success in helping people with health problems back to work. Section 5.3 examines the new balance between rights and responsibilities for various actors the four countries are aiming to achieve: the role of public authorities, with a focus on the timing of intervention, obligations to provide special services and new funding concepts; the rights and responsibilities of people with disability themselves and of benefit recipients in particular; and the responsibilities of and support for employers, also in terms of anti-discrimination legislation and employment quotas.

5.1. Employment and disability: where do we stand?

In all four countries, employment rates of (self-assessed) persons with disability are substantially below those of persons without disability (Chapter 1 and Table 5.1). The gap is almost 40 percentage points in Australia, Spain and the United Kingdom, but much lower in Luxembourg. Unemployment rates are also higher for people with disability everywhere. In this case, the gap is around 4 percentage points in Australia, Luxembourg and the United Kingdom, and 8 percentage points in Spain. Spain also has the highest unemployment level, for people with and without disability.

Table 5.1 also compares employment characteristics. Some differences are worth highlighting, such as the higher incidence of part-time employment of workers with disability in Australia and the United Kingdom (one-third and one-quarter of all workers with disability, respectively), both compared to Luxembourg and Spain and compared to people without disability in Australia and the United Kingdom. The low share of part-time work of people with disability in Spain and Luxembourg suggests room for further improvement in employment rates of this group in line with increasing acceptance of part-time employment.¹

In all countries, persons with disability do not appear to be overrepresented in temporary jobs. In Spain, however, the lack of any difference in the incidence of temporary employment between people with and without disability is partly a result of different age structures among these two groups. In fact, in each age group workers with disability are more likely to be employed on temporary contracts.

Table 5.1. Employment characteristics of people with disability are different from those of people without disability

Employment structures and characteristics, by age and disability status, percentages, latest available year^a

	Australia				Luxembourg				Spain				United Kingdom			
	20-34	35-49	50-64	Total	20-34	35-49	50-64	Total	20-34	35-49	50-64	Total	20-34	35-49	50-64	Total
Employment (% of population)																
Disabled	50	49	32	40	58	70	32	50	46	46	24	35	49	53	39	45
Non-disabled	80	84	72	79	69	80	53	70	70	74	54	68	79	88	76	81
Unemployment (% of labour force)																
Disabled	13	7	5	8	9	8	6	7	27	15	14	18	11	8	5	7
Non-disabled	6	3	3	4	6	3	1	4	13	9	7	11	6	3	3	4
Public sector employment																
Disabled	14	22	16	18	..	..	..	..	10	25	23	20	21	31	28	28
Non-disabled	16	22	20	19	..	..	..	..	11	26	26	19	20	28	29	25
Part-time employment ^b																
Disabled	34	28	37	33	8	16	11	13	10	9	10	10	27	25	30	27
Non-disabled	21	20	21	21	10	15	12	13	9	7	6	7	18	20	23	20
Temporary employment																
Disabled	10	10	8	9	4	2	0	2	48	30	19	31	5	4	6	5
Non-disabled	9	8	10	9	7	2	2	4	44	23	14	31	7	4	4	5
Casual employment ^c																
Disabled	36	23	43	33	..	..	..	..	..	..	..	..	..	..	..	..
Non-disabled	28	19	25	24	..	..	..	..	..	..	..	..	..	..	..	..
Self-employed ^d																
Disabled	9	19	23	19	4	3	9	5	6	19	31	21	9	13	18	15
Non-disabled	8	16	19	14	4	9	11	8	10	20	29	17	8	14	17	13
Share by industry																
Agriculture																
Disabled	2	7	7	6	2	2	4	3	7	8	14	10	1	1	1	1
Non-disabled	3	4	5	4	1	3	3	2	4	6	9	6	1	1	1	1
Industry																
Disabled	23	20	21	21	30	30	44	34	34	30	28	30	17	20	22	20
Non-disabled	22	23	22	22	17	20	20	19	33	29	31	31	21	24	23	23
Services																
Disabled	75	74	73	74	68	68	52	63	59	62	58	60	82	79	77	78
Non-disabled	76	73	72	74	82	78	77	79	62	65	59	63	78	75	76	76
Hiring rate ^e																
Disabled	32	17	17	22	16	8	..	7	34	19	9	18	29	14	16	16
Non-disabled	31	17	9	21	17	9	6	12	31	14	7	19	27	10	28	20
Job retention rate ^f																
Disabled	21	53	55	43	50	81	93	77	25	60	79	59	30	58	53	54
Non-disabled	24	51	68	43	39	72	85	60	26	66	82	52	31	70	26	47

a) Employment and unemployment for Luxembourg and Spain refers to 2004, employment characteristics to 2002.

b) Part-time work is defined as less than 30 hours per week.

c) Share of casual employees using the ABS definition (i.e. people without paid sick leave or holiday leave).

d) In Australia, it includes own account workers, employers and contributing family workers.

e) The hiring rate is calculated as the share of employees with tenure less than one year.

f) Job retention rate is defined as the share of employees with tenure with the same employer for five years or longer.

Source: OECD calculations based on national surveys: SDAC 2003 for Australia, except for temporary, casual employment and hiring and retention rates from HILDA 2007 (Wave 5); EULFS 2002 for Luxembourg and Spain, except for employment and unemployment rates from EU-SILC 2004, and LFS 2006 for the United Kingdom; for hiring and retention rates in Luxembourg, Spain and the United Kingdom, EULFS (2002) *ad hoc* module on disabled persons.

Similarly, people with disability are over-represented among casual workers in Australia.² One-third of all workers with disability are holding casual contracts compared to one-quarter of their peers without disability; especially large differences are found in the age group 50-64. Casual workers tend to work in lower-skilled occupations and in industries with substantial fluctuations in demand over the year, *e.g.* service sectors such as accommodation or cafes and restaurants (ABS, 2006). There is also a strong correlation in Australia between casual work and part-time work.

The high incidence of casual and temporary employment contracts in Australia and Spain is probably one reason for the higher hiring rates in these two countries. Hiring rates of people with disability are relatively lower in the United Kingdom and in particular in Luxembourg, where rates are almost half of those of people without disability. On the other hand, job retention rates of five years or more (as well as average job tenure) are higher for people with disability in all countries. Partly, this is a reflection of the lower likelihood to switch to a new job – as indicated by the lower hiring rates. However, the higher job tenure of workers with disability is also a result of a selection effect: those with shorter tenure are probably more likely to lose their job in case of health problems.

Differences by industry are only observable in Luxembourg, where workers with disability are strongly overrepresented in the industry sector, and in Spain, where they are overrepresented in the agricultural sector. Moreover, contrary to earlier findings (OECD, 2006b), in these four countries workers with disability seem to be equally represented in the public and the private sector.

In conclusion, therefore, differences between workers with and without disability are much larger in terms of employment and unemployment rates than in terms of employment distributions and characteristics. Even among workers with insecure contracts (temporary workers in Spain and casual workers in Australia), workers with disability are only somewhat overrepresented. This makes tackling low rates of employment and high rates of unemployment even more important.

Poor overall labour market outcomes of people with disability are partly a result of their lower average skill levels. In all four countries, educational attainment is, on average, substantially lower among persons with disability, both in employment and if unemployed (Table 5.2). The share of persons with disability with a tertiary education level, for instance, is only one-half or one-third that of people with no disability, and the share having primary education is correspondingly much higher. Most worryingly, the education gap between people with and without disability is not closing for the younger age groups, but instead widening in all four countries.

Overall, education levels of people with disability compare best to those of inactive people without disability, the group with the lowest level of qualifications among all people without disability. In Spain and the United Kingdom, people with disability have even lower qualification levels than inactives without disability. Only in Luxembourg, unemployed people without disability have lower levels of qualification than inactives, with the educational distribution among people with disability being even worse. Employed people with disability are much better qualified though still lagging far behind employees without disability.

Research in the United Kingdom has demonstrated that, at the age of 16, educational aspirations of those with and without disability are very similar. Ten years later, at age 26, almost 70% of those without disability had reached their higher education goal, while the

Table 5.2. Qualification levels of people with disability are lagging far behind everywhere
Distribution (in percentage) of all people in each category by age, most recent years available^a

	Panel A. People with disability															
	Employed				Unemployed				Inactive				Total			
	20-34	35-49	50-64	Total	20-34	35-49	50-64	Total	20-34	35-49	50-64	Total	20-34	35-49	50-64	Total
Australia																
Less than upper secondary education	26	34	37	34	..	..	..	49	52	64	60	60	40	49	52	49
Upper secondary education	50	31	34	36	..	..	..	29	38	22	25	26	43	27	28	30
Tertiary	24	34	29	30	..	..	..	22	10	14	15	14	17	24	20	21
	100	100	100	100	..	..	..	100	100	100	100	100	100	100	100	100
Luxembourg																
Less than upper secondary education	40	43	46	43	100	64	53	69	56	57	70	66	44	48	62	55
Upper secondary education	46	43	41	43	0	36	47	31	44	40	28	31	45	42	32	37
Tertiary	14	14	13	14	0	0	0	0	0	3	3	3	11	10	6	8
	100	100	100	100	..	..	..	100	100	100	100	100	100	100	100	100
Spain																
Less than upper secondary education	57	63	82	69	68	77	87	77	76	82	90	86	68	75	89	81
Upper secondary education	22	17	8	15	16	13	10	13	15	11	5	8	18	14	6	10
Tertiary	22	20	10	16	16	9	4	10	10	7	5	6	15	12	6	9
	100	100	100	100	..	..	..	100	100	100	100	100	100	100	100	100
United Kingdom																
Less than upper secondary education	39	59	71	61	65	72	71	70	66	79	88	82	53	68	81	72
Upper secondary education	32	25	15	22	23	18	17	19	18	14	7	10	26	20	10	16
Tertiary	29	17	13	17	12	10	12	11	15	7	5	7	22	12	9	12
	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
	Panel B. People without disability															
	Employed				Unemployed				Inactive				Total			
	20-34	35-49	50-64	Total	20-34	35-49	50-64	Total	20-34	35-49	50-64	Total	20-34	35-49	50-64	Total
Australia																
Less than upper secondary education	17	27	34	24	..	..	..	41	31	47	55	44	21	30	40	28
Upper secondary education	46	35	31	39	..	..	..	35	44	28	24	32	46	34	29	37
Tertiary	36	38	35	37	..	..	..	23	25	25	21	23	34	36	31	34
	100	100	100	100	..	..	..	100	100	100	100	100	100	100	100	100
Luxembourg																
Less than upper secondary education	29	33	32	31	53	60	62	56	31	45	52	44	30	36	42	35
Upper secondary education	50	44	40	46	27	31	23	29	54	46	39	45	50	44	40	46
Tertiary	21	23	28	23	20	9	15	15	15	8	9	11	19	20	18	19
	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Spain																
Less than upper secondary education	41	50	68	50	43	65	84	55	30	73	86	62	39	55	76	53
Upper secondary education	24	21	11	20	24	19	10	21	46	16	8	24	29	20	10	21
Tertiary	36	30	21	30	33	16	6	24	24	11	6	14	33	25	14	26
	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
United Kingdom																
Less than upper secondary education	34	53	62	49	47	63	72	56	40	58	77	59	36	54	65	51
Upper secondary education	27	24	18	23	22	20	16	21	18	23	12	17	25	24	16	22
Tertiary	39	23	21	28	31	17	12	23	42	19	11	24	39	22	18	27
	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

a) In Australia, persons with disability are defined as those who have at least a mild restriction of their core activities. In the other countries, it is defined as persons with long-lasting health problems that limit their daily life activities.

Source: For Australia, ABS, Disability, Ageing and Carers Survey 2003; for Luxembourg and Spain, EULFS 2002 Special module on Disabled people; and for the United Kingdom, Labour Force Survey 2006.

corresponding share was only 56% for people with disability (Burchardt, 2005). In Australia, around one-fifth of all people with a disability attended school only for eight years or less, compared to one in twenty among people with no disability (Lattimore, 2007). These findings point to a lack of support for people with disability to access (higher) education. A lower education level, in particular among those people with disability, adds to the difficulty in staying in or finding work – a situation that, relatively speaking, has worsened in the past decade and may exacerbate further in the future, because of continuous technical progress and a falling demand for low-skilled jobs (FaCS, 2003).³

5.2. More and better targeted employment services

Recognising the difficulties people with health problems have in staying in, or returning to, the labour market, countries have put in place a number of employment support and rehabilitation programmes. The success of these, however, is modest, and in particular these measures have not been very successful in helping people on disability benefits back to the labour market. Today, with the exception of Spain, the number of people on disability benefits is two to three times larger than the number of people on unemployment benefits. And in all countries, the number of jobseekers with impaired health is growing. Significant efforts will be needed to achieve a real change in outcomes, including better tailoring to people's needs and skills and recognising their disadvantages in terms of qualification levels. This section first outlines the necessary elements of adequate support programmes before moving on to describe available measures and the resulting employment outcomes. It concludes with a discussion on the restricted access to employment support.

A. What support is suitable for people with disability

Proper activation measures require well-targeted assistance including individual vocational rehabilitation, training, and employment support. To achieve sustainable employment outcomes, both programmes and individuals have to meet the demands from employers, and measures need to be better tailored to help meet these labour market demands (Work Directions, 2006).

What has also proven important is a close contact between the jobseeker with a disability and the employment adviser. Preferably, the same adviser should work with the jobseeker throughout their contact. Outcomes also improve when advisers use a more proactive approach in their contacts with clients, also after a job has been found (Lewis *et al.*, 2005). In this respect, individual action plans are a good way of setting up goals and targets that can be followed up and modified if and when needed.

In general, programmes closely linked to the labour market, *e.g.* apprenticeship, wage subsidies or in-work benefits, tend to be more successful than general training measures. Martin and Grubb (2001) concluded that the most important factors for employment measures to be successful are the following four: i) the need for tight targeting on participants; ii) the need to keep the programmes relatively small in scale; iii) the need for programmes to result in a qualification or certificate that is recognised and valued by the market; and iv) the need to have a strong on-the-job component and to establish strong links with local employers.

Although these conclusions refer to activation measures for the “ordinary” unemployed, there is no reason why they would be less valid for jobseekers with impaired health or for

measures to help people on long-term sickness benefits to remain in the labour market. This is supported in OECD (2006d) which emphasises the scope to apply activation strategies to persons receiving income support other than unemployment benefits if appropriate modifications are made to account for the specific characteristics of each group of people.

B. What support is available for people with disability

The use of individualised support

The regional Public Employment Service (PES) in Spain has no special advisers for jobseekers with disability (but special hiring subsidies are available for jobseekers with a legal disability certificate). In Luxembourg, the central PES office has a small unit of caseworkers that deals with people with disability and each caseworker assists around 400 persons with disability per year. In both countries, caseloads for PES officers are high and they act on the principle of first-come first-served.

In the United Kingdom, all new disability benefit claimants have to attend an initial work-focused interview with an Incapacity Benefit Personal Adviser (IBPA) at their local Jobcentre Plus. Most claimants will continue with another five interviews with the same adviser at (roughly) monthly intervals. These advisers are work facilitators who discuss ways to identify and deal with personal work barriers and support the claimant through the whole phase to overcome these barriers. Because of their very low caseloads of around 35 clients, they are well aware of their clients' needs and problems. A personal action plan is agreed between the client and the adviser that specifies the activities that will be undertaken. This plan is reviewed at each meeting.

In case of more severe health conditions, IBPAs can refer their clients to a Disability Employment Adviser or a Work Psychologist. Nevertheless, with the growing number of claimants with complex health problems, many IBPAs report a stressful work environment and lacking support and knowledge, especially in dealing with mental illness (Knight *et al.*, 2005). The House of Commons (2006) concluded that IBPAs would benefit from improved training and sharing of best practice.

Also in Australia, activation measures are increasingly tailored to individual needs based on the level of disadvantage in the labour market. Unlike the United Kingdom, however, personal guidance only starts once a service provider has been identified and selected, with the type of service most adequate for the person being determined through the Job Capacity Assessment. Average caseloads for service providers for people with disability are very low in an international perspective in both Australia and the United Kingdom. Work Directions, for instance, a larger private provider operating in both countries, reports caseloads around and sometimes below 50 clients. Such low caseloads allow for a service tailored very closely to the needs and abilities of the client (Box 5.1).

Assistance for people with disability differs

Employment measures for people with health problems differ considerably between the four countries. In Luxembourg and Spain, except for hiring subsidies activation programmes are still in their infancy, while they are more widespread in Australia and the United Kingdom. The latter two countries have recently made several important changes to their services. Delivery of programmes in Australia and the United Kingdom also differs substantially from most other OECD countries because increasing parts of the employment activation service are being privatised (see below).

Box 5.1. **Personalised employment service of Work Directions United Kingdom**

Work Directions is a private employment service, or Job Broker in UK terms. Originally founded in Australia, it started its operation in the United Kingdom in 2001, with the introduction of the NDDP. Since 2004, Work Directions has been delivering the United Kingdom's largest single NDDP contract (in Birmingham). In 2007, Work Directions won a significant proportion of the contracts in the first phase of outsourcing of the *Pathways to Work* programme (in London, Nottinghamshire, Birmingham and Edinburgh). In this context, they will work with over 80 000 clients over the next three years.

Their NDDP office in Birmingham serves a potential clientele of around 60 000 people on health-related benefits (most of them on Incapacity Benefit). However, as NDDP is an entirely voluntary scheme, reaching clients is one of the biggest challenges. 45% of their clients are referred by the public authorities, 15% by charity organisations, doctors, etc., 30% are reached through active outreach and 5% are walk-in clients. 80% of all their participants have been out of work for at least one year, and many for much longer.

They have 19 employment advisers with different backgrounds, one psychologist and a physiotherapist. Employment advisers are quite free to use whatever approach they want, and by and large they do not match jobseekers with vacancies but rather focus on developing personal skills and the interest for work, i.e. on breaking patterns of complete inactivity. The current caseload is 35 clients (to be increased to 40-45), and the target for each caseworker is one placement per week, i.e. 4.3 placements per month. Current average placement is 3.8 per month, which is similar to the performance of caseworkers dealing with jobseekers without disability.

As all NDDP providers, Work Directions is funded on the basis of outcomes: they receive GBP 300 upon registration of a client and GBP 4 100 for a full-time job after 13 weeks. Their recent statistics show that 4 400 people showed interest to participate, while only some 3 000 registered with them. Of these, 1 300 found a job (83% of them remained on the job for at least 13 weeks), 600 continued to search for a job and 1 100 left the programme. The average time length to place a person is ten weeks. The success rate does not correlate with the duration of inactivity.

In the United Kingdom, soon everyone making a new claim for a disability benefit will automatically be part of *Pathways to Work*.⁴ The aim of *Pathways to Work* is to improve the work focus of disability benefit claimants by providing: i) a better framework for support in the early stages of a claim (e.g. through IBPAs); ii) direct access to a wide range of provision (e.g. the New Deal for Disabled people and the Condition Management Programme); iii) improved financial incentives through the Return to Work Credit; and iv) better support for people with health problems who move from disability benefits to unemployment benefits.

In mid-2006, when the Australian government launched its *Welfare to Work* approach, activity-test requirements became mandatory for an increasing share of people with health problems (Chapter 3). People who no longer qualify for a disability benefit have to actively seek work compatible with their capacity and participate in certain activities as a condition of unemployment benefit receipt. There are four broad activation routes for these people: the Job Network (JN), the Disability Employment Network (DEN), Vocational Rehabilitation (VR), and the Personal Support Programme (PSP). People with moderate to profound disability who qualify for a disability benefit or another income support payment can also access Disability Business Services. Some of the more important measures in Australia and the United Kingdom are described in Box 5.2.

Box 5.2. **Specialised employment measures in Australia and the United Kingdom**

Measures in Australia

Job Network (JN) aims to help jobseekers into sustainable employment through personalised employment assistance involving job-search and employment-focused activities. Services are tailored to the person, based on individual needs, level of disadvantage in the labour market and duration of unemployment. JN is primarily aimed at providing assistance to jobseekers who are job-ready. If needed, JN providers can access the Job Seeker Account, a quarantined pool of funds that is used to purchase employment-related assistance such as employment-related training, work clothes and equipment required to accept a job offer, wage subsidies and interpreter services. JN is not targeted at jobseekers with disability but several JN providers are specialist in this field.

Vocational Rehabilitation (VR) provides specialist rehabilitation from health professionals with employment assistance to help participants find or keep a job. The focus of VR is on assisting people in understanding and managing their limitations imposed by their disability. The programme has a stronger focus on capacity building in the beginning and job search and placement typically come at the end. The programme is primarily delivered by health professionals. To be eligible, a client must be assessed as being able to work independently in the workplace after less than six months support.

Disability Employment Network (DEN) typically aims to find jobs for clients as quickly as possible, in accordance with their capacities and barriers. Assistance includes capacity building, training, counselling and improving motivation as well as job matching, employer support and on-the-job support for the worker and their co-workers. DEN providers can purchase vocational training and employment-related assistance for the client. To be eligible for uncapped services, a client must be assessed as likely to need more than six months but less than 24 months support after placement in a job. In the capped stream, resources permitting assistance can be provided for as long as it is required by the client.

The *Personal Support Programme (PSP)* provides up to two years assistance to people who are facing multiple non-vocational barriers (such as homelessness, mental health issues, drug problems, or social isolation) that prevent them from finding and keeping a job or benefiting from programmes delivered through JN or DEN. PSP can provide a range of services, including individual counselling, group work and specialist assistance. Outcomes may include employment, transfer to an employment assistance programme, or study. Like JN, PSP is not targeted at jobseekers with disability but many of the users do have health problems also.

Disability Business Services are commercial enterprises that provide supported/sheltered employment assistance to people with disability who are unlikely to be able to work in the open labour market at or above the federal minimum wage and who need ongoing support for a substantial period to obtain or retain paid employment. (However, transfers between this service and all other services are possible in both directions). Tasks in such a business involve packaging, assembly, production, recycling, garden maintenance and landscaping, screen printing, cleaning services, laundry services and food services. Workers receive the same working conditions as those in the general workforce, including pro rata wages linked to their productivity.

Box 5.2. Specialised employment measures in Australia and the United Kingdom (cont.)

Measures in the United Kingdom

New Deal for Disabled People (NDDP) was introduced as a pilot in 1998, and as a national programme in 2001. It was the first programme to target people with disability. The programme is voluntary and delivered through a network of private, public and voluntary-sector Job Brokers who have been chosen by Jobcentre Plus. The target group for NDDP is people on a qualifying benefit who are relatively close to the labour market but needing e.g. job-search advice, matching skills to jobs, confidence building, help with completing application forms, and interview preparation.

Condition Management Programme (CMP) is a medical rehabilitation scheme with a strong work focus and only available under Pathways to Work. The primary goal is to help people back to work by enabling them to deal with or overcome their health problems. The programme starts by a medical assessment that focuses on the impact of the person's health problems and personal situation. A team of health specialists is then setting up an action plan that is discussed with the client. CMP fills the gap between medical treatment in the health sector and work-readiness. The average programme duration is 14 weeks. Participants have often lost their labour market attachment and are not ready to be referred to a Job Broker.

Work Preparation is a programme to help identify the most suitable type of work by providing work experience and by developing new or existing skills through courses and training. This scheme is targeting people that either wish to return to work or are at risk of losing their job due to a disability. Participants join this programme by referral from a Disability Employment Adviser.

Access to Work provides practical advice and support to help people with disability enter or stay in paid employment. It is aiming at overcoming work-related barriers through a system of grants to buy special equipment, and it also covers additional travel costs. It can also cover contributions to adaptations of premises, and the provision of support workers.

Workstep provides tailored support to find or secure jobs for those who have more complex barriers (often more severe disabilities). It provides financial support and can reimburse the full wage of persons while taking up employment with the view to obtain a non-subsidised job.

Remploy is similar to Workstep, with the difference being that people on the Remploy scheme work directly for Remploy Ltd (normally in a factory). Participants usually join this scheme by referral from a Disability Employment Adviser. Remploy have recently announced plans to modernise their provision, with a reduction in the number of factories.

In Spain, the employment service is mainstreamed and measures for jobseekers with a disability cannot be separated from services offered to regular jobseekers. After the decentralisation of labour market services in 2002, activation measures now differ considerably between regions and monitoring of outcomes has become more complex. Programme development is based on agreements with the social partners and lately also with some disability organisations. Participation in these programmes is low in general, and even more so for people with disability.

In Luxembourg, as in Spain, the use of specialised and tailored activation measures for people with disability is rare. Persons with a health condition who are classified as

externally re-deployable are treated as ordinary jobseekers but with access to a wider range of training options. In addition, there is a semi-vocational rehabilitation programme. Although the majority of all rehabilitation cases are medical, there is a strong link to labour market returns (similar to the Condition Management Programme in the United Kingdom). People usually come to the (only) rehabilitation centre through referral from a doctor, an occupational therapist or a hospital. However, the PES has recently started to send people to the centre for orientation; there is also a plan to have a regular co-operation with the rehabilitation centre.

Sheltered work

Countries also use sheltered employment, which is targeted at people with severe disability. Often sheltered work is oriented towards a therapeutic function instead of work tasks. It also relies heavily on public subsidies.⁵ The United Kingdom uses this more traditional approach to an extent: while the preferred approach now is for supported employment in open workplaces, there remain a number of sheltered workplaces, including the factories operated by Remploy, although these are being reduced. Spain also has a number of traditional sheltered workplaces, but has recently introduced a new measure to help people with disability to move from sheltered employment into jobs in the open labour market. Sheltered workplaces can outsource certain activities to ordinary companies for up to three years (so-called enclave contracts). During this period, the person with a disability continues to be employed by the sheltered workplace.

Australia uses a more market-oriented approach of sheltered/supported work. In 2005-06, 21 250 Australians (around 3% of all disability benefit recipients) were employed in Disability Business Services. Wages paid are productivity based with an average salary of AUD 3 per hour (which is 25% of the minimum wage). Of all those workers, 97% receive a disability benefit. Employers receive funding for each worker with a disability based on an assessment using the Disability Maintenance Instrument. The funding depends on the support needs of the individual and does not exceed AUD 12 000 per year (almost half of all workers generate the highest subsidy). The funding covers the costs of support (e.g. training, costs of a support worker, etc.), but not the wage costs since workers are paid according to their productivity, which is adjusted every second year. The annual turnover of workers is around 3 000, of which around 450 transfer to the open labour market. However, Disability Business Services do not place people with disability in open labour market positions.

C. Participation in activation measures

Information on participation in employment or activation measures is only available for Australia and the United Kingdom (Table 5.3). Overall, even though different indicators are being used, there appears to be less age-targeting in employment service delivery in the United Kingdom compared to Australia.⁶ Every second programme participant in Australia is younger than 40, and even six out of ten of the clients in the Disability Employment Network. In the United Kingdom, Workstep is the programme which is most strongly targeting young workers (in this case jobseekers younger than 25).

Spending on employment support for people with disability is low

Data on overall public spending on Active Labour Market Programmes (ALMP) show that none of the four countries belong to those OECD countries with a strong emphasis on

Table 5.3. **Participation in employment measures in Australia and the United Kingdom**Age distribution by type of programme, percentage, 2005^a

	20-39	40-49	50-64	Total
Australia^b				
Programme participants	76 225	40 423	33 772	150 420
Disability Employment Service	61.5	23.0	15.5	100.0
Personal Support Programme	43.7	28.3	28.0	100.0
Vocational Rehabilitation	43.0	30.9	26.1	100.0
All programmes	50.7	26.9	22.5	100.0
<i>For comparison: current DSP recipients</i>	<i>22.2</i>	<i>22.1</i>	<i>55.7</i>	<i>100.0</i>
	18-24	25-49	50+	Total
United Kingdom^c				
Programme commencements	20 750	90 240	40 560	151 550
Pathways to Work	10.4	63.4	26.2	100.0
NDDP	15.2	56.9	27.9	100.0
Workstep	27.3	56.4	16.4	100.0
All programmes	13.7	59.5	26.8	100.0
<i>For comparison: inflows into incapacity benefit</i>	<i>13.6</i>	<i>54.1</i>	<i>32.3</i>	<i>100.0</i>

a) Data refer to current programme participants in Australia and programme commencements in the United Kingdom. Therefore, different items for comparison are used.

b) Data are not available for Job Network providers (because distinction with and without disability is not possible). The age groups for the Personal Support Programme (PSP) are 20-34, 35-44 and 45-64.

c) The lower age limit for disability inflow data is 20 and not 18 and the upper limit is 64.

Source: DEWR for Australia and DWP for the United Kingdom.

rehabilitation and employment measures. In 2005, Australia, Luxembourg and the United Kingdom had similar unemployment rates of around 5%. Expenditures on activation measures for the unemployed and for workers with disability amounted to 0.5% of GDP in the United Kingdom, 0.4% in Australia and 0.3% in Luxembourg. In Spain, the unemployment rate was almost twice as high as in the other three countries, while spending amounted to 0.7% of GDP (OECD, 2006d).⁷

Spending on employment measures for people with disability as a share of GDP in Australia, Luxembourg and the United Kingdom is only around one-tenth of total ALPM spending.⁸ This is substantially lower than in, for example, Norway and Switzerland (Figure 5.1). Interestingly, in the United Kingdom total expenditures are less than half of those in Australia, despite similar rates of inflow into disability benefits. Activation of people with disability is predominantly focused on regular labour market interventions. A smaller share of total spending in both Australia and the United Kingdom is used for sheltered employment measures.

Annual spending on employment measures per person corrected for differences in purchasing power in Australia and the United Kingdom come at similar costs (Table 5.4). The exceptions are the two programmes Remploy and Workstep in the United Kingdom, which are heavily based on wage subsidies. The low per capita spending on PSP in Australia, on the other hand, can be explained by the focus on individual counselling and group therapy with a very limited use of training and other more costly activities. The relatively lower costs for NDDP compared to Job Network is partly explained by the fact that people are probably more job-ready when they voluntarily participate in NDDP, which is why they only need less costly support.⁹

Figure 5.1. **Spending on activation measures for people with disability is low in all countries**

Annual expenditures in percentage of GDP, 2005



- a) *Regular employment* includes in Australia: Job Network, Disability Employment Service (open) and Personal Support Programme; in Luxembourg: measures of professional (re)integration of workers with disability, adaptation of the workplace for workers with disability, reimbursement of supplementary leave for workers with disability and the creation of positions for them; in the United Kingdom: Access to Work, Interwork, New Deal for Disabled People, Workprep, and Workstep.
- b) *Rehabilitation and training* includes in Australia: vocational rehabilitation; in Luxembourg this does not exist; in the United Kingdom this is integrated in the regular employment measures; in Norway, spending on vocational rehabilitation cannot be separated from spending on vocation rehabilitation benefits and are therefore not shown in the figure.
- c) *Sheltered employment* includes in Australia: Disability Employment Service (supported); in Luxembourg: no data is available; in the United Kingdom: Remploi.
- d) Spending data for the Job Network in Australia have been estimated as 7.5% of total Job Network expenditure.

Source: DEWR for Australia; INSS for Luxembourg; DWP for the United Kingdom; and OECD (2006b), *Sickness, Disability and Work: Breaking the Barriers*, Norway, Poland and Switzerland, Paris, for the remaining countries.

Table 5.4. **Per capita spending on activation measures is similar in Australia and the United Kingdom**

Annual expenditures per participant, in USD PPP, 2005

Australia ^a	Spending	United Kingdom ^b	Spending
Disability Employment Service (supported)	8 412	Remploi	28 296
Disability Employment Service (open)	4 993	Workstep	17 983
Vocational rehabilitation	4 395	Access to Work	4 705
Job Network	2 670	Workprep	1 165
Personal Support Programme	1 365	NDDP	1 054

a) Expenditure for Job Network could be underestimated. Calculations are based on total per capita Job Network spending and not per capita spending for jobseekers with health condition.

b) Participants in Workstep refer to inflows rather than stocks, which may overestimate expenditures.

Source: DEWR for Australia and DWP for the United Kingdom.

D. Access to employment activation services

A problem in all four countries is that, due to either particular regulations or resource constraints, many people do not get a chance to participate in an employment activation measure. This is to a varying degree also true for certain groups of jobseekers, or potential jobseekers, in Australia and the United Kingdom, despite these countries' recent efforts to change the employment policy approach.

How are activation measures assigned?

Participation in activation measures in Luxembourg and Spain is usually decided between the employment adviser at the PES and the client. In Spain, however, there are also other ways to access services. The 17 autonomous communities and the 57 provinces have a network of (currently 244) Evaluation and Orientation Teams. One of the roles of these teams is to evaluate a person's capacity and professional orientation. These teams are multi-professional and can include, for example, rehabilitation doctors, psychologists, vocational experts and social workers. They co-operate with the PES offices of the autonomous communities in determining support needs, and they make sure to exploit the person's own capacities and resources as well as the social resources available in the person's milieu. Notably, this service can be accessed by every citizen, irrespective of the labour force status (e.g. registered as unemployed, or not).

In the United Kingdom, the Incapacity Benefit Personal Adviser (IBPA) proposes support through a range of programmes within Jobcentre Plus as described above. When clients meet with the IBPA, the adviser identifies those who need substantial help and who should go through the *Pathways to Work* interview process (70-80% of all people with health problems fall in this category). The remaining "lighter" cases are referred to a Job Broker directly to get help in finding a job. The specialised Disability Employment Advisers (DEA) can access additional programmes (such as Work Preparation and Workstep). They conduct employment assessments to identify the type of work or support that would be most suitable for the person. Hence, the IBPA and the DEA are gatekeepers to most activation programmes unless the person is referred to a Job Broker directly.

The support needs of a jobseeker in Australia are identified at Centrelink by using the Job Seekers Classification Instrument (JSCI). The JSCI is performed when a client first registers for employment assistance. It recognises the labour market disadvantage of a jobseeker based on responses to a questionnaire and identifies persons who, because of their personal circumstances, are likely to become long-term unemployed. The instrument also provides eligible people with early access to more intensive employment supports through the Job Network. For disadvantaged jobseekers (e.g. people with disability), the JSCI may trigger the need for a Job Capacity Assessment (JCA), which, in addition to assessing the capability to work, determines the most appropriate service for the person. The specific activities within the respective service, however, are decided by the provider.

Employment service, but not for all

In the United Kingdom, *Pathways to Work* is primarily aiming at new incapacity benefit recipients, but it is also available to existing disability beneficiaries – mainly on a voluntary basis. To encourage existing recipients to consider leaving benefit rolls and take up work, a pilot was launched in early 2005 that extended the work-focused interviews (under the *Pathways* process) to people who claim incapacity benefits for less than two years – on a mandatory basis. A further extension of this pilot took place in 2006 for recipients in certain areas who had claimed disability benefits between two and six years (Blyth, 2006).¹⁰

In Luxembourg and Spain, jobseekers with health problems – whether receiving income support or not – can always register with the PES and thereby, in theory, receive available employment services. The biggest problem in these countries is that service supply is quite limited.

Australia is different from the other countries because most services are divided between a *capped* and an *uncapped* stream. The uncapped or demand-driven stream is available for jobseekers with an assessed capacity to work of 15-29 hours per week. Capped services operate with a fixed supply and therefore tend to have long waiting lists; these services are offered to those with a capacity to work of less than 15 hours or more than 30 hours (i.e. where they have a current capacity to work of less than 30 hours per week but will be able to work more than 30 hours per week within two years with assistance). People on disability benefits who want to participate in an activation measure to increase their chances of finding a job will also be directed to capped services, unless the JCA identifies a remaining work capacity of more than 15 hours per week, or 30 hours per week for the grandfathered group (Australian Government, 2005); in this case they would lose their disability benefit and be transferred to the unemployment benefit scheme – and such become eligible for uncapped employment services.

Demand for service in the capped stream is in most regions higher than the actual supply. ACOSS (2005) concluded that a key reason for low employment rates of disability benefit recipients is the limited amount of help and support they receive. This is particularly critical for unemployed people with (permanent) disability not on income support who are only eligible for capped places in disability employment and vocational rehabilitation services, and for basic employment assistance through the Job Network. For the Personal Support Programme (PSP) in particular waiting times are very long. This creates an additional problem for those people who would benefit from a period in PSP prior to entering the Disability Employment Network or Vocational Rehabilitation services, but who have no access to PSP within a reasonable time period.

Available evidence suggests that less restrictive access to employment services might help to raise employment participation of people with disability currently outside the labour force (even though no information is available about cost-efficiency of such an approach). As Box 5.3 describes, Australia's Job Network Disability Support Pension Pilot demonstrated that job placements of current benefit recipients – even long-term recipients – can have positive outcomes (DEWR, 2005). More generally, therefore, employment assistance should be open to all groups of jobseekers, including those who do not qualify for benefits and who are not subject to any participation requirements (OECD, 2006d).

Box 5.3. Australia's Job Network Disability Support Pension Pilot

Between December 2003 and June 2004, the Australian government conducted a pilot to explore possibilities for existing disability benefit recipients to obtain employment with available Job Network (JN) employment services. 788 recipients joined the pilot on a voluntarily basis. Of these, 679 started intensive support customised assistance (a more intensive support available at JN).

By June 2005, 45% had been placed in employment and 3% in training. Of the remainder, 24% were still receiving employment support at JN; 5% had been referred onto more specialised employment services; and 23% had exited Job Network services. Among participants with psychiatric or psychological conditions, 42% had obtained a job. However, the probability of either gaining or sustaining employment was lower than the average for this group.

Of those people who obtained a job, 80% had been receiving disability benefits for more than two years and over half of this group had been recipients for more than five years.

5.3. A new balance of rights and responsibilities

In spite of a range of supports, employment rates of people with disability are low and have even decreased relative to the population without disability in Australia and Luxembourg. Why is this so? Part of the explanation is changes in labour market requirements that may have made it more difficult for workers with health problems to stay in, or to find, work (Chapter 1). This is especially true for the increasing number of people with mental health conditions.

Another reason for the low employment rates of people with partially-reduced work capacity are inadequate policies. Assessment procedures and benefit systems often pull workers with disability into long-term benefit dependency. Countries are increasingly aware of this problem. Australia and Luxembourg have chosen to suppress access to disability benefits for people with partially-reduced work capacity, while Australia and the United Kingdom, in particular, are rethinking employment and rehabilitation policies.

This section describes the latest developments on the employment and rehabilitation policy side. To a large extent recent changes are driven by increased expectations on three main actors: public authorities, workers with disability and employers. The expectations relate to: i) the type and quality of support public authorities should be providing; ii) the form of participation and job-search efforts one can expect from workers with disability in exchange for more and better employment support; and iii) the extent of involvement of employers in the process.

A. New directions for the state to help people with health problems back to work

Since recently, the governments of Australia and the United Kingdom are taking a more active role in supporting people with partial work capacity back into work. In Australia, this is being done mainly by investing more resources in activation and rehabilitation of those no longer eligible for disability benefits (i.e. jobseekers able to work 15-29 hours per week), while the United Kingdom has in addition introduced new voluntary activities for current recipients along with in-work benefits to enhance incentives to move into employment. Luxembourg and Spain have to a lesser extent reoriented their expenditures towards active support for people with partial work capacity. However, Luxembourg is using in-work compensation payments to people with partial work capacity moving into lower-paid jobs.

Timing of identification and intervention is crucial

In Australia and the United Kingdom, employment services are often not available before a person claims or receives income support. In both countries, services are predominantly (and sometimes exclusively) focused on people on (qualifying) benefits. And in both countries, little is offered during the employer-paid sickness period (which is six months in the United Kingdom, but often quite short in Australia). Early identification and support to both the employee and the employer are necessary to preserve labour market attachment (Bambra *et al.*, 2005). Work motivation decreases rapidly: evidence from the United Kingdom suggests that longer-term benefit recipients have much lower expectations to return to work in the future than shorter-term recipients (Pires *et al.*, 2006).

Early identification of health problems is practiced in both Luxembourg and Spain through close monitoring of the sickness phase. In both countries, people have a possibility to return to their former employer: in Luxembourg through the (internal) redeployment

process and in Spain because of a legal right to do so within a two-year period following the onset of a health problem. What these two countries lack, however, are better supports for these people to keep their jobs when they return and the supply of adequate employment services for those who cannot go back to their job.

The forthcoming reform of the disability benefit scheme in Switzerland is a good example of how to introduce early identification and activation. The key focus of this reform is to get in contact as early as possible with people at risk of moving onto disability benefits. To facilitate this, a process involving three actions has been developed, all of them under the responsibility of the cantonal disability insurance office: i) early identification of health problems, ideally after a period of four weeks, to prevent long-term work incapacity; ii) early and short-duration intervention, if needed, to avoid job loss (i.e. relatively cheap but effective intervention that does not require a comprehensive assessment process, for instance adaptation of the workplace); and iii) provision of new types of integration measures predominantly aimed at preparing people for subsequent vocational rehabilitation and reintegration, targeted to persons who had been at least 50% work-incapacitated for a period of at least six months (OECD, 2006b).

A better focus on existing benefit recipients is needed

Early intervention is important for new potential beneficiaries. With high disability benefit recipiency levels, however, it is also necessary to increase the outflow from these long-lasting benefits into jobs. Reform processes in Australia and Luxembourg are mainly focusing on curbing high inflow rates onto disability benefits. Similarly, little is done about existing benefit recipients in Spain. Only the United Kingdom has started to take some steps towards this group; so far mainly on a voluntary basis, but mandatory involvement of existing customers is also tested in some Pathways areas.

The low ambitions of policy makers to assist existing recipients in leaving benefit rolls are contributing to the very low outflow from disability benefits. Not only are there hardly any policy initiatives towards this group of people, but there are several barriers for those who want to work. These include the award of more or less permanent life-time benefits; no (or few) obligations to participate in employment measures; low financial incentives to take up work; and a high risk of losing eligibility for the benefit if work is tried.

Among the four countries, there are three very different approaches on how to deal with existing beneficiaries in terms of helping them back to work. Reforms in Australia have so far avoided to address current recipients (commonly known as grandfathering). In the United Kingdom, existing recipients are increasingly targeted by policy through stricter participation requirements and better financial incentives for those taking up work. The new benefit reform will go further in this respect and differentiate benefit levels between those who participate in activation and those who do not (Chapters 2 and 4). A neutral approach is used by Luxembourg and Spain: These countries have few policies targeted to existing beneficiaries, but they are generally not excluded from participating either.

In Australia, the fear of losing the benefit and associated concessions was shown to be a major disincentive for beneficiaries to take up work (DEWR, 2005). The Australian Human Rights and Equal Opportunity Commission found that barriers were also arising from worries about the impact on benefits and the lack of accessible and comprehensive services (Human Rights and Equal Opportunity Commission, 2006). In the United Kingdom, barriers to and bridges into work were surveyed among participants in the NDDP programme.

66% responded that the single most important factor to consider taking up work was to have the possibility to return to their former benefit if needed. Being able to decide on the number of hours worked, mentioned by 60%, came second (Stafford *et al.*, 2006).

The fear of benefit-eligibility loss could be overcome by giving recipients the possibility to return to their former benefit within a period of several years – a possibility that exists in several countries including Australia (two years) and the United Kingdom (up to two years). In the United Kingdom, however, linking rules have a more limited logic: benefit eligibility would always be reassessed and benefit entitlement only upheld for people passing the Personal Capability Assessment test. The low outflow from benefits of longer-term recipients in both countries suggests that these regulations are not very effective and, possibly, too restrictive. Time limits may be too short, a problem which could perhaps be solved by relating the time limit to the number of years already on disability benefit (*i.e.* the longer the reciprocity period, the longer the time limit for benefit suspension).

Financial incentives for beneficiaries to take up work should include in-work benefits and better possibilities to combine benefits with income from work (Chapter 4). In addition, eligibility for employment activation measures should be broadened to include those who want and can work but are currently on disability benefits. Along these lines, reassessing of younger and prime-age beneficiaries, who tend to have a much higher work motivation, should be considered.

Improving the quality of employment service

More and better evaluations are needed in all countries. Luxembourg and Spain lack any rigorous evaluations of their employment service as a whole. Australia's employment programmes are only evaluated occasionally. Evaluations in the United Kingdom are considerably more extensive, although cost-benefit analyses are less common.

Employment outcomes for jobseekers with disability in the United Kingdom depend strongly on the measure used. Overall, outcomes appear to be poor – less than one-third of all new participants find a job, with little variation across age groups (Table 5.5). Outcomes from NDDP measures, however, are much better, with one job entry for every two new participants. Also in this programme, variation across groups of clients is limited; most importantly, participants with mental conditions appear to have similar success rates as those with other problems. In 2005, more than 60 000 people entered the NDDP programme. However, this only accounted for 2.4% of the population flowing onto qualifying benefits (with the take-up rate in *Pathways* pilot areas being almost three times higher than elsewhere). As NDDP participation is voluntary, participants were probably more job-ready than the average benefit recipient (Stafford *et al.*, 2006).

The very high outcome rates for Workstep are mainly explained by the fact that it is aimed at providing support at work. Moreover, two-thirds of these employment outcomes are into sheltered jobs in an ordinary enterprise or into sheltered-work companies.¹¹ In 2001, a target was introduced to raise the proportion of participants transferring from Workstep into mainstream employment without support to 30% over a two-year period; however, this target was dropped in 2004 (Meah and Thornton, 2005).

Limited available information on outcomes from activation measures in Luxembourg suggests that of all persons with disability below the age of 50 (who are obliged to accept training and re-integration measures) only 12-13% move into a job. One reason for the low

Table 5.5. Employment outcomes from activation programmes in the United Kingdom are promising

Job entries as a percentage of new participants in employment measures, 2005

	Programme			Total
	NDDP	Pathways to Work	Workstep	
Total	48	16	77	31
<i>Age</i>				
18-24	46	14	70	28
25-49	49	17	78	33
50 and over	48	13	84	29
<i>Health condition</i>				
Mental	48	16	85	33
Muscular-skeletal	51	15	..	33
Cardio vascular	50	..	..	50
Other	47	16	76	30

Source: Department for Work and Pensions (DWP).

success rate may be that the Ministry of Education does not recognise diplomas received from these training programmes. Very partial information on employment outcomes exists for Spain: each year around 12 000 people with disability are hired on permanent contracts in the open labour market (compared to 47 000 registered jobseekers with disability); however, this is less than 15% of the number of people granted a disability benefit each year.

For the Disability Employment Network in Australia, no outcome measures are available. For Job Network providers, however, success rates can be calculated, with a split between participants with and without disability. Results depend very much on the indicator used (Table 5.6). The government defines successful outcomes as the number of positive outcomes over the number of exits from the service, with positive outcomes being employment, training or education three months after programme completion. This results in success rates for jobseekers with disability of 49%, which is lower but not much lower than the figure for those without disability of 62%. Success rates are higher for job placement measures than for intensive support. Outcomes from Vocational Rehabilitation

Table 5.6. Employment outcomes for jobseekers with disability in Australia are slightly worse than for those without disability

In percentage of those who commenced and completed a Job Network service, 2005

	Number of commencements	Number of exits	Positive outcomes	Positive outcomes as a share of exits	As a share of commencements	
					Exits	Positive outcomes
Jobseekers with a disability						
Job placements	27 160	4 452	2 636	59%	16%	10%
Intensive support: Customised assistance	46 728	18 984	8 695	46%	47%	19%
Intensive support: Job search training		2 907	1 538	53%		
Total	73 888	26 343	12 868	49%	36%	17%
All jobseekers						
Job placements	518 008	121 815	90 630	74%	24%	17%
Intensive support: Customised assistance	614 842	185 126	98 117	53%	52%	16%
Intensive support: Job search training		133 136	84 009	63%		
Total	1 132 850	440 077	272 756	62%	39%	24%

Note: Data refer to period July 2003-June 2004 and outcomes achieved up to September 2004.

Source: DEWR (2004) for commencements; Australian Institute of Health and Welfare (2005) for exits.

services (not shown in the table) are not so different from Job Network outcomes: 44% of those who exit the programme are either in employment or education three months later.

Privatising the employment service – outcome-based funding

One way to improve the quality of employment services is to monitor better what service providers, especially the PES, are doing and delivering. An innovative route to this is to change the system from input-based block grants to outcome-based funding. Such funding system is now in force in Australia for most service providers.¹² A similar move has also been taken a while ago in the United Kingdom for Job Brokers that are delivering the NDDP.

Outcome-based funding in Australia and the United Kingdom means that authorities purchase employment and rehabilitation services for people with disability from the private sector. Instead of reimbursing these providers upfront, both countries are making efforts to ensure that providers have incentives to deliver employment outcomes. Hence, the bulk of the payment for taking on jobseekers is received for successful transfers into jobs. In this way the system has a built-in self-selection process; those providers who fail to deliver will not stay in business.

Payments to providers in Australia are split up in several phases: a certain amount is paid in the service phase, while most of the payment is conditional on employment outcomes where a small fee is paid for the placement, a second fee when the person has remained in work for 13 weeks and a third fee after 26 weeks of work. The largest part of the payment is received for persons being placed in a job (or training) for at least 13 weeks.¹³ Payments are also substantially higher when people have been referred to providers by either Centrelink or a Job Capacity assessor. Persons volunteering for service (e.g. those already on disability benefits) receive less support from providers because these people would only generate the providers AUD 65 for a placement. This is very different from the situation in the United Kingdom, where Job Brokers actively try to promote their service to attract disability benefit recipients to register and use their service.

The funding structure differs between the two countries in many ways. In Australia, fees are differentiated between clients depending on their disadvantage in the labour market. This system helps to make cherry-picking among service providers (or parking of more difficult clients) less appealing. In the early stage of Job Network, providers were often accused of providing fewer services to jobseekers that were more difficult to place (including people with disability). These jobseekers are now receiving a higher weighting in the Job Seekers Classification Instrument (JSCI) which is also used to determine service fees. Success in placing more difficult clients also results in higher points in the evaluation process – the so-called Star Ratings system. This system is currently used to monitor performance of Job Network members and a good rating is crucial to be included in the next round of tenders and, thereby, for staying in business.¹⁴ A similar system, also based on relative success of providers, for Disability Employment Network providers has been developed recently and is currently being implemented. A Star Ratings system for Vocational Rehabilitation services is also in the early stages of development.

Provider funding in the United Kingdom is also defined in terms of job placements, but without taking the degree of disability (or disadvantage) into account. This absence of differentiation between easier and more difficult clients creates a risk that Job Brokers become more concentrated on job-ready people (Lewis *et al.*, 2005). This may aggravate

further along with rising caseloads because of successful implementation of *Pathways to Work* and, hence, more referrals.

Payments for service also differ across providers in the United Kingdom. The reason is that the government is negotiating different payment rates for different providers. Providers asking for too low payments may obtain similar outcome results, but what is important is sustainability of a placement. This should also be taken into account when negotiating payment fees. Work Directions, the most expensive service provider in the United Kingdom, receives GBP 4 100 for a full-time job lasting 13 weeks or longer. More generally, for NDDP providers, 12% of the negotiated amount is received as an upfront payment, another 44% after a placement in a job and the remaining 44% if the person remains employed for at least 13 weeks.

In the United Kingdom in particular, the definition of sustainable employment outcomes of 13 weeks is too short and should be changed, for example, along the lines of a House of Commons report (2006), which proposed that contracts with providers should reward job retention lasting for at least 12 months. In addition, some people may need to upgrade their skills or to be retrained; these possibilities are not well covered in the current funding procedures in the United Kingdom. Ways should therefore be sought to better reward intermediate outcomes and inputs, an issue also raised in the recent Freud Report on welfare reform (Freud, 2007).

Strengthening institutional co-operation and co-ordination of services

Another issue that countries are facing to a different degree is the need for co-ordination of services across different layers of government. For Spain, this is a relatively new situation following the process of decentralisation of a whole range of responsibilities (Chapter 2). Along these lines, the purpose of the Australian Commonwealth State Territory Disability Agreements is to define the roles of the different government layers in the provision of services for people with disability. Better co-operation across institutions is another way to improve delivery of programmes and employment outcomes, but also to avoid unnecessary shifting of people between different benefit schemes.

In this respect, the non-stop-shop approach in Australia (via Centrelink) and especially the United Kingdom (via the new Jobcentre Plus, which resulted from merging the employment service with the benefit institution) is important. Offering employment and insurance services at one place helps to avoid that people move between different types of income support payments and services, enables a better-streamlined and more client-oriented service delivery and increases efficiency by pursuing common objectives. Customer responses in the United Kingdom reveal that a majority of clients reported to be satisfied with the new Jobcentre Plus service. Also the staff expressed very positive views about the office environment, which may have helped them to provide a better service to customers (Corkett et al., 2005).

In all countries, there is still a need to better involve the national health sector with the employment service. Steps in this direction have already been taken in the United Kingdom through the introduction of Condition Management Programmes and in Luxembourg through closer co-operation between the national insurance authority, the PES and the health-related rehabilitation service. In Spain, the social insurance authority (INSS) is also improving its collaboration with the autonomous communities and hospitals through bilateral agreements and special funds.

B. Increasing responsibilities for individuals with health problems

If more financial resources are made available for employment integration of benefit claimants, existing disability benefit recipients as well as those inactive people with disability outside the benefit system, it becomes more reasonable to expect people with remaining work capacity to make better use of them. Using some forms of mutual responsibilities for some of these groups is therefore a reasonable step taken by an increasing number of countries.

Are stricter responsibilities for people with disability the way forward?

A group that in many countries is no longer eligible for disability benefits are those with partially-reduced work capacity. In Australia, Luxembourg and the United Kingdom these people are covered by unemployment benefits and obliged to enrol in re-integration measures to continue to receive their unemployment payments. Although they will be subject to activity requirements, these will, in many cases, be less strict than for “standard” unemployed people.

In Australia, requirements for jobseekers to look for work are clearly defined. People with partial work capacity are required to look for suitable part-time work, consistent with their assessed capacity, or to participate in appropriate services. However, the new regulations introduced by the *Welfare to Work* reform are so far only directed towards new claimants, while there are no changes for those people with partial work capacity already on disability benefit.

The United Kingdom’s *Pathways to Work* process is another example of a first step towards establishing a new balance between rights and responsibilities for disability benefit claimants. However, at this stage the work-focused interviews, aiming for a personal action plan, are the only mandatory element of the new process. Any action taken in response to these interviews is still non-compulsory. A further strengthening of responsibilities is currently being discussed, but the whole process is likely to remain voluntary for longer-term claimants.

In Luxembourg, obligations are in place through the redeployment process with either *internal* redeployment in the previous job, possibly with fewer hours or in another job with the same employer, or *external* redeployment with another employer (Chapter 2). However, actual job-search requirements and supports for those people classified as externally re-deployable are very limited.

As mentioned earlier, activation support in Spain is limited and in particular so for people with reduced work capacity. This can be explained, at least partly, by the use of partial disability benefits for people with partially-reduced work capacity and by the weak obligations for people to participate. Indeed, participation in available programmes is very low.

A critical issue is whether benefit sanctions should be introduced for those who refuse to participate in activation programmes. On the one hand, participation requirements cannot be enforced without sanctions. On the other hand, countries tend to shy away from using sanctions, even if these are in place on paper. Enforcing sanctions on people with health problems is often perceived as socially questionable. In addition, some clients with health conditions may be more likely to get activated in voluntary measures to which they have a right rather than in obligatory and enforced programmes. Sanctions, such as withheld benefit payments, exist in Australia for those who are not fulfilling the participation requirement for unemployment benefits. In the United Kingdom, similar

sanctions are in place for disability beneficiaries in Pathways areas who fail to attend their work-focused interviews. In both countries, some forms of sanctions also exist for people not showing up for the capacity assessments.

There is no obvious right or wrong in imposing stricter responsibilities and sanctions on individuals. In any case, stricter eligibility for disability benefits should go hand-in-hand with more and better targeted support for those people who no longer qualify for the benefit. This is important in countries such as Australia and Luxembourg (for people with partially-reduced work capacity) where the unemployment benefit scheme is open-ended. However, even in countries with time-limited unemployment benefits, when people would be taken off the benefit roll, they would instead transfer to social assistance or similar income support. The likelihood that these people end up on a disability benefit in the long run is high, which might be an argument for stricter requirements on individuals.

Very few people leave disability benefits rolls for employment

The lack of any requirements for people already on disability benefits is one of the explanations for the very low share of recipients leaving these benefits for reasons other than deaths and transfers to retirement (Table 5.7). Overall outflow rates vary from 4.5% in Australia to 7% in the United Kingdom. These figures include flows not only into employment but also into inactivity, unemployment or other social benefits. In all three countries outflow rates fall with age, but less so in Australia. A positive sign in Luxembourg and the United Kingdom is that outflow rates in the two younger age groups are fairly high: two to three times higher than in the oldest age group. However, in terms of total numbers, this has little impact especially in Luxembourg where reciprocity rates are strongly skewed towards the age group 50-64.

Six out of ten people in Australia and the United Kingdom who leave disability benefits for other reasons than death and old-age retirement do so non-voluntarily (Table 5.8). Among those who leave benefits, only 12% in Australia and 22% in the United Kingdom move into jobs. These figures correspond to 0.6% of all recipients in Australia and to 1.6% in the United Kingdom. Analysis of Australian administrative data from 1990 to 2002 concluded that, each year, less than 1% of men on disability benefits transferred into jobs

Table 5.7. Outflows from disability benefits are relatively low everywhere
Outflows to other statuses than death or retirement in percentage of disability benefit recipients, 2005^a

		20-34	35-49	50-64	Total
Australia	Total	6.7	5.5	3.6	4.6
	Men	6.8	5.1	3.5	4.5
	Women	6.5	6.0	3.8	4.9
Luxembourg ^b	Total	11.4	12.7	5.3	6.1
	Men	12.7	12.3	4.8	5.5
	Women	9.7	13.4	6.4	7.2
United Kingdom ^c	Total	15.4	10.2	4.5	7.3
	Men	17.2	10.9	4.4	7.2
	Women	13.2	9.4	4.7	7.4

a) Data for Luxembourg refer to 2004.

b) Information on the number of deaths among disability benefit recipients are unavailable. These were imputed by using five-year age- and gender-specific death rates for Norwegian disability benefit recipients.

c) Data refer to the long-term incapacity benefit only.

Source: OECD estimates based on data supplied by national authorities.

Table 5.8. The majority of recipients in Australia and the United Kingdom leave disability benefits involuntarily

Reason for leaving disability benefits in percentage of outflows other than death and old-age retirement, 2005

Reason	Share in total terminations	Reason	Share in total terminations
Australia		United Kingdom^a	
Employment	12.5	Employment	22.2
Compliance Issues	44.1	Compliance Issues	8.7
Customer request	3.7	Customer request	11.1
Overseas	9.7	Closed certificate	15.9
Residency issues	4.6	Failed capacity test	39.6
Other	25.3	Other	2.4
Total	100.0	Total	100.0

a) Data refer to beneficiaries aged 18 to 64 on long-term incapacity benefits.

Source: DEWR for Australia and DWP for the United Kingdom.

(Cai et al., 2006). Hence, low outcomes into jobs appear to have been stable over time. Leaving the disability benefit scheme in Australia (like in most countries) because of death is much more likely than to re-engage with the labour force (Lattimore, 2007).

To raise the low outflow rates, disability beneficiaries could be reassessed more systematically. But reassessing all disability beneficiaries would be expensive and time-consuming and probably not very effective since many of them would not find their way back to employment. For this reason, certain criteria such as severity of the disability, age or time on benefits will have to be used in identifying cases for reassessment.¹⁵ For example, the share of people in receipt of benefits for less than two years ranges from 15% to 23% in the three countries for which such data is available (Table 5.9). If the duration is extended to five years, the corresponding figure reaches around 40% in all three countries. An additional approach would be to introduce a mandatory full reassessment after a few years for all future inflows, especially those younger than, say, 55 years of age.¹⁶

Table 5.9. Share of disability benefit recipients in receipt of a benefit for less than two years

In percentage of all persons receiving a disability pension, 2005

	Australia		Luxembourg		United Kingdom	
	Share within each age group	Share of the total	Share within each age group	Share of the total	Share within each age group	Share of the total
20-34	16.0	15.1	47.3	6.0	36.3	29.7
35-49	15.5	29.5	27.1	29.8	23.3	35.5
50-64	15.5	55.4	11.8	64.3	16.6	34.7
20-64	15.6	100.0	15.0	100.0	22.6	100.0

Source: DEWR for Australia, IGSS for Luxembourg, and DWP for the United Kingdom.

If support and assistance is improved, outcomes might well be more significant, as was shown by the voluntary Job Network Disability Support Pension Pilot in Australia (DEWR, 2005). In Pathways areas in the United Kingdom, the share of benefit recipients leaving benefit rolls is 8 percentage points higher compared to the national average (Blyth, 2006).

However, if former beneficiaries do not return to work but move onto other benefits, their mental health often deteriorates as do quality of life and overall well-being. Only interventions which encourage and support beneficiaries to come off benefits and

successfully assist them back into work are likely to improve health and well-being. Interventions which simply force recipients off benefits are more likely to harm their health and well-being (Waddell and Burton, 2006).

A similar situation appears for rejected benefit claimants. Because most of these applicants have, at the time of rejection, lost their job, they need additional support. Unless these people find a new job, they are likely to transfer to another scheme (such as unemployment benefits or social welfare benefits) and possibly end up on disability benefits in the long run.

C. New ways to better involve employers

Activation measures and stricter participation requirements on individuals are not enough to raise employment rates of people with disability. There is also a need to encourage employers to increase their hiring and retention of people with health problems or disability.

Raising employers' responsibilities

Experience-rating of employer premiums. Employers' responsibility for assisting workers and jobseekers with health problems can be raised by transferring more responsibilities to employers for the sickness phase. In the United Kingdom, employers are responsible for paying the costs of sickness benefits for six months and in Luxembourg for three and a half months for white-collar workers (similar rules will soon be introduced for blue-collar workers). In Australia and Spain, employers have few responsibilities during this phase and periods are substantially shorter (Chapter 3).

Extending the length of continuous wage payment for employers in case of sickness is one form of *experience-rating*. Another way is to raise contribution rates (or, in the case of Australia, taxes) to public sickness or disability schemes for employers who generate a higher incidence of sickness absence or disability benefit inflows. Such systems exist already in many work injury schemes across the OECD, but are still rare in sickness and disability insurance schemes.¹⁷ Obviously, it is not desirable to penalise employers who are willing to engage workers with health problems, but to hold responsible those employers who generate more sick workers and workers with disability than other employers in similar circumstances, *e.g.* in the same sector, for the extra costs involved.

A disadvantage with experience-rated contributions is that, although it most certainly improves health management in firms, it is likely to create adverse effects when it comes to new hires of persons with disability or persons with fragile health. Experience-rated systems should be carefully designed so to minimise this risk. This can be in the form of exemptions for employers hiring a chronically sick person or a person with a disability, or by combining experience-rating with a reduction in overall employers' social security contributions (or taxes), thereby rewarding employers investing in sickness management and prevention.

Employment protection legislation. Strict employment protection legislation (EPL) is another way of placing responsibilities on employers. In Australia and the United Kingdom, EPL is more flexible than in most other OECD countries, while in Spain it is one of the strictest (OECD, 2004).¹⁸ The effect of EPL, and its enforcement, on the employment of workers with health problems is complex. In general, too strict EPL discourages layoffs, thus increasing job security for incumbent employees, and reduces hiring when labour

demand increases (OECD, 2006d). The strict EPL in Spain is also a reason why the country has the highest incidence of temporary jobs in the OECD area.

Casual or temporary jobs may help workers with disability to find, and remain in, employment and such be a bridge into more stable and regular jobs. The higher hiring rates for workers with and without disability in Australia and Spain (Table 5.1) suggest that this may be the case. Research also shows that 42% of all casual workers in Australia in 2002 held a non-casual job in 2004 (Melbourne Institute of Applied Economic and Social Research, 2005). To what extent these figures vary by disability status is unknown. However, among the four countries, employment rates of people with disability are lower in Australia and Spain compared to Luxembourg and United Kingdom where temporary or casual work is rarely used. Hence, casual or temporary employment contracts could also be an additional barrier to stable employment for workers with disability.

Casual and temporary jobs also tend to reduce these workers' chances to participate in training. This was found for Australia in 2001: Among casual employees, 34% had attended training in the previous 12 months compared with 58% of regular full-time employees (OECD, 2005d). The *National Strategy for VET 2004-2010* also stressed the importance to continuously upgrade workers' skills and to give workers in part-time, casual contracts and occasional employment equal opportunities for learning (Australian National Training Authority, 2003).

Since the 1980s, the main employment strategy of Spanish governments has been to expand the legal scope for the use of fixed-term contracts and, in the 1990s, to legalise the use of temporary work agencies (OECD, 2007b). These changes may have trapped some workers with disability in short and successive temporary contracts and thus have hindered the upgrading of human capital through work-related training, with negative effects on career progression and productivity. Given the short average duration of temporary contracts, incentives to invest in job-specific training are very limited for both employers and temporary employees (OECD, 2007b).

In March 2006, Australia deregulated its labour market further by amending the Workplace Relations Act. Employers with up to 100 workers are now exempt from unfair dismissal laws and have more freedom in laying off workers (although they are still subject to unlawful dismissal laws which do not allow them to dismiss an employee for discriminatory reasons). This may increase incentives for employers to take on new staff but also to reduce their use of casual workers.¹⁹ Statistics show that, in the past 12 months, 96% of all jobs created were full-time compared to around 60% in the two previous years (Prime Minister of Australia, 2007). The new rules also introduced the right for workers, who have not used all their ten annual sick leave days, to cash out their remaining days.

Employment quotas. Another way to raise the responsibility of employers is by using an employment quota for people with disability, thereby forcing employers to hire a certain share of people with disability. Luxembourg and Spain use such a system; in Luxembourg the quota is set to 3% of the workforce and in Spain to 2%.²⁰ However, in Luxembourg the levy on companies not fulfilling their quota is low and in Spain the quota is not enforced.²¹ The employment effect of these schemes is therefore very limited.

Estimated overall employment quota fulfilment is 96% in Spain and 44% in Luxembourg (Table 5.10).²² The higher fulfilment in Spain is partly explained by a lower requirement for a legal disability certificate in combination with the lower employment

Table 5.10. **Fulfilment of the employment quota is weak in Luxembourg**
Numbers in thousands and percentages

	All employed	Legally disabled people		Legally disabled workers		Legal employment fulfilment	Quota fulfilment	People with moderate disability
		000s	In % of all employed	000s	In % of all employed			
Luxembourg	191.5	4.4	2.3%	2.5	1.3%	3%	44%	8.0%
Spain	18 833.7	1 114.0	5.9%	361.1	1.9%	2%	96%	6.6%

Source: OECD estimates based on data provided by national authorities.

quota.²³ In addition, in Luxembourg, a claimant also needs to be employed or a registered jobseeker. Since there is significant stigma associated with a legal disability certificate, presumably many workers with health conditions would not apply for such a certificate, which may explain the low levels of workers (less than 2% of the workforce) with a legal certificate in both countries. Another reason is that people with a legally-registered disability are not hired in the first place: in Spain, less than one-third of all people with a legal disability certificate work, while the share in Luxembourg is more than half.

It appears that the quota levels in Luxembourg and Spain are fairly low compared to other countries where such systems exist (e.g. 7% in Italy, 6% in France and Poland, 5% in Germany and Portugal, and 4% in Austria). How high should an employment quota be, provided there is societal consensus about having such quota? The quota should probably be related to some level of disability degree in society. In Luxembourg and Spain, the shares of people with a *moderate* self-assessed disability (assuming that this is the group of people employers should be expected to integrate) are 8% and 6.6%, respectively, i.e. markedly higher than the current quota levels (Table 5.10).

In sum, this indicates that there is room for Luxembourg and Spain to increase the quota itself as well as enforcement of the rules. On the other hand, research from Austria concludes that employment quotas may help workers with disability to stay in employment but are considerable barriers for those who want to enter the labour market, with the net effect being negative (Humer *et al.*, 2007). The United Kingdom also had an employment quota system (introduced in 1944), but rules were never enforced and the system was abolished in 1996 in exchange for anti-discrimination legislation.

Anti-discrimination legislation. Discrimination and stigma are key barriers for people with disability to enter the labour market and can further reduce self-esteem and discourage those who want to work to actually look for a job. To help avoid such situations, all EU countries should, since 2006, have implemented the EU Directive 2000/78, providing that direct and indirect discrimination on grounds of political views, membership of a trade union, sexual orientation, disability or age are prohibited. Although the Directive is fairly general, it signals that discrimination due to disability is unlawful and is, as such, important in itself. In addition to this legislation, the United Kingdom introduced already in 1996 the Disability Discrimination Act (DDA). This Act is much stronger than the EU directive.

The DDA in the United Kingdom covers, among other things, employment rights for people with disability in terms of job offers, terms of employment, promotion, transfer or training opportunities, and dismissal or redundancy. The DDA also states that compliance to the Act should be by “reasonable adjustments”. In terms of employment, a reasonable adjustment could include a transfer to another post, making adjustments to the building,

having a possibility to work flexible hours, providing training, or modifying work equipment. However, there is no clear distinction of what a reasonable adjustment is. Instead, the Disability Rights Commission (DRC) provides detailed guidance and advice for persons with disability and their employers. The absence of binding directions makes it very complicated to judge what is reasonable or not, especially in cases of mental illness.

According to the DRC in the United Kingdom, the DDA has had a positive impact on employers' behaviour. In larger enterprises recruitment procedures have changed in favour of people with disability. However, the extension of DDA to small and medium sized enterprises in 2004 has not yet resulted in any major changes. One explanation for this is the lack of information regarding this legislation. For this reason, DRC undertook an information campaign in 2004. Overall, DDA appears to have had a positive effect on employment rates of people with disability. Still, more could be done: while 90% of employers have a policy to support race equality and 74% to support gender equality, only 43% of them have a policy to support disability equality (The Employers' Forum, 2005).

In Australia, anti-discrimination provisions in relation to disability are regulated in the Commonwealth Disability Discrimination Act (CDDA) from 1992. The CDDA provides a national framework and covers also Australian government departments and agencies. The Act provides that a person with disability has a right to the same employment opportunities as a person without disability and people with disability are protected against discrimination in all aspects of the recruitment process, in the terms and conditions of employment, in the promotion process, and in dismissal or retrenchment. In addition, all states and territories have some form of anti-discrimination legislation, which in most areas complement Commonwealth legislation.

In a report by the Productivity Commission (2004), the effectiveness of the CDDA was reviewed. The review concluded that, overall, the CDDA had been reasonably effective in reducing discrimination. However, not all objectives had been achieved: in particular, people with mental disability had been excluded. Moreover, success has been greater in terms of access to public transport and education compared to improvements in employment opportunities. Employment rates for people with disability fell between 1998 and 2003, while these increased for people without disability. One possible reason for this may be that the CDDA does not include the obligation to make *reasonable adjustments* (like in the United Kingdom).

Similar to the employment quota system, evidence on employment effects of anti-discrimination legislation on people with disability is inconclusive. Empirically it appears that employment rates of people with disability increased after the introduction of the DDA in the United Kingdom, but causalities are difficult to establish. Evidence for the United States points in the opposite direction; after the introduction of the Americans with disability Act in 1990, until 1995 employment rates of men with disability dropped by more than 7 percentage points despite a very strong labour market (DeLeire, 2000). However, it is generally concluded that this drop was not caused by the new legislation but rather by earlier changes in the benefit system which have eased access to disability benefits (Burkhauser and Stapleton, 2004).

Providing better support to employers

Financial supports available for employers. Along with these responsibilities for employers, it is also important to consider measures that encourage hiring and retention of workers with health problems through, for example, the use of subsidised work, accommodation schemes and personalised support from either the PES or the social insurance institution. All four countries have some form of support to employers.

Australia has two main schemes that encourage employers to hire people with disability: the Workplace Modifications Scheme and the Wage Subsidy Scheme. The Workplace Modifications Scheme reimburses employers for the costs involved in modifying the workplace or purchasing special equipment to allow workers with disability to work, *e.g.* by building a wheelchair ramp. To qualify for assistance, companies must employ the person for at least eight hours a week in a job that is expected to last for at least three months. Between 1998 and 2002, the average amount paid per worker was AUD 2 200 (Productivity Commission, 2004). The Wage Subsidy Scheme provides incentives for employers to hire workers with disability under normal labour market conditions and is available to jobseekers participating in DEN and VR services. These subsidies are paid for a maximum period of 13 weeks and the maximum subsidy is AUD 1 500 per person.²⁴

In Luxembourg, an employer who hires or retains a legally-disabled worker may receive a wage subsidy of up to 100% of the salary (usually 40%) and a 10% reduction of social security contributions. The subsidy is received if the employer can prove that the worker with a disability has a reduced productivity. In this case, an allowance can also be granted for special equipment or accommodation of the workplace (this happened in only 13 cases in 2005). The employer may also be reimbursed of the additional six vacation days for which workers with legally recognised disability are entitled. Several private companies do, however, indicate that – although they are informed about wage subsidies and other financial privileges for employing workers with disability – these incentives are not important for their considerations to hire such a worker. The PES is also using wage subsidies. These are temporary, but usually last for three years or longer. To prolong these subsidies, the employer has to re-apply and prove that the productivity of the person is still reduced.

In Spain, subsidies to employers hiring a worker with a legally-certified disability can take different forms, including reduced social security contributions, subsidies to accommodate the workplace, or annual lump-sum payments varying with age, gender and the severity of the disability. The government also promotes the transfer of temporary employment contracts into permanent ones for workers with disability. Work accommodation subsidies amount to EUR 900 and lump-sum payments (which are paid during the entire duration of the work contract) range from EUR 3 500 per year for a men younger than 45 hired on a temporary contract to EUR 6 300 per year for a person over age 45 with a severe disability and hired on a permanent contract. In addition, there are tax advantages for employers such as the corporate tax deduction of EUR 6 000 per year for each hired person.

Contrary to the other countries, the United Kingdom has no large-scale employment subsidies available to employers who hire or retain workers with reduced productivity (except for Workstep, see above). Some smaller wage-subsidy schemes exist on local levels, but these are not specifically targeted at persons with disability.

Free and easy access to information. Equally important is easily accessible information for employers about what supports are available and about what an employer can do to help a sick worker or to hire a jobseeker with reduced work capacity. Often employers complain about lacking information on this, but also about very complex procedures for applying to subsidies and supports.

A good-practice example in this regard is Australia's JobAccess initiative. JobAccess is a one-stop information shop for all matters relating to the employment and retention of people with disability, and addresses employers but also jobseekers with disability, co-workers and employment service providers. It includes a comprehensive website (www.jobaccess.gov.au), a free telephone advice service (handled by trained JobAccess advisers), an online workplace adjustment tool giving a range of practical ideas and solutions for workplace modifications and adjustments, and an online claims process for the payment of workplace modifications.

Spain also has an increasing focus on workplace adaptation services, set up in 1997 under the umbrella of the National Centre for Personal Autonomy and Technical Aids (CEAPAT). CEAPAT is linked to IMSERSO and operates at the level of the autonomous regions. Multi-professional teams consist of experts in such fields as architecture, engineering, psychology, occupational therapy, computing and management. Services offered by CEAPAT include assessment and advice for workplace adaptations, production and adaptation of technical tools, training activities and information and advice on universal accessibility. CEAPAT also operates a comprehensive website on assistive technology and accessibility (www.ceapat.org).

In the United Kingdom, practical advice and support to help people with disability enter or stay in employment is provided by the Access to Work scheme (see above). What has been found to be of particular importance to motivate employers to hire workers with disability, is information based on experience from other employers. This is one of the aims of the United Kingdom's Employers' Forum on Disability, a charity organisation funded by voluntary contributions from its members (mainly large private companies). The Forum advises employers through regular exchange and conferences, produces relevant publications, such as a guidebook on sickness management, and benchmarks its members other members.

In Australia, the (still much smaller) Employers Network on Disability has a similar role, by helping small and medium-sized enterprises to improve their record in hiring or retaining workers with disability. The main tool of the network is the promotion of good practice. One of the network's founding members is Benbro Electronics, a small company in the electronics business with very dedicated leadership. 40% of their workers have a disability, which is why Benbro Electronics has repeatedly won employers' awards. The key factor is that the management is convinced about the business case of employing workers with disability (Box 5.4). This is one of the greatest challenges for the future: especially for smaller companies, it is often difficult to make a business case based on hard evidence, although anecdotal evidence suggests that workers with disability tend to be sick less often, are extremely reliable and have a high retention rate. According to the management of Benbro Electronics, the key challenge is to convince employers to hire *one* worker with disability: once employers have the experience, i.e. once "they got over the line", they are far more likely to hire another worker with disability.

Box 5.4. **Benbro Electronics: A recurrent best-practice price winner in Australia**

Benbro Electronics is a small company with 20 workers, eight of whom with intellectual disability. The company won various national and state employers' awards, most recently the Prime Minister's disability employer of the year award 2006. Tasks of workers with disability include, for instance, assembling electronic equipment (which is then sold to the Ministry of Defence) – this is a very repetitive work perfectly suited for their intellectually challenged. Workers.

Benbro refuses any public subsidies for hiring workers with disability so as to avoid creating two types of workers, normal workers on one end and subsidised workers on the other, thereby avoiding to devalue the latter group. Salaries are slightly above market level, with no difference between workers with and without disability. They do not monitor absence rates, but their perception is that there are no differences between different groups of workers. The average tenure of their workers is 10.7 years, compared to a nationwide average in comparable businesses of hardly more than two years.

5.4. Future policy directions

In all four countries, employment rates of people with disability are far below those of persons without disability. In addition, their unemployment rates are almost twice as high. This chapter has tried to shed some light on how this situation can be improved by changing the role of employers, public authorities as well as workers and jobseekers with disability themselves. This section outlines some of the more important policy directions resulting from the analysis.

Improve assistance to individuals to seek and find work

People with health problems who can and want to work, but are currently inactive, should as far as possible be supported and encouraged by the public authorities to do so. Currently, this is not sufficiently the case in the four countries. Explanations for this include the predominant focus on new or soon-to-be benefit recipients as well as limited and unsuitable services. Employment services and support should be equally accessible for all persons assessed with reasonable employment chances.

To reach sustainable job outcomes from this support, employment programmes need to be better tailored to meet current labour market demands on the one hand and the needs of the persons who participate in these programmes on the other. Preferably, participants should have an individual action plan that details the steps that have been taken and those that will be taken to improve chances of finding employment. Such action plan could, for example, be developed together with the jobseeker's personal adviser (like in the United Kingdom).

This requires not only changes of the current approach to deal with jobseekers, but in some cases also to develop new and better employment programmes. Unfortunately, little is known currently about what works and for whom and, in particular, about the cost-efficiency of existing employment programmes. In this respect, a first step countries need to take is to introduce, or further develop in the case of the United Kingdom, their methods to monitor implementations and outcomes of their employment-activation strategies – in particular when the responsibility is decentralised to regional offices. The innovative

outcome-based funding of services in Australia and the United Kingdom is a step in the right direction which should be further fine-tuned.

Improve services and incentives for employers to help them retain and hire workers with disability

Employers have a key role to play when it comes to raising employment rates of people with disability. Employers should be encouraged to hire these workers. First and foremost this requires closer co-operation of caseworkers and employers and better matching of workers skills and the demands of the labour market. In addition, better financial incentives for employers may be needed that outweigh any potential (be it actual or perceived) hiring costs. This should in particular include targeted work-accommodation programmes.

Employers should also be encouraged to retain workers that develop a health problem. To do so they need appropriate support and assistance at an early stage by, for example, occupational health therapists from the social insurance office. This would avoid that many workers are left alone with their health problems that later develop into long-term benefit reciprocity. What is important for employers to improve their hiring and retention records for workers with health problems is free and easily accessible one-stop information about existing schemes, as is provided by Australia's Job Access initiative.

Raise involvement and responsibilities among individuals and employers

Improved and extended employment support to people with health problems may have little impact on employment rates unless these people actively look for work. In particular, this is the case if support is extended to certain groups of existing beneficiaries who are currently outside the focus of employment assistance. The introduction of new and better-tailored employment programmes, such as vocational rehabilitation, should therefore go hand-in-hand with strong financial incentives to work and stricter requirements on individuals to participate in such programmes.

Again, this may only be helpful if employers have an interest to increase their efforts to hire and retain workers with health problems. Support and assistance to employers should therefore be complemented with certain obligations. Employers need to take a larger responsibility for monitoring sickness absences of their employees, to seek advice from occupational health specialists, and to inform national insurance offices at an early stage to help prevent that people fall out of the labour market. Such prevention can, for example, include the development of a rehabilitation plan jointly with the employee, use of flexible working hours, or new work tasks. For such approach to be effective, proper financial incentives have to be in place.

Improve co-operation between stakeholders

Better co-operation and co-ordination of policy and services across different public authorities is another way to improve delivery of programmes and employment outcomes. It is also a way to avoid that people fall between chairs. In this respect, the non-stop-shop approaches in Australia and the United Kingdom are good examples. However, this alone does not do away with large regional variation in take-up rates of disability benefits or employment outcomes from support programmes. Hence, policy at a regional level has to be better implemented and monitored so as to reduce local discretion in the decision process. Finally, in all countries, there is still a need to better involve the national health sector with the employment service.

Notes

1. Firms tend to offer part-time job opportunities to workers without rather than those with disability. In the United Kingdom, 27% of people with disability work part-time, but only 18% of employers with part-time employees hire people with disability in such positions. In Spain, 10% of all employees with disability work part-time, which is 2.5 times higher than the share of employers hiring workers with disability (EFILWC, 2007b).
2. Casual workers in Australia are employees who are not entitled to paid holiday or sick leave, have no expectation of ongoing employment and have a new contract of employment for each engagement with their employer. They receive a higher rate of pay (casual loading) to compensate for a lack of job security. Due to measurement problems, the Australian Bureau of Statistics defines casual employees simply as those employees who do not receive paid sick or holiday leave (ABS, 1999).
3. In Australia, for instance, between 1990 and 2000, the *net loss* of low-skilled full-time permanent jobs amounted to 200 000, while the *net increase* of full-time permanent professional jobs was 387 000 (ACOSS, 2005).
4. The United Kingdom's *Pathways to Work* is a process to better assist people with disability back to work. For a detailed description of this process see DWP (2002).
5. For a more detailed discussion of pros and cons of sheltered employment see OECD (2006b).
6. This is a crude and illustrative comparison, for two reasons. First, data refer to current programme participants in Australia and programme commencements in the United Kingdom. Secondly, neither are programme starts a subset of benefit inflows nor are programme participants a subset of current benefit recipients. While people are more likely to join programmes in the early stages of a benefit claim, there are starters who have been on benefit for years; nothing is known about the share of the latter, and how this differs between the countries.
7. For comparison, figures were 1% of GDP in Norway, 0.75% in Switzerland and 0.4% in Poland. The corresponding unemployment rates were around 4% in Norway and Switzerland, and 20% in Poland.
8. No data are available for Spain because of mainstreaming of employment schemes and the lack of a possibility to identify people with disability on mainstream programmes.
9. For comparison, corresponding per capita spending figures on activations measures in Switzerland are around 13 000 USD PPP, while spending in Norway is around 4 000 USD PPP (OECD, 2006b).
10. Initial evaluation results for the United Kingdom are so far based on qualitative research and shows that personal advisers welcomed this extension of the *Pathways* process but that, as expected, existing customers require significantly greater input than new customers (Barnes and Hudson, 2006).
11. The number of Workstep participants in the United Kingdom is around one-tenth of the number of participants in NDDP.
12. Outcome-based funding in Australia was introduced for the Job Network in 1998, for the Disability Employment Network in July 2005, and for Vocational Rehabilitation services in July 2006.
13. The information given in this paragraph applies only to Australia's Job Network. DEN and VR providers receive a monthly service fee for each client. Therefore, unless a person moves into employment very quickly after commencing with the service, the service fee received over time will amount to more than the outcome fees. The largest single payment for DEN and VR services, however, is the 26 week employment outcome payment. Moreover, contrary to Job Network, outcome fees are not dependant on how jobseekers have been referred to employment services.
14. One effect of these changes in Australia appears to be that the system has become administratively more costly and cumbersome for Job Network providers. Some providers indicated that 30-40% of their working day was spent on trying to achieve a high star-rating, i.e. finding jobs for a "perfect mix" of immigrants, people with disability, older and other jobseekers along with the filling out of the new administrative forms required by Centrelink (OECD, 2005c).
15. Changes in this regard are less needed in the United Kingdom, where part of the output of each disability assessment is a recommendation on when a person's status should be reviewed.
16. This is the approach taken in Poland, where benefits are only granted temporarily and, upon expiration of a temporary benefit (usually after three years), payments are terminated, individuals have to re-apply and their case will be fully re-examined. Together with a changed assessment process, this has reduced the number of disability benefits substantially in all age groups. However, many have transferred into other benefit schemes rather than moving into work (OECD, 2006b).

17. In the Netherlands, employers are responsible for paying the costs of sickness benefits for as long as two years. They are also paying for most of the costs of the first five years of disability benefit receipt of their former workers. Experience-rating has recently been introduced in the Swiss second-pillar disability insurance as well as in the private sickness benefit insurance (OECD, 2006b). Experience-rating also exist in the United States where employers' contributions to the unemployment insurance system depend on their firing behaviour.
18. Information for Luxembourg is not available.
19. The reason is that the old unfair dismissal laws did not apply to the majority of casual workers.
20. The reservation quota in Spain applies to public and private companies with 50 or more employees (in the entire company, not just the single office). In exceptional cases, companies may be partially or totally exempt from the quota provided that some of the substitute measures are applied instead. Substitute measures can include contracts with special employment centres or a self-employed worker with disability as well as donations to associations engaged in disability employment. Grounds for exemption include issues of productive, organisational, technical or financial nature on the one hand, and the inability of the PES to fill a vacancy with a qualified worker with disability on the other.
21. More generally, in Spain, it appears that, if a labour law is not included or referred to in the collective agreements, it is rarely enforced.
22. In 1999, in Spain, the estimated number of private companies that fulfilled the quota was 25% and in the public sector 30%. In France, Austria and Germany, the corresponding fulfillment rates ranged between 57% and 67% (OECD, 2003).
23. Such certificate requires that people have an incapacity level of at least 30% in Luxembourg and 25% in Spain (see Chapter 3 for a discussion of the assessment process of legal disability).
24. In Australia, wage subsidies are also available through the Job Seeker Account, which is available to people, such as people with disability, who are receiving intensive support through Job Network.

Bibliography

- ABS – Australian Bureau of Statistics (1999), *Labour Force, Australia*, Cat. No. 6203.0.
- ABS (2006), “Casual Employees, No. 1301.0 – Year Book Australia”, Canberra.
- ACOSS – Australian Council of Social Service (2005), “Ten Myths and Facts about the Disability Support Pension (DSP)”, *Info 362*.
- Adam, S., C. Emmerson, C. Frayne and A. Goodman (2006), “Early Quantitative Evidence on the Impact of the Pathways to Work Pilots”, Research Report No. 354, Department for Work and Pensions, London.
- ADEM (2006), “Bulletin luxembourgeois de l’emploi”, No. 08, August.
- Australian Government (2005), *The Welfare to Work Reforms Overview*.
- Australian Institute of Health and Welfare (2005), *Australia’s Welfare 2005*, Canberra.
- Australian National Training Authority (2003), *Shaping our Future: Australia’s National Strategy for VET 2004-2010*, Brisbane.
- Bacon, J. (2002), “Moving between Sickness and Unemployment”, Social Research Branch, Department for Work and Pensions, London.
- Bambra, C., M. Whitehead and V. Hamilton (2005), “Does ‘Welfare-to-work’ Work? A systematic review of the effectiveness of the UK’s ‘welfare-to-work’ programmes for people with a disability or chronic illness”, *Social Science and Medicine*, Vol. 60(9), pp. 1905-1918.
- Barnes, H. and M. Hudson (2006), “Pathways to Work – Extension to Some existing customers: early findings from qualitative research”, Research Report No. 323, Department for Work and Pensions, London.
- BBC News (2006), “Mental Illness Now ‘last taboo’”, <http://news.bbc.co.uk/1/hi/health/6038570.stm>.
- Bewley, H., R. Dorsett and G. Haile (2007), “The Impact of Pathways to Work”, Research Report No. 435, Department for Work and Pensions, London.
- Blackman, S. (2006), “Financial Incentives to Work for the IB Caseload and the Take-up of the Disability Element of the Working Tax Credit”, mimeo, Department for Work and Pensions, London.
- Blanco, A. (2000), “The Decision of Early Retirement in Spain”, mimeo, Universidad del País Vasco, Bilbao.
- Blyth, B. (2006), “Incapacity Benefit Reforms – Pathways to Work Pilots Performance and Analysis”, Working Paper No. 26, Department for Work and Pensions, London.
- British Occupational Health Research Foundation (2005), *Workplace Interventions for People with Common Mental Health Problems: Evidence Review and Recommendations*, London.
- Burchardt, T. (2003), “Employment Retention Following Onset of Sickness or Disability: Evidence from the Labour Force Survey Longitudinal Data”, Department for Work and Pensions In-House Report, London.
- Burchardt, T. (2005), *The Education and Employment of Disabled Young People: Frustrated Ambition*, London School of Economics, London.
- Burkhauser, R. and D. Stapleton (2004), “The Decline in the Employment Rate for People with Disabilities: bad data, bad health, or bad policy”, *Journal of Vocational Rehabilitation*, Vol. 20, No. 3, pp. 185-201.
- Cai L. (2004), “An Analysis of Durations on the Disability Support Pension (DSP) Program”, Working Paper No. 8/04, Melbourne Institute of Applied Economic and Social Research.

-
- Cai, L., H. Vu and R. Wilkins (2006), "Disability Support Pension Recipients: Who Gets Off (and Stays Off) Payments?", Working Paper No. 18/06, Melbourne Institute of Applied Economic and Social Research.
- CBI – Confederation of British Industry (2006), "Absence Minded: Absence and Labour Turnover 2006", London.
- Coleman, N. and L. Kennedy (2004), "Destination of Benefit Leavers 2004", Research Report No. 244 on behalf of the Department for Work and Pensions, London.
- Confédération syndicale indépendante du Luxembourg (2006), *Enquête sur le stress professionnel – rapport complet*, Stimulus/Capital-Santé, Paris.
- Corden, A. and K. Nice (2006), "Pathways to Work from Incapacity Benefits: A Study of Experience and Use of Return to Work Credit", Research Report No. 353, Department for Work and Pensions, London.
- Corkett, J., S. Bennett, J. Stafford, M. Frogner and K. Shrapnell (2005), "Jobcentre Plus Evaluation: Summary of Evidence", Research Report No. 252, Department for Work and Pensions, London.
- Council of Australian Government (2006), *National Action Plan on Mental Health: 2006-2011*, Canberra.
- DeLeire, T. (2000), "The Wage and Employment Effects of the Americans with Disabilities Act", *Journal of Human Resources*, Vol. 35, No. 4, pp. 693-715.
- DEWR – Department of Employment and Workplace Relations (2004), *Annual Report 2003-04*, Canberra.
- DEWR (2005), "Job Network Disability Support Pension Pilot: Progress Report", Canberra.
- DEWR (2006), *Characteristics of Mobility Allowance Recipients – June 2005*, Canberra.
- Dockery, A.M. (2005), "Mental Health and Labour Force Status in Australia", Curtin Business School, Curtin University of Technology, Perth.
- DWP – Department for Work and Pensions (2002), *Pathways to Work: Helping People into Employment*, London.
- DWP (2006), *A New Deal for Welfare: Empowering People to Work*, Green Paper presented to Parliament in January 2006, London.
- EFILWC – European Foundation for the Improvement of Living and Working Conditions (2007a), *Fourth European Working Conditions Survey*, Dublin.
- EFILWC (2007b), *Part-time Work in European Companies: Establishment Survey on Working Time 2004-2005*, Dublin.
- FaCS – Department of Family and Community Services (2003), "Improving Employment Opportunities for People with a Disability: Report of the Review of the Employer Incentives Strategy", Canberra.
- FaCS (2004), "Survey of New Disability Support Pension Customers", Canberra.
- Förster, M.F. and M. Mira d'Ercole (2005), "Income Distribution and Poverty in OECD Countries in the Second Half of the 1990s", OECD Social, Employment and Migration Working Paper, No. 22, OECD, Paris.
- Freud, D. (2007), "Reducing Dependency, Increasing Opportunity: options for the future of welfare to work", An independent report, Department for Work and Pensions, London.
- Grubb, D. (2006), "Australia's Quasi-market Delivery of Case Management", Paper presented at the ISSA workshop on Unemployment Insurance and Employment Maintenance, 10-11 April, Brussels.
- Grubb, D. (2007), "Audit du service public de l'emploi au Luxembourg", OECD Social, Employment and Migration Working Papers, OECD, Paris.
- Hallis (2003), "The Hallis 2003-2004 Turnover and Absenteeism Survey", Melbourne.
- Harding, A., Q. Ng Vu and R. Percival (2005), "The Distributional Impact of the Welfare-to-Work Reforms Upon Australians with Disabilities", NATSEM Working Paper, Canberra.
- Hartmann-Hirsch, C. (2006), "L'incapacité de travail. Une mesure de maintien à l'emploi aux effets pervers ?", *Population et Emploi*, No. 19, CEPS/INSTEAD, Luxembourg.
- Health and Safety Executive (2006), *Tackling Stress: the Management Standards Approach*, London.
- House of Commons (2006), "Work and Pensions – Third Report", London.

-
- Human Rights and Equal Opportunity Commission (2006), "National Enquiry into Disability and Employment", Final Report.
- Humer, B., J.P. Wuellrich and J. Zweimüller (2007), "Integrating Severely Disabled Individuals into the Labour Market: The Austrian Case", IZA Discussion Paper No. 2649, Bonn.
- Jones, A. and O. O'Donnell (1995), "Equivalence Scales and the Costs of Disability", *Journal of Public Economics*, Vol. 56, pp. 273-289.
- Knight, T., S. Dickens, M. Mitchell and K. Woodfield (2005), "Incapacity Benefit reforms – The Personal Adviser role and practices: Stage Two", Research Report No. 278, Department for Work and Pensions, London.
- Lattimore, R. (2007), *Men Not at Work: An Analysis of Men outside the Labour Force*, Productivity Commission Staff Working Paper, Canberra.
- Layard, R. (2004), "Mental Health: Britain's Biggest Social Problem?", Paper prepared for a seminar hosted by the DWP Strategy Unit, London.
- Lewis, J., A. Corden, L. Dillon, K. Hill, K. Kellard, R. Sainsbury and P. Thornton (2005), "New Deal for Disabled People: An In-depth Study of Job Broker Service Delivery", Research Report No. 246, Department for Work and Pensions, London.
- Martin, J. and D. Grubb (2001), "What Works and for Whom: a Review of OECD Countries' Experiences with Active Labour Market Policies", Working Paper No. 14, IFAU, Stockholm.
- Meager, N., P. Bates, S. Dench, S. Honey and M. Williams (1998), *Employment of Disabled People: Assessing the Extent of Participation*, Research Report No. 69, Department for Education and Employment, London.
- Meah, A. and P. Thornton (2005), "Desirable Outcomes of WORKSTEP: User and Provider Views", Research Report No. 279, Department for Work and Pensions, London.
- Melbourne Institute of Applied Economic and Social Research (2005), "Hilda Survey Annual Report".
- OECD (1999), *Economic Survey: Belgium/Luxembourg*, OECD, Paris.
- OECD (2001), *Innovations in Labour Market Policies: The Australian Way*, OECD, Paris.
- OECD (2003), *Transforming Disability into Ability: Policies to Promote Work and Income Security for Disabled People*, OECD, Paris.
- OECD (2004a), *Quarterly National Accounts*, Vol. 4-2003, OECD, Paris.
- OECD (2004), *Employment Outlook*, OECD, Paris.
- OECD (2005a), *Economic Survey: Spain*, OECD, Paris.
- OECD (2005b), *Benefits and Wages 2004*, OECD, Paris.
- OECD (2005c), *Ageing and Employment Policies: Australia*, OECD, Paris.
- OECD (2006a), *Economic Outlook No. 80*, OECD, Paris, December.
- OECD (2006b), *Sickness, Disability and Work: Breaking the Barriers: Norway, Poland and Switzerland*, Vol. 1, OECD, Paris.
- OECD (2006c), *Live Longer, Work Longer*, OECD, Paris.
- OECD (2006d), *Employment Outlook*, OECD, Paris.
- OECD (2007a), *Taxing Wages 2005/2006: 2006 edition*, OECD, Paris.
- OECD (2007b), *Jobs for Youth: Spain*, Paris.
- Orr, L., S. Bell and K. Lam (2007), "Long-term Impacts of the New Deal for Disabled People", Research Report No. 432, Department for Work and Pensions, London.
- Pires, C., A. Kazimirski, A. Shaw, R. Sainsbury and A. Meah (2006), "New Deal for Disabled People: Eligible Population Survey, Wave Three", Research Report No. 324, Department for Work and Pensions, London.
- Prime Minister of Australia (2007), www.pm.gov.au/media/Interview/2007/Interview24247.cfm.
- Productivity Commission (2004), *Review of the Disability Discrimination Act 1991, Inquiry Report*, Report No. 30, Australian Government.

-
- Purdon, S., N. Stratford, R. Taylor, L. Natarajan, S. Bell and D. Wittenburg (2006), "Impacts of the Job Retention and Rehabilitation Pilot", Research Report No. 342, Department for Work and Pensions, London.
- Sainsbury, R. and J. Davidson (2006), "Routes onto incapacity benefits: Findings from Qualitative Research", Research Report No. 350, Department for Work and Pensions. London.
- Sawney, P. and J. Challenor (eds) (2003), "Poor Communication Between Health Professionals is a Barrier to Rehabilitation", *Occupational Medicine*, Vol. 53, pp. 246-248.
- Stafford, B. and colleagues (2006), "New Deal for Disabled People: Second Synthesis Report – interim findings from the evaluation", Research Report No. 377, Department for Work and Pensions, London.
- The Employers' Forum (2005), *The Disability Standard 2005: Benchmark Report*, London.
- Trade Union Congress (2005), "Countering an Urban Legend: Sicknote Britain?", *Economic and Social Affairs*, London.
- Waddell, G. and A.K. Burton (2006), "Is Work Good for your Health and Well-being?", The Stationery Office, commissioned by the Department for Work and Pensions, London, September.
- Wagener, R. (2003), "The New Benefit Strategy being Implemented in Luxembourg", in B. Marin, C. Prinz and M. Queisser (eds.), *Transforming Disability Welfare Policies*, Ashgate, Aldershot.
- Work Directions (2006), "Buying Quality Performance: Procuring Effective Employment Services", United Kingdom.
- Zaidi, A. and T. Burchardt (2005), "Comparing Incomes when Needs Differ", *Review of Income and Wealth*, Vol. 51-1, pp. 89-114.

List of Acronyms

ABS	Australian Bureau of Statistics
ACOSS	Australian Council of Social Services
AETR	Average Effective Tax Rate
ALMP	Active Labour Market Programmes
AMC	Administration of Medical Control (Luxembourg)
AUD	Australian Dollar
AW	Average Worker
CBI	Confederation of British Industry
CEAPAT	National Centre for Personal Autonomy and Technical Aids (Spain)
CMP	Condition Management Programme (UK)
CRS	Commonwealth Rehabilitation Service (Australia)
DB	Disability Benefit
DDA	Disability Discrimination Act (UK)
DEA	Disability Employment Adviser (UK)
DEN	Disability Employment Network (Australia)
DEWR	Department of Employment and Workplace Relations (Australia)
DLA	Disability Living Allowance (UK)
DSP	Disability Support Pension (Australia)
DWP	Department for Work and Pensions (UK)
ECHP	European Community Household Panel
EFILWC	European Foundation for the Improvement of Living and Working Conditions
EPL	Employment Protection Legislation
ESA	Employment and Support Allowance (UK)
EULFS	European Union Labour Force Survey
EUR	Euros
EU-SILC	European Union Statistics on Income and Living Conditions
FaCS	Department of Family and Community Services (Australia; nowadays FaCSIA)
FRS	Family Resources Survey (UK)
GBP	British Pound
GDP	Gross Domestic Product
GP	General Practitioner
HB	Housing Benefit
HILDA	Household, Income and Labour Dynamics in Australia
IB	Incapacity Benefit
IBPA	Incapacity Benefit Personal Adviser (UK)
IGSS	Social Insurance Administration (Luxembourg)
IMERSO	Institute for Migrations and Social Services (Spain)
INSS	National Social Security Institute (Spain)

IS	Income Support (UK)
JCA	Job Capacity Assessment (Australia)
JN	Job Network (Australia)
JSCI	Job Seekers Classification Instrument (Australia)
MA	Mobility Allowance (Australia)
METR	Marginal Effective Tax Rates
MISSOC	Mutual Information System on Social Protection in the EU Member States
MTAS	Ministry of Employment and Social Affairs (Spain)
NDDP	New Deal for Disabled People (UK)
NRR	Net Replacement Rates
NSA	Newstart Allowance (Australia)
PCA	Personal Capability Assessment (UK)
PES	Public Employment Service
PPP	Purchasing Power Parities
PSP	Personal Support Programme (Australia)
RMG	Guaranteed Minimum Income (Luxembourg)
RTWC	Return-to-Work Credit (UK)
SDA	Severe Disablement Allowance (UK)
SDAC	Survey of Disability, Ageing and Carers (Australia)
SSP	Statutory Sick Pay (UK)
USD	United States Dollar
VR	Vocational Rehabilitation service (Australia)
WHO	World Health Organisation
WTC	Working Tax Credit (UK)

OECD PUBLICATIONS, 2, rue André-Pascal, 75775 PARIS CEDEX 16
PRINTED IN FRANCE
(81 2007 15 1 P) ISBN 978-92-64-03815-8 – 55865 2007

Sickness, Disability and Work: Breaking the Barriers

VOL. 2: AUSTRALIA, LUXEMBOURG, SPAIN AND THE UNITED KINGDOM

Too many workers leave the labour market permanently due to health problems, and yet too many people with a disabling condition are denied the opportunity to work. This is a social and economic tragedy common to virtually all OECD countries, and an apparent paradox that needs explaining. Why is it that average health status is improving, yet more and more people of working age end up out of the workforce relying on long-term sickness and disability benefits?

This second report in the OECD series *Sickness, Disability and Work* explores the possible factors behind this paradox. It looks specifically at the cases of Australia, Luxembourg, Spain and the United Kingdom, and highlights the roles of institutions and policies. A range of reform recommendations is put forward to deal with specific challenges facing the four countries.

Experiences in the four countries offer some lessons on how to reduce inflows into sickness and disability benefits through good sickness management for the employed as well as the unemployed, and how to promote the transition from benefits into employment through well-timed, well-targeted, accessible and effective supports. Despite a range of good-practice elements, however, in all four countries, more can be done to avoid the flow onto benefits and to move benefit recipients back to employment. Many people with health problems or reduced work capacity can work, and want to work. Helping those people to work is potentially a true 'win-win' policy: it helps people avoid exclusion and have higher incomes, at the same time as raising the prospect of higher economic output in the long term.

In the same series:

Vol. 1: Norway, Poland and Switzerland (2006)

Vol. 3: Denmark, Finland, Ireland and the Netherlands (to be published in 2008)

www.oecd.org/els/disability

The full text of this book is available on line via these links:

www.sourceoecd.org/employment/9789264038158

www.sourceoecd.org/socialissues/9789264038158

Those with access to all OECD books on line should use this link:

www.sourceoecd.org/9789264038158

SourceOECD is the OECD's online library of books, periodicals and statistical databases.

For more information about this award-winning service and free trials ask your librarian, or write to us at SourceOECD@oecd.org.