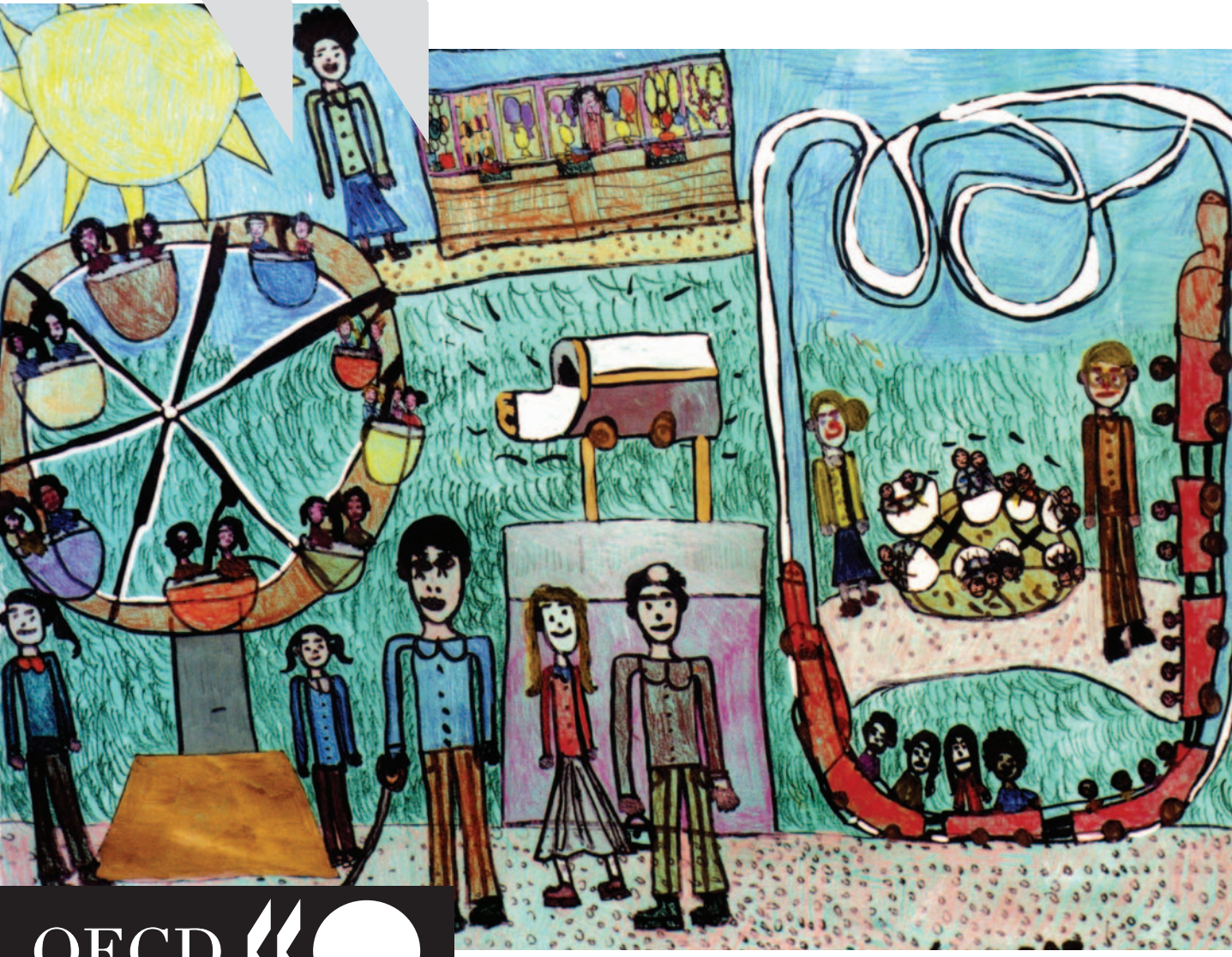
Transforming Disability into Ability

POLICIES TO PROMOTE WORK AND INCOME SECURITY FOR DISABLED PEOPLE



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Policies to Promote Work and Income Security for Disabled People

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Promouvoir le travail et la sécurité des personnes handicapées

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Foreword

Disability policy faces twin but potentially contradictory goals. One is to ensure that disabled citizens are not excluded: that they are encouraged and empowered to participate as fully as possible in economic and social life, and in particular to engage in gainful employment, and that they are not ousted from the labour market too easily or too early. The other goal is to ensure that those who are or who become disabled have income security: that they are not denied the means to live decently because of disabilities that (may) restrict their earning potential. How to reconcile these twin goals has yet to be resolved.

The main objective of this report is to analyse the policies the participating countries have designed to achieve these goals, and to look into the relationship and consistency between compensatory and employment-oriented disability policies in each country. Policy packages that have proven successful in promoting the employment of disabled people, reducing disability benefit dependence and securing decent incomes for this population group are identified. The report concludes that a promising new disability policy approach should move closer to the philosophy of unemployment programmes by emphasising activation, promoting tailored early intervention, removing disincentives to work, introducing a culture of mutual obligations, and involving employers. It finds that many countries' policies already include some elements that are important components of such a new approach.

A report of this richness could not have been prepared without the active assistance of a multitude of officials and collaborators in the twenty participating countries. Countries contributed by providing answers to a demanding interdepartmental questionnaire and administrative data on a wide array of disability-related social protection and labour market programmes, by participating in an interim project working meeting, and by reviewing drafts of several interim products as well as this final report. Some countries also helped in making national survey data accessible. Several countries also provided financial contributions to this project, which was entirely funded from voluntary offerings: Canada, Australia, the Netherlands, Norway, Switzerland and the United States, as well as the European Commission.

The work was undertaken by a team in the Social Policy Division of the Directorate for Education, Employment, Labour and Social Affairs. The project was co-ordinated and this report drafted by Christopher Prinz, under the supervision of Monika Queisser. Data analysis was undertaken and the tables and charts prepared by Maxime Ladaique, and administrative support was provided by Victoria Braithwaite and Cécile Cordoliani. Mark Keese, Mark Pearson, Peter Scherer and Philip de Jong also provided ideas and help at different stages of the project. This book is published on the responsibility of the Secretary-General of the OECD.

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Chapter 1

Summary of Key Findings

Abstract. *Chapter 1 presents key findings from the empirical analysis and the conclusions drawn from it.*

1.1. Structure of the report

In this chapter, the key findings from the empirical analysis and the conclusions drawn from it are summarised. Chapter 2 sets out the objectives of the report and introduces the conceptual framework (details on the approach followed and on some of its limitations are to be found in Annex 1).

Chapter 3 presents detailed findings from the comparative survey data analysis, *i.e.* empirical evidence on the economic and labour market integration of working-age disabled people. Chapter 4 looks at the compensation policies followed by countries, making use of administrative programme statistics.[1] This analysis includes, among other things, the extent of age profiling in transfer schemes, the relationship between disability benefits and unemployment and early retirement benefits and a discussion of benefit traps and coverage gaps. Country-specific policy details on these matters are found in Annex 3. Chapter 5 analyses integration policy approaches, including age profiling in employment programmes and new developments in employment-oriented disability policy. Country-specific policy details related to these aspects are found in Annex 4.

In Chapter 6, a disability policy typology is developed, which is used to classify countries according to their policy approach, and to analyse the relationship between policy design and policy outcome. Classification details are found in Annex 2. In Chapter 7, policy reforms during the 1990s are analysed, and the most important recent country-specific reform initiatives are described in some detail. In the last chapter, strategies for a coherent disability policy mix are developed. An approach is suggested that tries to overcome some of the problems and obstacles identified in the analytical chapters, and that aims to reshape disability policy based on a framework of mutual obligations.

1.2. Empirical evidence

Working-age disability policies target a large and *heterogeneous* group. One-third of this group have severe disabilities, and people with congenital disabilities are a small minority. The diversity of this group is at the root of most of the policy challenges that face policy makers attempting to improve the living conditions of disabled people.

Income security *is* high in many OECD countries: income levels of households containing disabled people are generally broadly similar to that of the population as a whole. The relative economic well-being of households is correlated with the structure of the disability benefit system and the benefit level paid: countries with individual benefit entitlements for the entire disabled population (*i.e.* full population coverage) and high earnings-related insurance benefits have the highest relative incomes of disabled people, while those with a strong focus on means-tested programmes have the lowest – but public spending on benefits is considerably lower in the latter group.

High income security is to a certain extent explained by high incomes of other household members. *Personal* incomes of disabled people depend primarily on their *work* status. Average work incomes of those disabled people who have a job are almost as high

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as average work incomes of people without disabilities. Disabled people without a job have considerably lower personal financial resources.

While employment is crucial for determining personal income resources, the employment rates of working-age disabled persons are rather *low*. This is particularly true for severely disabled people, and also generally for disabled people over age 50 and disabled people with low levels of educational attainment. Special employment programmes for people with disabilities play a minor role in determining disabled people's employment rates in general, but in some countries such programmes seem to make an important contribution to the employment of *severely* disabled people.

As employment rates of disabled people are low, benefits also play an important role in guaranteeing income security. *Disability* benefits are the main component of benefit income for working-age people with a disability. Permanent *retirement* benefits are also an important source of income for a considerable proportion of the working-age disabled population (either early or regular retirement, depending on the country). Unemployment benefits play a much less important role overall, despite relatively high non-employment rates among this group.

Perhaps surprisingly, recognising oneself as severely disabled does *not* imply receiving disability benefit, and *vice versa*. Many people on disability benefits do not claim to have a disability, while at the same time many people who subjectively classify themselves as severely disabled and do not work receive no benefits.

1.3. Disability policy challenges

Disability benefit *recipiency* rates are high in many countries. Nonetheless, the majority of people with disabilities (disabled according to self-assessment) do not report receipt of such benefits. Growth in disability benefit recipiency slowed recently. This is explained by reforms affecting benefit access, which have led to a stabilisation or even a decline in annual rates of benefit *inflow* in most countries, in particular since 1995.[2]

Outflow from disability benefits is *very* low in virtually all countries, despite considerable cross-country differences in regulations on reviewing entitlements, the availability of partial benefits, work incentives, etc. This is one reason why disability benefit recipiency rates have been rising. The low outflow partly reflects that regulations on reviewing benefit entitlements are not stringently applied and that there is a low take-up of work incentives.

Countries with high benefit levels generally tend to have high recipiency rates. But recently, countries with lower benefit levels have had equally high rates of inflow, and the rates of outflow have also been comparable. Similarly, countries with several grades of benefits for partial disability are among the group with high benefit recipiency rates. In these countries, one in three new awards is for partial disability.

Despite high rates of benefit recipiency, problems of exclusion from disability benefits remain, due partly to not fulfilling insurance requirements and partly to failing the (household) means test. In countries with a dual benefit system, *i.e.* insurance benefits for the labour force and means-tested disability benefits for those not qualifying for insurance benefits, the increasing proportion of recipients on means-tested benefits indicates an aggravation of this problem.

Women are generally under-represented on insurance programmes and over-represented on means-tested benefit programmes. This is not the case in some schemes

with individual entitlement for the entire disabled population, in which women below age 45 have much higher inflow rates than men.

Mental and psychological problems are responsible for between one-quarter and one-third of the disability benefit recipiency levels, and for a considerable portion of the increase in these levels.

Application rates for benefits differ less across countries than do inflow rates. Benefit rejection rates vary considerably between countries, and are highest in countries with the lowest inflows. Rates of successful appeal against benefit rejection, which are increasing in several countries, tend to be higher in countries with low rejection rates, indicating considerable differences in assessment procedures.

In a cross-country perspective, there is little evidence that high or increasing unemployment leads to high or increasing levels of disability benefit recipiency, while there is some indication that stricter access to disability benefits results in somewhat higher unemployment levels. There is also no evidence on programme interchangeability between early retirement benefits and disability benefits. On the contrary, countries in which the disability scheme is predominantly used by older workers tend to be countries with large numbers on early retirement programmes.

Considerable age profiling is apparent in disability benefit programmes. In many countries, disability benefit awards are highly concentrated among people over age 50. This reflects the age pattern of disability prevalence, at least in part. However, taking this age structure into account, some countries turn out to have particularly high rates of benefit inflow among younger disabled people.

Even more striking is the age bias in integration programmes. Vocational rehabilitation and training is predominantly offered to people below age 45, thus partly explaining the age bias in the disability benefit programme, but sheltered and supported-type employment programmes also tend to benefit mostly young severely disabled people.[3]

While the approach to vocational rehabilitation and training differs markedly between countries, this type of intervention is usually used too little, and often initiated too late. More can be done to involve the employers in this process. The average per capita cost for vocational rehabilitation and training is low compared to the average cost of a disability benefit. Provided that such intervention secures permanent employment, investments should pay off within a short period.

Countries differ markedly both in terms of the variety of special employment programmes for disabled people and the costs per participant. Where such programmes are permanent, in particular in sheltered employment, average costs can exceed the costs of per capita disability benefits. The type of employment programmes used has changed very slowly. While *sheltered* employment is increasingly seen as inappropriate and in need of being replaced by *supported* employment-type initiatives, empirically the protected sector remains as important as ever.

Different employment policy approaches seem to have similar effects. While legislative approaches to employment promotion differ in many respects (rights-based, obligations-based, incentives-based), all approaches tend to benefit people already in employment much more than those who are out of work and looking for a job. Proper sanctions on employers not fulfilling their obligations and adequate instruments to enforce these sanctions are crucial for an effective employment promotion policy.

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Variation in the employment rates of disabled people across participating countries is strongly correlated with variation in the employment rates of *non-disabled* people. This suggests, first, that general labour market forces have a strong impact on the employment of people with disabilities and, second, that general employment-promoting policies also foster the employment of special groups in the labour force, such as people with reduced work capacity.

Finally, lessons from general active labour market policy analysis are largely applicable to the situation of people with disabilities. Some of the critique, *e.g.* regarding deadweight or substitution effects, is less relevant, because of the permanent productivity loss of some groups of disabled people. Generally, it is necessary to balance measures affecting labour supply and labour demand.

1.4. Policy conclusions

No single country in this review can be said to have a particularly successful policy for disabled people. Nevertheless, there are differences in outcomes that appear to be related to the policy choices that countries have made. From these observations, the following policy positions can be recommended.

Recognise the status of disability independent of the work and income situation. Societies need to change the way they think about disability and those affected by it. The term "disabled" should no longer be equated with "unable to work". Disability should be recognised as a condition but it should be distinct from eligibility for, and receipt of, benefits, just as it should not automatically be treated as an obstacle to work. The disability status, *i.e.* the medical condition and the resulting work capacity, should be re-assessed at regular intervals. The recognised disability status should remain unaffected by the type and success of intervention unless a medical review certifies changes.

Introduce a culture of mutual obligations. Most societies readily accept their obligation to make efforts to support and (re)integrate disabled persons, but it is less common to expect disabled persons themselves and, if applicable, their employers to contribute to the process as well. This change of paradigm will require a fundamental rethinking and restructuring of the legal and institutional framework of disability policy in many countries. It will only be effective if it is accompanied by a change in the attitude of all those involved in disability issues. Note that the following three recommendations are to a varying degree related to this new culture of mutual obligations.

Design individual work/benefit packages. Merely looking after the financial needs of disabled people through cash benefits is insufficient; this would still leave many excluded from the labour market and sometimes even from society more generally. Therefore, each disabled person should be entitled to a "participation package" adapted to individual needs and capacities. This package could contain rehabilitation and vocational training, job search support, work elements from a wide range of forms of employment (regular, part-time, subsidised, sheltered) and benefits in cash or in kind. It could also in some circumstances contain activities that are not strictly considered as work, but contribute to the social integration of the disabled person.

Introduce new obligations for disabled people. Benefit receipt should in principle be conditional on participation in employment, vocational rehabilitation and other integration measures. Active participation should be the counterpart to benefit receipt. Just as the assisting caseworker has a responsibility to help disabled persons find an

occupation that corresponds to their capacity, the disabled person is expected to make an effort to participate in the labour market. Failure to do so should result in benefit sanctions. Any such sanctions would need to be administered with due regard to the basic needs of the disabled person and those of dependent family members. Furthermore, sanctions would not be justified in any case where an appropriate integration strategy had not been devised, or proves impossible to formulate, *e.g.* because of the severity or acuteness of the disability.

Involve employers in the process. Involving employers is crucial to the successful re-integration of disabled persons. Different approaches exist, ranging from moral suasion and anti-discrimination legislation to compulsory employment quotas. The effectiveness of the measures depends on the willingness of employers to help disabled persons stay in or enter work (which can be influenced through incentives aimed at raising labour demand), but also on the possibilities of circumventing legislation or paying the fines imposed for non-compliance.

Promote early intervention. Early intervention can in many cases be the most effective measure against long-term benefit dependence. As soon as a person becomes disabled, a process of tailored vocational intervention should be initiated, where appropriate including, *e.g.* job search, rehabilitation and/or further training. Where possible, such measures should be launched while the person is in an early stage of a disease or a chronic health problem. Preventive measures at the workplace could even be delinked from being temporarily out of work.

Make cash benefits a flexible policy element. The cash part of the work/benefit package needs to reflect the disabled person's capacity to work, but also needs to take into account whether the person has actually been able to find a job. Thus, cash benefits would have to be available with sufficient flexibility to take account both of different cases of remaining work capacity and of the evolution of an individual's disability status over time. In addition, benefit entitlements should be designed such that the disabled person is not penalised for taking up work.

Reform programme administration. A more individual approach will place a wide range of new demands on disability gatekeepers, *i.e.* the people who administer entitlement for, and arrays of, active and passive interventions offered to a disabled person. Caseworkers will need an extensive knowledge of the range of available benefits and services. More time will be required to assist individuals and follow each case. Implementation of a one-stop approach will help gatekeepers to manage the full menu of available interventions, and promote equal access to all programmes for all people.

Design disability programmes as active programmes. Often, disability benefit systems function as early retirement programmes, providing a route for quasi-permanent exit from the labour market. Emphasising activation and the mutual obligations of both society and the disabled person moves disability policy closer to the underlying logic of unemployment programmes, which expect an active contribution and effort from beneficiaries. Unreformed disability programmes are likely to attract applicants who may find it difficult to comply with the stricter obligations of unemployment schemes. There is a need for a consistent strategy in disability and unemployment policy that extends the culture of mutual obligations to all labour market programmes.

Notes

1. Twenty member countries have participated in this comparative review of working-age disability policies and outcomes: Australia, Austria, Belgium, Canada, Denmark, France, Germany, Italy, Korea, Mexico, the Netherlands, Norway, Poland, Portugal, Spain, Sweden, Switzerland, Turkey, the United Kingdom and the United States.
2. In this report, the term (disability) benefit recipiency is used to denote the number of people on disability benefits, while the term (disability) benefit inflow refers to the annual inflow of people onto disability benefits. Disability prevalence, finally, is the share of disabled people in the working-age population.
3. Supported employment in this study is defined as any form of personal assistance given at a job (on-the-job coaching or training) granted to the employer or the employee. Sheltered employment is defined as employment in a segregated environment, be it in a special workshop or a social firm or in a protected job or segment in the open labour market.

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Chapter 2

Objectives and Analytical Framework

Abstract. *Chapter 2 sets out the objectives of the report and introduces the conceptual framework. Details on the approach followed and on some of its limitations are to be found in Annex 1.*

2.1. Introduction

Ten years ago, the OECD published a report on "Employment Policies for People with Disabilities" (OECD, 1992), which aimed to identify some common problems or barriers for the labour market integration of people with disabilities, and to describe some emerging trends, issues and promising interventions in 14 countries.

In some respects, the starting position of this report remains the same. There is still growing concern in OECD countries about the exclusion of people with disabilities from the labour market and about the costs of disability income support programmes, both already mentioned in 1992. How to reconcile the twin, but potentially contradictory, goals of disability policy has yet to be resolved. One goal is to ensure that disabled citizens are *not excluded*: that they are encouraged and empowered to participate as fully as possible in economic and social life, and in particular to engage in gainful employment. The other is to ensure that those who are disabled have *income security*: that they are not denied the means to live decently because of disabilities that restrict their earning potential. Many member countries have been faced with a growth in the proportion of their population who are reliant on disability-related transfer payments – but find it difficult to reverse this trend without risking denial of support to those who really need it.

The labour market participation of people with disabilities is still unsatisfactory, as is illustrated by the higher non-employment rates and lower labour earnings of disabled persons.[1] The former is of particular concern, as non-employment often leads to ineligibility for transfer and/or employment-related programmes and thus increases the risks of poverty and social exclusion. But low employment rates of disabled people are also increasingly becoming an issue for reasons of macro-economic efficiency, which is concerned with making progress in using grossly under-utilised human resources.

In a majority of countries, the costs of disability benefits as a percentage of GDP have increased over the period 1990-1999, although with considerable differences between countries both in expenditure levels and in changes over time (Table 2.1).[2] In 1999, spending on disability benefits ranged from 0.02% of GDP in Korea to 3.2% in Poland, with an overall average of 1.3% and an average of 1.5% in countries with mature welfare systems. On the whole, though not necessarily for individual countries, the increase since 1990 has been compensated by a corresponding decline in public sickness benefit expenditure – in turn partly caused by shifting more responsibilities for income support or continued wage payments to employers.

By 1999, in all countries except Belgium expenditure on disability-related programmes exceeded expenditure on unemployment compensation – on average by a factor of two, and to a much larger extent in particular in Norway, Poland and the United States. Measured as a percentage of public social expenditure, the costs of disability benefit programmes fluctuate around 11%, and are almost 20% in the high-spending countries. In many countries this share has declined over the 1990s as a consequence of even more rapid rises in old-age pension expenditures.

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Table 2.1. **Considerable variation in public expenditure on disability-related[a] programmes**

Disability programme expenditure in percentage of GDP

	Disability benefits		Broad disability benefits		All disability-related programmes		
	Percentage of GDP		Percentage of GDP		Percentage of GDP	Percentage of expenditure on unemployment compensation	Percentage of total public social expenditure
	1990	1999	1990	1999	1999		
Australia	0.51	0.86	1.01	1.39	1.44	137	8
Austria	1.30	1.75	2.62	2.85	2.92	254	11
Belgium	1.32	1.06	2.21	1.61	1.72	95	7
Canada	0.46	0.67	1.19	1.23	1.28	130	7
Denmark	2.31	2.28	3.70	3.31	3.80	227	13
France	0.73	0.83	1.70	1.58	1.67	113	6
Germany	1.05	1.01	3.22	2.90	3.08	146	11
Italy	1.69	0.95	2.25	1.82	1.83	330	7
Korea	0.00	0.02	0.20	0.28	0.29	164	5
Mexico	0.09	0.20	0.15	0.29	0.29	..	3
Netherlands	3.42	2.65	5.74	4.14	4.64	178	19
Norway	2.23	2.36	4.92	4.83	5.58	1 190	21
Poland	2.39	3.28	3.15	4.42	4.60	719	20
Portugal	1.32	1.03	1.89	1.48	1.53	235	8
Spain	0.96	1.24	2.11	2.26	2.28	162	12
Sweden	2.03	2.05	5.21	4.02	4.66	292	15
Switzerland	1.05	1.83	1.58	2.21	2.40	267	8
Turkey	0.03	0.07	0.70	1.46	1.46	..	13
United Kingdom	0.88	1.27	1.39	1.52	1.54	268	6
United States	0.56	0.71	1.48	1.37	1.40	554	10
OECD (20)	1.22	1.30	2.32	2.25	2.42	217	11
OECD (17)[b]	1.42	1.52	2.67	2.53	2.73	233	11
EU (11)	1.55	1.46	2.91	2.50	2.70	190	11
Non-EU (9)	0.81	1.11	1.60	1.94	2.08	326	12

. . Data not available.

a) Various definitions of disability benefits are as follows:
Disability benefits = Contributory (earnings-related) and non-contributory disability benefits.
Broad disability benefits = Disability benefits, sickness cash benefits and work injury benefits.
All disability programmes = Broad disability benefits and employment-related programmes for disabled people.
Note: Sickness cash benefits include mandatory private benefits, *i.e.* continued wage payment.

b) Excluding Korea, Mexico and Turkey.

Source: See Annex 1, Table A1.1; OECD (2001c).

The fact that the problems do not appear to have changed since 1992 does not imply that policy has not changed during this last decade. All through the 1990s, most if not all OECD countries have undertaken substantial policy reform affecting working-age people with disabilities. The often new orientation of many of these reforms reflects a growing consensus as regards the underlying policy goals, such as, for instance, an "employment-for-all" policy. It appears that a major trend during the last decade is the convergence of policy objectives, and to some extent also instruments. In particular, countries with modest or partial disability policy packages seem to have moved to a more comprehensive

and balanced approach, increasingly emphasising the mutual obligation of the disabled person, the employer and the state.

This is also the policy approach arising from a number of supra-national developments. Following the UN Decade of Disabled Persons 1983-1992, the *UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities* were adopted in 1993.[3] Although not a legally binding instrument, these Standard Rules, which incorporate the human rights perspective that had developed during the UN Decade, represent a moral and political commitment by governments to take action in this area. In 2000, as another important example, an EU Council Directive establishing a *general framework for equal treatment in employment and occupation* (referring not only to disability) was issued. This Directive, which is aimed at combating discrimination, must be adopted by all EU member states by the end of 2003.

There is one more development that needs to be underlined, as it has strongly influenced these transformations. Associations of disabled people have become much more active, visible and accepted as independent actors in the policy process. The greater acceptance of these pressure groups has enabled them to go beyond pointing out problems, to participate in finding and obtaining tangible solutions.

2.2. Objectives of the project

The 1992 OECD report concluded that, in order to provide a basis for the development of sound economic policies in this area, more priority had to be given to investigations into the relationship between compensatory policy and work-enhancing programmes. The large number and new directions of policy reforms during the last decade suggest that it is again time for a review of disability policies for the working-age population, using a more far-reaching approach.[4]

Since 1992, cross-national disability policy research has in most cases continued to focus on either employment policies (for instance, Lunt and Thornton, 1993; Leichsenring and Strümpel, 1995; Thornton and Lunt, 1997; European Commission, 2000a), or income support policies (for instance, Bloch, 1994; Aarts *et al*., 1996; Andrews, 1998; Prinz, 1999). More integrated approaches have recently been adopted by other international organisations, most importantly by the ILO (international research project on "Job retention and return to work strategies for disabled workers", involving eight OECD countries, see, *e.g.* ILO, 1998), the ISSA (study on "Work incapacity and re-integration", involving five OECD countries plus Israel, see Bloch and Prins, 2001), and the European Commission ("Active employment policies and labour integration of disabled people: estimation of the net benefit", involving seven EU countries, see Fundación Tomillo, 2000). But in all these cases, the focus is overwhelmingly on the employment side.

This new OECD study, *Transforming Disability into Ability,* is a continuation of the work undertaken in the early 1990s. It aims to investigate disability policies for the working-age population from the perspective of the broader institutional system.[5] Some of the main objectives are:

- To understand better participating countries' approaches to disability policy and, in particular, to explore the consistency of and the relationship between employment-oriented and compensatory elements of the policy package. The success of labour market integration policies for people with disabilities cannot be tested or benchmarked without careful consideration of compensatory benefit systems. The need for consistent

policy is frequently underlined, but rarely analysed in a comparative manner. For instance, while it is common knowledge that definitions of disability vary not only between countries but also between different welfare programmes within countries, the potential effects of differences in definitions of disability between compensation and activation systems have yet to be described and understood.

- To identify policy packages that have proven successful in providing income security and promoting labour market participation and/or reducing disability benefit dependency. This requires analysis of policy reforms, and the linking of policy change and policy outcome, with special attention to the incentives created by the particular combination of interrelated programmes. Generally, the focus is on policy packages, as it is difficult and in many cases impossible to single out the effect of a single policy measure or instrument.
- To assess each country's distance from benchmarks of disability policy, and each country's position relative to other OECD member states. Covering a large number of countries in different stages of policy development results in a broader range of alternative policy approaches and possibilities for analysis. This study is not only looking at the challenges facing mature welfare states, but also at – sometimes different, sometimes similar – challenges facing developing and maturing welfare states. It will be interesting to see to what extent those countries that are trying to catch up with vanguard countries can do so by avoiding some of the "wrong tracks".

Details on the approach to achieve the project targets and on some project limitations are found in Annex 1 (Technical Annex).

2.3. Conceptual framework

Assessing consistency in policy settings requires a very broad system perspective. While two programmes, say for disability benefits and vocational rehabilitation, may appear largely compatible, their consistency may be obscured by a third programme, such as sickness benefits. The incentive structure of any particular system can only be understood in a broader institutional context. As a consequence, a large number of employment and benefit programmes directly or indirectly aimed at people with disabilities need to be taken into account.

Aarts *et al.* (1996) identified five paths that workers may take following the onset of a health condition: *a)* the *work* path, encompassing public programmes that provide or encourage rehabilitation to overcome any work limitations caused by a disability; *b)* the *early retirement* path, encompassing public or private provisions that allow the worker to retire prematurely; *c)* the *health* path, encompassing traditional disability insurance-based transfer programmes (sickness, general disability and work injury); *d)* the *unemployment* path, encompassing short-term and at some point longer-term provisions of unemployment benefits to replace lost wage earnings; and *e)* the *welfare* path, encompassing means-tested programmes that serve as a safety net for those ineligible for other programmes. Depending on the situation (*e.g.* employed or not employed at the time the disability occurs) and on individual characteristics, a disabled person may or may not have access to or even a choice between some of these five paths. The emphasis on and consistency between the paths will determine which type of pathway is more predominant in a particular country.

The conceptual framework used in this study is an extension of this approach. It distinguishes between two principal policy orientations within which several policy directions or paths are differentiated (Table 2.2). While some of the latter overlap with the

Table 2.2. **Scheme of the conceptual framework**

Policy orientation	Policy direction/Path	Description of the respective path
Integration/activation	Accommodated work	Regulations that enforce or encourage job retention and work accommodation or adaptation, including special subsidies for that purpose
	Subsidised work	Financial subsidies or other economic incentives to compensate for lower productivity
	Supported work	Provision of personal assistance at the job (*e.g.* job coach or training at the workplace)
	Sheltered work	Employment in a sheltered environment (special workshops, enclaves, social firms)
	Reserved work	Employment for specific groups in certain sectors/ professions in the open labour market
	Vocational rehabilitation	Programmes for vocational training and vocational rehabilitation
Compensation/transfer	Sickness cash benefit	Income replacement scheme for short-term sickness or disability
	Contributory disability benefit	Contributory income replacement scheme for general longer-term disabilities
	Non-contributory disability benefit	Non-contributory income replacement scheme for general disabilities (usually means-tested)
	Work injury benefit	Transfer programme covering work-related injuries, accidents and occupational diseases
	Unemployment benefit	Contributory as well as non-contributory provisions replacing lost wage, *e.g.* as a consequence of economic restructuring
	Early retirement benefit	Programmes for premature retirement for various reasons (*e.g.* long insurance record)
	Social assistance	Means-tested social assistance or welfare programme not related to the disability status; safety net for those ineligible for other transfers

Source: OECD.

paths used in Aarts *et al.* (1996), others are considerably more detailed. The main reason for extending and refining the five-paths approach is to enable the analysis of consistency relationships at a finer programme level, in particular between different work paths (*e.g.* subsidised employment and vocational rehabilitation) and between work and transfer paths (*e.g.* work accommodation or vocational rehabilitation and sickness cash benefits), but also between different – or rather subsequent – health paths.[6] Furthermore, with this refined framework the group of people currently not in the labour force (persons with congenital or youth disabilities, but also persons becoming disabled while performing housework who may or may not have previous work histories) can be captured. Approaching policies in this way allows for analysis of how people switch between or combine different paths.

Any of these policy directions can only be followed if certain conditions, *e.g.* regarding health status, work ability or insurance requirements, are fulfilled. Some paths may contain an element of choice. A few paths will be followed almost automatically (for instance, at least in most countries, sickness cash benefit), while most of them require individual action, or more formal action. Paths also differ in their involvement of the state, the employer and other actors.

No path can be analysed and understood in isolation. Programme coverage, entry conditions, benefit or programme duration and benefit levels for one path often directly influence the timing and extent of use of one or several other paths. For instance, the mandatory waiting period for sickness benefits will have an instantaneous impact on the disability programme and vocational rehabilitation. Or, to give another example, ease of access to early retirement will have a strong impact on disability benefit application by older workers. Hence, routes taken by workers following the onset of a disability depend on the national operation and policy context at a given point in time – and may affect different groups, *e.g.* age, differently. The complexity of these systems and the changes imposed by various reform steps are rarely addressed.

In addition, not all paths listed above exist in all countries. For instance, the Netherlands does not have a separate programme for work injuries. Only about half the countries have a supported employment programme, and very few have reserved areas of the labour market. Non-contributory disability benefit programmes, to give a last example, also exist in only about half of the countries.[7] These differences are an additional reason why the weight of one particular path within the disability policy package will vary from country to country.

Notes

1. In this report, non-employment is understood to be the sum of unemployment and inactivity.
2. Throughout this study we use the term "disability benefit" to denote public transfer programmes designed to pay benefits to persons with reduced work capacity caused by a health problem.
3. The Standard Rules consist of 22 rules concerning disabled persons, which cover all aspects of life of disabled persons and consist of four chapters: preconditions for equal participation (*e.g.* awareness-raising), target areas for equal participation (*e.g.* employment), implementation measures and the monitoring mechanism.
4. For the purpose of this project, working-age is defined as the 20 to 64 age range, irrespective of statutory retirement ages or early retirement regulations. Details on the different definitions of disability used in this report respectively in the different data sets are found in Annex 1 (Technical Annex).
5. This study aims to bring together the social insurance and the employment policy view. Several other features of the social, economic, physical and political environment that are not directed at the working-age population only – *e.g.* housing policy, infrastructure and accessibility, schooling and education, care policy, and in-kind/cash assistance with disability-related living costs – are not explicitly taken into account. For a similar reason and also because of problems in identifying expenditures and corresponding beneficiaries, tax policies are also disregarded, although they do play a sometimes increasing role in some of the English-speaking countries.
6. Work accommodation is understood to comprise all measures taken at the workplace (adjusting working hours, adapting the workplace, accessibility measures, etc.) that enable continued employment of employees after the onset of a disability and facilitate new recruitment of people with disability.
7. Australia and Denmark are the only two countries in this group in which the main public disability benefit is non-contributory. In all other countries, the main public programme is contributory (*i.e.* funded from social insurance contributions). Many of these countries have a second public disability programme, which is means-tested and non-contributory (*i.e.* funded via general taxes). These systems, often introduced more recently, provide disability benefits to needy persons with no or only a limited insurance record.

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Chapter 3

Evidence on Income and Labour Force Participation

Abstract. *Chapter 3 presents detailed findings from the comparative survey data analysis,* i.e. *empirical evidence on numbers of working-age disabled people and their socio-demographic composition as well as their incomes and degree of labour market integration. It also discusses the role of public policy in explaining those outcomes.*

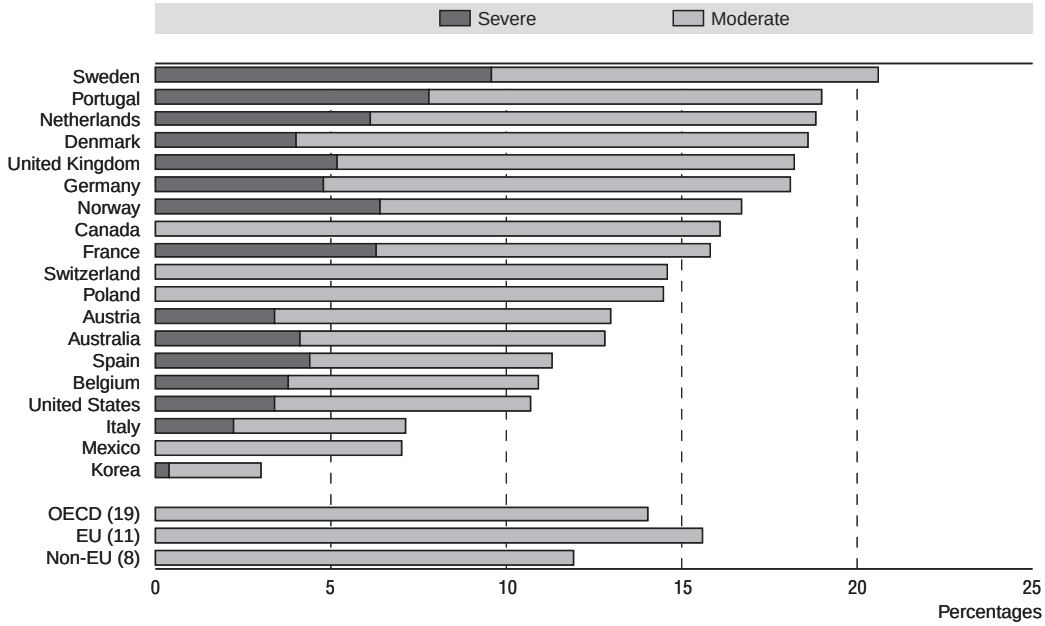
3.1. Identifying the working-age population with disabilities

A universal concept and definition of disability, and common measurement instruments, are not at hand. As a consequence, comparative statistics on the prevalence of disability are not easily available (Box 3.1). Objective measures may be desirable, but as they are not available, analysis must be based on self-reported disability, either using global questions about activity limitations in general, or instruments that ask about limitations in relation to specific activities of daily living. As the latter are not available for many countries, this project focuses on general activity limitations – *i.e.* questions on whether or not a person has a health problem that is limiting activities of daily living (ADL) in general (see also Annex 1).

Disability policies target a large and heterogeneous group of persons. In the twenty countries studied, on average about 14% of the working-age population classify themselves as disabled; the average in countries of the European Union is about one percentage point higher (Chart 3.1). In the "Northern" European countries (including the Netherlands, Germany and France) and in Portugal, disability prevalence is above this average – in these countries, more than one in six persons in the 20-64 year-old population reports being disabled. In four countries, disability prevalence is lower than the overall average:

Chart 3.1. **Average disability prevalence of 14%, of which one-third are severely disabled**

Disability prevalence, by severity of disability, as a percentage of 20-64 population, late 1990s



Note: Sum of "Severe" and "Moderate" for Canada, Mexico, Poland, Switzerland and unweighted averages.
Source: See Annex 1, Table A1.1.

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somewhat lower in the United States and Spain, and significantly lower in Italy and Mexico.[1] These figures are based on general population surveys and refer to persons who subjectively identify themselves as disabled, regardless of whether they are officially recognised as disabled.[2]

About one-third of this group of working-age disabled people are severely disabled, with a lower relative share in Austria and Denmark and a higher share in France and in particular Sweden. Persons with congenital disabilities form a minority of usually less than 10% of the entire group of working-age people with disabilities.

As one would expect, the prevalence of disability gradually increases with age: disability prevalence rates in the 50-64 age group are around 25%, but only 10% in the 20-49 age range (Table 3.1). Some of this increase is explained by the fact that a large part of disabling conditions have a permanent character. The age gradient is particularly strong in Austria, Germany, Poland and Portugal, and significantly below the overall average in Belgium, Korea and Switzerland.

The level of education also plays an important role: disability prevalence rates are significantly higher among groups with lower educational attainment, with an OECD average of 19%, compared to 11% among the better educated. Again, this result is not surprising given that this group is often employed in physically more demanding and

Table 3.1. **Higher disability prevalence with age and low educational attainment**

Disability prevalence by age group, gender and educational attainment, percentages, late 1990s

	All	Age group		Gender		Educational attainment	
	age 20-64	20-49	50-64	Male	Female	Lower	Higher
Australia	12.8	9.0	24.4	12.9	12.7	16.9	7.4
Austria	13.0	7.8	27.0	13.8	12.2	18.1	11.3
Belgium	10.9	8.4	17.5	9.8	12.0	12.2	9.1
Canada	16.1	13.4	24.2	15.4	16.8	18.5	14.9
Denmark	18.6	15.2	27.4	16.5	20.9	25.9	15.8
France	15.8	11.5	28.1	15.5	16.3	19.9	12.5
Germany	18.1	11.4	31.6	18.9	17.2	20.9	16.9
Italy	7.1	4.1	14.2	6.8	7.4	9.4	3.9
Korea	3.0	2.2	5.8	4.2	1.9	3.6	1.0
Mexico	7.0	5.1	15.8	7.8	6.2	..	..
Netherlands	18.8	14.8	29.9	15.9	21.6	23.2	16.8
Norway	16.7	13.3	26.4	13.6	19.8	22.6	13.9
Poland	14.5	7.5	31.1	..	..	..	..
Portugal	19.0	12.8	34.9	17.1	20.8	22.5	6.6
Spain	11.3	6.7	24.3	11.1	11.6	16.0	4.0
Sweden	20.6	15.5	34.1	18.4	22.9	31.8	17.9
Switzerland	14.6	12.1	21.3	13.6	15.5	20.6	13.3
United Kingdom	18.2	13.7	29.3	17.0	19.3	22.8	14.9
United States	10.7	8.2	18.8	10.4	10.8	22.3	8.9
OECD (19)	14.0	10.1	24.5	13.3	14.8	19.2	11.1
EU (11)	15.6	11.1	27.1	14.6	16.6	20.2	11.8
Non-EU (8)	11.9	8.9	21.0	11.1	12.0	17.4	9.9

.. Data not available.

Source: See Annex 1, Table A1.1.

Box 3.1. **Are survey data comparable?**

All data discussed in this chapter are derived from national population surveys. These survey data, which are used to identify the disabled population and to measure their income and labour force participation, suffer from several limitations. First of all, the institutional population, including many severely disabled people, is not covered in these household-based surveys. As a consequence, relative employment rates of the entire group of disabled people, for instance, will be slightly overestimated. Cross-country comparisons can be affected to the extent the degree of institutionalisation differs between countries. As far as the working-age population is concerned, however, this seems a minor problem.

Secondly, all information collected is self-reported. Estimates of the prevalence of disability based on self-assessment are sometimes criticised for being biased and endogenous; in other words, there may be a tendency to exaggerate the severity of health problems and the incidence of disability in order to rationalise labour force non-participation and the receipt of disability benefits. In addition, the perception of the individual affects their answer. But in fact there is ample evidence that self-reported disability indicators are a reasonable predictor of a person's objective health status (*e.g.* Benítez-Silva *et al.*, 2000). This seems particularly true for self-assessed disability relating to general (rather than work) limitations.

Self-reporting of employment and unemployment status, benefit recipiency status and income levels can be problematic and, at least partly, inaccurate. The magnitude of any bias and differences between countries are unknown. Even estimates are not feasible, as there is no possibility of linking the data sets used with official administrative data sources. Unemployment research has found significant under-reporting of benefit recipiency status (*e.g.* OECD, 1998; EUROSTAT 2001). This result is unlikely to be transferable to disability research. While disability benefits are quasi-permanent benefits, unemployment benefits are transitional payments bound to an activity test, which makes non-reporting of the benefit recipiency status much more plausible. On an aggregate level, the proportion of disability benefit recipients identified in the surveys does indeed show reasonable correspondence with the administrative data.

Cross-country comparisons can also be affected by differences in survey design, such as the definition of certain variables (*e.g.* Disability, employment), the formulation and sequence of questions, or the choice and number of answer categories. This is generally a minor problem for those eleven countries for which data from the European Community Household Panel (ECHP, see Annex 1) are available, as these surveys are based on an agreed questionnaire. Both ECHP data and some other surveys have a problem of mismatch of information provided for the time of the interview (*e.g.* current disability status, current employment status) and information referring to the year preceding the interview (last year's income). For the ECHP, analysis based on last year's status (taken from the previous wave of the survey) and income during this same year has shown that the economic well-being of disabled people relative to those of people without disabilities – on the basis of personal as well as equivalised household income – is not affected.

hazardous occupations and may also have more health problems as a result of lower incomes. In addition, congenital and youth disabilities are likely to affect schooling careers and the ultimate level of educational attainment (Box 3.2).

Box 3.2. **Disability prevalence and population ageing**

It is often argued that population ageing has had and will have considerable impact on disability prevalence. If age-specific prevalence rates remain constant during the coming three decades, the total disability prevalence of the working-age population would indeed increase significantly simply as a consequence of substantial shifts in the age structure: by more than three percentage points in Austria, and by over two percentage points in Italy and the Netherlands, as shown in the examples below – using three European countries with very different prevalence levels in the mid-1990s (Table Box 3.2).

Table Box 3.2. **Effect of population ageing on disability prevalence**

Disability prevalence applying 1996 age-specific disability prevalence to 1960, 1995 and 2030 population

	Prevalence			Index (1960=100)		
	1960	1995	2030	1960	1995	2030
Austria	14.9	13.0	16.5	100	87	111
Italy	7.3	7.7	10.0	100	106	137
Netherlands	18.7	18.4	20.6	100	98	110
Mexico[a]	12.5	11.7	14.8	100	94	118

a) EU14 average age-specific disability prevalence applied to Mexican population.
Source: United Nations, World Population Prospects 1950-2050 (2000 Revision), February 2001; EUROSTAT (2001a), Chart 3.

Until 1995, however, disability prevalence was not driven upwards by changes in population age structures. In Austria, an extreme case, the critical population in the 45-65 year age range has even declined considerably since the 1960s. The increasing prevalence rates that have been reported in the last few decades in a few countries (*e.g.* Jee and Or, 1998) cannot, therefore, generally be attributed to demographic changes, but are likely to be associated with a change in perception and an increase in expectations.

This simple calculation shows that the low disability prevalence in Mexico is partly a consequence of the younger population structure there. Applying average EU prevalence rates to the Mexican 1995 population structure gives a prevalence of 11.7% – compared to the EU average of 15.6%. In other words, about 45% of the difference between Mexico's disability rate of 7% and the EU average is explained by the different age structure. In addition, future age structure changes in Mexico will have an impact on disability prevalence that is of the same order of magnitude as for rapidly ageing European populations.

Women tend to report higher disability prevalence rates in a majority of countries – most especially in the Netherlands and the Scandinavian countries – but gender differences are usually small. Austria, Germany, Korea and Mexico report higher disability prevalence for men. It also appears that in most countries the age gradient is steeper for women than for men.

3.2. Income security: is the principal aim achieved?

Relative economic well-being

The income security of working-age disabled people seems reasonably *high* in many countries (see columns in Chart 3.2, Panel A).[3] The survey data analysed in this study show that in several European countries (Austria, Denmark, Germany, Netherlands, Sweden and Switzerland) the equivalised incomes of households with a disabled person reach around 95% of households without a disabled person.[4] The situation is slightly less favourable in several other countries where equivalised relative incomes of households with a disabled person amount to between 85% and 90% (Belgium, Canada, France, Italy, Norway and Poland).

Disabled people in Portugal, Spain, the United Kingdom and the United States are in a worse overall income position; in these countries, incomes of households with a disabled person are between 70% and 80% of the income of households without a disabled person.[5] Part of the cross-country difference in income security can be explained by differences in the structure of disability benefit schemes (*i.e.* earnings-related benefits or not, high or low replacement rates, means-tested or not; see Section 6.2). The relatively low income of households with a disabled person in Spain, however, is largely due to high non-employment rates among disabled people (see Section 3.3).

In terms of the *personal* incomes of people with disabilities, the situation is similar. The personal relative income of disabled over non-disabled people is generally around 5 to 10 percentage points lower than on a household basis. Not surprisingly, the lowest figure is found for Australia, with average personal income of disabled people equal to 44% of that of a non-disabled person.[6]

Data on personal incomes by *severity* of disability, which is available for 13 countries, show that on average severely disabled persons have 15% lower personal incomes than moderately disabled persons (Chart 3.2, Panel B). The difference is larger than this in Spain, Portugal and the United States, and also in Austria and Belgium. Sweden and the United Kingdom stand out as the only two countries where severely disabled people do not appear to be worse off than moderately disabled people. Some of the reasons for these cross-country differences are found in the following sections.

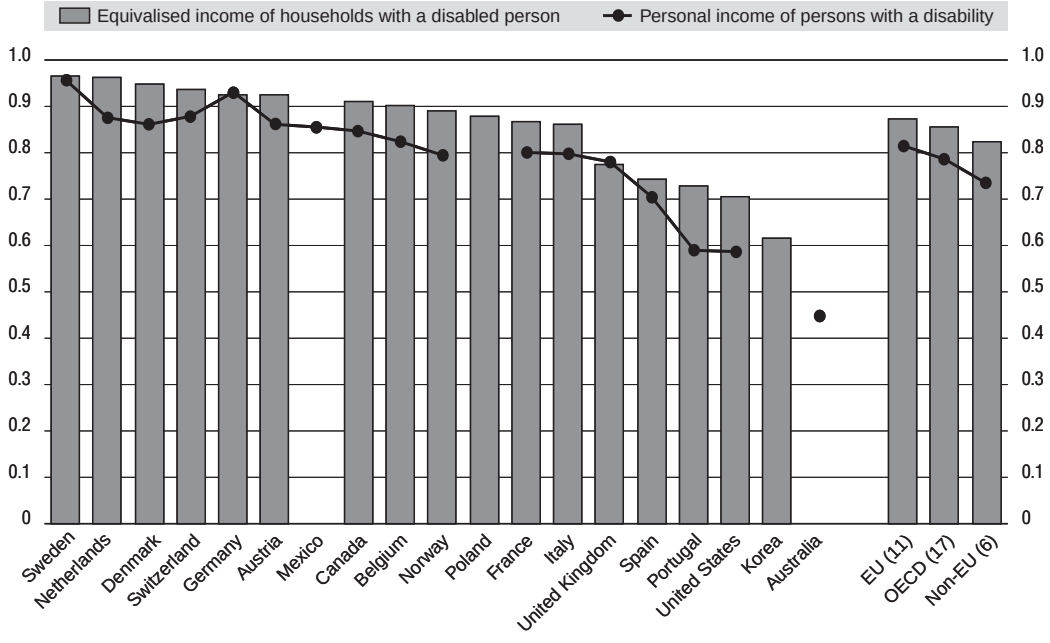
Income packages

The incomes of working-age people with disabilities come from a number of different sources. Overall, by far the most important component in all countries is *income from work*, which accounts for between 40% of total personal income in Belgium and 65% in France and the United States (Chart 3.3) – with over 50% on average across the countries for which comparable data are available.[7]

The other two important sources of income are disability-related benefits and, to a lesser extent, early or regular retirement benefits.[8] There are considerable differences between countries in the importance of those benefits in the overall income package. *Disability-related benefits* account for shares of between 10% in France and Sweden and 35% in Spain, with an average of about 20%. *Retirement benefits* usually represent about 10%; only in Italy and Sweden do they account for more than 20% and are therefore more important in the income package than disability-related benefits.[9] In a few countries, unemployment benefits and other – mostly family or lone parent – benefits can also amount to 10% of total income each.

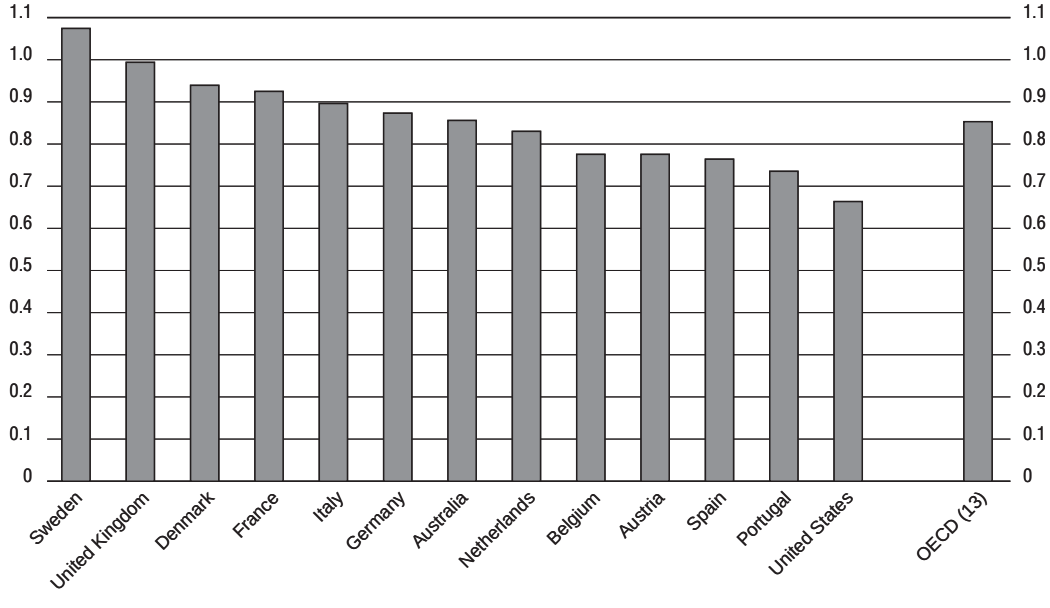
Chart 3.2. **Successful economic integration in many but not in all countries**

Panel A
Relative average income of disabled over non-disabled, for persons and households with a disabled person, late 1990s



Note: Countries are ranked in decreasing order of the ratio of equivalised incomes with a disabled person over those without.
No personal income data for Korea and Poland, and no household income data for Australia and Mexico.

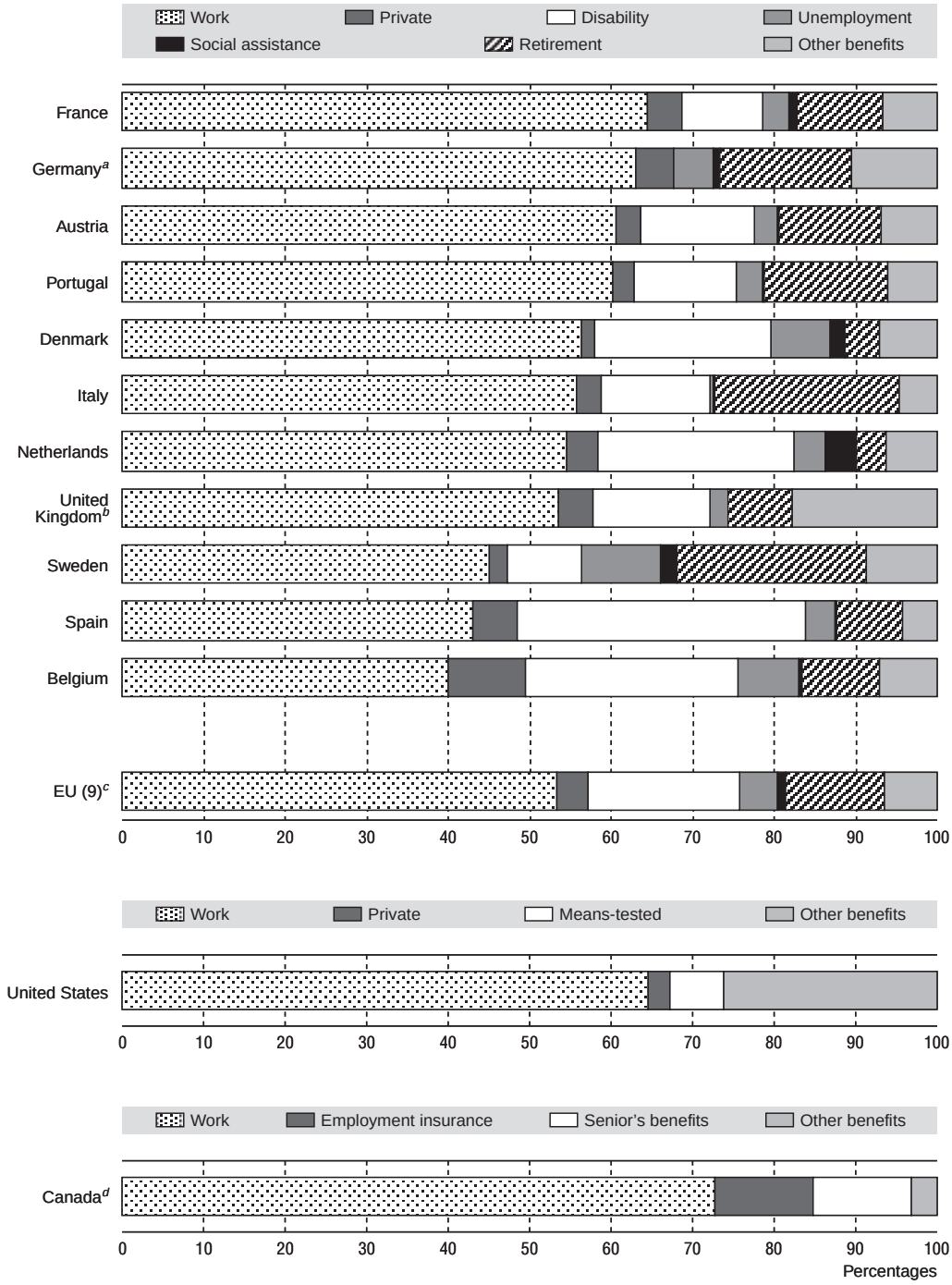
Panel B
Relative average personal income of severely over moderately disabled persons, late 1990s



Source: See Annex 1, Table A1.1.

Chart 3.3. **Three main sources of income for disabled persons: work, disability benefits, retirement benefits**

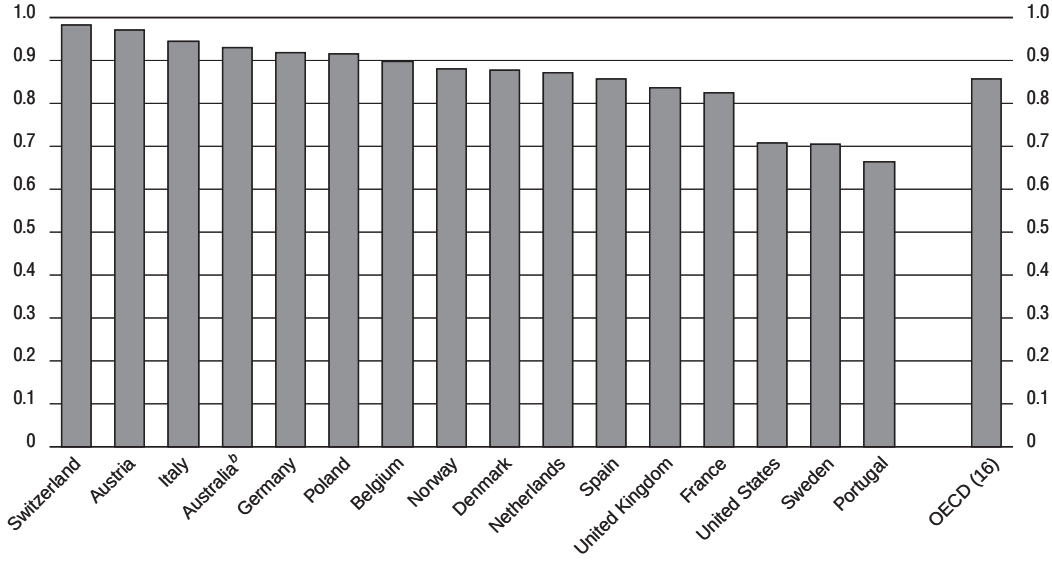
Distribution of personal income of disabled persons by source, percentages, late 1990s



a) Germany: restricted comparability – no data on income from disability benefits.
b) United Kingdom: restricted comparability – no data on income from Social assistance.
c) EU (9): excluding Germany and the United Kingdom.
d) Canada: equivalised household income.
Source: See Annex 1, Table A1.1.

Chart 3.4. **Little difference in work incomes between disabled and non-disabled persons**

Relative average personal[a] income from work of disabled over non-disabled persons who work, late 1990s



Note: Countries are ranked in decreasing order of the ratio.
a) Equivalised household income for Poland and Switzerland.
b) Australia: median income instead of average income.
Source: See Annex 1, Table A1.1.

Comparing disabled and non-disabled people who earn an income from work yields an important result: disabled people *in a job* earn almost as much as their non-disabled peers. In most countries, their work income is only about 5 to 15% lower, and in Switzerland and Austria, there is practically no difference in work incomes by disability status (Chart 3.4). Only in three countries (Sweden, the United States and Portugal) is work income around 30% lower for people with disabilities. In Sweden, this difference is largely due to a considerable share of part-time workers among disabled people.

Needless to say, there is a large difference in the *composition* of income between those disabled people who work and those who do not work. The income package of the latter group is generally dominated by disability-related benefits, which account for 40% on average for the nine EU countries with comparable data, while retirement benefits represent about 30% on average (Table 3.2; see also Section 3.4).

In addition, disabled persons *out of work* are generally much less well off than those *in* work. Their total personal income is, on average, only half that of disabled people in employment (Chart 3.5). But there are exceptions on both ends: in Denmark, the Netherlands and Sweden, the personal income of disabled people without work is over two-thirds that of their working counterparts, while disabled people without income from work are in a relatively worse position in the United States (about one-third) and in particular in Mexico.[10] Note that the lower personal income of disabled people out of work also explains the relatively lower incomes of *severely* disabled people, who generally have lower employment rates (see the following section).

Table 3.2. **Similar composition of income by work status in most countries**

Main sources of income of disabled persons according to work status, percentages adding to 100%, late 1990s

		Work	Private	Disability	Unemploy-ment	Social assistance	Retirement	Other benefits
Austria								
	Working	88.9	2.2	2.6	1.0	0.0	1.6	3.7
	Not working	0.0	4.4	38.5	7.1	0.1	36.2	13.7
Belgium								
	Working	72.9	7.9	11.9	3.3	0.2	0.3	3.5
	Not working	0.0	11.3	43.4	12.3	0.9	20.6	11.6
Denmark								
	Working	83.4	1.6	4.4	4.1	1.0	0.8	4.8
	Not working	0.0	1.7	57.8	13.8	3.7	11.1	11.9
France								
	Working	86.9	3.6	3.5	1.4	0.2	1.0	3.4
	Not working	0.0	6.1	28.5	8.4	2.7	38.5	15.9
Germany[a]								
	Working	86.3	3.6	..	1.7	0.3	2.6	5.4
	Not working	0.0	7.3	..	13.7	2.0	52.8	24.2
Italy								
	Working	90.1	2.2	2.1	0.3	0.0	3.3	2.0
	Not working	0.0	4.1	31.9	0.8	0.4	54.1	8.9
Netherlands								
	Working	85.1	1.6	5.8	2.0	0.4	0.5	4.7
	Not working	0.0	7.8	56.9	7.2	10.0	8.9	9.3
Portugal								
	Working	89.4	1.2	3.6	0.9	0.1	2.0	2.7
	Not working	0.0	5.6	30.8	8.6	0.1	42.1	12.8
Spain								
	Working	85.7	5.0	4.3	3.2	0.1	0.5	1.3
	Not working	0.0	5.6	67.0	4.0	0.2	15.7	7.5
Sweden								
	Working	59.4	2.0	9.1	8.2	0.7	13.7	6.9
	Not working	0.0	2.4	9.0	14.5	6.8	52.7	14.6
United Kingdom[b]								
	Working	87.2	4.7	1.6	0.3	..	1.4	4.8
	Not working	0.0	3.7	34.6	5.1	..	18.1	38.6
EU (9)[c]								
	Working	82.4	3.1	5.2	2.7	0.3	2.6	3.7
	Not working	0.0	5.4	40.4	8.5	2.8	31.1	11.8

.. Data not available.

a) Germany: no data on income from disability benefits.

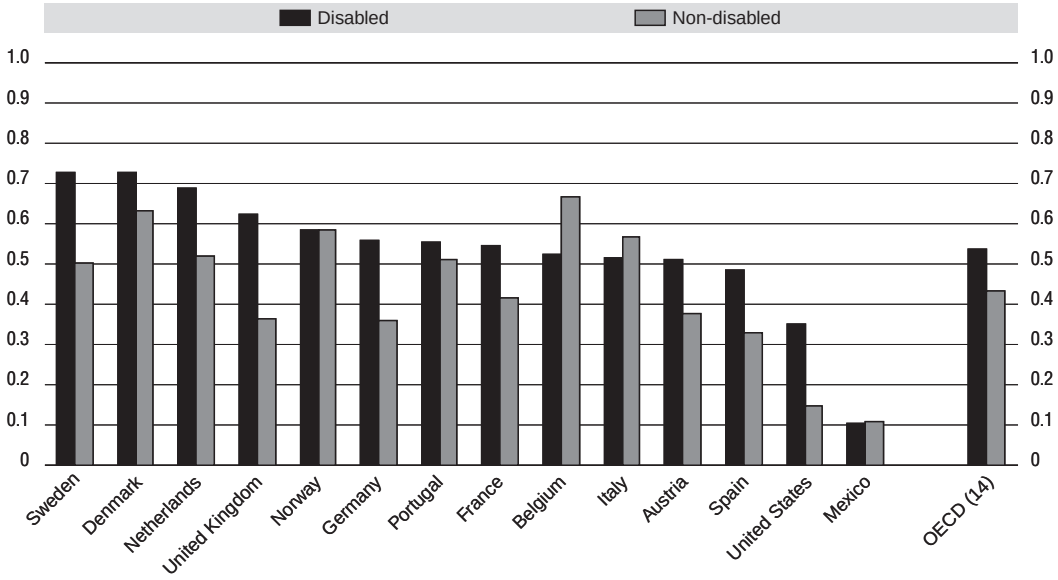
b) United Kingdom: no data on income from social assistance.

c) EU (9): excluding Germany and the United Kingdom.

Source: See Annex 1, Table A1.1.

Chart 3.5. **Big variation in income according to work status both for disabled and non-disabled persons**

Relative average personal income of those not working over those working, late 1990s



Note: Countries are ranked in decreasing order of the personal income ratio for disabled persons.
Source: See Annex 1, Table A1.1.

3.3. Work integration: is labour market participation satisfactory?

Employment rates

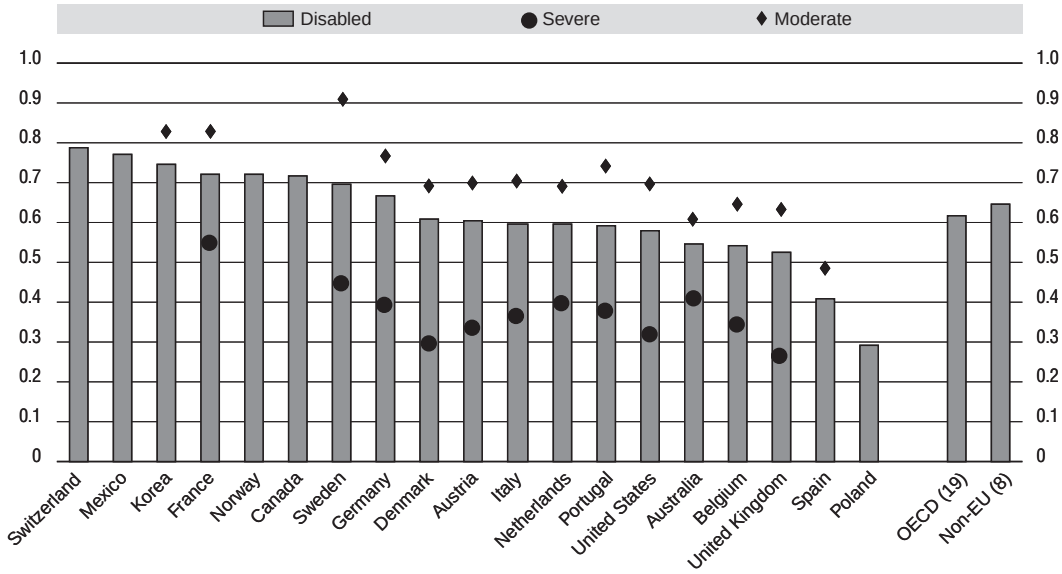
In the previous section it is argued that differences in incomes are largely a result of differences in employment rates. And indeed, the labour market integration of disabled people is not satisfactory. Over all age groups and countries, the employment rates of *severely* disabled people are only about one-third of those for the general non-disabled population, and for *moderately* disabled people around 70%. In total this gives an average relative employment-population ratio of around 60% (Chart 3.6).

By and large, the differences between countries in the relative employment rates of people with disabilities are fairly small. In almost all countries, the resulting relative employment rate is between around 50 and 70% – despite very different approaches to disability policy. Some countries achieve above average relative employment outcomes, notably Switzerland, France, Norway, Canada and Sweden. Korea and Mexico also belong to this group, although – as discussed later – on a lower absolute employment level. Note that countries with strong anti-discrimination legislation are found to do relatively badly on this relative employment measure, while countries with a mandatory employment quota are found all over the distribution (see Section 5.1 on this issue). France is the only country – for which such data are available – where the relative employment rate for *severely* disabled people is comparatively high, at almost 55%.

Spain (especially for moderately disabled people) and Poland have very low relative employment rates. The low figure for Poland must be interpreted with some caution, as this data set only identifies *registered* disabled people.[11] For the same reason, however, the high relative employment-population ratio in Korea (where also only registered disabled

Chart 3.6. **Unsatisfatory social integration of persons with disabilities in most countries**

Relative employment rate of disabled over non-disabled people, by severity of disability, late 1990s



Note: Level of disability not available for Switzerland, Mexico, Norway, Canada and Poland.
Source: See Annex 1, Table A1.1.

people are covered) is rather surprising – and can only be understood by the low level of benefit eligibility in a recently introduced and slowly maturing benefit scheme. It seems that in this country many people do not have any choice other than making an income through work; this hypothesis is supported by the unusually large difference in relative employment rates between moderately disabled and severely disabled people (80% *vs*. 20%).

In absolute terms, cross-country differences in the employment rates of disabled people are considerably larger than in relative terms.[12] In Norway and Switzerland, six out of ten working-age disabled people work, while in Spain and Poland this is true only for two out of ten (Table 3.3). For half of the countries, the rate is very close to 45%. The United States is the only country which, due to the high overall employment level, ranks much better in absolute than in relative terms (rank 5 in Table 3.3 compared to rank 14 in Chart 3.6). Mexico, Korea and Italy rank much worse in terms of absolute employment rates, due to their low overall employment rate.

In Australia and Spain, differences in employment rates between severely and moderately disabled people are much smaller than on average – a consequence of extremely low employment rates among moderately disabled Spaniards and relatively high employment rates of severely disabled Australians. The opposite, *i.e.* very large differences in employment rates between severely and moderately disabled people, is found in four countries (Denmark, Korea, Sweden and the United States).

When interpreting these survey data on relative and absolute employment rates, one always has to keep in mind differences between countries in the proportion of the working-age population subjectively identifying themselves as disabled (see Chart 3.1). A large proportion of disabled people may indicate a milder average disability level in this group, which could have an impact on employment rates. Overall, however, there is no

Table 3.3. **Lower employment rate with higher degree of disability**

Employment rate by severity of disability, percentage of 20-64 population, late 1990s

	All	Disabled			Non-disabled
		All disabled	Severe	Moderate	
Australia	72.1	41.9	31.4	46.9	76.6
Austria	68.1	43.4	23.9	50.2	71.8
Belgium	58.7	33.5	21.1	40.0	61.7
Canada	74.9	56.3	..	..	78.4
Denmark	73.6	48.2	23.3	55.1	79.4
France	63.6	47.9	36.4	55.5	66.6
Germany	64.8	46.1	27.0	52.9	69.0
Italy	52.2	32.1	19.4	37.9	53.8
Korea	61.2	45.9	13.4	51.5	61.7
Mexico	60.1	47.2	..	..	61.1
Netherlands	61.9	39.9	26.5	46.4	67.0
Norway	81.4	61.7	..	..	85.8
Poland	63.9	20.8	..	..	71.2
Portugal	68.2	43.9	27.6	55.3	74.0
Spain	50.5	22.1	15.1	26.5	54.2
Sweden	73.7	52.6	33.8	69.0	75.8
Switzerland	76.6	62.2	..	..	79.1
United Kingdom	68.6	38.9	19.3	46.8	73.9
United States	80.2	48.6	26.4	58.8	83.9
OECD (19)	67.1	43.9	..	..	70.8
OECD (14)[a]	65.5	41.3	24.5	48.8	68.1
EU (11)	64.0	40.8	24.9	48.7	67.9
Non-EU (3)[a]	71.2	45.5	23.7	52.4	74.1

.. Data not available.

a) Degree of severity of disability not available for Canada, Mexico, Norway, Poland and Switzerland.

Source: See Annex 1, Table A1.1.

correlation between disability prevalence and relative employment rates, suggesting that other factors – which are analysed in later sections – are much more important.

Looking at specific age groups gives a more differentiated and revealing overall picture. In many European countries, the relative employment rates of people with disabilities in prime working-ages (defined as people younger than 50 years of age) are very high – as high as around 85% in Austria, France, Germany, Italy and Switzerland, and close to 80% in Norway and Sweden (Table 3.4). Among non-European countries, only Canada and Korea come close to those relative employment levels at this age. In the other countries, however, the relative employment rates of disabled people in the 20-49 age group are only around two-thirds of those of non-disabled people in this age group, and in Spain and Poland even lower than that.

Disabled people over age 50 are in a much worse situation. The employment rates of disabled people drop much faster with age than the employment rates of non-disabled people. On average, these rates are only a little above 50% of those of people without disabilities. The low relative employment rates of disabled people over age 50 suggest considerable overlap between the disability and the older workers issues. The

Table 3.4. **Higher relative employment rates for persons of prime working age and with higher educational attainment**

Relative employment rate of disabled over non-disabled persons, by age group, gender and educational attainment, late 1990s

	All	Age group		Gender		Educational attainment	
	Age 20-64	20-49	50-64	Men	Women	Lower	Higher
Australia	0.55	0.66	0.45	0.54	0.56	..	..
Austria	0.60	0.85	0.55	0.60	0.59	0.49	0.67
Belgium	0.54	0.73	0.30	0.59	0.52	0.46	0.64
Canada	0.72	0.80	0.62	0.71	0.73	0.64	0.77
Denmark	0.61	0.74	0.42	0.61	0.62	0.44	0.73
France	0.72	0.83	0.67	0.75	0.69	0.71	0.83
Germany	0.67	0.84	0.65	0.69	0.62	0.57	0.71
Italy	0.60	0.84	0.52	0.59	0.63	0.48	1.02
Korea	0.74	0.82	0.66	0.66	0.69	0.73	0.89
Mexico	0.77	..	..	..	..	..	..
Netherlands	0.60	0.70	0.52	0.61	0.64	0.55	0.63
Norway	0.72	0.81	0.62	..	..	..	..
Poland	0.29	0.32	0.35	..	..	..	..
Portugal	0.59	0.70	0.56	0.59	0.62	0.58	0.85
Spain	0.41	0.53	0.36	0.43	0.37	0.41	0.57
Sweden	0.69	0.78	0.56	0.77	0.64	0.64	0.72
Switzerland	0.79	0.87	0.68	0.84	0.75	..	..
United Kingdom	0.53	0.64	0.42	0.51	0.56	0.41	0.65
United States	0.58	0.66	0.48	0.55	0.61	0.40	0.66
OECD (19)	0.62	..	..	..	..	..	..
OECD (14)[a]	0.61	0.75	0.52	0.62	0.61	0.54	0.74
EU (11)	0.60	0.74	0.50	0.61	0.59	0.52	0.73

.. Data not available.

a) Age, gender or educational attainment not available for Australia, Mexico, Norway, Poland and Switzerland.

Source: See Annex 1, Table A1.1.

disadvantage of middle-aged disabled people (50-64 age group) relative to younger disabled people (20-49 age group) is particularly striking in Austria, Belgium, Denmark and Italy. In these countries, high rates of early retirement appear to a considerable degree to be explained by the early labour market exit of people with disabilities.

While relative employment rates decline with the age of the disabled person, gender differences are insignificant. The combination of disability and low education, however, puts people at a particular disadvantage. On average, the relative employment rates of disabled people with lower educational attainment are as low as those for disabled people over age 50, whereas the employment rates for disabled people with higher educational attainment reflect those of the prime working-age group. The Netherlands and Sweden are the two countries with the smallest relationship between educational level and employment rates. In the Netherlands, this is due to a rather low relative employment rate among better-educated disabled people. By far the largest discrepancy by educational level is found in Italy, where better-educated disabled people appear to have very high relative employment rates.

Unemployment and non-employment

Low employment rates can be a consequence of two factors: higher inactivity rates and higher unemployment rates among disabled people. Unemployment rates of disabled people are indeed very high, on average over the countries for which data are available around 80% higher than those of their non-disabled peers (Table 3.5).[13] In Austria, Germany and the Netherlands, unemployment of disabled people (in relative terms) is particularly high – about 170% higher than for the population as a whole.[14]

In addition, the severity of disability makes a big difference. Among severely disabled people, unemployment rates are on average 180% above those of non-disabled people and 70% above those of moderately disabled people. The difference in unemployment rates between severely and moderately disabled people is highest in Denmark and Germany, and lowest in the United States and Australia. The latter could be a result of successful anti-discrimination legislation, although this speculative conclusion is not supported by data for the United Kingdom, which also has strong anti-discrimination legislation, but where unemployment rate differences are very much in line with those for other countries.

Table 3.5. **High unemployment rate with high degree of disability**

Unemployment rate by severity of disability, percentage of 20-64 population, late 1990s

	All	Disabled			Non-disabled
		All disabled	Severe	Moderate	
Australia	7.1	10.2	10.1	11.8	6.8
Austria	5.6	13.0	22.0	11.2	4.9
Belgium	14.4	22.8	35.9	18.2	13.9
Denmark	9.4	15.7	29.3	13.7	8.5
France	13.2	17.5	20.8	16.0	12.6
Germany	9.3	20.5	35.6	16.9	7.4
Italy	13.2	14.5	23.1	12.2	13.1
Korea	14.9	47.4	84.0	41.5	13.7
Mexico	3.6	1.8	..	..	3.7
Netherlands	12.5	26.8	39.6	22.3	10.1
Poland	13.6	19.7	..	..	13.2
Portugal	8.8	12.7	17.9	10.8	8.2
Spain	20.4	27.0	31.1	25.4	20.2
Sweden	10.2	18.0	21.4	16.4	11.9
Switzerland	3.7	6.8	..	..	3.3
United Kingdom	6.9	12.1	18.9	10.9	6.3
United States	3.7	5.3	5.7	5.2	3.6
OECD (17)	10.0	17.2	..	..	9.5
OECD (14)[a]	10.7	18.8	28.2	16.6	10.1
EU (11)	11.3	18.2	26.9	15.8	10.6
Non-EU (3)[a]	8.6	21.0	33.3	19.5	8.0

.. Data not available.
a) Degree of severity of disability not available for Mexico, Poland and Switzerland.
Source: See Annex 1, Table A1.1.

It is difficult to explain cross-country variation in unemployment rates by disability status. Some of the countries with small differences in unemployment rates, like the Southern European countries, are countries with particularly high inactivity rates of disabled people – with out-of-work shares of between 60 and 70%, compared to an OECD average of 48% for the whole group of working-age people with disabilities. Such a situation suggests very strong work discouragement in those countries, leading to a situation in which disabled people do not even try to enter the labour market. In this sense, lower excess unemployment rates can also be a sign of particularly strong disadvantages of disabled people in the labour market. Further, the interpretation of cross-country evidence on the unemployment rates of disabled people seems more restricted by differences in definitions used than for other indicators (see Annex 1). Therefore, analysis of outcomes will largely be based on data on employment rates.

3.4. Is labour force participation and income security explained by public policy?

Being employed and receiving a benefit

The survey data show that a considerable number of disabled persons receive income both from work and from public benefits. This share is by far highest in Sweden at over one-third, which is explained by a strong focus on partial benefits for all public transfer programmes, followed by Denmark with over one-fifth (Table 3.6, third column). In most

Table 3.6. **Work and benefit status of disabled persons**

Distribution of disabled persons by work-benefit status, percentages, late 1990s

	Employed			Non-employed		
	Total	*Of which:*		Total	*Of which:*	
		No benefits	Benefits		No benefits	Benefits
Australia	41.9	39.1	2.8	58.1	15.7	42.4
Austria	43.3	26.4	16.9	56.7	14.2	42.5
Belgium	33.4	15.1	18.3	66.5	16.2	50.3
Denmark	48.2	25.7	22.5	51.8	6.3	45.5
France	47.9	30.0	17.9	52.1	11.7	40.4
Germany	46.1	30.5	15.6	53.8	11.9	41.9
Italy	32.1	25.4	6.7	68.0	28.8	39.2
Korea	45.9	40.1	5.8	54.0	49.5	4.5
Mexico	47.1	44.8	2.3	52.9	52.5	0.4
Netherlands	39.9	23.3	16.6	60.1	19.5	40.6
Norway	61.7	56.5	5.3	38.3	12.2	26.1
Portugal	43.9	26.0	17.9	56.0	20.9	35.1
Spain	22.1	16.8	5.3	77.9	28.0	49.9
Sweden	52.7	14.8	37.9	47.3	1.1	46.2
Switzerland	62.4	52.0	10.4	37.6	14.2	23.3
United Kingdom	38.9	23.5	15.4	61.1	9.1	52.0
United States[a]	48.6	42.0	6.6	51.4	18.8	32.6
OECD (17)	44.5	31.3	13.2	55.5	19.4	36.1
ECHP (11)	40.8	23.4	17.4	59.2	15.2	44.0

ECHP: European Community Household Panel.
Note: Family benefits are considered as no benefits.
a) Benefits are disability benefits only.
Source: See Annex 1, Table A1.1.

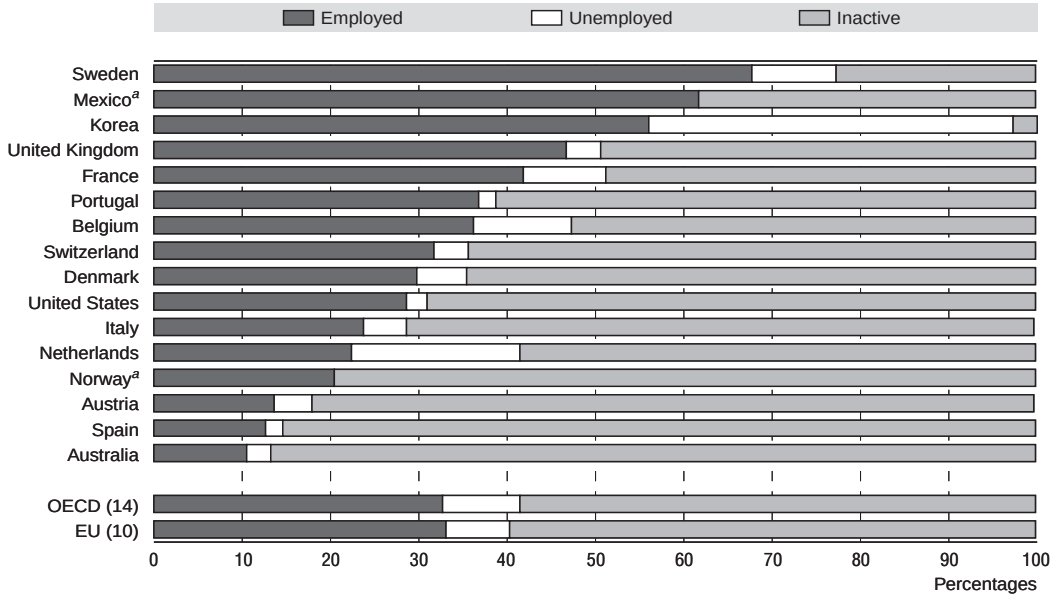
other countries, some 5 to 15% of all working-age disabled people who receive income from work at the same time receive a public benefit – usually a disability, unemployment or retirement benefit. In Australia (due to means-testing of public benefits) and in Mexico (where most of those people entitled to benefits receive an old-age pension), the percentage is particularly low.

Aside from Sweden, there is not a measurable correlation between the number of disabled people who have income from both work and benefits and a policy that provides for partial disability benefits paid to compensate for partially reduced work or earnings capacity (see Section 4.2 for more information on the issue of partial benefits). For instance, according to these data such work-benefit accumulation is higher in a country like Austria (with 17%), where no such partial disability benefit exists, than in Switzerland (with 10%), which provides for a quarter, a half and a full disability benefit.

Among recipients of disability-related benefits, on average, about one in three are also employed (Chart 3.7).[15] In three countries, however, more than one in two recipients of disability-related benefits report being employed (Sweden, Mexico and Korea). In three other countries, which have no partial disability benefit option, only about one in nine benefit recipients works (Australia, Austria and Spain). The low figure for Australia is surprising given that the means test does allow for partial income from work. Similarly, the figure for the Netherlands (at around 20%) is rather low, taking into account the large number of people on partial disability benefits – which only requires 15% earnings-capacity reduction.

Chart 3.7. **One in three recipients of a disability-related benefit works**

Work status of disability benefit recipients, percentages, late 1990s



Note: Countries are ranked in decreasing order of the share of employed.
a) Inactive means not employed.
Source: See Annex 1, Table A1.1.

In a few countries, significant proportions of disability benefit recipients report themselves unemployed; this is most pronounced in Korea but also in the Netherlands, two countries which were also shown to have unemployment rates that are much higher among disabled than non-disabled persons.

Being disabled versus *receiving a disability benefit*

A major challenge for disability benefit schemes is to find a proper balance in minimising both the exclusion error (*i.e.* refusing transfer payments to people who need them) and the inclusion error (*i.e.* granting benefits to people who do not need them).

The share of all working-age people with disabilities who receive neither income from work nor any type of benefits is therefore quite alarming (Table 3.6 and Chart 3.8, panel A). In Italy and Spain, this critical group accounts for nearly 30% of all working-age disabled people.[16] In Korea and Mexico, the proportion of disabled people with neither work nor income is almost 50%, in part because disability benefit schemes were introduced more recently. In most other countries, the proportion of this most vulnerable group is between 10 and 20%. In the Netherlands, a country in which disability benefit recipiency is perceived to be very high, still about one in five disabled people receives neither income from work nor public benefits. The proportion is only somewhat lower in Switzerland and Norway, two countries that have full population coverage in their benefit systems. Only in the United Kingdom, Denmark and especially Sweden do less than 10% of all disabled people have neither work nor benefit income.

Among disabled people who are not working, not surprisingly, the situation is much more acute. In most countries, between one-fourth and one-third of all disabled persons without a job have no benefit income (Chart 3.8, Panel B, first column). The figure is much higher in Korea and Mexico, over 90%, again a consequence of only slowly rising entitlement to recently introduced disability benefits. Otherwise, Italy turns out to be the country with the largest proportion (42%) of disabled people without a job who are not entitled to any benefit income. The proportion is again significantly lower than average, with 15% or less, in the United Kingdom, Denmark and Sweden.[17]

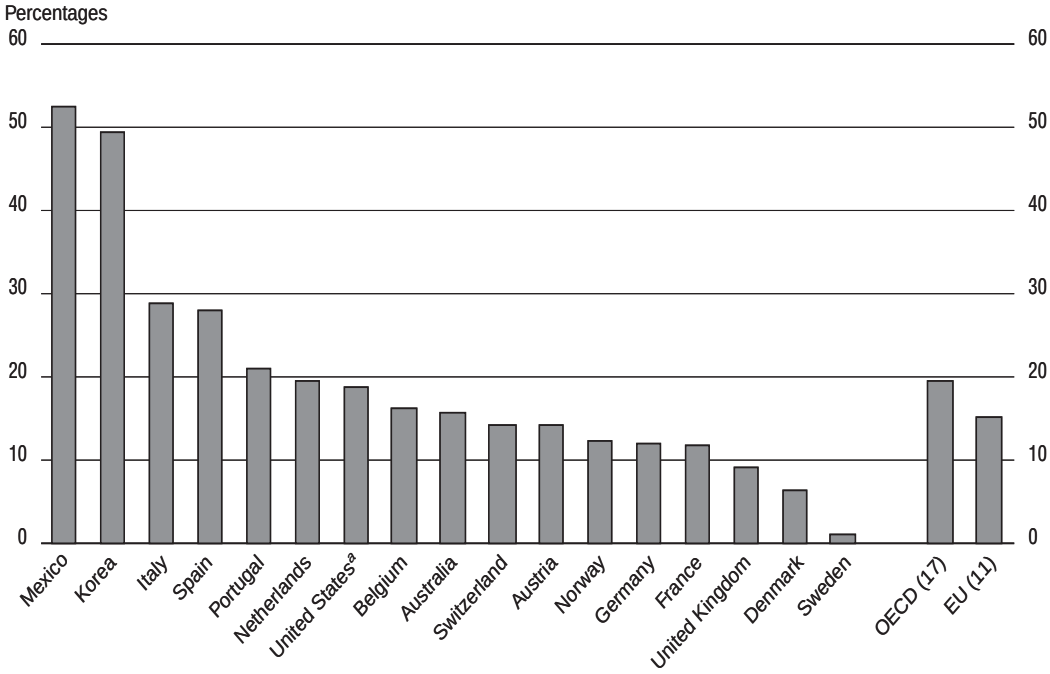
In several countries, exclusion from work and benefit income is strongly age-related, thereby affecting prime working-age disabled people more than those over age 50, who are entitled to some form of early retirement benefit. This is especially true for Southern Europe and for Austria, where more than 40% of all disabled persons below age 50 fall into this most vulnerable group – compared to just over 30% (in Southern Europe) or only 20% (in Austria) among those over age 50 (Chart 3.8, Panel B).

An important reason for disabled people not being entitled to benefits although being unable to work is individual non-coverage. People who never entered the labour force and people several years out of the labour force may not qualify for any disability benefit (*i.e.* no entitlement for insurance benefit although potentially fulfilling the disability criteria), or may only do so if meeting a strict household income-related means test (*i.e.* no entitlement because not meeting the household income threshold).

Even taking into account possible methodological problems, the difference between being disabled and receiving disability-related benefits is substantial and is found not merely in cases of moderate disability. Between 20 and 40% of all people classifying themselves as disabled receive a disability benefit (Table 3.7). Aside from Korea and Mexico, the proportion is lowest in Switzerland (18.5%) and highest in Belgium, Spain and the United States (39-40%).[18]

Chart 3.8. **Considerable proportion of disabled persons without any personal income**

Panel A
Proportion of disabled persons age 20-64 with neither income from work nor income from benefits, late 1990s



Panel B
Proportion of non-employed disabled persons with no benefit income, by age group, late 1990s

	20-64	20-49	50-64
Australia	27.0	..	..
Austria	25.0	40.9	19.6
Belgium	24.4	31.0	19.8
Denmark	12.2	16.2	9.0
France	22.5	23.2	21.8
Germany	22.1	23.3	21.8
Italy	42.4	60.8	34.4
Korée	91.7	..	..
Mexico	99.2	..	..
Netherlands	32.4	38.7	26.8
Norway	31.9	..	..
Portugal	37.3	48.4	30.1
Spain	35.9	42.6	31.7
Sweden	2.3	1.4	3.4
Switzerland	37.9	..	..
United Kingdom	14.9	13.4	16.0
United States[a]	36.6	..	..
OECD (17)	35.0	..	..
EU (11)	24.7	30.9	21.3

.. Data not available.
a) Benefits are disability benefits only.
Source: See Annex 1, Table A1.1.

Table 3.7. **Large proportions of severely disabled people do not receive a disability-related benefit**

Disability benefit recipiency rates in each disability status, percentages, late 1990s

	Panel data					Administrative data[a] All persons	
	Disabled			Non-disabled	All persons		
	All disabled	Severe	Moderate			1995	1999
Australia	28.6	41.6	22.4	0.8	4.3	4.2	5.2
Austria	20.9	37.7	15.0	1.2	3.8	4.3	4.6
Belgium	39.0	49.4	33.5	3.7	7.7	5.9	5.9
Denmark	34.3	64.7	25.9	2.8	8.7	8.1	7.7
France	22.8	35.4	14.5	2.1	5.4	4.6	4.7
Italy	20.7	35.7	13.9	1.2	2.6	7.2	5.5
Korea	10.3	4.7	11.3	0.0	0.3	0.1	0.3
Mexico	0.3	..	..	0.2	0.2	0.7	0.6
Netherlands	29.0	42.8	22.4	3.0	7.9	8.6	9.0
Norway	28.4	41.5	20.0	2.0	4.6	8.0	9.2
Portugal	21.2	31.6	13.9	2.0	5.6	6.6	6.5
Spain	39.6	59.0	27.3	1.1	5.5	5.0	4.7
Sweden	35.6	46.6	26.1	8.9	14.8	8.2	8.2
Switzerland	18.5	..	..	1.3	3.8	4.5	5.3
United Kingdom	37.0	63.6	26.4	6.3	11.6	6.5	6.6
United States	39.2	62.2	28.6	4.1	7.8	4.4	4.7
OECD (16)	26.6			2.5	5.9	5.4	5.5
OECD (14)[b]	29.0	44.0	21.5	2.8	6.5		
EU (10)	30.0	46.7	21.9	3.2	7.4	6.3	6.2

.. Data not available.
a) Disability benefit recipiency rates from administrative programme statistics are shown for comparison.
b) Excluding Mexico and Switzerland.
Source: See Annex 1, Tables A1.1 and A1.2.

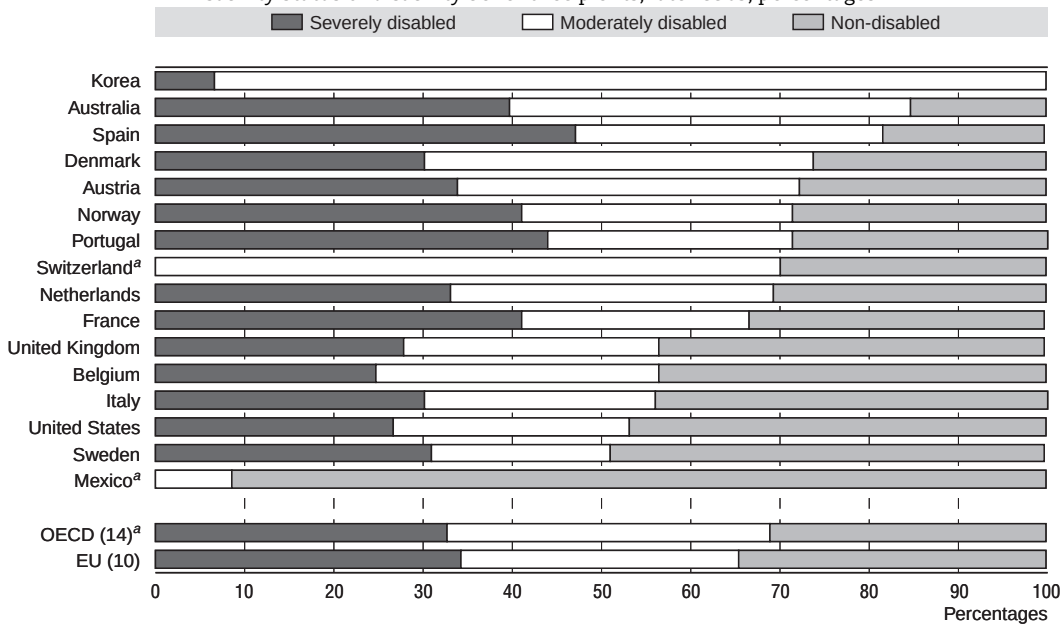
In the majority of countries, even among those people classified as severely disabled, 50 to 70% say that they do not receive disability-related benefits, although they may receive other types of cash benefits. So far as these people work, this may be a desirable policy outcome. To the extent that these people do not work and are excluded from receipt of public benefits, this points to a policy challenge. Only in four countries (Denmark, Spain, the United Kingdom and the United States) do the majority of working-age people with a severe disability receive a disability-related benefit.

Similarly, in half of the countries only about 25% of all moderately disabled people report receipt of disability-related benefits. This proportion is lower in, *e.g.* Austria, France, Italy and Portugal, which is explained mostly by the large share of disabled people receiving retirement benefits rather than by the stricter application of entry criteria in these countries. Belgium is the only country in which as many as one in three moderately disabled people receives a disability-related benefit.

While the majority of disabled people do not report receipt of a public disability benefit, at the same time, on average one in three qualified recipients of a disability-related benefit claims to have no subjectively perceived disability.[19] This type of mismatch is found in almost all participating countries, with rather small variations in percentages (Chart 3.9). Countries with partial benefit options, like Sweden, as well as countries that

Chart 3.9. **One in three disability benefit recipients do not classify themselves as disabled**

Disability status of disability benefit recipients, late 1990s, percentages



Note: Countries are ranked in decreasing order of the share of severely and moderately disabled persons among disability benefit recipients.
a) "Severe" and "Moderate" for Mexico and Switzerland. Excluded in averages.
Source: See Annex 1, Table A1.1.

lack such an option and have relatively strict access to disability benefits, such as the United Kingdom and the United States, are found among those with a high share (*i.e.* between 40 and 50%) of seemingly non-disabled people – non-disabled according to their own subjective perception – on disability benefit rolls.

Australia and Spain stand out as countries in which fewer – only about one in six – people on disability-related benefits claim to be not disabled or at least not hampered in daily activities by their health problem or disability.[20]

The difference between considering oneself disabled and receiving a disability benefit leads to different lines of conclusions – apart from issues of the quality and reliability of the data in general and of self-assessment of disability status in particular. One aspect obviously is that fluidity in disability status can have an impact. Being disabled is not necessarily a static characteristic; disability can be temporary or permanent, reversible or irreversible, progressive or regressive. In a recent longitudinal study using annual data from the British Household Panel Survey for the years 1991-97, Burchardt (2000) showed that, among those identified as ADL-limited during the observation period, 10% were found to be disabled in just one year, another 10% in two or three consecutive years and yet another 10% in two or three years but not consecutively.

Another key explanation is that the reasonably objective definition of disability used for disability benefit eligibility is not necessarily – and to a varying degree in different countries – a subset of the subjective self-assessment of disability used in the national surveys.[21] In other words, the subjective individual perception is partly based on different

implicit criteria and assessments, and this kind of mismatch is likely to be particularly strong for moderately disabled people. In addition, the findings seem to be a strong indication of the most critical difficulty or challenge for disability benefit schemes, namely to assess properly a benefit applicant's disability status. Empirical evidence seems to suggest that inclusion as well as exclusion errors are rather large in virtually all countries.

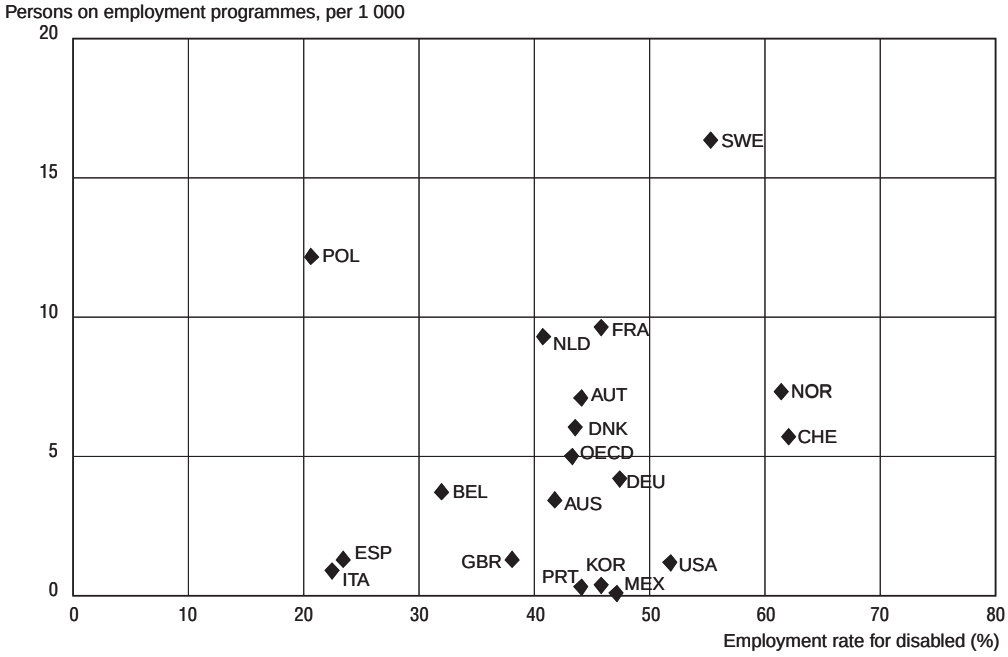
The role of special employment programmes

Higher employment rates of people with disabilities in some of the countries could be a consequence of two elements: better integration into the regular labour market, and a stronger focus on special employment programmes for people with disabilities. As to the latter, there are indeed considerable differences between countries' policies. In several countries, special employment programmes for disabled people are still virtually non-existent. In many West and North European countries, in contrast, up to 1% of the working-age population – and in Sweden even more than 1.5% – are found on such programmes.

The statistical correlation between this percentage and the outcome in terms of employment rates of disabled people, however, is weak (Chart 3.10). Admittedly, with one exception, no country with a significant focus on employment programmes for disabled people has below average employment rates, and many have relatively high employment rates. Poland is a real exception, with the second largest proportion of working-age people on special employment programmes for disabled people – most of it sheltered employment – and at the same time the lowest employment rate for this group. But there are also some countries without an employment policy focus that achieve relatively high employment outcomes, most notably the United States, and to some extent also Korea,

Chart 3.10. **Only a weak relationship between employment rates and focus on employment programmes**

Employment programme participants in 1999 *versus* employment rates in late 1990s



Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Mexico and Portugal. The within-group variation in terms of employment outcome is rather large in both the group with and the group without a particular focus on employment programmes for disabled people.

Another more illuminating way to look at this issue is to compare the number of people on special employment programmes (based on administrative data) with the number of disabled people in employment (derived from survey data). The result is pretty clear. Poland is the only country where special employment programmes apparently account for a significant part of the overall employment of disabled people. In all other countries, the number of people on such programmes is small in relation to the number of disabled workers – with a ratio below 0.15 and in most cases even below 0.07 (Chart 3.11, Panel A).

Part of this finding is explained by the fact that special employment programmes are generally not targeted at the broad group of disabled people identified in the survey, but at different and much smaller population groups. A comparison of the number of severely disabled people with the number of people on sheltered or supported employment may be less affected by this problem, as these programmes are by definition targeted at people with severe reduction in work capacity – even though, again, the definition of "severe" differs from the self-assessment of being severely disabled. Indeed, the ratio of the number of people on sheltered or supported employment programmes over the number of severely disabled workers is much higher, suggesting that in some countries the employment of severely disabled people is likely to be significantly influenced by these programmes (Chart 3.11, Panel B). This is particularly true for the Netherlands, with a ratio close to 0.6, which is due to this country's very broad sheltered employment programme. Austria, Belgium, Denmark, Korea and Germany all have ratios between 0.3 and 0.4, also predominantly resulting from sheltered rather than supported employment. Nonetheless, it is difficult to judge the impact of these programmes. France, the country with the highest employment rate among severely disabled people, for instance, has a relatively low ratio of only just over 0.15 (Box 3.3).

The role of disability benefits

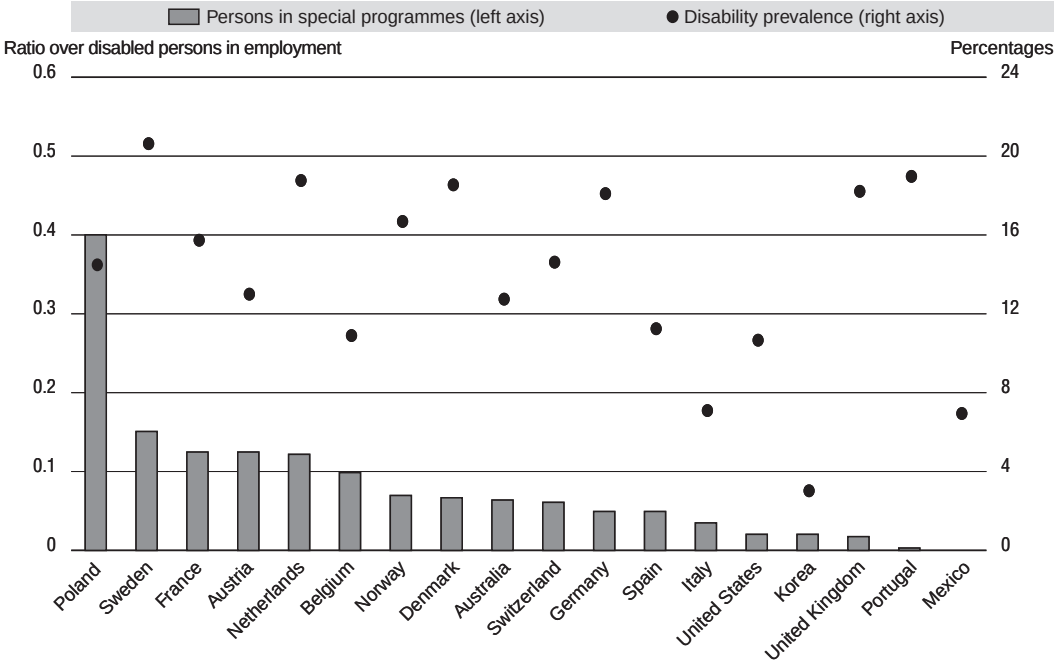
One may expect that low employment rates of people with disabilities are associated with high rates of benefit recipiency for this group of the population. Disability benefit recipiency rates, which give the number of recipients of public disability benefits per 1 000 people of working-age, show considerable variation across countries but do not seem strongly correlated with differences in employment rates between disabled and non-disabled people (Chart 3.12). Poland, the country with the lowest relative employment rate for disabled people, has indeed by far the highest benefit recipiency rate. Similarly, Korea and Mexico, countries that have much lower benefit recipiency rates than elsewhere, have high relative employment rates for people with disabilities. Among the remaining countries, though, there is no evidence of any correlation between the relative employment rates of disabled people and disability benefit recipiency rates.

Public disability benefit programmes can make an important contribution to the economic well-being of disabled people. The extent to which these programmes fulfil this role largely depends on benefit coverage and benefit levels (see also Section 6.2, in which the relationship between systems and outcomes is analysed using regression analysis). Earlier in this section, it is shown that in many countries a considerable proportion of people with disabilities have no personal income from work or any public benefits, which also has an impact on household incomes.

Chart 3.11. **Most employed people with disabilities are in regular employment…**

Panel A

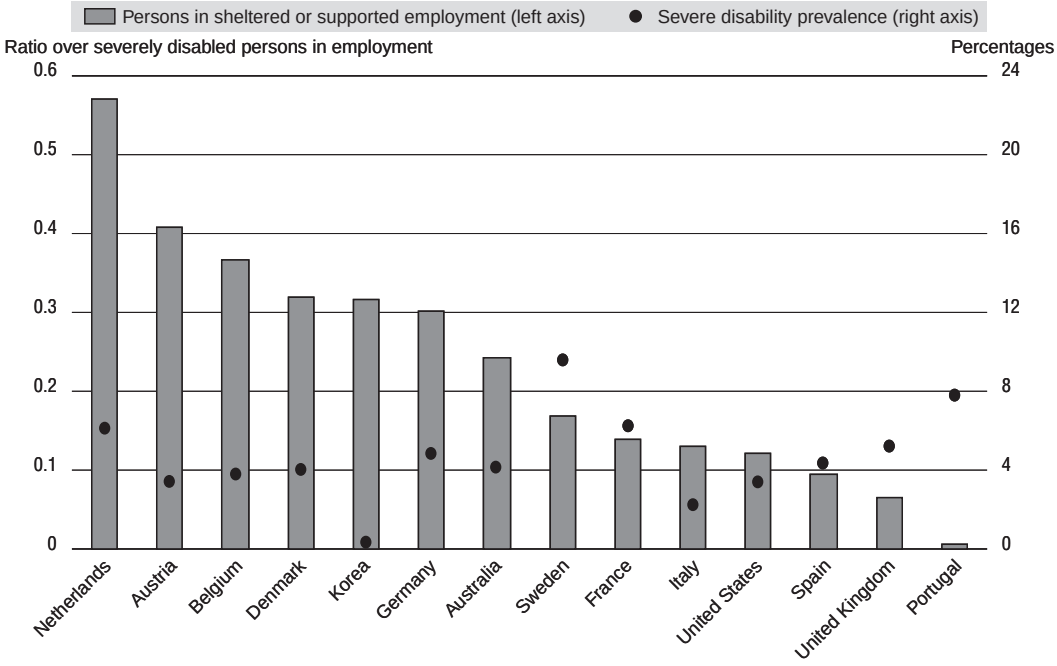
Relation between persons in special employment programmes and disabled persons in employment, late 1990s



… but many of those with severe disabilities are likely to be in sheltered or supported employment

Panel B

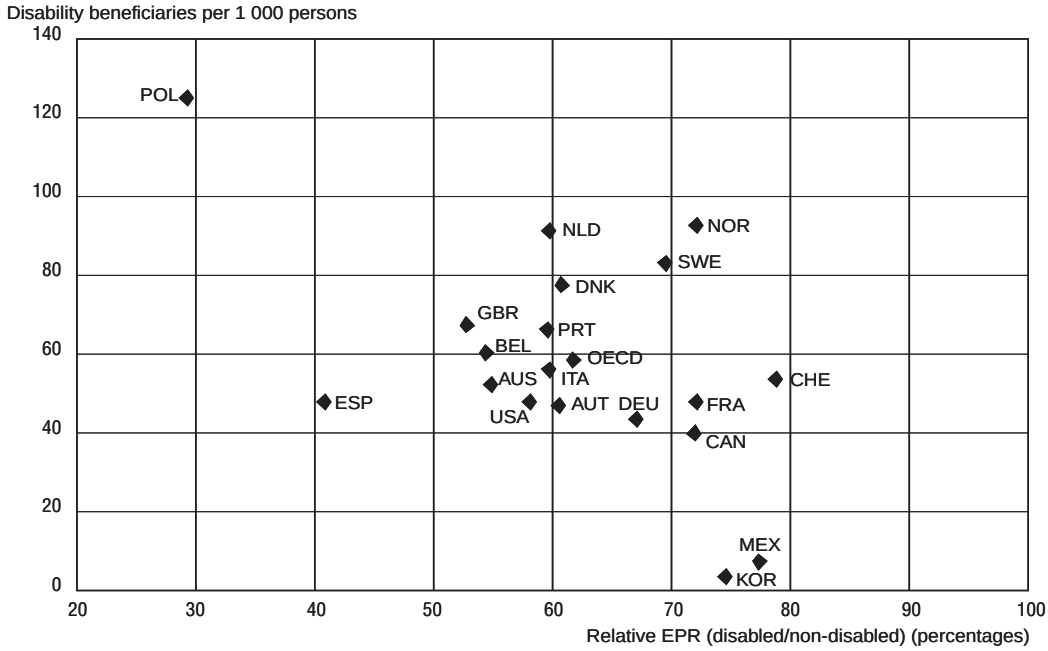
Relation between persons in sheltered or supported employment and severely disabled persons in employment, late 1990s



Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Chart 3.12. **No clear relationship between benefit recipiency and employment rates**

Disability beneficiaries per 1 000 persons of working-age population in 1999, and relative employment rate of disabled persons in late 1990s



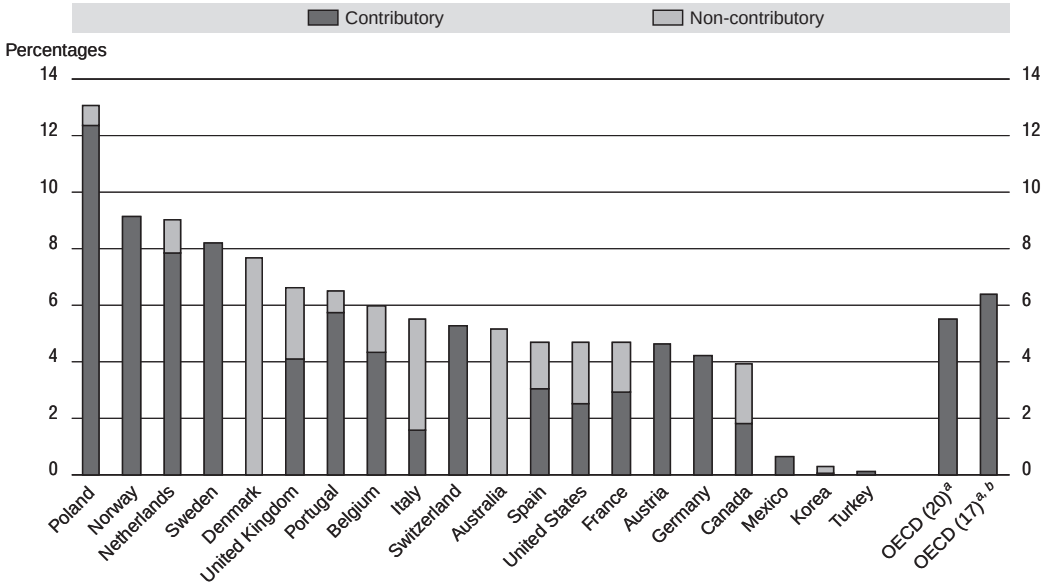
Source: See Annex 1, Table A1.1 and OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Poland is the country with the highest disability benefit recipiency level in the OECD and also worldwide – in 1999, more than 12% of the working-age population have received a public disability benefit. In four countries (the three Scandinavian countries included in this study and the Netherlands), disability benefit recipiency is between 9 and 8% of the working-age population. In twelve of the twenty countries (in descending order the United Kingdom, Portugal, Belgium, Italy, Switzerland, Australia, Spain, the United States, France, Austria, Germany and Canada) the respective rates are between 6.5 and 4%. In the three countries with maturing welfare states, disability benefit recipiency rates are still below 1% (Chart 3.13).

While, with a few exceptions, disability benefit recipiency rates are fairly similar, there are strong cross-country differences in the composition of recipients by type of benefit programme. In several countries, disability insurance is the only public disability programme. These are generally contributory, earnings-related programmes, although the systems in Norway, Sweden and Switzerland also cover the non-insured population via a basic – and hence non-contributory – benefit.[22] Denmark and Australia are the only two countries in this group with only a non-contributory disability programme with flat-rate benefits (with means-testing in Australia and without means-testing in Denmark). Half of the countries have a *dual* public benefit system: contributory earnings-related benefits from a disability insurance, plus non-contributory and in most cases means-tested disability benefits for those without a sufficient insurance record.[23] In some of these countries, insurance benefits dominate (Netherlands, Poland, Portugal, Belgium, Spain, France). But in the others, almost half or even the majority of benefit recipients are on

Chart 3.13. **Disability benefit recipiency rate concentrated at 5 to 7%**

Disability benefit recipiency rates in 1999 by benefit programme, percentage of 20-64 population, late 1990s



Note: The rate is corrected for persons receiving both contributory and non-contributory benefits, except for Canada (unknown).

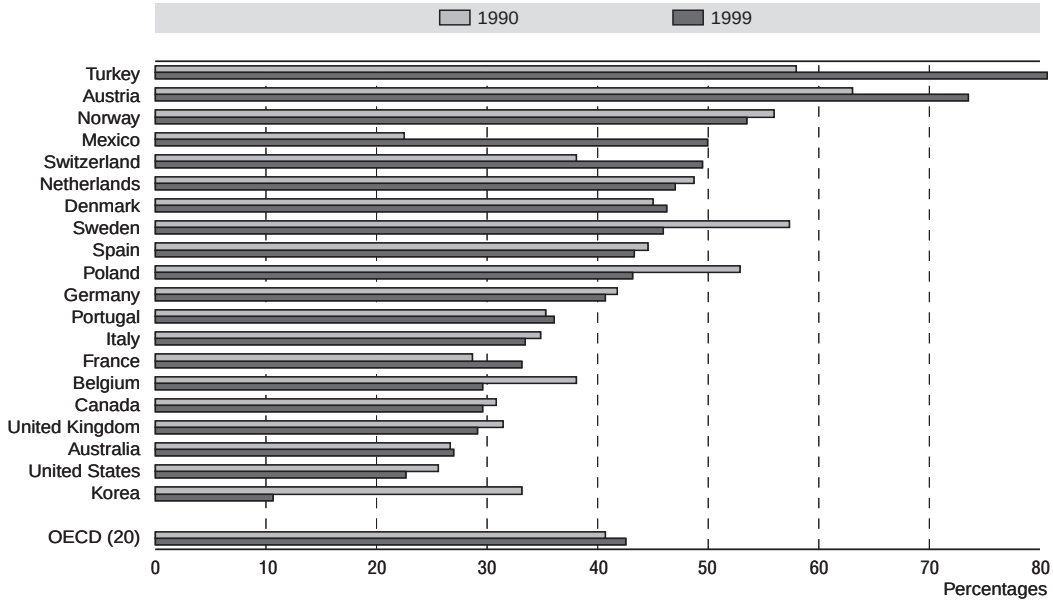
a) Contributory and non-contributory benefits.

b) Excluding Mexico, Korea and Turkey.

Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Chart 3.14. **Two different patterns in trends in average *per capita* disability benefits**

Average disability benefit in percentage of per capita wages 1990 and 1999



Note: Countries are ranked in decreasing order of the percentage of the 1999 per capita disability benefit.

Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Box 3.3. **National and regional/local disability programmes**

Analysis of special employment programmes for people with disabilities suffers from a particular problem: in some countries, such programmes are run on the regional or municipal rather than the national level, and respective statistics on programme participants and sometimes also programme expenditures are either not available or at least very difficult to obtain. This is particularly true in a federated country like Canada, where the federal administration has no access to provincial level data, and which therefore could not be included in this analysis. But similar problems also arise in some other countries, such as Austria, Belgium, Denmark, Germany, Spain and the United States. While for these countries data has been made available, this data may not cover their entire policy effort. In Austria, for instance, this problem arises for much of the sheltered employment sector, for which recipiency data was estimated on the basis of verbal communication, but also for vocational rehabilitation, which is only covered partially. In Spain, to take another example, broad competencies have been devolved to the autonomous communities, which has made collecting and systematising statistical data difficult.

In addition, analysis of special employment programmes designed for people with disabilities is partial, as it excludes disabled people participating in general active labour market measures. This is unavoidable as in the statistics disabled people in these programmes are usually not identifiable. Recent "mainstreaming" tendencies in several countries have led to a situation in which people with disabilities potentially may have access to a larger multitude of employment programmes, while this is not apparent from the statistics. This will increasingly blur the findings for some countries, including countries with a strong emphasis on active measures, such as Sweden, where the costs of special programmes have declined recently. At present, however, statistically this problem is still so small that it seems unlikely to invalidate the conclusions.

means-tested disability benefits. Only in Poland and the Netherlands is the non-contributory benefit not means-tested (Box 3.4).

These differences in the importance of non-contributory means-tested disability benefits are reflected in the level of the average disability benefit received. In countries with a dual disability benefit scheme, the average disability benefit is typically around or somewhat below 30% of the average wage (Chart 3.14).[24] In most of these countries, averages have declined over the last decade, as a consequence of a decrease in the proportion of recipients on insurance benefits. This is particularly true for Korea, where the non-contributory programme, which was only introduced after 1990, will play a major role until the maturing of the disability insurance programme. Countries with heavier emphasis on the means-tested scheme are found on the lower end, as is Australia with its entirely means-tested programme. Spain, although it also has a dual disability benefit system, is in a group with higher benefit levels, over 40% of the average wage, because the average earnings-related benefit is rather high.

Several of the countries with only insurance schemes have average disability benefits of around 45 to 50% of average wage. The figure is somewhat higher in Norway and much higher in Austria (over 70% in 1999) and Turkey (over 100% in 1999). Such large differences have a range of explanations, some country-specific. Countries with a strong focus on

Box 3.4. **Making recipiency and inflow data comparable across countries**

Data on (disability) benefit recipiency and inflow rates are not directly comparable between countries. In some countries, the entire population is insured or covered; in this case, the total population of working age is the appropriate denominator. In other countries, benefit systems only cover the labour force or perhaps only the employed population, which would then be the correct denominator for calculating rates or risks. But choosing the often very different insured population for the denominator is unlikely to give comparable results, for various reasons. Employed people have a different risk of applying for and being awarded a disability benefit than those who are unemployed or not part of the labour force. In addition, the age structure of the labour force is very different from the age structure of the working-age population, which would create another bias because the risk of becoming disabled is highly age-related. Moreover, even between countries with labour force coverage only, for the same reason differences in the age structure of the labour force would affect the comparability of estimated recipiency and inflow rates.

To make things more complicated, yet another – and in fact the largest – group of countries has a dual benefit system, where different parts of the population are covered by different schemes. In theory, if both components of the system are taken together, the total working-age population should be the appropriate denominator in this case. But this is not really true because the non-contributory benefit component is usually means-tested; hence, a certain part of the theoretically insured population is *de facto* ineligible for benefits. In these countries, the labour force has a very different likelihood to be awarded a benefit than those with insufficient insurance records. This raises issues of comparability between countries with a dual benefit system, and of course between these countries and countries with only one programme. Moreover, the Netherlands is a very special case that does not fit any of these groups, as this system covers the labour force and all disabled youth, but not those who become disabled in adulthood while out of work.

There is no easy solution to this problem. The trouble is aggravated by the fact that reforms affecting benefit access (*e.g.* lengthening the insured period required to become eligible for an insurance benefit) would need to be reflected in a change of the denominator. The simplest approach, which is chosen in this study, is to relate the number of (new) benefit recipients to the entire working-age population for all countries, irrespective of the benefit scheme. Variations in recipiency and inflow rates are then naturally to be explained by a whole range of systemic differences, including the definition of coverage. With this approach, countries with labour force coverage only are expected to have lower recipiency and inflow rates. But correcting the data for differences in coverage rules may not be desirable anyway, as the variation in recipiency outcomes resulting from differences in these rules are particularly important for the analysis.

partial benefits are generally found in the group with lower average benefit levels. And some of the recent decline in benefit levels in these countries is explained by the increase in the proportion of partial benefits (in particular in Sweden, where an additional partial benefit level was introduced in 1993). But these arguments do not hold for Switzerland, which also pays benefits for partial disability. This country has seen a substantial increase in average benefit levels during the 1990s, which can be attributed to several components:

a decline in the proportion of partial benefits, an over-proportional increase in mandatory second-pillar benefits (to which around 50% of all benefit recipients are entitled) and an increase in the proportion of people entitled to top-up payments (by 1999, 25% of all recipients had received such payments).

The low average benefit in Germany is partly a consequence of reunification and the considerably lower wage and consequently benefit level in the Eastern Länder. The high benefit level in Austria is, except for the lack of partial benefits, explained to a considerable extent by the unusually high proportion of men among benefit recipients (76% in 1999) and partly by high average benefits of civil servants, which constitute a sizeable share of the beneficiary population. The recent very sharp increase is partly a consequence of policy reforms during the 1990s. In Mexico and Turkey, increases are related to the maturing process of the system. In addition, the particularly high average benefit level in relation to the average wage in Turkey reflects selective coverage of the benefit scheme.

The role of other public benefits

These considerable cross-country differences in disability benefit coverage and average benefit levels are only partly reflected in the estimates of the economic well-being of disabled people. Some of the expected effect is obscured by the fact that disability benefits are not the only types of transfer payments that people who identify themselves as disabled receive. On average, only one in two disabled people who are not employed and receive some public benefit reports receiving a disability benefit – although the proportion is more than 70% in Spain, and even close to 90% in Norway, where other benefits play a very minor role for people with disabilities (Table 3.8).

In several countries, (early) retirement benefits are as important as disability benefits for disabled persons of working-age. In Austria and Portugal, for instance, one in

Table 3.8. **Which benefit for non-employed disabled persons?**

Distribution of non-employed disabled persons by type of benefit, late 1990s

	Disability	Unemployment	Social assistance	Retirement	Other
Australia	60.8	..	..	..	39.2
Austria	44.2	11.3	1.9	32.5	10.1
Belgium	61.2	16.5	0.4	17.9	4.0
Denmark	63.3	18.7	0.0	9.2	8.8
France	38.9	11.6	10.6	25.2	13.6
Italy	47.4	0.8	0.8	46.7	4.3
Mexico	25.0	..	..	..	75.0
Netherlands	59.6	8.4	17.2	5.4	9.4
Norway	88.7	8.4	..	2.9	..
Portugal	45.0	9.1	1.4	33.6	10.8
Spain	73.3	8.6	2.0	10.2	5.8
Sweden	34.2	13.9	5.0	38.3	8.7
Switzerland	54.1	..	..	..	45.9
United Kingdom	58.5	2.7	..	10.4	28.5
OECD (14)	53.9	..	..	..	..
EU (10)	52.6	10.2	4.4	22.9	10.4

. . Data not available.

Source: See Annex 1, Table A1.1.

three non-employed disabled persons receives an early or regular retirement benefit, and in Italy and Sweden the importance of retirement benefits is even more pronounced. These high percentages are to a certain extent explained by the fact that access to early retirement benefits is usually easier – once the insurance requirements are fulfilled – and requires no medical examination and qualification procedures.

Unemployment benefits generally are used much less frequently than retirement benefits. In the United Kingdom, for example, less than 5% of non-employed disabled people of working-age who are on benefits receive unemployment benefits – compared to 60% who receive disability-related benefits. In some other countries, though, such as Belgium or Denmark, unemployment benefits do play a more important role – with almost one in five people in that group receiving such benefits. Despite a longer duration of unemployment payments for older workers in many countries, the proportion of non-employed disabled people on unemployment benefits is generally higher among those younger than 50, largely because these people have no access to (early) retirement entitlements.

Social assistance benefits empirically appear to be less relevant as support to disabled persons.[25] In many countries, even among this group of non-employed disabled people less than 3% receive means-tested welfare payments. Higher proportions, around or above 10%, are found only in France and the Netherlands – noting that data on social assistance are not available in all surveys.

Table 3.9. **Disability benefits much more widespread than unemployment benefits**

Share of benefit status in non-employment, and non-employment rate, 1990, 1995 and 1999

	Share of benefit status in non-employment (adding to 100%)											
	Unemployment			Disability-related benefits			Other			Non-employment rate		
	1990	1995	1999	1990	1995	1999	1990	1995	1999	1990	1995	1999
Australia	15.4	18.1	15.6	10.6	24.8	27.1	73.9	57.2	57.3	29.4	29.8	29.7
Austria	..	9.2	9.3	..	18.1	19.2	..	72.7	71.5	..	29.0	29.0
Belgium	11.2	16.0	16.6	18.8	21.0	24.2	69.9	63.0	59.2	40.3	38.6	35.7
Canada	22.2	23.5	20.3	21.3	19.5	22.2	56.4	57.0	57.5	27.4	29.5	26.8
Denmark	31.6	22.5	18.2	44.2	41.7	40.8	24.2	35.8	41.0	22.5	24.7	22.1
France	19.6	24.3	25.5	13.6	13.2	13.7	66.7	62.5	60.8	33.6	35.0	34.1
Germany	10.2	18.7	21.0	13.9	18.2	18.9	75.9	63.1	60.1	33.3	32.4	31.3
Italy	15.7	14.8	15.8	27.5	20.7	16.7	56.8	64.4	67.5	41.5	44.8	43.4
Korea	5.4	4.9	13.2	0.0	0.3	1.8	94.6	94.8	85.0	30.1	29.0	33.4
Mexico	..	9.0	3.7	..	3.0	2.9	..	88.0	93.4	..	37.8	34.8
Netherlands	13.1	13.8	8.2	25.1	25.7	33.4	61.8	60.5	58.4	36.4	33.4	27.1
Norway	16.1	16.0	11.7	35.2	35.4	48.9	48.7	48.6	39.4	23.1	23.0	19.2
Poland	..	27.0	24.9	..	37.7	37.2	..	35.3	37.9	..	35.7	36.5
Portugal	11.5	17.1	12.2	29.8	21.8	24.6	58.7	61.2	63.1	28.6	31.1	27.3
Spain	21.0	29.0	23.9	11.7	10.3	11.0	67.3	60.7	65.1	45.8	48.9	42.7
Sweden	9.9	30.7	23.8	60.9	39.0	39.5	29.2	30.3	36.6	13.6	24.0	23.5
Turkey	9.9	9.1	9.3	1.6	0.9	0.8	88.5	90.0	89.9	42.8	44.1	45.6
United Kingdom	19.0	21.8	15.8	17.3	23.8	26.7	63.7	54.4	57.6	26.6	29.1	26.7
United States	15.7	15.6	12.5	30.2	33.8	34.9	54.1	50.6	52.6	25.1	24.8	23.1
OECD (18)	..	18.0	15.9	..	21.5	23.4	..	60.5	60.7	..	32.9	31.1
EU (11)	..	19.8	17.3	..	23.0	24.4	..	57.1	58.3	..	33.7	31.2

Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2; OECD database on labour force statistics.

Figures on the distribution of different types of benefits received are not available in all surveys. Linking labour force statistics with administrative disability benefit recipiency statistics gives another view on the relative importance of disability and unemployment benefits for the non-employed population of working-age. The comparability of these data, though, is limited by differences in the causes of non-employment.[26] In some countries, especially the Scandinavian countries, disability is the major cause of non-employment. In these countries, therefore, the relationship between unemployment and disability benefits will be similar for disabled people not employed and the general working-age population not employed. In other countries, most especially in Italy and Spain, this is not the case; in these countries, disability benefits will play a much more limited role for the general non-employed population than for the non-employed disabled population.

These differences are reflected in the benefit distribution of the non-employed population. In a majority of countries, disability benefit recipiency is more widespread than unemployment benefit recipiency. This is not the case in the three countries with maturing disability schemes, and – partly for the reasons given above – also in Spain, France and Italy. In some countries, disability benefit recipiency is several times higher than unemployment benefit recipiency. This is particularly true for Norway, the Netherlands, Denmark and the United States – all of which, except for the Netherlands, are countries with very low levels of non-employment. As expected, among the whole group of non-employed people at working-age, a large share are receiving neither a disability nor an unemployment benefit – 60% on average over all countries (Table 3.9).

3.5. Summarising the empirical evidence

The survey analysis shows a number of multifaceted and sometimes unexpected findings:

- Working-age disability policies target a large and heterogeneous group. One-third of this group have severe disabilities; people with congenital disabilities are a small minority. The diversity of this group is at the root of most of the policy challenges that face policy makers attempting to improve the living conditions of disabled people.
- Income security is high in many OECD countries: the income levels of households containing disabled people are in general broadly similar to those of the population as a whole. The relative economic well-being of households is correlated with the structure of the disability benefit system and the benefit level paid: countries with individual benefit entitlements for the entire disabled population (*i.e.* full population coverage) and high earnings-related insurance benefits have the highest relative incomes of disabled people, while those with a strong focus on means-tested programmes have the lowest – but public spending on disability benefits is considerably lower in the latter group.
- The personal incomes of disabled people depend primarily on their work status. The work incomes of those disabled people who do work are almost as high as the work incomes of people without disabilities. Disabled people without a job have considerably fewer personal financial resources.
- While employment is crucial for determining personal income resources, the employment rates of working-age disabled persons are rather low. This is particularly true for severely disabled people, and also generally for disabled people over age 50 and disabled people with low levels of educational attainment.

- Special employment programmes for people with disabilities play a minor role in determining disabled people's employment rates in general, but in some countries such programmes seem to make an important contribution to the employment of severely disabled people and of people with certain types of disabilities, such as intellectual and mental health disabilities.
- As employment rates are low, benefits also play an important role in guaranteeing income security. Not surprisingly, disability benefits are the main source of benefit income for working-age people with a disability. Among those who are not in work, on average such benefits make up around half of personal income.
- Permanent retirement benefits can also be an important source of income for a considerable proportion of the working-age disabled population (either early or regular retirement, depending on the country). Unemployment benefits play a much less important role overall, despite relatively high non-employment rates among this group.
- Recognising oneself as severely disabled does not necessarily imply receiving disability benefit, and *vice versa* . Many people on disability benefits do not claim to have a disability, while at the same time many people subjectively classified as severely disabled and who do not work receive no benefits.

Notes

1. These differences between countries with a similar socio-economic context seem large. It is beyond the scope of this project to explain this variation, which is likely to be also partly due to cultural differences. In any case, it is important to keep the differences in prevalence rates in mind when comparing outcomes.
2. In all those surveys (except for Korea and Poland), disability is defined as a self-reported limitation in relation to activities of daily living. To be classified as disabled, a person would have to report a long-term health problem, disability or disease *and* a limitation in daily activities resulting from this health condition. The very low figure for Korea is not really comparable, as it only comprises people officially registered as disabled according to a strict medical procedure. Data for Poland also refer to registered disabled people.
3. Turkey and Poland have not provided national survey data, hence, many of the figures reported in this section refer to only 18 countries. For Poland, some aggregate figures on the employment and earnings of registered disabled persons or households with a disabled person are available through the annual labour force survey. This source is also used to identify the population with disabilities.
4. Equivalence scale: 1.0 for the first adult in the household, 0.5 for all other adults, and 0.3 for children below age 16. For the definition of incomes and any deviation from this scale, see Annex 1, Table A1.1.
5. Unfortunately, data on equivalised household income is not available for Australia, the only country with a means-tested public disability benefit scheme. In Korea, the relative economic well-being of households with a disabled person is less favourable than elsewhere, at around 60%, which is partly explained by the fact that the data only comprise – presumably more severely hampered – registered disabled people.
6. Although the means test in the Australian disability benefit scheme is structured to reward part-time work by those receiving benefits, its household-based nature means that disabled spouses of those in full-time employment will not, in general, be eligible to receive a disability benefit.
7. Data for the United States and Canada are not strictly comparable. In both countries, the benefit classification is different (in the United States, disability benefits are part of the group "other benefits", and in Canada they are merged with "senior's benefits"). In addition, Canadian data refer to equivalised household income rather than personal income, which explains the higher share of income from work.
8. Note that in these surveys disability-related benefits comprise disability benefits (contributory or earnings-related and non-contributory), sickness cash benefits (but continued wage payment by the employer is excluded), and work injury or workers compensation benefits. Retirement benefits comprise all old-age pension payments to people under age 65; in many countries these are only early or advance retirement payments, but in countries with a statutory retirement age below

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65 years (men and women in France and Korea, and women only in Australia [where women can access the Age Pension as of age 60], Austria, Belgium, Italy, Poland, Switzerland and the United Kingdom) this includes regular retirement payments for the 60-64 age group.

9. The Swedish micro data are quite unusual in many respects, not only because of exceptionally high disability prevalence. It seems that most people on early retirement benefits classify themselves as disabled, thereby considerably affecting all estimates on incomes and on income packages in particular.

10. Note that, as Table 3.2 shows, in most countries the personal income resources of non-disabled people without work are even lower – but this group includes a large subgroup of people voluntarily out of the labour force for, usually, a temporary period.

11. Even adjusting for this bias, the figure would probably still be lower than in the other countries, for two reasons. First, other survey data found that – in contrast to most other countries – a high 85% of those people subjectively classifying themselves as disabled are also officially registered. And second, not less than 14.5% of the working-age population are registered as being disabled – a figure that corresponds to the average proportion of self-assessed disability in this set of countries (see Chart 3.1).

12. Cross-country comparison of such absolute employment rates is more strongly affected by differences in the timing and the design of the different surveys (*e.g.* differences in a country's economic cycle or differences in definitions of being employed). Hence, comparisons of the relative position of disabled people in each country are more reliable. At the same time, though, it is the absolute employment level that ultimately matters. For this reason, throughout this report both measures – relative employment rates as well as absolute employment levels – are used.

13. Note that the overall rates of unemployment in Table 3.4, which refer to the year of the national survey, can be different from official unemployment rates. The major concern here, though, is the difference in unemployment rates of disabled and non-disabled people, rather than a country's overall unemployment level. See again Annex 1, Table A1.1 for the definitions of unemployment used in the country surveys.

14. Note that the official rate of unemployment of *registered* disabled people in Austria is lower, but the definition of disability used for disability registration is not comparable in this context. The high unemployment rate for disabled people in Korea means that as many of those people are employed as are unemployed, and that only about one in eight disabled people are classified as inactive.

15. This figure would be somewhat lower if sickness cash benefits could be excluded. Recipients of sickness cash benefits, a sub-category of disability-related benefits, are usually defined as part of the employed population. In most countries, though, this group is rather small because a large proportion of shorter-term sickness absence – *i.e.* the period of continued wage payment by the employer – is not included.

16. Keeping in mind that we are relating self-assessed disability prevalence derived from national population surveys with disability benefit recipiency, which is based on quite a different definition of disability.

17. Note that not all of those people without work and without benefit entitlements are necessarily poor or economically excluded. Depending on a country's family and work pattern, a certain proportion will be people with only moderate disabilities who can afford not to work.

18. Remember that this is information derived from national surveys. In general, self-reported rates of recipiency of disability-related benefits show reasonable correspondence with estimates derived from administrative data sources (which are the basis for the analysis in Chapter 4). In most countries, the survey estimate is higher (compare last three columns in Table 3.7). This is explained by the fact that in most countries (except Korea, Norway and Switzerland), survey estimates on disability-related benefits include sickness benefits. The particularly high survey estimates in Sweden and the United Kingdom are explained by a particularly high number of people on long-term sickness benefits, which also becomes obvious from the high proportion of non-disabled people receiving such benefit in these two countries. The low survey estimates for Italy and Norway can only be attributed to survey design (*e.g.* sample selection bias).

19. Again, one has to keep in mind that some longer-term sickness benefit recipients are included in this figure. Correcting for this overestimate, if it were possible, however, would not change the conclusion. This is confirmed by the data for Norway and Switzerland, which do not include sickness benefit recipients.

20. In the Korean survey, by definition only people registered as disabled are identified; since the same definition is also used for disability benefit entitlements (and because a sickness cash benefit programme does not exist in this country), nobody classified as non-disabled can receive a disability benefit.

21. The extremely high proportion of non-disabled people on disability-related benefits in Mexico is indeed a consequence of a very strict definition of disability used in the survey (see Annex 1) when compared to the definition used for disability benefit eligibility (50% reduced earnings capacity in the previous job caused by an illness or injury).

22. Switzerland is quite exceptional, because it has a public invalidity insurance that covers the entire population and, in addition, a compulsory occupational second pillar. Empirically, half of the current recipiency population (employees with incomes above a certain threshold) receive a benefit from the second pillar.

23. In Canada, people without a sufficient insurance record would be entitled to regular social assistance benefits rather than to a special means-tested benefit for disabled people, and it is possible to identify people with disabilities receiving such benefit. *de facto* these provincial assistance benefits play exactly the same role as special benefits in other countries, and they are in fact as important as benefits from disability insurance. This is also true in some other countries (*e.g.* income support – with a disability premium – in the United Kingdom). The United Kingdom is a special case, because it has two non-contributory programmes, one that is means-tested (income support) and one that is not (severe disablement allowance), although the latter is currently being phased out.

24. This indicator has been chosen to increase cross-country data comparability as well as within-country comparability over time. It is less affected by differences between economies and therefore more robust than average benefits in purchasing power parities or benefits relative to per capita GDP, and its calculation is quite straightforward (actual average replacement rates, for instance, are difficult to obtain; stylised replacement rates – for typical family/income/work history cases – are of little help for this purpose).

25. This conclusion does not hold for some of the countries for which no comparable data are available. This includes in particular Canada, where as many disabled people receive social assistance as receive a disability pension, and the United Kingdom, for which data on social assistance is not included. Further note that throughout this report special means-tested transfer programmes for disabled persons are treated as disability benefits rather than as a special form of social assistance, even if the characteristics of these programmes more closely resemble those of social assistance or welfare programmes.

26. Another limitation arises from cross-country differences in the overlap between benefit recipiency and employment.

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Chapter 4

Compensation Policy Challenges

Abstract. *Chapter 4 looks at the compensation policies followed by countries, making use of administrative programme statistics. This analysis includes, among other things, the extent of age profiling in transfer schemes, the relationship between disability benefits and unemployment and early retirement benefits, and a discussion of benefit traps and coverage gaps. Country-specific policy characteristics on disability-related benefit schemes are found in Annex 3.*

4.1. Permanence of disability benefits

Beneficiary numbers are high while, at the same time, many people who subjectively classify themselves as disabled do not receive disability benefits. This conundrum requires a whole range of explanations.

Outflow rates

One of the reasons for large and increasing beneficiary numbers is a general focus on benefits of a permanent or quasi-permanent nature. The outflow from early retirement back into employment is zero almost by definition. But empirically the same applies to disability benefits; once a benefit is awarded, the recipient likewise rarely returns to the labour market. Even in countries where disability benefits are formally granted temporarily in most or even all cases, or in countries where a large share of recipients are on partial benefits, the outflow is virtually zero.

In those countries for which data are available (Australia, Austria, Canada, Germany, Norway, Portugal, Sweden, the United States), only around 1% of the disability benefit stock leaves the rolls each year due to recovery or work resumption. This low rate of outflow is found in countries with a strong focus on avoiding inflow through vocational rehabilitation and training, like the Germanic and the Scandinavian countries, in which it may be expected to be difficult to re-integrate those people who are granted a disability benefit. But the same low rate is also found in countries like Australia or the United States, which have employed a strong and increasing focus on economic incentives to get benefit recipients off the rolls.[1] There was also no relevant increase in outflow rates in the last few years in any of these countries (Chart 4.1).

Exceptions to the general picture are the Netherlands and the United Kingdom, with 3% and 5% annual outflow, respectively. These exceptions are easily explained. For the Netherlands, greater outflow is explained by the young beneficiary population, the low level of earnings-capacity reduction required (15%) and the fact that the general disability scheme also covers work injuries. The high outflow rate of 7% in this country in the mid-1990s was also a consequence of mandatory re-testing of the classification of all benefit recipients below age 45, after which a considerable number of partial benefit recipients lost their entitlement. This re-testing was launched in 1994 and completed in 1998, and has led to reclassifications – or even benefit loss – in 30% of all cases.[2]

The high figure for the United Kingdom is also explained by a combination of several factors, including the relatively low benefit level, a reasonably rigorous medical testing regime (flexibly repeated personal capability assessment), a larger turnover for temporary incapacity (cases which in other countries would be classified under sickness rather than disability, *i.e.* a less clear separation between sickness and disability) and also – like the Netherlands – the atypically young beneficiary population.

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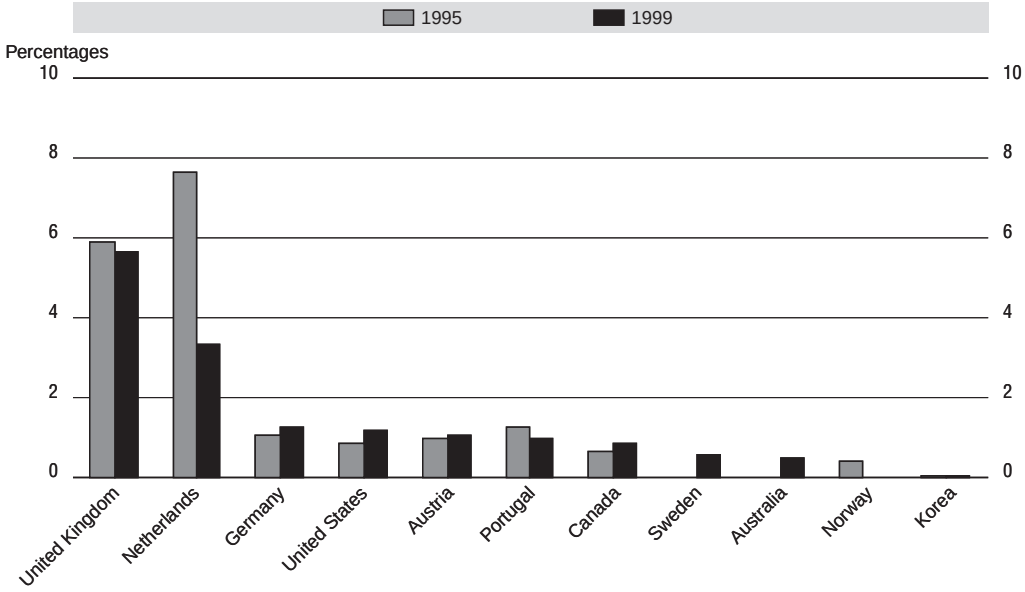
Chart 4.1. **Low outflow rates from disability benefits**

Annual rates of outflow from disability benefits, 1995 and 1999, percentages



Note: Countries are ranked in decreasing order of the 1999 rate.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Reviewing entitlements

One reason for low benefit outflow could be lenient re-testing of benefit entitlements. In more than one-third of the countries, disability benefits are granted permanently, at least *de facto* , meaning that although legally re-tests are possible at any time, in practice they rarely occur. This includes countries like Denmark, Norway and Spain, where a benefit can be granted only if rehabilitation has failed; it is assumed that such failure indicates that re-integration at any later stage is impossible. Canada and the United States, where re-tests are rather unlikely to take place, also belong to this cluster (see Annex 3, Table A3.1 and also Table 4.1 in the next section).

In another group of countries regulations are fairly flexible. In Belgium, for instance, benefits are granted indefinitely, with flexible examinations, which in practice means that in many cases several control examinations are made before a benefit becomes permanent, usually after three years. Similarly, in Portugal benefits are "permanent" but revision tests by an evaluation commission are possible at any time and are, for instance, common after three years on sickness benefit. In Switzerland, one revision usually takes place after around three years, after which a benefit becomes *de facto* permanent.

In a third group of countries, re-testing procedures are much more rigorous or have been made much more stringent in recent years. In these countries benefits are always granted temporarily, at least formally. The review frequency is typically 2-3 years (Austria, Germany, Italy) or up to 5 years (Australia, the Netherlands), or it is more flexibly regulated, as in France or via the personal capability assessment in the United Kingdom. In most cases, the period also depends on the prospects for improvement; hence, permanent awards are usually possible if permanent 100% disability is established (*e.g.* 20-25% of the inflow in Austria, and around 10% of the inflow in Italy). Generally, benefits can also

become permanent after one or several reviews – in Italy, this is always the case after six years, *i.e.* after the second review.

In most countries, little information is available on how stringently regulations on re-testing health status and the resulting work or earnings-capacity reduction are applied in practice. In the Netherlands, for example, due to a lack of personnel, reviews of disability status are done via a questionnaire that is sent to the benefit recipient. Hence, the difference between a formally temporary benefit and a *de facto* permanent benefit can become almost inconsequential.

The low rate of outflow in all countries, irrespective of the formal review procedure, implies that temporary benefits are rarely discontinued. This would suggest either that more frequent and more stringent reviews are ineffectual because nobody recovers anyway, or that these reviews, although formally required, are not properly applied. Anecdotal evidence on countries' gate-keeping indeed indicates considerable differences in the administration of initial assessments, which follow a prescribed procedure, and of follow-up reviews, which often amount merely to asking whether anything has changed. An important explanation given for not doing comprehensive assessments during reviews is a lack of resources, *i.e.* a lack of – qualified – staff.

However, the example of the Netherlands also shows that consistent re-testing of entitlements can increase the rate of outflow from disability benefits. A similar situation occurred in the United States after 1980, when the greater use of continuing disability reviews explicitly aimed at getting recipients off the benefit rolls. But the example of the United States is also somewhat discouraging. Research has shown that most of those taken off the rolls have again become disability benefit recipients a few years later. This is only partly explained by the fact that already in 1984, following a major political outcry, the tightened administrative control had to be relaxed.[3] Recent trends in the Netherlands – an unexpected upsurge in the disability inflow rate during the last few years, after a seemingly very successful reduction in benefit inflow in the mid-1990s (see Section 4.4) – may well be an indication of a similar phenomenon.

Benefit recipiency trends

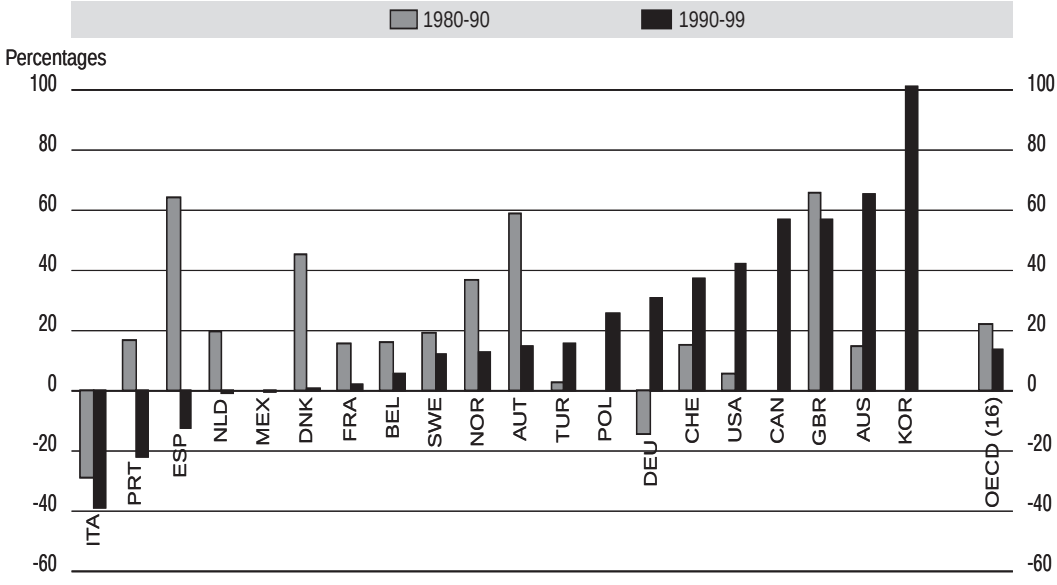
As a consequence of very low outflow, beneficiary numbers have been rising continuously, reaching the levels discussed in Section 3.4: between 4 and 6.5% of the working-age population in most countries; as much as 8 to 9% in some countries with full population coverage, high benefit levels and benefits for partial disability; and even 12% in Poland, which is partly related to the economic transition the country is undertaking.

During the 1990s, the recipiency rate increased in almost all countries (Chart 4.2, Panel A). The largest increase in relative terms occurred in Korea, albeit at an extremely low recipiency level. Next followed, in order, Australia, the United Kingdom and Canada (all around 60% increase in the 1990s), and then the United States and Switzerland (both around 40% increase). The countries with particularly large increases in the 1990s all had had below-average recipiency rates in 1990, thus resulting in some convergence in recipiency levels.

Declines in disability benefit recipiency rates during the 1990s occurred only in the three Southern European countries. In Italy, recipiency declined by 40%, following a similarly sharp decline during the 1980s (see Box 4.1 for detailed explanations). In Portugal, the decline was about 20%, and followed stagnation during the second half of the 1980s.

Chart 4.2. **Declining recipiency growth in most countries**

Panel A
Growth in disability benefit recipiency, 1980-90 and 1990-99
Percentages



Note: Countries are ranked in increasing order of growth in 1990-99.

Panel B
Growth in disability benefit recipiency, 1980-85, 1985-90, 1990-95 and 1995-99
Percentages

	1980-85	1985-90	1990-95	1995-99
Australia	3	11	35	22
Austria	38	15	6	8
Belgium	10	6	4	1
Canada	..	..	41	11
Denmark	32	10	6	–5
France	4	11	0	2
Germany	9	–22	29	2
Italy	–15	–17	–20	–24
Korea	..	..	..	255
Mexico	..	..	15	–13
Netherlands	9	10	–6	5
Norway	13	21	–2	15
Poland	..	..	26	0
Portugal	15	1	–21	–1
Spain	39	18	–6	–6
Sweden	9	9	12	0
Switzerland	9	6	17	18
Turkey	–3	6	10	5
United Kingdom	36	22	54	2
United States	–8	15	34	7
OECD (16)	12	8	9	3

.. Data not available.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Box 4.1. **Explaining benefit recipiency trends in selected countries**

Some of the trends in benefit recipiency since 1980 seem irregular, but in most cases are easily explained by looking at reform measures in some detail (for an analysis of trends in the Netherlands and Norway during the 1990s, see Section 4.4). In Germany, for instance, data seem to suggest a sharp decline in the late 1980s followed by an equally sharp increase in the early 1990s. In fact, this is largely an artefact caused by changing eligibility requirements in 1984 – after which entitlement required that three of the five necessary insurance years must fall into the last five-year period. The announcement of this change led to a boom in disability inflow, (particularly) among women, before enactment of the reform. After 1985, then, inflow rapidly dropped. For instance, in 1988 only one in five women retired via the disability programme, whereas in 1984 this was the case for one in two. Balancing out this fluctuation took until almost the mid-1990s. Without this change, Germany would have seen a slow gradual increase in recipiency rates over the last twenty years.

The fluctuation in benefit recipiency levels in the United States is the result of the reform process described above: the tighter administration established in 1980, which had to be relaxed after 1984. Note that this reform has only affected disability insurance, while the number of people on non-contributory disability benefits gradually increased during the 1980s. The relaxation of tighter control does not, however, explain the sudden increase in recipiency rates in the first half of the 1990s, which affected both the contributory and non-contributory schemes. The number of benefit recipients on these programmes increased by one million each within only five years – and this during a period of economic growth and falling unemployment rates. It seems that during the 1990s, disability benefits have become a "catch-all" benefit replacing long-term unemployment and social assistance payments, as eligibility criteria for these other benefits were tightened and more job search requirements were introduced.

The large increase in disability benefit recipiency in the United Kingdom throughout the entire 1980-1995 period is explained mainly by the lack of any far-reaching reform on either the benefit or the activation side, although this trend is due in part to the restructuring of the benefit components, which has led to a certain shift towards incapacity benefits. Within fifteen years, the number of people on incapacity benefit has increased by one million, and the number of people on non-contributory disability programmes by slightly less than half a million. The reversal of the trend in the second half of the 1990s is related to a comprehensive reform of access to insurance benefits (an "all work" test, later modified into a "personal capability assessment") and to a reduction in the generosity of the contributory benefit for new claimants.

Table Box 4.1 **Disability benefit recipiency rate estimates for Italy, 1975-1999**

	1975	1980	1985	1990	1995	1999
Contributory programme[a]	100	108	72	40	27	16
Non-contributory programme[b]	11	19	36	50	45	39
Both programmes	111	127	108	90	72	55
Share non-contributory scheme	10%	15%	33%	55%	63%	71%

a) Data for contributory scheme 1975-1985 derived from ISTAT's survey on number of pensions.
b) Data for non-contributory scheme 1975-1995 estimated on basis of recipiency data for 1999 and expenditures until 1995; expenditure data taken from Baldacci and De Santis (Prinz, 2003), assumption: constant 1999 expenditure per capita in percentage of GDP.

Box 4.1. **Explaining benefit recipiency trends in selected countries** *(cont.)*

The trend in Italy is most unusual. Disability prevalence in 1980 was higher here than in any other OECD country at any point in time (127 per 1 000). A drastic reform of the contributory benefit programme in 1984 – more drastic than any other disability benefit reform in any other OECD country (see also Annex 3, Table A3.5) – marked a turning point. Since then, benefit recipiency has fallen very rapidly. The extent of the effect of this reform is not well known, because of the lack of data. Estimates given below, however, probably reflect real trends. Until 1990, half of the decline in recipiency of insurance benefits was offset by an increase in recipiency of means-tested benefits. During the 1990s, following a reform of the non-contributory programme, recipiency for both types of benefits declined, thus further accelerating the overall decline of the 1980s. By 1999, the recipiency rate stood at 55 per 1 000, an average level in an OECD comparison. Expenditures declined over-proportionally, because means-tested benefits now account for 70% of all recipients, compared to only 10% in 1975.

The amazing decline in the numbers on insurance benefits in Italy – noting that the numbers are still continuing to decline – obviously has reduced the fiscal burden of the scheme, but it has also had widespread social consequences. By the turn of the century, the inappropriate use of the disability benefit system, in particular in high unemployment regions, had been halted. But the unemployment benefit scheme in this country has a short payment duration of up to six months, and a low replacement rate of 30%. Effectively, therefore, the comprehensive disability benefit reforms resulted in a gradual phasing-out of contributory insurance benefits, making people with disabilities largely dependent on means-tested benefits.

Both Portugal and particularly Italy had extremely high recipiency rates in the early 1980s, higher than any other country at that time. In Spain, the decline during the 1990s was about 10%, but this followed a period of rapid growth in the 1980s.

Compared to the 1980s, growth rates have declined in the 1990s in most countries, with the exception of Turkey, Germany, Switzerland and – most especially – the United States and Australia. The change in the second half of the 1990s is quite remarkable: after 1995, the large majority of countries halted the increase in the benefit recipiency rate (Chart 4.2, Panel B). The main exceptions are Australia and Switzerland, where the trend of the early 1990s continued, and Norway, which after a decline in the period 1990-95 suddenly experienced a rather unexpected increase recently (see Section 4.4 for further explanations).[4] The average OECD benefit recipiency increase (average over those countries with a complete time series since 1980) fell from 9% in the 1990-95 period to 3% in the 1995-99 period.

4.2. Disability benefit levels and benefit traps

One reason for non-existent outflow is the poor design of the benefit system. Regulations may make it difficult for benefit recipients to try to work without having to go through the cumbersome award procedure again should their work experience turn out to be unsuccessful. Benefit traps can also – just as for other kinds of social transfers – arise when income from work is little if any higher than benefit income, leaving no real immediate financial incentive to work.

Work incentives

The evidence concerning such types of benefit traps is inconclusive. A number of countries have rules that allow benefit to be put on hold for a few years (see Annex 3, Table A3.2). In the Netherlands, Norway and Sweden, this is possible for up to three years, in Australia for up to two years, in the United Kingdom ("linking rules") for up to one year, in Germany for up to 6 months and in Belgium for up to 3 months.[5] In Canada, there is no particular time limitation; former benefit recipients can always go through a "fast track" re-application process.

Similarly, several countries have very distinct work incentives to get benefit recipients off the rolls. In Denmark, for instance, a special in-work supplement is paid to people with at least two-thirds reduced vocational ability if they forego the disability benefit. In Turkey, there is an income tax abatement for workers with disabilities. And in the United Kingdom, former benefit recipients are entitled to a disabled person's tax credit, which effectively provides a reasonably generous minimum income for disabled people who work at least 16 hours per week. In both the Netherlands and the United States, benefit payment is continued during a trial work period of six and nine months, respectively.[6]

Empirical evidence is scarce, but the take-up of all these schemes is generally low. The low rates of outflow in all countries – irrespective of the existence of such rules – also suggest that few people make use of these various work incentives. For recipients of disability benefits, low outflow appears to be related more to the lack of opportunities for quality employment, *i.e.* policy failure on the labour *demand* side and, perhaps equally important, to the fact that these people officially have to be labelled disabled (or in other words, "unable to work") to become entitled to such benefits – the inherent dilemma of disability policy.

Benefit levels

High long-term benefit levels can work as a benefit trap whenever the net gains of taking up work are low. Outflow rates are not higher in countries with relatively low benefit levels, such as the English-speaking countries, though of course other factors may determine this as well.[7] However, it seems that benefit levels may be important as an incentive for benefit application – and certainly to that extent at least indirectly function as a benefit trap.

It is far from trivial to calculate an average replacement rate, and this has not been done in this study for various reasons (see Box 4.1). Theoretical maximum replacement rates at average earnings indicate considerable differences between countries, although there are many countries in which benefit levels tend to be around 60 to 70% of covered pensionable gross earnings (see Annex 3, Table A3.3, which refers to the main public disability benefit, *i.e.* contributory disability insurance, where such insurance exists, and non-contributory benefits in Australia and Denmark). The lowest benefits are flat-rate at around 25% of average earnings, and are paid in both Australia (in this case means-tested, but with generous income thresholds) and the United Kingdom. In Canada, the benefit is only slightly higher. In a number of countries (Mexico, United States, and also, for single people, in Belgium), the maximum replacement rate at average earnings is around 40%, and in France 50%.

In a few countries income replacement rates can exceed 70%. This is particularly true in Denmark, where the maximum flat-rate benefit – which consists of several

components – is as high as 150% of average income. In Sweden, replacement rates are also particularly high as a consequence of almost universal coverage with second pillar occupational pensions (which are also paid in case of disability), in addition to a rather generous benefit from the first pillar. In the Netherlands, benefits are usually topped up through collective agreements to the previous level of income, but only for the first and possibly second year. Some supplementary collective payments also exist in Norway. In the Southern European countries and in Poland, the replacement rate can also be as high as 80% (in Spain 85%, in Poland 76%).[8] But in Portugal, Poland and for partial benefit recipients in Italy such levels are rarely reached *de facto* and if so, only by people close to retirement age, because remaining years until that age are either credited only at a reduced accrual rate (Poland) or not credited at all (Italy, Portugal).

There are also considerable differences in the extent of redistribution in these public disability benefit systems. In countries with flat-rate benefits, replacement rates are by definition much higher for people with lower earnings. This is particularly striking for Denmark. Most of the earnings-related insurance systems also have some sort of arrangement that can raise the replacement rate for people on lower incomes – be it via a basic component (Canada, Norway, Sweden), or a minimum pension (Belgium, Italy, Korea, Portugal, United States) or a low income supplement (Austria, France, Switzerland).

It is obvious that all countries with high benefit recipiency rates have high income-replacement levels – even if it is difficult to get a clear picture on what average or typical replacement rates are in each country (Box 4.2).

If disability benefit levels are seen as an important benefit gateway, levels of short-term sickness benefits – and also the duration of such payment – are equally important. Norway is the only country with 100% income replacement throughout an entire sickness period of up to one year (see Annex 3, Table A3.3). The same is *de facto* true for the Netherlands, where for nearly all employees a 70% sickness benefit is topped up by collective agreements to 100% of net wage. In Poland, the benefit is increased from 80% to 100% after the first three months on sick pay. All these countries have especially high disability benefit inflow and recipiency rates. Several other countries have full wage replacement during an employer-paid period of several weeks or even a few months, though the long-term sickness benefit rate is usually much lower.

There are several countries – Canada, Germany, Mexico, Sweden, but also Switzerland and the United States – where the benefit rate for sickness is higher than for disability. The three Southern European countries, on the contrary, are the only countries in which sickness benefits can be significantly lower than disability benefits, though only for older workers with a considerable insurance period whose potential disability benefit entitlement would be relatively high. These relative sickness benefit levels, however, are only partly reflected in the disability benefit recipiency rates of those countries.

Note that Korea is the only country without any sickness cash benefit programme. Such a programme does not exist in the United States either, but about three in four employees there are covered by either short-term disability benefits (voluntary, usually employer-paid) or temporary disability insurance (compulsory programme in five states).

Partial benefits

Granting benefits for partial disability (*i.e.* for partial work or earnings-capacity reduction) can lead to another indirect benefit trap.[9] Indeed, countries that have a

Box 4.2. **Estimation of income replacement rates**

Even for retirement pension analysis, estimating (average) replacement rates is a rather complex task. Several approaches can be applied. One way is to look at gross and/or net replacement rates as a function of individual earnings, *e.g.* as a proportion of average earnings (OECD, 2001b). Another option is to calculate replacement rates as a function of the number of years worked (at a given, usually the average, earnings level). Often a "typical-case" approach is applied – *e.g.* by combining two or three typical family arrangements with two or three typical work biographies and two or three income trajectories. This analysis becomes very complex, because the life histories of people vary so much.

For disability benefits, all the above apply, but the situation is much more complex. First of all, in several countries there is more than one public disability benefit, which in addition in some countries can be cumulated. Secondly, some countries pay benefits to people without any, or any recent, work (or rather insurance) record – a group that may even be rather large – while other countries do not. Thirdly, choosing a typical family arrangement is very difficult or virtually impossible; in contrast to old-age retirement, disability can occur at any age, and thus includes a much broader range of family arrangements. Fourthly, it is much more difficult to choose an appropriate income trajectory, because this will depend on the disability (type, onset, severity). As the importance of these components differs between countries, it is not possible to define any typical cases that would be equally relevant in each country context.

For all those reasons, it was decided not to calculate any income replacement rates in the context of this project, although these rates can be an important ingredient in the decision to apply for a benefit. It is still relevant to look at the major benefit level parameters of the systems, such as the maximum replacement rate for a full disability benefit, but one has to keep in mind that this may only concern a minority of the group of people who potentially depend on such benefits.

graduated system of partial benefits reflecting different degrees of disability are by and large countries with particularly high disability benefit recipiency rates (compare Table 4.1 and Chart 3.13). If people on partial disability benefits work, the notion of a benefit trap is inappropriate, as these benefits compensate for the reduced work capacity and work income. In many cases, however, people on partial benefits do not work – in the Netherlands, for instance, this is true for almost 40% of this group. Note that, despite the correlation between benefit recipiency rates and partial benefit options, there were and still are examples of countries that lack such an option and yet have high benefit recipiency levels (*e.g.* the UK today, Italy in the early 1980s before a partial benefit was introduced and Portugal in the late 1980s).

There is no relationship between regulations on re-testing disability benefit entitlements and the availability of benefits that are granted for partial disability (Table 4.1). All kinds of combinations do exist, including *de facto* permanent benefit awards for partial disability, although it would seem particularly relevant to strengthen the review efforts for recipients of partial benefits. The motive for this is to prevent partial benefits from becoming an easy entry into *de facto* permanent benefits.

Much of the relevance of the discussion on benefits for partial disability depends on the extent to which disabled people actually make use of such benefits. In all four countries

Table 4.1. **Re-testing benefit entitlements and partial disability benefit options**

		Partial disability benefit option(s)		
		Several steps	One partial benefit option	Only full benefit possible
Re-testing the health status/ the entitlement	(*de facto*) permanent	Denmark Norway	Spain[a]	Canada Turkey United States
	more flexible procedure	Switzerland Korea Sweden	Poland[a]	Belgium Mexico Portugal United Kingdom
	in principal temporary	Netherlands	France Germany[a] Italy	Australia Austria

a) The partial benefit is paid for full work incapacity in the usual occupation; the same regulation was also applied in Germany until 2001 when a real partial benefit was introduced.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

with a graduated benefit scheme, the Netherlands, Norway, Sweden and Switzerland, two in three new benefit recipients are awarded a full disability benefit (Table 4.2). Hence, partial benefits are quite frequent, and the question of the extent to which such systems "invite" higher benefit inflow (from which there is almost no outflow) becomes important.[10]

It is surprising that the proportions of people on full benefits in these four countries are virtually identical, because different levels of work incapacity are required for entitlement to such benefit. This may suggest that the formally specified required incapacity level is merely a reference point. Switzerland, the country with the lowest requirement, is the only country in which the share of full benefits has increased during the last decade – which partly explains the continued recipiency growth. The three other countries have seen sizeable increases in the share of partial benefits since 1990, most markedly in the Netherlands.

Denmark, where only one in ten new applicants is granted the highest flat-rate benefit, is not really comparable. In this country, benefits consist of various components, some of which are designed partly to compensate for special expenses incurred by the disability, which also explains the high level of the highest state benefit. Hence, even partial benefits are intended to be sufficient to maintain a livelihood.

Table 4.2. **One in three applicants is awarded a partial benefit**
Proportion of partial benefits in the disability benefit inflow, 1999

	Proportion of new recipients granted a partial benefit (%)	Required work capacity reduction for a full benefit
Denmark	89	100%
Netherlands	33	80%
Norway	33	close to 100%
Sweden	34	close to 100%
Switzerland	34	67%

Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Extra-costs benefits

The Danish case links to yet another benefit category, *i.e.* benefits designed only for the purpose of compensating the extra costs of a person's disability. The high flat-rate benefit in Denmark implicitly includes such components, while the low flat-rate disability benefits in Australia and the United Kingdom do not. In the overwhelming majority of countries with earnings-related insurance benefits, however, the disability benefit is designed to replace (previous) earnings irrespective of additional costs that may incur. This issue is important in the context of potential benefit traps, for the reason that – in contrast to earnings replacement benefits – extra-costs benefits, which are paid irrespective of the person's work status, do *not* function as a benefit trap.

Where such (flat-rate) benefits exist, these are usually paid to persons in need of constant care, and they often vary with the degree of care needed. The disability living allowance in the United Kingdom, which consists of a mobility and a care component at several rates, might be the best example of a benefit that is not related to receipt of any other benefit or income from work – also because its flat-rate level is generally very high relative to the equally flat-rate level of a regular disability benefit. Other examples are the Australian carer allowance, the Austrian attendance allowance, the Belgian integration allowance, the Danish care allowance, the German care insurance, the Italian carer's allowance, the Korean disability allowance, the Norwegian constant-attendance benefit, the Portuguese dependency complement and the Swedish personal assistance compensation. In many countries, such benefits are only paid to persons in need of considerable support, who would typically not be in work.[11] The Austrian attendance allowance is an exception, as a small "extra costs benefit" can be paid to people with small extra costs, who would certainly be able to work.[12] Such benefits do *not* hinder the take-up of work. In some countries (Belgium, Korea), on the contrary, these benefits are means-tested and can therefore create an additional benefit trap.

Similar forms of constant-attendance allowances or supplements exist in several other countries (*e.g.* Spain), but only as a top-up payment to a regular disability benefit. Again, such regulation can *increase* the implicit trap resulting from benefit payment.

4.3. Coverage gaps

Disability benefit programmes seem to produce a high degree of benefit dependency. As already noted in Section 3.4, in most countries, despite already high expenses on disability transfer schemes, a sizeable proportion of disabled persons do not receive such benefits.

Entitlement requirements

Only in a few countries is the entire working-age population entitled to an individual benefit from the public disability benefit programme, irrespective of both the person's work and insurance record as well as other household incomes or means. Countries with individual full population coverage include Denmark, Norway, Sweden and Switzerland (see Annex 3, Table A3.4 and also Table 4.3). In these countries, only residence requirements have to be fulfilled to be entitled to a flat-rate benefit – be it a regular disability benefit in Denmark, or a special basic benefit in the three other countries.

Non-coverage can be a problem in countries with a public insurance system that covers the labour force only, like Austria, Canada, Mexico and, until 2003, Germany. Such systems potentially leave a considerable and vulnerable group behind – those with little or

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Table 4.3. **Disability benefit coverage for different groups not in the labour force**

		People previously belonging to the labour force (caring for a family for eight or more years)			
		No contribution requirements	Means-tested disability benefit	Considerable contribution requirements	No coverage
People with congenital or youth disability never belonging to the labour force	some basic benefit	Denmark Norway Sweden Switzerland	–	–	Netherlands[c]
	means-tested disability benefit	–	Australia[a] Belgium France Italy Korea Portugal Spain Turkey United Kingdom United States	–	–
	no coverage	–	–	Austria Mexico Poland[b]	Canada[d] Germany[e]

a) Entire population in Australia is only covered by means-tested benefits, but with generous earnings rules.
b) Social pensions under the social assistance programme offered for disabled people in Poland.
c) There is no contribution requirement in the Netherlands as soon as one enters or returns to the labour force.
d) General social assistance programme takes the role of a special means-tested programme, which also exists in three Canadian provinces.
e) New means-tested non-contributory benefit to be introduced in Germany as of 2003.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

no previous labour market attachment.[13] These can be people with disabilities present since birth or acquired during youth who have never been integrated into the labour market (even if, in Austria and Germany, such people can receive a family allowance, without any age limit). This group also includes people, predominantly women, who become disabled at a later age but have been out of the labour force for a considerable period. Some insurance systems may exclude such people from disability benefit receipt altogether (Germany and Canada), while in others insurance years from previous work periods can be sufficient to qualify for a low disability benefit.

In disability insurance systems, typically five years of insurance are required to build up entitlements, and in several countries some of these years need to fall into the most recent period before the disability occurred. The Netherlands is an exception, as there are no contribution requirements for the current labour force. Belgium, France, Korea and the United Kingdom are also countries with unusually short required contribution periods of up to or even less than one year.

The problem of exclusion from cash benefits for a certain fraction of the labour force due to too short a contribution record is less evident for sickness cash benefits. In about half of the countries, employees are covered from the first day of work (see Annex 3, Table A3.4, first column). Some countries, though, do have requirements of up to six months of insurance. This is true for Belgium and France, where the same insurance record is required for entitlement for a sickness and a disability benefit, and for Portugal and Spain.[14]

Almost half of the countries have a dual disability benefit system with contributory, earnings-related insurance entitlements for the workforce and special non-contributory, usually means-tested claims for those not entitled to the former. In these countries, if prescribed disability criteria are fulfilled, entitlement to a means-tested flat-rate benefit can be granted, which is not at the discretion of the social assistance authorities.

Effectively, the difference between such a system and one with only the option of social assistance benefits for people with insufficient insurance records may be small, as the large shares of non-employed disabled people without any benefit entitlement in Italy and Spain demonstrate. A means-tested safety net targeted to disabled people seems superior to reliance on the general welfare or social assistance scheme (as *e.g.* in Canada) exactly because the entitlement is a right and, therefore, benefit receipt less stigmatised. The disadvantage, however, is that such a programme may implicitly be used as a justification to tighten access to insurance benefits, thus automatically leading to a shift of benefit recipients from the contributory to the means-tested programme and, thus, to a rise in the number of people not receiving benefits.

The Netherlands is an interesting "hybrid" case: people becoming disabled before age 18 or during their studies are entitled to a flat-rate benefit, which is not means-tested – very much like in countries with full population coverage. People becoming disabled at a later age who are neither in education nor in employment, on the other hand, are not entitled to any disability benefit – just as in countries like Austria or Germany (Table 4.3). The situation is similar in Poland, where people with disabilities acquired before age 18 (or age 25, if a student) who are unable to work because of this disability have access to a special "social pension", which is regulated under social assistance law but also paid without a means test.

Australia is another exceptional case, because the public disability programme – like every other social protection programme in this country – is non-contributory, universal and means-tested.[15] For this reason, the group of people not receiving any benefit may *de facto* be similar to that in insurance systems that cover the labour force only. In both situations, non-working spouses often receive no benefits. The United Kingdom is another special case, because the combination of and requirements for available benefits guarantee broad population coverage.

Gender composition

This "similarity" of the Australian means-tested system with insurance systems (*i.e.* all contributory programmes except those with full population coverage) becomes obvious from looking at the gender composition of disability benefit recipients. In countries with insurance systems (Austria, Germany, Spain, Italy and Mexico), women are typically under-represented in the beneficiary population when compared to their share in the labour force (Table 4.4).[16] For the opposite reason, *i.e.* because they are excluded from insurance entitlements, women are generally over-represented in "second" non-contributory schemes despite the means testing in those schemes. Women are also very much over-represented in most schemes that cover the entire population (Scandinavian countries).

The particular situation in some countries is worth mentioning. The share of women among disability benefit recipients is extremely low in countries where insurance systems were introduced more recently (Korea, Mexico). Also, the share of women is much lower than their current share in the labour force would suggest in the insurance systems in

Table 4.4. **Fewer women on disability benefits except in schemes with universal coverage**

Proportion of women in the disability benefit stock and inflow, and in the labour force, percentages

	Stock			Inflow			Labour force		
	1990	1995	1999	1990	1995	1999	1990	1995	1999
Australia (nc)	..	30	37	..	..	37	41	43	43
Austria	24	25	24	29	29	28	...	43	43
Belgium	30	34	38	..	..	..	39	41	43
Canada	31	42	46	37	45	47	44	45	46
Denmark (nc)	61	59	57	60	56	55	47	46	46
France	..	..	..	..	..	42	44	45	46
Germany	34	38	39	27	35	33	40	43	43
Italy	49	46	40	..	30	28	37	37	38
Korea	6	9	9	..	..	..	40	40	40
Mexico	17	17	17	17	17	17	...	33	34
Netherlands	31	34	40	44	49	54	39	41	43
non-contributory	44	44	44	45	43	47	–	–	–
Norway	57	57	58	53	53	56	45	46	46
Poland	..	43	43	..	42	40	...	46	46
Portugal	53	50	55	46	43	50	43	45	46
non-contributory	55	54	52	52	44	..	–	–	–
Spain	25	24	25	..	..	..	34	38	40
non-contributory	..	62	61	..	..	..	–	–	–
Sweden	54	55	56	53	52	55	48	48	47
Switzerland	41	41	42	..	39	47	...	...	...
United Kingdom	28	33	33	27	32	38	43	44	44
non-contributory	53	49	48	..	41	43	–	–	–
United States	35	39	42	37	42	44	45	46	47
non-contributory	..	55	57	50	51	53	–	–	–
OECD (14)	–	–	42	–	–	42	–	–	44

nc: Non-contributory benefits only.
. . Not available, – Not applicable.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2; OECD database on labour force statistics.

Austria (because early retirement is accessible five years earlier for women) and Spain (because of low economic activity among women until very recently).

Comparing the gender composition of beneficiary stocks with that of the inflow gives additional insights. In Italy, for instance, the share of women in the contributory benefit stock was unexpectedly high in 1990 given their low proportion in the labour force. The only tenable explanation is the inappropriate use of the system before the 1985 benefit reform. The much lower proportion of women in the current inflow, on the contrary, mirrors the low female participation rates and the benefit system's insurance requirements. In the Netherlands, to take an opposite example, the share of women among recipients of contributory insurance benefits was very low in 1990, bearing in mind that there are no minimum insurance requirements for the labour force. The much higher share of women in the disability benefit inflow shows that women are catching up rapidly – more rapidly than one should expect (see also the following section on benefit inflow).

4.4. Benefit access

Reforming benefit access

In response to the large and rising number of disability benefit recipients and to the rising expenditures on disability payments, various attempts have been made to restrict access, in particular to earnings-related disability benefit schemes (see Annex 3, Table A3.5). While countries have chosen different policies, there are several more universal trends.

In some countries, the concrete availability of a job is no longer explicitly taken into account when determining benefit eligibility (*e.g.* Italy 1984, Netherlands 1987, Sweden 1993). In other countries, the range of jobs to be accepted was broadened, either because the own-occupation assessment was loosened (Spain 1997) or abolished (Italy 1984, Norway 1991, Netherlands 1994, Germany 2001 for cohorts born after 1960), or because higher demands on regional mobility were introduced (*e.g.* Norway 1991).

Other reforms directly affected the (medical) process leading to long-term benefit awards. Some countries introduced stricter reviews of sickness status (*e.g.* Norway 1993, Denmark 1997, Spain 1997, Poland 1999), while others established a tighter disability assessment procedure (*e.g.* Portugal 1987, United Kingdom 1995, Poland 1997, Sweden 1997, Australia 1998). Both types of measures seek to reduce the inclusion error (*i.e.* granting benefits to people who may not need them), while tolerating a certain increase in the exclusion error (*i.e.* refusing benefits to people who may need them).

In several countries, disability benefits nowadays are granted mostly on a temporary basis (*e.g.* Italy 1984, Austria 1996, Germany 2001), another measure designed to avoid long-term benefit payment to people no longer unable to get by without. Surprisingly few countries have chosen to reduce the disability level directly, *e.g.* by changing the benefit formula, one example being the United Kingdom where the earnings-related component of the contributory benefit was abolished for new claimants after May 1995. Reducing the (short- or long-term) sickness benefit level was more common.

As a consequence, in several countries annual inflow rates to these reformed public disability benefit schemes have indeed stabilised or even declined recently (Table 4.5). Very distinct declines in rates during the 1990s were reported in Poland (by almost half), Denmark (by one-third), Portugal and Sweden (by over one-fourth each) and the United Kingdom (by one-fifth in the second half of the 1990s). Note that these are all countries with benefit inflow rates significantly above the OECD average in earlier periods. Mexico is the only country where the inflow rate declined drastically, minus 70% between 1990 and 1999, despite a very low level of inflow and recipiency rates – a consequence of the gradual introduction of an entirely new disability benefit programme.[17]

A surprising finding is the considerable convergence in inflow rates across this set of OECD countries. In the majority of countries, by 1999 the inflow rate into public disability benefits was very close to 6 per 1 000 of the working-age population each year (Table 4.5, last column). This is true for countries with a non-contributory public benefit programme (Australia, Denmark), countries with an earnings-related programme (Austria, Germany, Switzerland) and countries with a dual benefit programme (Belgium, Portugal, Spain, United States). Canada and France are the only two countries with mature benefit schemes in which inflow rates are significantly below this OECD benchmark, while Italy, Sweden and Poland are found somewhat above the benchmark. Three countries stick out with far higher inflow rates in 1999: the Netherlands, Norway and the United Kingdom, where

Table 4.5. **Convergence in disability benefit inflow rates in the 1990s**

Total number of new disability benefit recipients, by benefit programme, per 1 000 population aged 20-64

	Contributory			Non-contributory			Contributory and non-contributory		
	1990	1995	1999	1990	1995	1999	1990	1995	1999
Australia	–	–	–	..	..	6.3	..	..	6.3
Austria	5.8	6.7	5.8	–	–	–	5.8	6.7	5.8
Belgium	..	..	4.3	..	..	1.6	..	..	5.9
Canada	2.9	2.8	1.8	..	..	2.5	..	..	4.3
Denmark	–	–	–	8.6	7.6	5.7	8.6	7.6	5.7
France	..	..	3.1	..	..	2.0	..	..	4.8
Germany	4.8	6.7	5.3	–	–	–	4.8	6.7	5.3
Italy	..	1.9	1.2	..	..	5.9	..	..	7.1
Korea	0.0	0.1	0.3	..	..	..	..	..	..
Mexico	0.9	0.4	0.3	–	–	–	0.9	0.4	0.3
Netherlands	11.5	6.9	9.7	0.5	0.4	0.7	12.0	7.2	10.4
Norway	10.5	9.1	12.1	–	–	–	10.5	9.1	12.1
Poland	15.3	10.0	7.9	..	..	..	15.3	10.0	7.9
Portugal	7.2	5.4	5.3	0.6	0.4	0.3	7.8	5.8	5.7
Spain	3.6	3.5	3.3	2.6	2.6	2.5	6.2	6.1	5.8
Sweden	10.2	7.6	7.6	–	–	–	10.2	7.6	7.6
Switzerland	..	5.3	6.0	..	1.4	2.3	..	5.3	6.0
United Kingdom	8.2	9.7	6.8	..	7.0	6.5	..	16.2	12.9
United States	3.0	3.9	3.6	2.9	3.5	2.9	5.4	6.9	6.0
OECD (11)[a]	7.3	6.0	6.1	3.0	2.9	2.4	8.0	6.7	6.6

. . Data not available.
– Not applicable.
Note: The rate is corrected for persons receiving both contributory and non-contributory benefits (except for Canada (unknown).
a) Unweighted average of 11 countries with data available in 1990, 1995 and 1999.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

additional measures to curb inflow rates appear to be warranted.[18] Note that the annual inflow into disability benefits is still far below 1 per 1 000 in the developing welfare states of Korea, Mexico and Turkey (Box 4.3).

Shifts in disability benefit programmes

Another consequence of recent reforms in benefit access, which largely concerned the main public disability programme, is a gradual shift of recipients onto means-tested programmes. In those countries with a dual benefit system, inflow into non-contributory benefits targeted at needy disabled persons with insufficient insurance records has not declined and in most cases increased. Hence, for these programmes, recipiency rates have generally increased as well: very much so in Canada, the United Kingdom and the United States during the 1990s, and in Italy during the 1980s. As a result, virtually all countries with a dual benefit system have seen a substantial increase in the share of people on means-tested disability benefits (Chart 4.3). For instance, the share has increased from 55 to 71% in Italy, from 33 to 46% in the United Kingdom, from 34 to 41% in France, and from 23 to 27% in Belgium – in all cases referring to the period 1990-1999.

This, in turn, has led to a decline in per capita disability benefit income in many countries (compare Chart 3.14), because non-contributory benefits are usually lower. In Belgium, Italy,

Box 4.3. **What has happened in the Netherlands and in Norway?**

Recent trends in two of the countries with extremely high inflow rates, Norway and the Netherlands, are striking, because they experienced a dramatic increase in inflow rates in the 1995-1999 period of over 30-40% despite a very high recipiency level.

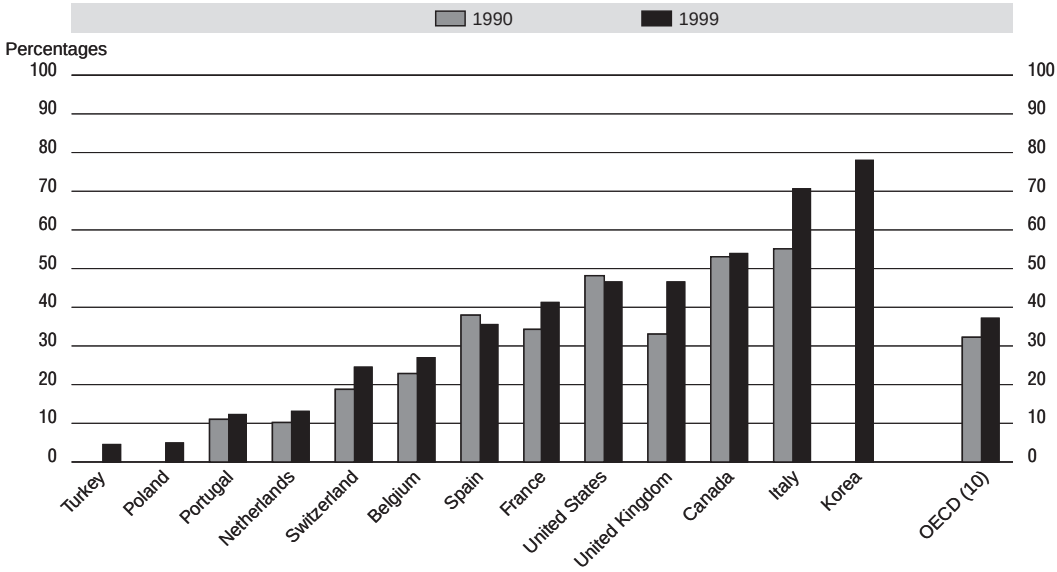
In the Netherlands, comprehensive reform measures between 1987 and 1994 had, by the mid-1990s, led to an all-time low in inflow and an all-time high in outflow as well as in the benefit rejection rate. It seemed then that developments here were going to be a success story. After 1995, however, trends in inflow and outflow rates reversed and, as a consequence, recipiency rates again increased. Particularly striking in this context is the much larger increase in inflow rates among women (55% increase within only four years, compared to a "mere" 29% among men), which can be explained only in part by rapidly growing female labour force participation rates. As a result, by 1999 the share of men aged 45 and over in benefit inflow had declined from 40 to 25%, whereas the share of women younger than 55 had increased from 25 to 50%. However, the overall 1999 inflow rate in the Netherlands was still lower than it was all through the 1980s. This is explained by a higher rate of benefit rejection (which increased from around 10-20% in the 1980s to around 40% in the late 1990s) and, in particular, a lower rate of successful appeals (this rate suddenly dropped from around 60% in the 1980-1995 period to only 12% in 1999). The number of benefit applications was in fact much higher in 1999 than ever before. These trend reversals seem to reflect the US phenomenon of the mid-1980s, when people taken off the benefit rolls after a country-wide review of benefit status often re-entered the benefit rolls only a few years later.

Norway has followed a similar path. Between 1970 and 1990, inflow rates gradually increased to a very high level. In 1991, a comprehensive benefit reform (tighter medical criteria, tougher regional and occupational mobility requirements) was aimed at making benefit access more difficult. The overall inflow rate started to decline, by as much as 20-30% in the 1990-1995 period among people aged 45 and over. Among men and women age 20-34, however, it continued to increase. In 1995, following a verdict of the Social Security Court, previous regulations on tighter medical criteria had largely to be annulled. The consequence was a considerable increase in inflow rates until 1999 among men and women at all ages, which this time was most pronounced among women aged 45 and over (although over the entire 1990-1999 period the increase was highest in the 20-34 age group among both sexes). By 1999, the overall inflow rate was higher than ever before and also higher than anywhere else (except the United Kingdom), even if it was still lower than in several other countries in the younger age groups. Rates of benefit rejection (which were always extremely low) and rates of successful appeals (which stayed constant at around 25%) do not explain these trends – although they do partly explain the high inflow levels. This high inflow is particularly striking in light of the fact that Norway is also the country with the strongest focus on vocational rehabilitation and training (measured in terms of recipients in such programmes), which is usually offered prior to any benefit award.

The large recent increase among older people in Norway is surprising as it occurred in parallel to the introduction and gradual broadening of eligibility for early retirement, inflow into which also doubled in the 1995-1999 period. This may partly reflect a cultural change, *i.e.* a late occurrence of an early retirement culture that has developed much earlier elsewhere. Other than that, high and increasing disability benefit recipiency in this country seems to be related to the power given to doctors who – in the absence of any effective control – are awarding such benefits *de facto*.

Chart 4.3. **General increase in share of recipients on non-contributory benefits**

Proportion of disability benefit recipients on non-contributory benefit
(only countries with a dual benefit system)



Note: Countries are ranked in increasing order of the 1999 share.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Spain and the United States, insurance benefits are on average about 70-100% higher than non-contributory means-tested benefits (Table 4.6). The same relation is found for the non-contributory but not means-tested top-up payment in Switzerland.[19] Korea is an extreme case, as in this country insurance benefits, though not high from an international perspective, are fives times higher than non-contributory payments.

Canada, in which every second disability benefit recipient receives a means-tested social assistance benefit, stands out as a country in which these means-tested benefits are on average on the same level as the average insurance benefit. More recently, contributory and non-contributory benefit levels have also become quite similar in the United Kingdom. In the Netherlands, there is only a 20% difference, on average, between benefits from disability insurance and those from the non-contributory but not means-tested programme for disabled youth – although this is explained partly by the fact that among the latter group there are almost no recipients of a partial benefit.

Gender issues

Benefit applications and awards show considerable gender variation by age. For the entire 20-64 age span, women usually have lower inflow rates than men. On average, there is a rather typical age pattern: women have only slightly lower inflow rates up until age 55, after which their rates are significantly lower than among men, and even more so at age 60-64 (Table 4.7). In general this is explained largely by a combination of relatively lower female rates of economic activity among older cohorts and earlier access of women to (early) retirement programmes.

In most systems that cover the labour force only (*e.g.* Austria, Germany, Italy, Poland and in particular Mexico), women have relatively lower inflow rates at all ages. The

Table 4.6. **Contributory benefits 50% more generous than non-contributory benefits**

Average disability benefit in contributory and non-contributory benefit programmes
Expenditure per head in percentage of per capita GDP

	Contributory			Non-contributory			Ratio contributory/non-contributory		
	1990	1995	1999	1990	1995	1999	1990	1995	1999
Australia	–	–	–	28	28	28			
Austria	53	57	61	–	–	–			
Belgium	43	37	34	24	23	20	1.8	1.6	1.7
Canada	32	31	29	29	31	27	1.1	1.0	1.0
Denmark	–	–	–	46	50	45			
France	27	33	32	25	26	23	1.1	1.3	1.4
Germany	51	39	38	–	–	–			
Italy	40	39	38	23	23	23	1.7	1.7	1.6
Korea	32	30	26	..	6	5	..	4.6	5.3
Mexico	32	40	61	–	–	–			
Netherlands	59	51	46	49	45	39	1.2	1.1	1.2
Norway	48	46	44		–	–			
Poland	42	51	43	..	..	23	..	..	1.9
Portugal	28	30	27	19	19	19	1.5	1.6	1.4
Spain	50	51	52	..	26	26	..	2.0	2.0
Sweden	48	49	43	–	–	–			
Switzerland	39	48	52	22	26	26	1.8	1.8	2.0
Turkey	41	84	86	..	..	..	..	..	..
United Kingdom	38	41	31	23	31	29	1.7	1.3	1.1
United States	32	32	29	20	21	16	1.7	1.5	1.8
OECD	41	44	43						
OECD (9)	38	38	35	26	27	25	1.5	1.4	1.5

. . Data not available; – Not applicable.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

extremely low rates at age 55-59 in both Austria and Poland are fully explained by the statutory (early) retirement ages. Canada and Portugal are noteworthy exceptions, as in these countries gender differences are very small at most ages. Considering the gender difference in labour force participation rates, this seems to indicate relatively high inflow rates among women in these two countries.

The Scandinavian countries with full population coverage have higher female inflow rates at all ages. In Norway and Sweden, women aged 35-44 are 57 and 64% more likely to start receiving benefit than men. The reasons for this over-representation of women in the disability benefit inflow are unclear. Both in Norway and Sweden, the ratios of female to male inflow rates have stayed pretty constant all through the 1990s, but increased during the 1970s and 1980s in parallel to the increase in female labour force participation rates. This could be due to higher disability rates caused by combining paid work with care for children, or a higher likelihood for gatekeepers to diagnose disability as a consequence of this double burden, but there is no empirical evidence for this in any of the countries concerned.

The Swiss distribution of gender inflow ratios across age is similar, though more gender neutral – except for the oldest age group, which is again caused by gender

Table 4.7. **Very different gender pattern in inflows**

Ratio of female over male inflow rates in 1999, by age group

	20-34	35-44	45-54	55-59	60-64	20-64
Australia	0.52	0.61	0.87	0.76	0.17	0.60
Austria	0.81	0.79	0.59	0.24	x	0.39
Canada	0.95	1.14	0.98	0.75	0.58	0.88
Denmark	0.78	1.21	1.38	1.18	1.67	1.26
France	0.65	0.92	0.84	0.62	x	0.72
Germany	0.82	0.80	0.72	0.54	0.19	0.51
Italy	0.42	0.51	0.47	0.35	0.10	0.39
Mexico	0.36	0.31	0.26	0.20	0.16	0.20
Netherlands	2.25	1.31	0.96	0.52	0.49	1.19
Norway	1.25	1.57	1.54	1.24	0.98	1.33
Poland	0.56	0.83	0.75	0.15	0.14	0.65
Portugal	0.79	0.94	0.90	0.88	0.88	0.95
Sweden	1.40	1.64	1.45	1.20	1.00	1.27
Switzerland	1.01	1.13	1.21	0.98	0.31	0.93
United Kingdom	0.88	0.81	0.74	0.62	x	0.63
United States	0.82	0.88	0.85	0.72	0.56	0.79
OECD (16)	0.89	0.96	0.91	0.68	0.56	0.79
Netherlands (nc)	1.00	0.79	0.72	0.86	0.81	0.90
United Kingdom (nc)	0.72	0.77	0.79	0.70	3.54	0.76
United States (nc)	0.95	1.13	1.12	1.15	1.14	1.12

x: Retirement age for either women, or men and women, 60 years.
nc: Non-contributory programme in a dual benefit system.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

differences in statutory retirement age. The Danish gender pattern is rather unusual, as women show relatively lower inflow rates than men in the 20-34 age group but – quite exceptionally – much higher rates at age 60-64. This seems related to the incentives created by a system with high flat-rate benefits – making receipt of such benefits more attractive for people with lower earnings. The difference in the oldest age group could be related to gender differences in eligibility for voluntary early retirement benefits.

Relatively low inflow rates in the Netherlands of women aged 55 and over (largely explained by low activity rates at this age) are contrasted by amazingly high inflow rates in the 20-34 age group – more than two times higher than among men. It was only after the sudden increase in female labour force participation in the late 1980s that female inflow rates at this age surpassed those of men, and this trend has accelerated since. To a certain extent, this mirrors the development in Norway and Sweden during the 1970s and 1980s. It is unlikely that the current gender ratio of 2.25 properly reflects gender-specific disability risks at this age. However, Dutch survey data on self-assessed disability do in fact suggest that disability prevalence rates among women aged 20-34 are more than 50% higher than among men at this age. This is worth mentioning, because the Netherlands is quite an exception in this sense. In other countries, the age pattern of gender differences in disability prevalence is generally either flat or in the opposite direction. Hence, if there is a gender difference over age, it is women over age 50 who tend to report being disabled over-proportionally when compared to their male counterparts, particularly in the countries of Southern Europe.[20]

4.5. Age profiling in disability benefits

People aged 50 and over are in many ways treated differently from the rest of the working-age population, resulting in high benefit expenditures without necessarily targeting those most in need of support. This age profiling can have many facets. One is that legal differences still exist – even if some of these have gradually been abolished in the 1990s (*e.g.* in Sweden). In Denmark, for instance, persons aged 50 and over can be granted disability benefits on the basis of severe social problems without *any* medical cause. In Austria, disabled people aged 55 and over are not obliged to accept jobs other than in their current occupation. In Australia, local labour market conditions can be considered in assessing whether persons aged 55 and over can be re-skilled for work within the next two years.[21]

Benefit formulas can also enforce age profiling (see Annex 3, Table A3.6). This is explicitly the case in the Netherlands, where older people get higher benefits for a longer period. A 35-year-old person would get 70% income replacement for six months, after which it will drop to about 55%. A 55-year-old person would get the same 70% for three *years*, and it would only drop to about 65% thereafter. The practical impact of these benefit formulas, however, is lessened, because about 80% of the workforce have regulations via collective agreements according to which benefits are topped up to 100% in the first year of disability benefit receipt, 90% in the second, 75% in the third and 70% for many more years thereafter or even until age 65.

In several other cases, age profiling occurs implicitly through unattractive benefit formulas for younger applicants. In some countries, further years until statutory retirement age are not credited at all (in Korea, Portugal and, except for full permanent disability, also in Italy) and in others only part of those years are credited (in Austria, Germany and Poland). In the three countries in which these years are not credited at all, young benefit recipients typically receive only the minimum benefit (*e.g.* 30% of average earnings both in Korea and in Portugal). Switzerland is a noteworthy exception: not only are remaining years until retirement age fully credited, but in addition for younger applicants a "career factor" is added to account for lower incomes at a young age.[22]

Age profiling can also be the product of seemingly neutral regulations. The actual labour market situation, for instance, is *de facto* frequently considered for benefit applicants over a certain age.

Age structures

The outcome of these various forms of age bias is a very skewed age structure of both the stock and the inflow of disability benefit recipients. In one-third of the countries, the disability programme has an (implicit) early retirement function, with nine out of ten benefit recipients aged 45 and over, and still more than 85% of that age in the inflow (Table 4.8). All of these systems have labour force coverage only.

In several other countries, people aged between 20 and 44 make up between one-third and one-fourth of all recipients. This is typical of countries with a rather low required minimum level of work incapacity and/or with several partial benefit options, like Australia, the Netherlands, Sweden and Switzerland. The contributory programmes in Belgium, the United Kingdom and the United States also fall into this category, although not for the same reason, because these programmes require rather substantial work-capacity reduction and lack a partial benefit option.

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Table 4.8. **Persons aged 45 and over dominate the disability benefit rolls**

Proportion of persons aged 45 and over in disability benefit stock and inflow, percentages

	Stock			Inflow		
	1990	1995	1999	1990	1995	1999
Australia (nc)	..	68	67	..	..	61
Austria	91	92	92	89	91	85
Belgium	76	73	72	..	..	..
Canada	88	84	84	80	75	75
Denmark (nc)	88	87	87	85	80	79
France	..	..	..	..	..	85
Germany	94	91	89	91	86	85
Italy	98	97	97	..	88	88
Korea	34	58	69	..	..	..
Mexico	91	91	91	91	91	91
Netherlands	72	78	75	45	44	46
non-contributory	17	16	19	..	..	21
Norway	79	79	78	77	72	74
Poland	..	74	78	..	59	64
Portugal	90	91	92	88	87	89
non-contributory	45	35	..	30	16	..
Spain	94	92	91	..	86	84
non-contributory	..	54	52	..	..	..
Sweden	82	72	71	85	78	75
Switzerland	68	67	67	..	..	69
United Kingdom	77	76	75	65	62	60
non-contributory	49	45	46	..	39	40
United States	71	70	73	65	67	69
non-contributory	..	59	63	62	63	67
OECD (19)	–	–	76	–	–	70

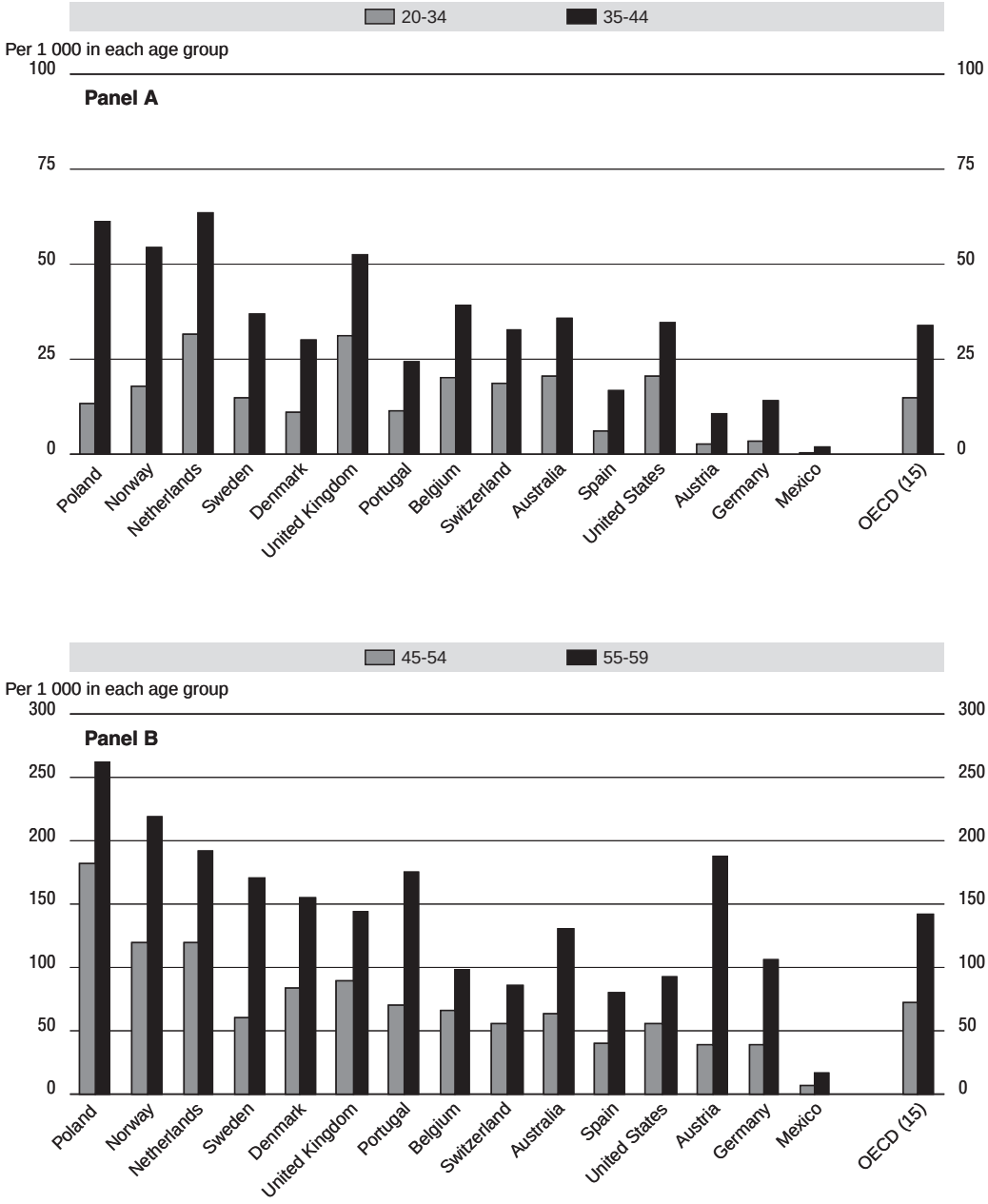
nc: Non-contributory benefits only.
. . Data not available; – Not applicable.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Quite consistently, the average age of recipients of non-contributory disability benefits is considerably lower, with people younger than 45 typically forming the sometimes overwhelming majority, in particular in the Netherlands. In the United States, an exception to the rule, the age structure of non-contributory supplemental security income (SSI) recipients is little different from that of contributory social security disability insurance (SSDI) recipients.

Cross-country differences are better revealed by comparing age-specific benefit recipiency rates (Chart 4.4). Note that in this chart countries are ranked from the highest to the lowest overall recipiency rate; any peak or trough, therefore, suggests an atypically high or low recipiency level for a particular age group in a given country. For instance, both the Netherlands and the United Kingdom stand out as countries with an unusually high recipiency level at age 20-34, and still very high levels at age 35-44. Austria and to a lesser extent also Germany show up as countries with a very low recipiency level at this young age (at age 20-34, only about one-tenth of the level in the Netherlands and the United Kingdom), but at the same time relatively high recipiency rates at age 55-59 – in Austria even as high as in the Netherlands and higher than in the United Kingdom, which is only possible due to a very high number of new recipients at this age.

Chart 4.4. **Remarkable age differences in benefit recipiency**

Age-specific disability benefit recipiency rates, 1999, per 1 000 in each age group



Note: Countries are ranked in decreasing order of the 1999 recipiency rate for 20-64 years old. Different scales are used in Panels A and B to make cross-country differences visible.

Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Table 4.9. **Large differences in age-specific inflow patterns**

Age-specific disability benefit inflow rates, and ratio over age group 35-44, 1999

	Inflows per 1000, by age group					Ratio over age group 35-44				
	20-34	35-44	45-54	55-59	60-64[b]	20-34	35-44	45-54	55-59	60-64
Australia	3.2	5.1	8.6	17.7	14.6	0.6	1.0	1.7	3.5	2.9
Austria	0.7	2.2	9.5	34.9	5.1	0.3	1.0	4.2	15.6	2.3
Canada[a]	0.4	1.0	2.4	4.7	4.1	0.4	1.0	2.3	4.6	4.0
Denmark	1.6	3.1	7.0	11.1	11.1	0.5	1.0	2.3	3.6	3.6
France[a]	0.2	0.7	1.9	4.7	0.0	0.2	1.0	2.8	6.9	0.0
Germany	0.6	2.3	6.9	18.5	16.6	0.3	1.0	2.9	7.9	7.1
Italy[a]	0.1	0.4	2.8	1.4	1.5	0.2	1.0	6.4	3.3	3.5
Mexico	0.0	0.1	0.3	0.7	4.1	0.1	1.0	3.6	8.4	48.0
Netherlands	8.3	11.6	15.6	12.0	12.5	0.7	1.0	1.3	1.0	1.1
Norway	3.3	8.5	18.2	36.9	60.0	0.4	1.0	2.1	4.3	7.1
Poland	1.6	7.1	18.1	11.7	2.7	0.2	1.0	2.5	1.6	0.4
Portugal	1.2	2.0	7.7	19.8	30.5	0.6	1.0	3.8	9.9	15.2
Spain[a]	0.4	1.6	3.6	8.4	9.0	0.3	1.0	2.3	5.3	5.7
Sweden	1.9	5.0	9.6	19.8	31.6	0.4	1.0	1.9	4.0	6.3
Switzerland	2.4	4.4	8.5	14.1	12.4	0.5	1.0	1.9	3.2	2.8
United Kingdom	9.7	12.4	17.8	22.3	11.8	0.8	1.0	1.4	1.8	0.9
United States	2.7	4.5	7.8	13.9	12.8	0.6	1.0	1.7	3.1	2.8
OECD (17)	2.3	4.2	8.6	14.9	14.1	0.4	1.0	2.7	5.2	6.7

a) Contributory programmes only rather than both programmes.
b) No or reduced inflow for this age group in countries with statutory retirement ages below 65 (men and women in France, and women only in Australia, Austria, Italy, Poland, Switzerland and the United Kingdom).
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

The average age of new benefit recipients is in most cases lower than that of the stock of recipients. Usually, the difference in the share aged 45 and over is around five percentage points (Table 4.9). In the Netherlands, however, the difference is constantly at around 30 percentage points (75% aged 45 and over in the stock, but only 45% of that age in the inflow). This translates into an age difference of about eight years and must partly be explained by higher outflow among younger recipients. Poland and the United Kingdom, each with a 15 percentage point difference, are also exceptional.

Age-specific inflows

To judge the existence of an age bias in the benefit scheme, figures on the age-specific disability benefit inflow rate, *i.e.* the annual age-specific probability of becoming a disability benefit recipient, are even more illuminating than the age structure of current or new recipients. Table 4.9 shows that for the 55-59 age range, for example, the inflow rate ranges from less than 0.5% in Canada, France, Italy (though only covering the contributory programme in these three countries) and Mexico to about 3.5% in Austria and Norway. In the 35-44 age group, for comparison, the same rate is less than 3 per 1 000 in most countries, with over 0.7% in Poland and Norway, and over 1% in the Netherlands and the United Kingdom. Note that the largest variation is found in the 60-64 age group, which is explained mainly by differences in the statutory ages of early and regular retirement, and the availability of such programmes.

Typically, the inflow rate is about 3 to 5 times higher at age 55-59 than at age 35-44. But this ratio is considerably higher in France, Germany, Mexico and Portugal, and is very

pronounced, at a factor of 15.6, in Austria – suggesting an implicit use of the disability programme as an early retirement path, especially in Austria.[23] On the other end of the spectrum, there are three countries – all with high overall beneficiary numbers – in which disability benefit inflow rates are only slightly lower among younger than among older workers: the United Kingdom, with a ratio of 1.8, Poland, with 1.6, and the Netherlands, with a ratio of only 1.0 – the only country in which the likelihood of being awarded a disability benefit is not related to age at all.

Adjusting for prevalence

All these figures, and in particular the differences between age groups, must be seen in relation to the age profile of disability prevalence. Since disability is much more likely among older age groups, disability benefit inflow rates should also be expected to increase with age. Correcting for the age distribution of disability prevalence gives a fresh and less pronounced picture of age profiling.[24]

In Poland and the Netherlands, disabled people under age 50 appear to have a higher likelihood to be granted disability benefits than disabled people in the 50-64 age group, while in Australia and the United Kingdom there is no particular difference between those under and over age 50 (Table 4.10).[25]

In the majority of countries, however, age profiling persists. In ten countries, the estimated likelihood for persons subjectively classified as disabled to become a disability benefit recipient is about 50 to 170% higher at age 50-64 than at age 20-49.[26] France (ratio

Table 4.10. **Less age-profiling if age structure of disability prevalence is taken into account**

Hypothetical age-specific inflow rates if applied to the disabled population only, 1999

	Inflow per 1 000 of the disabled population			Ratio
	Age 20-64	Age 20-49	Age 50-64	50-64 / 20-49
Australia (nc)	49.1	48.0	57.5	1.2
Austria	44.7	28.6	65.1	2.3
Canada	11.1	5.9	16.1	2.7
Denmark (nc)	30.6	24.5	47.0	1.9
France	19.4	4.6	14.2	3.1
Germany	29.4	17.1	46.7	2.7
Italy	16.3	13.1	19.5	1.5
Mexico	3.8	1.0	9.0	9.0
Netherlands	51.7	65.2	50.3	0.8
Norway	72.5	50.1	133.3	2.7
Poland	54.8	69.0	48.3	0.7
Portugal	28.1	12.6	52.9	4.2
Spain	29.4	16.7	43.8	2.6
Sweden	36.7	25.5	54.2	2.1
Switzerland	41.0	31.7	57.1	1.8
United Kingdom	37.5	37.5	42.3	1.1
United States	33.8	26.8	47.4	1.8
OECD (17)	34.7	28.1	47.3	2.5

nc: Non-contributory benefit.

Source: See Annex 1, Table A1.1; OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

of 3.1) and Portugal (ratio of 4.2) are the two countries with mature benefit systems where age profiling seems most pronounced. The ratio for Mexico is as high as 9.0, although even at age 50-64 the hypothetical inflow rate is significantly lower than elsewhere.

4.6. Assessment procedures

The unusual gender and age patterns of benefit inflows and benefit recipiency evoke the need for further investigation of the assessment procedures that eventually lead to benefit awards.

Eligibility criteria

High benefit expenditures may be due to a lot of the "wrong" people getting benefits from the system (inclusion error), even while accepting that some of the "right" people are likely to be excluded (exclusion error). This is very much related to the notoriously difficult assessment of what constitutes disability and work incapacity. In practice, it is exceedingly difficult to distinguish those who are able to work from those who are not, and to make a proper distinction between full disability and partial disability.[27] Making access to benefits more difficult does not make the assessment decision itself any easier and, thus, cannot remove this dilemma of disability benefit policy. Essentially, policies that make access more difficult merely shift the borderline, thereby probably reducing the inclusion error at the expense of an increase in the exclusion error.

Countries use a variety of eligibility criteria in their benefit schemes. The majority of countries make reference to a reduction in work capacity, while others refer to earnings-capacity reduction (see Annex 3, Table A3.7), but this choice is not correlated with the resulting level of benefit recipiency. The latter criterion often relates to the earnings capacity in the usual occupation (Belgium, Mexico, Portugal and to a lesser extent also France and Switzerland).

In a few countries that use a work-capacity criterion, the assessment is based on an "own occupation" test, which can implicitly discriminate against the low skilled, who are the only ones who could be referred to any other job. An own occupation test is applied in Austria, in Germany (until recently and still for pre-1960 cohorts), in the United Kingdom (only for entitlements for the first 28 weeks for those previously in employment), in Spain (for total permanent disability and for partial disability) and for benefits for partial disability in Italy and Poland. Again, there is no correlation with observed recipiency levels. In all countries, the reduction in earnings or work capacity needs to be caused by a physical, psychological or mental health problem or disability.

Some countries use a combination of work capacity and earnings capacity. In Norway, for example, the level of work-capacity reduction determines benefit eligibility, while the earnings-capacity reduction determines the partial benefit level. A few countries use a more specific eligibility criterion. Australia, for instance, requires applicants to fulfil two criteria: to have a score of 20 points or more on the impairment tables, which relate to different medical conditions and are designed to assess whether the applicant meets an empirically agreed threshold in relation to the effect of the impairment on the ability to work; and to have a continuing inability to work 30 hours per week at full wages for the next two years. In the United States, as another example, the inability to engage in substantial gainful activity, *i.e.* to be able to earn US$ 780 per month, is taken as reference.

Table 4.11. **Minimum and full level of work incapacity for disability benefit entitlement**

		Incapacity level for a full benefit		
		0-60%	61-80%	81-100%
Minimum required level of incapacity	0-40%	Australia[a]	Germany Netherlands Switzerland	(Norway)[d] Spain Sweden
	41-70%	Austria Poland[b] Mexico	Belgium Portugal Turkey	Denmark France Italy Korea[b] (Norway)[c]
	70-100%	–	United Kingdom[a] (United States)[c]	Canada[a] (United States)[c]

a) Not formally specified as a percentage, but understood to correspond to those percentages.
b) Percentage not specified; estimate for Korea, pre-1996 practice (personal communication) for Poland.
c) United States: Meant to include totally disabled people only, but seems to be more like the UK situation.
d) Norway: Currently 50%, but ongoing tests with a minimum of 20%.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

There are also considerable differences as to the required degree of work or earnings-capacity reduction (Table 4.11). Countries with a partial benefit scheme tend to have a low entry level for eligibility for a partial benefit, but often have a relatively high level of required incapacity – often close to 100% – for eligibility for a full benefit. Australia stands out as the only country with no benefits for partial disability and with a rather low entry level for full benefits, corresponding to about 25% work incapacity (though not specified as a percentage).[28] This is perhaps the single most important factor explaining the level of recipiency and inflow rates in this country, which – although only around the OECD average – appears to be very high given the low level of the benefit and the means-test requirement. On the other end of the scale, Canada – another country not offering benefits for partial disability – is worth noting, as in this country only people who are fully disabled can be awarded a disability benefit. The requirement of a severe and prolonged disability that prevents a person from doing any work on a regular basis is one of the explanations for the low recipiency rate for insurance benefits – less than 2% of the working-age population – in this country.

Assessment process

In the large majority of countries, the medical assessment is nowadays performed by specialised (insurance) doctors (see Annex 3, Table A3.8). Differences exist as to the role of privately submitted medical certificates, *e.g.* certificates prepared by the applicant's doctor ("treating doctors"). In Austria, for instance, such a certificate or opinion is not taken into account in the assessment at all. In other countries, like Germany or Sweden, it can have an impact, because the decision is often taken on the basis of the medical files with no additional medical assessment. In the United Kingdom, there is a kind of mixed approach, where treating doctors provide the medical evidence, but the focused personal capability assessment is then done by contract specialists.

In Australia and Switzerland, treating doctors (can) play a more important role, although their assessment is increasingly supplemented by independent medical examinations for verification (*e.g.* in two-thirds of all claims in Australia). This reflects the ever-increasing complexity of the medical assessment, which requires the involvement of

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medical specialists, such as psychologists or psychiatrists, in an increasing number of cases. This is contributing to the growing costs and extended duration of the assessment process.

Norway and the United States are the only two countries in which treating doctors bear sole responsibility for the medical assessment of a benefit applicant, although in the latter country contract doctors are also involved.

It is notable that in all the countries in which treating doctors have an important role, recipiency and/or inflow rates have recently (continued to) increase. This suggests the growing importance of the generally well-acknowledged problems of involving treating doctors in the disability benefit award process (*e.g.* the fact that they are often too close to the patient to be able to make a neutral assessment even if they may be best informed about the applicant's set of medical problems, and also that they lack knowledge of the legal disability criteria and of the applicant's job requirements).

The ultimate benefit decision is usually taken by a single insurance officer or (in France, Italy, Switzerland and the United States) by an – often interdisciplinary – team of experts at the insurance body (see again Annex 3, Table A3.8).[29] In a majority of countries, the decision-makers are not medical doctors, but countries differ in the extent to which vocational experts are involved in the assessment and decision process. In some countries, special commissions have been created to be responsible for benefit awards. Examples include the central medical commissions in Belgium, the verification commissions in Portugal (which consist of three technically independent experts, one of them a vocational expert), and the disability assessment teams in Spain (which are a separate body in the insurance institute). These more formal commission structures were generally established in order to pursue greater objectivity in decision-taking, an aim that other countries have pursued by involving a team of insurance officers. Recent developments in Poland show an interesting move in the opposite direction, though using the same argument. In this country, responsibility for the benefit decision has recently been transferred from a team of insurance officers to a single insurance officer, with the aim of tightening the decision by making this single person accountable.

Mental illness

There are indications that the assessment of disability and work capacity is becoming more difficult. From a medical perspective, the situation has gradually worsened with the widespread increase in the share of more difficult to diagnose diseases, such as new mental illnesses as well as many physical stress-related conditions like lower back pain. It is difficult not only to diagnose these disabilities and to assess their implications for work capacity but also to predict how these conditions may evolve in the future.

The increasing proportion of people with mental or psychological problems among the recipiency population is a major concern in many countries. Today, mental and psychological problems comprise around one-quarter or even one-third of the stock and flow of disability benefit recipients in most countries where such data are available (Table 4.12). The younger the recipiency population, the higher, by and large, is the share of recipients with mental conditions. This also explains the unusually low share of this disease category in Austria, where benefit inflow is more concentrated than elsewhere in the 55-64 age group.

Table 4.12. **One in three disability benefits due to mental conditions**

Proportion of mental illness in disability benefit stock and inflow

	Stock			Inflow		
	1990	1995	1999	1990	1995	1999
Australia (nc)	..	..	31	..	..	32
Austria	9	10	..	10	11	17
Canada	11	16	21	10	17	25
France	..	..	..	..	..	27
Germany	..	..	..	17	23	28
Netherlands	27	31	30	30	26	33
non-contributory	36	39	46	63	53	52
Norway	28	29	29	20	23	25
Sweden	24	26	..	16	20	24
Switzerland	34	36	39	..	..	34
United Kingdom	16	17	23	13	18	26
non-contributory	..	40	37	..	31	35
United States	27	31	31	21	23	22
non-contributory	53	58	59	41	42	40
OECD (10)	–	–	35	–	–	32

nc: Non-contributory benefits.
. . Data not available; – Not applicable.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Mental problems are considerably more common among recipients of means-tested non-contributory benefits. This is explained partly by the younger average age of this group, which is caused by the fact that many of these diseases are congenital, and partly also by the more severe nature of many of these disabilities, which prevent people from working and thus from qualifying for a contributory benefit.

The gradual growth in mental illness has a whole range of possible explanations. One is greater willingness on the part of the public to seek help with mental problems than in the past, when such problems tended to be more hidden and less recognised. This is confirmed by a rapid increase in the number of psychiatrists and psychotherapists in many countries. Related to this are new diagnostic techniques that make it possible to identify mental illness. Other explanations relate to the work sphere. New, more complex and more demanding labour market requirements may "produce" a higher number of people with mental illness, as do higher rates of long-term unemployment. Similarly, less stable family structures may add to the problem. Finally, because mental illnesses on average occur earlier in the lifecycle than other disabilities and therefore last longer, their proportion in the total recipiency stock and inflow should be expected to increase for purely numerical reasons.

Some of the increase in recipiency rates over the last decades, *e.g.* in Canada, Sweden, Switzerland and the United Kingdom, certainly is explained by the increase in mental illness. In many countries, this group's share in total inflow has indeed increased by some 10 percentage points over the last decade. At the same time, it is interesting to note that in most countries the share of mental problems in inflow is in most cases lower than in the stock of recipients (Table 4.12). This seems to be related to the age-structure effect mentioned above – the fact that, on average, people with mental problems stay longer on benefits. The continued increase in the share of mental illnesses in annual inflow in most countries suggests further increases in benefit recipiency rates.

In this table, all people entering the benefit rolls with any kind of mental condition are subsumed. This simplification – chosen because administrative data usually do not have more detailed classifications – does not acknowledge the heterogeneity of this group. In particular, there is an important distinction between people with usually congenital learning disabilities and those with other forms of mental illness, including for instance depression, which are often acquired later in life. Congenital learning disabilities are not more difficult to diagnose than earlier and are probably not increasing in scale very much, although they may be identified better because of greater awareness and improved testing techniques.

Benefit rejection and appeals

Rather high benefit rejection rates in many countries are another indication of the assessment problem. In about half of the countries for which data are available, benefit rejection rates are close to around 50% (Austria, Canada, Portugal, Spain and the United States). In Italy, the proportion of rejected applicants is as high as 68%, and a similar rate of denial is also reported for the non-contributory disability programme in the United States.[30] The lowest rejection rate reported in 1999, 17%, is found in Norway, followed by three countries – France, Denmark and Korea – in which one in four applications is denied (Table 4.13).

The data show that countries with higher rejection rates are generally those with lower disability benefit inflow rates. By and large, rejection rates were rather stable throughout the 1990s. Nonetheless, for several countries tighter benefit access has been associated with more frequent benefit rejection. There were major increases in benefit rejection between 1990 and 1999 in Austria (from 39 to 49%), Canada (from 42 to 55%), Denmark (from 15 to 25%) and the Netherlands (from 21 to 37%).

Table 4.13. **Large differences in benefit rejection rate**

Proportion of rejected benefit applicants and of successful appeals

	Share of rejections among total applications			Share of of successful appeals among rejected applicants		
	1990	1995	1999	1990	1995	1999
Australia	..	..	31	..	..	6
Austria	39	44	49	19	14	11
Canada	42	51	55	..	14	11
Denmark	15	13	25	47	64	51
France	..	..	25	..	..	..
Germany	32	34	38	..	..	..
Italy	..	69	68	..	..	..
Korea	30	10	23	1	3	3
Netherlands	21	42	37	41	63	12
Norway	12	17	17	23	25	26
Portugal	..	48	46	..	11	14
Spain	..	..	44	..	..	8
United States	56	52	48	..	..	..
United States (nc)	68	66	64	..	..	..
OECD (13)	–	–	39	–	–	16

. . Data not available; – Not applicable.
nc: Non-contributory benefits only.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

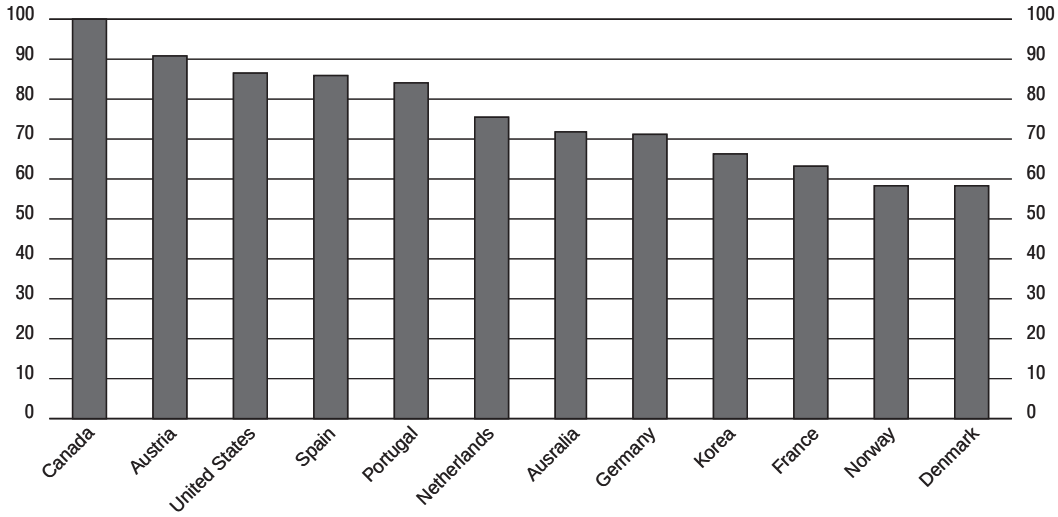
Successful appeals by rejected applicants can accentuate cross-country differences in benefit rejection. One in two rejected applicants in Denmark and one in four in Norway, both of which are among the countries with the lowest rejection rates in the first place, eventually is granted a disability benefit.[31] In all other countries, rates of successful appeals in 1999 were only between 3 and 14%. The Netherlands is an interesting case, because the rate of successful appeals has declined from around 50% in the early 1990s to only 12% in 1999 – which nevertheless did not stop the drastic increase in the inflow rate in the second half of the 1990s (see also Box 4.3).

Both phenomena – rates of benefit rejection and rates of successful appeal – taken together mean that benefit application rates are more similar than effective benefit inflow rates. Were Canada's high rates of disability benefit rejection and its low rates of successful appeals applied in Denmark or Norway, for instance, the resulting disability benefit inflow rates in these two countries would be more than 40% lower (Chart 4.5). In France, Korea, Germany, Australia and the Netherlands, inflow rates would be lower by around 25 to 35%, and in Portugal, Spain, the United States and Austria by 10 to 15%.

High rates of benefit rejection may be a sign of very stringent access rules and of consistent application of these rules. At the same time, high rates of 50 or even 70% raise a number of questions. Many of those people applying for a disability benefit will have been out of work for a rather long time, generally at least between six months and a full year (see Annex 3, Table A3.7). For those people it will often be difficult to get back into work, and many of them are likely to be found among new applicants again at a later stage. Others will either depend on incomes of other household members, or on means-tested social assistance payments.[32] Large numbers appealing against the initial decision create substantial backlogs, which will be worked off very slowly; indeed, in several countries this process can take years, during which these applicants may suffer economic hardship. In Canada, many people with disabilities consider the rejection and appeals process there to be scandalous. There is no easy

Chart 4.5. **Considerable impact of rejection rates on eventual inflow rates**

Estimated inflow rate if using Canadian rejection and appeals rates, as a percentage of actual 1999 inflow rate in each country



Note: Countries are ranked in decreasing order of the percentage.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

way out of this dilemma, but certainly the procedure must guarantee some security during the application and partly also the appeals phase. At the same time, rejected applicants need to be given as much support as possible to find their way back into work.

4.7. Sickness, disability and work-related injury

Work incapacity recipiency

Much of the analysis so far has focused on public programmes for longer-term disability. To get a fuller picture and to make data even more comparable, other disability-related programmes may also need to be taken into account. In particular, comparability of disability recipiency data may be restricted because people already found on the disability programme in some countries will not have access to such programmes in others where a waiting period of, say, one year is required for benefit application – such as in Belgium, the Netherlands, Switzerland and generally also Spain (see Annex 3, Table A3.7). Figures for these countries may be underestimated. One way to correct for such differences would be to add people on long-term sickness benefits to those on disability benefits. But this approach has two limitations: first, this would assume that all people on long-term sickness absence will eventually end up on the disability programme, which is certainly not always the case (though it may be to a considerable extent); and, second, data on sickness absence by duration are unavailable for a large number of countries.[33]

Another comparability restriction on disability recipiency data is that they include work injury cases to differing extents. The Netherlands is the only country in which the general disability programme covers all disabilities irrespective of their cause, so it is the only country with no work injury scheme (compare also Table 4.14). For this reason, data for the Netherlands will be an overestimate.[34] But there are other countries in which the programme for general disabilities covers a varying share of work injury cases as well. One example is Italy, where only a certain group of workers – manual workers and employees in hazardous work – are covered by a separate work injury programme. Another example is

Table 4.14. **Structural set-up of transfer schemes regarding work incapacity**

		Set-up of the social insurance system: relationship of the disability scheme with the other benefit programmes		
		Disability scheme linked with old-age scheme	Disability scheme linked with sickness scheme	Disability as a separate insurance or flat-rate scheme
Relationship of disability with the work injury scheme	work injury linked to disability	Spain Turkey	–	Netherlands[a] Poland
	work injury as separate programme	Austria Canada Germany Italy Korea (Norway)[b] (Portugal)[b]	Belgium France Sweden	Denmark Mexico (Switzerland)[b] United Kingdom
	work injury via private carriers	(Norway)[b] (Portugal)[b] United States	–	Australia United States (Switzerland)[b]

a) The Netherlands is the only country in this group in which the work injury risk is fully integrated into the general disability programme.
b) Work injury insurance in Norway, Portugal and Switzerland partly provided by private carriers.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Norway, where *de facto* very few people are found on the work injury benefit rolls. Again, one way to correct for these differences would be adding work injury and disability benefit recipients together, but again such an approach raises new problems. Depending on the particularities of the scheme, often a large proportion of work injury cases involve short-term or even one-off payments, in particular in the schemes in Canada and the United States. The data do not make it possible to distinguish these groups, and in some countries it is even impossible to get any data on the number of work injury benefit recipients.

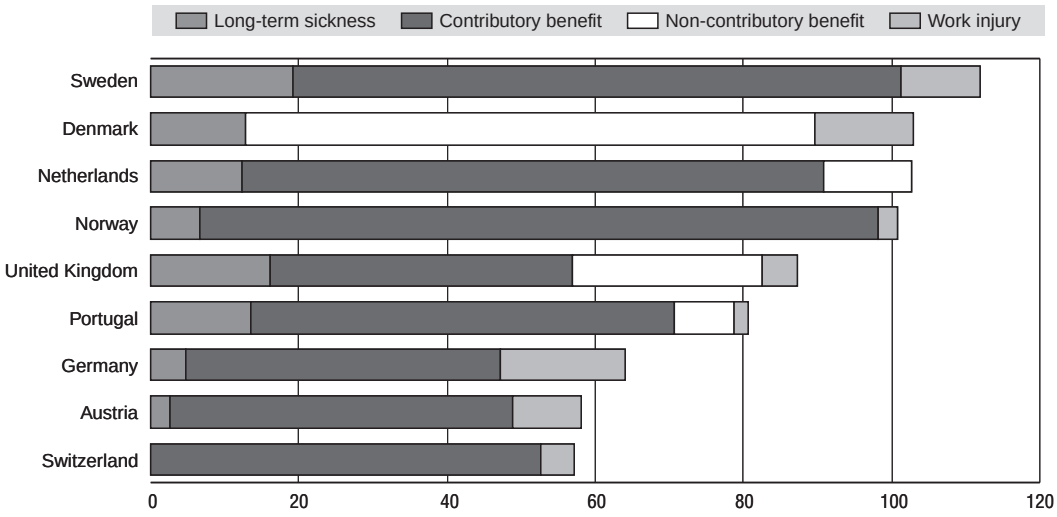
Notwithstanding these caveats, recipiency rates that cumulate contributory and non-contributory disability benefit claims, work injury claims and long-term sickness cases – long-term being defined as more than six months – are presented in Chart 4.6. Such compound work incapacity recipiency can only be worked out for about half of the countries, not including Poland, which has the highest disability benefit recipiency level.

Sweden appears to be the country with the highest work incapacity recipiency rate, over 11%, leaving behind countries with a higher disability benefit recipiency rate. This position is explained largely by the large number of people on long-term sickness benefits. Denmark, Norway and the Netherlands have almost identical overall work incapacity recipiency rates, all around 10%. The larger number of long-term sickness cases in the Netherlands more than offsets the additional recipients in Norway, while Denmark catches up with both countries due to larger numbers on both sickness and work injury benefits. Germany has the largest number of work injury benefit recipients, resulting in a higher overall work incapacity rate than Austria and Switzerland, for example.

The large number of long-term sickness cases in both Sweden and the United Kingdom deserves particular attention. In Sweden, the share of long-term sickness in total sickness absence has increased from 20% in 1980 to over 50% in 1999, with the largest increase occurring in the 1990-1995 period. This is strongly related to reforms in both the sickness and disability programmes. Reforms to the sickness benefit scheme during the 1990s (introduction of waiting periods, lowering of benefit levels) have drastically reduced short-term sickness absence (*i.e.* absence of less than one month) – from a level of

Chart 4.6. **Long-term sickness and work injury can change the picture**

Benefit recipients per 1 000 of working-age population, 1999



Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

70 000 cases in 1990 to only about 20 000 in 1995 and 1999. At the same time, tightening access to disability benefits has increased the number of people on long-term sickness benefits – from 65 000 in 1995 to 100 000 in 1999 (and the trend further accelerated during the last few years). This latter increase is explained partly by a system that pays very high sickness benefits – often 90% of last wage – for an unlimited duration, thus "inviting" long-term sickness absence, in particular for older workers as a bridging benefit into retirement.[35]

In the United Kingdom, the number of short-term sickness absences of less than one month has also fallen very drastically. The entire decline (from 250 000 in 1980 to 40 000 in 1990) occurred in the 1980s. This was clearly related to reform of the sickness benefit programme (introduction of statutory sick pay in 1983, gradually transferring responsibility to the employer). Long-term sickness and disability has been increasing steadily since the late 1980s. For instance, in 1985 there were 800 000 long-term sickness/disability benefit recipients, but nearly 2 million by 1999.

Set-up of the social security system

The respective roles of the sickness and work injury programmes in a country may also be influenced by the structure of the social security system. Having separate disability insurance, like in the Netherlands and Switzerland and more recently also in Mexico and Poland, or another form of a separate public programme, like in Australia, Denmark and the United Kingdom, appears to be an effective way to keep control over the programme and to help ensure this is a specific labour market programme for specific groups of the working-age population (see also the concluding chapter). Integrating the sickness benefit and disability programmes, as was done in Belgium and France and soon will be in Sweden, has the advantage of furthering a smooth assessment process – as the Belgian example shows.

Integrating the disability programme into the retirement programme, as was done in half of the countries, however, has disadvantages (Table 4.14). It implicitly suggests that a disability benefit is a permanent pension payment, and it does so not only to the benefit applicant or recipient. For the pension insurance system itself, it will be difficult to operate an efficient disability programme because two very different risks, disability and old age, are mixed up.

Empirically, it is evident that countries with linked disability/old-age schemes have considerably older recipiency populations, the United States being the only real exception. There is no evidence of an impact on disability benefit recipiency rates resulting from the relationship between the general disability and work injury programmes. Countries with work injury programmes that are partly linked to or even integrated into the disability scheme are among those with particularly high (Poland and the Netherlands) and low (Spain and Turkey) recipiency rates.

4.8. Disability and unemployment

The relationship between the disability and unemployment programmes is important for understanding how people with disabilities move through the transfer system. Several potential relationships between the two programmes may be expected. One hypothesis is that high and/or increasing unemployment rates lead to high rates of disability benefit application and awards, some of which are hidden unemployment. The mechanism behind this can be that people with disabilities experience particular labour market

problems during periods of rising unemployment, but also that higher unemployment in itself creates conditions (stress, poverty) that lead to higher rates of disability benefit application. A contrasting hypothesis is that low disability benefit recipiency is an indication of a system that is not hiding unemployment and therefore is likely to be complemented by higher rates of unemployment.

Empirical evidence

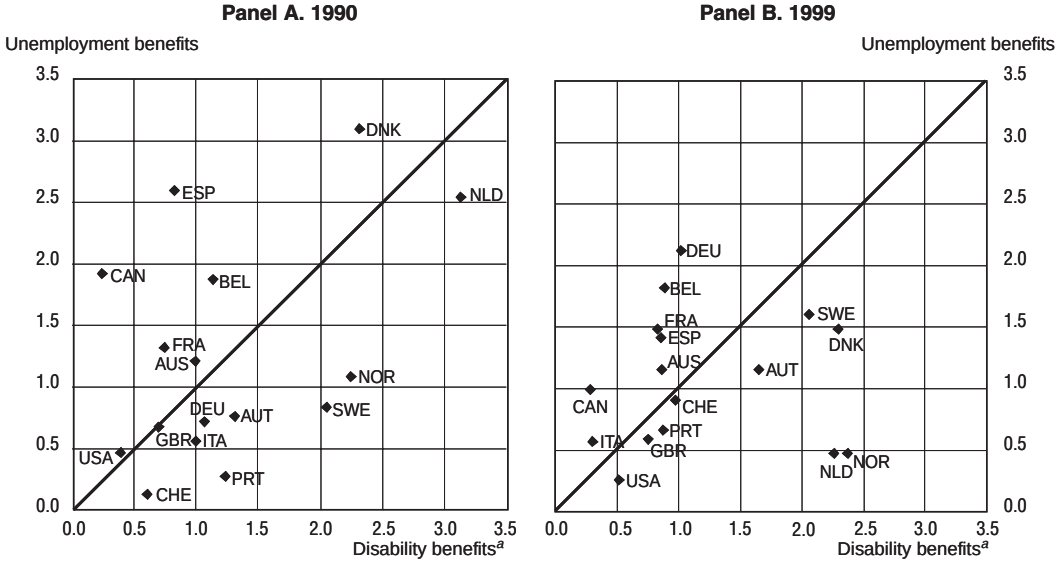
Both in 1990 and in 1999, in a majority of countries disability benefit expenditure was higher than unemployment benefit expenditure (Chart 4.7). In 1990 (and although not shown in the chart also in 1980), there appeared to be a weak negative relationship, *i.e.* higher disability benefit expenditure was loosely associated with lower unemployment benefit expenditure, suggesting some sign of programme interchangeability.[36] By 1999, any kind of relationship had disappeared, possibly as a consequence of reforms in the disability programme (*e.g.* tighter access) as well as the unemployment benefit programme (*e.g.* stricter work requirements) in many countries.

A comparison of the disability and unemployment benefit programmes is complicated by the fact that certain groups of people with disabilities are found in different transfer programmes in different countries. Including other disability-related transfer programmes (non-contributory disability benefits, sickness cash benefits and work injury benefits), however, gives largely the same result.

Chart 4.8, in which subsequent five-year periods are related, again suggests insufficient evidence for the hypothesis that increasing unemployment results in higher

Chart 4.7. **No clear relationship between unemployment and disability benefit expenditure**

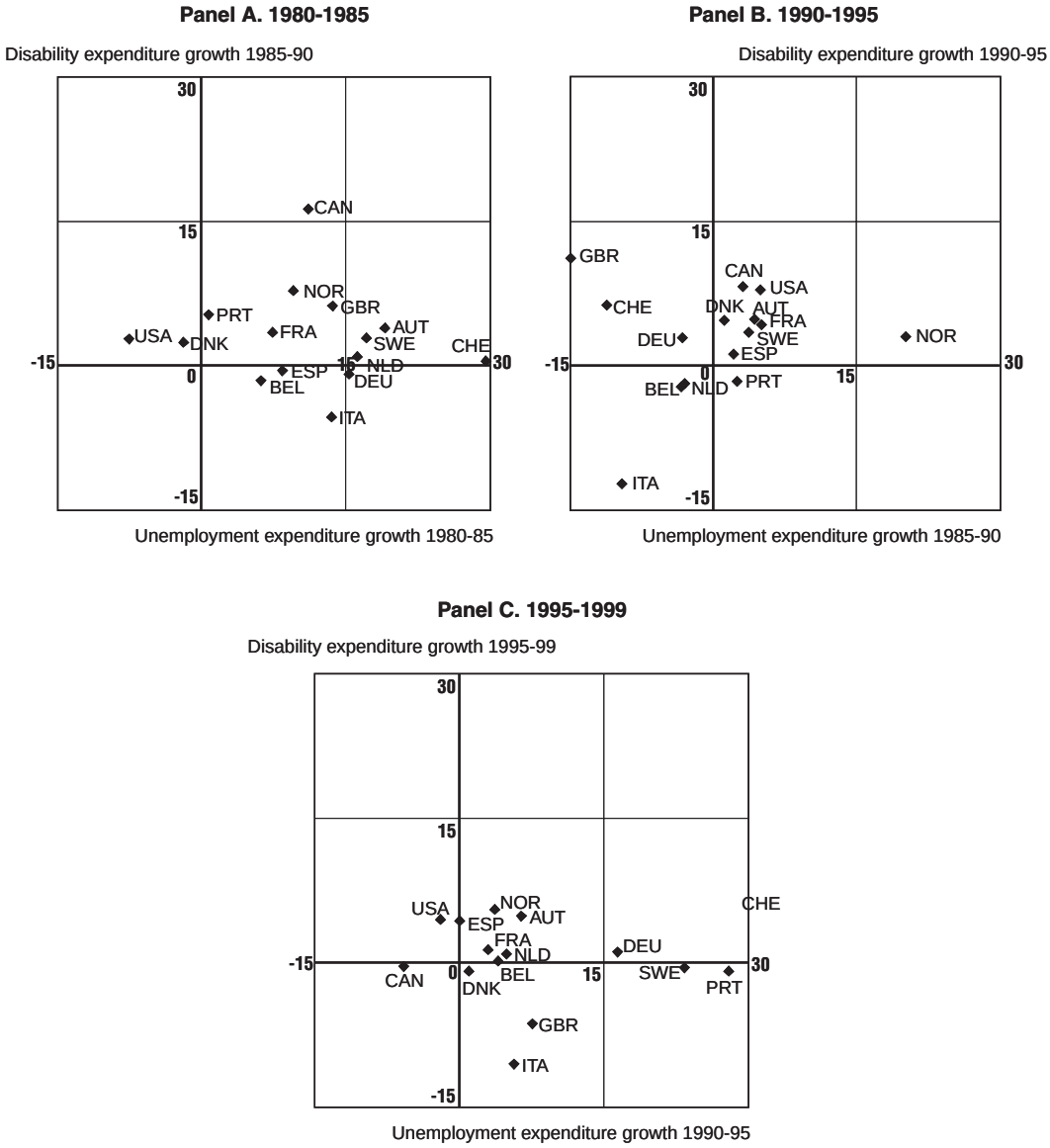
Expenditure on disability benefits and on unemployment benefits, in percentage of GDP



a) Contributory benefit, except non-contributory disability programme for Australia and Denmark.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Chart 4.8. **No clear relationship in expenditure growth in subsequent periods**

Average annual growth in real expenditure on unemployment and disability[a] benefits, percentages



a) Contributory benefit, except non-contributory disability programme for Denmark.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

disability benefit recipiency, at least when measured in terms of expenditure. Only in the first half of the 1990s is there a sign that disability benefit expenditure growth might be related to unemployment expenditure growth in the second half of the 1980s, but in none of the periods is a significant relationship found.

Within-country variation, on the contrary, does suggest an increase in disability recipiency as a consequence of rising unemployment in some countries (*e.g.* United Kingdom and United States).[37] At the same time, there is some indication of programme interchangeability, *i.e.* restricting access to disability benefits leading to higher numbers (and easing access to lower numbers) on unemployment benefits. This would suggest that

changes to the disability benefit programme may have a stronger impact on the disability-unemployment relationship than changes to the unemployment benefit programme.

Incentives and pathways

Generally, the lack of participation requirements can operate as an incentive for people on unemployment benefits to test their eligibility for a disability benefit, depending on the regulations on access to disability benefits. The relationship between disability and unemployment is also influenced by relative benefit levels for different types of entitlements (including differences in tax treatment and, where applicable, means-testing arrangements).

In most countries, unemployment benefit recipients are covered by disability insurance or, as in Australia and Denmark, the non-contributory public disability programme. But there is considerable cross-country variation in the transition from unemployment to disability benefit. In many countries, direct transition from unemployment to disability is possible, or even – as in Belgium – required. In most cases, during the application phase unemployment benefit payment would continue. Unfortunately, data on pathways into disability benefits (*i.e.* on the work and benefit status of new benefit recipients before applying for a disability benefit) is scarce. In Australia, Austria and the United Kingdom, three countries in which direct transition is possible, around one-third of all new recipients were previously unemployed (Table 4.15).[38]

In other countries, direct transition from unemployment into disability is not possible or requires completion of a waiting period, during which sickness benefits may or may not be paid. In one of these countries, the Netherlands, five in six new recipients were previously on sickness benefit. Disability benefit application is only possible after a one-year sickness period, so unemployed people would also have to receive sickness benefit for a year before applying for a disability benefit.[39] In other countries, like Poland and Canada, the unemployed are not covered by sickness insurance and can only move directly into disability benefits once the waiting period and entitlement requirements are fulfilled.

The proportion of inflow into disability benefits from groups other than the employed, the unemployed or those on sickness absence is small in insurance systems, but is generally high, in some cases approaching 100%, in non-contributory systems. In the Netherlands, all people being awarded a non-contributory "Wajong" benefit must have been out of work when applying for the benefit, which accounts for 7% of the total disability benefit inflow (Table 4.15). In Australia, to take another example, as many as one

Table 4.15. **Very different pathways into disability benefit recipiency**

New disability benefit recipients by status before benefit award, 1999

	Status before disability benefit award:			
	Employed	Sick leave	Unemployed	Other status
Austria	42	28	27	2
Netherlands	7	86	0	7
United Kingdom	60		35	4
	No benefit incl. employed	Sickness benefit	Unemployment benefit	Any other benefit
Australia	44	3	35	19

Note: Data for the Netherlands include new recipients of non-contributory Wajong benefits, whereas data for the United Kingdom only include contributory incapacity benefits.

Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

in five new awardees had received other payments, such as Parenting Payment, Youth Allowance or Carer Payment.

Regulations on access to benefits is one side of the story, benefit levels another. In most countries, the formulae for calculating disability and unemployment benefits are very different. While the former is generally based on the applicant's contribution or employment history, the latter is usually calculated as a percentage of last wage or net income (see Annex 3, Table A3.9). Further, the two types of benefits often have different regulations regarding benefit minima and maxima (typically, unemployment benefits have a lower upper limit), and regarding top-up payments for dependent family members (which are more widespread for unemployment benefit schemes). Hence, the incentives vary from individual case to case, depending on age, the employment record, the wage level and possibly the family situation. The relationship is reinforced where the duration of unemployment payments also depends on these same factors.

From a broad perspective, nonetheless, disability and unemployment benefit levels are generally quite similar in most countries. Only in a few countries (in particular Canada, Korea and the United States) are replacement rates from the disability programme significantly lower than from the unemployment programme. Since these are countries with rather short duration of unemployment benefit payment, however, this is unlikely to have a strong effect. Poland is the only country in which the disability insurance benefit would consistently be significantly more generous than the flat-rate unemployment compensation. This is probably a particularly important factor behind the high disability benefit recipiency level in this country and the rapid increase during the years of economic transition.

By and large, as far as insurance systems are concerned, unemployment benefit levels will be more attractive than disability benefits for younger people, while the opposite is more likely to be true for people of pre-retirement age. For the younger group in particular, relative incentives may show a closer relationship to the duration of unemployment benefit payments. Unemployment systems with long benefit payment periods are likely to reduce the pressure on the disability programme. This is particularly true for countries where there is no such time limit (*e.g.* Belgium), or where unemployment assistance at a similar benefit level can be received without time limit (Austria, Germany; see again Annex 3, Table A3.9). All these are indeed countries with relatively low disability benefit recipiency levels.

In several countries the period of unemployment payment is considerably longer for older workers, and such benefits become bridging payments into early or regular retirement. This effect is very pronounced in the Netherlands and France, and also exists to a lesser degree in Austria, Germany, Korea, Norway, Portugal, Spain, Sweden and Switzerland. Such regulations were often introduced in line with early retirement regulations, due to a particular reluctance to accept high unemployment rates among older workers. In several of these countries, payment duration was only recently related to age, while it used to be more closely related to the insurance record. Regulations of this kind probably reduce the pressure on the disability programme, although this effect does not show up in the empirical data (see also the following section).

4.9. Disability and early retirement

During the 1970s and 1980s, early retirement programmes were introduced with the dual aim of alleviating the labour market problems of older workers and (as it was hoped) of increasing the labour market chances of young labour force entrants. Most OECD countries have at least one scheme that allows early withdrawal from the labour market, typically five years before the statutory retirement age, if certain eligibility conditions are met (see Annex 3, Table A3.10). Often a recent period of long-term unemployment is one of the relevant criteria (as in Austria, Germany, Poland, Portugal, and – via an unemployment supplement – Belgium).

In many countries, such schemes are an integral part of the public pension scheme, with or without actuarial or less than actuarial reduction of entitlements (no benefit reduction: Korea, Poland, early retirement over age 60 following a period of unemployment in Portugal; some benefit reduction: Austria, Germany, Italy, other early retirement in Portugal; actuarial benefit reduction: Canada, Spain, Sweden, United States). Typically such schemes are rather generous and make early exit from the labour market attractive.

In other countries, comparably generous early retirement options have been introduced via collective agreements, thus covering large parts, but not the entirety, of the workforce (Netherlands, Norway). In yet a third group of countries, early withdrawal regulations are less generous but are possible via a mandatory funded occupational scheme (Australia, Switzerland) or voluntary early retirement insurance (Denmark, United Kingdom).[40]

Empirical reflection

Empirically, around 35% of the 50-64 age group receives retirement benefits, much of which is early or advance retirement (Table 4.16); see also the discussion in Chapter 3, Section 3.4). In Austria, France, Italy, Portugal and Sweden, almost as many (if not more) disabled people in this age group receive retirement benefits as receive disability-related benefits.[41] In these countries in particular, but also in the other countries, recent and forthcoming pension reforms, such as raising the minimum age of entry or lowering

Table 4.16. **Large proportions of disabled aged 50-64 receive retirement benefits**

Disabled persons aged 50-64 by type of benefit received, percentages adding to 100%, late 1990s

	Disability	Unemployment	Social assistance	Retirement	Other
Austria	43.1	8.5	0.0	40.5	7.9
Belgium	54.5	11.8	0.0	28.2	5.5
Denmark	71.9	9.5	0.0	16.0	2.5
France	36.3	7.2	7.6	43.5	5.4
Italy	37.6	0.9	0.0	57.3	4.2
Netherlands	66.8	6.6	10.2	8.9	7.5
Portugal	40.8	9.0	0.9	42.1	7.2
Spain	67.5	7.5	1.9	15.8	7.3
Sweden	33.1	3.7	2.5	60.7	–
United Kingdom[a]	66.3	2.0	..	18.2	13.5
EU (9)[b]	50.2	7.2	2.6	34.8	5.9

. . Data not available; – Not applicable.
a) United Kingdom: no data on income from social assistance.
b) EU (9): excluding the United Kingdom.
Source: See Annex 1, Table A1.1.

replacement rates for either early or regular retirement, are likely to have a considerable impact on the disability benefit scheme.[42]

Somewhat unexpectedly, those countries in which (early) retirement seems to play a very important role for people with disabilities as an alternative route for labour force exit, like Austria or Portugal, are also countries in which disability benefit recipients are overwhelmingly aged 45 and over. It seems that generous early retirement schemes pull older workers out of the labour market, without lowering the pressure on the disability benefit scheme.

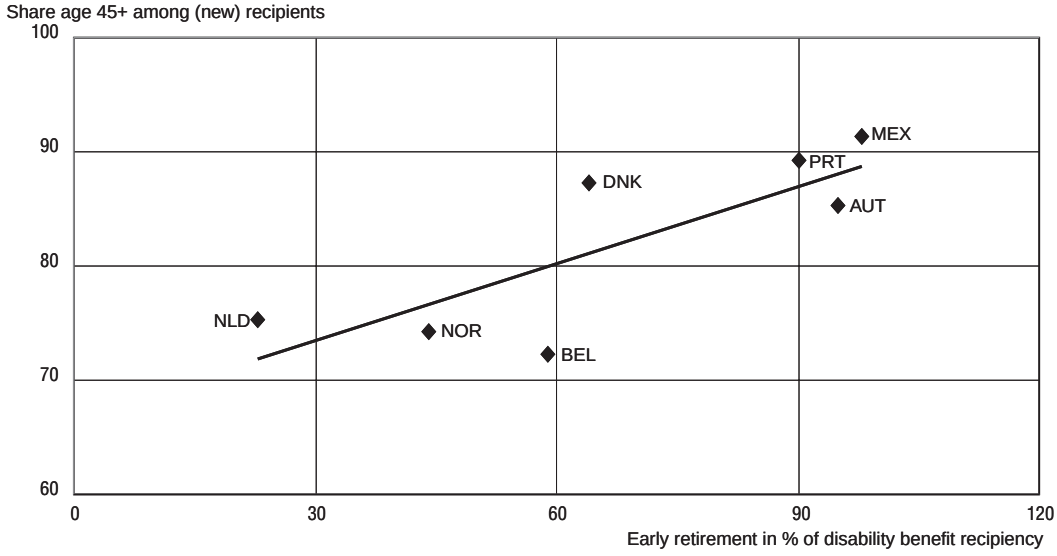
There appears to be a correlation between generous early retirement and (de facto) age profiling in the disability benefit regulations (Chart 4.9). This creates an early exit culture, which increases the burden on both the retirement and disability schemes, because it makes it easier for employers to suggest to those of their employees about to lose their job to request a disability benefit (for those people with a potentially more severe disability) or an early retirement benefit (for the others). Norway is a particularly telling example in this context, because the introduction of an early retirement programme in 1989 and the gradual broadening of this programme ever since has led to a rapid increase in the influx into this programme in parallel to a rise in the influx into disability benefits.

Programmes and incentives

In this context it is important to observe a certain imbalance in incentives. It is (at least moderately) disabled people who would potentially be in a position to "choose" between either a disability or an early retirement benefit – be it a free choice or employer-forced coercion. For people without measurable disability, who could not pass the medical test for a full disability benefit, the situation is very different. For this group, relative incentives between disability and early retirement programmes in terms of benefit levels

Chart 4.9. **Early retirement coincides with age bias in disability benefit inflows**

Share of disability benefit recipients aged 45 and over, and early retirement in % of disability benefit inflow, 1999



Note: Data for Denmark and the Netherlands refer to benefit stocks, data for all other countries to inflows.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2; OECD database on labour force statistics.

are likely to be quite irrelevant. On the other hand, the boundaries between full and reduced work capacity are increasingly blurred at higher ages.

Disregarding this imbalance issue, incentives in terms of relative benefit levels for full disability and early retirement appear to differ somewhat between countries. In a good one-third of the countries, for a 55 or 60-year-old person benefit levels under both systems are generally quite similar. In another group of countries (Canada, Korea, Spain, Sweden, Switzerland and the United States), disability benefits tend to be slightly higher because early retirement benefits are actuarially reduced for each year of retirement before the statutory age.[43]

In a smaller group of countries, replacement rates from an early retirement benefit are likely to be higher than for a disability benefit. This is the case with the public pension schemes in Belgium and Italy, but also, for instance, in the collectively agreed schemes in the Netherlands. Private pension arrangements can also include attractive early retirement clauses, and thus give incentives to retire prematurely.[44]

4.10. Summarising the findings of the compensation policy analysis

Some of the main findings of the analysis of compensation policy challenges are:

- Disability benefit recipiency rates are high in many countries and have risen steadily in most.
- Reforms affecting benefit access have led to a stabilisation or even a decline in annual rates of inflow in most countries – thereby stabilising the recipiency rate, in particular since 1995.
- Outflow from disability benefits is low in all countries, despite considerable differences in regulations on reviewing entitlements, availability of partial benefits, and work incentives.
- Regulations on re-testing benefit entitlements do not appear to be applied stringently in practice.
- Countries with high benefit levels tend to have high recipiency rates. But recently, countries with lower benefit levels have had equally high rates of inflow, and the rates of outflow are also similar.
- Countries with several grades of benefits for partial disability are among the group with high benefit recipiency rates. In these countries, one in three new awards is for partial disability.
- Despite high rates of benefit recipiency, problems of exclusion from benefits remain, partly due to not fulfilling insurance requirements, and partly due to failing the (household) means test.
- In countries with a dual benefit system, the proportion of recipients on means-tested benefits is increasing, resulting in a decline in average per capita benefit income.
- Women are generally under-represented on insurance and over-represented on means-tested benefit programmes. This is not the case in some schemes with individual entitlement for the entire disabled population, in which women below age 45 have much higher inflow rates than men.

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- Mental and psychological problems are responsible for between one-quarter and one-third of disability benefit recipiency levels, and for a considerable portion of the increase in those levels.
- Application rates for benefits differ less across countries than inflow rates. Benefit rejection rates are highest in countries with the lowest inflows, and rates of successful appeals against benefit rejection tend to be higher in countries with low rejection rates.
- Considerable age profiling is apparent in disability benefit programmes. In many countries, disability benefit awards are highly concentrated among people over age 50. However, taking the skewed age structure of disability prevalence in the population into account, some countries turn out also to have very high rates of benefit inflow among younger disabled people.
- In a cross-country perspective, there is little evidence that high or increasing unemployment leads to high or increasing levels of disability benefit recipiency. At the same time, there is some indication that stricter access to disability benefits results in somewhat higher unemployment levels.
- There is no evidence on programme interchangeability between early retirement and disability benefits. On the contrary, countries in which the disability scheme is predominantly used by older workers tend to be countries with large numbers on early retirement programmes.

Notes

1. Note that the outflow rate in Australia is higher, at 2% annually, if other causes for benefit termination are taken into account – in particular losing entitlement because of no longer passing the means test. The same outflow rate of about 2% is found in the means-tested programme in the United States (the supplemental security income programme), in which the annual rate of recovery and work resumption is otherwise only 0.9%, *i.e.* slightly lower than for this country's social security disability insurance.
2. Among people younger than 40 years, 24% lost their benefit, 16% were re-classified into a lower partial benefit and only 2% were re-classified into a higher category (hence, 58% remained in the same category).
3. In particular, the social security administration was obliged to prove a medical improvement prior to any benefit termination – legislation that is still in force today.
4. The trend in Australia is partly explained by women's declining access to alternative payments such as Wife Pension and Widow Pension. This trend is likely to continue in the future as more alternative payments are closed (*e.g.* Partner Allowance and Mature Age Allowance).
5. In Sweden, "freezing the pension", as it is called, is possible for up to three years, but after one year nonetheless a new application is necessary. Note that in this country it is also possible to pause a wage subsidy payment for up to three years, and to break sheltered work for up to one year.
6. In the United States, there is considerable flexibility, as this nine-month period can even be spread over five years. In addition, Medicare coverage is continued for more than three years (provided the medical condition has not improved).
7. One should not forget that many of those on disability benefits are lower-skilled people with lower pre-disability incomes and/or low income potential, for whom benefit replacement rates even in these countries may not be so low. Hence, much more detailed data (*e.g.* outflow rates by skill, income and benefit level) are necessary to come to a final conclusion on this issue.
8. In Portugal, following new legislation on the calculation of pensions in 2002, the maximum replacement rate can be as high as 92%.
9. Indirect, because partial benefits directly affect benefit inflow, which in turn – due to almost no outflow – affects long-term benefit recipiency.
10. Note that, correcting for partial benefit receipt, in the Netherlands, Norway and Sweden a full-time equivalent benefit recipiency rate would be 10% lower than the one shown, *e.g.* in Chart 3.12, and

more than 15% lower in Switzerland due to the higher share of partial benefits in the stock of beneficiaries in this country. For the comparative analysis, though, the uncorrected recipiency rate is used, because partial benefit recipients also, and in many cases exclusively, depend on these benefits. Overall disability benefit expenditures, on the contrary, reflect the lower costs of partial benefits.

11. The Australian mobility allowance is another example, but this is only paid to people with significant mobility difficulties who are participating in work, training or voluntary activities.

12. Note that the Austrian attendance allowance can be very high – in absolute terms even significantly higher than the British disability living allowance – but only for people with severe care needs who are almost unable to move at all, for whom the benefit trap issue becomes irrelevant.

13. Although these people may be entitled to regular social assistance benefits, particularly in Canada.

14. Note that in all countries sickness caused by a work injury or an occupational disease is covered from the first day of employment.

15. The Australian pension means test is based on the income of the applicant and, if relevant, their (heterosexual) partner. Child income or income from others sharing accommodation does not affect a person's rate of disability benefit.

16. Note that in Australia women are also under-represented because they receive other payments, which are less administratively difficult to assess (*e.g.* parenting payment, partner allowance or widow allowance) – although the disability support pension payment rate is usually higher than for any of these benefits.

17. The new scheme is a mandatory social insurance that is to be purchased on the private insurance market.

18. One has to keep in mind that the data on the non-contributory programme in the United Kingdom include a small group of recipients of a severe disablement allowance as well as a large group of recipients of income support (*i.e.* of regular social assistance) with a disability premium. Like in the United States and Canada, disabled people on social assistance programmes can be identified because they receive special allowances or premiums, and they need to be included to reflect properly the benefit situation of people with disabilities. In most other countries, data on non-contributory schemes refer to a special programme for people with disabilities. In these and other countries, though, some people with disabilities will be found on social assistance – even if data are not available. Judged from the survey data and from other material available, this may be true particularly in Belgium, France, Germany, Italy and the Netherlands.

19. This top-up payment can only be received by recipients who are not entitled to a benefit from the mandatory second-pillar occupational pension scheme (one-quarter of all benefit recipients in 1999).

20. Sweden and Norway are the only countries somewhat similar to the Netherlands in this respect. Also in these countries, the excess disability prevalence of women is higher under age 50 than above this age. This means that for these two countries too, some of the higher disability benefit inflow among younger women may be a result of relatively higher disability prevalence.

21. Concern about the growth in grants to people aged 55 and over has led to a reconsideration of this legislative provision. Subject to the passage of necessary legislation, it will be repealed so that it is not considered for people applying after mid-2003.

22. This factor gradually declines with age from 2.0 at younger than 23 years to 1.0 at over age 45 (*e.g.* 1.5 at age 27, 1.2 at age 32-34 and 1.05 at age 39-45). Note that this factor is only applied for calculating entitlements from the first pillar, public invalidity insurance.

23. Note that for men the figure for Austria is even higher (18.5), because the total is lowered as a consequence of the fact that many women are entitled to early retirement before age 60. The single most important explanation for this unusually high ratio in Austria is the strict form of "own occupation" assessment for people aged 55 and over, combined with considerable age profiling in vocational rehabilitation (see Chapter 5, Section 5.5).

24. Correcting for the age distribution of disability prevalence is done by relating the annual disability benefit inflow to the disabled population of the corresponding age group only, rather than to the total population in this age group. In absolute terms, this procedure implicitly increases the annual disability benefit inflow rate from 6 per 1 000 to about 36 per 1 000, on average – in other words, it multiplies the inflow rate by a factor of six because about one-sixth of the working-age population is classified as disabled.

25. This is largely an illustrative calculation. The resulting inflow rates are hypothetical because previous analysis has shown that non-disabled people (non-disabled according to the survey definitions used) are not necessarily excluded from benefit receipt. To the extent that this relationship is age-related as well, the resulting ratios shown in Table 4.10 (last column) could also be affected.

26. Note that this conclusion is based on the age pattern of disability benefit inflow in each country. A relatively high ratio between age groups indicates a larger age bias. In absolute terms, however, France in particular has comparatively low disability benefit inflow rates at age 55-59 (Table 4.9, although the data on France in this table are incomplete, because age-specific data on the non-contributory programme is not available). This suggests that, though an age bias exists, the disability scheme is rarely used as a path to early retirement in this country.

27. The key problem is that there is not a simple dichotomy between people who either can or cannot work, while assessment procedures are usually structured as if there were such a dichotomy.

28. Entitlement for partial benefits exists for people passing the means test only partially, but this is not related to the disability level. Note that, with the 2002-2003 budget, it has been proposed to reduce the "inability to work threshold" from 30 hours a week to 15 hours a week at award wages, thus implicitly changing the necessary percentage of work incapacity to around 60%. These changes are subject to the passage of legislation and will only affect new applicants from July 2003 (see Chapter 7, Box 7.1, for more details).

29. In the two countries without an insurance system, the decision is taken by a single Centrelink officer (in Australia) or a caseworker of the municipality (in Denmark).

30. It is obvious that non-contributory programmes have higher rejection rates, due to people who fail to pass the means test. In this respect, the relatively low rejection rate in Australia seems surprising, but this is explained by rather generous income and asset thresholds.

31. In the United Kingdom, the appeal success rate is about 40%.

32. A relevant factor in the issue of rejections and appeals is what is available for those rejected, as it makes a big difference whether this is a similar level of (another) benefit, but with added work-search conditions, or substantially less money.

33. Cumulating disability and long-term sickness cases would also correct for breaks in data series resulting from reclassifications caused by benefit reform. One such example is the 1991 disability reform package in Australia, under which a newly introduced disability support pension replaced the previous invalid pension and about 30% of the former sickness benefit.

34. Correcting for this difference by simply eliminating work injury cases from the Dutch disability data is impossible because there is no indication in the programme statistics on this matter. The share of recipients who entered the rolls as a consequence of a work injury, a work accident or an occupational disease is unknown.

35. Also note that sickness absence in Sweden has been shown to fluctuate considerably with the business cycle, more so than in most other OECD countries, which is another indication of a programme with relatively easy access.

36. Note that the relationship between disability and unemployment is measured in terms of expenditure rather than benefit recipients, because comparable recipiency data for both programmes for the entire 1980 to 1999 period are only available for a few countries. Nonetheless, the main relationship between the two programmes should be similar with both indicators. In addition, this chart only includes the main public disability benefit programme, *i.e.* supplementary means-tested non-contributory programmes are not included.

37. The relationship between disability and unemployment is very complex: rising unemployment can lead, and has in many cases, to stricter work requirements in the unemployment programme, thereby implicitly increasing the pressure on the disability programme. Hence, counteracting developments may well suppress any effect on an aggregate level.

38. In Australia, transition is frequent for recipients of "unemployment incapacitated" benefits. In the United Kingdom, direct transition is restricted to short-term incapacity benefit (*i.e.* entitlement for a higher-rate long-term incapacity benefit requires receipt of the short-term rate in the first place). Austria is an interesting case, as in this country people on sickness benefit (a benefit that usually can be paid for up to one year) become entitled to unemployment benefit after completion of the vocational rehabilitation process.

39. Note that for unemployed people, sickness benefit is paid from and financed by unemployment insurance, while for employees it is paid by the employer or the insurance is taken out by the employer.

40. Where early retirement is possible by private arrangements, using a disability benefit as a top-up for early retirement income can become an issue. The United Kingdom has recently taken counter-measures in this respect, because for claimants after April 2001 50% of any occupational or private pension above a certain threshold is offset against incapacity benefit.

41. Again, some of this is explained by a statutory retirement age of 60 years either for the total population (as in France) or for women only (as in Austria and Italy).

42. One such example is the recent pension reform in Austria, which closed access to early retirement for men aged 60-61.5 and women aged 55-56.5 (phased in between 2000 and 2002). Through this measure, the disability programme became the only alternative for early labour market exit for these particular age groups – and as a consequence of the widespread early retirement culture in this country and the easy access to disability benefits for people aged 55 and over, the programme is likely to be used for this purpose.

43. Possibly Portugal also falls into this group, although this effect is less clear, as for a disability benefit missing years until the statutory retirement age are not credited.

44. With the recent comprehensive pension reform in Italy, this will no longer be the case in the long run.

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Chapter 5

Integration Policy Challenges

Abstract. *Chapter 5 analyses integration policy approaches and resulting employer obligations, including age profiling in training, rehabilitation and employment programmes and new developments in employment-oriented disability policy. Country-specific policy characteristics of the approach to employment promotion are found in Annex 4.*

5.1. Legal framework for employment promotion

There are several problems in the (re)integration of disabled people into the labour market, and there is little evidence that different policy measures have a strong impact on outcomes.

The legislative approach to promoting the employment of disabled people is perhaps the most hotly debated issue in the context of disability policy. During the 1990s, with the introduction of anti-discrimination legislation in many OECD countries, this debate became even more intense. The difference between an approach based on civil rights and one built on obligations to employ people with reduced work capacity seems large. At the same time, recent developments suggest that different approaches may be less incompatible than is usually maintained.

Anti-discrimination legislation

In Australia, the United States and the United Kingdom, policy is shaped by anti-discrimination legislation that was introduced during the early 1990s – first in the United States, and then in the other two countries. All these pieces of legislation have special chapters prohibiting discrimination against disabled people in all aspects of employment or the employment process. Canada pursues the same goals on the basis of its Canadian and provincial human rights acts.

Anti-discrimination legislation obliges employers to accommodate disabled people able to fulfil the job requirements at the workplace, unless this would cause undue hardship or cost (see Annex 4, Table A4.1). Differences exist as to the category of persons to which the act applies, the definition of the term undue hardship, and the consequences of breaking the law.

During the last few years, several European countries also adopted more general anti-discrimination acts (*e.g.* Sweden 1999, Norway 2001, Germany 2002), but these were designed to complement existing regulations and not to establish a new policy foundation regarding the employment of disabled people. Other countries have introduced a general anti-discrimination clause into their constitution (*e.g.* Austria 1997, Switzerland 1999), although such instruments are mostly of symbolic importance, and yet other countries have adopted anti-discrimination provisions in other parts of their legislation (*e.g.* Spain 1994).

Employment quotas

In more than one-third of the countries, policy is based on a mandatory employment quota, usually written down in a special act on employing or promoting the employment of disabled people.[1] According to such regulations, employers are obliged to have a certain proportion of disabled people among their staff: 7% of the workforce in Italy, 6% in France and Poland, 5% in Germany, 4% in Austria, 3% in Turkey and 2% in Korea and Spain (see Annex 4, Table A4.2). Only registered disabled people who fulfil the eligibility criteria

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count towards the quota.[2] In all countries these quotas relate to both the public and the private sector, but only apply to employers with a certain number of employees – the minimum being 300 employees in Korea, 50 employees in Spain and Turkey, and 15-25 employees elsewhere. Some countries allow for double or even triple counting of severely disabled people.

Quota fulfilment may seem relatively low, fluctuating around 50-70% in most countries, with much lower levels of compliance in Poland and Spain (and a lack of any such data in Italy and Turkey). Nonetheless, in all of these countries, the mandatory quota is seen as an important and successful policy element.

Other than these countries, four countries have or had certain quota regulations. Belgium has a 2-2.5% quota for the public sector (with high compliance), and Portugal has recently introduced a 5% quota for new recruitment in the public sector. In the United Kingdom, the quota introduced during the 1940s was abolished in 1996 following a rapid decline in quota compliance. In the Netherlands, a legal authorisation exists to impose a quota system as an ultimate solution should all other measures prove inadequate.

Other approaches

General labour or work environment legislation is important in other countries. This is particularly true for Sweden and Norway, but also for Spain, Belgium and more recently also the Netherlands. Such legislation regulates employer responsibilities, which can, for instance, rule out discrimination in hiring or include an obligation to adapt the workplace for or foster the rehabilitation of a disabled employee.

Finally, in a few countries policy is largely based on voluntary action and information – most explicitly in Denmark, and more residually elsewhere. Such an approach can range from regular awareness-raising campaigns about the certification of good practice employers, possibly including naming and blaming bad practices, to efforts to increase the use of incentive instruments (*e.g.* subsidies for work accommodation). Denmark has strengthened its approach through the introduction of two basic principles, which are also a response to the anti-discrimination movement: the principle of compensation, according to which society has to compensate disabled people to enable the use of their abilities, and the principle of sector responsibility, which made every sector of society responsible for its own affairs.

Rights, incentives and obligations

The underlying legislative approach to promoting the employment of disabled people as such seems of relatively minor importance for policy outcomes in terms of raising or securing employment for different sub-groups of that population. Whether the approach is rights-based (anti-discrimination laws), obligations-based (quota) or incentives-based (voluntary action), it is predominantly current employees with a disabling condition who receive protection. It is difficult for a new job applicant to establish legally that he or she was refused a job because of a disability, in spite of equal qualifications. Similarly, experience in quota countries shows that employees who become disabled and are thus eligible for counting towards the quota are more likely to be kept in a job, while quota schemes give little incentive to employ a disabled job applicant. This is certainly also the case for systems that encourage voluntary action, and for regulations that directly address the employer.

In particular, the choice between anti-discrimination legislation and a mandatory employment quota largely seems to be based on cultural differences, attitudes and experiences. In the Scandinavian and the English-speaking countries, mandatory top-down policies are not considered appropriate or effective. In other OECD regions, such as Central, Western and Southern Europe but also Korea and Japan, on the contrary, such policy is well established. While these policies are sometimes considered to be diametrically opposed, they rather seem to be substitutes and – in the best case – even complements. A major difference is that quota policies tend to emphasise difference and incapacity rather than ability, which partly explains why some quota countries have recently introduced new anti-discriminatory policy elements as well.

5.2. Employer obligations

Work creation and retention

Policies based on mandatory employment quotas can be coupled with major employer obligations (*e.g.* Italy and to a lesser degree Germany) or only minor ones (*e.g.* Korea, Turkey, and to some extent Austria) (Table 5.1). Special employment provisions in anti-discrimination legislation tend to result in above-average obligations for the employer, usually including a requirement to adjust equipment, to make facilities accessible and to modify work schedules.

In addition to the nominal extent of obligations, two policy elements are relevant in determining the real level of obligations on employers: whether there are proper sanctions on employers who do not fulfil their obligations, and whether there are adequate instruments to enforce these sanctions. It is the existence of these two elements that guarantees that either anti-discrimination measures or mandatory employment quotas will compel employers to take on responsibilities.

The ultimate degree of employer obligation in anti-discrimination legislation entirely depends on the interpretation of undue hardship – which in turn depends on the size and the economic situation of the company – and the array of sanctions used. Sanctions are typically payments or fines, but can also include non-financial elements such as, in the case of the United States, accommodation, reinstatement and job offers (see Annex 4,

Table 5.1. **Legislative framework and extent of employer responsibility**

		Legislation shaping the framework			
		Strong anti-discrimination legislation	Mandatory employment quota	Legislation on employer obligations	Policy based on voluntariness
Extent of employer responsibility	major employer obligations	Australia Canada United Kingdom United States	(Germany)[a] Italy	Sweden	–
	some, but less for new applicants		(Austria)[a] France (Germany)[a] Poland Spain	Netherlands Norway	Denmark
	only few employer obligations	–	(Austria)[a] Korea Turkey	Belgium	Mexico Portugal Switzerland

a) The classification of Austria and Germany regarding employer obligations straddles two groups.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Table A4.3, first column). In practice, the major difficulty arises from the fact that suing an employer or a potential employer is a considerable hurdle in most cultures. Even in the United States, relatively few legal cases are reported.

For quota schemes, enforcement is a function of the level of the quota and, again, the extent of sanctions on the employer. Empirically, the latter ranges from the virtual absence of sanctions in Spain, to low sanctions – effectively amounting to an extra payroll tax on the order of around 0.5% – in most countries, and relatively high sanctions in only two countries, Italy and Poland.[3] In Italy, considerable sanctions for non-compliance (up to ten times higher than elsewhere) and even more so for non-declaration were recently introduced, although this is mitigated by a rule according to which only an "appropriate candidate" cannot be refused.[4] In Poland, fines are around four times higher than in the other quota countries, but again these sanctions were introduced only relatively recently. Without real enforcement, a quota scheme is an incentive to employ registered disabled people, or retain those becoming disabled, but does not automatically result in any obligations for employers.[5]

Differences in the extent of enforcement of employer obligations have a much greater impact than differences in approach between anti-discrimination legislation or mandatory employment quotas. An absence of sanctions and a lack of instruments to enforce them are usually at the heart of the problem. For this reason, systems like the Swedish one with specific employer obligations in various pieces of legislation, towards both current employees and new job applicants, and the relatively rigid enforcement of those responsibilities, seem most effective.

Policies based on voluntary compliance by employers do not aim to create obligations. Such policies need to provide particularly strong financial and technical support for workplace accommodation to be successful, although similar support is equally helpful in combination with other employment promotion policies.

Rehabilitation and sick pay

There are two other important areas in which obligations on employers matter: vocational rehabilitation and sick pay.

Few countries have mandatory involvement of employers in the rehabilitation process. In the Netherlands and in Sweden, employers theoretically have to submit an individual rehabilitation plan to the social insurance authority, within 8 weeks of sickness in Sweden and within 13 weeks in the Netherlands. The majority of employers, however, do not do so, partly because they do not feel able to judge what should be done and partly also because there are (virtually) no sanctions. In some other countries, disabled employees are entitled to special rehabilitation absences (Germany, Poland, Spain, United Kingdom). By and large, however, employers are not involved in this stage of the policy process.

Making employers partly responsible for continued wage payment in case of sickness absence is driven by the hope that they will invest in prevention and retention measures. Considerable employer obligations for sick pay have been introduced recently in the Netherlands (for a one-year period, although several groups are exempted) and the United Kingdom (for a 28-week period, with reimbursement in case of exceptional expenses), and they have always existed in Switzerland. In these countries, employers will usually take out private insurance to cover their risk.[6]

Considerable employer obligations have also been set in this area in Austria (up to 12 weeks), Germany (up to 6 weeks), Poland (35 days) and Belgium (one month), in particular because re-insurance is not possible. In several other countries, only a short-term absence of about two weeks is covered by continued wage payment by the employer (Australia, Denmark, Norway, Spain, and Sweden). In all other countries, sick pay is paid by the sickness insurance programme from the first day onwards (or possibly after one or more waiting days).

In a cross-country perspective, no clear relationship can be identified between employer obligations for wage payment during sickness periods and the resulting average number of full-time equivalent sickness cases. Within-country experiences, however, show that *initially* behaviour has changed dramatically in response to policy changes (*e.g.* in the mid-1990s in the Netherlands and in the mid-1980s in the United Kingdom). In the longer term, however, behaviour has gradually reverted, at least in part.

One issue that runs through all different policy settings is balancing the promotion of employment for disabled people looking for a job with the obligation for the employer to retain employees who become disabled. Over-protective regulations are likely to lead to further discrimination against disabled persons in the hiring process. This is the main reason for the recent abolition or alleviation of special dismissal protection for disabled people in several countries (*e.g.* Austria, Germany). Similarly, shifting too much of the costs for sickness absenteeism onto employers may foster new checks and methods to identify job applicants potentially threatened by a higher sickness risk.

Since job retention policies can operate to the disadvantage of disabled persons seeking work, it is essential to recognise that employers need help to fulfil their obligations. In many countries, for instance, subsidies for workplace accommodation are available. Such programmes are of particular importance for small companies. This critical issue is taken up again in more detail in the concluding chapter of this report.

5.3. Vocational rehabilitation and training

Vocational rehabilitation and training can in many cases be critical to achieve or secure employment. A person becoming disabled may, even after completion of the medical rehabilitation process, not be able to continue to work in the previous occupation. This person may need additional vocational counselling and training, ranging from smaller interventions, including, for instance, initial needs assessment, to training of several years (*e.g.* a full university curriculum).[7] Similarly, a disabled person trying to enter the labour market for the first time may need additional vocational training at an adult age.

Countries have very different approaches to satisfying these needs, and large variation exists as to how often, at what stage of the process, and with how much financial input such interventions occur.

Programme characteristics

There is a major distinction between countries in which participation in such programmes is entirely voluntary, and those in which it may be compulsory before a disability benefit could be granted (see Annex 4, Table A4.4). In some countries, a benefit claim is automatically treated as a request for vocational rehabilitation; this "rehab goes before pension" principle is applied in Austria, Denmark, Spain, Sweden and Switzerland.[8]

The approach is similar in Germany, Norway and Poland, though the degree of compulsion is mitigated slightly.[9]

In Austria (for those disabled people in the labour force) as well as in France, Germany and Poland (for all disabled people without restriction), vocational rehabilitation is a right, while in the United States – an example of a country with a voluntary programme – this is restricted to a right to submit an application.

In all countries, eligibility is bound to the potential to gain from the programme, usually defined as the prospect that another job can be carried out. In mandatory rehabilitation schemes, this prospect may be restricted to jobs commensurate with the person's qualifications (like in Austria, Spain and to some extent also in Switzerland), or could include "inferior" jobs (Denmark, Sweden).

Entitlement may be restricted to those entitled or potentially entitled to disability benefits (*e.g.* in Austria), or may involve a separate assessment process independent of benefit eligibility and thus be accessible for everybody (like in Denmark, France, Portugal and Switzerland). In some countries, it is assumed that people with moderate disabilities do not need special vocational rehabilitation. In Australia, for instance, special vocational rehabilitation and employment assistance programmes are restricted to people with a more severe disability (*i.e.* with a score of 50 points on the work ability tables), while those with moderate disabilities are referred to mainstream programmes. In the United States, special vocational rehabilitation is increasingly targeted at more severely disabled people without any work experience.

A most important issue is the timing of vocational intervention. Even if the need for intervention becomes apparent at an early stage of the sickness process, vocational measures would typically be launched at a rather late stage. There are a few countries, most importantly Sweden and Germany, in which vocational intervention starts early and is implemented promptly (Table 5.2). In Germany, for instance, the health insurance authority is required to check the necessity for vocational rehabilitation before, during and after the medical rehabilitation process. In a larger number of countries, vocational

Table 5.2. **Focus on and timing of vocational rehabilitation and training**

		Focus on vocational rehabilitation		
		(Quasi) compulsory	Intermediary approach	Entirely voluntary
Timing of vocational rehabilitation	any time possible (also very early)	(Austria)[a] (Denmark)[a] Germany (Spain)[a] Sweden	–	–
	intervention not very early	(Austria)[a] (Denmark)[a] Norway (Spain)[a] Switzerland	Belgium Netherlands Poland	Australia France Italy Korea United Kingdom
	only after long-term sickness	–	Turkey	Canada Mexico Portugal United States

a) Note that Austria, Denmark and Spain straddle two timing classification groups.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

rehabilitation will only begin after stabilisation of the person's medical condition, and rarely in the first year after the disabling condition has commenced – which is often simply too late. This is attributable in part to a lack of access to the necessary information at an earlier stage, often because the authorities responsible for vocational rehabilitation have no link to those responsible for the medical recovery.

There are various ways to finance vocational measures. In many countries, vocational rehabilitation is funded partly by social insurance and partly by the labour market authorities for those not covered by disability insurance (Austria, Germany, Spain and the United States). In another group of countries, such measures are all funded from government revenues (Australia, Poland and Norway). A third group consists of countries where the benefit authority has sole responsibility for covering the costs of vocational interventions (the municipality in Denmark, and invalidity insurance in Switzerland).

In countries with more than one responsible authority, the co-ordination of services is an important issue. In Austria, to take one example, there is almost no co-ordination between pension insurance, work injury insurance, the labour market authorities and the regional authorities. In Germany, on the contrary, the federal labour authority bears the responsibility to co-ordinate the intervention process, and recent legislation is likely to mainstream the process further.

Rehabilitation services are sometimes provided by state authorities, such as the specialised centres for vocational rehabilitation in France or the special employability institutes in Sweden. In other countries, competing private providers offer their services (*e.g.* in Australia, the United States and the Netherlands, where such a structure is currently being created). Yet another group of countries, including Austria, Germany, Portugal and Spain, draw on a mix of private and public service providers. In these countries, the responsible insurance authorities usually run their own rehabilitation centres but outsource the required services whenever this is more suitable.

Quality assurance is increasingly becoming an issue, in particular but by no means only in those countries where authorities reimburse private providers. In Australia, for instance, quality standards are controlled via predefined performance targets and various reporting requirements. In the United States, new forms of consumer-directed services (individual training accounts, ticket to work vouchers) were recently introduced through which the client can choose and contract with an approved provider. In both countries, new outcome-based funding procedures were launched.

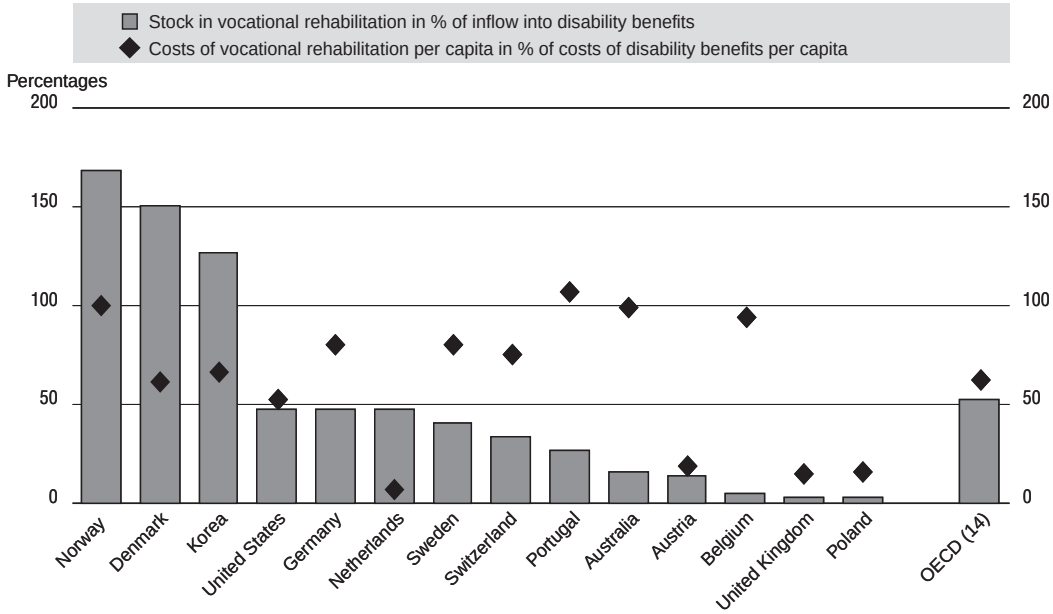
Take-up and outcome

Among mature social protection systems, only in Denmark and Norway do more people go through vocational rehabilitation and training each year than are granted a disability benefit – though the data do not tell what proportion of those ultimately being granted a benefit have received vocational measures beforehand (Chart 5.1).[10] The ratio is only slightly lower in Korea; while this is partly explained by the currently low level of entitlement for disability benefits, it also underlines that Korea is implementing a disability policy with a balance between compensatory and integrative elements.

In a few other countries, the number of people on vocational rehabilitation programmes is around 50% of the annual disability benefit inflow. These countries are Germany, Sweden, since very recently the Netherlands, and also the United States.[11] Next are Switzerland, Portugal, Australia and Austria with around 20-30%.[12] In half of the

Chart 5.1. **More people are awarded a disability benefit than receive vocational rehabilitation services**

Stock in vocational rehabilitation as a ratio of disability benefits inflows,[a]
Percentages, 1999



Note: Countries are ranked in decreasing order of the ratio vocational rehabilitation over benefit inflow.
a) Contributory disability benefit, except non-contributory disability scheme for Australia and Denmark.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

countries, in contrast, the number is less than 5% of the annual disability benefit inflow. By and large these figures mirror whether the rehabilitation system set-up is mandatory or voluntary, although the figure is also high in Korea, the Netherlands and the United States, three countries with a voluntary programme.[13]

The per capita expenses for people in rehabilitative services are as relevant for the programme assessment as the numbers receiving the services. Unfortunately, comparable data are hard to find. National statistics on vocational rehabilitation may include the costs not only of the services but also of special benefits paid during this process. Differences will appear between countries in which all or most rehabilitees receive sickness or disability benefits (in which case expenditure data only refer to costs of the services) and those in which all or most rehabilitees receive a special rehabilitation benefit or allowance, the costs for which are fully covered in the statistics. Correcting for these differences, which is attempted in the following, requires an approximation of the distribution of rehabilitees by the type of benefit received.

The countries in which most if not all rehabilitees receive a special benefit or allowance during the rehabilitation phase include Denmark, France, Germany, Korea, Poland, Portugal, Sweden and Switzerland. In some of these countries, incentives to participate in rehabilitation programmes are set in place via a rather high level of this benefit. In France, for instance, this benefit is 100% of last salary (up to a ceiling) or 30% of that ceiling for people not previously employed. In Portugal, a special flat-rate allowance of 70% of minimum wage is received in addition to any other benefit.

Two groups of countries can be identified (Chart 5.1): those in which expenditures per rehabilitee are small when compared to the per capita cost of a disability benefit – in particular, the Netherlands, but also Poland, the United Kingdom and, surprisingly, Austria; and those in which rehabilitation costs on average are between 60 and 100% of an average disability benefit. Some countries with relatively low disability benefits (Australia and Portugal) appear to have high relative rehabilitation expenses, but this is due to the denominator used in this indicator. These data also show that in the Netherlands – only one year after introduction of the new rehabilitation act in 1998 – already a large number of people have received services, but only at a very low per capita scale.

The data suggest that even the highest average per capita costs will pay off in the medium term should the vocational intervention result in successful labour market re-integration. Unfortunately, however, information on the effectiveness of vocational rehabilitation is scarce and often inconclusive. People are rarely followed over a period of years to identify longer-term effects. And any effect must always be seen in relation to the proportion of potential benefit claimants receiving such services. Furthermore, creaming in the process of selection of rehabilitees – quite common according to anecdotal evidence – is likely to provide superficially satisfying outcomes. In addition, one reason evaluation of rehabilitative measures is so difficult is that standards of comparison are difficult to construct. There is always a sizeable proportion of people with a longer-term health problem who do not need any vocational intervention. Typically these are people with less severe problems who have a high propensity to return to their previous workplace at some point in time – very likely a higher propensity than most people going through vocational measures ever have.

5.4. Special employment programmes

Over and above vocational rehabilitation and training services, people with disabilities might be helped into work through a whole range of employment programmes, ranging from special protected and usually segregated employment to various forms of support in the open labour market. Such programmes and services are particularly important for promoting the employment of disabled people who have never worked or do not have any relevant employer-relationship upon which to build.

Subsidised employment

One possibility is to subsidise employers for employing disabled people by compensating part of the labour costs (wages and/or social security contributions).[14] Several countries have a considerable share of their working-age population on such programmes, in particular Sweden (with almost 11 per 1 000) and France (with over 6 per 1 000), but also Austria, Denmark and Norway – all countries with rather high relative employment rates among prime-age working-age disabled people (Table 5.3, second column).

In Austria, Norway and Sweden, such subsidies can be very high (up to full wage costs both in Norway and Austria) and are phased out over a period of a few years. Sweden has a flexible scheme in which the subsidy level varies with the degree of work-capacity reduction and any respective changes over time (see also Annex 4, Table A4.5). In addition, this subsidy can be interrupted if non-subsidised work is taken up and can be resumed within three years. Belgium, Denmark, France and Korea are the only countries that offer permanent or repeatedly renewable wage subsidies – though generally on a lower subsidy

Table 5.3. **Large variation in focus and type of employment programmes**

Persons in special employment programmes for disabled persons per 1 000 of the population, 1999

	All employment programmes	Subsidised employment	Supported employment	Sheltered employment
Australia	3.4	0.2	1.6	1.5
Austria	7.0	3.6	0.7	2.7
Belgium	3.6	0.7	0.0	2.9
Denmark	5.9	3.0	0.6	2.4
France	9.5	6.3	*b*	3.2
Germany	4.1	0.2	0.6	3.3
Italy	0.8	0.3	*b*	0.6
Korea	0.3	0.1	0.0	0.2
Netherlands	9.2	*b*	*a*	9.2
Norway	7.2	2.4	0.5	4.3
Poland	12.1	2.0	x	10.1
Portugal	0.2	0.1	x	0.1
Spain	1.2	0.6	x	0.6
Sweden	16.2	10.8	0.2	5.2
Switzerland	5.6	x	x	5.6
United Kingdom	1.2	0.5	0.7	*a*
United States	1.1	*b*	1.1	*a*
OECD (17)	5.2	–	–	–

x No such programme up to the present; – Not applicable.
a) Significant programme, no data available.
b) Minor programme, no data available.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

level (50% of wage costs in the Belgian system, regulated through collective agreements). In Denmark, the subsidy is related to the minimum collective wage and payable at three levels according to work-capacity reduction (flex-job scheme).[15] Korea is another interesting case, where in line with the recently introduced employment quota the existing subsidy scheme was also restructured: rather than subsidising the employment of any registered disabled worker over a period of three years, only employment in excess of the mandatory quota is subsidised, but then for an unlimited duration. The minimum subsidy is 100% of the minimum wage, topped up by another 50% if severely disabled and yet another 25% if female.

Supported employment

Alongside such more established employment subsidies, recently a variety of supported employment-type programmes have been spreading, such as different kinds of schemes offering extensive on-the-job support through individual job coaches, who can be employed by either the employer or the community. More than or close to 1 in 1 000 working-age people currently can be found on such programmes (Table 5.3, third column) in one-third of all countries analysed (Australia, Austria, Denmark, Germany, Norway, the United Kingdom and the United States).

Like wage subsidies, such intensive personal support is phased out over time in most countries. Denmark is the only country that offers considerable personal assistance – of up to 20 hours per week for a full time job of 37 hours – for an unlimited duration (see also Annex 4, Table A4.6). Australia, Germany, Norway, the United Kingdom and the United States (though,

in the latter country, depending on the programme and the state) offer some type of ongoing assistance or accompanying support for severely disabled people. A comprehensive vocational counselling programme has also been developed in Austria, aimed at obtaining a job in the open labour market and securing the job by means of mediation. Germany is the only country that has recently introduced a *right* to support involving work assistance for a period of up to three years (financed by the rehabilitation authorities).

Sheltered employment

Most OECD countries offer special employment in a sheltered environment, be it in sheltered workshops, special businesses or protected segments in ordinary companies. The Netherlands and Poland are the two countries that have gone furthest in developing segregated employment in a protected labour market. Both countries provide such employment for about 1% of the working-age population (Table 5.3, last column). Hand in hand with very high disability benefit recipiency rates, this practice results in the particular segregation of people with disabilities in these two countries. Sheltered employment is also widespread, with around 5 per 1 000, in Switzerland, Sweden and Norway, followed by 3 per 1 000 in Austria, Belgium, France and Germany. In most countries, a majority of those in sheltered employment are more severely disabled people with mental illnesses, often involving congenital learning disabilities.

While sheltered employment increasingly is considered inappropriate for large numbers of people with disabilities and most countries would prefer to see it replaced by supported employment-type initiatives, empirically there are no signs of any significant cutbacks yet. In several countries there have been attempts to make the sheltered sector more business-like and competitive, in the hope of increasing the chances of transition into the open sector. The Netherlands is one such example; in 1998, a significant programme re-orientation took place with the aim of increasing efficacy (*e.g.* responsibility shifted to municipalities, flexible per-person rather than per-company subsidies). In the United Kingdom, progression targets have been introduced more recently with the change to Workstep. And in Spain, to give a third example, since 1997 sheltered entities have greater contract flexibility, can dismiss their workers under the same provisions and procedures applying to other workers, and have more flexibility regarding the percentage of their workers without disabilities. So far, however, these attempts to raise transition rates have been successful in only a few cases. The Norwegian labour market enterprises with a 30% transition rate into regular employment seem a real exception (see also Annex 4, Table A4.7).[16]

It is also worth noting that wage levels in this sheltered work environment vary considerably both between and within countries, ranging from programmes that offer merely symbolic remuneration to jobs that give full social security and pay regular sector-specific minimum wages, often through wage subsidies. France, with two types of sheltered employment – one for people with more than two-thirds of work-capacity loss, another one for people with less – is a good example here.

Programme access

In most of the quota countries (France, Germany, Italy, Poland and Spain, and to a lesser extent also Austria, Belgium and Korea), by and large one and the same definition is used both for eligibility to all employment programmes (see Annex 4, Table A4.8) as well as for registration for employment quota places. This largely guarantees consistent access to

all programmes. In these countries, a special disability assessment procedure is used, although special groups such as war or work injury victims may also qualify. For access to sheltered employment, additional requirements often have to be fulfilled.

The situation is similar in several of those countries without a quota scheme that also require some kind of registration as vocationally or work disabled with the responsible authority (Netherlands, Norway, Sweden). Again, such an approach should guarantee adequate access for all to the whole set of available programmes. There is variation in the degree to which these countries distinguish the group of severely vocationally disabled people who are eligible for sheltered and maybe also supported employment.

The English-speaking countries all use a special definition in their anti-discrimination legislation, which is however not used for any other purpose. In all of these countries, employment programmes are provided by competing private service providers and/or different states or provinces, which use their own configurations and eligibility criteria. A common definition is therefore unavailable and coherent access to all programmes not necessarily secured. Potential programme participants may have to turn to many different providers before being accepted.

Finally, in Denmark and Portugal rather different definitions are used for eligibility for different programmes. However, since in both countries one authority is responsible for determining access to these programmes (the municipalities in Denmark, the institute for employment and vocational training in Portugal), this seeming inconsistency in eligibility criteria need not result in access restrictions.

To conclude, therefore, most countries other than the English-speaking countries have developed a consistent assessment and eligibility structure that should guarantee that people with reduced work capacity get access to the most appropriate employment programme. A possible advantage of systems that are based largely on competing private providers is a broader variety of programmes.

Programme participants

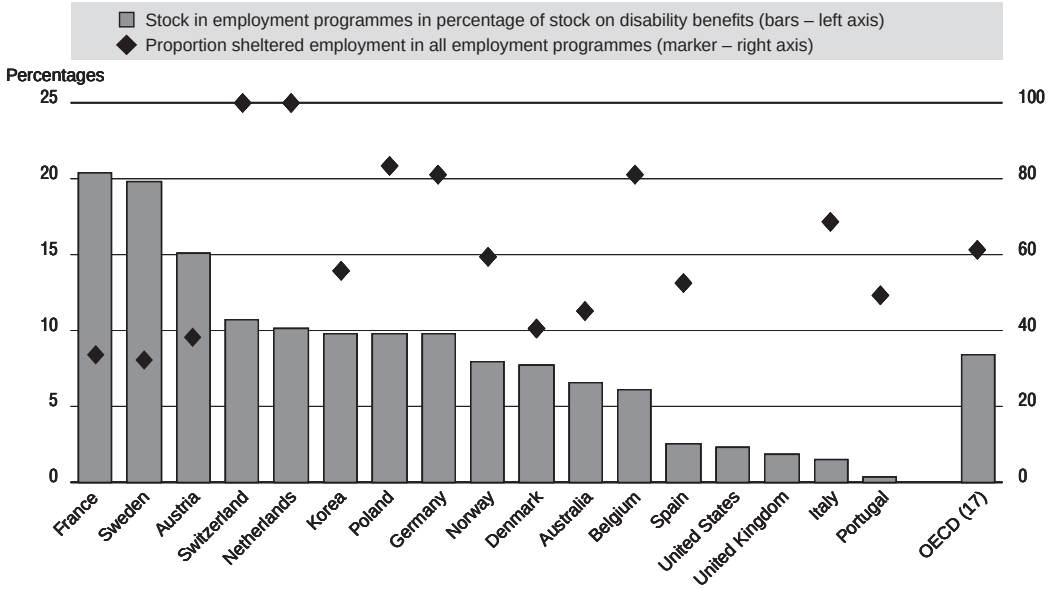
Taking all special employment programmes for people with disabilities together, France, Sweden and Austria are the three countries with the largest number of programme participants relative to the number of people on disability benefits (15-20%, see Chart 5.2). All three countries overwhelmingly focus on employment subsidies, whereas sheltered workplaces only account for about one-third of the participants.

A large group of countries have about one-tenth of their stock of disability benefit recipients on special employment programmes. In half of these countries, most or even all of these people are in sheltered employment (Switzerland, the Netherlands, Poland, Germany, Belgium), while the other half use a more balanced mix of subsidised and sheltered employment (Korea, Norway, Denmark, Australia). In the Southern European countries, but also in the United Kingdom and the United States, very few people are found on special employment programmes.

Considering all types of programmes together, annual per capita costs are typically lower than the average disability benefit. In half of the countries, this ratio is around 40-60%, and it is even lower in Austria (Table 5.4). In Germany, Norway and the United Kingdom, these expenses are much closer to the average disability benefit level, and in Belgium, Portugal and Sweden about one-third higher. The Netherlands is exceptional for its enormously expensive and very widespread sheltered employment programme.

Chart 5.2. **Ten times more people on benefits than in special employment programmes**

Stock in employment programmes in percentage of stock on disability benefits,[a] 1999



Note: Countries are ranked in decreasing order of the stock in employment programmes over stock on disability benefits.
a) Contributory benefit, except non-contributory disability programme for Australia and Denmark.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Sheltered employment is sometimes less and sometimes more expensive than subsidised employment. For most countries, the per capita costs of supported employment programmes are not particularly high, and typically are lower than for employment subsidies. The United Kingdom and to a lesser extent also Denmark are exceptions in this respect.

5.5. Age profiling in integration programmes

As with transfer policy, age profiling may also occur in employment-related policies, thereby possibly explaining part of the age bias in disability transfer programmes.

Age structures

While regulations are generally age neutral, the age distributions of programme participants are extremely skewed. For vocational rehabilitation, for instance, age-specific data have been provided by seven countries. The share of persons aged 45 and older among programme participants is astonishingly low given the fact that the large majority of potential awardees are in this age group (Table 5.5; note that the last column shows the corresponding share in the disability benefit inflow). In Portugal, less than 5% of all people on vocational rehabilitation are 45 and older, in Switzerland and Austria the proportion is below 15%, in Denmark 20%, in Norway and the United States 25% and in the Netherlands around 30%.

Data on age structures of participants in employment programmes are scarce, but suggest quite considerable age profiling as well. Sheltered employees generally tend to be younger males with congenital mental illness, such as learning disabilities: less than 25% of these programme participants are aged 45 and older, except for Norway with about 40%

Table 5.4. **High expenses per employment programme participant**

Per capita employment programme expenditure in percentage of per capita disability benefits, 1999

	Relative per capita costs of employment programmes:			
	Subsidised	Supported	Sheltered	All three schemes
Australia	43	58	73	63
Austria	26	9	24	24
Belgium	90	..	146	135
Denmark	62	98	44	58
France	23	..	102	49
Germany	128	54	78	78
Italy	39	..	..	39
Korea	57	42	57	57
Netherlands	..	..	184	184
Norway	139	66	67	91
Poland	153	..	37	56
Portugal	185	..	78	133
Spain	23	..	72	49
Sweden	120	..	164	135
Switzerland	..	..	42	42
Turkey	..	..	..	..
United Kingdom	24	150	..	93
United States	..	41	..	41
OECD (17)	80	65	83	78

.. Data not available.

Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Table 5.5. **Few disabled persons aged 45 and over in active programmes**

Proportion of persons aged 45 and over among persons in rehabilitation and employment progammes, percentages, 1999

	Vocational rehabilitation	Subsidised employment	Supported employment	Sheltered employment	For comparison: share in disability benefit inflow
Australia	..	..	11	20	61
Austria	14	..	..	24	85
Belgium	..	..	..	19	..
Denmark	20	47	..	..	79
France	..	55	..	..	85
Germany	..	51	..	..	85
Netherlands	32	..	..	..	46
Norway	26	30	11	41	74
Portugal	3	..	..	8	89
Spain	..	24	..	18	84
Switzerland	13	..	..	..	69
United States	25	..	..	..	69

. . Data not available.

Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

(data available for six countries), and 50 to 90% of them are people with mental illness. Disabled employees receiving individual support and coaching seem even younger, with only about 10% aged 45 and older (data only available for Australia and Norway), and also overwhelmingly mentally ill or intellectually disabled. People in subsidised employment, however, show a more balanced age structure with a higher proportion aged 45 and over (around 25% in Norway and Spain, but around 50% in Denmark, France and Germany). Hence, programmes targeted towards more severely disabled people tend largely to benefit younger disabled people, while this is not the case to the same extent with wage subsidies.[17]

Estimating the bias

The size of the age bias in vocational rehabilitation can be further elaborated by comparing, age group by age group, disability benefit inflows with the number of people on vocational rehabilitation. Take Switzerland as an example, where the total annual participation in vocational rehabilitation services in 1999 was about one-third of the disability benefit inflow in that year (Table 5.6). Among the 20-34 age group, the ratio of people on vocational rehabilitation over the disability benefit inflow is 1.66 (*i.e.* at this age, there are more people in vocational rehabilitation programmes than people who are granted a disability benefit); in the 35-44 age group this ratio is 0.47; in the 45-54 age group 0.11; in the 55-59 age group 0.03 (*i.e.* for each person in vocational rehabilitation there are more than 30 new disability benefit awards); and in the 60-64 age group 0.004.

Such figures seem to reflect considerable age profiling in the selection process for vocational rehabilitation. Switzerland is no outlier in this respect. The pattern is almost identical in Austria, and it is also similar though not as pronounced in Denmark and Norway. The pattern is most extreme in Portugal, where (as in Denmark and Norway) below age 35 the number of persons on rehabilitation programmes is more than six times higher than the disability benefit inflow, but, in contrast to the two Scandinavian countries, it is zero at age 45 and over.

With the exception of the Netherlands, disabled people aged 45 and older are virtually excluded in all countries. Apparently it is assumed that any rehabilitation efforts would no

Table 5.6. **Dramatic mismatch between disability benefit inflow and vocational rehabilitation offers**

Age-specific ratios of persons on vocational rehabilitation over disability benefit inflow, percentages, 1999

	20-64	*20-34*	*35-44*	*45-54*	*55-59*	*60-64*
Austria	0.14	1.70	0.44	0.04		0.02
		18-39		*40-59*		*60-66*
Denmark[a]	1.47	5.83		0.60		0.01
					55-64	
Netherlands[b]	0.49	0.72	0.51	0.42	0.18	
Norway	1.69	8.12	2.02	1.41	0.51	0.15
Portugal[b]	0.28	6.64	1.15	0.00	0.00	0.00
Switzerland	0.33	1.66	0.47	0.11	0.03	0.004
					55-64	
United States[b]	0.78	2.94	1.17	0.46	0.14	

a) Inflows of non-contributory benefit.
b) Inflows of contributory benefit only.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

longer pay off; people are probably not even offered any vocational measures. This way of age profiling naturally must contribute to the age bias in transfer schemes.

This observation raises a number of issues. Given limited budgets for vocational intervention, targeting rehabilitation services to those who are most easily re-integrated is a reasonable approach. Analysis for Switzerland, for example, has shown a very high likelihood of re-integration after completion of the vocational rehabilitation process (Buri, 2000), which is related partly to a high degree of selection of cases with good integration potential.[18] It is questionable, though, whether age is an adequate indicator for that purpose. People over age 50 may as easily be helped with some vocational intervention, not least because they often have longstanding work experience. A simple economic efficiency argument – the younger a person initially having received services, the larger the long-term economic return – may not always be appropriate. In this sense, discrimination against middle-aged disabled people in the process of selection for vocational intervention only mirrors the general discrimination facing this age group in current labour markets and labour market policies. It appears that such age selection is particularly strong in Austria and Switzerland, where vocational rehabilitation is compulsory.

It is interesting to note that the United States explicitly applies a different line, namely to target these services to those who are most severely disabled (so-called order of selection criteria), based on the assumption that those with better integration potential may be able to find their way back into the workforce even without such help. Nonetheless, the age structure of participants in vocational measures in this country is also very skewed.

5.6. Integration policy and active labour market policy (ALMP) analysis

Progress in integration policy

Expenditure on employment and rehabilitation programmes for disabled people as a proportion of total expenditure on active and passive disability-related programmes has gradually increased everywhere (Chart 5.3).[19] Nevertheless, this share is still low in most countries. Only in the three Scandinavian countries does it approach 14% – and note that these are countries with high expenditures on transfers. In Switzerland and the Netherlands, the share is around 8-10%, reflecting the costs of a very substantial sheltered employment sector. In Belgium, Germany and France, the share of active expenditure is close to 5%, while in a few countries it is less than 2% – the United Kingdom, Italy, Spain, and also Mexico and Turkey.

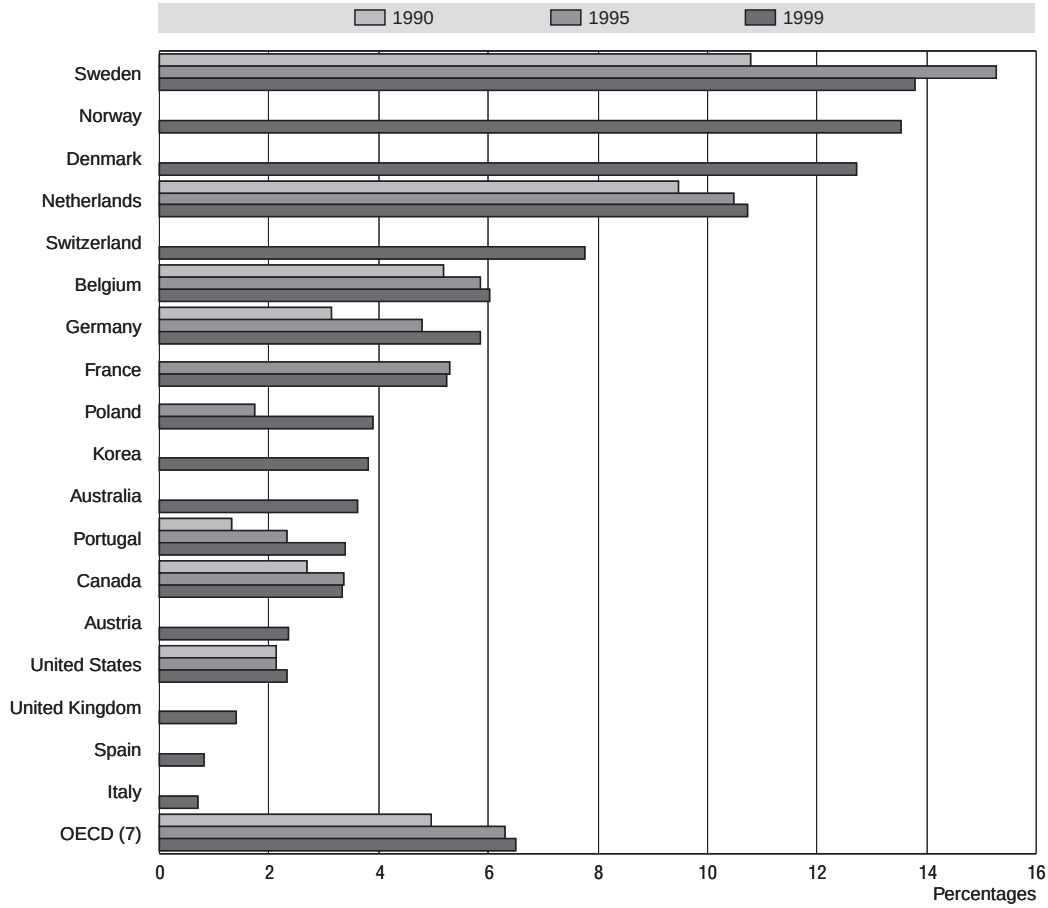
There is only a weak correlation between the total expenditure on special active programmes for disabled people (measured as a percentage of GDP) and the outcome in terms of employment rates of people with disabilities (derived from the national surveys). Countries with a high expenditure on employment-related measures generally have above-average employment rates, although this is not really true in the Netherlands (Chart 5.4). Switzerland, to give another example, achieves very high employment rates of disabled people despite the lack of any subsidised or supported employment programme.

Lessons from ALMP analysis

Such crude macroeconomic evaluation is likely to be inconclusive due to data and measurement problems. One major constraint in the area of disability employment policies is the lack of evaluation of separate programmes. This can partly be attributed to the lack of clear-cut programme goals.[20] As a result, the focus of programme assessment is

Chart 5.3. **Increase in spending on active programmes in most countries**

Expenditure on employment-related programmes[a] as a percentage of total disability-related expenditure, 1999



Note: Countries are ranked in decreasing order of the 1999 ratio.

a) Caution:
- data only include special programmes for people with disabilities;
- data on provincial programmes or on programmes at the community level not available for all countries.

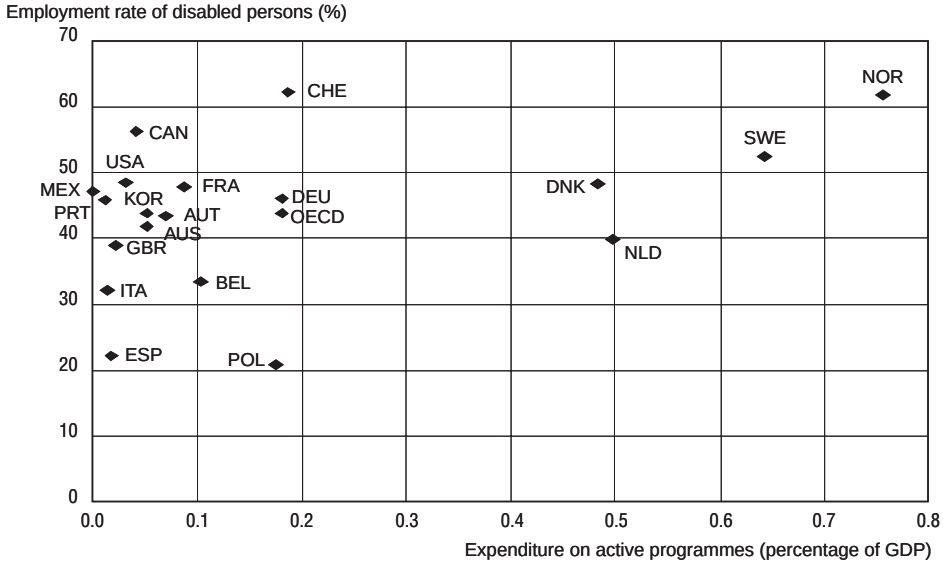
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

primarily on monitoring costs rather than programme performance and outcomes. Where evaluations exist, these usually refer to short-term effects rather than to longer-term monitoring of clients of services; long-term (employment) effects are mostly unknown. In addition, evaluations often lack an overall policy perspective and do not take the entire social security and employment policy environment into account. It is worth examining, therefore, the extent to which findings from general active labour market policy analysis can or cannot be translated to the particular group of people with disabilities as well.

In ALMP analysis, general training programmes, in particular formal classroom training, are found to be highly ineffective, especially for the most disadvantaged groups (youth and people with lower initial education). Only well-targeted measures, both to the individual and to local labour market needs, seem successful. These findings are certainly

Chart 5.4. **Weak relationship between employment rate and expenditure on active programmes**[a]

Employment rate of disabled persons (percentage) in late 1990s, and expenditure on all employment-related programmes for disabled persons (percentage of GDP)



a) Active programmes consist of subsidised, supported and sheltered employment, and vocational rehabilitation programmes.

Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

likely to be applicable to people with disabilities – which also partly explains the growing emphasis on supported employment-type initiatives.

Another major finding of ALMP analysis is that employment subsidies have large dead-weight, displacement and substitution effects. Such programmes often lead to only small net employment gains, and sometimes they can be justified only by equity considerations in that they provide jobs to the most vulnerable, such as the long-term unemployed, even if this happens at the expense of the short-term unemployed. This equity argument seems particularly appropriate for people with severe disabilities.

Direct job creation in the public sector may help non- or unemployed people to get into or keep in contact with the labour market, thus creating or maintaining motivation and skills. ALMP analysis also makes the case, however, that for exactly this reason such intervention should be short in duration and not become a disguised form of permanent employment. Sheltered employment is a special form of direct job creation to which these findings generally apply. Nevertheless, all countries have deliberately decided to offer disabled people permanent employment in this segregated sector. In fact, the large majority of disabled workers in sheltered employment are employed on a permanent basis – even if this may formally require repeated renewal of the contract. For some groups of very severely disabled people, this may be perfectly justified. For those with higher work capacity, on the contrary, this will often be an undesirable side-effect of a widespread trend towards more commercial forms of sheltered work entities.

Subsidies paid to the employer to hire a difficult-to-integrate unemployed person have sometimes been found successful in helping people to get into the labour market. This may

also be true of wage subsidies granted for the recruitment of people with disabilities. There may be a difference between temporary and permanent subsidies. The latter can easily become a deadweight loss after an initial period for the unemployed. For disabled people whose disability-related productivity loss cannot be accommodated or made up for through vocational rehabilitation measures, however, some form of permanent subsidy or benefit may be justified to enhance equal opportunities.

5.7. Summarising the findings of the integration policy analysis

Some of the main findings of the analysis of integration policy challenges are:

- Different employment policy approaches (rights-based anti-discrimination policy, obligations-based employment quotas, or incentives-based voluntary action) all tend to promote primarily job retention of current employees.
- Proper sanctions on employers who do not fulfil their obligations and adequate instruments to enforce these sanctions are crucial for an effective employment promotion policy.
- While the approach to vocational rehabilitation and training differs markedly between countries, this type of intervention is usually used too little, and often initiated too late. More can be done to involve the employers in this process.
- The average per capita cost for vocational rehabilitation and training is low compared to the average cost of a disability benefit. Provided that such intervention secures permanent employment, investments should pay off within a short period.
- Countries differ markedly both in terms of the variety of special employment programmes for disabled people and the costs per participant. Where such a programme is permanent, in particular in sheltered employment, average costs can exceed costs of per capita disability benefits.
- The type of employment programmes used has changed very slowly. While sheltered employment is seen increasingly as inappropriate and in need of being replaced by supported employment-type initiatives, empirically the protected sector remains as important as ever.
- There is a striking age bias in integration programmes. Vocational rehabilitation and training is offered predominantly to people below age 45, and sheltered and supported-type employment programmes tend to benefit primarily young (more severely) disabled people.
- Lessons from general active labour market policy analysis are largely applicable to the situation of people with disabilities. Some of the critique, *e.g.* regarding deadweight or substitution effects, is less relevant, because of the permanent productivity loss of some groups of disabled people.

Notes

1. Note that in some of those countries in which a quota was introduced only more recently, such as Spain, policy in fact includes many different elements from different approaches.
2. It is interesting to note that all countries with a quota system established a system of registration as a disabled person. This is interesting because such registration is independent from the actual work status (see the discussion in the concluding chapter of this report). While this registration system is, in principle, only used to determine eligibility for the quota regulation (which is sometimes linked with better protection against dismissal), it can or could also determine entitlement to other benefits or services. Further note that public disability benefit systems always use their own definition of disability.

3. In Spain, disciplinary measures are foreseen, but have never been enacted, although failure to fulfil the quota is seen as a serious offence. Recently, more control has been introduced via an obligation to report the number of employees with disabilities, with systematic verification by labour inspection bodies. In addition, companies complying with the quota enjoy preferential treatment in contracts with the public administration.
4. While statistics on the outcome and effectiveness of the new law, enacted in the year 2000, are not available yet, anecdotal evidence suggests that it is easy to prove that no "appropriate candidate" can be found.
5. Much of the success of quota systems results from the fact that employer penalties or compensatory levies are directly used to finance employment promotion programmes, thereby stimulating the employment of disabled people one way (*i.e.* via the quota) or the other (*i.e.* via levy-funded employment programmes).
6. In Switzerland, this is compulsory for most employers. Furthermore, co-financing of this type of insurance by the employee is quite common (up to 50% of the premium).
7. The importance and need of vocational intervention also depends on the legal requirements to accept other – and in particular lower-rated and lower-paid – jobs (see further below on this issue).
8. In Denmark, the possibility to apply for a disability benefit has formally been abolished. Rather, a disabled person would have to turn to the responsible body in the municipality, which would then have to decide which kind of intervention (subsidised job, sheltered employment, vocational rehabilitation) or benefit seems most appropriate.
9. In Germany, the rule says that agreement of the disabled person is required, and in Norway the formulation is that rehabilitation should be tried before any benefit award. The situation in Poland is similar (the principle is placed in the legislation, and it says that the advisability of occupational retraining should be taken into account). Further note that in the case of work injuries, compulsory vocational rehabilitation is more widespread.
10. Note that the figure for Denmark has increased from 70% in 1995 to 150% in 1999.
11. Note that the figure for Sweden has declined from 90% in 1995 to 40% in 1999, which is to an unknown degree explained by mainstreaming of hitherto specialised services.
12. The figure for Austria is significantly underestimated, because it only includes vocational rehabilitation programmes offered by the pension insurance system. The correct figure is probably at least twice as high, perhaps similar to the level in Switzerland (hence, it would still fall into the same group of countries).
13. The figure for the Netherlands seems high, because such programmes have only been introduced very recently. Data for the United States show restricted comparability, because the majority of those on rehabilitation programmes are severely disabled people not entitled to disability benefits.
14. Tax deductions could also fall into this category, but no comparable data on this are available.
15. As of 2003, this flex-job scheme will be expanded considerably and eventually replace the current disability benefit scheme for partially reduced work capacity.
16. In Norway, sheltered employment in labour market enterprises is structured into three phases: testing training prospects (phase 1, usually while on sickness benefits), testing transition prospects (phase 2) and permanent employment (phase 3). During the second and third phases, standard wages are paid. At least 50% of sheltered workers have to be in phase 2, which cannot last more than two years. Around 30% make the transition from phase 2 into the open labour market rather than into permanent phase 3.
17. All programmes show a similar gender structure, with around 35 to 40% of the participants being women.
18. Vocational rehabilitation was also found to be consistently more frequent in cantons with better labour market conditions (Prinz, 2002).
19. As already discussed in Box 3.3 in Chapter 3, this data does reflect the order of magnitude of the emphasis on active programmes, but does not capture the entire effort in some of the countries – in particular in countries with partly federated disability policy systems or those where broad competencies are under the responsibility of the regions or communities, and also more generally as a consequence of recent mainstreaming tendencies in several countries.
20. Disability programmes tend to have many explicitly stated objectives – such as, for instance, sheltered workshops that offer permanent employment and at the same time employment training for placement into open employment.

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Chapter 6

A Disability Policy Typology

Abstract. *In the previous chapters, issues and problems have been identified in a cross-country perspective. In Chapter 6, a disability policy typology is developed with the aim of classifying and clustering countries according to their policy approach. The typology is then used to analyse the relationship between policy design and policy outcome, and to compare the policy reform processes in the different countries. Classification details are found in* **Annex 2**.

6.1. Assessing policy approaches: a typology as a tool for comparative analysis

Following the principal policy orientations, the entire policy package can be split into two dimensions: compensation measures or benefit transfer programmes (passive policies), and employment or integration measures (active policies). The purpose of such a simplified two-dimensional view is to develop a tool for comparative policy analysis.[1]

Description of the typology

Each of the two policy typology dimensions, compensation and integration, is divided into ten sub-dimensions. Each sub-dimension is measured according to a predefined quantitative and/or qualitative scale, resulting in a certain number of points, ranging from zero to five points for each sub-dimension. Though this is often a judgmental classification, it is not a black box, because the criteria are clearly spelled out and the resulting classification can be adjusted if needed (see Annex 2, Tables A2.1–A2.4). The points for each sub-dimension are added to obtain the overall score for each dimension; hence, each sub-dimension receives the same weight. Connecting the scores for the compensation and integration dimension positions each country unequivocally on a two-dimensional policy diagram.

For the most part, the compensation dimension refers to the main disability benefit scheme, be it contributory or – in the case of Australia and Denmark – non-contributory. It is split into the following ten sub-dimensions: *i) coverage* (from total population to selected employees); *ii) minimum disability level; iii) disability level for a full benefit; iv) maximum benefit level* (in terms of replacement rate for average earnings with a continuous work record); *v) permanence of benefits* (from strictly permanent to strictly temporary); *vi) medical assessment* (from exclusive responsibility of treating doctors to that of teams of insurance doctors); *vii) vocational assessment* (from strict own-occupation assessment to most open criterion); *viii) sickness benefit level* (distinguishing short- and long-term sickness absence); *ix) sickness benefit duration* (including the period of continued wage payment); and *x) unemployment benefit level and duration* (level in comparison with the disability benefit level). In each of these sub-dimensions, a higher score means easier access, higher benefit levels, longer duration, etc.

The integration dimension refers to the whole range of employment and rehabilitation measures, and distinguishes between the following ten sub-dimensions: *i) coverage consistency* (access to different programmes and possibility to combine them); *ii) assessment structure* (responsibility and consistency); *iii) employer responsibility* for work retention and accommodation; *iv) supported employment* programme (extent, permanence and flexibility); *v) subsidised employment* programme (extent, permanence and flexibility); *vi) sheltered employment* sector (extent and transitory nature); *vii) vocational rehabilitation* programme (obligation and extent of spending); *viii) timing of rehabilitation* (from early intervention to late intervention only for disability benefit recipients); *ix) benefit suspension* regulations (from considerable duration to non-existent); and x) additional *work incentives* (including

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possibilities to combine work and benefit receipt). In each of the sub-dimensions, a higher score indicates a more active approach.

The main strength of this policy typology is that it takes into account a large range of very important policy features on both integration and compensation measures directed towards people with disabilities, and that it tries to achieve a balance between the two policy spheres. The main weakness is the somewhat arbitrary choice of sub-dimensions, which are largely but not entirely independent, which cannot represent the full set of attributes of either an "idealised" strongly integrative or strongly compensatory system, and which, for the sake of simplicity, are all given equal weight and the same score range.

Based on these twenty sub-dimensions, several policy approaches or policy types are distinguished:

- The *compensation policy* approach (high score on compensation, low score on integration) reflects a strong focus on adequate and permanent benefits with broad eligibility and liberal access regulations, combined with a lack of integration efforts. It places little emphasis on the employment of disabled people and would be thought likely to result in high benefit recipiency rates and low employment ratios.
- The *integration policy* approach (low score on compensation, high score on integration) reflects the exact opposite, *i.e.* a strong focus on adequate, broadly accessible or even mandatory employment-related measures, with very restricted access to and a low level of public transfers. Such an approach would be thought likely to result in low benefit recipiency rates and high employment ratios.

The other policy types – with similar scores on the compensation and the integration dimension – are more indeterminate as regards both the desirability and the likelihood of an employment outcome:

- A *weak intermediate policy* (low score on both dimensions) is characterised by limited benefits with strict access, combined with a general lack of public integration measures; in this sense, employment – even if perhaps not regarded as productive – is implicitly necessary in order to get a decent standard of living, though it is still difficult to achieve.
- An *intermediate policy* (intermediate score on both dimensions) is one that undertakes some integration efforts and chooses a midway benefit strategy; the employment incentives of such an approach are particularly ambiguous.
- Finally, a *strong intermediate policy* (high score on both dimensions) is typified by adequate, permanent and broadly accessible benefits combined with considerable and broadly accessible integration efforts; hence, while employment is seen as highly desirable, there are also considerable incentives to apply for, or remain on, benefits.

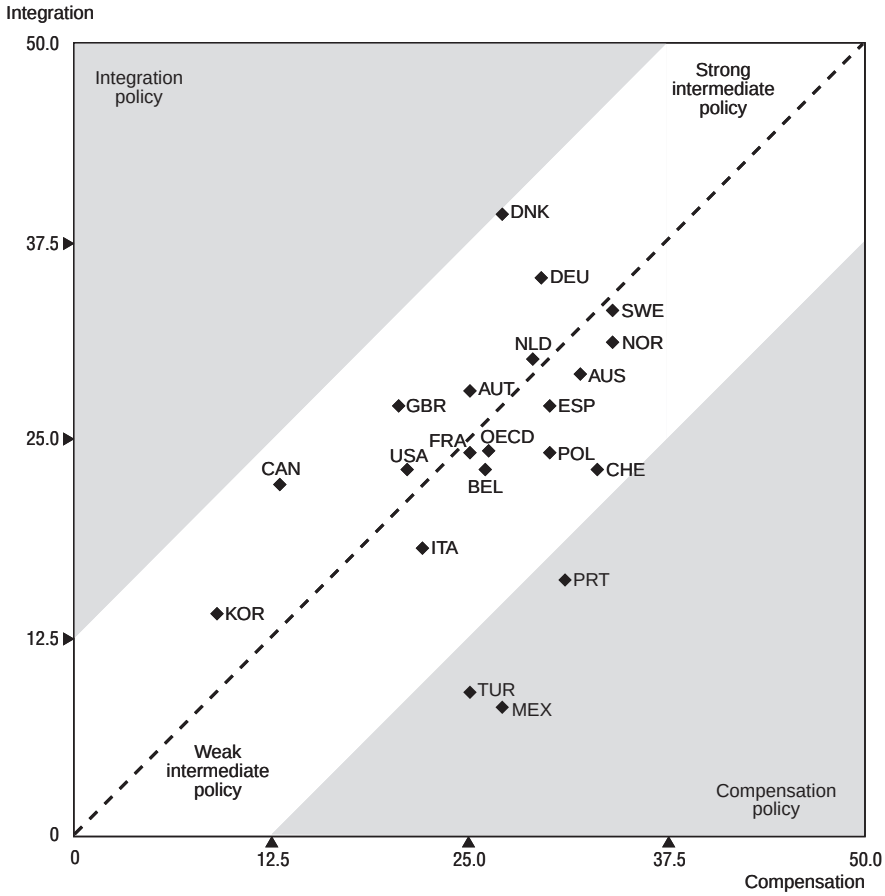
Application of the typology

Chart 6.1 shows the two-dimensional diagram resulting from applying the typology. Every country can be located unequivocally according to the scores on the two axes and, thus, can be approximately classified with one of the five different policy approaches. The diagonal is meant to represent the line with equally strong or weak incentives for benefit application and labour market participation.

One has to keep the qualitative nature of this typology in mind. A certain score in the integration dimension does not necessarily have the same implication as an equal score in the compensation dimension. Moreover, one and the same spot in the diagram can be the

Chart 6.1. **Most countries apply an intermediate disability policy**

Disability policy typology around year 2000



Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

result of different parameters in each of the two sub-dimensions. Generally speaking, though, a policy classified on, or rather close to, the diagonal would be one expected to result in a more ambiguous outcome in terms of employment rates. The further away from the diagonal, the clearer the expected employment outcome of the policy – high for an integration focus and low for a compensation focus.

The classification of countries' disability policies shows that almost all of them are located near the diagonal – they all operate some type of an intermediate policy. Following from the description above, this suggests that most policies are fairly ambiguous in terms of employment incentives. This is just another indication of the dilemma facing disability policy: to reconcile the twin goals of ensuring income security as well as inclusion. Among these intermediate policy countries, the Scandinavian countries and Germany implement a stronger policy and Canada and in particular Korea a weaker policy. The unweighted average of the 20 OECD countries involved in this project is indeed very close to the centre.

Mexico, Turkey but also Portugal have a more distinct compensation policy, in all three cases resulting from a relatively weak integration focus, which is coupled with an intermediate compensation focus. Korea, with a similarly weak integration focus, is found in the intermediate policy group, because its compensation scores are much lower.

Not a single country can be said to have a distinct integration policy focus. Denmark comes closest, and also has the highest score among all countries on the integration dimension – which is due to a very comprehensive rehabilitation and employment policy in this country. Rather limited employer obligations, some inconsistencies in access to different programmes and a rather traditional sheltered employment programme "prevent" Denmark from scoring even higher on this dimension.

Policy clusters

Running a "complete linkage cluster analysis" over the 20 sub-dimensions of the policy typology helps group the countries further. The following six clusters of countries crystallised:[2]

- Cluster A (Immature systems): Turkey and Mexico;
- Cluster B (Anglo-American): Canada, the United States, the United Kingdom and Korea;
- Cluster C (Scandinavian): Norway, Sweden and Denmark;
- Cluster D (Germanic): Austria and Germany;
- Cluster E (Romanic): France, Italy, Portugal, Poland, Spain and Belgium;
- Cluster F (Mixed): the Netherlands, Australia and Switzerland

Cluster A is broadly characterised by limited disability benefit coverage, relatively low sickness and disability benefit levels and the absence of any rehabilitation and employment programmes.

Cluster B, the Anglo-American model, is characterised by a dual benefit system, very strict medical requirements and all-occupation assessment for benefit entitlements, relatively low sickness and disability benefit levels (generally lower than unemployment benefits), large inconsistencies in coverage and assessment of integration measures, substantial employer responsibilities and significant developments in the area of supported employment, a weak rehabilitation programme and significant back-to-work incentives.

Cluster C, the Scandinavian model, is characterised by full population coverage in the benefit scheme, a strong focus on partial benefits, strict medical and vocational criteria for a full benefit, generous benefit levels, largely permanent benefits, a strong focus on employment subsidies, a strong rehabilitation programme and new possibilities to interrupt benefit payment.

Cluster D, the Germanic model, is characterised by labour force coverage for benefits, medium benefit levels, temporary benefits, own-occupation assessment, continued wage payment during sickness absence, a strong focus on all types of employment programmes and a strong rehabilitation programme.

Cluster E, the Romanic model, is characterised by a dual benefit system, strict medical criteria but partly own-occupation assessment for access to insurance benefits, medium employer responsibilities, quite a strong focus on employment subsidies (and in Poland also on sheltered employment) and a weak rehabilitation programme (except Poland and Spain).

Cluster F, the Mixed model, is characterised by full population coverage in the benefit scheme (though with means-testing in Australia, and with some restrictions in the Netherlands), low minimum required work-capacity reduction for (partial) benefit entitlement, a consistent integration policy approach, significant employer responsibility (less in Switzerland), a relatively strong focus on sheltered employment (less in Australia)

and – as it groups three countries that are different in some respects – substantial variations in benefit levels and the approach to vocational rehabilitation.

6.2. Comparing policy and outcome using the disability policy typology

The policy typology is a strong tool for the comparative analysis of policy outcome across countries. Correlating the policy components with the main outcome variables gives a number of expected, but also less expected, results. Using the policy clusters helps in interpreting the findings.

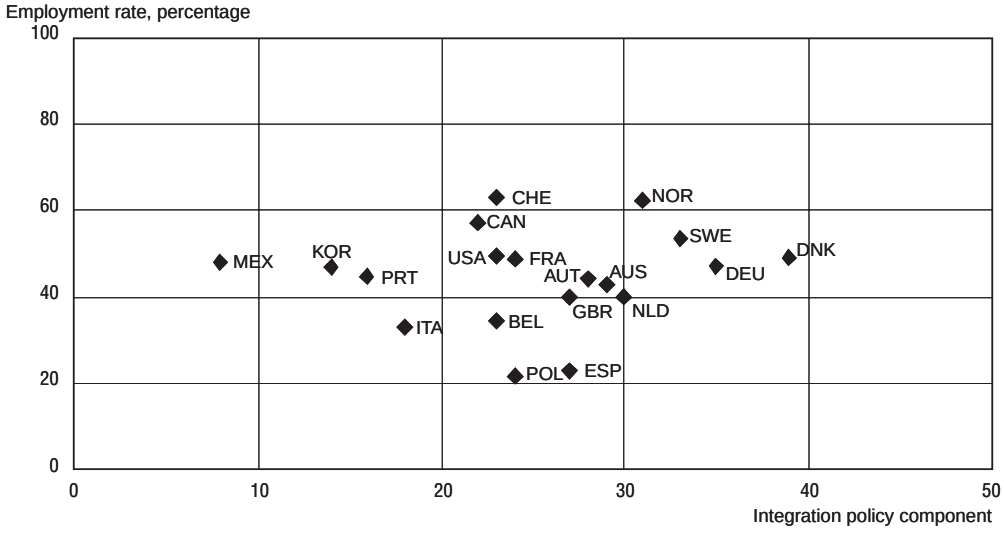
Employment outcomes

It might be expected that a strong *integration policy* leads to high employment rates of disabled people. This hypothesis, however, is not confirmed; there is no aggregate correlation between integration policy and overall employment outcomes (Chart 6.2 and Table 6.1, M2 and M4). There are several countries in which employment rates of disabled people in the 20-64 age group are relatively high, given the below-average integration efforts (Mexico, Korea, Portugal, Canada, United States and Switzerland). Employment rates are low in Denmark and Germany relative to those countries' integration focus. In fact, none of the ten integration sub-dimensions show a strong correlation with employment outcomes.

It would be wrong, though, to conclude that employment measures are ineffective or even irrelevant. The lack of any correlation with employment outcomes may be caused partly by the countries' *compensation policies*, which tend to be strong in countries with a strong integration policy, and often relatively weak in countries with a less developed integration policy.[3] As strong as the integration focus may be, a generous and accessible benefit scheme – like in the Scandinavian countries – may mask any employment effect.

Chart 6.2. **No correlation between integration policy and employment outcome**

Integration component from policy typology around 2000 *versus* employment rate in late 1990s



Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Table 6.1. **General employment level determines employment rate of disabled people**

Results of various linear regression models concerning employment outcomes, late 1990s

Dependent variable	Explanatory variables	Results for coefficients		Overall model results	
		Coefficients	t-statistic	R Square	F-statistic
Employment rate of disabled people	M1: EPR non-disabled	0.87	4.4**	0.53	19.2**
	M2: Integration policy	0.19	0.5	0.01	0.2
Relative employment rate of disabled people	M3: EPR non-disabled	0.42	1.5	0.11	2.1
	M4: Integration policy	–0.31	–0.8	0.04	0.6

** significant at 1%.

Source: Own calculations based on Annex 1, Table A1.1 and OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Similarly, high employment rates among disabled people can also be an indication that disabled people must work in order to have a decent standard of living.

It transpires that half of the amount of variation in the employment rates of *disabled* people across countries is explained by the variation in the general employment rate of *non-disabled* people. In a linear regression model, this variable is significant at the 1%-level, and the coefficient is positive at 0.87 (Table 6.1, M1).[4] In other words, a country with a 1 percentage point higher employment rate among non-disabled people has, on average, a 0.87 percentage point higher employment rate among the disabled population. Hence, there is a strong impact of general labour market forces on the employment of people with disabilities, which suggests that policies that promote employment in general will also help to foster the employment of people with reduced work capacity.[5]

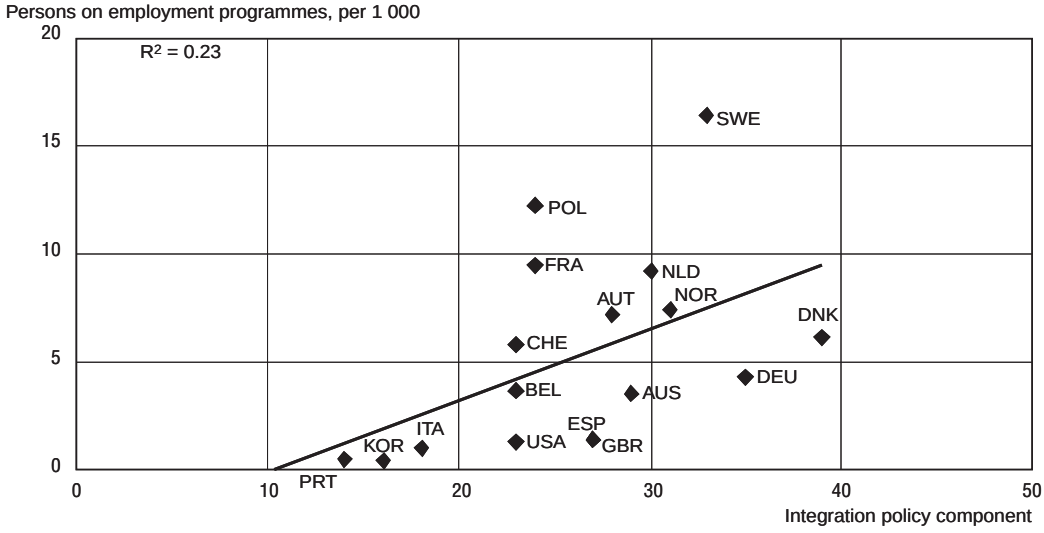
In contrast, the employment level of non-disabled people has no explanatory power for the *relative* employment rate of disabled people, *i.e.* the employment level of disabled people relative to their non-disabled peers does not appear to be correlated with general labour market forces (Table 6.1, M3).

Scores on the integration policy component are not only unrelated to employment rates, but also appear to show only a weak correlation with the number of participants in special employment programmes (measured per 1 000 of the working-age population). Again, Denmark and Germany are the two countries that show a low number of programme participants relative to their integration focus, while Poland, with its strong sheltered employment sector, is an opposite example (Chart 6.3). Eliminating these three countries would increase the correlation coefficient from 0.23 to 0.47.[6]

Another way to eliminate, or average out, the effect of single country outliers is to look at the six policy *clusters* defined in the previous section. If we were to reconstruct the same chart on the basis of these clusters rather than the 20 individual countries, the correlation coefficient would jump from 0.23 to 0.78 – with only the Anglo-American group showing low numbers on employment programmes relative to their integration policy classification. This may be explained partly by policies that have been introduced only very recently (the United Kingdom in particular) and so do not yet show up in employment statistics.

Chart 6.3. **Strong integration policy does not always lead to large numbers on employment programmes**

Employment programme participants in 1999 *versus* integration policy component in late 1990s



Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Recipiency outcomes

Beneficiary outcomes are related more directly to scores on the *compensation policy* component. This is true both for the stock of disability benefit recipients (Chart 6.4) and the annual inflow into such benefits (Chart 6.5). In both cases, the correlation coefficient is around 0.40, with Poland having a higher than expected recipiency rate and Norway (recently) having a higher than expected inflow rate.[7] Mexico and Turkey both have very low recipiency rates compared with their compensation policy scores. This is to a large extent explained by more restricted benefit coverage in these countries, which is only explicitly taken into account in one of the ten compensation policy sub-dimensions.

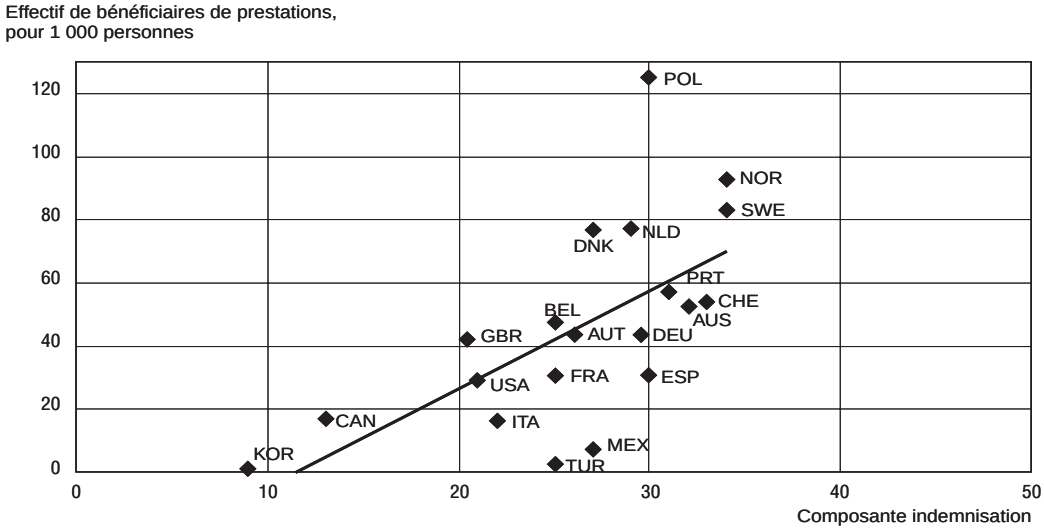
Basing the chart on the six policy clusters rather than the 20 countries does not seem to have much of an impact on the correlation between compensation policy and beneficiary outcomes. As the two main outliers, Mexico and Turkey, form a separate cluster, they remain outliers in this more aggregate perspective. Eliminating this group of immature welfare states from the clustered relationship, *i.e.* basing the chart on only five policy clusters, raises the correlation coefficient to a level of 0.80 – suggesting that it is indeed compensation policy itself that to a large extent determines beneficiary outcomes.

Further statistical analysis suggests that, indeed, compensation policy scores "explain" a significant amount of the variance in disability benefit recipiency rates: the compensation policy variable is significant at 1%, and the coefficient is positive at 3.0 (Table 6.2, M5). This means that, on average, one additional score point on the compensation policy axis increases the disability benefit recipiency rate by three percentage points.[8]

Table 6.2 illustrates that *disability prevalence* – measured through self-assessment – is equally significant in explaining the variation in disability benefit recipiency rates (M6).[9] It is impossible to tell the extent to which this is because people on disability benefits are

Chart 6.4. **Generous compensation policy results in large beneficiary numbers**

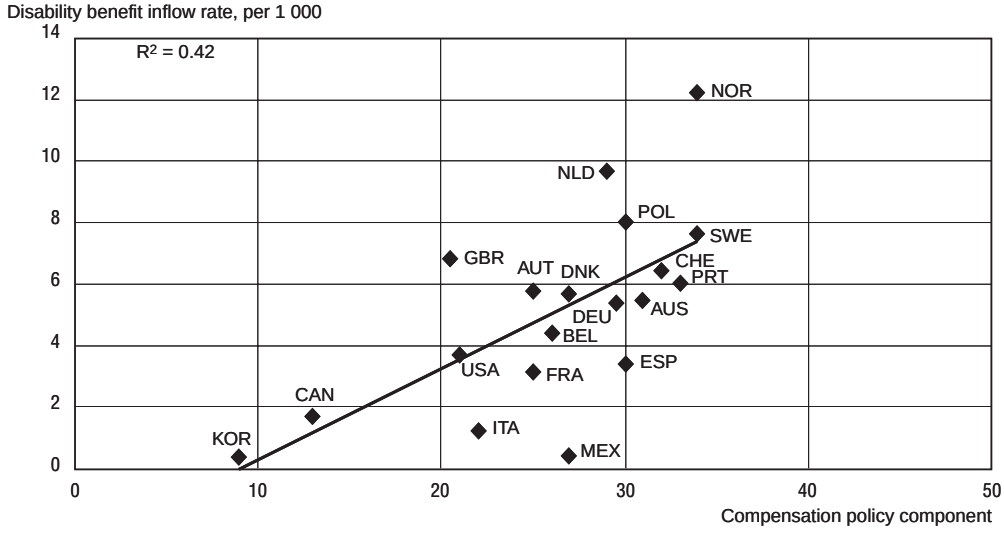
Compensation component from the typology in 2000 *versus* benefit recipiency outcome 1999



Note: Data refer to the main public disability benefit programme only.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Chart 6.5. **Inflow as closely related to compensation policy as stock of recipients**

Compensation component from the typology in 2000 *versus* disability benefit inflow rate 1999



Note: Data refer to the main public disability benefit programme only.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Table 6.2. **Compensation policy and disability prevalence affect disability benefit recipiency**

Results of various linear regression models concerning benefit recipiency outcomes, late 1990s

Dependent variable	Explanatory variables		Results for coefficients		Overall model results	
			Coefficients	t-statistic	R Square	F-statistic
Disability benefit recipiency rate (main programme only)	M5:	Compensation policy	3.02	3.5**	0.42	12.5**
	M6:	Disability prevalence	4.17	3.4**	0.40	11.5**
	M7:	Disability prevalence	2.70	2.1*	0.55	9.8**
		and compensation policy	2.05	2.3*		
Disability benefit recipiency rate (excluding Poland)	M8:	Coverage score	13.95	5.6**	0.66	31.5**
	M9:	Benefit level score	11.02	4.3**	0.54	18.9**
	M10:	Sum of coverage and benefit level scores	7.46	6.4**	0.72	41.5**

* significant at 5%.
** significant at 1%.
Source: Own calculations based on Annex 1, Table A1.1 and OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

more likely to claim to be disabled (in order to justify benefit receipt or because going through all the assessment procedures makes them feel disabled). The analysis in Chapter 3, however, identifies a considerable mismatch in this respect, *i.e.* many people on disability benefits do not claim to be disabled while, at the same time, the majority of disabled people do not receive disability benefits. This would suggest that this regression result is indeed significant, or in other words that high disability benefit recipiency rates in some countries, like the Netherlands or the Scandinavian countries, are to a certain extent caused by those countries' high levels of disability prevalence.[10]

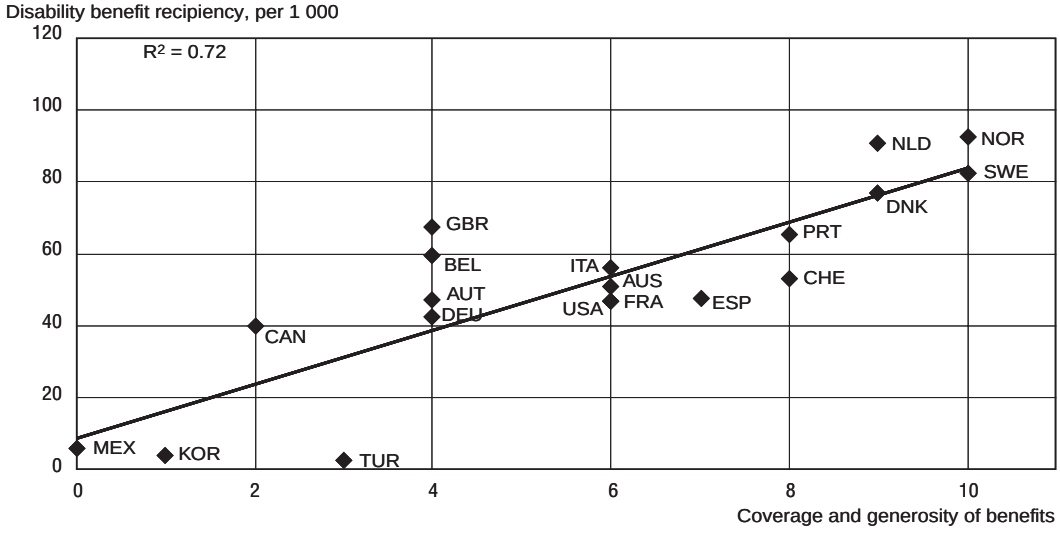
As disability prevalence and compensation policy appear as rather independent variables, a model with *both* of them as explanatory factors should be particularly telling. The joint model is also significant at 1%, although the F-statistic is slightly smaller (Table 6.2, M7). Both coefficients are positive and significant at 5%. While each of the two factors individually explain about 40% of the variance in recipiency outcomes, the joint model explains about 55% of the total recipiency variation.

It is interesting to look further into the details of compensation policies by relating beneficiary outcomes with single compensation policy *sub-dimensions*. The result is unequivocal. Eight of the sub-dimensions show no or a negligible correlation with these outcomes, which are largely explained by only two sub-dimensions: approximate benefit levels and benefit coverage (again see Annex 2 for country details on these sub-dimensions). Benefit generosity and benefit accessibility together appear to explain almost three-quarters of the cross-country difference in benefit recipiency levels (Chart 6.6).[11] Basing the analysis on the six policy clusters further increases the correlation coefficient from 0.73 to as much as 0.91, and even to 0.96 if – as above – the group "Mexico and Turkey" is disregarded.

Again, regression models give additional information. Chart 6.6 reflects the model in which the *sum* of the coverage and the benefit level scores forms one single explanatory variable. This is the model with the highest significance of all models used (Table 6.2, M10).[12] Both the coverage score and, with a slightly lower F-statistic, the benefit level score are also individually significant at 1% (M8 and M9).[13]

Chart 6.6. **Coverage and generosity determine benefit recipiency levels**

Benefit coverage and benefit generosity 2000 *vs.* benefit recipiency outcome 1999



Note: Poland excluded (including Poland reduces the R^2 to 0.54).
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Economic well-being outcomes

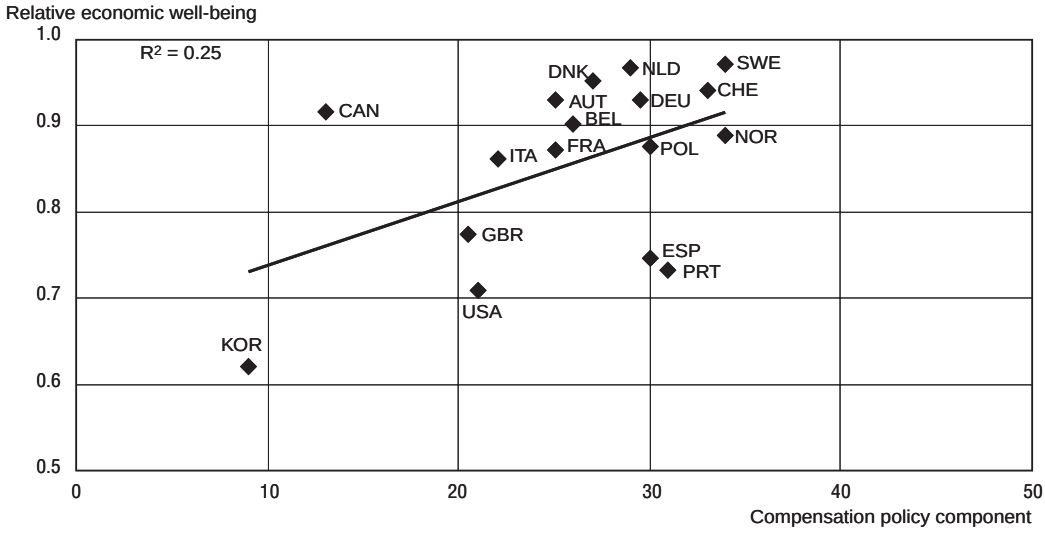
The analysis in Section 3.2 indicated that economic well-being outcomes, measured through relative equivalised incomes of households with a disabled person, may be related to the structure of the disability benefit scheme. The results shown in Chart 3.2 (see Chapter 3) indeed suggest that disabled people in countries with individual benefits for the entire population and/or high earnings replacement rates fare best, and those in countries with a strong focus on the means-tested programme and/or comparatively low replacement rates in their earnings-related insurance programme do worst.

Using the policy typology, some correlation between *compensation policy* scores and economic well-being is identified. The amount of cross-country variation explained is low (R^2= 0.25, see Chart 6.7), but the correlation is statistically significant at 5% (Table 6.3, M11). There are several countries that do not fit the trend line. This is particularly true for Spain and Portugal, which offer generous insurance benefits but only to a relatively small group of disabled people – because of either lower benefits for younger disabled people (Portugal) or extremely high non-employment, and therefore non-eligibility, rates (Spain). Canada is the only relevant opposite example, with high relative economic well-being notwithstanding a restrictive benefit scheme. Eliminating these three countries from the analysis would raise the correlation coefficient to over 0.70.

At the same time, analysis shows that there is also an even stronger correlation, significant at 1%, between *integration policy* scores and the outcome in terms of households' economic well-being (Chart 6.8 and Table 6.3, M12).[14] As concluded in Chapter 3, on the level of the *individual* the income of disabled persons primarily depends on their work status. However, as we find no significant aggregate correlation between integration policy and employment outcomes (Chart 6.2), the mechanisms through which integration policy

Chart 6.7. **Measurable correlation between economic well-being and compensation policy**

Compensation component from the 2000 typology *versus* relative economic well-being[a]



a) Economic well-being: equivalised household income, late 1990s.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Table 6.3. **Integration policy has the largest impact on relative economic well-being**

Results of various linear regression models concerning economic well-being outcomes, late 1990s

Dependent variable	Explanatory variables		Results for coefficients		Overall model results	
			Coefficients	t-statistic	R Square	F-statistic
Relative economic well-being of households with disabled people	M11:	Compensation policy	0.74	2.2*	0.25	5*
	M12:	Integration policy	1.00	3.2**	0.41	10.4**
	M13:	Employment rate of disabled people	0.15	0.7	0.03	0.5
	M14:	Disability benefit recipiency rate	0.18	2.1*	0.23	4.5*
	M15:	Compensation policy,	0.13	0.3		
		integration policy,	0.71	1.9		
		employment rate	0.11	0.6		
		and benefit recipiency	0.09	0.9	0.49	2.9

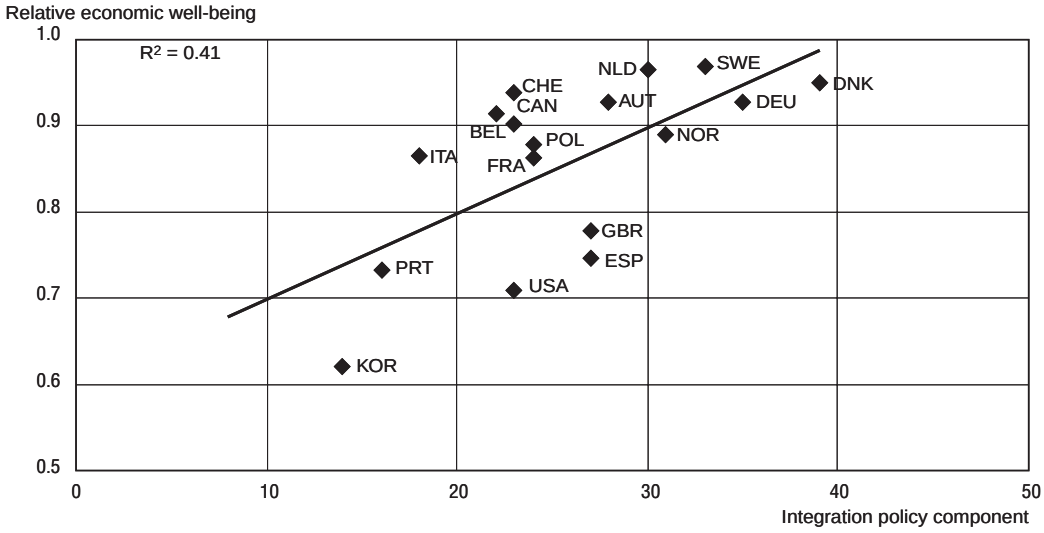
* significant at 5%.
** significant at 1%.
Source: Own calculations based on Annex 1, Table A1.1 and OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

might influence the economic well-being outcome need further examination. Indeed, Table 6.3 also shows that the *employment rate* of disabled people is not a significant factor to explain cross-country variation in the economic well-being of households with disabled people (M13).

On the contrary, the disability *benefit recipiency rate* is significantly correlated with relative household economic well-being (significant at 5%) – probably a consequence of the higher benefit levels in countries with higher overall benefit recipiency rates (Table 6.3, M14).

Chart 6.8. **But stronger correlation between economic well-being and integration policy**

Integration component from the 2000 typology *versus* relative economic well-being[a]



a) Economic well-being: equivalised household income, late 1990s.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

A joint regression model with all four variables – compensation policy scores, integration policy scores, employment rates of disabled people and disability benefit recipiency rates – is not significant at 5% (although significant at 10%), but it confirms that the integration policy score is the single most important explanatory factor (M15).[15]

Notes

1. The typology is influenced by Dropping *et al.* (2000), who developed a framework for analysing differences in disability policy responses. They distinguished five models: market-led, incentive-led, integration-led, choice-led and rights-led. Each model is associated with certain institutional arrangements for benefits and services, and expectations about labour market participation. In contrast to the typology used in this study, their framework is based on ideal-type policy formulation rather than the policy actually implemented, and they consider labour market participation as an input rather than outcome variable.
2. Some countries are identified as having particularly similar disability policy approaches: Canada and the United States, Norway and Sweden, and France and Italy. Reducing the chosen number of clusters would involve the following sequence of steps: 1. merging cluster F and cluster E, 2. merging cluster EF and cluster D, 3. merging cluster DEF and cluster C, 4. merging cluster B and cluster A, and finally 5. merging cluster AB and cluster CDEF. This suggests a strong divide between OECD-Europe and OECD-non-Europe, except that Australia's disability policy approach appears to be more European and the United Kingdom's approach more non-European.
3. Although, due to several outliers, the coefficient of correlation between the two policy components over all twenty countries is small ($R^2 = 0.15$).
4. All regression models referred to in this section are based on the equation $X_{(\text{late 1990s})} = \alpha + \beta (Y_{(\text{late 1990s})})$.
5. If one adds integration policy scores as a second explanatory variable to this regression model, the joint model remains significant at 1%, but because the F-statistic declines (*i.e.* the significance of the model decreases) and the integration coefficient is not significant, this model is rejected.
6. Note that at least for Germany this is partly due to incomplete data, because programmes operated on the provincial level there are not fully covered.

7. Both charts refer to the main public disability programme – the public non-contributory programme in Australia and Denmark, and the insurance programme in all other countries – because the sub-dimensions of the compensation policy component largely refer to this main programme only.
8. This result is based on taking recipients of the main public disability benefit programme as a dependent variable. By also taking recipients from the second, non-contributory disability programme into account, the significance of the model is reduced, although it is still significant at 5%. This ought to be expected because, as was already mentioned in the previous footnote, most of the compensation policy sub-components are related to the main benefit programme only.
9. In this case the model results are independent of whether the dependent variable is taken to be recipients of only the main disability benefit programme or those of all public disability programmes.
10. It is beyond the scope of this study to examine the reasons for higher disability prevalence in some countries, as well as the reasons for the increase in disability prevalence found in many developed countries.
11. Correlating benefit recipiency rates with the sub-dimension benefit coverage only gives an $R^2 = 0.67$, while correlating it with the dimension benefit levels only results in an $R^2 = 0.53$ (in all cases excluding Poland).
12. The F-statistic in this model is equal to 41.5, and the corresponding significance level is 0.000008.
13. Note that the joint model with both parameters as two separate independent explanatory variables is also highly significant, although the F-statistic is considerably lower than in the model that uses the sum of the two parameters as one independent variable. In the joint model, the coverage coefficient is significant at 1% while the benefit level coefficient is only significant at 10%.
14. The joint model with both policy components is also significant, though only at 5%, but explains little more of the variance in economic well-being than does the simple integration policy model. Not surprisingly, therefore, in the joint model only the integration policy coefficient is significant.
15. Note that, although the results appear to be pretty significant, regressions concerning economic well-being outcomes have to be interpreted cautiously, as they are not very robust. Eliminating Korea from the analysis, for instance, removes the significance of both the compensation policy model and the benefit recipiency model, and reduces the significance of the integration policy model from the 1%- to the 5%-level. Similarly, were data on relative household well-being also available for Mexico and Australia, this would probably remove the significance of the integration policy factor (because data on personal incomes of disabled people suggest comparatively high levels of relative economic well-being for this group in Mexico, despite the virtual absence of any integration policy, and comparatively low levels of relative well-being in Australia, notwithstanding a rather strong integration focus in this country).

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Chapter 7

Recent and Forthcoming Policy Reforms

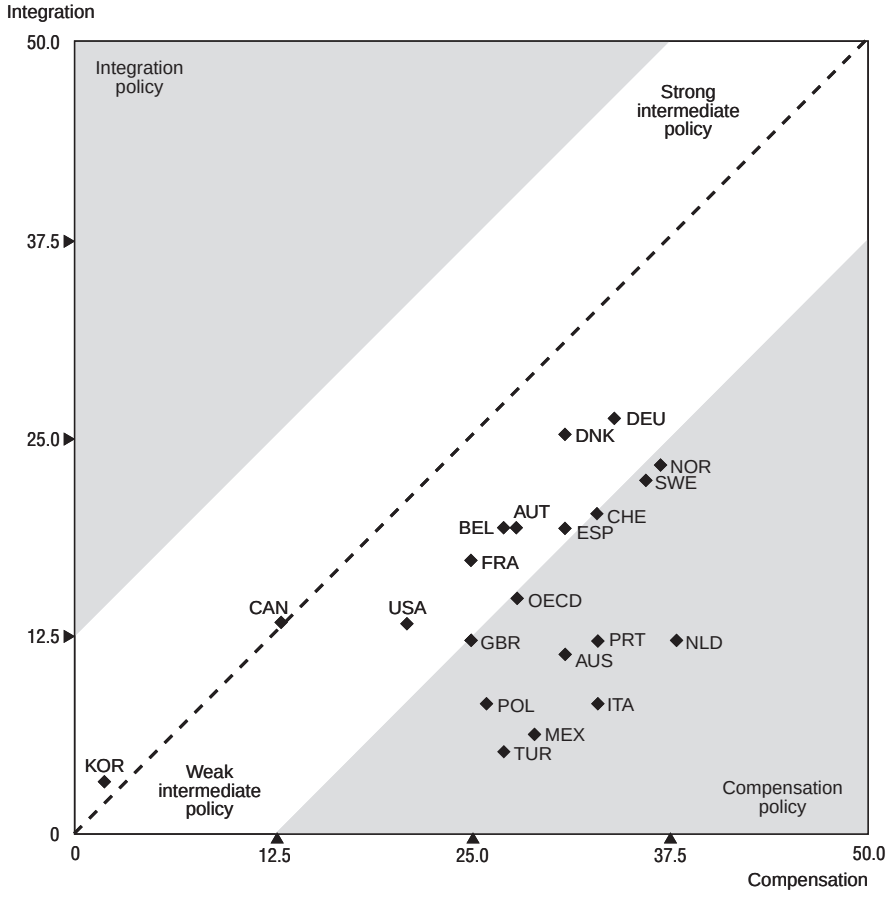
Abstract. *In Chapter 7, disability policy reforms during the 1990s are analysed and the most important recent country-specific reform initiatives described in some detail. This analysis is also meant to help understand the extent to which suggested future policy strategies discussed in the concluding chapter are a continuation of recent developments in the field of disability policies for the working-age population or a movement away from these trends.*

7.1. Extent and direction of recent reforms

The policy typology developed in the previous chapter is illuminating for the analysis of disability policy *reform*, and in particular shifts in the direction of policy. Chart 7.1 shows the disability policy classification in 1985 – which can be compared directly with Chart 6.1. Some fifteen years ago, a majority of countries' policies could be characterised as distinctly compensation-oriented. To a considerable degree, this finding probably explains the high disability benefit recipiency rates of today. No country's policy mix was placed at, much less above, the diagonal, with two exceptions: Korea, which only introduced its disability benefit systems (and also most of the employment programmes) after 1985; and Canada, which has never run a generous benefit scheme – probably a major factor explaining the low disability benefit recipiency rate there.

Chart 7.1. **Strong focus on compensation policy until recently**

Disability policy typology around year 1985



Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

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Driven by disappointing experiences with existing policy approaches, virtually every OECD country undertook substantial reforms during the 1990s. Also spurring policy change were initiatives at the supra-national level and the more active and visible role of associations of disabled people, which gained increasing acceptance as independent actors in the policy process.

In many countries, the reforms of the 1990s were more far-reaching than ever before. New or strengthened emphasis on civil rights and anti-discrimination measures for disabled people has often resulted in policy re-orientation. By and large, a considerable convergence in policy objectives can be observed. Countries that have until recently focused on compensation alone (like Italy, the Netherlands and the United Kingdom) are in the process of implementing a range of employment-related programmes. Countries with a more developed integration focus (like Germany and the Scandinavian countries) have considerably strengthened their employment promotion strategy. And countries with developing welfare states, in particular Korea, and those with gradually maturing public programmes for people with disabilities (like Portugal and Spain) have taken other countries' experiences into account and are building their disability policy on a balanced mix of employment and transfer policies.

More specifically, the following elements have been put forward in many countries and in different ways:

- the introduction of anti-discrimination legislation;
- a significant increase in employers' responsibilities towards people with disabilities;
- the promotion of streamlined administration and one-stop service centres; and
- the introduction of various forms of work incentives with continued recognition of disability status.[1]

Concerns about equality of opportunity have motivated the introduction of anti-discrimination legislation, with a special focus or chapter on non-discrimination in all aspects of the employment process. Such legislation was first introduced in the United States in 1990 (although human rights legislation in Canada existed much earlier) and was then adopted by several other English-speaking countries. More recently, similar legislation has also been introduced or is under preparation in several European countries.

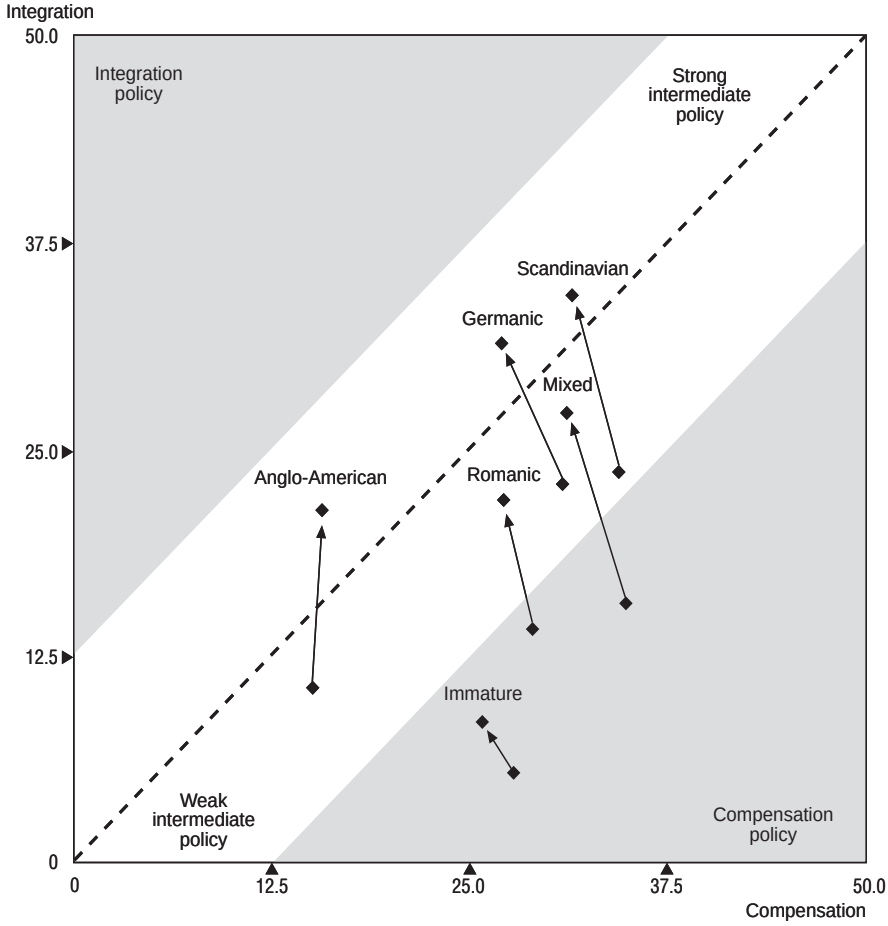
In many countries, transfer policies have also changed due to an increasing awareness of the incentives created by disability benefit schemes. In countries with a dual benefit scheme, this has led to different forms of restrictions on access to disability insurance benefits in particular. In several countries, tighter access has included one or more of the following:

- a more regulated and standardised medical assessment procedure;
- a softening or abolition of the previous "own" occupation assessment;
- use of an abstract labour market criterion;
- emphasis on granting benefits on a more temporary basis; and
- a reduction of benefit levels.

Overall, the last fifteen years were a period of strong expansion of employment-related integration measures, with some contraction of compensatory transfers. The changes were equally comprehensive in all groups of countries (Chart 7.2), though somewhat less pronounced in immature systems (Mexico and Turkey). In 1985, for instance, both the Romanic and the Mixed group were still using a more distinct

Chart 7.2. **Strong shift towards integration in all policy clusters**

Disability policy typology around 1985 and 2000



Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Table 7.1. **Direction of disability policy change in the period 1985-2000**

		Compensation policy		
		Strong contraction	Some contraction	No contraction or expansion
Integration policy	strong expansion	Netherlands	Australia Denmark United Kingdom	Poland
	intermediary expansion	Italy	Austria Germany Norway Spain Sweden	Canada France Korea United States
	minor expansion	–	Belgium Mexico Portugal Turkey	Switzerland

Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

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compensation policy approach, which was no longer the case in 2000. If the same policy trend continues during the next 15-year period, by 2015 most groups will be characterised by having a distinct integration policy approach.

Among the 20 countries studied, the policy shift during the last fifteen years was most pronounced in the Netherlands, while Switzerland is the only country with only minor shifts in both dimensions (Table 7.1). The first positive results of these rather far-reaching reforms were stabilising or even declining rates of disability benefit inflow. But there were also some unexpected setbacks in the form of increasing inflow rates in some countries, partly because the expansion of integration measures was not accompanied by making transfer programmes conditional on participation in these programmes.

7.2. Country-specific reform initiatives

In this section, the most important policy changes in the 20 participating OECD countries during the last ten to twenty years are summarised, country by country. They are ordered along the six policy clusters identified in the previous chapter.

Immature systems: Turkey and Mexico

Mexico seems to be at the same stage as Korea was about ten years ago. While the legislative framework itself has not really changed yet, during the second half of the 1990s several programmes were implemented and agencies established that recognise the need for the promotion and integration of persons with disabilities. The aims of these initiatives include institutional awareness-raising, education for prevention and integration, and co-ordination of policies, strategies and action programmes. The social security system, on the contrary, underwent two major structural reforms. A new mandatory private pension insurance was introduced in 1995 (and implemented as of 1997) for those entering the labour force in 1997 (with a voluntary switching possibility for all others). In 1997, disability and survivor insurance was reformed into a social insurance that is to be purchased on the private insurance market.

In Turkey, integration-related reforms were characterised by new developments in vocational rehabilitation and training. Special employment programmes are non-existent. Since 1984, municipalities have been required to provide rehabilitation services, and, in 2000, the Turkish Employment Institution was requested to set up vocational training centres either by itself or in co-operation with other public or private organisations. The 1987 Regulation on the Employment of Disabled Persons introduced a new definition of disability – a minimum of 40% and a maximum of 70% work-capacity reduction – which is used for the employment quota and for vocational rehabilitation. The 2000 amendment of the Labour Law raised the mandatory employment quota from 2 to 3%. Disability benefits underwent considerable change in the context of a far-reaching pension reform that aimed at restricting access (introducing and increasing the minimum retirement age) and strengthening the link between contributions and benefits (new benefit formula takes the contribution record into account, lifetime earnings as reference earnings). Further steps to increase social security coverage (introduction of unemployment insurance in 2000 with first benefits paid as of February 2002, broadening of pension scheme coverage) are currently underway.

Anglo-American policy approach: Canada, the United States, the United Kingdom and Korea

Canada has seen considerable changes in the legal framework. In 1982, the Canadian Charter of Rights and Freedoms was signed by the federal government and all the provinces, except Quebec. In 1992, the Canadian Human Rights Act was amended to include a "reasonable accommodation" clause, meaning that employers have to provide accommodation unless this causes undue hardship. Apart from that, recent trends have been characterised by changes in structures with continuing devolution to the provinces and territories of responsibility for the provision of employment measures, and the establishment of a shared federal-provincial framework or partnership for dealing with disability issues ("In Unison: A Canadian Approach to Disability Issues"). On a provincial level, there has been a greater focus on active measures to foster employment. Work incentives were also increased by the provision of top-up income in the form of various tax credits for low-income earners. Benefit-related reforms, in contrast, were of minor importance. The tax system is also increasingly being used as an instrument of federal disability policy.

In Korea, the 1980s were a period of increasing awareness of disability. This gained momentum through the paralympics held in Seoul in 1988, which ended in a period of active and rapid policy change in the late 1980s and throughout the 1990s. Within the short period of less than 15 years, all kinds of new employment and benefit programmes were introduced: a disability registration system (1989), anti-discrimination regulations and an employment quota scheme (1990), vocational rehabilitation and employment promotion (2000), and, on the transfer side, a contributory disability benefit (1988), a non-contributory disability allowance (1990) and unemployment benefits (1995). Although the policy history in this area is short, a major policy reorientation took place in the late 1990s. While policy initially was based on the quota scheme, with the second round of reforms the focus was turned to the vocational rehabilitation of severely disabled people (more services available, better management). On the social security side, the major aim during the 1990s was to broaden coverage – both for the disability programme and for the industrial accident insurance programme.

Disability policy in the United Kingdom underwent considerable re-orientation during the 1990s, with a new focus on vocational rehabilitation, individual needs and personalised services, and various efforts to make work pay (minimum income for disabled people introduced in 1992, further reformed into a disabled person's tax credit in 1999). In 1996, the employment part of the new anti-discrimination legislation replaced the hitherto existing but unsuccessful mandatory employment quota (unsuccessful because quota fulfilment had rapidly declined). In 1994, the "access to work" programme, which offered practical help to overcome obstacles on the job or to get into work, had already been introduced. In 1998, two "New Deal for Disabled People" pilot schemes were set up to assist disabled people back to work. One involved a personal adviser service, while the other included a range of schemes, such as unpaid work trials and job-match payments for part-time work. In 2001, a nationally-extended NDDP was launched, in which various organisations are contracted to deliver job broker services, working with both disabled people and employers. In the same year, in an effort to increase efficiency and to provide better service, the benefits agency and the employment service were merged into one single working-age agency (Jobcentre Plus), as part of the newly created Department of Work and Pensions. Supported and sheltered employment were integrated and re-launched as Workstep (less strict eligibility criteria with a focus on people on benefits;

challenging but achievable targets for progression, coupled with new output-oriented funding arrangements; development of quality standards). In the future, more emphasis will be put on personal assistance and on vocational rehabilitation through job retention and rehabilitation pilot schemes to test the impact and cost-effectiveness of early work-focused help. On the benefit side, efforts were made to simplify different benefits (*e.g.* in 1995 new incapacity benefit replaced invalidity and sickness benefit), to shift costs to employers (8 weeks of statutory sick pay by the employer since 1983; 28 weeks of sick pay fully borne by the employer since 1995), to tighten entitlement conditions (new medical test, the all-work test, introduced in 1995, only five years later replaced by the personal capability assessment, which provides additional information to the personal adviser on the claimant's capability), and to increase work incentives (linking rules for disability-related benefits were extended from 8 to 52 weeks in 1998, permitted work rules were modified – *e.g.* doctor's permission for work no longer necessary – in 2002). As of 2001, following the abolition of the severe disablement allowance, contribution requirements for incapacity benefit were lowered to ensure access to this benefit for persons with disability acquired congenitally or in youth.

In the United States, the most important reform element during the last two decades was the implementation of far-reaching anti-discrimination legislation in 1992, which had a major impact on obligations for employers. Aside from this, there have also been employment-related reforms aimed at increasing the employability of severely disabled people, a trend that started in 1973. This involved both supported employment (legally defined and equipped with appropriate funding in 1986, broadened in 1992 to include other than developmental disabilities) and priority treatment in vocational rehabilitation (also since 1992). There has been another more recent trend to give more weight to clients' individual preferences: individual training accounts that allow clients to choose their provider were introduced in 1998, and complemented a year later by "ticket-to-work" vouchers for vocational rehabilitation, which are offered by the social security administration. The 1998 reform also started to establish full-service one-stop centres in each local workforce investment area, functioning as a seamless co-ordinated service delivery system for people with or without disability. Other benefit-related reforms focused closely on increasing work incentives for disability benefit recipients: the so-called extended period of eligibility of 15 months (which follows the trial work period) was introduced in 1980 and was extended to 36 months in 1987; in 1986, so-called 1619b) legislation greatly relaxed work restrictions for benefit recipients; and 1999 saw the introduction of Medicare coverage for those who return to work and of incentives for Medicare buy-in. Attempts in 1980 to tighten access to disability benefits and to increase control through the greater use of continuing disability reviews largely failed, because by 1984 a major political outcry had forced the relaxation and even partial withdrawal of these measures.

Scandinavian policy approach: Norway, Sweden and Denmark

In Denmark, the 1990s in particular were a decade of far-reaching reform. One major trend was the gradual decentralisation of competencies, which started in 1976 and was completed in 1998; since then, municipalities have the responsibility for almost all disability-related matters (one-stop shops) as well as other obligations (*e.g.* regarding early vocational intervention or follow-up reviews of sick-listed people). The state exercises a directing role via varying reimbursement rates to set incentives to use more active rather than passive programmes. In addition, in 1993 the legal situation of disabled persons was improved through the introduction of two new policy principles as parts of the social

model of disability: *sector responsibility* and *compensation*. Employers' social responsibility has been brought increasingly to the fore, *e.g.* through a focus on enterprise rehabilitation. Employment-related reforms were aimed at broadening options in the open labour market. A strong supported employment programme was introduced in 1992, and new and more flexible subsidised employment schemes were launched in 1994 (social chapters in collective agreements) and especially in 1998 (full-time flex-jobs, part-time protected jobs, icebreaker scheme). A far-reaching benefit reform aimed at reducing benefit dependence is envisaged for around 2003. According to the reform plans, partial benefits will be abolished and replaced by readily available and adaptable flex-jobs. At the same time, a work ability criterion will be applied, which focuses on ability to handle a flex-job rather than loss in employability, and which gives less emphasis to medical aspects.

In Norway, employment-related reforms during the last decade were aimed at increasing employment in the open labour market (introduction of supported employment in 1993, strengthening of the transitional function of sheltered employment in 1994). In 1994, the efficacy of vocational intervention was increased by transferring the overall responsibility for active employment measures for vocationally disabled persons to the public employment service. This was accompanied by a reform of the sickness benefit programme (possibility to stop payment upon client rejection of rehabilitation measures, requirement for employers to report measures taken at the workplace). For the future, there are plans to simplify regulations, to reduce the number and types of programmes and to reconsider the length and level of support. Two goals underpinned reforms in the sickness and disability benefit systems: to restrict access (tighter medical disability assessment, higher demands on occupational and geographical mobility in 1991; since 1988, sickness benefits exceeding 8 weeks have been conditioned on a detailed statement from the treating doctor, and since 1993, after 12 weeks a special judgement from the national insurance authorities has been required), and to expand flexibility. In 1995, new regulations on medical criteria for disability benefit awards had to be abrogated after a verdict of the Social Security Court (since then, medical criteria have been defined more precisely in the law). For the future, a group of experts have proposed far-reaching reforms, which have, however, been turned down by the government in favour of voluntary agreements to be formulated by the social partners. The group had suggested focusing on earlier vocational intervention (individual follow-up plan during the first 8 weeks); strengthening cost-sharing for sickness benefits (employers should carry 20% of the benefit after the first 16 days, employees should receive an 80% replacement rate during the first 16 days); introducing a temporary disability benefit for up to four years; and reconsidering the disability benefit claims of those younger than 50 years who were granted partial benefits during the last five years.

In Sweden, too, the 1990s were a period of very wide-ranging reform, including considerable change in the legal framework. One major trend was towards increasing the responsibilities of the employer, including obligations on work accommodation (amendments to the working environment act both in 1991 and in 2000), vocational rehabilitation (since 1992, rehabilitation analysis to be provided within the first 8 weeks of sickness, focus on workplace rehabilitation) and sickness benefit payment (employer period of 14 days, also since 1992). There was another major trend towards new rights and obligations for disabled persons, in particular as concerns vocational rehabilitation (right and obligation introduced in 1992), but also as provided in the 1999 Discrimination Act. Both of these trends should continue: the appropriateness of the legal instruments is being

analysed currently by two commissions; and there are preparations to make further changes in vocational rehabilitation with a stronger focus on the individual and one responsible person to aid them. Employment-related reforms were aimed at broadening the options for disabled people, especially but not only in the open labour market. Sheltered employment was strengthened in 1980 and 1985, employment subsidies were reformed in 1991 (greater flexibility in line with changes in work capacity, time-limited), and in 1998 supported employment became a regular programme (five years after it was launched on a trial basis). Benefit reforms were characterised by restricting access to benefits, both in the area of disability – especially in 1997 (tighter medical criteria) – and work injury (link to the sickness programme and tighter eligibility as of 1993). For the near future, very far-reaching changes are planned: disability and sickness insurance are to be merged; employers' responsibility for continued wage payment is to be increased from 14 to 60 days; and permanent disability benefit is to be abolished altogether and replaced by *i)* a temporary activity benefit with special work incentives for the 19-29 age group and *ii)* a temporary sickness benefit for those aged 30 and over.

Germanic policy approach: Austria and Germany

In Austria, employment-related reforms were focused on broadening employment options through the introduction of sheltered employment (in 1979) and supported employment or vocational counselling (in 1999, after various trial projects since 1992). Vocational rehabilitation reforms increased the rights and obligations of disabled people; the principle "rehab goes before pension" was introduced in 1996. Benefit reforms were characterised by various unsystematic changes in the application of own-occupation assessment in the disability benefit programme, albeit without challenging the concept itself. In particular, in 1993 a special early retirement programme on the basis of reduced work capacity was introduced (with a very generous interpretation of the term "own-occupation") but, following the large-scale use of this form of labour market exit, it was abolished in 2000. Since 1996, disability benefits generally have been granted temporarily unless someone is 100% disabled. The new government has commissioned an expert group that is in the process of completing its work. The draft report proposes the following: separating the disability risk from the retirement risk; introducing rehabilitation teams that start to act early on in the disability process and increasing the obligations for the disabled person; abolishing much of the own-occupation assessment (though not entirely); making the benefit formula independent of the insurance record (60% of insured earnings); and introducing a benefit for partially-reduced work capacity (only one partial level) and a special unemployment benefit for those on partial disability benefits who are unable to find a job.

In Germany, disability policy reform has gained considerable momentum in the second half of the 1990s (*e.g.* reduction in wage subsidies in 1994 and 1997), leading to far-reaching reforms in particular in the year 2001 and the introduction in 2002 of a new equal opportunity law for people with disabilities. In 2001, a whole range of rights and possibilities was introduced through a new law to fight the unemployment of disabled people. This includes a right to work assistance, workplace accommodation, part-time employment and early offer of qualification measures, but also more employer obligations and some changes to the employment quota. Vocational rehabilitation was made more efficient and accessible, first by abolishing the vocational guidance monopoly of the public labour market service (1998), and later on through improving the integration and co-ordination of the activities of the different responsible authorities (2002). Consequently, the right to vocational

rehabilitation has become more enforceable. On the benefit side, measures were taken to tighten access to disability benefits (1984) and to reduce benefits in the case of cumulation with other benefits (1992) or income (1996). A major reform initiated during the late 1990s came into force in 2001: own-occupation assessment was abolished (though only for people born after 1960), a new disability definition with an explicit distinction between full and partial benefits – related to the hours a person can work – was introduced, and it became mandatory to grant benefits on a temporary basis. As of 2003, a special non-contributory benefit for disabled people – similar to that in many other OECD countries – will be introduced. Finally, it is worth mentioning that recent reforms to the unemployment scheme (3% benefit reduction per year) and in particular to early retirement (abolition of most of these programmes) are likely to increase the pressure on the disability scheme.

Romanic policy approach: France, Italy, Portugal, Poland, Spain and Belgium

Only minor reforms have been implemented in Belgium during the last twenty years. In 1991, the National Fund for the Social Rehabilitation of Disabled People was dissolved and the responsibility for employment services and vocational rehabilitation devolved to the regional level (while medical rehabilitation, like social security, remained at the federal level). Since then, the range of programmes for employment in the open labour market has broadened in every region (new wage subsidy schemes, various supported-employment-type initiatives). A major disability benefit reform in 1987 abolished distinctions by type of disability and modified the conditions and types of benefits, with small-scale policy adaptation ever since.

In France, the most important employment-related reform took place in 1987 with the enactment of the Employment of Disabled Workers Law. This law introduced a new 6% employment quota (replacing a previous scheme that had not been enforced) and extended the obligation of employment to the public sector. At the same time, four other options to fulfil this obligation were introduced: paying compulsory contributions for under-fulfilment of the quota, (sub)contracting with sheltered employment entities, signing special collective agreements on an enterprise or branch level and accepting disabled trainees. A separate body (AGEFIPH) was made responsible for disbursing the funds collected through this scheme. The mode of financing of sheltered workshops was changed twice during the 1990s and is now again under consideration. In 1991, the subsidising of sheltered workshops was devolved to the regional level, and, in 1996, a central fund was established partially to guarantee loans contracted by sheltered workshops. Finally, in late 2000 different types of special employment services were regrouped and new outcome requirements specified, with the aim of making the placement of disabled workers in the labour market more efficient (CAP EMPLOI).[2]

Italy went through two very different periods. Following the introduction of sheltered employment legislation in 1991, the 1990s were characterised by a recognition of the importance of the social integration and rights of disabled people. Specific employment measures were eventually enacted in 1999, with a focus on abilities, targeted placement via a reformed employment quota and new employer responsibilities. These changes were partly a consequence of measures taken in the 1980s aimed at restricting a hitherto generous disability pension programme. A very comprehensive reform of the disability benefit scheme had already taken place in 1984: the earnings-capacity criterion was replaced by a work-capacity criterion, the (regional) labour market was no longer taken

into account in determining eligibility, the assessment procedure was made more stringent, permanent benefits were granted only to fully disabled people, while the majority of applicants were granted a much lower partial temporary benefit, with re-tests of disability status after three and six years. This was followed by a phenomenal decline in the size of the benefit population, which in turn led to reforms of the non-contributory benefit programme. The access rules for this programme were tightened (1988), and the re-testing of certain beneficiary groups led to loss of benefits in 25% of the tested cases (1996).

In Poland, there were considerable efforts during the 1990s to push active labour market measures and to increase employer responsibilities towards disabled people. In 1991, an initial comprehensive law established a mandatory quota scheme and a range of rehabilitation and employment programmes funded from levies collected from the quota system. In 1998, the range of support offered was further broadened. Considerable focus was put on sheltered workshops, which are viewed as providing suitable working conditions and medical care, while for the future it is planned to improve access to the open labour market. The social security system was considerably expanded in the last fifteen years. In 1990, a special retirement and disability benefit system for farmers was introduced, along with social pensions for disabled people not covered by any other system (as part of the social assistance scheme, but not means-tested). In the early 1990s, disability benefits functioned as a major labour market instrument (there was very easy access for farmers, who make up a considerable proportion of the workforce). Since 1997, a new disability assessment procedure has been used to keep inflow onto this scheme under control. Following a radical old-age pension reform in 1999, the disability programme became a separate insurance scheme, although benefits are still calculated according to the old system. Rules governing entitlement to sickness benefits were also tightened in 1999.

In Portugal, more or less all currently existing employment-related measures were introduced during the last two decades (employment subsidies in 1982, the sheltered employment programme in 1983, a legal basis for the vocational rehabilitation system in 1989, a quota in recruitment for public administration services and bodies in 2001). Several initiatives are at the planning stage, including new wage subsidies, a supported employment scheme, and a network of specialised institutions that are to help increase the effectiveness of vocational rehabilitation and training. On the disability benefit side, measures were taken to increase coverage (special regulations for certain diseases in 1990, 1998 and 2000) and security (introduction of minimum benefits in 1983, 1993 and 1998). At the same time, several attempts were made to make benefit access more stringent (implementation of a new three-stage assessment procedure in 1987, extended to cover the sickness period in 1992, and harmonisation of assessment procedures in 1997 – the so-called verification of incapacity system) and to strengthen anti-fraud controls. Recently, a new dependency complement was created for severely disabled people, which is paid according to two levels. Gradually benefits will be based on the entire contribution record (40 years, rather than on the best 10 of the last 15 years), with different accrual rates (ranging from 2% to 2.3%), according to income level. There are also plans to adjust minimum pensions and means-tested social pensions to the level of the national minimum wage.

Trends in Spain are characterised by a gradual expansion of labour market integration measures for disabled people – both through mandatory measures (*e.g.* compulsory employment quota introduced in 1982, preferential treatment of recovered benefit recipients in 1983) and incentive instruments. In the second half of the 1990s, there was more emphasis on service orientation to provide complete pathways to integration. For the

near future, regulation of supported employment, in particular for mentally disabled people, is envisaged. In addition, the aim is a greater focus on prevention, retention and workplace adaptation; better co-ordination of different measures; and a more active role for the private sector. Social-security-related reforms were characterised by continual efforts to make benefit application less attractive and long-term benefit dependence less likely (*e.g.* more insurance requirements in 1986, a reduced short-term sickness benefit level, stricter control of sickness status, and a slight change in the definition of own occupation – "usual" rather than "own" job – for a disability benefit in 1997). In addition, the scope of action of the "mutual work insurance companies" (*Mutuas de Accidentes de Trabajo*), which only used to be allowed to manage work-related sickness and disability, was broadened. Their role is likely to continue to increase in the future (note that it is the employer who can choose between public management and management by these private mutual insurance companies).

Mixed policy approach: the Netherlands, Australia and Switzerland

In Australia, the 1990s were a period of wide-ranging reforms, including considerable change in the legal framework. In 1986, a framework that articulated the rights, responsibilities and expectations of disabled persons and disability services providers was set up. In 1992, anti-discrimination legislation that had a major impact on employer obligations was introduced, which was supplemented by a workplace modification scheme

Box 7.1. **Ongoing and recently announced changes in Australia**

Various new interventions are on trial to further improve the individual focus and outcome of employment and rehabilitation programmes: 1) A quality assurance system, with possibilities to audit and certify service providers using prescribed service standards. 2) Case-based funding of services to develop a more equitable funding scheme (with three instalments: a commencement payment, an outcome payment and a maintenance payment), which is linked to individual needs, with three levels of funding. 3) New approaches to assessing the needs and work ability of people with disabilities (for pension and intervention) and to identifying appropriate interventions through case management. 4) Examination of the capacity of the private rehabilitation market to provide contestable services (contestability trials).

With the delivery of the 2002-2003 Budget, the government has announced several new changes, which are subject to the passage of the necessary legislative amendments. People who apply for a disability support pension (DSP) on or after 1 July 2003 will need to meet new eligibility criteria. These criteria will restrict DSP to new claimants with a very restricted capacity to work (of 15 hours a week at full wages, down from the current 30 hours threshold). This change will not apply to current recipients of DSP and those who lodge a claim before this date. For applicants aged 55 years and over, local labour market conditions will no longer be considered in the assessment of their work capacity. These changes will be complemented by broadening the range of both specialist and mainstream interventions to improve work capacity, and up to 73 000 extra places will be created in vocational rehabilitation, education and training, employment assistance and pre-vocational programmes.

a few years later. Employment-related reforms were aimed at broadening the opportunities for disabled people by introducing new programmes (*e.g.* wage subsidy scheme in 1993), adding places to existing programmes (especially with the 1991 Disability Reform Package) and working in various ways to improve the quality and outcome of services. Benefit-related reforms were characterised by tightening eligibility criteria for disability benefits, again through the 1991 Disability Reform Package, but also in 1997 and 1998 (new claim assessment model, stricter assessment process). Restructuring the programmes and tightening access to non-disability-related benefits has indirectly affected application for disability-related benefits (Box 7.1).

The Netherlands is another country in which the intensity and speed of reform substantially increased in the mid-1990s (Box 7.2). Until the late 1990s, employment-related reforms were characterised by efforts to increase the efficacy of the very large sheltered employment programme, the only existing employment measure at that time (1981 programme simplified, 1984 funding levels restricted, 1989 more business-like management introduced, 1998 full responsibility given to municipalities that receive subsidies per person employed in a sheltered environment). Also in 1998, with the enactment of the law on re-integrating work-disabled persons, a total policy change was instigated, aimed at broadening access to employment for various groups, in particular including those already on benefits: a new supported employment programme was launched; several elements of subsidised employment were established; and much more emphasis was put on vocational rehabilitation (upon the responsibility of the employer, with consent from the social insurance authorities). At the same time, the voluntary quota scheme, introduced in 1986, was abolished. Reforms of disability benefit aimed at lowering benefit recipiency through restricting access (*e.g.* criterion to look at concrete availability of commensurate jobs eliminated in 1987, own-occupation assessment abolished in 1994) and through changing incentives for employers and potential beneficiaries. Incentives for potential applicants were reduced by lowering benefit levels (though this was to a considerable extent offset by collective agreements providing for top-ups) and making benefit awards temporary (though they are still *de facto* permanent). As for employer incentives, there was a gradual privatisation of the costs for the mandatory sick pay period until 1996 (following the introduction of experience-rated premiums to the sickness insurance programme in 1992). In 1998, premiums to the disability benefit programme were also changed to reflect employers' experiences (this scheme had a predecessor between 1992 and 1996 – a bonus-fine scheme, with a bonus for employing a beneficiary and a fine for producing a beneficiary).

In Switzerland, disability policy has only changed at the margin during the last two decades, reflecting the comparatively low levels of benefit receipt until recently. Employment policy is still based largely on voluntary action, although a special anti-discrimination clause is in preparation. The only change in vocational rehabilitation was making these schemes accessible to people with congenital disabilities (1987). One important benefit reform was the introduction of a mandatory, general work injury scheme in 1984 (until then existing only for special groups of employees). The disability programme has seen the introduction of "one-quarter" benefits in 1986, in addition to the existing full and half benefit; attempts to abolish this new benefit category for partial disability in 1999 remained unsuccessful. A major reform of the disability administration took place in 1995, when decentralised one-stop shops were established in each canton and given full responsibility for rehabilitation and benefit awards – and, in doing so, a new funding

Box 7.2. **Continued reform initiatives in the Netherlands**

Given the continued increase in the number of disability benefit recipients, notwithstanding the various reform steps taken during the 1990s, an expert group on disability benefit reform was commissioned in early 2001. The committee, led by Mr. Donner, published its report, "Making work of labour ability", in June 2001. Its recommendations are based on the premise that the recovery and re-integration of available labour capacity has the highest priority, and that employer and employee together are responsible for securing the best use of labour capacity. The thrust of the proposal is i) to introduce new responsibilities for both the employer (*e.g.* wage payment continues if the employer does not comply with his duties) and the employee (*e.g.* non-co-operation can lead to benefit cuts and even dismissal), with a strong focus on preventive measures, and ii) to drastically reform the disability benefit scheme. This benefit reform includes replacing the earnings-capacity criterion by a functional work-capacity criterion; abolishing partial benefits (only permanent and full loss of work capacity will generate disability benefit entitlement); abolishing re-examinations as well as rules regarding wage income earned in addition to any benefit; separating work injuries (which are to be covered by compulsory private insurance) from general disabilities; and abolishing the experience-rating of premiums to the general disability scheme. Employees not entitled to disability benefits could, if their job cannot be secured or no new job found during a two-year intervention period, be dismissed and would then be covered by unemployment benefits and services for the unemployed instead. This proposal is rooted in the assumption of considerable misuse of the system, and the belief that this type of misuse can be stopped with appropriate incentives. It is based on very strong mutual obligations for employers and employees, thus creating new challenges (*e.g.* to determine whether obligations have been fulfilled), but also new problems for those people without a labour contract. In addition, a solution would have to be found to determine full and permanent disability in a proper way without putting pressure on gatekeepers to assess such a status in order to create the possibility of a disability benefit.

In response to this proposal, the Social Economic Council (SER) published an agreement that uses some of the ideas of the so-called Donner proposal, but adds considerable new elements. While accepting that disability benefits are only granted to people who are fully (80% or more) and permanently (at least 5 years) disabled, a new benefit is introduced for people with a substantial capacity loss (35-80%). This new benefit would be paid by a private insurance scheme specially created for this purpose. This group shall receive 100% of final salary during the first year, and 70% during the second year. Top-up payments during this second year are to be forbidden. After the second year, the worker will get a salary proportional to his/her actual working hours, topped up by payments from the new private insurance. Governmental activation regulations are to be set up for this group. If employment with either the previous or a new employer is not possible, this group is entitled to unemployment benefits. Employers and employees (at the organisational level) share full responsibility for people with minor reductions of work capacity (less than 35%). In addition, the benefit for fully disabled people would be increased from 70 to 75% of the wage, and the experience-rating of premiums to the disability programme would be abolished, in spite of the fact that work injuries are not treated in a separate programme. The disability benefit for fully and permanently disabled people is to be paid from the government budget.

Box 7.2. **Continued reform initiatives in the Netherlands** *(cont.)*

A major problem with this SER agreement is the perplexing incentives that would be created for the newly established private insurance for people with substantial work incapacity. The top-up benefit is only paid in addition to any income from work, creating incentives in this private insurance for re-integration to fail (if the person in question does not work, no entitlement for the top-up benefit arises, but instead a benefit from unemployment insurance is paid). Further problems arise from not separating work injuries from general disabilities, putting people with work injuries of less than 35% work incapacity in a difficult position, and taking away the argument for abolishing the experience-rating of premiums. In addition, people with substantial work incapacity who have not been able to keep their job or to find another job and thus have been transferred to unemployment benefits will be in a difficult position, as will people judged to be temporarily fully disabled. People without a labour contract would experience the same kind of disadvantage in this agreement as in the original proposal.

The extent to which the new government draws on these recent initiatives and agreements remains to be seen.

structure was complemented by a well co-ordinated structure of responsibilities between the different tiers of government. In the future, major efforts are planned to eliminate the remaining inconsistencies in this exemplary structure. These anticipated reforms include both the introduction of regional medical offices (covering several cantons) under the direct supervision of the federal disability authority in order to harmonise assessment procedures, and the introduction of quality criteria, performance goals and an information management system for the cantonal insurance offices.

7.3. A new reform strategy in Luxembourg

Luxembourg, a country with generous sickness as well as disability insurance benefit systems with own-occupation assessment and relatively minor insurance requirements, has not participated in this project. Nonetheless, in the following section a recent reform initiative to improve the labour market (re)integration of working-age disabled persons is described in some detail – because it is interesting, but also because it is in many respects very much in line with the policy conclusions drawn at the end of this report (see Chapter 8, Section 8.2).

The proposed law (due to be discussed in parliament later this year) envisages a series of stages accompanied by different types of benefits. The *first stage* sets in during sick leave: by the fourth month of sickness the worker must take a medical exam. If the worker is found able to return to work, sickness benefit payments are stopped (and administrative procedures in case of contest are accelerated). If the exam shows that the sickness is likely to continue, sickness benefit continues to be paid and another exam is scheduled at a later date. If the worker is found disabled, application for a disability pension is launched. In the *second stage*, two different outcomes are possible: either the worker is indeed found eligible for a disability pension and the work contract is dissolved; or the worker is found not disabled in a general sense. In the latter case, further exams are conducted to see whether the worker can return to the previous job.

Inability to continue to work in the previous job will lead to the *third stage*, the reclassification of the worker. Internal reclassification, *i.e.* in the same enterprise, is compulsory for all companies with more than 25 employees. If the new job pays less than the previous one, the Labour Fund pays a compensatory benefit to make up the difference (up to five times the social minimum wage). In addition, the reclassified worker enjoys special protection from dismissal during one year. The employer is entitled to special support as well as special tax deductions; on the other hand, sanctions (half of the social minimum wage during a maximum period of 24 months) may be imposed on employers who fail to comply with their obligation to internally reclassify their disabled workers. If internal reclassification is not possible, the worker is registered as unemployed with the Labour Office and entitled to unemployment benefits while the search for other suitable employment continues. If such employment can be found, disabled workers and their employers are entitled to the same benefits as in the case of internally reclassified workers. Compensatory benefits are calculated according to the previous wage and regardless of the level of unemployment benefits the worker received in the interim. The *fourth stage* applies to cases where the disabled person could not be placed in alternative employment during the legal duration of unemployment benefit payments. In this case, the worker is entitled to a waiting allowance, which corresponds to the level of a disability pension. The disabled worker, however, has to remain available for any placement attempts, and the waiting allowance will be stopped once a suitable occupation is found. The waiting allowance is not paid by the Labour Fund, but by the pension insurance scheme.

The financial consequences of these new measures depend heavily on whether vocational re-integration is successful. The compensatory benefit and the waiting allowance as well as support and tax deductions for employers entail additional expenditures, but savings can be expected since sickness benefits will not necessarily be paid for a full year anymore and successful re-integration into the labour market will reduce disability pension expenditures. In the short to medium term, higher spending will also be required to improve medical assessments of disability, speed up administrative processing of disability benefit applications and better assist disabled workers in the reclassification process.

Notes

1. "Continued recognition of disability status" refers to a situation in which disability continues but benefits can be interrupted when a recipient takes up work. Benefit payments immediately resume should the person turn out to be unfit for work. Such regulations are designed to increase the incentive to try out work, while the benefit entitlement remains fully intact.
2. Note that information on social-security-related reforms in France was not provided.

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Chapter 8

Policy Conclusions

Abstract. *In Chapter 8, strategies for a coherent disability policy mix are developed that seek to resolve some of the problems and obstacles identified in the previous analytical sections. An approach is suggested that tries to overcome some of the problems and obstacles identified in the analytical chapters, and that aims to reshape disability policy based on a framework of mutual obligations.*

8.1. Policy principles

To improve the integration of disabled persons, societies need to change the way they think about disability and those affected by it. The term "disabled" should no longer be equated automatically with "unable to work". Disability should be recognised as a condition, but it should be *distinct* from eligibility for, and receipt of, benefits, just as it should not *automatically* represent an obstacle to work. A disabled person's health status should, if necessary, be re-tested at regular intervals, independently of whether or to what extent the person is working.

This concept of unbundling disability and benefit receipt would shift the character of disability policy away from a passive approach towards a stronger emphasis on activation measures. It would also help solve another problem: in many countries, rehabilitation and vocational training are only available to persons who have been insured in disability insurance systems or to persons receiving some kind of disability benefit. The full range of disability-related benefits and services should be available to every person with a disability, according to their individual needs but regardless of their work situation, insurance status or benefit receipt.

This change of paradigm will require a fundamental rethinking and restructuring of the legal and institutional framework for disability policy in many countries. It will only be effective if it is accompanied by a change of attitude of all actors involved in disability issues. Most societies readily accept their obligation to make special efforts to support and (re)integrate disabled persons, but it is less common to expect disabled people themselves and, when necessary, their employers, to contribute to the process as well.

In the logic of social insurance schemes, the insured person has a right to benefit payments once the insured risk, *i.e.* a disabling condition, occurs. This right is earned through payment of contributions. With the unbundling approach – which, in fact, many countries with social insurance schemes are already moving towards – contributions to disability insurance still earn entitlement, but do not necessarily result in a fully or partially income-replacing benefit. Instead, the insured person is entitled to individually-tailored assistance aimed at re-integration into the labour market. Income support is provided to the extent to which these efforts have not wholly succeeded or are inappropriate due to the severity of the disability. In most cases, the assistance will consist of a mix of activation measures, cash transfers and services.

At the same time, co-operation should be expected of the insured person, in particular if only a partial benefit is awarded because the person is judged to be not fully disabled. Just as the assisting caseworker has a responsibility to help the disabled person find an occupation that corresponds to his or her capacity, the disabled person is expected to make an effort to participate in the (re)employment process. Failure to do so would result in sanctions in the same way that the failure of society to provide work results in an obligation to pay the disabled person a cash transfer. An obligation to co-operate, however,

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does not mean that any disabled person, particularly those with severe disabilities, will be forced to work, nor will sanctions result in full benefit withdrawal.

In some means-tested disability schemes, the method of income testing may have to be reconsidered if the mutual obligations approach is applied. As the focus is on the disabled person and on the degree of their capacity to participate in the labour market, individual income-testing that takes into account the capacity of the beneficiary to earn income from work may be more appropriate than household-based means-testing. A disabled person not entitled to any transfer payment because of other household income sources cannot be obligated to participate in integration programmes. Also, in some means-tested schemes, non-eligibility for benefit bars access to certain rehabilitation or employment measures; this would have to be changed.

Involving the employers is crucial for the (re)integration of disabled persons. There is less unanimity, however, about the best way to achieve this goal. Different approaches exist, ranging from moral suasion and anti-discrimination legislation to compulsory employment quotas. The effectiveness of the measures depends on the willingness of employers to help disabled persons stay in or enter work, but also on the possibilities of circumventing legislation or paying the fines imposed for non-compliance. Striking the proper balance between promoting employment and imposing undue hardship on employers is a major policy challenge, especially because protective regulations may lead to further discrimination against disabled persons in the hiring process. Stronger trade union involvement in representing the interests of disabled persons may also be helpful to the success of activation policies in some countries.

Even with a stronger emphasis on activation measures and mutual obligations, however, the success of disability policies depends on a range of other factors. In particular, disability programmes cannot be expected to solve broader problems in the labour market, such as a high level of overall unemployment or low demand for older workers in general. Most countries have been considering work or earnings-capacity reduction and the "actual labour market situation" in the award of disability benefits, but there has not been much emphasis on activation policies. In fact, an unfavourable "actual labour market situation" has often served as an argument to apply less stringent assessments of work capacity and grant income-replacing benefits without making further efforts at re-integration. Societies and policy makers should be honest about what job opportunities can be offered to middle-aged disabled workers, and in some cases, it might simply prove impossible to find appropriate work for the disabled person.

Even if one acknowledges that some disabled persons will remain out of work, this does not mean that there is no room for policy improvement. Some groups in particular have received almost no help at all; in few of the participating countries are persons over the age of 45, for example, considered for vocational rehabilitation and training programmes. While it may be more efficient – given limited budgets – to concentrate re-integration efforts on those groups that have the highest chance of returning to work, this does not justify discrimination against older persons or any other groups selected purely on the basis of non-work-related criteria. Instead, selection should be based on the individual's capacities and chances to return to work, which may be as good or as bad for an older person as they are for a younger disabled person.

In adopting these principles, disability policy would undergo a profound change. Until recently, disability benefit systems functioned much like early retirement programmes, in

that they provided a route for quasi-permanent exit from the labour market. Emphasising activation policies and introducing the notion of the mutual obligations of both society and the disabled person moves disability policy closer to the philosophy of unemployment programmes, which also expect an active contribution by and effort from beneficiaries. Disability programmes should operate to discourage exclusion from the labour market and prevent social isolation by encouraging work and other forms of participation in society.

8.2. The constraints under which disability policy operates

In trying to shape policy according to these general principles, disability policy makers have to operate under a number of constraints, for which no easy solutions exist.

- *Disability is notoriously difficult to assess*. Actual "true" knowledge of a person's health status and its impact on work capacity is difficult to determine. This is particularly true for many of the newer mental illnesses as well as many physical stress-related conditions like lower back pain, which are on the rise in most countries. Diagnosis of these disabilities is difficult, as are any predictions of how these conditions may evolve in the future. These problems can be reduced, but not fully avoided, through the involvement of a wider range of medical specialists and vocational experts.
- *Even after unbundling disability status and benefit eligibility, the problem of exclusion and inclusion errors will persist*. Due to difficulties in assessing health status and work capacity, errors of both exclusion (*i.e.* refusing benefits and services to people who need them) and inclusion (*i.e.* granting benefits to people who do not need them) are made. A disability benefit system with stringent access rules and restricted coverage will result in low benefit rolls and less benefit dependence and, thus, a small inclusion error but potentially a large exclusion error. The opposite is true for systems with easier access and wide coverage. This problem can be partly addressed but not eliminated through more flexible menus of benefits and services coupled with frequent re-testing.
- *The target group is extremely heterogeneous*. In the general debate, disability is often associated with persons suffering from severe congenital and permanent disabilities. But this group constitutes the minority of disabled persons: many more people become disabled at a later stage in their lives. Some disabling conditions are reversible, others irreversible, some occur suddenly, others develop gradually, and some are, of course, severe and others moderate. To address the labour market problems of disabled persons effectively, it also matters whether the disability occurs while a person is in employment or not, whether the person has been inactive for some time, or perhaps has never worked. While those who become disabled in employment can build on an existing employer-employee relationship, persons out of employment need more assistance in finding work and may not even be aware of their eligibility for certain benefits. Another important characteristic – in practice, though in theory it should not be – is the age of the disabled person; middle-aged disabled persons have much lower chances of finding suitable employment. Thus, disability policies that take a uniform approach towards the disabled are bound to fail; highly individualised solutions will be more effective but also more demanding in terms of time, effort and cost.
- *Labour market integration may be very difficult or virtually impossible for certain groups*. Efforts to bring disabled persons (back) to work reach their limits if the labour market cannot absorb the supply. In principle, probably every disabled person who wishes to participate in the labour market can be brought into some form of employment – sheltered or

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subsidised if necessary – but for some cases this may require more resources than a society can or wants to devote to this policy area. Further it is clear that not all disabled persons, especially those with severe disabilities or in the acute stage, may want to (re)enter employment since it may require a disproportional personal effort. Acknowledging these limits provides a further reason for restructuring and increasing effectiveness of the expenditure on disability policies.

8.3. Reshaping disability policy based on mutual obligations

This section discusses several, more specific reforms that should be taken in line with the proposed policy principles. The recommendations try to take account as much as possible of the wide range of existing disability policies and benefit systems in the participating countries. It is clear, however, that each country has to find its own way to adopt the general policy principles outlined above.

The proposed reform measures are grouped according to eight policy objectives:

- Introduce a culture of mutual obligations;
- Recognise the status of disability independently of the work and income situation;
- Design individual work/benefit packages for disabled persons;
- Promote early intervention;
- Involve employers in the process;
- Restructure benefit systems to remove disincentives to work;
- Reform programme administration;
- Improve co-ordination of transfer schemes.

Introduce a culture of mutual obligations

The approach of mutual obligations, in particular the emphasis on the beneficiary's obligation to co-operate in the rehabilitation and (re)employment process and if appropriate to make an effort to (re)enter the labour market, is being adopted by many countries in the areas of unemployment and social assistance programmes. In disability policy, the approach is still less common, but it is slowly gaining momentum.

Introducing mutual obligations in disability policy means that society will have to make more effort than merely paying cash benefits to ensure the economic well-being of disabled persons. Disabled persons need to be given the help necessary to participate in work and, where this is not possible, other forms of social activities and actions should be offered in order to prevent the disabled person from becoming isolated and excluded from society.

On the other hand, benefit receipt should be conditional on participation in these rehabilitation and employment measures. Active participation is the counterpart to benefit receipt. This implies that beneficiaries who fail to co-operate in (re)integration efforts could face sanctions in the form of benefit reductions. Clearly, any such sanction would need to be administered with due regard to the person's basic needs and to those of dependent spouses and children. Furthermore, sanctions would not be justified in any case where an appropriate integration strategy had not been devised, or proves impossible to formulate due to the severity or acuteness of the health condition. But if disability benefit systems are to cease serving as a path to permanent withdrawal from economic activity, attention to the mutual obligations of benefit administrators and beneficiaries is essential.

Several countries use elements of mutual obligations in their policy setting. Participation in vocational rehabilitation measures, for instance, is compulsory in a number of countries (Austria, Denmark, Spain, Sweden, Switzerland, and in a mitigated form also in Germany and Norway), and disability benefit settlement is conditional upon completion of the vocational rehabilitation process. In most cases, however, this obligation is administered with great flexibility and subjectivity, *e.g.* as to the age or the employment experience of the disabled person.

Recognise the status of disability independently of the work and income situation

The former medical model of disability, according to which disability is a biological characteristic of the individual, has recently been replaced by a social model, which looks at disability as an attribute resulting from the interaction between the individual and the social and physical environment (see also Annex 1). This social model explicitly distinguishes between biological difference (body functions, *i.e.* impairment, and body structures, *i.e.* functional limitations) and the interaction with the social and economic roles of the individual (activities and participation, *i.e.* handicap, and "environmental" factors which for example comprise policies as well as issues of accessibility).

Disability assessment should reflect this new model. Functional limitations should be assessed on medical grounds, and a wide range of medical specialists with particular competence in "new" and sometimes more difficult to diagnose diseases should be available to perform this assessment. In a second step, an assessment of work capacity should determine the degree to which the disabling condition affects the person's ability to work, in this case involving specialists for such vocational reviews.

The recognised disability status resulting from this two-step procedure should remain unaffected by the type and success of work-related measures, unless a medical review certifies changes. This approach would allow beneficiaries to "risk" taking up work even if they are not sure to be fit for work. In addition, the disability status itself should be the basis for certain benefits that are designed to compensate the extra costs of the disabling condition, such as special costs for medication, care or mobility. Benefits for these purposes should not be related to the work status of the disabled person, should not be means tested, and should be paid as long as the condition exists, *i.e.* as long as the additional costs arise.

The disability assessment should be repeated at regular intervals to determine whether the person's functional limitation and/or the work capacity resulting therefrom has changed. These re-assessments should be handled flexibly at the level of both the individual and the nature of the disability; re-testing is unnecessary if the disabling condition is permanent. Regular reviews to determine the person's ability to participate in different types of activities (*e.g.* rehabilitation, training, employment) are likely to lead to changes in the beneficiary's work/benefit package over time. If a review finds considerable health improvement, or if the vocational outcome of a stable health condition is judged differently, for instance due to the availability of new supportive technology, active intervention should be re-initiated. The aim of the re-test is not so much to withdraw benefit payments as to identify people who should (again) be offered training, rehabilitation or re-employment services.

Some of the participating countries have recently moved in the direction of unbundling disability status and benefit receipt. Countries use different terminology, such

as "linking rules" (United Kingdom), "let the pension rest" (Denmark) or "freezing a disability pension" (Sweden) to allow for the possibility of keeping the disability status while trying to work – with the option to go back on benefits should the person lose their job or should work not be acceptable. But all of these models are limited in time, with a maximum of three years in the Netherlands, Norway and Sweden. Currently, Canada is the only country where at least a fast track re-application process – *i.e.* a process for repeated disability benefit application, which is less comprehensive than at the initial stage – is available without any time limitation.

To some extent unbundling disability status assessment from the person's work and benefit status is also taking place in most countries with a mandatory employment quota that use a disability registration system to determine eligibility for placement under the quota scheme. This registered disability status is kept irrespective of the work status. There are large differences between countries, however, as to the extent to which this status opens entitlement to other benefits. Often it would enable the person to access a whole range of employment programmes. In Germany, it also means access to a special pension benefit five years before the statutory retirement age. In Austria, the registered disability status is lost once the person starts a vocational training programme or becomes entitled to a permanent disability benefit. Such automatic consequences are counter to the recommendation to delink the disability status from the entitlement to services and/or income replacement benefits.

More frequent re-testing of the disability status has also been introduced in several countries. To date, however, disability benefit outflow rates do not seem to have been affected significantly. Anecdotal evidence suggests that re-testing was often legislated but not properly resourced, which means that the policy change was only partially implemented.

Many countries are also paying benefits that are based on disability status alone and not related to work status. Interesting examples of this type of benefit are the attendance allowance in Austria, which varies with the degree of care needed, and the disability living allowance in the United Kingdom, which consists of a mobility and a care component at several rates. Similar forms of supplements, compensation payments or constant-attendance allowances exist in several other countries (*e.g.* the Scandinavian countries, Belgium, Germany, Italy, Korea and Portugal). By and large, however, these benefits are designed to compensate only very high costs for daily care and are thus generally only accessible for a small group of severely disabled people. Assessment for these benefit entitlements is usually separate from any other disability assessment and thus often not adequately integrated with any other policy component.

Design individual work/benefit packages for disabled persons

Each disabled person should be entitled to a "participation package" adapted to individual needs and capacities. The package should contain rehabilitation and vocational training, work elements from a wide range of forms of employment (regular, part-time, subsidised, sheltered employment) and cash or in-kind benefits. It could also contain activities that are not strictly considered as work but contribute to the social integration of the disabled person.

The cash benefit part of the package would be determined depending on the disabled person's capacity to work, but also needs to take into account whether the person has

actually been able to find a job. Most countries would also want to take into account the level of the beneficiary's previous income from work. Thus, cash benefits would have to be available with sufficient flexibility to take account both of different cases of remaining work capacity and of the evolution of an individual's disability status over time. Benefit entitlements should be designed such that the disabled person is not penalised for taking up work, *i.e.* after-tax income including all transfers should not be lower than the income that the person received while out of work.[1]

The new policy proposal in Luxembourg (see Section 7.3) suggests reform in this direction, by providing a compensatory benefit that is aimed at compensating for the difference between pre-disability and post-disability pay in cases where a person was transferred to a lower level job. In addition, payment of a waiting allowance is proposed to disabled people judged able to work but unable to find a job – a payment corresponding to unemployment compensation but at a level equivalent to a disability pension.

Some countries have tried to ensure access to a wider range of disability-related services through legislation that gives disabled persons a legal entitlement to certain services. In Germany, legal entitlements to workplace accommodation, vocational rehabilitation and supported employment were recently established. In Sweden, an obligation to provide workplace accommodation and vocational rehabilitation was imposed, though in this case on employers. Vocational rehabilitation is a right, at least for some groups of disabled persons, in several of the countries where such intervention is mandatory before benefits can be granted.

Tailoring individualised labour (re)integration packages will only be possible if special, small-scale, focused programmes are available. Many countries have recently mainstreamed their programmes by requiring all general labour market programmes to be accessible to disabled people. For this strategy to succeed, special support for disabled persons in these programmes may be required and additional more specialised qualifications for caseworkers may be needed.

More permanent on-the-job support is necessary for many disabled persons participating in the regular labour market. Supported employment-type initiatives, such as individual job coaches and personal help for various work-related and social activities, appear to have strong potential. In Denmark, for example, a personal assistant with a regular employee contract can be hired to assist in occupational tasks; this type of assistance is unlimited in duration, and granted for up to 20 hours per week for a full-time job. Permanent accompanying support is also available in some other countries, but for significantly fewer hours per week.

Promote early intervention

The evidence has shown that in many countries disability benefit systems have functioned as a quasi-permanent exit route from the labour market. To some extent this is a consequence of the demanding, comprehensive assessment procedures that have to be passed before a benefit is awarded. As these procedures are being made more stringent, it will be even more difficult to increase benefit outflow. But the timing of activation measures also plays an important role. The longer a disabled person stays out of work, the lower will be the chances of re-integration.

The most effective measure against long-term benefit dependence appears to be a strong focus on early intervention. As soon as a person becomes disabled, which can mean

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immediately after a certain disabling event or, more commonly, at an early stage of a disease or a chronic health problem, a process of tailored intervention should be initiated. Medical rehabilitation requires a certain stabilisation of the medical condition and, thus, will be initiated after medical treatment. If necessary, vocational (re)training and rehabilitation, in contrast, can be launched concurrently with medical treatment to avoid occurrence of the worst case, *i.e.* that the person becomes unable to work.[2] In the course of the process, the participation plan can be adjusted to changing circumstances. Several countries (Denmark, France, Portugal, Sweden and Switzerland) have even introduced a specific benefit that is paid during the rehabilitation period. An added advantage of a special rehabilitation or training allowance is its special eligibility conditions; such benefits can cover the entire population and can easily be disconnected from other benefit schemes.

Early "in-work" intervention is most common in Germany and Sweden, where rehabilitation schemes are explicitly designed to kick in early. Norwegian active sick leave, to give another example, is designed to prevent long-term disability by combining sickness absence with either of two types of intervention: adjustment of tasks at the regular workplace, or vocational rehabilitation. Sickness benefit payments can be stopped if the claimant rejects rehabilitation measures. In Belgium, sickness benefit can be put on hold for up to 14 days during which the beneficiary can try to take up work again without loss of benefit entitlement. This is a strong incentive to try to work, from the point of view of the employer, who would not have to go through a new cycle of guaranteed wage payment, and also the employee, as these periods count as a waiting period for disability benefit application. To go back on benefit, the treating doctor has to certify that the deterioration of health status is due to the initial cause of work incapacity.

In many countries, in contrast, the period of sickness absence is "lost", because vocational intervention, if any, starts only when a person is potentially entitled to or paid a disability benefit. This means that, in some cases, the affected person will remain inactive for up to a year without any disability-related services. If a participation plan were started immediately, be it under the responsibility of the employer, like in the Netherlands and Sweden, or under the responsibility of the disability benefit or rehabilitation authority, the chances of re-integration would increase.

Involve employers in the process

Existing employer-employee relationships should be utilised as much as possible, both through positive incentives and through mandated obligations. Many countries have regulations that legally oblige the employer to make an effort for disabled employees. In Italy, employers were recently made responsible for assigning the disabled person equivalent tasks, or, if that is not possible, lower-graded tasks but under the previous conditions. Similarly, Swedish employers must provide reasonable accommodation of the work(place) or, if possible, a different job in the company. In Germany, employers have a general obligation to promote the permanent employment of disabled employees – via provision of adequate workplaces according to skills and capabilities, and both preferential selection for in-house training and support for external training. And in France, employers with at least 5 000 employees are obliged to offer (re)training to make sure that persons hit by a disease or an accident can either keep their job or be transferred to another job in the same company.

In practice, however, many of these regulations are difficult to enforce, despite the possibility that employers who do not comply will be sanctioned. Most regulations contain

wording that is open to interpretation, and it has to be determined from case to case what constitutes undue hardship on the employer or whether it is really impossible to accommodate a person's disabling condition in the company. The same holds true for anti-discrimination legislation, which is often undermined by the undue hardship clause. Even in those countries that have mandatory quotas for the employment of disabled persons, fines for non-compliance are often so low that employers may find it easier to pay than to make an effort.

Apart from legal loopholes, another reason for ineffectiveness appears to be that employers need help to fulfil their obligations. Workplace and job adjustments generally require small financial investments. More crucial are technical assistance and guidance, including assessment of the problem and development of an intervention strategy for the participation plan. Recent disability management service pilot programmes in the Netherlands, which aim to match job requirements with the disabled person's possibilities, are a good example.

Employers who make an effort to (re)employ disabled persons should not be penalised financially *vis-à-vis* employers who fail to make an effort. In some cases, compensation payments for the higher cost of employing disabled persons may therefore be appropriate. The justification, however, would depend on the system in the individual country. If quotas or strong anti-discrimination legislation exist, for example, compensation payments would theoretically be unnecessary or even inconsistent with the legal obligation.

Special employment protection for disabled people per se, on the other hand, will only help people to stay in work or go back to their workplace if accompanied by individual assistance. The Netherlands has had a negative experience with a regulation forbidding employers to dismiss an employee because of sickness during a period of two years. Without activation support, the regulation proved ineffective; it merely shifted costs and delayed the transfer of the beneficiary to a long-term disability benefit. People often waited on sickness benefits without any intervention until applying for a disability benefit – a problem that Dutch policy makers have been addressing with several reforms since the mid-1990s.

Employer involvement can also be influenced by financial incentives to invest in prevention and retention measures, *e.g.* promotion of life-long training accessible to all employees. Obliging employers to continue wage payment during the first phase of the sickness absence period is a strong incentive. Austria (with continued wage payment for up to 12 weeks) and Germany (up to 6 weeks) are the most striking examples, as there is no re-insurance possibility for the employer. Employers are thus directly confronted with the cost of sickness.

The optimum length of such a wage payment period is difficult to determine. Six months may be too long, since such a long absence is likely to require a replacement, while two weeks – like in the Scandinavian countries – may be too short. Full reinsurance of these costs with a private insurer may undermine the policy goals. In the Netherlands and the United Kingdom, where employers bear full responsibility for sick pay for one year and 28 weeks, respectively, experience has shown that re-insurance can lead to considerable socialisation of costs as long as insurance premiums are not differentiated at the level of the company. This would reduce the incentives for investing in prevention.

Shifting some of the costs of sickness absence onto employers may lead to discrimination in the recruitment process against anyone likely to need sick leave. There

are various possibilities to overcome this problem. First, discrimination in hiring can be countered by excluding critical risk groups (former disability benefit recipients, people with chronic diseases, people with repeated sickness spells) from the employers' responsibility to continue wage payments, making those groups eligible for social insurance benefits from the start. Another option is to rule out detailed investigation of a job applicant's health condition. Both of these were legislated in the Netherlands and partly also in the United Kingdom.

Financial incentives or disincentives for the employer should also be introduced or strengthened in work injury programmes. Risk-rating according to industry (or similar characteristics) is widely practised, although in Austria, Norway, Sweden, the United Kingdom and – until 2003 – Poland uniform premiums are levied, which socialises the costs of high-risk industries and implicitly subsidises employment in these high-risk sectors. Only a few countries, however, base work injury insurance premiums on the individual employer's experience (Australia, France, the Netherlands and the United States, and – only with a focus on preventive initiatives – Portugal and Spain).

Restructure benefit systems to remove disincentives to work

In many countries, the structure of the benefit system and current practice in the award of disability benefits will need to undergo fundamental change. Many disability schemes are centred on income-replacing benefits and tie other types of benefits and services to eligibility for cash transfers, thereby discouraging disabled persons from trying to return to work and thus contributing to benefit dependency. Should the attempt to work fail, the person would have to go through the whole process again until a benefit (and its complements) is awarded. Such systems need to be dismantled so that benefits and services can be awarded independently and at different levels corresponding to the situation of the beneficiary.

As discussed earlier, sanctions will have to be introduced to enforce the beneficiary's obligation to co-operate. To date, few countries impose sanctions for lack of beneficiary co-operation. A more common approach is to encourage take-up of work by offering financial incentives. The Danish permanent special in-work supplement for those people forsaking a disability benefit is the only far-reaching example – but no evaluation of this measure is available yet. Continued benefit payment for a couple of months, like in the Netherlands and the United States, may also be useful, but the time periods seem too short to give a sufficient incentive to take up work.

Permanent in-work top-up payments are likely to be more effective in terms of encouraging beneficiaries to work. Such top-up payments would be similar to partial disability benefits, which already exist in many countries. The difference, however, is that top-up payments would be strictly work-related for compensation of the lower earnings that may result from either a lower-level job or reduced working hours. The levels at which such compensation should stop would need to be determined by each country according to preferences, resources and the structure of the social protection system.

Wage subsidies paid to the employers of disabled persons would play a less important role under the new approach, since beneficiaries would receive direct in-work benefits and when necessary employers would be compensated for the extra cost of workplace accommodation. Today, many countries use temporary wage subsidies as a policy

instrument to give employers an incentive to enter into an employment contract with a disabled person; this practice would not contradict the individualised approach.

In a few, generally English-speaking countries, the potential loss of complementary cash or in-kind benefits upon taking up work acts as a further disincentive to engage in work. A particularly striking example is in the United States, where entitlement to free health care is coupled with a disability benefit claim through Medicare and Medicaid coverage. Such problems need to be acknowledged and carefully addressed in designing benefit suspension regulations and extending work incentives. The example of the United States shows that this can be very difficult.[3]

In some countries, however, the restructuring problem is not limited to incentives to work, as a large number of people are still excluded from cash benefits altogether. These are primarily persons with little or no attachment to the labour force. In Austria and Germany, for example, systems cover the labour force only, and in Mexico and Turkey the self-employed and several special occupations are also excluded.

Reform programme administration

The individual approach will place a wide range of new demands on disability gatekeepers. Caseworkers will need more extensive knowledge of the range of available benefits, services and programmes. More time will be required individually to assist and follow each case. More and better qualified staff will be necessary to fulfil these much more labour-intensive tasks.

Doctors must also be enabled (*e.g.* through special training courses) to fulfil their role as medical assessors, in particular for diagnosis of stress-related and mental diseases, which are more difficult to assess. Further, independent medical specialists must be involved in the compilation of medical evidence. Giving treating doctors almost sole responsibility as gatekeepers in this process, for instance, appears to be the single most important explanation for the exceptionally high benefit award rates in Norway. Separating decision-making, which does not require a medical degree, from compiling evidence would prevent conflicts of interest, reduce bias and promote equal treatment of equivalent cases.

Similarly, the vocational assessment process needs to be critically reviewed. If benefits are to be contingent on participation, then participation will need to be defined much more broadly, possibly even to include non-work activities. In some countries, work capacity is still assessed with regard to the person's previous ("own") occupation only, which does not seem adequate to determine a person's capacity to participate in the labour market. Caseworkers assessing the work capacities of a disabled person will need to take into account a much wider range of training and employment opportunities than previously.

A one-stop philosophy can promote equality of access to all programmes for all people, and would help gatekeepers to manage the full menu of available interventions. In many countries, disabled people have to approach many different institutions (*e.g.* public employment service or insurance authority) at different levels (*e.g.* municipal/local, provincial or federal level) to access different types of benefits and services. An individualised participation approach requires better co-ordination between agencies providing different services and benefits. Several countries have recently established one-stop service centres where potential clients can get all the necessary information and access to all available services. An interesting example of how to put this approach into

practice is provided by the British disability employment advisers, who have thorough knowledge of local employers, vacancies and new pilot projects.

In Australia, Centrelink, the government's social service delivery agency, unites responsibility for almost all disability-related issues – ranging from assessing eligibility for all kinds of integration programmes (even if Centrelink does not do the assessments itself) to awarding sickness allowance or disability support pension. Through its regional offices, Centrelink functions as a one-stop centre. In Denmark, the 275 municipalities run the entire social system and are responsible for all the employment and rehabilitation programmes as well as sickness and disability benefits. In Switzerland, 26 antonal disability authorities are fully responsible for awarding disability benefits and for determining eligibility for any kind of employment or rehabilitation programme.

Several other countries (Belgium, France, Norway, Portugal, the United States) have opted for a structure where one agency has responsibility for all kinds of rehabilitation and employment services, but one or several other agencies have responsibility for assessing benefit eligibility and benefit award. This arrangement at least guarantees the seamless co-ordination of service delivery, but it needs additional synchronisation with benefit award procedures.

In those countries in which responsibility for vocational rehabilitation is shared between different labour market and insurance authorities, better co-ordination between those agencies and government departments is needed – ith clear responsibilities as to who has to co-ordinate what. The recent reform in Germany, which established joint service centres of the various rehabilitation funds (with 544 such centres until end 2002), is a good example.

Improve co-ordination of transfer schemes

Blurred boundaries between different transfer schemes contribute to low employment rates for disabled persons and high benefit dependence. The current practice of many countries to award quasi-permanent disability benefits tends to hide problems of structural as well as cyclical unemployment. As a consequence, particularly older workers with only moderate health problems and considerable remaining work capacity are often excluded from participation in active labour market programmes.

Whether a person receives unemployment or disability benefits makes a big difference due to the asymmetric relationship between disability and unemployment. Unemployment cases taken onto the disability rolls in economically difficult times do not generally return to the labour market when economic growth resumes. Hence, a temporary growth in the unemployment benefit rolls is much less dramatic in the long run than a similar growth in the disability benefit rolls.

As mentioned earlier, many countries are moving their unemployment programmes towards the approach of mutual obligations. Unreformed disability programmes are likely to attract applicants who may find it difficult to comply with the stricter obligations of unemployment schemes. Indeed, this interrelation may partly explain the recent large increases in disability benefit rolls in Australia, the United Kingdom and the United States. This emphasises the need for a coherent strategy in disability and unemployment policy that extends the approach of mutual obligations to all labour market programmes.

Disability benefits would also be made more flexible by separating the status of old-age and disability. In half of the participating countries, these two programmes are dealt

with in the same system. In most cases, disability benefits are labelled disability pensions, which indicates a quasi-permanent payment. Separating the two statuses, however, requires the establishment of a mechanism for the payment of contributions on behalf of the disabled person that maintains the old age pension contribution record.

In many countries, health assessments for the sickness and disability programmes are completely different. This leads to inconsistencies and makes targeted early intervention of vocational rehabilitation difficult. Merging the two health-related programmes would make it easier to harmonise the respective assessment procedures and would lead to the earlier involvement of independent medical experts. In Sweden, Belgium and France, the disability programme and the sickness benefit programme are managed by the same institutions. In Belgium, for example, after a sickness absence of one month, a controlling doctor employed by the insurance authority follows further developments throughout the entire sickness and disability process. This doctor can impose medical examinations whenever considered necessary, and may also be involved in assessing a disability benefit claim. Portugal and to a lesser extent Spain have also made attempts to harmonise assessment procedures for shorter-term sickness and longer-term disability.

The relationship between the work injury programme and the general disability programme should also be addressed. These two risks are separated in most countries, because they require a different funding structure (costs of work injuries should be fully borne by the employer) and justify a different minimum level of disability (even relatively minor capacity reductions from a work injury need to be compensated). But there are also arguments for partial integration of the two. Whether a disability originates from a work accident or any other accident, from an occupational disease or any other disease, the person will need the same type of support and participation package. For this reason, it is quite appropriate to use the same assessment procedure to establish the existence and degree of disability and of remaining work capacity, even if in the case of work injuries there is an additional need to determine the level of compensation for bodily damage. Using the same process and approach to vocational rehabilitation and training is also appropriate. Only three countries have this kind of structural integration – whether with identical benefits (Poland and Spain) or higher benefit levels for people with work injuries (Turkey). Those countries that have a strong focus on mandatory vocational rehabilitation have often largely harmonised the active intervention process for people with work injuries and those with general disabilities, even if under two different authorities.

Workers over age 50 are a particular problem group. Firstly, in many countries this age group has access to special early retirement programmes; and secondly, blurred boundaries between disability and unemployment are of particular relevance, because of age discrimination in the disability programme (either legally or implicitly) and even more so in vocational rehabilitation.

In many countries, policy has been reluctant to accept higher unemployment rates among older workers. The effect of such policy – easier access to generous disability as well as early retirement benefits for older workers – is considerable age discrimination; push and pull factors accumulate and oust older workers from the labour market. Especially in the light of population ageing, this policy needs to be reconsidered and reversed. Retirement policy has started to react in many countries by reducing the options and attractiveness of early retirement, *e.g.* through the introduction of actuarially determined benefit deductions. This will have a strong impact on disability programmes, because older

workers may be trying to exit the labour market through the disability programme, especially if the benefit level is higher than the actuarially adjusted old age pension. Disability policy has yet to react, and in particular needs to emphasise employment-promoting instruments for older workers and the development of a culture of mutual obligations.

Concluding remark

All policy actors and concerned persons agree that more people with disabilities are able to work. That many of these people do not is more down to policy failure and policy choice than anything else. Societies have dealt with some groups of disabled people by hiding them out of the way on often generous benefits. Other groups were isolated on sheltered employment programmes, while programmes enabling work in the open labour market were often lacking or insufficient. To a varying degree, this conclusion holds for both moderately and more severely disabled people, and in particular for people over age 50, who represent the large majority of this group and who may have access to a whole range of transfer payments.

This segregating approach is not good enough for disabled people, even if it may provide income security for many of them. This approach is also very expensive and therefore, ultimately, not good enough for the taxpayers as well. This is why there is a need for disability policy to focus on the abilities of people with disabilities and to follow the mutual obligations strategy outlined in this concluding chapter and adapt it to national conditions and circumstances.

Notes

1. For a more detailed discussion of this point, see also the section on restructuring the benefit system.
2. For instance, if there is a high likelihood that, due to a slowly developing chronic health problem, the current job is unlikely to be fulfilled for many more years, retraining for another job in the same company – if possible at the same or even a higher level – could be initiated. A transfer to another job in the same company may sometimes not even require additional training. French legislation on the reclassification of disabled workers should be particularly conducive to such transfers.
3. In the United States, various rules have been implemented to dissociate loss of a disability benefit from loss of health coverage. Full health coverage during the extended period of eligibility (*i.e.* the three years following completion of the trial work period) plus three more months was introduced as early as 1980. Since loss of health coverage was still held to create benefit dependence, in 1999 additional measures were implemented (extended Medicare coverage for those who return to work and incentives for Medicare buy-in for those permanently off benefits), mainly aimed at recipients of disability insurance benefits.

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Annex 1

Technical Annex

A1.1. Approach to achieving the project targets

The aims of the project were pursued by a combination of three different methods, each offering a different perspective on disability policy: *i)* analysis of descriptive reports of policy settings, *ii)* administrative data analysis and *iii)* micro data analysis. The descriptive reports comprise current regulations and major changes in disability policy during the last two decades. Analysis of those reports provides the information needed to understand each country's disability policy.

Administrative programme statistics are processed to assess how disability-related employment and social protection programmes have developed during the last two decades, to investigate the relationship between programme participation and policy reform, and to analyse the incentives generated by each policy package. Data are used on the average annual stocks of programme participants or beneficiaries, on the annual flows of persons into and out of programmes or benefit schemes, and on annual programme expenditures.

Micro data from national population surveys – representative for the working-age population and combining information on disability status, employment status and income status – are collected to *identify* the disabled population; to assess the *level of participation* of the disabled population (activity status, working with/without support from public programmes, receiving cash benefits, neither working nor getting public transfers); and to measure the *relative economic well-being* of the disabled population (in terms of personal and household income levels and income sources in relation to the non-disabled population).[1]

A1.2. Data limitations

The analysis is limited by the non-availability and/or non-uniformity of some of the administrative programme statistics (see also Table A1.2). In many countries, data are partial or non-existent, in particular for programmes that are administered on a regional or provincial level. Often programme statistics refer to one year only, making assessments of developments over time impossible. Where general employment programmes are used to integrate people with disabilities through mainstreaming, analysis becomes more difficult because disabled people may not be recorded separately. Apart from missing data and disabled people "hidden" in general programmes, further problems arise through the double counting that results from an (often unknown degree of) overlap between various benefit programmes, but also between benefit and employment or rehabilitation programmes.

An additional problem is caused by the blurring of boundaries between active and passive policy measures. For example, it does not seem revealing to classify partial benefits as a passive measure, but permanent wage subsidies as an active measure. In effect, these are more or less different labels for the same kind of policy, or financial assistance. Or, to give another example, it is particularly difficult to make a proper classification of benefits received during a rehabilitation phase. Where specific rehabilitation benefits exist, these are usually counted towards active instruments, while they would be counted as passive were the same rehabilitee to stay on sickness or disability benefits during this phase instead.

In the case of national population survey data, lack of comparability is a major concern. Interpretation of quantitative results – *e.g.* on the employment rates and economic well-being of disabled *vis-à-vis* non-disabled people – requires careful consideration of several data-related aspects. Data quality and thus comparability can be affected by *i)* differences in survey populations and survey design, *ii)* differences in the formulation and sequence of questions, *iii)* differences in definitions, *e.g.* of disability, employment or income, *iv)* differences in answer categories, *e.g.* regarding receipt of public social benefits and *v)* different years, *i.e.* different stages of the business cycle in which surveys are taken.

It was mainly for these reasons that it was decided to make use of ECHP data – which are available for 11 of the 20 countries involved in the project – notwithstanding the imperfect quality of these data and the rather low sample size. The strengths of the ECHP data are that they provide detailed information on employment and income, and also that quite an appropriate and widely accepted definition of self-assessed disability is used. The ECHP uses two questions, "Do you have any chronic physical or mental health problem, illness or disability?" and "Are you hampered in your daily activities by this chronic physical or mental health problem, illness or disability?" In the analysis, people are classified as *disabled* if they have such a long-term health problem *and* are – moderately or severely – hampered in daily activities by this problem.

For non-ECHP countries, surveys using questions resembling those used in the ECHP as closely as possible had to be found (see Table A1.1). To overcome some of the possible problems of comparability, only the position of disabled people *relative* to the non-disabled population was analysed, such as differences in relative employment rates. It is not the aim of the study to compare absolute levels of the prevalence of disability in each country. Essentially, the aim is to contrast the relative position (in terms of economic activity and incomes) of a comparable proportion of people classified as disabled, using a similar definition of self-assessed disability.[2] Nevertheless, it remains difficult to distinguish a "real" difference between countries that is caused by differences in policy from a difference that is caused by underlying definitions or factual differences in levels of disability.

There is another inherent limitation related to the interpretation of population survey data as well as administrative programme statistics. The effects of new policies often become apparent very slowly, as new regulations – in particular in the field of social security – often apply to new applicants only. The stock of benefit recipients usually remains unaffected in the short term. As a consequence, the size of the current stock of benefit recipients is always more a result of the policy framework during the last decades than it is of recent reforms. This problem is aggravated by the fact that the population survey data used usually refer to a year around 1997, providing a snapshot at a particular moment after which several new policies could have been – and indeed often were – enacted.

A1.3. Defining the term disability

Analysis of social protection and employment policies directed towards people with disabilities first requires an answer to the question of "what constitutes a disability". As disability policies evolve, definitions and labels change to reflect changes in community attitudes towards disability. In recent years, the term disability has come under particularly close scrutiny. New policies are increasingly focused on abilities rather than disabilities. The medical model of disability, according to which disability is seen as a characteristic of the individual, has been replaced by a social/environmental model, whereby disability is interpreted as a social/environmental construct, *i.e.* an attribute resulting from the interaction between the individual and the social and physical environment.

The WHO's new ICF classification (international classification of functioning and disability) is a reflection of the move from a static to a dynamic view of disability.[3] This classification distinguishes four layers: body functions, body structures, activities and participation, and "environmental" factors. Body functions are what used to be called impairment, *i.e.* any loss or abnormality of any structure or function. Body structures reflect functional limitations or disability, *i.e.* restrictions or lack of ability to perform an activity, caused by a body function. Body functions and to a large extent also body structures refer to characteristics of the individual (or biological difference), while the other two layers refer to the interaction with the social and physical environment, thus resulting in a disadvantage for a given individual – a disadvantage resulting from a body function (impairment) or body structure (functional limitation). Activities and participation is what used to be called a handicap, the new label making the interaction with the social and economic roles of the individual more explicit. The new fourth layer allows for the fact that "environmental" factors intervene that, for instance, may facilitate or prevent work.[4]

A major aim of this project is to analyse the impact of one part of the "environmental" factors – namely, social security and employment policies. Administrative programme statistics as well as population survey data are used to analyse the extent to which biological difference translates into disadvantage. The criteria for self-assessed disability employed by the ECHP and, by and large, all the other surveys used follows "layer two" of the WHO classification, *i.e.* functional limitation or disability caused by a chronic or long-term impairment. Disadvantage in terms of work and economic well-being (*i.e.* layer three) is what should be measured on the basis of these data, thereby identifying the contribution of certain elements of "layer four".

While the social/environmental model of disability is now widely accepted, the relationship between ability and productivity is by no means settled. Establishing the degree of ability (or disability) and, hence, the degree of productivity is – and will always be – a difficult task, particularly in the case of mental and psychological conditions. In addition, the WHO classification suggests that respective outcomes depend on "environmental" factors, *i.e.* that the same degree of biological difference does not necessarily imply the same degree of disability or capacity reduction under all circumstances. Policy development also reflects this controversy. Disability benefit schemes in most, but not all, countries are built on the notion of a fixed percentage reduction in work or earnings capacity – a concept that, by definition, mixes various layers of the WHO classification. Theoretically it seems desirable, yet practically impossible, to abolish this kind of thinking and assessment.

Notes

1. For Austria, Belgium, Denmark, France, Germany, Italy, Netherlands, Portugal, Spain, Sweden and the United Kingdom, data from the European Community Household Panel (ECHP) are used. Data refer to the 1997 wave of the ECHP except for Germany and the United Kingdom for which data from the 1996 wave are used (change of database from 1997 onwards). For the other countries, national surveys with a comparable definition of disability are analysed: the Survey of Disability, Ageing and Carers 1998 for Australia, the National Population Health Survey 1998 for Canada, the National Survey on Disabled Persons 2000 for Korea, the National Survey on Employment and Social Security 1996 for Mexico, the Living Level Survey 1998 for Norway, the Health Survey 1997 for Switzerland, and the Survey of Income and Programme Participation 1997 for the United States. For Poland, published material from the Labour Force Survey 2000 is used. Turkey has not provided any survey data.
2. Note that in this context the methodological incomparability of data using two answer categories (yes, no) or three categories (yes severely, yes somewhat, no) becomes a minor issue; our empirical data seem to indicate that the sum of "somewhat and severely" closely resembles the total "yes" category.
3. In the case of the WHO, this is also reflected in the acronym of the new classification – ICF replacing the acronym ICIDH, the international classification of impairments, disabilities and handicaps.
4. According to the ICF, these environmental factors comprise five different chapters: products and technology; natural environment and human-made changes to the environment; support and relationships; attitudes; and services, systems and policies (including, among other things, social security and employment policies).

Table A1.1. **National survey data: data sources, sample sizes and definitions used**

	Survey	Year: late 1990s	Sample size	Disability status			
				Disabled persons		Non-disabled persons	
				Severe	Moderate		
Austria	ECHP (European Community Household Panel), UDB-version of September 2001	1997	5 197	lasting health problem, severely hampered	lasting health problem, somewhat hampered	lasting health problem, not hampered	no lasting health problem
Belgium	see Austria	1997	4 381	see Austria	see Austria	see Austria	see Austria
Denmark	see Austria	1997	3 641	see Austria	see Austria	see Austria	see Austria
France	see Austria	1997	9 337	see Austria	see Austria	see Austria	see Austria
Germany	see Austria	*1996*	6 920	see Austria	see Austria	see Austria	see Austria
Italy	see Austria	1997	12 987	see Austria	see Austria	see Austria	see Austria
Netherlands	see Austria	1997	7 217	see Austria	see Austria	see Austria	see Austria
Portugal	see Austria	1997	8 367	see Austria	see Austria	see Austria	see Austria
Spain	see Austria	1997	10 728	see Austria	see Austria	see Austria	see Austria
Sweden	see Austria	1997	7 427	see Austria	see Austria	see Austria	see Austria
United Kingdom	see Austria	*1996*	5 215	see Austria	see Austria	see Austria	see Austria
Australia	SDAC (Survey of Disability, Ageing and Carers)	1998	..	profound/severe core activity restriction (incl. self care, mobility and communication)	moderate/mild core activity restriction (incl. self care, mobility and communication)	no core activity restriction (incl. employment and/or schooling restriction)	no disability
Canada	NPHS (National Population Health Survey) Health file	1998/99	10 900	restriction of activities		no activity restriction	
Korea	National Survey of Disabled People	2000	75 784 persons aged 20-64 (35 426 hholds)	need help for all or almost all daily activities	can do all or almost all daily activities by oneself, or need help for some daily activities	–	no disability
Mexico	ENESS (National Survey on Employment and Social Security)	1996	25 804	permanent and temporary disability		–	no disability
Norway	LLS (Living Level Survey)	1998 moderate	2 500	permanent disease, strong limitations in moderate activities	permanent disease, minor limitations in moderate activities	permanent disease, no limitations in moderate activities	no illness/disease of permanent nature
	as above	1998 strenuous	as above	permanent disease, strong limitations in strenuous activities	permanent disease, minor limitations in strenuous activities	permanent disease, no limitations in strenuous activities	as above
Poland	Labour Force Survey (GUS) 2000	1st quarter 2000	30.6 million persons aged 25-64	legally disabled people (with three degrees of disability)		–	survey population minus legally disabled people
Switzerland	SGB (Swiss Health Survey)	1997	9 800	lasting health problem, reduced capacity		–	no lasting activity restricting physical or mental problem
United States	SIPP (Survey of Income and Program Participation) core and topical modules	1996 (wave 4)	49,124 persons aged 20-64 (86,173 all ages)	long-term health condition that substantially limits abilities to perform common daily activities	long-term health condition that sometimes limits abilities to perform common daily activities	–	no long-term health condition that makes it difficult to perform common daily activities

. . Data not available; – Not applicable.

Table A1.1. **National survey data: data sources, sample sizes and definitions used** *(cont.)*

	Disability benefit	Educational attainment	Employment	Unemployment	Personal income	Equivalised household income
Austria	received sickness/invalidiy benefit	higher education: second secondary + tertiary; lower: less than second secondary (ISCED 0-2) + still at school	normally working fifteen hours or more	unemployed in percentage of labour force	annual total net personal income (year prior to the survey)	annual total net household income (year prior to the survey) divided by equivalised size
Belgium	see Austria	see Austria	see Austria	see Austria	see Austria	see Austria
Denmark	see Austria	see Austria	see Austria	see Austria	see Austria	see Austria
France	see Austria	see Austria	see Austria	see Austria	see Austria	see Austria
Germany	see Austria	see Austria	see Austria	see Austria	see Austria	see Austria
Italy	see Austria	see Austria	see Austria	see Austria	see Austria	see Austria
Netherlands	see Austria	see Austria	see Austria	see Austria	see Austria	see Austria
Portugal	see Austria	see Austria	see Austria	see Austria	see Austria	see Austria
Spain	see Austria	see Austria	see Austria	see Austria	see Austria	see Austria
Sweden	see Austria	see Austria	see Austria	see Austria	see Austria	see Austria
United Kingdom	see Austria	see Austria	see Austria	see Austria	see Austria	see Austria
Australia	people in receipt of disability support pension, sickness allowance or workers compensation	higher education: second secondary + tertiary lower: less than second secondary + primary	currently employed (including family worker and own account worker)	unemployed in percentage of (unemployed + employed)	median weekly gross income	..
Canada	..	higher: post secondary lower: secondary and less school graduation	currently working	looking for work or on labour dispute/layoff	total personal income from all sources	total household income from all sources equivalised
Korea	disabled in receipt of national pension (incl. public officials, private school teachers, soldiers and veterans pension) or workers compensation	higher education: university or graduate school or more lower: college or less than college	currently employed	unemployed in percentage of labour force	..	monthly wage/household income/equivalised household size
Mexico	in receipt of invalidity or work injury benefit	..	worked last week or self-employed or on holidays/sick leave/strike	looking for work	income from main job	..
Norway	receives disability benefit	higher education: second secondary and tertiary lower: first secondary and less	person has income from work during the last week	..	total personal gross income	household 's gross income divided by equivalised househlod size (1 + .4 per other person in househlod)
	as above	as above	as above	..	as above	as above
Poland	..	..	currently employed	unemployed in percentage of labour force	..	monthly income per household (year prior to the survey)
Switzerland	health benefit (includes all types of disability, work injury, and rehabilitation benefits)	higher education: second secondary and tertiary lower: first secondary and less	currently working or self-employed	unemployed in percentage of (unemployed + employed)	net monthly income	net monthly household income, equivalised
United States	in receipt of disability benefit (SSDI or SSI) or veterans or workers compensation or employer/ union temporary sickness benefit or employer disability payment	higher: high school graduate or high school diploma or equivalent or higher level lower: 12th grade or under	had a paid job during the reference period or temporary unable to work because of injury/illness/ pregnancy/child birth	unable to find work or on layoff or not interested in working at a job	total person's income for the reference month	total household's income for the reference month divided by equivalised househlod size (1 + .4 per other person in househlod)

. . Data not available; – Not applicable.

Table A1.2. **OECD database on programmes for disabled persons: sources and estimates**

Note that in most countries data provided by the collaborating ministries were partial or incomplete. Whenever possible, data were adjusted to fit to the desired structure. In several cases, missing data were estimated on the basis of available material and corresponding information from countries with similar schemes. While such estimates are unlikely to be fully correct, they should reflect the country's situation with sufficient accuracy. In the following table, all those estimates undertaken by the OECD are described.

Country	Data sources	Data estimates
Australia	Department of Family and Community Services (FaCS)	Disability support pension: expenditure data prior to 1998 estimated on the assumption of constant 2000 per capita benefits in relation to per capita GDP Work injury schemes: benefit recipients estimated on the basis of data for Canada and the United States
Austria	Ministry of Social Security and Generations and Chamber of Labour	Disability benefits: public sector data estimated by Chamber of Labour Sickness benefits: recipiency data estimated on basis of number of sickness cases and duration per case Vocational rehabilitation: data only refer to pension insurance authorities Sheltered employment: data on provincial places estimated on basis of verbal communication
Belgium	Ministry of Social Affairs and Public Health	Disability benefit expenditure: 1999 data estimated on the basis of the 1999/95 recipients ratio, corrected for inflation Disability benefit inflows (contributory and non-contributory programme): data estimated on the basis of the ratio flow/stock for countries with similar age structure in their benefit stock Non-contributory disability benefits: recipiency data prior to 1999 and expenditure data for all years adjusted to 20-64 age group according to share of this age group in 1999 recipiency data
Canada	Human Resources Development Canada	Non-contributory disability benefits (social assistance payments by reason of disability): inflows estimated on the basis of the ratio flow/stock for countries with non-contributory schemes
Denmark	Ministry of Social Affairs	Subsidised employment: expenditure estimated on the basis of respective Swedish data (reduced by ⅓) Sheltered employment: expenditure estimated on the basis of respective Norwegian data (reduced by ⅓) Work injury scheme: recipiency data estimated on the basis of data for countries with similar expenditure levels (Austria, Germany, Italy, Sweden)
France	Ministry for Work and Solidarity (DARES)	Subsidised and sheltered employment: expenditure data taken from OECD social expenditure database (SOCX) Contributory disability benefits: recipiency data estimates from Netherlands Economic Institute (NEI), inflow data from CNAMTS (adjusted with the ratio "régime général/total" taken from SOCX to be representative for the entire population) Non-contributory disability benefits: recipiency data from annual statistical yearbook, expenditure data from SOCX, inflows estimated on the basis of the ratio inflow/stock for the contributory programme Work injury scheme: expenditure data from SOCX, no recipiency data
Germany	Ministry for Labour and Social Affairs	Sheltered employment: expenditure data estimated on the basis of respective Austrian data Disability benefits: data include old-age benefits for severely disabled persons (age 60-64)
Italy	Ministry for Labour and Social Affairs	Contributory disability benefits: recipiency data prior to 1990 taken from Baldacci and De Santis (estimate based on ISTAT survey on number of pensions, see Prinz, 2003); expenditure data adjusted to 20-64 age group according to age structure of recipients (adjusted for trend in per capita benefits) Non-contributory disability benefits: expenditure data taken from Baldacci and De Santis (Prinz, 2003); recipiency data prior to 1999 estimated on the basis of constant expenditure per capita in percentage of GDP
Korea	Ministry of Health and Welfare	–
Mexico	Mexican Social Security Institute	–

Table A1.2. **OECD database on programmes for disabled persons: sources and estimates** *(cont.)*

Country	Data sources	Data estimates
Netherlands	Ministry of Social Affairs and Employment	Sickness benefits: recipiency data for 1995 and 1999 are estimates based on a CBS survey on 17 000 private companies, which is performed annually to measure trends in sickness absence (survey data give percentage of days lost due to sickness, not recipients)
Norway	Ministry of Finance and Ministry of Health and Social Affairs	–
Poland	Ministry of Labour and Social Policy	Vocational rehabilitation: covers only those programmes financed by PFRON funds Contributory disability benefits: ZUS and KRUS programmes, expenditure data adjusted to 20-64 age group according to share of this group in the stock (age structure taken from ZUS programme) Non-contributory disability benefits: data on social pensions
Portugal	Ministry for Work and Solidarity	Disability benefits: for 1995 and 1999, expenditure on social supplements paid to recipients of contributory benefits (source: social security accounts) subtracted from the non-contributory and added to the contributory programme Non-contributory disability benefits: 1999 inflow estimated on the basis of flow/stock ratio 1995
Spain	Ministry of Labour and Social Affairs	Disability benefits: expenditure data adjusted to 20-64 age group according to share of this group in the stock
Sweden	Ministry of Health and Social Affairs	–
Switzerland	Federal Office for Social Security	Disability benefits: expenditure data include benefits from the second pillar programme (mandatory occupational pension), which are estimated on the basis of data for selected years during the 1990s
Turkey	Ministry of Labour and Social Security	–
United Kingdom	Department of Work and Pensions	Sickness benefits: recipiency data include "credits only" cases Non-contributory disability benefits: includes severe disablement allowance and income support with a disability premium, corrected for double counting according to estimate for year 1999
United States	Department of Labour	Vocational rehabilitation: recipiency data derived from the number of people ending rehabilitation services Non-contributory disability benefits: expenditure data adjusted to 20-64 age group according to age structure of benefit recipients in 1999 (16% aged 65 and over)

Annex 2

Classification for the Policy Typology

Tables A2.1 to A2.4

Table A2.1. **Classification for the compensation dimension of the policy typology**

Dimension	5 points	4 points	3 points	2 points	1 point	0 point
X. Compensation						
x1. Coverage	total population (residents)	some of those out of the labour force (*e.g.* congenital)	labour force plus means-tested non-contrib. scheme	labour force with voluntary self-insurance	labour force	employees
x2. Minimum disability level	0-25%	26-40%	41-55%	56-70%	71-85%	86-100%
x3. Disability level for full benefit	< 50%	50-61%	62-73%	74-85%	86-99%	100%
x4. Maximum benefit level	RR > = 75%, reasonable minimum	RR > = 75%, minimum not specified	75 > RR > = 50%, reasonable minimum	75 > RR > = 50%, minimum not specified	RR < 50%, reasonable minimum	RR < 50%, minimum not specified
x5. Permanence of benefits	strictly permanent	*de facto* permanent	self-reported review only	regulated review procedure	strictly temporary, unless fully (= 100%) disabled	strictly temporary in all cases
x6. Medical assessment	treating doctor exclusively	treating doctor predominantly	insurance doctor predominantly	insurance doctor exclusively	team of experts in the insurance	insurance team and two-step procedure
x7. Vocational assessment	strict own or usual occupation assessment	reference is made to one's previous earnings	own-occupation assessment for partial benefits	current labour market conditions are taken into account	all jobs available taken into account, leniently applied	all jobs available taken into account, strictly applied
x8. Sickness benefit level	RR = 100% also for long-term sickness absence	RR = 100% (short-term) > = 75% (long-term) sickness absence	RR > = 75% (short-term) > = 50% (long-term) sickness absence	75 > RR > = 50% for any type of sickness absence	RR > = 50% (short-term) < 50% (long-term) sickness absence	RR < 50% also for short-term sickness absence
x9. Sickness benefit duration	one year or more, short or no wage payment period	one year or more, significant wage payment period	six-twelve months, short or no wage payment period	six-twelve months, significant wage payment period	less than 6 months, short or no wage payment period	less than 6 months, significant wage payment period
x10. Unemployment benefit level and duration	DI > UE level, short duration of unemployment	DI > UE level, long duration of unemployment	similar levels, short duration of unemployment	similar levels, long duration of unemployment	DI < UE level, short duration of unemployment	DI < UE level, long duration of unemployment

RR = Replacement rate; DI = Disability benefit; UE = Unemployment benefit.
Source: OECD.

Table A2.2. **Classification for the integration dimension of the policy typology**

Dimension	5 points	4 points	3 points	2 points	1 point	0 point
Y. Integration						
y1. Coverage consistency	all programmes accessible	minor discrepancy, flexible mixture	minor discrepancy, restricted mixture	major discrepancy, flexible mixture	major discrepancy, restricted mixture	strong differences in eligibility
y2. Assessment structure	same agency for assessment for all programmes	one agency for integration, benefits co-ordinated	same agency for benefits and vocational rehabilitation	one agency for integration, benefits not co-ordinated	different agencies for most programmes	different agencies for all kinds of assessments
y3. Employer responsibility	major obligations towards employees and new applicants	some obligations towards employees and new applicants	major obligations towards employees, less for applicants	some obligations towards employees, none for applicants	no obligations at all, but dismissal protection	no obligations of any kind
y4. Supported employment	strong programme, permanent option	strong programme, only time-limited	intermediary, also permanent	intermediary, only time-limited	very limited programme	not existent
y5. Subsidised employment	strong and flexible programme, with a permanent option	strong and flexible programme, but time-limited	intermediary, either permanent or flexible	intermediary, neither permanent nor flexible	very limited programme	not existent
y6. Sheltered employment	strong focus, with significant transition rates	strong focus, but largely permanent employment	intermediary focus, with some "new" attempts	intermediary focus, "traditional" programme	very limited programme	not existent
y7. Vocational rehabilitation	compulsory rehabilitation with large spending	compulsory rehabilitation with low spending	intermediary view, relatively large spending	intermediary view, relatively low spending	voluntary rehabilitation with large spending	voluntary rehabilitation with low spending
y8. Timing of rehabilitation	in theory and practice any time (*e.g.* still at work)	in theory any time, in practice not really early	early intervention increasingly encouraged	generally *de facto* relatively late intervention	after long-term sickness or for disability recipients	only for disability benefit recipients
y9. Benefit suspension	two years or more	at least one but less than two years	more than 3 but less than 12 months	up to three months	some, but not for disability benefits	none
Y10. Work incentives	permanent in-work benefit provided	benefit continued for a considerable (trial) period	income beyond pre-disability level allowed	income up to pre-disability level, also partial benefit	income up to pre-disability level, no partial benefit	some additional income allowed

Source: OECD

Table A2.3. **Country scores for the sub-dimensions of the typology around 2000**

	Dimension x – compensation (values from 0-50)										
	1	2	3	4	5	6	7	8	9	10	
	Coverage	Minimum disab. level	Level for full disability	Benefit generosity	Permanence of benefits	Medical assessment	Vocational assessment	Sickness ben. level	sickness ben. duration	UE benefit level and duration	SUM
Australia	5	5	5	1	2	4	2	1	5	2	32
Austria	2	3	4	2	1	1	5	3	2	2	25
Belgium	3	2	3	1	4	2	4	3	2	2	26
Canada	1	1	1	1	4	1	0	2	1	1	13
Denmark	5	3	1	4	4	3	1	2	2	2	27
France	3	2	1	3	1	2	4	2	5	2	25
Germany	2	5	3	2	1	3	3.5	4	4	2	29.5
Italy	3	2	0	3	1	1	3	3	3	3	22
Korea	0	3	0	1	2	1	0	0	1	1	9
Mexico	0	3	4	0	3	2	5	2	3	5	27
Netherlands	4	5	2	5	3	1	1	3	3	2	29
Norway	5	3	0	5	5	5	2	5	2	2	34
Poland	2	3	4	4	2	2	3	4	2	4	30
Portugal	3	2	3	5	4	1	4	2	5	2	31
Spain	3	4	1	4	5	0	3	2	4	4	30
Sweden	5	5	1	5	3	3	1	4	4	3	34
Switzerland	5	4	3	4	4	4	2	4	2	1	33
Turkey	2	2	3	2	5	3	0	2	3	3	25
United Kingdom	3	1	2	1	2	3	1.5	1	2	4	20.5
United States	3	1	2	3	4	4	1	2	0	1	21
OECD(20)	3.0	3.0	2.2	2.8	3.0	2.3	2.3	2.6	2.8	2.4	26.2

Table A2.3. **Country scores for the sub-dimensions of the typology around 2000** *(cont.)*

	Dimension y – integration (values from 0-50)										
	1	2	3	4	5	6	7	8	9	10	
	Coverage consistency	Assessment structure	Employer responsibility	Supported employment	Subsidised employment	Sheltered employment	Rehabilitation programmes	Rehabilitation timing	Benefit suspension	Work incentives	SUM
Australia	4	4	4	2	2	3	1	3	4	2	29
Austria	2	3	1	4	4	2	5	4	0	3	28
Belgium	3	3	2	1	5	2	2	3	2	0	23
Canada	1	0	4	3	2	2	1	0	5	4	22
Denmark	2	5	2	5	5	2	5	5	3	5	39
France	5	2	2	2	5	2	1	2	0	3	24
Germany	4	0	3	5	4	3	5	5	3	3	35
Italy	4	2	4	1	1	2	0	2	0	2	18
Korea	0	0	1	2	3	2	1	2	0	3	14
Mexico	2	2	0	0	0	0	0	1	0	3	8
Netherlands	4	2	3	2	1	5	2	2	5	4	30
Norway	4	2	3	2	4	3	5	3	5	0	31
Poland	5	2	2	0	4	4	2	2	0	3	24
Portugal	3	2	2	1	2	2	1	1	1	1	16
Spain	4	3	3	1	3	3	4	4	0	2	27
Sweden	3	3	5	2	4	2	5	4	5	0	33
Switzerland	4	3	1	1	1	3	5	3	0	2	23
Turkey	3	2	0	0	1	0	2	1	0	0	9
United Kingdom	2	2	4	3	1	2	1	3	4	5	27
USA	0	0	4	5	1	2	1	1	5	4	23
OECD(20)	3.0	2.1	2.5	2.1	2.7	2.3	2.5	2.6	2.1	2.5	24.2

Source: OECD.

Table A2.4. **Country scores for the sub-dimensions of the typology around 1985**

	Dimension x – compensation (values from 0-50)										
	1	2	3	4	5	6	7	8	9	10	
	Coverage	Minimum disab. level	Level for full disability	Benefit generosity	Permanence of benefits	Medical assessment	Vocational assessment	Sickness ben. level	sickness ben. duration	UE benefit level and durat.	SUM
Australia	5	5	5	1	2	3	2	1	5	2	31
Austria	2	3	4	2	4	1	5	3	2	2	28
Belgium	3	2	3	1	4	2	4	3	3	2	27
Canada	1	1	1	1	4	1	0	2	1	1	13
Denmark	5	3	1	4	4	4	2	2	4	2	31
France	3	2	1	3	1	2	4	2	5	2	25
Germany	2	3	4	2	4	4	5	4	4	2	34
Italy	3	2	3	3	4	2	5	3	3	5	33
Korea	0	0	0	0	0	0	0	0	2	0	2
Mexico	0	3	4	0	4	3	5	2	3	5	29
Netherlands	4	5	2	5	5	1	4	5	3	4	38
Norway	5	3	0	5	5	5	5	5	2	2	37
Poland	1	3	4	4	2	1	1	4	2	4	26
Portugal	3	2	3	4	4	3	4	2	5	3	33
Spain	1	4	1	4	5	0	5	3	4	4	31
Sweden	5	4	1	5	3	4	2	4	5	3	36
Switzerland	5	3	3	4	4	5	2	4	2	1	33
Turkey	2	2	3	2	5	3	0	2	3	5	27
United Kingdom	3	1	2	1	2	3	5	1	3	4	25
United States	3	1	2	3	4	4	1	2	0	1	21
OECD(20)	2.8	2.6	2.4	2.7	3.5	2.6	3.1	2.7	3.1	2.7	28.0

Table A2.4. **Country scores for the sub-dimensions of the typology around 1985** *(cont.)*

	Dimension y – integration (values from 0-50)										
	1	2	3	4	5	6	7	8	9	10	
	Coverage consistency	Assessment structure	Employer responsibility	Supported employment	Subsidised employment	Sheltered employment	Rehabilitation programmes	Rehabilitation timing	Benefit suspension	Work incentives	SUM
Australia	2	2	1	0	0	2	0	2	0	2	11
Austria	2	3	1	0	4	1	3	2	0	3	19
Belgium	3	3	2	0	3	2	2	2	2	0	19
Canada	1	0	1	1	1	2	1	0	5	1	13
Denmark	1	4	2	0	3	2	4	2	2	5	25
France	5	1	1	0	3	2	1	2	0	2	17
Germany	4	0	1	1	4	2	5	4	2	3	26
Italy	2	2	1	0	0	0	0	2	0	1	8
Korea	0	0	0	0	1	1	0	0	0	1	3
Mexico	1	1	0	0	0	0	0	1	0	3	6
Netherlands	2	1	1	0	0	4	0	0	2	2	12
Norway	3	1	2	0	4	2	5	2	4	0	23
Poland	1	1	1	0	1	1	0	0	0	3	8
Portugal	3	2	2	0	1	1	0	1	1	1	12
Spain	4	1	2	0	2	2	4	2	0	2	19
Sweden	3	3	2	0	5	1	3	2	3	0	22
Switzerland	4	2	1	0	1	2	5	3	0	2	20
Turkey	1	1	0	0	0	0	2	1	0	0	5
United Kingdom	2	1	1	1	0	2	0	1	2	2	12
United States	0	0	1	1	1	2	0	1	3	4	13
OECD(20)	2.2	1.5	1.2	0.2	1.7	1.6	1.8	1.5	1.3	1.9	14.7

Source: OECD.

Annex 3

Characteristics of Disability-related Benefit Schemes

Tables A3.1 to A3.10

Table A3.1. **Regulations on re-testing of disability benefit entitlements**

	Type and frequency of re-testing of benefit entitlements
Australia	Temporary; medical review every two or, usually, five years; randomised review of income and assets via a questionnaire on changes since last review
Austria	Temporary for up to two years (repeated renewal), continuation of payment if no health improvement; permanent if 100% disabled (about 20-25% of the inflow)
Belgium	Granted indefinitely, with flexible examinations (in most cases, several control examinations); after three years usually permanent
Canada	*de facto* permanent
Denmark	Permanent if rehabilitation failed (no re-tests)
France	Temporary subject to flexible re-evaluation
Germany	Temporary for up to three years if reasonable prospect for improvement, with repeated renewal; partial entitlements that are paid as full benefits because of poor labour market (concrete labour market perspective), always temporary
Italy	Permanent for full permanent disability; up to three years, temporary for partial benefit, *i.e.* partial disability (after six years benefit becomes permanent)
Korea	Flexible; periodic review of not completed diseases
Mexico	Temporary for renewable periods (with periodical examinations in the first year) if there is recovery potential; usually permanent after two years
Netherlands	Temporary up to maximum of five years; regular re-tests but – due to lack of personnel – generally only via questionnaire to the benefit recipient
Norway	Basically permanent; no regular review of the disability status (work ability improvement could only be derived from tax authorities' income records)
Poland	Flexible (depending on chances of improvement), temporary benefits withheld after expiration of payment period (beneficiary must provide new evidence)
Portugal	Permanent but not definitive, *i.e.* re-test every three to ten years, although by an evaluation commission – revision test – is possible any time (and common after three years on sickness benefit)
Spain	Permanent, but for temporary disability a long-term sickness benefit can be paid for up to 30 months (after that, benefit becomes permanent)
Sweden	Flexible but *de facto* mostly permanent; a temporary benefit can be awarded for long-lasting but non-permanent incapacities
Switzerland	*de facto* permanent but re-test every three to ten years, although possible any time (either on request of the benefit recipient or *ex officio*)
Turkey	Permanent
United Kingdom	Generally temporary as long as the personal capability assessment threshold is met; review frequency assessed at each new assessment
United States	In most cases *de facto* permanent, but subject to continuing disability review (but authorities have to prove that health conditions have improved)

Table A3.2. **Regulations on disability-related benefit suspension and work incentives**

	Benefit suspension	Other work incentives
Australia	Up to two years in case of full-time work	Part-time work is compatible in line with means-test conditions (no benefit cuts below the "free area" of AUS$ 200-230 per month; only above 70% average earnings entire benefit is foregone)
Austria	Not possible; and no incentives to resume the original occupation	Work in a different job permitted (benefit cut of 30-50% above certain ceiling)
Belgium	Up to three months for trial work; sickness benefit suspension for up to 14 days	Some additional income allowed
Canada	Possible without time limitation; "fast track" re-application process	Three months paid work trial without loss of benefits
Denmark	"Letting the pension rest" is possible during trial work and vocational rehabilitation	Special in-work supplement for people with at least two-thirds reduced vocational ability if foregoing the disability benefit
France	Not possible	Income up to pre-disability level (in first six months even above) allowed
Germany	Up to six months; immediate resumption if trial work unsuccessful for health reasons	Benefits (also partial benefits) compatible with work beyond pre-disability earnings: benefit may be reduced to ¾, ½ or ¼
Italy	Not possible	Partial benefit fully compatible with earnings up to four times the minimum pension, and partially also with higher earnings
Korea	Not possible	Earnings totally irrelevant for benefit entitlement
Mexico	Not possible	Work in a different occupation does not affect the benefit
Netherlands	Up to three years during periods of work	Benefit payment continued for up to six months with trial work
Norway	Up to three years for trial work; sickness benefit suspension in rehabilitation phase	Low additional income allowed
Poland	Not possible	Benefit for partial disability fully compatible with earnings up to 70% of average wage, and partly with earnings up to 130%
Portugal	Only in case of sheltered work	Earnings allowed up to reference wage (with subsidy for contributions payments up to this level of income)
Spain	Not possible	With partial or total own occupation disability benefits, work in different job suitable for health condition is allowed
Sweden	Up to three years during trial work (only one year without new application); wage subsidy suspension up to three years; sheltered work break up to one year	Limited additional income allowed
Switzerland	Not possible	Income up to pre-disability level allowed
Turkey	Not possible	Disability-related benefits not compatible with work; income tax abatement for workers with disabilities (granted according to three levels of work-capacity reduction)
United Kingdom	Up to one year to try work (linking rules) and up to eight weeks during first 28 weeks (*i.e.* short-term incapacity); two years if entitled to disabled person's tax credit	Benefit compatible with work of less than 16 hours per week (permitted work rules; since April 2002, permission by a doctor no longer required)
United States	Extended period of eligibility of three years during which benefits are paid for each month with earnings below substantial gainful activity (SGA) if medical condition has not improved; application within five years without new waiting period	Full benefit during trial work period up to nine months (which can be spread over five years); full Medicare coverage during extended period of eligibility plus three more months

Table A3.3. **Regulations on sickness and disability benefit levels**

	Maximum disability benefit level (main public benefit programme)	Sickness cash benefit level
Australia	Means-tested flat-rate benefit depending on family status, benchmarked at 25% male average earnings (most household income sources are considered, but with generous thresholds)	Means-tested flat-rate benefit depending on family status, about 87% of the disability benefit (no statutory benefit duration)
Austria	60% of covered pensionable earnings, remaining years partially credited	100% of earnings for 6-12 weeks (subject to contract duration), then 60% of covered earnings (up to 52 weeks in total)
Belgium	40% of lost wage if single between small minimum-maximum margin, else 65% (*i.e.* remaining years implicitly credited); flat-rate benefit for self-employed	100% of earnings in first month (one waiting day), manual workers 86% except for first week, then 60% of earnings (singles 55%) and flat-rate benefit with 3-month waiting period for self-employed (one year in total)
Canada	Around 30% of covered earnings at average income up to CAN$ 935 per month, consisting of a flat-rate basic amount and 75% of the corresponding retirement pension (with dependant's supplements)	55% of weekly insurable earnings, with a family supplement for low income earners (up to 15 weeks in total)
Denmark	Flat-rate benefit with several components (some of which own income- or also partner income-tested) depending on disability, age and marital status – up to about 150% of average income maximum	Up to about 100% of maximum unemployment benefit – *i.e.* 88% of the highest disability benefit – depending on wage and contractual working hours (up to 52 weeks within any 18-month period)
France	50% of covered earnings (*i.e.* remaining years implicitly credited), 30% for partial disability, low income supplement	50% of earnings, possibly topped up by collective agreements, raised to 66.66% after 30 days if three or more children (up to three years in total)
Germany	58% of pensionable lifetime earnings, remaining years partially credited	100% of earnings for up to six weeks, then 70% of covered earnings (up to 78 weeks in total within each 3-year period)
Italy	80% of pensionable earnings (defined-contribution), remaining years credited for full benefit only, minimum pension offered	50% of last earnings (with 3-day waiting period which may be covered at 100% via collective agreements), increased to 67% after day 20 (up to 180 days in total)
Korea	Mature system: 60% of covered earnings, remaining years not credited; currently: 30% of earnings; minimum also 30%	No sickness cash benefit programme (for work-related sicknesses, covered by work injury scheme, 70% of earnings)
Mexico	40.25% of pensionable earnings regardless of age and contribution period, with family supplement of 15% of the benefit	60% of earnings with 3-day waiting period (up to 52 weeks, or 78 weeks if incapacity remains beyond the first 52 weeks)
Netherlands	70% earnings for up to 3-6 years, subject to age (for first year usually topped up to 80-100% through collective agreements); thereafter partly calculated in relation to minimum wage, *i.e.* reduction depending on age and wage; flat-rate benefit for self-employed and youth handicapped	70% of earnings, which is for nearly all employees topped up by collective agreements to 100% of net wage (for up to 52 weeks)
Norway	Around 65% covered earnings with average income (considerable redistribution); supplementary payments via collective agreements common for higher incomes	100% of pensionable income (up to 52 weeks); self-employed either 65% or, with additional voluntary coverage, also 100%
Poland	76% of pensionable earnings (57% for a partial benefit), remaining years credited but with reduced accrual rate	80% of earnings, topped up in some collective agreements (100% if work-related or if pregnant), generally 100% from day 91 onwards (up to six months in total)
Portugal	80% of pensionable earnings (or up to 92% according to the new formula); remaining years not credited, but minimum of 30% and absolute minimum (65-100% of minimum wage) subject to work record	65% of earnings during first year (waiting period of three days for employees, 30 days for self-employed and other voluntarily insured), and 70% thereafter (for up to three years in total)
Spain	85% of last eight years' earnings (*i.e.* remaining years implicitly credited); and 47% for own occupation disability	51% of last eight years' earnings (3-day waiting period, topped up in some collective agreements), increased to 64% after first three weeks (up to 12-18 months in total)

Table A3.3. **Regulations on sickness and disability benefit levels** *(cont.)*

	Maximum disability benefit level (main public benefit programme)	Sickness cash benefit level
Sweden	Around 70% covered earnings with average income (considerable redistribution); plus almost universal coverage with occupational pensions	80% of earnings (one waiting day), generally topped up by another 10% via collective agreements (benefit payable for an unlimited period, but usually about one year)
Switzerland	Around 60% of covered earnings (public first pillar, which guarantees subsistence income, plus mandatory second pillar); a means-tested supplement can be granted for those with a half or a full disability benefit	Generally 80% of previous earnings, both for continued wage payment (between three weeks and six months subject to contract duration) and for private insurance (up to 720 days in 900-day period)
Turkey	60% of average earnings in last five years (*i.e.* remaining years implicitly credited)	67% of earnings for out-patients, 50% for inpatients (2-day waiting period), 100% for Civil Servants (up to 6-18 months in total)
United Kingdom	Flat-rate benefit (but not means-tested) paid at three different rates; long-term rate 20-25% average earnings (plus family supplements), first six months 75% and second six months 89% of that	Flat-rate benefit paid at the middle rate disability benefit (3-day waiting period); supplemented by occupational sick pay up to full wage, which is operated by 85% of employers (up to 28 weeks in total)
United States	Around 35-40% of covered earnings at average income up to US$ 1,700 per month (plus supplements for dependants and free Medicare coverage)	100% of wage via leave accrual plans (for a very short period), 50-70% with up to 7-day waiting period via temporary disability benefits (up to 13-52 weeks in total)

Note: If not specified otherwise, percentages relate to gross earnings.

Table A3.4. **Regulations on coverage of public disability-related benefit schemes**

	Sickness cash benefits	Contributory or earnings-related disability benefits	Non-contributory disability benefits
Australia	Non-contributory means-tested scheme for those employed or in full-time education above age 21	No such system	Universal means-tested programme (residents currently present in country); ten years of residence for pre-arrival disability
Austria	All employees	Labour force plus voluntarily insured with five years of contribution in last ten years (more if over age 50, less if under age 27); former labour force with 15 years	No such system (only ordinary means-tested social assistance available)
Belgium	Labour force with minimum amount of contributions and 6 months of insurance, including 120 days of paid or credited work and insurance in the last quarter		Own- and partner's income-tested income supplement for those over age 21
Canada	Employees with 600 hours insurable earnings in last 52 weeks	Labour force with four years of contribution in last six years (more flexible in Quebec)	No federal system; special means-tested benefit in three provinces, otherwise general social assistance
Denmark	Labour force with (generally) 120 hours of work in last 13 weeks	No such system	Universal "pre-pension" programme (residents aged 18-65); main components are not income-tested
France	Employees and unemployed with work record of 800 hours in last 12 months; 200 hours paid work in last three months for sick pay entitlement for the first six months; special scheme for self-employed		Means-tested supplemental allowance below certain income thresholds
Germany	All employees	Labour force plus voluntarily insured with five years of contribution, three of which in last five years	No such system until now; new means-tested system for fully disabled persons as of 2003
Italy	All employees	Labour force plus voluntarily insured homemakers with five years of contribution, three of which in last five years	Own income-tested benefit for Italian residents and EU citizens with longer-term resident card
Korea	No such system (some collective agreements, *e.g.* for government officials)	Employees with one month of contribution	Means-tested disability allowance for severely or multi-disabled persons
Mexico	Employees and unemployed with four weeks of contribution preceding illness	Employees with 250 weeks of contribution (150 weeks if 75% incapacitated)	No such system
Netherlands	All employees and unemployed	Labour force without requirements, self-employed with 52 weeks contribution	Youth handicapped persons without requirements (not means-tested)
Norway	Entire labour force	Universal (all residents aged 18-67 with three years of residence or contribution)	(non-contributory component for those people not in the labour force)
Poland	Employees with 30 continuous days of insured employment	Labour force with five years of contribution if over age 30 (less if younger); special scheme for farmers	Social pension for youth handicapped persons not covered by any other system (not means-tested)
Portugal	Employees with six months of insurance, including 12 days of insured work in last four months (voluntary insurance for self-employed)	Self-employed and employees with five years of contribution (special schemes three years, voluntarily insured six years)	Own and partner's income-tested benefit for persons in a situation of need and over age 18
Spain	Labour force with 180 days of contribution in last five years (no minimum for work injuries/ accidents)	Labour force with five years of contribution, one-fifth (full) or half (partial) of which in last ten years; former labour force with 15 years, one-fifth of which in last ten years	Means-tested benefits for those not meeting the contribution requirements

Table A3.4. **Regulations on coverage of public disability-related benefit schemes** *(cont.)*

	Sickness cash benefits	Contributory or earnings-related disability benefits	Non-contributory disability benefits
Sweden	Entire labour force	Universal (all residents aged 16-65 with three years of residence or contribution)	(non-contributory component for those people not in the labour force)
Switzerland	No public system; continued wage payment for employees plus voluntary private insurance	Universal (resident or working in the country), with one year of contribution	Extraordinary benefit if less than one year of contribution (not means-tested)
Turkey	Employees with 120 days of contribution in last 12 months	Employees with 1 800 days of contribution, or five years at 180 days each, or with old-age pension entitlement	Means-tested benefit for needy, frail and destitute persons not covered by social insurance
United Kingdom	Employees with contract for more than three months (currently about to change to all employees); access to short-term incapacity benefit if fulfilling conditions shown in next column	Labour force with six months paid contribution in last three years and 12 months paid or credited contribution in last two years	(1) non-contributory severe disablement allowance until 2001; (2) means-tested income support (*i.e.* social assistance) with special disability premiums
United States	No public system; temporary disability insurance in six states, relatively broad coverage with employer-provided programmes (*e.g.* short-term disability benefit)	Labour force with 5-10 contribution years in last ten years if over age 31 (less otherwise); youth handicapped can become eligible with three-year work period	Means-tested supplemental security income for blind and disabled people with no or low income

Table A3.5. **Attempts to prevent benefit application: some policy examples**

	Measures aimed at preventing sickness and disability benefit application
Australia	Disability reform package: tighter eligibility criteria, clearer benefit structure (1991); tightening of assessment process for disability and sickness benefits, revised impairment tables (1998); introduction of independent work capacity assessments (2002); planned: tightening of eligibility criteria (mid-2003)
Austria	Disability benefits granted temporarily (1996); special early retirement due to reduced work capacity abolished (2000); work income reduces benefit (2001)
Denmark	No direct application for disability benefits but only for social benefit, *i.e.* municipality decides whether disability benefit could be appropriate (1998) together with reduced reimbursement rates for municipalities (1990s); stricter review of sickness status (1997); planned: abolition of partial disability benefit (2003)
Germany	Work income reduces benefit (1996); disability benefits always granted temporarily, own-occupation assessment abolished for cohorts born after 1960 (2001)
Italy	New partial disability benefit (about 90% of inflow) which is granted temporarily, without crediting of remaining years (1984), work capacity criterion replaces earnings-capacity criterion, own-occupation assessment (except for partial benefit) and concrete labour market perspective abolished (also 1984); no combination of disability and work injury benefit for the same cause (1995)
Netherlands	Concrete labour market perspective abolished (1987); disability benefits granted temporarily, own-occupation assessment abolished, long-term benefit level reduced subject to age, review of benefit stock below age 45 with reclassification in 30% of all cases (1994); responsibility for sickness benefits partly (1994) and later on fully shifted towards the employer (1996), with private re-insurance; introduction of experience-rated premium rates for disability benefits (1998)
Norway	Tighter medical criteria for disability benefit receipt and for statements of treating doctors, abolition of own-occupation assessment, higher demands on regional mobility (1991); tighter medical criteria for sickness benefit receipt, judgement from insurance authority required after 12 weeks on sickness (1993); however: 1991 regulations on tighter medical disability benefit criteria had to be largely annulled after a verdict of the Social Security Court (1995)
Poland	Sickness costs shifted partly to the employer, harmonisation and reduction of sickness benefit level (1995); new disability assessment procedure with new criteria and clearer responsibilities, stricter handling of temporary entitlements (1997); better control of sickness status (1999)
Portugal	Implementation of the Verification of Permanent Incapacity System (1987); extension to sickness status assessment (1992); creation of the Verification of Incapacity System with a new assessment of disability and sickness status with more objectivity and consistency (1997)
Spain	Contribution requirements for disability benefits increased (1986); stricter control of sickness status, reduction of long-term sickness benefit level, usual occupation replaces own job assessment (1997)
Sweden	Employer has to cover first 14 days of sick leave (1992); labour market reasons as basis for disability benefit entitlement over age 60 abolished, one waiting day for sickness benefits introduced (both 1993); tighter medical criteria including abolition of the so-called elderly rules, *i.e.* milder enforcement for older disability benefit applicants (1997)
United Kingdom	Responsibility for sickness benefits shifted towards the employer (1986) with reimbursement rate reduced to 80% (1991) and abolished altogether (1995), though with private re-insurance; reduction in contributory benefit level through abolition of the earnings-related component (1995); tighter disability benefit access through a new all work test (1995) which was later replaced by personal capability assessment (2000)
United States	Reduced replacement rate, greater use of continuing disability reviews (1980) but tighter administrative control had to be relaxed after political outcry (1984)

Table A3.6. **Age-specific regulations in the disability benefit programme**

	Selected regulations that affect age groups in different ways
Australia	Benefit level: years until retirement irrelevant (means-tested and flat-rate); availability of suitable jobs effectively taken into account for persons aged 55 or above as a consequence of different eligibility criteria
Austria	Benefit level: remaining years only credited until age 56; own-occupation assessment: covers also unskilled workers over age 55
Belgium	Benefit level: years until retirement implicitly fully credited, because number of insurance years is not taken into account
Canada	Benefit level: years until retirement implicitly fully credited, because number of insurance years is not taken into account; assessment: own occupation perspective for persons between 60 and 65 (only in Quebec)
Denmark	Benefit level: years until retirement implicitly credited, because number of insurance years is not taken into account, and slightly reduced benefit for those who have the pension awarded over age 60 (not eligible for pre-pension supplement equal to 7.5% of maximum benefit); assessment: for persons over age 50, eligibility is created by work-capacity reduction induced by severe social problems
France	Benefit level: years until retirement implicitly fully credited, because number of insurance years is not taken into account (and supplement tops up low income)
Germany	Benefit level: remaining years until age 55 fully credited, plus one-third of the period 55-60; own-occupation assessment for cohorts born 1960 or earlier
Italy	Benefit level: years until retirement fully credited for full benefit, but not credited for partial benefit, hence, majority of new claimants rely on minimum pension
Korea	Benefit level: years until retirement age not credited, entitlement to basic benefit if less than 20 insurance years (30% replacement rate at average earnings)
Mexico	Benefit level: years until retirement implicitly credited, because number of insurance years is not taken into account
Netherlands	Benefit level: wage-related duration of benefit payment, with 70% of earnings, increases with age – from ½ year if age 33-37 to three years if age 53-57, six years if age 58 and until age 65 if 59 or older; similarly, reduction of benefit level during subsequent period, in which benefit is partially related to minimum wage, declines with age – at average earnings, the reduction would be about 35% if age 30 but only about 10% if age 55
Norway	Benefit level: remaining years until age 67 (statutory retirement age) are fully credited if coverage conditions are met
Poland	Benefit level: years until retirement credited as non-contribution years, *i.e.* with accrual rate of 0.7 rather than 1.3%
Portugal	Benefit level: years until retirement not credited, hence, most younger claimants will receive (earnings-related or absolute) minimum
Spain	Benefit level: benefit for total own occupation disability increased by 20% if aged 55 or older; years until retirement implicitly fully credited, because number of insurance years is not taken into account
Sweden	Benefit level: remaining years until age 65 (statutory retirement age) are fully credited if coverage conditions are met
Switzerland	Benefit level: years until retirement are fully credited, and in addition for younger benefit applicants (*i.e.* under age 45) a career factor is added to the reference income, which gradually declines from 100% if under age 23 to 5% if 39-44
Turkey	Benefit level: years until retirement implicitly fully credited, because contribution record is not taken into account
United Kingdom	Benefit level: years until retirement implicitly credited, because number of insurance years is not taken into account (flat-rate benefit)
United States	Benefit level: years until retirement implicitly credited, because number of insurance years is not taken into account (only income during insured period)

Table A3.7. **Regulations on the definition of disability and on waiting periods**

	Definition of disability	Mandatory waiting period
Australia	Two criteria: having a disability that results in a score of at least 20 points on the impairment tables, and continuing inability to work 30 hours or more a week or be re-skilled for work at full wages within the next two years	None (but mandatory waiting period of ten years for people who acquire their disability before moving to Australia)
Austria	50% work-capacity reduction (earnings-capacity reduction for unskilled workers); critical role of court decisions due to imprecise legal definition	None, but health restriction must have lasted six months
Belgium	66.6% earnings-capacity reduction in the usual occupation	One year
Canada	Severe and prolonged disability that prevents doing any work on a regular basis	None
Denmark	50% work-capacity reduction (over age 50, such reduction can be due to social reasons only)	None, but rehabilitation must be completed
France	66.6% earnings-capacity reduction, but full benefit also requires loss of work capacity	None, if condition has stabilised, but often only after three years
Germany	25% work-capacity reduction; partial disability determined in relation to hours a person can work (0-3 hours or 3-6 hours)	None, but disability must have lasted 26 weeks
Italy	66.6% work-capacity reduction (for partial benefit referring to suitable job)	None
Korea	Medical criterion (four precisely defined degrees of disability)	Waiting period of about 50 days (sickness benefits not available)
Mexico	50% earnings-capacity reduction in previous job	None
Netherlands	15% earnings-capacity reduction (25% for self-employed and disabled youth); degree of disability determined as the wage in job matching the functional limitation relative to pre-disability wage	One year
Norway	50% work-capacity reduction; but earnings-capacity reduction determines the benefit level	None (after completion of proper vocational rehabilitation)
Poland	Temporary or permanent work-capacity reduction (for benefit for partial disability referring to the usual occupation)	None
Portugal	66.6% earnings-capacity reduction in the usual occupation	None, but in practice usually after three years (end of long-term sickness)
Spain	33% work-capacity reduction in usual occupation for a partial lump sum benefit; inability to carry out "usual"/"any" work for "total"/"absolute" disability	One year (but earlier claiming for clearly permanent cases possible)
Sweden	25% work-capacity reduction; degree of partial disability determined in relation to daily hours a person can work (0-2/2-4/4-6 hours)	None (after proper vocational rehabilitation)
Switzerland	40% earnings-capacity reduction; for inactive persons, degree of disability is determined in relation to the current activity (*e.g.* housework or education)	One year
Turkey	66.6% work-capacity reduction, with a strong medical focus	None
United Kingdom	Limitations in everyday activities that are relevant to work (*i.e.* predominantly medical "personal capability assessment"); but own occupation test for first 28 weeks (sickness benefit receipt)	28 weeks
United States	Earnings-capacity reduction: inability to engage in substantial gainful activity (*i.e.* to earn US$ 740 per month)	Five months (not always covered by short-term benefits), and 24 months period for Medicare coverage

Table A3.8. **Description of the assessment procedure for disability benefit claims**

	Medical assessment	Benefit decision-making	Vocational assessment
Australia	Medical reports by treating doctors; with independent medical examinations in 65% of all cases	Single Centrelink officer based on a prescriptive set of criteria	Impairment tables refer to work in general; labour market conditions considered in assessing whether persons aged 55 and over can be re-skilled for work in the next two years
Austria	Team of insurance doctors; privately submitted medical certificates have no effects	Responsible insurance officer (in local or central insurance office)	Strict own-occupation assessment for skilled workers and unskilled workers over age 50
Belgium	Insurance doctor (in addition to follow-up of nominated reporting doctor)	Medical commission of insurance authority (decision by central commission)	Reference to equivalent worker
Canada	Insurance staff (doctors and nurses)	Single insurance officer	All jobs (own occupation for age 60-64 in Quebec)
Denmark	Treating doctor and assessing specialists contracted by the municipality	Caseworker of the municipality	Any job; rehabilitee has influence on vocational plan
France	Insurance doctor	Team of experts at the insurance authority	Reference to previous earnings (but not as regards remaining work capacity)
Germany	Social-medical consultants; through examination or on basis of medical files (*e.g.* after in-patient treatment); treating doctor's certificate taken into account but usually not sufficient	Insurance officer assesses the impact on work capacity and verifies availability of a part-time job (on the local labour market) in case of partial disability	Own-occupation assessment abolished 2001, except for cohorts born before 1961; concrete labour market view (full benefit granted if proper part-time work is not available)
Italy	Specialised insurance doctor	Assessment team (head doctor monitors all assessments)	Suitable job for partial, any work for total incapacity
Korea	Consulting doctors committee of the National Pension Corporation	Officer of the National Pension Corporation	All possible jobs taken into account
Mexico	Insurance doctor (based on a table of percentages for specified diseases)	Insurance officer	Strict own-occupation assessment (referring to pre-disability job)
Netherlands	Insurance doctor assesses functional limitation	Doctor together with vocational expert	All jobs theoretically available (though rehabilitation is voluntary)
Norway	Treating doctor (consulting doctors can be involved)	Regional officer based on assessment by local officer	Any job; actual labour market conditions may influence evaluation of return-to-work possibilities
Poland	Single certified social insurance doctor	Insurance officer in one of the regional divisions	Any job for full disability, commensurate job for benefit for partial disability
Portugal	Reporting doctor appointed by regional social security centre	Verification commission (three technically independent experts)	Reference to one's usual occupation
Spain	Team of experts at the insurance institute	Provincial director of insurance institute on basis of recommendation issued by disability evaluation team (which is a separate body)	Usual occupation for partial (33%) and total disability, any occupation for absolute and severe disability
Sweden	Insurance doctor on basis of medical files (other experts can be involved)	Insurance officer	Any possible occupation (normal job has priority)
Switzerland	Treating doctor; increasing involvement of additional medical experts	Interdisciplinary team at the cantonal disability authority	Job with reasonable income; relates to theoretical balanced labour market
Turkey	Reports issued by medical boards or health commissions of health establishments or hospitals	Insurance officer in the headquarters of the insurance authority	Refers to any work
United Kingdom	Treating doctors provide medical evidence; PCA by contracted and approved medical services doctors	Non-medical personnel in the local benefits agency	Own occupation in first 28 weeks; any occupation in PCA for disability benefit
United States	Treating doctors or consulting doctors	State disability officers (work in teams, usually not medical doctors)	Substantial gainful activity is related to any work that exists

PCA = Personal Capability Assessment.

Table A3.9. **Important aspects of the unemployment benefit scheme**

	Unemployment benefit level	Unemployment benefit duration
Australia	Means-tested flat-rate benefit, identical to sickness benefit, *i.e.* about 87% of the disability benefit (depending on family status)	No time limit; payable as long as actively seeking work or satisfying an activity test (exemptions from activity test for periods of temporary illness or incapacity)
Austria	55% of covered previous net income (with flat-rate supplements for dependants), means-tested unemployment assistance 92-95% of the preceding benefit	Minimum 20 weeks, increases to 30/39/52 weeks if employed during 3/6/9 years in last 5/10/15 years and over age –/40/50; then unlimited unemployment assistance
Belgium	55% of former earnings (60% with dependants) in first year, thereafter reduced to 44% if single (no reduction if household head with dependants)	Indefinite duration regardless of insurance period; if sharing a household with other income sources present, benefit reduced to 22% of the minimum (flat-rate)
Canada	55% of weekly insurable earnings, with a family supplement for low income earners (identical to sickness benefit)	Up to 45 weeks, depending on individual employment history and regional unemployment rate
Denmark	90% of wage up to a certain maximum (which is about 88% of the maximum disability benefit), minimum for full-time employees 82% of this maximum	Up to four years; during the benefit period (one year or, if under age 25, six months), no requirement to accept job offers, during activation period jobs must be accepted
France	57.4% of former earnings (or 40.4% plus flat-rate amount) in initial period, reduced in steps for each further six-month period (but not lower than 70% of minimum), income-tested unemployment assistance	7-60 months subject to contribution period and age (< 50/ > 50), divided in two periods; then unlimited unemployment assistance if worked five in last ten years, higher benefit if age 55/57.5 and insured 20/10 years
Germany	60% of covered previous net income (67% with a dependent child), means-tested unemployment assistance 53%/57%	Minimum six months, 12 months with two years employment in last seven years, increases up to 18/22/26/32 months if fulfilling contribution requirements and age 45/47/52/57; then unlimited unemployment assistance
Italy	30% of earnings (7-day waiting period); but up to 80% through special unemployment schemes (*e.g.* in industrial crisis)	Usually 180 days, sometimes up to one year; special schemes have a longer duration, usually around two years
Korea	50% of last wage	90-240 days depending on age (under 30, 30-49, 50 +) and insurance period (maximum with ten or more insurance years); generally 240 days if disabled
Mexico	No unemployment insurance; labour law requires employers to pay dismissal indemnity, which is a lump sum of three months pay plus 20 days pay for each year of service	
Netherlands	70% of last wage up to a maximum; follow-up benefit, which is not means-tested, equal to 70% of minimum wage (or 70% of last wage if this is less than that)	Benefit period depends on age and employment record in last five years – gradually increasing from six months to five years (if age 58); follow-up benefit for a further period of two years (or until age 65, if age 57½ when becoming unemployed)
Norway	62.4% of last year's income	Up to three years, if income exceeds two times the base amount (and for all persons over age 64), otherwise one and a half years
Poland	Flat-rate (but not means-tested) depending on employment record: 80/100/120% of PLN 446.7/month with < 5/5-19/20 + years	Varies with local unemployment rate: below average six months, above average 12 months, twice the average rate and 20 years of employment 18 months
Portugal	65% of earnings (between one and three times minimum wage), means-tested flat-rate social unemployment benefit 80% of minimum wage (100% for a family)	12-30 months, depending on age (30 months over age 45), followed by social unemployment benefit for half of this duration; if not entitled to contributory benefit, means-tested benefit for 12-30 months
Spain	70% of earnings (60% after 180 days) within 75% and 170% of minimum wage (100%/220% with dependent children); means-tested non-contributory unemployment benefit 75% minimum wage	Up to 720 days maximum with six contribution years; non-contributory benefit usually payable for 6-18 months (various groups, *e.g.* contributory benefit exhausted and children, no contributory benefit, over age 45 with additional conditions, over age 52)

Table A3.9. **Important aspects of the unemployment benefit scheme** *(cont.)*

	Unemployment benefit level	Unemployment benefit duration
Sweden	80% of daily earnings up to a maximum (5-day waiting period) for regular benefit, flat-rate 40% of this maximum for basic benefit (*i.e.* not fulfilling insurance criteria)	Up to 300 days, or 450 days if age 57-64 (for both basic and regular coverage)
Switzerland	80% of covered earnings with dependent children or low earnings or if disabled, and 70% otherwise (5-day waiting period)	150 days if under age 50, 250 days if age 50-59, 400 days if age 60 or over, and 520 days if recipient of partial disability benefit
Turkey	50% of daily net earnings up to net minimum wage	180-300 days, depending on days of contribution (300 with 1,080 contribution days)
United Kingdom	Flat-rate benefit payable at three rates: similar to low-rate disability benefit if age 25 or over, 80% of that if age 18-24, 60% of that under age 18 (3-day waiting period)	Up to 182 days in any job-seeking period, irrespective of length and level of contributions, followed by means-tested jobseeker's allowance up to 100% of the regular benefit for unlimited period
United States	About 50% of wage (state-specific insurance with some differences)	Up to 4-26 weeks (in two states 30 weeks) depending on labour force attachment in first four of last five quarters; possibly followed by extended benefit programmes or emergency benefits

Note: If not specified otherwise, percentages relate to gross earnings.

Table A3.10. **Overview on characteristics of early retirement schemes**[1]

	Important features of (the) early retirement programme(s)
Australia	As of age 55, *i.e.* 10/6.5 years earlier for men/women, via mandatory funded occupational pension scheme (superannuation guarantee) if permanently retired; as of age 60 with special unemployment allowances and no recent work experience (mature age allowance and partner allowance, which are being phased out and will be closed to new entrants mid-2003)
Austria	3.5 years before statutory age with either *i)* long insurance record (37.5 years) or *ii)* long-term, *i.e.* one year, receipt of unemployment or disability-related benefit in last 15 months and 20 insurance years in last 30 years
Belgium	Pre-pension supplement to unemployment benefit if age 58, eligible for unemployment benefit, made redundant and having 25 years of employment
Canada	Five years earlier with reduced benefit (only for the earnings-related component, not for the universal basic flat-rate benefit)
Denmark	Seven years before statutory age of 67 via voluntary early retirement insurance with 25 years unemployment fund membership and – with mature scheme – 30 years with special contribution payment (note: part of the equally voluntary unemployment insurance, with special contributions introduced in April 1999)
France	No option in public scheme (statutory retirement at age 60), but more generous rules for older unemployed workers; various private bridging-pension schemes
Germany	Two years earlier with long insurance record (35 years); five years earlier if *i)* long-term, *i.e.* one year unemployment in last 78 weeks or 24 months elderly part-time and 15 insurance years, or *ii)* women with 15 insurance years and ten contribution years after age 40, or *iii)* severely disabled and 35 insurance years
Italy	No age limit for seniority pension, which required 35 insurance years or many fewer years in public sector (currently increased to 40 years, or 35 years and age 57, and phased out altogether by 2010)
Korea	Five years earlier (statutory age currently 60 years) with ten years of contribution
Mexico	Five years earlier with corresponding benefit (from individual accounts) if 1,250 weeks with contributions (new system for those entering the labour force in 1997); ten years earlier with 15 years of service for public employees
Netherlands	No early retirement in the public pension scheme; typically five years earlier according to collectively bargained regulations which cover 70% of all employees and 100% of all civil servants
Norway	No early retirement in the public pension scheme (except for special age limits for certain professions); five years earlier according to the collectively agreed AFP programme if currently employed, 10 years of contribution since age 50, and income exceeding two base amounts (covers 60% of the working-age population)
Poland	Five years earlier for women with 30 years of insurance, war veterans, recipients of a work injury or disability benefit; special ages for certain professions; no age requirement if unemployed with 35/40 years of insurance (women/men); pre-retirement unemployment pension with an employment record of 25/30 years
Portugal	Flexible retirement ten years earlier with 30 years registered earnings with benefit reduction; five years earlier if long-term unemployed (ten years earlier with 20 years registered earnings, with benefit reduction); special age limits for certain professions; ten years earlier non-permanent pre-retirement (can precede early retirement if in business in crisis situation)
Spain	Five years earlier with considerable actuarial reduction (with 15 insurance years); one year earlier if employer concludes replacement contract; special ages for certain professions; special arrangements in some collective agreements
Sweden	Old system: advance retirement five years earlier with reduced benefit, or partial retirement four years earlier; new system: flexible retirement, also with reduced benefit (contribution-defined), up to four years earlier
Switzerland	Advance retirement 1/2 years earlier (for women until 2004/for women as of 2005 and for men) with reduced benefit in the first pillar, and up to five years earlier in the second pillar, also with a reduced benefit
Turkey	Statutory age 50/55 for women/men with minor contribution requirements; no age limit with 25 years of insurance (average age at retirement of 47-48 years, currently being phased out and mandatory retirement ages re-introduced)
United Kingdom	No early retirement in the public pension scheme; advance retirement via voluntary occupational schemes or also voluntary permanent health insurance (the latter usually provides a bridging-benefit of 50% salary for a period of ten years after retirement on ill-health grounds)
United States	Advance retirement three years earlier with reduced benefit (with ten years covered employment); up to ten years earlier in many private pension plans (defined-benefit or defined-contribution) with certain service requirements

1. The information given in this table refers to the current situation, as these are the regulations relevant to an understanding of current behaviour and incentive dynamics. In many countries, far-reaching reforms of the early retirement arrangement will be phased in during the coming years or decades – including the complete abolition of previous arrangements (for instance, with the new Polish three-pillar pension reform, early retirement regulations are phased out altogether and replaced by a system with voluntary contributions to an early retirement fund).

Annex 4

Characteristics of the Approach to Employment Promotion

Tables A4.1 to A4.8

Table A4.1. **The legislative framework shaping employment promotion**[1]

	Most important legislation influencing employment of disabled people
Australia	(1) Commonwealth Disability Discrimination Act: rules out dismissal on the grounds of a person's or his/her associates' disability, defines standards in employment; (2) Disability Services Act: outlines the rules on disability service provision (supported employment, vocational rehabilitation); (3) Workplace Relations Act: regulates employment subsidies in the open labour market
Austria	(1) Disabled Persons Employment Act: mandatory employment quota for registered disabled people, dismissal (after first six months of a new contract) only with the consent of a regional committee for disabled persons; (2) Austrian Constitution: general non-discrimination article
Belgium	(1) Social Rehabilitation Act, which formed the basis of new legislation promoting equal opportunities in each of the communities; (2) Labour Legislation: rules out discrimination in hiring on the basis of, among other things, disability
Canada	(1) Canadian Charter of Rights and Freedoms: guarantees equal rights before and under any legislation without discrimination on the grounds of disability; (2) Canadian Human Rights Act and provincial human rights acts: regulate employer obligations; (3) Employment Equity Act: requires that the composition of the federally-regulated workforce reflects the population composition
Denmark	(1) Social Model of Disability: principle of compensation (disabled people have to be compensated by society to enable the use of their abilities) and principle of sector responsibility (every sector of society is responsible for its own matters); (2) generally, policy is based on voluntariness and information
France	(1) Disabled Persons Orientation Act: promotion of equal opportunities for people with disabilities; (2) Employment of Disabled Workers Act: mandatory employment quota for disabled people, longer notice period for dismissal
Germany	(1) Severely Disabled Persons Integration Act: mandatory employment quota for severely disabled persons, dismissal (after six months of contract) only with approval by the public welfare office, various employer obligations; (2) Social Code: social right of integration (legal basis for rehabilitation); (3) new law on equality of opportunity for people with disabilities (effective as of May 2002)
Italy	(1) Framework Law on the Assistance, Social Integration and Rights of Disabled People: lays down (integration) policy principles and prescribes a series of rights; (2) Regulations for the Right to Work of Disabled People: mandatory employment quota for registered disabled people, disability up to 60% and work-disability up to 33% does not constitute grounds for fair dismissal
Korea	(1) Act on Employment Promotion and Vocational Rehabilitation of Disabled Persons: prohibits discrimination, minor mandatory employment quota for disabled people; (2) Labour Standard Act: dismissal only with justifiable reason; (3) Welfare of Disabled Persons Act: prohibits discrimination by employers and employment protection institutions
Mexico	(1) Federal Labour Law: states the right to work and protects all workers from unjustified dismissal; (2) Organisation of American States Convention for the elimination of all forms of discrimination by disability (recently ratified)
Netherlands	(1) Re-integration of Disabled Workers Act: aims to prevent labour market outflow of disabled employees and regulates employer responsibilities; (2) Dutch Civil Code: rules out dismissal because of sickness for a period of 2 years
Norway	(1) Working Environment Act: regulates employer obligations towards disabled employees; (2) Anti-Discrimination Act: prohibits discrimination on grounds of disability
Poland	(1) Vocational and Social Rehabilitation and Employment of Disabled Persons Act: mandatory employment quota for registered disabled people; (2) Labour Code: rules out discrimination in employment relations by reason of disability
Portugal	(1) Basic Act on Prevention, Rehabilitation and Integration of Disabled People: defines national policy, aims to ensure implementation of constitutional rights; (2) Portuguese Constitution: same rights and obligations for disabled people, dismissal without a justified cause prohibited; (3) Act which defines the role of the Institute of Employment and Vocational Training (support to promoters of programmes for the vocational rehabilitation of disabled people)
Spain	(1) Act on Social Integration of Handicapped Persons: mandatory employment quota, special protection to former employees receiving disability pension; (2) Workers Standing Rule: prohibits discrimination against disabled job applicants; (3) Spanish Constitution: provision on non-discrimination
Sweden	(1) Discrimination Act: prohibits discrimination against disabled people in working life; (2) Working Environment Act: regulates employer obligations; (3) Act on Support and Services for Persons with Functional Limitations: regulates obligations of the municipalities and counties

Table A4.1. **The legislative framework shaping employment promotion**[1] *(cont.)*

	Most important legislation influencing employment of disabled people
Switzerland	(1) (New) Swiss Constitution: general anti-discrimination clause; (2) generally, the system is not based on legal mandates but on voluntariness and incentives
Turkey	(1) Labour Law: mandatory employment quota for disabled people; (2) Regulations on Employment of Disabled Persons: criteria for definition of disability
United Kingdom	(1) Disability Discrimination Act: protects disabled people in all aspects of employment, prohibits dismissal for reason of disability, mandates mainstreaming of services (to be fulfilled by employers with at least 15 employees)
United States	(1) Americans with Disabilities Act: prohibits discrimination against qualified individuals with disabilities in all aspects of the employment process (to be fulfilled by employers with at least 15 employees); (2) Rehabilitation Act (to be fulfilled by federal government and organisations receiving federal funding): empowers people with disabilities, ensures that federal government plays a leadership role in promoting employment of disabled people

1. In many countries, Social Insurance Acts can be equally important for (re)integrating disabled people into the labour market. This is particularly true for countries in which vocational rehabilitation is largely under the responsibility of the insurance authorities. Those laws are not listed, because they are not targeted at disabled people.

Table A4.2. **Details on (mandatory) employment quota schemes**

	Quota	Fulfilment	Sanction	Use of levy
Australia	–			
Austria	4% (with double counting), public and private employers with over 25 employees	64% of all quota places filled; one in four employers fulfils entire quota	Levy of € 200 per month for each place not filled (0.4% of payroll)	Employment programmes for disabled persons and/or their employers
Belgium	2-2.5% in public sector, no quota for private sector	rather high	–	–
Canada	–			
Denmark	–			
France	6% (with double counting, *e.g.* in first two years of contract), public and private sector with over 19 employees	67% of all quota places filled; four in ten employers fulfil entire quota and more than one in three disregards it	300-500 times hourly minimum wage, 25% penalty for failure to pay (€ 150-250 per month, 0.45-0.75% of payroll)	Training, job retention and employment measures for disabled people, run by a statutory body (AGEFIPH)
Germany	5% (double/triple counting), public and private employers with over 19 employees	57% of all quota places filled; one in eight employers fulfils entire quota and one in three disregards it	€ 100-250 per month for each place not filled, depending on fulfilment (0.25-0.65% of payroll)	Range of integration services for disabled people (55% managed by provinces, 45% by ministry)
Italy	7% for public and private sector with over 50 workers, one / two places for 15-35/36-50 employees	no statistics since new law was introduced (2000), but about 50% of quota fulfilled during 1986-1998	€ 52 per work day (€ 1 075/month) for each place not filled (one-fourth if no appropriate candidate (4% or 1% of payroll)	Regional programmes for disabled people (*i.e.* regional funds)
Korea	2% for public sector and private sector with over 300 employees	72% fulfilment in public, 46% private sector; one in six employers fulfils entire quota	65-75% of minimum wage, depending on fulfilment ($ 324 per month for each place not filled, 0.5% of payroll)	Employment promotion projects for disabled people (subsidies, equipment, guidance, research)
Mexico	–			
Netherlands	Legal authorisation to impose a quota system as ultimate solution			
Norway	–			
Poland	6% (double/triple counting) for private employers with at least 25 full-time employees; 2% for public sector	limited available data indicate a quota fulfilment of around 33%	Levy of 40.65% of average wage per month for each place not filled (2.4% of payroll)	Rehabilitation and employment programmes for disabled people, run by a special state fund (PFRON)
Portugal	5%, but only for new recruitment in public sector	–	–	–
Spain	2% for private sector with over 50 employees and entire public sector	25% in private and 30% in public sector (non-fulfilment seen as serious offence)	No sanctions; obligation to report disabled employees and verification by labour inspection bodies	Employment activities carried out by NGOs and non-profit organisations
Sweden	–			
Switzerland	–			
Turkey	3% for public and private sector with over 50 workers	no statistics on quota fulfilment available	$ 410 per year for each place not filled (around 0.2% of payroll)	Almost only vocational rehabilitation and training measures
United Kingdom	(3% quota for employers with over 20 workers abolished 1996)	(rapidly declining quota compliance until 1996)	–	–
United States	–			

Table A4.3. **Major obligations for the employer**

	Regarding work	Regarding rehabilitation	Regarding sick pay
Australia	Employer obliged to accommodate work or workplace, unless this would impose unjustifiable hardship (rigid interpretation of the term "unjustifiable")	No employer obligations	Continued wage payment during first days of sick leave (5-8 days per year for blue-collar, 8-20 days for white-collar workers)
Austria	Take the state of health of disabled employees into account (no sanctions, but considered in dismissal procedure); contribute "reasonably" to the adaptation of the workplace	No employer obligations	Continued wage payment for 6-12 weeks (depending on length of employment); no re-insurance possibility
Belgium	Only for some high-risk sectors of the economy: reassign or adapt job after absence of four weeks due to illness or accident	No employer obligations	Continued wage payment for one month for salaried employees; manual workers: 100% in 1st, 86% in 2nd, 26% in 3rd/4th week
Canada	Duty to accommodate workplace conditions (*i.e.* eliminate discrimination resulting from a rule, practice or barrier) except for cases of undue hardship (with fines in case of non-compliance)	No employer obligations	no employer obligations, *i.e.* no period of continued wage payment
Denmark	None; emphasis on encouraging social responsibility of employers (social index, social accounting)	No employer obligations	Continued wage payment for two weeks (if employed for 13 weeks, and no increased risk of sickness); longer periods (collective agreements) with sickness benefit reimbursement
France	Guarantee ease of access (to work, toilet, eating facilities), should adapt work station; adapt work or working time for victims of work injuries/accidents	No employer obligations	no obligation, but several collective agreements top up low sickness benefits
Germany	Provide employment according to skills and abilities, preferential selection for training within company, support to attend training elsewhere, examine vacancies for potential for disabled persons	No employer obligations	Continued wage payment for first 6 weeks; without re-insurance possibility
Italy	Assign equivalent tasks or lower-graded tasks but under old conditions, make necessary adaptations to work organisation	No employer obligations	No obligation, but several collective agreements bridge the waiting days
Korea	Should – with technical guidance – offer employment in line with abilities (but no sanctions)	No employer obligations	Collective agreements can include regulations on sickness-related payments (*e.g.* government officials)
Mexico	No employer obligations	No employer obligations	No employer obligations, *i.e.* no period of continued wage payment
Netherlands	Rehabilitation obligation can include work accommodation and working hours reduction; prohibition of medical checks during hiring process	Employer ought to submit a plan on rehabilitation measures after 13 weeks of sick leave (only minor sanction, most employers do not feel responsible); responsibility remains for entire first year as long as employee may be able to return to the employer	Sickness benefit payment during entire 52-week period (except for work disabled persons during first five years of employment), but employers can re-insure with a private insurer; obligation to contract with sickness absenteeism management service

Table A4.3. **Major obligations for the employer** *(cont.)*

	Regarding work	Regarding rehabilitation	Regarding sick pay
Norway	Ensure suitable work (but dismissal possible after 6-12 months), arrange work conditions in general so as to enable employment of people with disabilities	No employer obligations	Continued wage payment during the first 16 days
Poland	Ensure workplace accommodation and access; for work injuries: arrange for suitable workplace if employee declares readiness to return to work	Disabled employees have a right to special breaks for rehabilitation exercises	Sickness benefit payment during first 35 days
Portugal	Only for work injured: adapt workplace, offer compatible job and part-time work	Again, only for work injured: offer vocational training and leave to train for other employment	No obligation; moreover, topping up sickness benefits is not permitted
Spain	Former employees on disability benefit who recover have absolute priority for filling a suitable vacancy; or (after partial benefit) must be offered same or similar job, possibly with up to 25% reduced wage	During promising rehabilitation process, employer must keep post for two years	Sickness benefit payment from day 4 to day 18
Sweden	Provide reasonable suitable accommodation if the employee or job applicant is sufficiently qualified (*e.g.* purchase tools and change working environment, work organisation, work tasks and working hours); provide, if possible, a different job in the company	Employer is responsible for submitting a rehabilitation analysis to the regional insurance office within first eight weeks of sickness, also for repeated short-term sickness (no sanctions, only 35% do so); and for taking rehabilitative measures that can be conducted in the company (not against the will of the employer, and again no sanctions)	Continued wage payment during the first 14 days (except for first day)
Switzerland	No employer obligations (protection against dismissal during period of continued wage payment)	No employer obligations	Continued wage payment at reduced level (80% of the wage) for between three weeks and six months, subject to contract duration
Turkey	Work-injured workers are given a priority right; civil servants have the right to ask for a suitable job	No employer obligations	Continued wage payment for civil servants borne by state as employer
United Kingdom	Employer has to make reasonable adjustments, *e.g.* adjust premises, reallocate duties, alter working hours, provide different workplace, modify equipment, provide supervision (mostly financial and compensatory sanctions)	No employer obligations except for allowing rehabilitation absences	Sickness benefit payment during entire 28-week period (reimbursement possible where costs exceed 13% of total social security contributions), but employers can re-insure with a private insurer
United States	Provide reasonable accommodation (*e.g.* adjust equipment, make facilities accessible, modify work schedules) unless this would be undue hardship (sanctions include, *e.g.* back and front pay, attorney fees, accommodation, re-instatement, job offers)	No employer obligations	Voluntary employer-paid benefits like leave accrual plans (paid sick leave up to 12 days per year or balance of 6-12 weeks, paid time off up to 20 days per year or balance of 4-6 weeks) or short-term disability benefits (cover first 13-52 weeks)

Table A4.4. **Approaching vocational rehabilitation and training: selected examples**

	Approach to vocational rehabilitation
Australia	Voluntary (except for unemployment beneficiaries and people with injuries acquired in the workplace or through motor vehicle accidents); services can include initial needs assessment, disability management and post-placement support; eligibility assessed on the basis of severity of disability (with required minimum of 50 Work Ability Tables), impact on work capacity, and potential to gain from a programme; Centrelink, the government's key social service centre, refers potential clients to providers; services are delivered and access determined by the Commonwealth rehabilitation provider, which receives government funding under an annual service level agreement with predefined performance targets and reporting requirements, and under a new quality assurance framework; there are no established programme guidelines for voluntary vocational measures; intervention possible any time (*e.g.* at the client's request, during benefit receipt or review), but acceptance into a programme unlikely during sickness benefit receipt
Austria	Compulsory (benefit claim treated as a request for vocational rehabilitation) and also a right; aims to restore or improve the work capacity of the insured; implemented if present job cannot be resumed but prospect that another job commensurate with the person's qualifications can be carried out; persons are eligible who meet or are soon likely to meet the requirements for a disability pension; far-reaching training and occupation measures (can include university curriculum); operated by insurance authorities in collaboration with the labour market service and financed by insurance contributions; secure benefit income (disability pension or special transitory allowance)
Denmark	Compulsory for access to systems run by the municipalities, *i.e.* disability benefits as well as subsidised jobs and sheltered employment; entitlement, which requires possibility for full or partial self-reliance, settled by a caseworker in the municipality (based on medical and vocational information); recently, encouragement of voluntary primary rehabilitation within firms; rehabilitation process consists of pre-rehabilitation phase (clarify vocational aim, draft vocational plan) and rehabilitation phase; implemented according to the principle of "the earlier the better" after stabilisation of medical condition, but possible when already on disability benefits; secure benefit income (special rehabilitation benefit if not entitled to any other benefit); municipalities' cash expenses reimbursed from the federal budget at a rate of 50% (compared with 35% for disability benefits)
France	Optional; financed by sickness/disability insurance bodies and offered by specialised centres for vocational rehabilitation; eligibility assessed by COTOREP, the departmental commission for assessing work capacity (but stabilisation of medical condition required); strong incentives to enrol due to generous rehabilitation benefit (100% of former salary up to a ceiling, or 30% of ceiling if not previously employed)
Germany	General right for all disabled people – without any restrictions – to the extent this is necessary to maintain, improve or restore work capacity and secure integration into the labour market; quasi-compulsory (agreement of the disabled person required, but benefit suspension possible); early intervention and efficient and prompt implementation; far-reaching measures; financed and operated by insurance authorities and the federal labour authority (which is responsible for co-ordination); also health insurance has to check the necessity for vocational rehabilitation before, during and after medical rehabilitation; secure benefit income (usually special transition or education allowance)
Netherlands	Voluntary programme because work motivation is seen as vital factor for success, but disabled person is expected to follow the rehabilitation plan; early intervention should (in theory) be assured and offered by the employer, who has to prepare a rehabilitation plan after 13 weeks of sickness and who keeps responsibility during the entire one-year sickness benefit period; rehabilitation plan has to be approved by the national institute for social insurance, which becomes responsible after the first year (*i.e.* also for all those people who have been granted a disability benefit), or earlier if the disabled person is not able to return to the employer or if the employer does not assume responsibility; consequently, attendance of vocational rehabilitation programmes often starts only in the second year; the plan is implemented by the national institute, but contracted out to private service providers, which are currently being created
Norway	Not mandatory, but in principle rehabilitation should be tried before benefit award; everybody classified as vocationally disabled (definition of the public employment service – PES) or eligible for social security benefits (social insurance definition) is eligible for vocational rehabilitation; PES bears responsibility for setting up an individual training plan and for funding vocational rehabilitation; traditionally implemented before disability benefit award, but increasingly both early intervention for people with shorter sickness spells – with suspension of sickness benefit – and also late intervention for people on disability benefit; secure benefit income (special allowance if no other benefit entitlement)
Poland	Voluntary, but a right; meant to help disabled persons – who are registered as unemployed or as job-seekers – to get adequate employment and promotion at work through vocational counselling, training (up to 36 months) and job placement services; includes special assessment of inability to work; financed from contributions to compensatory levy fund and other state budgets; secure benefit income (training pension) during six months up to a maximum of 36 months

Table A4.4. **Approaching vocational rehabilitation and training: selected examples** *(cont.)*

	Approach to vocational rehabilitation
Portugal	Voluntary, although legislation favours vocational rehabilitation before compensation pay; far-reaching programmes offered by various public and private institutions; accessible for everybody (with strong focus on mainstreaming); eligibility assessed by expert teams in the Institute for Employment and Vocation Training (IEFP); vocational training typically divided into three phases: pre-training (up to one year), training/qualification (up to two years) and apprenticeship in an enterprise (up to one year); usually offered after receipt of sickness benefits (*i.e.* often at a rather late stage); secure benefit income through training allowance of 70% of minimum wage (in addition to other benefits)
Spain	Compulsory for persons entitled to disability-related benefit (payment conditioned on follow-up of plan); insurance authority responsible for determining a recovery plan and programme, and funding, with early intervention; special subsidy (75% of sick pay) available to workers on sick leave not entitled to sick pay; rehabilitation services voluntarily accessible by other groups (funded from government revenues, responsibility of public employment service and social services)
Sweden	Compulsory, *i.e.* disability pension cannot be granted if there is still a possibility that the person will be rehabilitated; training must also be accepted for inferior jobs; eligibility only requires that the person be considered in need of rehabilitation by the national insurance office; employer is responsible for submitting a rehabilitation analysis, while the national insurance office is responsible for funding, making a rehabilitation plan and co-ordinating various measures; vocational rehabilitation is usually provided by special employability institutes (Ami), while training is offered by labour market training centres; measures are taken whenever need is identified – also after short sickness spells (though rarely during first eight weeks), preventively while still working, or late intervention when already on disability benefits; rehabilitation is always connected with a special rehabilitation allowance, which is higher than the sickness benefit
Switzerland	Compulsory (integration-before-benefits principle is applied since introduction of invalidity insurance in 1960); vocational rehabilitation is granted if work capacity could be improved or maintained, and until the person can be re-integrated; eligibility also requires the person being declared disabled in line with the Invalidity Insurance Act (or in case of an impending disability); insurance authorities are responsible for eligibility assessment and for setting up an individual rehabilitation plan; measures are financed by statutory contributions and government subsidies of invalidity insurance; wide range of rehabilitation measures; rehabilitation often starts at a relatively late stage (permanent or long-lasting work-capacity reduction); authorities have no information about the need for rehabilitation during sickness absence, because there is no duty to register during periods of continued wage payment or receipt of sickness cash benefits from a private insurer; secure income through daily allowance that is higher than a disability benefit
United States	Voluntary, but everybody has the right to submit an application; eligibility requires that rehabilitation services are needed to achieve an employment outcome; assessment is made by a rehabilitation counsellor or case manager, who also has to approve the plan; generally, clients themselves have to seek out services; systematic outreach only during disability benefit application and review; broad range of services with emphasis on the client's preferences; focus more and more shifted towards assisting severely disabled people without any work experience; flexible and individualised, but difficult to enter and – notwithstanding the substantial budget – lacking funding to serve the needs of all; matching federal-state funding for public rehabilitation services and reimbursement by social insurance authority for benefit recipients; very limited subsidies to rehabilitation clients but SSA benefit recipients usually retain their benefit; several new forms of consumer-directed services (individual training accounts, ticket to work voucher) through which the client can choose and contract with an approved provider, and new outcome-based funding procedures

Table A4.5. **Good practice subsidised employment programmes**

	Subsidised employment: examples of good practice
Belgium	Both through collective agreements (CCT 26, 50% of labour costs) and through regional regulations (with lower subsidy level, *e.g.* 30% sector-specific minimum wage in Flanders), subsidies are granted for reduced productivity of a disabled worker; most of these subsidies, including CCT 26, are renewable and can thus become permanent; claimants have to enrol with the regional disability agency, loss of productivity is assessed by a doctor, external multidisciplinary teams make recommendations to the responsible authority (the federal inspectorate of labour for CCT 26, regional administration for other subsidies)
Denmark	Flex-job scheme: subsidy to the employer according to three levels of work-capacity reduction, equal to one-third, half, or two-thirds of the minimum collective wage; eligibility requires permanent work-capacity reduction, completion of vocational rehabilitation and impossibility to work in a normal job or under social chapter employment (which is special employment with reduced wage under collective agreements); subsidies are granted for an unlimited duration; flex-jobs must always be full-time jobs and, hence, cannot be combined with disability benefit payments; for the future, considerable increase in the number of flex-jobs offered is planned (from 9 000 to something like 40 000), thereby gradually replacing partial disability benefits (the ability to handle a flex-job will be introduced as the major criterion for determining disability benefit eligibility)
Korea	Employment subsidies for any disabled worker for a period of three years (with declining subsidy rate) have been abolished in 1999, and replaced by far more generous subsidies, with unlimited duration, only for employment in excess of the mandatory employment quota; the new subsidy varies with the degree of disability and gender – the basic rate is 100% of the minimum wage, topped up by another 50% if severely disabled and another 25% if female
Sweden	Flexible wage-subsidy scheme, mainly for new recruitment: subsidy covers up to 80% of wage costs up to a maximum level (empirical average is 60%) depending on the degree of, and changes over time in, reduction in work capacity; assessment of eligibility and work-capacity reduction (on the basis of a medical certificate and the type of work the person shall carry out) is done by the employment agency; funded by he labour market authorities; subsidy is payable up to four years, with regular adjustment of the subsidy level, and can be resumed within three years after having started non-subsidised work

Table A4.6. **Good practice supported employment programmes**

	Supported employment: examples of good practice
Austria	Vocational counselling (Arbeitsassistenz) aims at obtaining jobs in the open labour market, and at securing jobs at risk by means of mediation; it is provided by non-profit organisations and qualified social workers, psychologists or other specialists; it is financed by rehabilitation authorities; it consists of five phases: *i)* contact with the disabled person, *ii)* preparation of an occupational or training plan, *iii)* information and entrance phase (reconcile employer and employee needs), *iv)* follow-up assistance (few weeks or months) and *v)* crisis intervention whenever needed; tasks of Arbeitsassistenz involve: developing profiles of skills, identifying and minimising obstacles on the way to employment, finding the right job, introduction at the workplace, psychological and social assistance at the workplace, developing personal working methods and organisational structures, installation of working aids, establishing communication, exchange of information between the disabled person, their colleagues and supervisors, conflict management, and crisis management in case of a pending dismissal
Denmark	Personal assistant can be hired to assist in practical occupational functions arising from specific employment; this type of assistance is granted unlimited in duration, and for up to 20 hours per week for a full-time job of 37 hours per week; the subsidy is given to the employer (or the self-employed disabled person), because the assistant is a regular employee; assistant must be approved by the disabled person; similar type of assistance can also be granted in work-related education and during vocational rehabilitation
Germany	Accompanying support, financed from the compensatory levy fund, can be granted to severely disabled people unlimited in duration (also for temporary jobs and part-time employment of at least 15 hours per week) in order to make full use of skills and capabilities and secure full integration; in addition, recently there is a right to support by work assistance for a period of up to three years (this is granted and financed by the rehabilitation authorities)

Table A4.7. **Good practice sheltered employment programmes**

	Sheltered employment: examples of good practice
France	Two main types of sheltered employment: (1) centres for help through work for severely disabled people with more than two-thirds work-capacity loss (zero transition rate), and (2) sheltered workshops for people with less than two-thirds capacity loss (1.5% transition into open employment each year); both types offer permanent employment; eligibility is assessed by COTOREP; workers in centres for help, which are run by not-for-profit bodies, must be paid at least 5% of the minimum wage ("SMIC", which is about € 900 per month) and are guaranteed 55-110% of SMIC via top-up payments; workers in workshops, which operate as commercial enterprises, must be paid at least 35% of SMIC and are guaranteed a minimum income of 90-130% of SMIC (also via subsidy)
Netherlands	A strong focus on sheltered employment has existed since the 1950s, with introduction of more business-like management and in 1989 more attention on the transition to open employment; in 1998, significant programme re-orientation took place in order to increase efficacy: responsibility was fully shifted to the municipalities, which are obliged to provide sheltered labour market opportunities, and which receive a central government subsidy for every disabled person employed in sheltered employment; three subsidy levels depending on the severity of the disability; per person subsidy to encourage the creation of sheltered workplaces in a regular work environment or of so-called guided work (regular job with guidance from a special institution); sheltered employees work in competitive enterprises, with regular labour conditions and statutory collectively agreed wages; permanent employment is still possible, though only with renewable temporary contracts
Norway	Labour market enterprises with strong focus on the transition into the open labour market; these sheltered employment entities consist of three distinct phases: phase 1 – testing the training prospects, phase 2 – testing the transition prospects, and phase 3 – permanent employment; unusually high percentage makes the transition into the open labour market (around 30%); at any stage, at least 50% of the workforce has to be in phase 2, which cannot last more than two years; phase 1 usually takes place while being on sickness benefits, while during second and third phase standard wages are paid

Table A4.8. **Access to different employment programmes**

	Anti-discrimination, employment quota	Subsidised employment	Supported employment	Sheltered employment
Australia	Anti: disability that presently exists, previously existed, may exist in the future or is imputed to a person	Eeligibility is assessed on the basis of support needs; all persons with a disability can in principle qualify, and they can also approach service providers directly		
Austria	Quota: "registered disabled", *i.e.* long-lasting disability of at least 50% (strictly medical)	Registered supportable disabled, *i.e.* at least 30% disability, unable to find job without such measures	Severely disabled, most with mental or sensual disabilities or psychological disorders	Registered disabled whose output matches at least 50% of that of an average productive worker
Belgium	Public quota: long-term limitation in opportunities for social or professional integration	Similar to quota and registered with the regional disability agency; some regions in addition require a minimum incapacity level depending on the type of disability		
Canada	Anti: previous or existing disability, including disfigurement and drug or alcohol dependence	Provincial programmes, often with differing definitions; federal wage subsidies target unemployed persons having difficulties finding work; supported employment focuses on people with intellectual or developmental disabilities		
Denmark	Principles: apply to all disabled persons	Reduced work capacity, normal employment impossible, vocational rehabilitation completed	Severe visual or hearing impairment or severely reduced functioning (permanent help needed)	Severely reduced functioning, unable to access any other employment programme
France	Quota and employment subsidies and support: registered with COTOREP (commission for assessing disability status) or work injury victim or disability benefit recipient or war veteran			Degree of work-capacity loss determines type of programme
Germany	Quota: "registered severely disabled", *i.e.* disability of at least 50% or equal status (*e.g.* 30-49% and unable to obtain a job)	Same as for quota and registered as unemployed	Same as for quota	Extent and type of disability makes open employment impossible, but able to do some productive work
Italy	Quota and the few available employment programmes: "registered disabled", *i.e.* 45% general work-ability reduction or 33% work-related ability reduction or military service disability or visual/hearing/speech impairment ("compulsory placement list")			
Korea	Quota, anti-discrimination and subsidies: considerable restriction in working life caused by disability for an extended period of time (medical definition)		Severely disabled or judged to have difficulty in finding proper work/need on-site support	Severely disabled living in the community who are difficult to employ
Mexico	No such programmes			
Netherlands	–	Classified as work disabled: current or former disability benefit recipient or on sheltered employment waiting list or passed the work disability test, which is valid for five years and renewable		Severe disability, *i.e.* can only work under adapted circumstances
Norway	–	Classified as vocationally disabled by the PES	Classified as severely vocationally disabled by the responsible authority, the public employment service (PES)	
Poland	Quota and all employment programmes: disability assessment carried out by local assessment teams – to determine degree of disability and identify appropriate training and employment measures; note: assessment obtained to receive social insurance benefits is also recognised			
Portugal	New quota: disability of at least 60% and able to perform the job	Difficulty in securing or retaining a suitable job	Disabled in training at work (initial integration phase)	Inferior productivity, unable to work in open employment, registered with department
Spain	Quota, grants for workplace accommodation and for employers, and employment programmes: assessed to be handicapped, *i.e.* certified degree of handicap of at least 33%			Same as for quota and registered as unemployed

Table A4.8. **Access to different employment programmes** *(cont.)*

	Anti-discrimination, employment quota	Subsidised employment	Supported employment	Sheltered employment
Sweden	Anti: any lasting impairment resulting from an injury or disease	Registered vocationally disabled at regional employment office	Registered as severely vocationally disabled	Registered; can work half-time but cannot obtain any other work
Switzerland	–	Declared disabled along with the invalidity insurance act		Subsidy to institution requires 50% disability
Turkey	Quota: disability identity card, *i.e.* 40-70% work-capacity reduction		No such programmes	
United Kingdom	Anti: substantial and long-term disability with adverse effect on ability to carry out ADL	Blurred boundaries between programmes: nature and severity of disability prevents person from finding job in open employment (open employment must be considered first and shown not to be feasible)		
United States	Anti: qualified person (*i.e.* able to perform the job) with disability that limits one or more major life activities	Disability-label neutral, *i.e.* access is determined by programme characteristics	Eligibility varies with the funding agency	State programmes use their own configurations and criteria

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