

15. Approaches to Assisting Working-Aged People with Disabilities: Insights from Around the World

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INTRODUCTION

A 2003 report from the Organisation for Economic Co-operation and Development (OECD), *Transforming Disability into Ability*, concluded that sickness and disability policies in the member states were afflicted with serious efficiency and equity problems requiring fundamental and comprehensive reform (OECD 2003). The 2010 OECD report, *Sickness, Disability, and Work: Breaking the Barriers*, indicated that in the intervening years, several countries had made efforts to reform their disability and sickness policies (OECD 2010). While evaluation results are not definitive, there is evidence that these efforts have achieved some success in reducing the growth in benefit reciprocity rates, and encouraging rehabilitation and continued work.

In the next section, I present some background on the size and characteristics of the population of workers with disabilities across developed countries. They are older and have less education, far less contact with the labor market, and a relatively low economic position.

The third section discusses the overall structure of policy targeted on the working-age disabled population in six Western, developed nations. This overview describes overall policy structure from the bottom tier of social minimum support policies to the third tier of disability and old-age pensions. The nature of disability-related income support programs in each country is described. The basic characteristics of the income support programs targeted on workers with disabilities in those countries are presented in some detail. For each country, the percentage of the working-age population receiving disability income support benefits is shown, as well as the percentage of each nation's Gross Domestic Product (GDP) spent on income support and sickness benefits for workers with disabilities.

The fourth section of the paper describes in broad-brush terms the nature of the changes in disability policy that have been made in several Western developed nations. The fifth section presents a country-by-country analysis of the nature of policy revisions over the past several decades in the six countries on which we have concentrated.

The sixth section draws lessons from these reform efforts of other nations for the United States, and the final section concludes.

BACKGROUND ON THE DISABLED WORKING-AGE POPULATION

In spite of differences in the definition of working-age disability, the general characteristics of the disabled population are similar. Those individuals tend to be older than the average working-age person and have less education. For example, the percentage of the working-age population with less than a high school degree is substantially higher among the disabled than it is among the able-bodied

(OECD 2010). For both of these reasons, the average employment rate for persons with disabilities tends to be lower than that for the able-bodied working-age population.¹ Consistent with this, their incomes are lower as well.² Because of differences in the generosity of the social welfare systems, poverty rates across countries vary widely. While Sweden and the Netherlands have achieved relatively equal rates of poverty across households both with and without a disabled person, countries with less generous social program benefits have not.

It should be emphasized, however, that the outcomes of those with disabilities reflect both basic underlying conditions that lead to a lack of work capability and their behavioral responses to incentives created by existing policies. Without a clear counterfactual, it is difficult to ascertain how these employment and economic well-being characteristics would be altered should policy be changed. Our cross-national approach is one way to attempt to observe changes in behavior/economic well-being in response to a policy change. However, even with this approach, establishing a clear counterfactual is not straightforward; a variety of other economic and policy changes may occur simultaneously with changes in disability policy. In sum, two things seem clear: first, there are real and meaningful differences in economic status and well-being between those with and without disabilities, and, second, that policies directed at people with disabilities may affect behavior and hence these observed characteristics.

Interpreting these conclusions regarding the economic position of people with disabilities is difficult, as countries vary in terms of how they interpret the concept of work disability. To identify this group and observe their characteristics—and hence the choice of policies designed to protect and support them—requires both a definition of disability and a performance norm or standard. From an economic point of view, individuals of working age with disabilities are those with physical or mental characteristics that limit normal daily activities or result in a substantial decrease in work productivity. In order to establish a clear definition, it is necessary to establish a performance norm or standard—just how much must a person be constrained or fall short of being able to fully undertake normal daily activities or to be productive at work in order to be classified as disabled? Different nations have chosen different characteristics to be used in establishing disabled status, as well as different performance norms and standards to which performance shortfalls are compared. As a result, the rates of working-age disability vary widely across countries, as do their characteristics.

THE STRUCTURE OF POLICY ASSISTING DISABLED WORKERS IN SEVERAL WESTERN NATIONS

Overview

Virtually all Western developed nations have a complex set of policies that provide protection to workers with disabilities. As Burkhauser, Daly, and Ziebarth (2015) have discussed, most countries provide this protection in tiers, which vary across the countries. As they have noted, the first tier typically provides universal, long-term, needs-based cash transfers designed to guarantee a minimum

¹ Across the OECD countries, the employment rates of people with disabilities were about 40 percent compared with about 75 percent for people without disability. Across these nations, about 25 percent of employed disabled people work part-time, while only about 13 percent of working nondisabled people work part-time. Across OECD nations, the unemployment rate for people with disabilities is about twice that as for those without (OECD 2010).

² In most OECD countries, working-age households with a disabled person have a significantly higher risk of *relative* income poverty than do other households. Across OECD countries, the poverty rate for households with a person with a disability is about 22 percent, compared with 14 percent for other households (OECD 2010).

level of income support to families headed by a working-age person. The second tier supports the income of those able and expected to work, but who are temporarily unemployed. The amount of support provided tends to be based on the level of past work and earnings; the benefits are time-limited and in some cases related to household needs. The third tier provides income support to those who are aged, sick and disabled. These programs can either be needs-based or based on past earnings. Since recipients of sickness benefits are viewed as temporarily unable to work, support is generally time-limited. Disability pension benefits are reserved for those who are not expected to be employed; hence, support is not time-limited. The generosity of disability pension benefits tends to be greater than the support available in tiers one and two.³

All industrialized nations have third-tier, pension-type programs that provide financial assistance to working-age individuals with disabilities. Governments face a difficult balancing act in designing their disability benefits programs. They want to ensure that people who cannot work because of their health do not fall into poverty, while at the same time not creating undue incentives for the healthy to retire early by offering generous benefits.

In all nations, in order to secure benefits, workers are required to meet established eligibility standards concerning the extent of the disabling condition and the implication of the condition for successful participation in the labor market. The benefits from these disability pension programs offset the income loss due to the inability of the worker to engage in full-time work.

I have chosen a set of Western, developed countries to illustrate these patterns; they include the Federal Republic of Germany, the Netherlands, Sweden, Australia, the United Kingdom, and the United States. Brief descriptions of the basic characteristics of the income support programs targeted on workers with disabilities are presented in the next part.

A review of the disability-related programs across these countries reveals the following:

- Most of these nations have a first-tier universal needs-based cash transfer program providing social minimum income support to all working-age citizens. For some of the nations, such basic income support is limited to people with specific characteristics; for example, in the United States, minimum income support through the Supplemental Security Income program (SSI) is available to the aged and people with disabilities who do not qualify for pension-type benefits or in conjunction with pension-type benefits for the severely poor.
- All of the nations have a cash income support program providing assistance to workers who become unemployed. Typically, these unemployment benefit programs are funded by a payroll tax paid by both workers and employers. The generosity of the benefits varies widely among the countries, as does the period of time for which support is available.
- The extent and generosity of sickness benefits varies widely across the nations. All of the countries except the United States offer some form of sickness benefit.⁴ In most of the countries, receipt of sickness benefits is a gateway to the receipt of disability pension benefits.
- All of the countries have well-developed and long-standing disability pension programs that provide income support to working-age people with serious health conditions. Some of the nations (e.g., the United States) provide support only to workers who are totally disabled, while

³ Burkhauser, Daly, and Ziebarth (2015) provide a more full-bodied discussion of the typical three-tier structure of social protection policies.

⁴ The United States does not have a general public sickness benefit program but provides paid sick leave to government employees.

other nations provide support to workers who are totally and partially disabled. The benefit levels (relative to average wages) vary substantially across these programs.

- All of these nations have well-defined rules that determine whether applicants for support are eligible for public full-and partial disability-related income support. The stringency of these rules varies substantially across the nations, as does their application.

Table 1 indicates the substantial variation in the disability and sickness income support programs across the six countries. For each country, the percentage of the working-age and the older (ages 60-64 years) population receiving disability and sickness benefits is shown in column 2. The percentage of the working-age population that receives disability benefits varies from a low of 3 percent in Germany to about 7.5 percent in Sweden (Burkhauser, Daly, and Ziebarth 2015; Burkhauser et al. 2014).⁵ Column 3 gives some insight into the extent to which older working-age people (ages 50-64) are receiving benefits from the disability insurance (DI) program in their country. The percentage of older workers—those aged 50-64—receiving disability benefits is substantially greater than the overall percentages. While about 21.5 percent of the people in this age range receive DI benefits in Sweden, only about 7.5 percent of these older working-age people receive DI benefits in Germany.⁶ In the United States, about 10 percent of people of these ages receive disability benefits. Column 4 shows the level of public spending (as a percentage of GDP) devoted to disability-related programs across the countries. Expenditures on disability-related benefits, including sickness benefits, ranges from a low of 1.4 percent of GDP in the United States to 2.9 percent of GDP in the Netherlands.⁷ Finally, column 5 shows the growth rate of overall disability pension reciprocity across a selection of these countries. The 3.1 percent growth rate for the United States is the highest among the countries shown.⁸

Country	Percent of working-age population receiving disability benefits	Percent of population aged 50-64 receiving disability benefits	Disability-related public expenditures as a percentage of GDP (2011)	Average Annual Growth in disability benefit reciprocity: 1970-final
Federal Republic of Germany	3 percent	7.5 percent	1.3 percent (sickness benefits = 0.3 percent)	-0.93 percent
The Netherlands	6 percent (other disability-related benefits = 2 percent)	15.1 percent	2.9 percent (sickness benefits = 0.9 percent)	2.69 percent
Sweden	7.5 percent	21.5 percent	2.2 percent (sickness benefits = 0.7 percent)	2.30 percent
Australia	5.3 percent	11.5 percent	2.1 percent (sickness benefits = 0.6 percent)	NA
United Kingdom	6 percent	12.0 percent	2.0 percent (sickness benefits = 0.1 percent)	2.08 percent
United States	4.8 percent	10.1 percent	1.4 percent (sickness benefits = 0.2 percent)	3.10 percent

⁵ Statistics on the percentage of the working-age population receiving benefits are from Burkhauser, Daly, and Ziebarth (2015) and Burkhauser et al. (2014).

⁶ Data on the percentage of the population aged 50-64 receiving disability benefits taken from Figure 2.A1.2., page 72 of OECD (2010).

⁷ Data on the percentage of GDP spent on sickness and disability cash benefits is from the OECD Statistics Library, accessed on September 2, 2015.

⁸ The growth rates were calculated from statistics in the OECD Statistics Library. (See also OECD [2010, figs. 1.1-1.7].)

Disability-Related Support Programs in Six Developed, Western Economies

In this subsection, I briefly describe the disability-related income support programs in each of these countries, emphasizing the basic characteristics of the income support programs targeted on workers with disabilities.⁹

Federal Republic of Germany

As do other European nations, Germany provides a social minimum income to all citizens through a universal needs-based cash transfer program. Benefits are funded out of general revenues. In general, beneficiaries of the first tier program are considered to be able to work. Benefit levels are set nationally and vary based on household size and composition (Burkhauser, Daly, and Ziebarth 2015).

Germany also provides second- and third-tier benefits. Benefits targeted on workers temporarily not working are provided through an unemployment insurance (UI) program funded by a payroll tax; support is available to workers who have been employed for at least 24 months prior to applying. Unemployed workers under the age of 50 are paid benefits for up to 12 months. The duration of benefits for workers older than age 50 increases in steps up to the maximum level of 24 months, which is reached at age 58. Earnings replacement rates vary from 60 percent to 67 percent (SSA 2014; Burkhauser, Daly, and Ziebarth 2015).

Third-tier benefits in Germany include the sickness benefits program, the Statutory Old-Age Pension Scheme (OAP) and the Work Disability Pension (WDP) for both partially and totally disabled workers. Full- or part-time employees who become unfit for work due to sickness, have 100 percent of their net wages paid by their employer for six weeks. If the sickness spell continues, workers are evaluated for access to long-term sickness benefits that replace 70 percent of net wages for an additional 78 weeks during a period of three years.¹⁰

The WDP disability pension program pays benefits to workers who have paid into the system during their work life. Similar to UI, employers and employees are each subject to a payroll tax—9.45 percent of the monthly gross wage up to the social insurance contribution ceiling. In 2014, total WDP benefits paid per month were about €11 billion, or about 4 percent of total OAP/WDP spending (Burkhauser, Daly, and Ziebarth 2015).

The entry into the disability pension program is typically through the receipt of sickness benefits. Upon the exhaustion of sickness benefits, workers can apply for WDP benefits. They must present documentation of continued health problems that require them to work less than six hours per day. If it is determined that they are able work between three and six hours per day, they receive partial disability benefits. If the worker is able to work no more than three hours per day, he/she is awarded a full disability pension (Burkhauser, Daly, and Ziebarth 2015; OECD 2010; SSA 2014).

There are about 80,000 partial WDP beneficiaries; their annual average cash benefit equals about €6,000. There are nearly 1.3 million full WDP beneficiaries and their average annual benefit received is about €8,700 (Burkhauser, Daly, and Ziebarth 2015; OECD 2010; SSA 2015). WDP beneficiaries

⁹ Most of these nations also have programs, often tied to the income support programs, which emphasize work, and are designed to encourage and facilitate the labor market connections of the disabled worker. The country-specific descriptions that follow emphasize the disability-related income support programs.

¹⁰ See Burkhauser, Daly, and Ziebarth (2015) for a discussion of the benefit programs in the three tiers.

total about 3 percent of the working-age population. OECD estimates that, in 2011, public spending on incapacity was 1.3 percent of GDP (OECD 2015).

The Netherlands

As in Germany, the Netherlands has a social minimum benefit program for disabled adults with little or no work history. This categorical disability-based welfare program is not means tested. The Netherlands also offers social insurance programs that protect workers against lost labor earnings if disabled.

The Dutch sickness benefit program mandates that employers provide 70 percent wage replacement to employees too sick to work for up to two years. Collective bargaining agreements often raise the replacement rate to 100 percent (Burkhauser et al. 2014).

The main disability benefit program (WAO/WIA) distinguishes between fully and partially disabled workers.¹¹ Those who are fully disabled receive guaranteed income until age 65; the benefits paid to the partially disabled depend upon their work history and level of incapacity as determined by medical providers. Fully disabled workers covered by the program have 75 percent of their daily wage covered by public benefits. The programs are supported by employer contributions (Burkhauser et al. 2014; Prinz and Tompson 2009; Van Sonsbeek and Gradus 2011; OECD 2010; SSA 2014).

Currently, about 6 percent of the working-age population, or about 650,000 people, receives disability pension benefits. When all disability related programs are taken into account, the percentage increases to about 8 percent, or about 850,000 individuals. OECD estimates that public spending on incapacity was 2.9 percent of GDP in 2011 (OECD 2015).

Sweden

As in Germany and the Netherlands, Sweden has a three-tier social benefit structure. At the base is a public and universal needs-based cash transfer program providing a social minimum income guarantee to all residents. Applicants are required to specify the reason for seeking support; disability, parental needs, or old age are all options.

The second tier of the income support system is the unemployment insurance benefits program. The mandatory component of the program is supported by employers and replaces a minimum fraction of wages for covered workers for at least six months. A voluntary unemployment insurance program also exists and covers most workers; benefits in this program reflect negotiations between firms and trade unions. Swedish residents can also privately purchase unemployment insurance.

The third tier of income support benefits in Sweden includes national social insurance programs providing pensions for retired and disabled workers. These programs are financed by statutory employer and employee contributions. Collectively bargained occupational-based insurance and pension programs supported by employers are also available to many Swedish workers. Sickness

¹¹ A worker is judged to be fully and permanently disabled if his/her earning capacity is less than 20 percent of former earnings. Partial disability benefits are paid to workers younger than age 65 with assessed disabilities prohibit them from earning 79 percent of former earnings.

benefits are available for the first 14 days of illness, with a doctor's approval. Workers are required to periodically document their health problems.

Two forms of disability income support are available to those judged by program administrators to have permanent reductions in work capacity. The first is a universally guaranteed pension which provides assistance to all those residing in Sweden; the second provides an earnings related pension in which benefits depend on weeks of work and past earnings (Burkhauser, Daly, and Ziebarth 2015; OECD 2010).

About 450,000 people receive a disability-related pension, which is about 7.5 percent of the working-age population. OECD estimates that public spending on incapacity was 2.2 percent of GDP in 2011(OECD 2015).

Australia

Australia has a sickness benefit program, the Sickness Allowance program. To be eligible, a worker must be judged unable to work or study full-time because of a temporary medical condition, illness, or injury. Eligibility also requires a job to return to; if a full-time student is on public support, the applicant must return to full-time study upon recovery. The program covers Australian citizens between age 21 and the pension age.

Australia's disability income support program—the Disability Support Pension (DSP)—is basically a universal, means-tested guaranteed income benefit program available to all workers with disabilities over the age of 16. As such, it is both a tier one benefit program and a disability pension program. An eligible worker must be determined to have a physical, intellectual, or psychiatric impairment with a severe impact on his/her ability to function. Severity is determined as an inability to work at least 15 hours per week in a minimum-wage job for at least two years.

The benefits provided do not reflect past earnings, and benefits are available even if the worker has not contributed to the funds that support benefit payments. Hence, the Australian program is not a typical social insurance program. Benefits in the program exceed those in the welfare and unemployment insurance programs. Overall, benefits are substantially less generous than those in Sweden, the Netherlands, or Germany (Burkhauser, Daly, and Ziebarth 2015; OECD 2010; SSA 2015).

Recipients total about 5.3 percent of the working age population. OECD estimates that public spending on incapacity was 2.1 percent of GDP in 2011 (OECD 2015).

United Kingdom

Great Britain, like the other European countries, provides first-tier benefits through its universal, needs-based income support program, the Supplementary Benefits program. The central program in the second tier is the Unemployment Benefit program for those expected to work.

Starting in the 1970s, Great Britain established the third-tier Invalidity Benefit program (IVB) designed to provide social insurance-type benefits to working-age people with disabilities. Workers with sufficient social insurance contributions (made while employed) whose physical or mental health condition kept them from working in their usual occupation were deemed eligible for income support through the IVB program. They established eligibility via their family doctor, who certified the nature

of their condition. If they met these conditions they first received a Sickness Benefit (which lasted for 28 weeks) through the IVB, followed by IVB disabled worker payments. The income support payments exceeded the benefits paid in the unemployment insurance program. In addition, some recipients with long work histories were provided an additional subsidy related to the level of their market earnings. Even for these workers, the replacement rate was lower than those in the other western-European programs (Burkhauser et al. 2014; OECD 2010; SSA 2015).

Workers with insufficient contributions to the social insurance program who established eligibility for disability income support had their social insurance contributions paid by the IVB program, and were then provided lower, first-tier Supplementary Benefits payments.

This basic program structure, though modified over time in several ways,¹² stood until 2008. In 2008, the Employment and Support Allowance (ESA) program replaced the disability pension program that had evolved from the IVB program. Like the original IVB program, the ESA also provided a social insurance-type benefit for those with sufficiently long work histories and means-tested benefits for those without sufficient work history. However, the process of establishing eligibility for benefits was greatly tightened, and the emphasis was directed toward work-related activities. In the new work assessment program, workers must be judged to have “limited capacity to work” based upon a numerical scoring system, i.e. scoring 15 or more points on a points-based assessment of physical and mental capabilities.¹³

OECD estimates that public spending on incapacity was 2 percent of GDP in 2011. About 6 percent of the working age population receives disability-related income support. Over 1.8 million people are benefit recipients (OECD 2015).

United States

Unlike the European countries, the United States has neither a universal needs-based cash transfer program nor a mandated sickness benefit program. The nation’s only long-term needs-based cash transfer program is the Supplemental Security Income (SSI) program, which is limited to the aged, disabled adults, and parents of disabled children. The Temporary Assistance for Needy Families (TANF) program is the successor to the Aid to Families with Dependent Children (AFDC) program and provides needs-based cash transfers to single mothers at a benefit level lower than the SSI program. Support is limited to five years, and efforts to secure employment are required.

The second tier of benefit programs in the United States includes unemployment insurance which provides wage replacement for 26 weeks (which is often extended during recessionary periods, reaching 99 weeks after the onset of the Great Recession).

The Social Security Old-Age and Survivors’ Insurance retirement (OASI) and disability (SSDI) programs constitute the third tier of benefits, and provide social insurance benefits to workers who have contributed to the programs over their working lives through payment of Social Security taxes. To qualify for OASI and SSDI benefits, workers must have accumulated quarters of coverage

¹² For example, in 1995 the IVB program was replaced by the Invalidity Benefits program (IB). This change reduced the level of income support, raised the bar for establishing ability to work, and tightened the process through which eligibility was determined.

¹³ See Morris (2015) for a detailed description of this process. See also Adam, Bozio, and Emmerson (2010).

representing substantial attachment to the work force. Benefits paid are based on past earnings and are higher than the benefits guaranteed by the SSI aged and disability programs.

The SSDI program provides benefits to workers who meet a federal disability standard. State-based administrative evaluators and adjudicators make a determination of eligibility. Eligibility requires that a worker be “unable to perform any substantial gainful activity on any job in the economy for at least one year.” The United States has no disability-related program that provides support in case of a partially disabling condition (Burkhauser, Daly, and Ziebarth 2015; OECD 2010; SSA 2014; Burkhauser et al. 2014).

In 2011, 10.6 million people collected SSDI benefits, up from 7.2 million in 2002. The share of the US working-age (ages 25-64) population receiving SSDI benefits stood at about 4.8 percent. In 2013, the average monthly disability payment was \$1,146, or about \$14,000 per year.¹⁴ OECD estimates that public spending on incapacity was 1.4 percent of GDP in 2011 (OECD 2015).

RECENT TRENDS IN DISABILITY POLICY ACROSS SELECTED DEVELOPED COUNTRIES

The structure of public support provided to working-age people with disabilities varies widely across nations. These different approaches reflect different values and disparate assessments of the economic gains and costs assigned to alternative approaches to assisting the population with disabilities.

For example, public policies supporting people with disabilities are used to provide better economic outcomes for these people. Income support and rehabilitation policies are the natural responses to this desire to help people with disabilities. However, cash transfer programs, like income replacement programs, also produce work disincentives and impose increased costs on the rest of the economy. These costs lead to initiatives that would correct the market distortions, such as measures to reduce the private costs of hiring people with disabilities and to increase the possibility that people with disabilities would find and hold a job. Proposals for direct job creation programs, such as employment subsidies, the subsidization of private sector efforts to adapt workplaces, and quotas for hiring people with disabilities reflect this emphasis. An equal access rationale supports antidiscrimination laws for workers with disabilities designed to guarantee equal access to employment, education, and mobility.

The nations with the most comprehensive approach to the population with disabilities—Denmark, the Netherlands, Switzerland, Finland, Germany, Norway, and Sweden—tend to have universal benefit programs that provide generous financial support. These nations also tend to have a relatively low threshold for determining the presence of disabling conditions, though such thresholds have been increasing in recent years. Most of these countries also tend to have a broad, accessible employment integration policy with a strong focus on rehabilitation.

A second set of countries, including the United States, Canada, United Kingdom, Japan, Korea, Australia, and New Zealand, also have an extensive set of programs supporting people with disabilities. However, the benefits paid are relatively low and the criteria for establishing disability tend to be rather strict. For example, in assessing the work capacity of applicants for benefits, authorities may assess an

¹⁴ http://ssa.gov/policy/docs/statcomps/di_asr/2013/sect01b.html Accessed September 1, 2015.

individual's capabilities relative to *any* job rather than the applicant's usual occupation. Rehabilitation efforts tend to be modest and direct incentives to work are evident in only some of the countries.

Many of the nations have programs that are intermediate to those in the first two categories in terms of generosity, eligibility leniency, and rehabilitation. In general, the policies that characterize this set of countries—including Austria, Belgium, Hungary, France, Luxembourg, Ireland, Italy, and Spain—also tend to have fewer work incentives and more limited coverage of the population.¹⁵

In this section, we present an overview of recent efforts to reform public policy toward people with disabilities across these OECD nations, recognizing the wide disparities in their policy approaches toward working-age people with disabilities.¹⁶ In the next section, we discuss the nature of these policy changes in a selection of Western, developed economies, including Germany, Sweden, the Netherlands, Australia, the United Kingdom, and the United States.

Over the past decade, reform in disability pension programs has taken many forms, but in most cases policy changes have been concentrated on disability pension policies. These changes have focused on reducing the rate of disability beneficiary status while simultaneously encouraging continued labor market work for those with disabilities. While nations have sought to attain these goals in different ways, two major thrusts have dominated policy changes:

1. Creating incentives to encourage rehabilitation, accommodation, and continued employment.
2. Tightening both the level of and access to disability pension benefits.

Employment and Rehabilitation Measures

Over past decades, nearly all developed countries have established policies designed to encourage people with disabilities to remain in or re-enter the workforce. Most of these policies are tied to disability benefit program reform. Vocational rehabilitation efforts seek to restore and develop the skills and capabilities of people with disabilities increasing their productivity and participation in the workforce (OECD 2010).

Early rehabilitation efforts have played an important role in Germany, Sweden, the Netherlands, and the United Kingdom. Sweden has imposed workplace accommodation requirements on employers, also for new job applicants. In the Netherlands, employers are required to undertake efforts to reintegrate sick employees into the workplace. In line with their obligation to provide sickness benefits for two years (described above), employers are also responsible for retraining over this period (OECD 2010). Other countries have also emphasized early rehabilitation efforts. In Austria, provision for vocational rehabilitation became compulsory in 1996; claims for disability benefits are treated as an application for rehabilitation. Hungary, too, has introduced a “rehabilitation-before-benefit” principle, allowing workers with disabilities to transition into the disability benefit program only if there is no potential for rehabilitation. Switzerland has gone a step further, and is moving towards a rehabilitation-instead-of-benefits principle, requiring applicants to fulfill explicit

¹⁵ These categories of policy approaches to people with disabilities rest upon distinctions made in OECD (2010, 88). There these approaches were referred to as the ‘Social Democratic model’, the ‘Liberal model’, and the ‘Corporatist model’.

¹⁶ The discussion of the various reform measures across countries in this section draws heavily from OECD (2010, 78-84). Discussion of reforms in a more limited set of countries is found in Burkhauser, Daly, and Ziebarth (2015) and Burkhauser et al. (2014).

rehabilitation obligations before receiving benefits, with sanctions for noncompliance. Several countries, including Sweden and the United Kingdom, have brought forward the assessment process to ensure that rehabilitation is much closer to disability onset (when return to work is more likely).

Several countries have focused on *strengthening employer incentives* to keep sick people or people with disabilities in work. Both the Netherlands and Sweden have merged their sickness and disability programs, since a key driver of beneficiary inflows was from workers who take extended sick leave. As described above, employers in the Netherlands pay sickness benefits for up to two years, and a third year of benefit support is required if it is found that insufficient efforts have been made to reintegrate sick workers into the workforce. In some countries including the Netherlands, Finland, Canada, and Switzerland, employer contributions to social insurance depend upon the number of their workers that lodge disability claims (“experience rating”), providing a strong an incentive for employers to maintain and rehabilitate workers with disabilities.

The focus on controlling access to disability benefits through receiving sickness benefits has also led to *stricter sickness absence monitoring* in a number of countries. Danish municipalities have been given increased incentive to rigorously monitor worker absence because of sickness and to introduce early intervention efforts. Spain has established an agency charged with monitoring absence rates, and thereby reducing them. Both the Netherlands and Sweden have provided general practitioners with detailed medical guidelines to be used in granting sick-leave certificates. These measures seek to ensure that sick workers return to work as soon as feasible (OECD 2010).

Other countries including the Netherlands have *turned partial benefits into work payments* rather than passive income support. In 2006, the Netherlands instituted an employer-based wage supplement for workers with partial work capacity if they work a sufficient number of hours. The objective of the wage subsidy is to change labor costs in favor of workers with disabilities, so as to increase the demand for them. Several countries including Belgium and Denmark have abolished partial benefit schemes due to their high costs, and instead provide an in-work subsidy which covers the difference between the wage a person was receiving before the onset of disability and their new wage. Denmark subsidizes the wages of workers with disabilities who are not able to perform their work under normal conditions; the subsidies are available only after rehabilitation efforts have been exhausted (OECD 2010). Others, such as Australia, Germany, the United Kingdom, and Norway have also sought to link disability and other benefit programs with work requirements, encouraging the enforcement of such requirements.

Many countries, including the United Kingdom and Germany, have also *increased the emphasis on work capacity in addition to medical injury in the eligibility determination process*. Since 2003, Denmark began assessing a person’s functional capabilities and the tasks the person can perform in determining eligibility for income support.

Tightening Benefit Compensation Policy

A number of developed countries have reduced the access to benefits in recent decades, but few countries have actually reduced benefit payments; the Netherlands and Denmark are exceptions. Access to benefits by new applicants has been restricted through tighter eligibility criteria or more rigorous application of them. A focus of these efforts is increasing the effectiveness of the monitoring of the sickness absence phase, which often leads to the receipt of long-term disability benefits.

One way to restrict access to disability benefits is to ***increase the minimum level of incapacity*** required to gain eligibility for benefits. Australia (along with the Netherlands, Italy, and Luxembourg) has followed this strategy. In Australia, eligibility was changed by increasing from 15 to 30 the number of hours per week that the partially disabled worker was capable of working. In the Netherlands, the minimum earnings capacity loss necessary to qualify for disability benefits was increased from 15 percent to 35 percent.

Another approach has been to ***centralize medical assessment***, assigning responsibility for assessing capability to government agencies instead of family doctors. The goal is to make medical assessments more objective by reducing the reliance on judgments by a diverse range of family medical practitioners. The United Kingdom has embraced this approach most strongly. Spain, New Zealand, and Switzerland have recently tightened the application of medical assessments by assigning the responsibility for disability determination to personnel employed by the public sector rather than the doctors of benefit applicants (OECD 2010).

Other countries have introduced ***more stringent vocational criteria*** into the determinations process, often by expanding the range of jobs taken into account in determining eligibility. The Netherlands, for example, requires applicants to demonstrate that they are unable to do any theoretically available job in order to receive benefits. The United Kingdom also moved to assess work capacity based on an applicant's ability to do any work, rather than just their usual occupation. Germany implemented such a change for younger workers, but insured workers older than 40 years have their capabilities compared to the norms of their own occupations.

There has also been a shift toward ***providing temporary, rather than permanent benefits***. Germany (as well as Austria and Poland) has moved from a situation where benefits were permanent (with no robust reassessment) to making them temporary, except in the case of a full disability. In Poland, benefits are awarded for a three-year period, after which recipients must reapply and be reassessed. In practice, moving to a temporary benefits system requires some form of reassessment after a set period of time; countries have adopted quite different approaches to handling this reassessment.

A number of countries have attempted to ***increase the work incentives*** for disability benefit recipients. In the United Kingdom, for example, a special working tax credit and a temporary earnings subsidy were introduced to increase the take-home earnings of labor market work. Similarly, the Netherlands offers a wage subsidy for partially or temporarily disabled people who perform market work. Other countries have increased work incentives by enabling people with disabilities to combine work and disability benefit receipt, often through an "earnings disregard" benefit structure. The Nordic countries (Sweden, Norway, Denmark, Finland) and Canada enable workers with disabilities to put their awarded benefit on hold while they try to succeed in employment; no reassessment is required to return to benefit status.

Improving Institutional Arrangements

In several countries, the expansion of employment measures has been accompanied by changes in the structure of service provision. Financing mechanisms have also been strengthened by providing incentives to public authorities and service providers for encouraging work by those with disabilities (OECD 2010).

Some countries have moved toward a *one-stop-shop model* for benefit and service provision for people with a disability. In Australia, one agency determines disability payment eligibility and provides benefit payments for disability and unemployment, along with a range of government support services. A new customer-oriented UK agency coordinates employment arrangements and benefits advice for people of working age. New Zealand and Norway have also attempted to move toward this coordinated model in which income support and employment assistance is provided by a single agency.

In a related policy change, some countries have attempted to provide *stronger incentives for benefit authorities* to assist those with partial work capacity to become employed. Denmark, for example, pays higher reimbursement rates to local governments (which are responsible for employment support and benefit grants) if they provide effective employment supports; the hope is that with the higher rates, local governments will have an interest in avoiding benefit payments. In a similar but less developed way, Dutch municipalities are rewarded if they can demonstrate improved utilization of the work-related programs available to their clients.

A more recent development in some countries—Australia, the Netherlands, and the United Kingdom, for example—is a shift toward *outcome-based funding* of employment services. With such a policy, service providers are reimbursed only for the actual employment or participation outcomes delivered (OECD 2010).

DISABILITY POLICY REFORMS IN SELECTED DEVELOPED COUNTRIES

This section describes the nature of recent changes in disability policy in five developed nations—Germany, Sweden, the Netherlands, Australia, and the United Kingdom. Germany, Sweden, and the Netherlands have been characterized by OECD as conforming to a Social Democratic model; Australia and the United Kingdom are thought of as conforming to the Liberal model.¹⁷ These countries have been the focus of our earlier discussion of disability policy in the third section. These country-specific descriptions draw heavily from Burkhauser, Daly, and Ziebarth 2015; Burkhauser et al. 2014; and OECD 2010.

Germany

Germany, like most European nations, has a needs-based program of assistance that provides a guaranteed minimum income to all citizens. Benefit levels are set nationally and vary based on household size and composition. Beneficiaries are considered to be able to work at least three hours per day and are counted as part of the workforce. Beginning in 2004, the program imposed job search and job training requirements on beneficiaries.

As described in the third section, Germany also has a generous unemployment benefits program paying benefits for up to 12 months with extensive work experience (up to 24 months for workers who are at least 50 years old when becoming unemployed). Benefits range from 60 to 67 percent of average monthly wage earnings over the prior year.

¹⁷ See OECD (2010, 88).

Workers in Germany are also eligible for sickness benefits that pay between 70 and 100 percent of their net wages. Those benefits are provided by employers, and receiving the sickness benefit is often the first step toward receipt of a disability pension.

As discussed in the third section, partially and totally disabled workers who have contributed to the payroll tax supporting the program during their working life are covered by the Statutory Old-Age Pension Scheme (OAP) and the Work Disability Pension (WDP).

Starting in the early-1970s, policy changes to expand eligibility for WDP benefits resulted in an increase in the prevalence of disability pension receipt. As a result, during this period Germany had among the highest recipiency rates of any of the countries shown in Table 1. One reason for this higher rate was a change in WDP rules in 1969 that allowed partially disabled workers to receive full WDP benefits if they could demonstrate an inability to find a job. Further expansions in 1972 extended coverage to housewives and the self-employed and allowed workers with disabilities to transition to the retirement program at age 62 without an actuarial reduction in benefits. Both of these measures contributed to the rapid growth in disability recipiency throughout the 1970s. By 1984, 5.8 percent of the working-age population received disability pensions.

After 1984, in response to the rise in beneficiaries and program cost, Germany tightened the criteria for gaining coverage. The number of years of market work experience required to gain coverage was increased, reducing access to program benefits for women not working in the paid labor market.

Additional changes were made in the 1990s and 2000s. In 1996, caps on the earnings of WDP beneficiaries were introduced to reduce the inflow of (primarily male) workers into the program by about one-half. In 2001, another round of structural WDP changes occurred, principally an increase in the standard for being declared “work limited” from the occupation in the last job (or a job comparable to it) to being unable to work in any available job. WDP changes in 2004 continued to focus on reducing the flow of new recipients into the program, largely by promoting worker accommodation on the job. Employers were required to provide reintegration to the job in the case of a work-limiting impairment. The goal was to keep impaired workers on the job and off the WDP roles.

In sum, the early expansion of coverage and generosity of the German program resulted in both a high level of recipiency and rapid program growth. Subsequent reforms limited access, made benefits less attractive, and mandated that employers undertake reintegration activities. These changes resulted in a decrease in disability benefit recipiency rates over the past four decades.

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Prior to reform efforts beginning in the 1980s, Germany had one of the most generous and inclusive sickness and disability benefit systems among the countries studied; recipiency rates were high and rising. In response, a series of restrictive reforms were introduced, including:

- The number of years of required market work was increased to gain coverage (reducing access to previously covered nonworkers including housewives) (mid-1980s)
- A cap on the earnings of disability pension recipients was imposed (reducing substantially the number of new male recipients) (mid-1990s)

- Eligibility for coverage was tightened (from being work-limited in the last or comparable job to any job in the economy); employers were required to provide rehabilitation and reintegration services for workers experiencing work limitation (early and mid-2000s)

The Netherlands

As in most northern European nations, one disability pension system supports the income of workers with health impairments while a second program provides minimum benefits for those with insufficient work history. The Dutch disability pension program (WAO/WIA) provides benefits for both partially and fully disabled workers. The benefits provided are related to the extent of lost earnings due to the health impairment. Conversely, the welfare-type program targeting people with disabilities without sufficient work history provides a social minimum level of income support. The Dutch disability pension program grew rapidly over the decade of the 1970s, largely because of a high level of wage replacement. The Dutch sickness benefit program—the gateway to the receipt of disability benefits—covers up to 80 percent of lost earnings for up to a year. In addition, sick workers received additional income support through agreements bargained with their employers. After receiving a year of sickness benefits, workers whose health kept them from working in a job consistent with their training or experience were eligible to receive disability pension benefits. Benefits paid to those viewed as fully disabled were equal to 80 percent of their net earnings; those who were partially disabled received benefits commensurate with their impairment with a minimum of 15 percent of wage replacement (Burkhauser, Daly, and Ziebarth 2015).

Legal developments also contributed to the rapid growth. In the 1970s, court decisions required those responsible for evaluating disability status to find that discrimination caused the absence of work for those found to be partially disabled. As a result of these rulings, it became standard practice to classify partially disabled workers without employment as being fully disabled. Those rulings effectively eliminated the designation of partial disability. The combination of relatively high benefit payments and the effective elimination of partial disability benefits explained the high (11 percent) growth rate of disability reciprocity in the Netherlands during the 1970s (Burkhauser, Daly, and Ziebarth 2015). This rapid growth in reciprocity and costs led to changes in the Dutch disability pension system in the early 1980s. By the mid-1980s, the level of benefits relative to wages was reduced from 80 percent to 70 percent. Although the “discrimination rule” was eliminated, most of those granted a disability pension were awarded full benefits. Moreover, the percentage of applicants denied benefits remained low. The rate of growth in reciprocity and cost was lower in the 1980s than in the 1970s (Burkhauser, Daly, and Ziebarth 2015). In recent years, the Netherlands has reoriented its approach to sickness and disability income support by placing more responsibility on firms. In 1994, eligibility criteria were further tightened. Firms were required to cover the sickness benefits of workers for the first six weeks; in 1996 this was extended to one year, and in the early-2000s to two years. In addition, firms were required to follow rather fixed procedures in assisting the rehabilitation or accommodation of workers. This deliberate shift toward employer responsibility for accommodation and rehabilitation relieved the demands on the disability pension program.

In 2002, a third phase of reforms was initiated in Holland. The disability pension program (WAO) was replaced in 2004 by a new scheme—the Work and Income Act (WIA). Work rather than benefit receipt was viewed as the norm and even greater incentives were provided both workers and firms to provide accommodation and rehabilitation to workers with health limitations. These changes represented a fundamental change in Dutch disability policy (Burkhauser, Daly, and Ziebarth 2015).

With these work-orientation mandates in place, workers with limitations had to wait for two years before applying for a disability pension. Upon application, they were required to provide detailed documentation of efforts to gain employment during the prior two years. The rate of benefit denial increased, and employers continued to be responsible for the worker's support until a job was found or the application accepted. Requirements designed to stem the high rate of benefit recipiency were complemented by other changes. A pay-as-you-go rate was imposed on employers to support the disability pension program. In addition, employers were required to pay premiums in support of the first 10 years of benefit receipt based on their experience in employing workers with disabilities.¹⁸ The partial disability program also required employer support, although employers could avoid this cost if they enrolled their workers in a private disability insurance program (Burkhauser, Daly, and Ziebarth 2015).

Because of these reforms, the Dutch disability system is increasingly viewed as an example for other countries to follow. Researchers suggest that by 2040, these post-2002 policy changes will reduce the number of disability pension recipients by nearly 1 million (van Sonsbeek and Gradus 2011).

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In recent decades, disability benefit reform in the Netherlands has been triggered by concern over the high and rising disability recipiency rates in the 1970s and early 1980s. The major reforms occurred at three different times and consisted of the following:

- Reduction in replacement rates from 80 percent to 70 percent; attempted tightening of eligibility criterion (mid-1980s)
- Continued tightening of eligibility criteria; assignment to employers of responsibility for first year of sick pay in order to encourage efforts to provide continued employment to workers with illness and other limitations (mid-1990s)
- Employer responsibility for sick pay increased from one to two years; a prescribed list of rehabilitation and accommodation requirements stipulated for firms to provide employee assistance in returning to work or finding a new job; workers required to document their work efforts in order to claim disability benefits after two years on sickness benefits; employers required to pay for the full disability program through a uniform premium payment and for the partial disability program through experience-rated premiums (mid-2000s)

Sweden

As described above, Sweden, like most European nations, has a base universal means-tested income support program providing an indexed social minimum income floor. Benefits are uniform across the nation and indexed.

Sweden's second-tier program supports covered workers who have lost their jobs or are temporarily laid off. The mandatory part of the program relies on employer payments and replaces a fraction of

¹⁸ After 10 years, the uniform pay-as-you-go rates that cover the fully and permanently disabled and the stock of current beneficiaries under the old system also cover the partial disability program.

lost wages. There is also a voluntary unemployment benefits program that is the result of union-firm negotiations. At least six months of income support is provided.

Finally, Sweden has both sickness benefits and a disability benefits programs. Workers with sufficient work history are covered by both programs, which are financed by employer and employee contributions. In addition, many private firms contribute to occupational programs providing disability coverage for employees.

During the 1970s, the Swedish disability pension program grew rapidly, in part due to the attraction of generous benefits and the ease of access to benefits. For example, the sickness benefit program had an earnings replacement rate of about 90 percent for workers experiencing a loss of work capacity of at least 25 percent.

After one year of receipt of sickness benefits, employees experiencing a loss of work capacity greater than 50 percent are able to apply for long-term disability pension benefits. In addition to receiving income support, rehabilitation and vocational training services are provided to workers aged less than 60 years. The earnings replacement rate in the disability benefits program is similar to the generous benefits provided by the sickness program.

During the 1970s, it became possible for a worker to receive disability income support if unemployed for more than one year. In effect, the disability benefit program became a long-term unemployment insurance program offering generous benefits. This change, together with the high earnings replacement rate and the ease of gaining access to benefits, led to continued rapid growth in disability benefit reciprocity through the 1980s and into the early 1990s recession.

In the early-1990s, policymakers made adjustments designed to slow the growth of disability program costs and recipients. Employers were first required to pay sickness benefits for the first two weeks of absence from work due to illness; subsequent changes further increased employer costs for worker sickness absence. Moreover, the threshold for gaining access to benefit receipt was increased. In part due to these changes, the size of disability roles stabilized until the 1990s.

In the early 2000s, the reforms begun in the 1990s were accelerated. Taken as a package, these policy changes reflected the decision that public support for work would replace income support in lieu of work. As a first step, the sickness and disability programs were merged in 2003. The screening process was standardized between the two programs, and rehabilitation and vocational training to promote participation in work prior to cash benefit receipt was emphasized. This merger also required that vocational and rehabilitation experts become involved early in the process in an effort to reduce the rate of initial application for long-term disability benefits. Receipt of sickness benefits was limited to one year, and reevaluation of recipients was done every six months. Employers were mandated to cooperate with disability program administrators in creating rehabilitation and training programs. These efforts to emphasize work rather than income support and to tighten access to benefits led to reductions in the prevalence of both sickness and disability benefit receipt.

Further reforms designed to curb increases in sickness and disability program reciprocity and costs were undertaken within the past decade. These reforms continued the emphasis on work rather than income support in lieu of work. Additional work incentives were provided to workers with health conditions at the same time that employers were required to accelerate the development of rehabilitation and training plans. Periodic reevaluation of benefit recipients was pursued and the

generosity of sickness benefits awarded to those who should have—but did not—return to work. As a result of these changes, increasing numbers of sickness benefit recipients returned to work, and the average time spent in receipt of benefits was reduced.

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Sweden has undertaken a series of reforms designed to reduce growth in the disability reciprocity rate. Many of these changes did not take place until after the turn of the century. There is evidence that these changes reduced beneficiary inflows into the program, and increased return to work for new sickness program entrants. Reforms included:

- The replacement rate in the sickness benefit program was reduced, employers were made responsible for covering the early months of sickness benefits, and the threshold eligibility criteria was increased (1990s)
- The sickness and disability benefit systems were merged in an effort to break the connection between sick absence volumes and inflows onto the disability benefits; work support, rather than income support without work became the driving principle. In addition, the screening process in the two programs was standardized and vocational and rehabilitation personnel became involved earlier. Sickness benefits cease after one year, and beneficiaries are evaluated for work ability after six months of absence from work (early-2000s)
- Employers were required to document the types of accommodation they made for workers; new deadlines for provision of rehabilitation services were set; the extent of work capacity was regularly evaluated while sickness benefits were received; sickness benefit payments for those who should—but did not—return to work were reduced; assessments of work capacity were performed after 3, 6, and 12 months of sickness benefit receipt (late-2000s)

Australia

Australia's disability income support program—the Disability Support Pension (DSP)—provides a guaranteed minimum income for eligible people with disabilities; the income guarantee exceeds that in the nation's welfare and unemployment benefit programs, but by European standards the replacement rate is not high. Nonetheless, the DSP program is susceptible to substantial growth, as disability benefits tend to exceed those paid in other programs. That the concept of disability on which access to benefits is based is not tightly defined may also encourage growth in both recipients and costs.

While there have been some changes since 1970 in the DSP formula for determining benefits, benefit levels relative to average wages have remained quite constant. However, since 1993, DSP benefits to lower-income workers with disabilities have become somewhat more generous relative to earnings, the minimum wage and other income support payments (e.g., unemployment benefits). However, these changes in program generosity seem insufficient to explain the growth in disability reciprocity that has been experienced.

Another candidate to explain the increasing reciprocity rate is the pattern of changes in disability eligibility criteria. Research evidence suggests that more rigorous eligibility rules which placed greater emphasis on medical factors rather than socioeconomic considerations explains the small decrease in

the number of DSP recipients between 1980 and 1982. However, after 1982 the eligibility criteria were again relaxed (Cai and Gregory 2003).

The most significant increase in the DSP reciprocity rate occurred in the 1990s. In the midst of the serious recession in the early 1990s, the DSP eligibility criterion was relaxed. The standard for determining eligibility was decreased from an 85 percent impairment standard to about 25 percent impairment. As a result, the emphasis of the DSP program tended toward a long-term partial disability program rather than a program providing support for workers who were totally disabled. DSP officials were required to determine whether a worker with some disabling conditions (25 percent or less) became unemployed due to the impairments or because of poor macroeconomic conditions.

In the absence of a substantial increase in benefits, it is likely that the large increase in the DSP reciprocity rate during the early 1990s is due to this change in the eligibility criterion. DSP provided a higher permanent income floor than benefits in the base welfare program, but with no work requirement.

As the Australian economy expanded after the recession in the early 1990s, growth in DSP reciprocity rates slowed. Although Australia did not experience a significant slowdown during the 2001 and 2008 worldwide recessions, DSP reciprocity increased during both recessionary periods. Indeed, since 2008, DSP reciprocity rates have tended upward despite: a) a major tightening in the eligibility criterion in 2006 (which effectively increased the impairment standard from 25 percent to about 62 percent), and b) abolition of partial disability benefits requiring those with partial work capacity to seek income support through regular unemployment benefits requiring beneficiaries to be actively seeking work. Research studies suggest that the growth in DSP benefit levels relative to both the minimum wage and social minimum benefits in the welfare program explains this growth. The studies also note the role played by the introduction of verifiable job search and participation in active labor market programs requirements in the unemployment and lone parents benefits programs. Those requirements made DSP benefits an increasingly appealing alternative (Cai and Gregory 2003; McVicar and Wilkins 2013). Over the period from 1993 to 2011, receipt of public income support benefits other than DSP by people with a disability fell, while the DSP reciprocity rate rose.

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Over the years, Australia has also made a number of changes to the disability pension program, only a few of which were designed to slow the growth of disability reciprocity; these included tightening eligibility criterion and shifting partially disabled recipients onto the unemployment rolls. Several policy changes, however, have encouraged access to disability pension benefits. As a result, since 1970, the growth in Australia's disability reciprocity rate was the largest among the countries studied, save for the United States.

United Kingdom

Over the past four decades, the United Kingdom has substantially changed its social insurance and social welfare cash transfer programs. In 1971, basic minimum benefits were provided through the Supplementary Benefit program. The Unemployment Benefit program provided somewhat higher benefits for those expected to work. Between 1971 and 1995, the Invalidity Benefit (IVB) program was the primary source of income support for working age people with disabilities (Burkhauser et al. 2014). People of working age who suffered ill health or were disabled and hence found unable to work

in their usual occupation (as determined by the family doctor) and who had sufficient work history were eligible, first for Sickness Benefit (the first 28 weeks) and then for IVB. For longer-duration recipients, IVB paid a benefit which was more generous than unemployment benefits. However, the disability benefit replacement rates paid were considerably below those in northern European countries including Sweden or the Netherlands. These policies existed throughout the 1970s and early 1980s, when the disability reciprocity rate grew steadily.

A number of major changes in the 1980s contributed both positively and negatively to IVB reciprocity rates. The introduction of Statutory Sick Pay in 1983 required that employers pay the first eight weeks of sickness benefits; in 1986, that was extended to 28 weeks. The resulting shift of costs to employers likely reduced many short-duration claims for sickness benefits. And, because receipt of sickness benefits is an access route to disability pension payments, this change also had a negative effect on IVB benefit claims.

Recessions in the early 1980s and early 1990s and the rapid shift from heavy industry towards services during the same period acted to increase disability reciprocity. The growth in the IVB program in the late 1980s and early 1990s suggests that it served as a form of hidden employment. Unemployed workers with health-related impairments who faced a depressed labor market tended to apply for IVB benefits after they exhausted their support from the unemployment benefit program (Burkhauser et al. 2014).

In the late-1980s, long-term unemployment benefits claimants were required to have work-focused interviews, reducing the attractiveness of this source of public support. Studies suggest that moves from unemployment benefit support to IVB resulted in an increase in disability reciprocity rates. At the same time, it became possible for those who claimed social minimum welfare benefits on grounds of disability to receive a higher benefit than those claiming support on other grounds. Those claiming benefits because of disability were counted in the disability reciprocity rate, which also contributed to the increase (OECD 2010).

By the mid-1990s, the growth in disability reciprocity rates slowed. At that time, the IVB program was replaced by the Incapacity Benefit (IB) program. The new program (IB) was less generous than IVB, and tightened eligibility requirements. Government doctors rather than family doctors were assigned responsibility for medical screening. The threshold to gain benefits through the screening was also raised; a claimant now had to be assessed as unable to perform work of any sort, rather than work in their usual occupation. Further, in 1999 a form of means test was introduced for new claimants with substantial private pension income (even though they had a sufficient work history). At about the same time, the requirements for receiving unemployment benefits were tightened, and generosity was reduced. Both of these factors contributed to the slower growth in the costs and recipients of disability benefits.

In the mid-2000s, a new set of work-first reforms was introduced in order to further reduce inflows to the disability benefit rolls and to increase outflows. They made it mandatory for those who claimed disability-based support to attend work-focused interviews designed to steer at least some recipients back into the labor market. This move was supported by the introduction of a bonus paid for return to employment and the provision of additional in-work health support for those who did find work. Finally, medical assessments were now made earlier into the IB claim. Evaluation evidence suggests that these changes contributed to reduced disability reciprocity rates (OECD 2010; Adam, Bozio, and Emmerson 2010).

Indeed, the number of disability recipients has continued to decline since the mid-2000s, in spite of the high unemployment that accompanied the 2008 financial crisis. Additional IB reforms undertaken in recent years supported this trend. In 2008, the Employment and Support Allowance (ESA) program replaced the IB program. This program provided both an insurance-based pension benefit for workers with disabilities with sufficient work history and a means-tested social assistance benefit for those without. The disabled worker program included a new tougher Work Capability Assessment, with relatively few exemptions. Engaging in a work-related activity was required for all but those who were disabled; benefits for about one quarter of beneficiaries were available only if they complied with this requirement. Also, payment of a higher benefit for longer-duration claims was abandoned. These changes decreased the role of disability income support programs as an alternative to unemployment benefits. Finally, between 2009 and 2013, the eligibility of existing IB recipients was reassessed using the new and more rigorous eligibility standards. As a result, many recipients have been judged ineligible, leading to both appeals (many of which were successful) and migration onto the unemployment benefits program.

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In summary, the United Kingdom has undertaken several policy changes designed to reduce the growth of disability recipiency rates. These included:

- Additional employer responsibility for sickness benefits was required (mid-1980s)
- Benefit generosity was reduced and the medical requirements necessary to gain benefit eligibility were tightened; assessments are to be done by program doctors rather than family doctors (1995)
- Disability benefit claimants were required to attend work-focused interviews designed to encourage reemployment; a “back-to-work” bonus payment was introduced; medical assessments were required earlier in the period of benefit receipt, occurring at three months into the claim rather than six months (mid-2000s)
- Applicants were assessed on the basis of their capacity to carry out any work rather than being employed in their usual occupation; work-related activities were required for all but severely disabled (late-2000s).

LESSONS FROM ABROAD FOR IMPROVING THE U.S. DISABILITY SYSTEM

As our review has shown, countries have adopted several reforms to their disability pension systems in order to better manage the number of recipients and the costs of the programs. Overall, the results in terms of restraining the recipient rolls and the costs have been mixed. Although rigorous evaluations are scarce, the evidence suggests that slowing the inflow of people with disabilities onto the rolls is much more successful than efforts to wean recipients off the rolls and back into the labor market.

In many of the countries studied, but not in the United States, two disability program characteristics exist that facilitate management of the caseload. These are: a) a public sickness benefits program (which typically serves as the gateway into disability pension receipt), and b) support provided to people who are partially disabled (as opposed to totally and permanently disabled, as in the United States). As a result, early intervention (e.g., rehabilitation and reintegration) and stricter monitoring of work absence through the sickness benefits program are not available in the United States. Because

SSDI requires total and permanent disability, the conversion of partial disability benefits into payments for work is also not possible.

Across the countries studied, a number of options to better manage the disability pension caseload—aside from reforms to the public sickness benefit programs—have been pursued; these include:

- The introduction of more stringent vocational criteria into the eligibility determination process, e.g., in determining ability to work, moving from reference to jobs in the worker’s own occupation or jobs for which the worker has been trained to all jobs in the economy.
- The centralization of disability assessment. Instead of relying on an applicant’s own doctors, responsibility for assessing capability has been assigned to government agencies. The goal is to make medical assessments more objective and consistent over applicants.
- Increasing the emphasis on work capacity itself relative to medical conditions in the eligibility determination process. (For example, in the US system, a physical and mental Listing of Impairments has been established to identify conditions considered sufficiently severe to prevent an individual from performing any gainful activity.)
- Changing the emphasis in the disability pension program toward a “rehabilitation before benefits” model involving the requirement that benefit applicants have undertaken rehabilitation efforts, as well as requiring employers to pursue workplace accommodation.
- Substituting for the current uniform payroll tax obligations an arrangement in which employer contributions to social insurance depend upon the number of their workers that apply for disability benefits (“experience rating”).
- Limiting the duration of disability pension payments to a fixed period (say, three years), with the need to reapply and reestablish eligibility after that period in order to continue benefit receipt.
- Increasing work incentives for benefit recipients through wage or employment subsidies or disregarding earnings in calculating benefits for recipients who combine work and disability benefit receipt.

These policies—and evidence regarding their effectiveness—lead to two basic lessons for reform of the US SSDI program. The first lesson is that *being classified as “disabled” does not mean that productive activity is impossible*. Efforts to reform SSDI need to seriously consider the available options for promoting work and labor force participation of potential benefit applicants. The second lesson is that *provision of strong pro-work incentives to workers, employers, and SSDI officials responsible for eligibility determination is likely to increase the share of people with disabilities that remain in the workforce*. Incentives are able to induce desirable behaviors, and the challenge is to craft a set of incentives for all parties that promote continued work and labor force participation of people with disabilities, rather than having them rely on pension benefits as their primary income source. Given these overarching lessons, the trick is to identify a set of policy changes consistent with them that could manage the rolls, while not imposing large costs on people with disabilities. If such policies can be developed, the flow of new beneficiaries is likely to be reduced—a much more productive path than attempting to reduce the existing stock of beneficiaries.

CONCLUSION

This paper has presented an international comparison of disability pension policies and has drawn lessons from the international experience that might inform policy toward people with disabilities in the United States. After presenting background information on the size and characteristics of working-

age people with disabilities in selected Western countries, the basic structure of disability policy in these countries is described. The nature of policy among these countries varies from those with universal and generous benefits and relatively low hurdles for accessing benefits to those with relatively low benefit levels, strict criteria for accessing support, and relatively low rehabilitation efforts.

The paper then presents a full-bodied discussion of the nature of disability policy reform in the countries studied. Reforms to benefit structures, eligibility criteria, rehabilitation and employment efforts, and a variety of institutional arrangements are described. Finally, the paper has drawn lessons for the United States from the reform efforts of these other nations. The basic lesson from these international efforts is that it is possible to achieve a responsible balance between providing support to people with disabilities and creating incentives for people with physical and mental health problems to remain active labor force participants. Having disabling conditions does not require the foregoing of productive labor market work.

REFERENCES

- Adam, Stuart, Antoine Bozio, and Carl Emmerson. 2010. "Reforming Disability Insurance in the UK: Evaluation of the Pathways to Work Programme." Institute for Fiscal Studies, London.
- Autor, David, and Mark Duggan. 2003. "The Rise in the Disability Rolls and the Decline in Unemployment." *Quarterly Journal of Economics* 118 (February): 157–206.
- Blomberg, Renee. 2013. "Who Is Granted Disability Benefit in Sweden? Description of Risk Factors and the Effect of the 2008 Law Reform." Master's thesis in Mathematical Statistics, Royal Institute of Technology, School of Engineering Sciences, Stockholm, Sweden.
- Cai, Lixin, and Robert Gregory. 2002–03. "Inflows, Outflows and the Growth of the Disability Support Pension (DSP) Program." *Australian Social Policy* 121–43.
- Burkhauser, Richard, Mary C. Daly, Duncan McVicar, and Roger Wilkins. 2014. "Disability Benefit Growth and Disability Reform in the US: Lessons from Other OECD Nations." *IZA Journal of Labor Policy* 3 (4): 1–30.
- Burkhauser, Richard, Mary C. Daly, and Nicholas Ziebarth. 2015. "Protecting Working-Age People with Disabilities: Lessons from Four Industrialized Nations." Unpublished working paper.
- Haveman, Robert H., Victor Halberstadt, and Richard Burkhauser. 1984. *Public Policy toward Disabled Workers: Cross National Analyses of Economic Impacts*. Ithaca, NY: Cornell University Press.
- McVicar, Duncan, and Roger Wilkins. 2013. "Explaining the Growth in the Number of Recipients of the Disability Support Pension in Australia." *Australian Economic Review* 46 (3): 345–56.
- Morris, Zachary A. 2015. "Disability Benefit Reform in Great Britain from the Perspective of the United States." *International Social Security Review* 68 (1): 47–67.
- Organisation for Economic Co-operation and Development (OECD). 2010. *Sickness, Disability and Work: Breaking the Barriers: A Synthesis of Findings across OECD Countries*. OECD Publishing, Paris. DOI: <http://dx.doi.org/10.1787/9789264088856-en>
- Organisation for Economic Co-operation and Development (OECD). 2003. *Transforming Disability into Ability. Paris, France*. Available at http://www.virk.is/static/files/4_disability%20to%20ability.pdf. Accessed August 1, 2015.
- Organisation for Economic Co-operation and Development (OECD). 2015. Statistics Library. *Public expenditure on disability and sickness cash benefits, in % GDP*. Available at <http://stats.oecd.org/index.aspx?queryid=33415>. Accessed September 2, 2015.
- Prinz, Christopher, and William Tompson. 2009. "Sickness and Disability Benefit Programmes: What Is Driving Policy Convergence?" *International Social Security Review*, Special Issue: Policy Learning and Social Protection 62 (October/December): 41–61.

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Social Security Administration (SSA). 2014. *Social Security Programs throughout the World: Europe, 2014*. SSA Publication No. 13-11801. Washington, DC. Available at <http://www.ssa.gov/policy/docs/progdesc/ssptw/2014-2015/europe/ssptw14europe.pdf>. Accessed September 1, 2015.

Van Sonsbeek, Jan-Maarten, and Raymond Gradus. 2011. "Estimating the Effects of Recent Disability Reforms in The Netherlands." Tinbergen Institute Discussion Paper 2011-121/3. Amsterdam, NL: Tinbergen Institute. Available at <http://papers.tinbergen.nl/11121.pdf>. Accessed August 1, 2015.