ISBN 978-92-64-03815-8
Sickness, Disability and Work
Breaking the Barriers – Vol. 2

Chapter 3

Absence Monitoring and Assessment of Disability

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

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

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

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

3.1. Inflow into disability: what do we know?

A. Evidence on inflows into disability

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

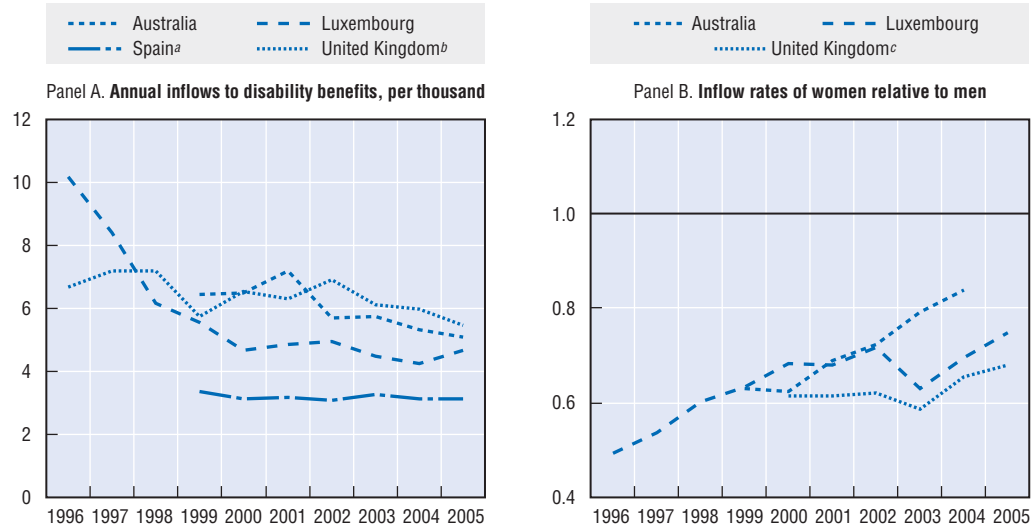
Inflow rates of women are consistently lower than those of men (Figure 3.1, Panel B). This gender gap has narrowed over time in the three countries for which gender-specific information is available, but is still wide, especially in the United Kingdom.

The impact of disability benefit reforms

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

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

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



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

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

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

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

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

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

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

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

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

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

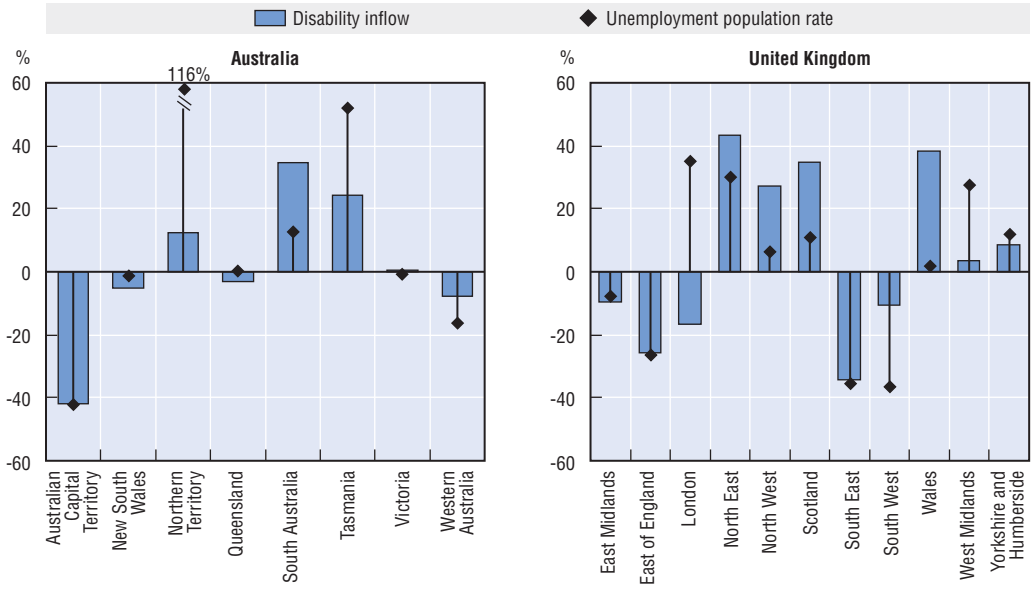
Source: DEWR for Australia; IGSS for Luxembourg; and DWP Work and Pensions Longitudinal Study for the United Kingdom.

Regional variation in disability

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

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

Figure 3.2. **Disability inflow rates and unemployment-population ratios are highly correlated**
Differences in percentage from the overall rate in the country, 2005[a]



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

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

SICKNESS, DISABILITY AND WORK: BREAKING THE BARRIERS – VOL. 2 – ISBN 978-92-64-03815-8 – © OECD 2007

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

B. Evidence on sickness absence

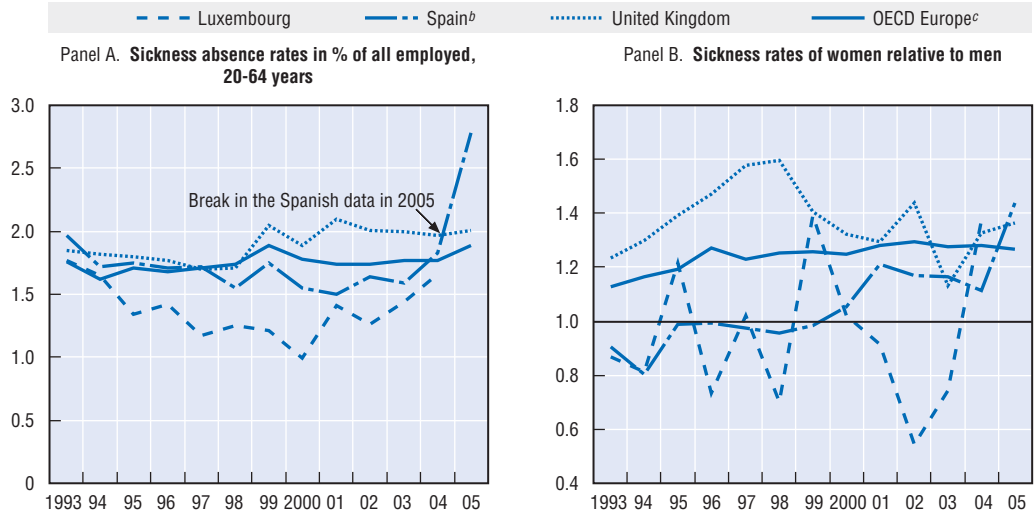
Trends in sickness absence over the past decade

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

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

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

Share of employees absent from work, 1993-2005[a]



a) Employed persons reporting not having worked at all during the week prior to the survey, due to illness, injury or temporary disability.

b) Because of a change in the question in the Active Population Survey in 2005, there is a break in the series between 2004 and 2005. Figures for 2005 are a better reflection of the actual situation.

c) Unweighted average of EU19, Iceland, Norway and Switzerland.

Source: EULFS, 2006.

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

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

Long-term sickness absence

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

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

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

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

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

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

C. Pathways into disability benefits

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

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

Table 3.3. **Pathways into disability benefits are poorly documented**

Origin of new disability benefit claimants as a percentage of all inflows, most recent available year

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

a) Based on people entering onto Disability support pension between June 2004 and June 2005.
b) Based on people entering into either temporary disability benefit, permanent disability benefit or the tide-over allowance in 2005.
c) Data refer to 2001/2002. Previous benefit status is defined as SSP receipt immediately before commencing an IB claim but refers to a 90-day period before starting an IB claim in case of Jobseeker Allowance and Income Support.
Source: Data provided by DEWR for Australia; IGSS for Luxembourg; and a 1% sample of annual benefit administration data for the United Kingdom.

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

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

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

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

3.2. Preventing disability early on

A. Early identification and early intervention

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. The role of employers

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

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

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

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

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

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

Box 3.2. **Harmonisation of sickness benefit regulations in Luxembourg**

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

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

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

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

C. Monitoring absences of sick workers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Health status monitoring of the unemployed

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

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

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

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

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

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

3.3. Disability benefit for those who need it

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

A. Assessing disability

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

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

Box 3.4. **Innovative Job Capacity Assessment in Australia**

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

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

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

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

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

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

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

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

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

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

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

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

B. Health conditions and disability benefits

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

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

In most OECD countries, mental health problems (such as depression, stress and anxiety) have grown rapidly over the past one to two decades and are currently the fastest growing health problem – in particular among younger and prime-age people (OECD, 2003; and OECD, 2006b). Data for the United Kingdom show that the share of all people on disability benefits with mental health problems is around 15 percentage points higher today compared to 1995. In Australia, mental illness has increased even more dramatically from 2% in 1990 to almost 30% in 2005.[24]

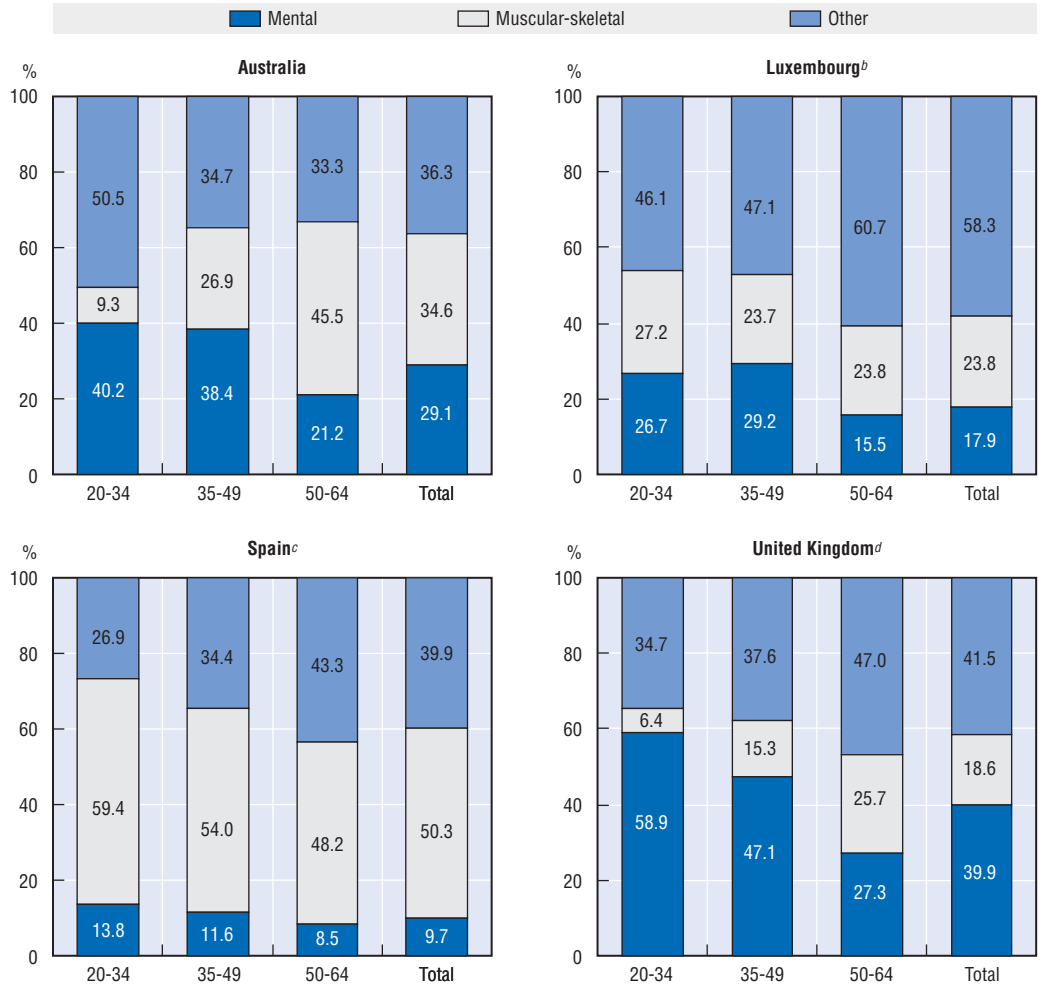
The increasing prevalence of mental health problems necessitates changes in assessment methods. The reform proposal in the United Kingdom to further improve the health assessment component of the PCA certainly is a step in the right direction. More generally, assessments usually focus on current health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

Mental health problems and the labour market

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

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

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



a) 2004 for Luxembourg and Spain, 2005 for Australia and 2006 for the United Kingdom.
b) For Luxembourg, data on health reasons for people on disability benefits do not exist. Instead, data are based on ambulatory treatments and shares are calculated according to the number of visits to a specialist among people with a disability benefit. Data cover the resident population only.
c) Data for Spain refer to a sample of people with legal disability.
d) Data on mental disability include learning disabilities which account for approximately 6% of all mental disabilities.

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

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

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

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

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

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

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

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

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

Recognition and treatment of mental health problems

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

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

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

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

C. Addressing partial work capacity

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

Partial disability benefit for partial work capacity in Spain

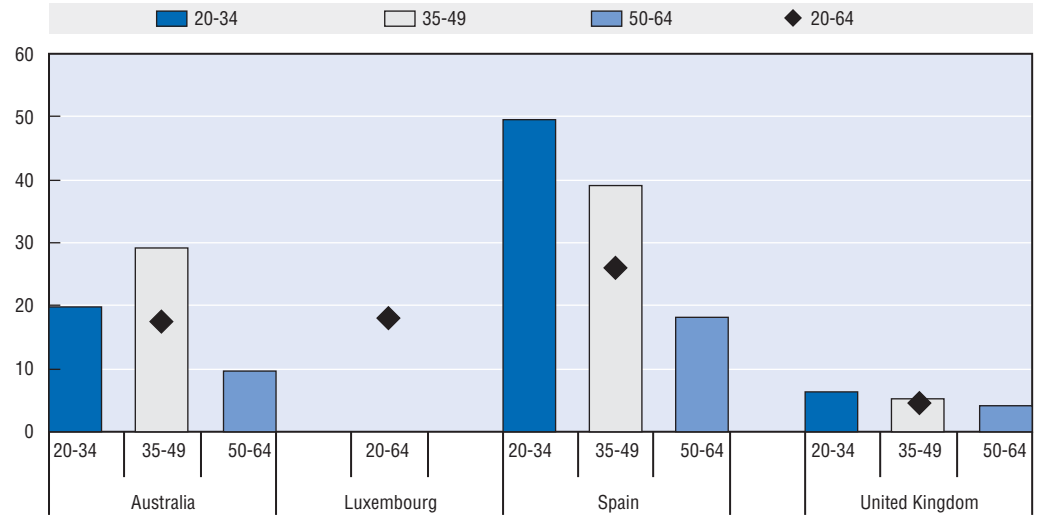
A potential problem with partial disability benefit schemes is that people with minor disability rather than those with substantially-reduced work capacity leave the labour market. Another risk is that people tend to apply for the highest possible benefit rate, which means that more people may end up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

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

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

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

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



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

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

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

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

Unemployment benefit for partial work capacity in Australia and Luxembourg

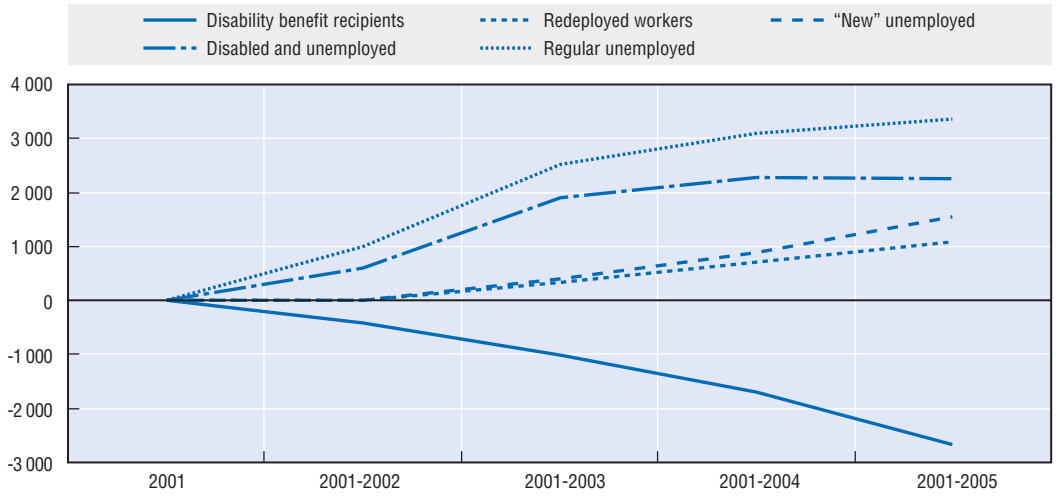
Until recently, Australia and Luxembourg also granted (in this case full) disability benefits to people with minor reduction of their work capacity. To improve workforce participation of people with reduced work capacity, through different types of changes both countries chose to close their disability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

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

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

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

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



Source: Social Security Administration.

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

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

3.4. Future policy directions

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

Improve health monitoring during the sickness phase…

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

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

… but also of people on unemployment benefits

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

Improve the assessment of rights to disability benefits for mental illness

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

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

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

Notes

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

12. A very special problem in Luxembourg, not further elaborated here, is that cross-border workers can use sickness certificates of a GP in their home country and the control of these certificates is not in the hands of the IGSS. For further cross-border related policy issues, see Grubb (2007).

13. A recent randomised controlled trial in the United Kingdom tested various interventions (workplace and/or health interventions) aimed at increasing the return-to-work rate of people who were off sick (Purdon *et al.*, 2006). Surprisingly, the control group had almost the same return rate as the different intervention groups, even though some impact was found for certain subgroups. It is important to better understand why this experiment showed so little success; the factors identified in this study included inappropriateness of the interventions, more pro-activity among people in the control group and non-cooperative employers.

14. In Luxembourg, employers can seek a second opinion from an occupational doctor. If the employer decides to do so, the employee is obliged to see this doctor, who albeit not being able to control the validity of a sick leave certificate can criticise the absence duration and may be able to identify problems at the workplace. In the United Kingdom, employers also may choose to refer employees to their own doctors or to doctors under contract with the public authorities in cases where their workers' temporary work incapacity seems in doubt.

15. The new group of unemployed with detected health problems in Luxembourg remain on the unemployment benefit scheme and receive special support to find another job. After the introduction of this procedure in 2002, total unemployment rose rapidly and, by 2006, the share of unemployed people with detected health problems had increased to 17% of total unemployment (ADEM, 2006).

16. The assessment of the INSS in Spain is usually taking place during the first 12 months after onset of a health problem. The average duration is 50-60 days from the applicant's visit to the decision taken by the assessment team, a fall from around 300 days a few years ago.

17. Spain has two disability benefit levels: a full benefit for those assessed as not being able to work at all and a partial benefit for those assessed as not being able to perform their previous job.

18. Luxembourg's AMC is a public control unit (consisting of medical doctors with different specialties) under the Ministry of Social Affairs, but independent of the Social Insurance Administration.

19. The PCA in the United Kingdom is required for people who have not worked during the last two months or have previously been on public sickness benefits, or on sickness or short-term disability benefits for six months.

20. A similarity with Australia is that the medical service performing the PCA in the United Kingdom is contracted to a private company consisting of PCA-trained medical services doctors.

21. Forthcoming benefit reform in the United Kingdom will do away with this problem in so far as claimants will, during the initial three months, only receive an amount of benefit equivalent to unemployment benefit and they will only receive the higher rate on completion of the PCA.

22. IMSERSO is an agency in responsible for benefit policies directed towards elderly and dependents, operating at the level of the Spanish autonomous communities.

23. These benefit-processing centres in the United Kingdom deal with all kinds of benefits, including dealings with the PCA and the companies responsible for PCA assessments.

24. One reason for this rapid growth in mental illness in Australia is a change in the definition of disability in 1991, opening the door to people with mental conditions. Prior to this reform, these people tended to be counted towards the long-term unemployed.

25. "Bad" jobs are often defined as jobs with, for example, high job insecurity, unsatisfactory work environment and too high work loads.

26. The rules on permitted work also reflect the policy approach in the United Kingdom. Those capable of work should be encouraged to leave benefits, so that the low proportion working while on benefits is to be expected. The risk of increasing this number through more relaxed regulations is that it might not only concern those currently on benefits and not working, but also some of those currently working and not on benefits returning to benefits, *e.g.* by reducing their hours of work.

27. In this context it is worth noting that within the United Kingdom's unemployment benefit scheme there is provision for disabled people to have restrictions on their job search requirements.

ISBN 978-92-64-03815-8
Sickness, Disability and Work
Breaking the Barriers – Vol. 2

Bibliography

ABS – Australian Bureau of Statistics (1999), *Labour Force, Australia,* Cat. No. 6203.0.

ABS (2006), "Casual Employees, No. 1301.0 – Year Book Australia", Canberra.

ACOSS – Australian Council of Social Service (2005), "Ten Myths and Facts about the Disability Support Pension (DSP)", *Info 362*.

Adam, S., C. Emmerson, C. Frayne and A. Goodman (2006), "Early Quantitative Evidence on the Impact of the Pathways to Work Pilots", Research Report No. 354, Department for Work and Pensions, London.

ADEM (2006), "Bulletin luxembourgeois de l'emploi", No. 08, August.

Australian Government (2005), *The Welfare to Work Reforms Overview*.

Australian Institute of Health and Welfare (2005), *Australia's Welfare 2005*, Canberra.

Australian National Training Authority (2003), *Shaping our Future: Australia's National Strategy for VET 2004-2010,* Brisbane.

Bacon, J. (2002), "Moving between Sickness and Unemployment", Social Research Branch, Department for Work and Pensions, London.

Bambra, C., M. Whitehead and V. Hamilton (2005), "Does 'Welfare-to-work' Work? A systematic review of the effectiveness of the UK's 'welfare-to-work' programmes for people with a disability or chronic illness", *Social Science and Medicine,* Vol. 60(9), pp. 1905-1918.

Barnes, H. and M. Hudson (2006), "Pathways to Work – Extension to Some existing customers: early findings from qualitative research", Research Report No. 323, Department for Work and Pensions, London.

BBC News (2006), "Mental Illness Now 'last taboo'", *http://news.bbc.co.uk/1/hi/health/6038570.stm*.

Bewley, H., R. Dorsett and G. Haile (2007), "The Impact of Pathways to Work", Research Report No. 435, Department for Work and Pensions, London.

Blackman, S. (2006), "Financial Incentives to Work for the IB Caseload and the Take-up of the Disability Element of the Working Tax Credit", mimeo, Department for Work and Pensions, London.

Blanco, A. (2000), "The Decision of Early Retirement in Spain", mimeo, Universidad del País Vasco, Bilbao.

Blyth, B. (2006), "Incapacity Benefit Reforms – Pathways to Work Pilots Performance and Analysis", Working Paper No. 26, Department for Work and Pensions, London.

British Occupational Health Research Foundation (2005), *Workplace Interventions for People with Common Mental Health Problems: Evidence Review and Recommendations*, London.

Burchardt, T. (2003), "Employment Retention Following Onset of Sickness or Disability: Evidence from the Labour Force Survey Longitudinal Data", Department for Work and Pensions In-House Report, London.

Burchardt, T. (2005), *The Education and Employment of Disabled Young People: Frustrated Ambition*, London School of Economics, London.

Burkhauser, R. and D. Stapleton (2004), "The Decline in the Employment Rate for People with Disabilities: bad data, bad health, or bad policy", *Journal of Vocational Rehabilitation,* Vol. 20, No. 3, pp. 185-201.

Cai L. (2004), "An Analysis of Durations on the Disability Support Pension (DSP) Program", Working Paper No. 8/04, Melbourne Institute of Applied Economic and Social Research.

Cai, L., H. Vu and R. Wilkins (2006), "Disability Support Pension Recipients: Who Gets Off (and Stays Off) Payments?", Working Paper No. 18/06, Melbourne Institute of Applied Economic and Social Research.

CBI – Confederation of British Industry (2006), "Absence Minded: Absence and Labour Turnover 2006", London.

Coleman, N. and L. Kennedy (2004), "Destination of Benefit Leavers 2004", Research Report No. 244 on behalf of the Department for Work and Pensions, London.

Confédération syndicale indépendante du Luxembourg (2006), *Enquête sur le stress professionnel – rapport complet*, Stimulus/Capital-Santé, Paris.

Corden, A. and K. Nice (2006), "Pathways to Work from Incapacity Benefits: A Study of Experience and Use of Return to Work Credit", Research Report No. 353, Department for Work and Pensions, London.

Corkett, J., S. Bennett, J. Stafford, M. Frogner and K. Shrapnell (2005), "Jobcentre Plus Evaluation: Summary of Evidence", Research Report No. 252, Department for Work and Pensions, London.

Council of Australian Government (2006), *National Action Plan on Mental Health: 2006-2011*, Canberra.

DeLeire, T. (2000), "The Wage and Employment Effects of the Americans with Disabilities Act", *Journal of Human Resources,* Vol. 35, No. 4, pp. 693-715.

DEWR – Department of Employment and Workplace Relations (2004), *Annual Report 2003-04*, Canberra.

DEWR (2005), "Job Network Disability Support Pension Pilot: Progress Report", Canberra.

DEWR (2006), Characteristics of Mobility Allowance Recipients – June 2005, Canberra.

Dockery, A.M. (2005), "Mental Health and Labour Force Status in Australia", Curtin Business School, Curtin University of Technology, Perth.

DWP – Department for Work and Pensions (2002), *Pathways to Work: Helping People into Employment*, London.

DWP (2006), *A New Deal for Welfare: Empowering People to Work*, Green Paper presented to Parliament in January 2006, London.

EFILWC – European Foundation for the Improvement of Living and Working Conditions (2007a), *Fourth European Working Conditions Survey*, Dublin.

EFILWC (2007b), *Part-time Work in European Companies: Establishment Survey on Working Time 2004-2005*, Dublin.

FaCS – Department of Family and Community Services (2003), "Improving Employment Opportunities for People with a Disability: Report of the Review of the Employer Incentives Strategy", Canberra.

FaCS (2004), "Survey of New Disability Support Pension Customers", Canberra.

Förster, M.F. and M. Mira d'Ercole (2005), "Income Distribution and Poverty in OECD Countries in the Second Half of the 1990s", OECD Social, Employment and Migration Working Paper, No. 22, OECD, Paris.

Freud, D. (2007), "Reducing Dependency, Increasing Opportunity: options for the future of welfare to work", An independent report, Department for Work and Pensions, London.

Grubb, D. (2006), "Australia's Quasi-market Delivery of Case Management", Paper presented at the ISSA workshop on Unemployment Insurance and Employment Maintenance, 10-11 April, Brussels.

Grubb, D. (2007), "Audit du service public de l'emploi au Luxembourg", OECD Social, Employment and Migration Working Papers, OECD, Paris.

Hallis (2003), "The Hallis 2003-2004 Turnover and Absenteeism Survey", Melbourne.

Harding, A., Q.Ng Vu and R. Percival (2005), "The Distributional Impact of the Welfare-to-Work Reforms Upon Australians with Disabilities", NATSEM Working Paper, Canberra.

Hartmann-Hirsch, C. (2006), "L'incapacité de travail. Une mesure de maintien à l'emploi aux effets pervers ?", *Population et Emploi*, No. 19, CEPS/INSTEAD, Luxembourg.

Health and Safety Executive (2006), *Tackling Stress: the Management Standards Approach*, London.

House of Commons (2006), "Work and Pensions – Third Report", London.

Human Rights and Equal Opportunity Commission (2006), "National Enquiry into Disability and Employment", Final Report.

Humer, B., J.P. Wuellrich and J. Zweimüller (2007), "Integrating Severely Disabled Individuals into the Labour Market: The Austrian Case", IZA Discussion Paper No. 2649, Bonn.

Jones, A. and O. O'Donnell (1995), "Equivalence Scales and the Costs of Disability", *Journal of Public Economics*, Vol. 56, pp. 273-289.

Knight, T., S. Dickens, M. Mitchell and K. Woodfield (2005), "Incapacity Benefit reforms – The Personal Adviser role and practices: Stage Two", Research Report No. 278, Department for Work and Pensions, London.

Lattimore, R. (2007), *Men Not at Work: An Analysis of Men outside the Labour Force*, Productivity Commission Staff Working Paper, Canberra.

Layard, R. (2004), "Mental Health: Britain's Biggest Social Problem?", Paper prepared for a seminar hosted by the DWP Strategy Unit, London.

Lewis, J., A. Corden, L. Dillon, K. Hill, K. Kellard, R. Sainsbury and P. Thornton (2005), "New Deal for Disabled People: An In-depth Study of Job Broker Service Delivery", Research Report No. 246, Department for Work and Pensions, London.

Martin, J. and D. Grubb (2001), "What Works and for Whom: a Review of OECD Countries' Experiences with Active Labour Market Policies", Working Paper No. 14, IFAU, Stockholm.

Meager, N., P. Bates, S. Dench, S. Honey and M. Williams (1998), *Employment of Disabled People: Assessing the Extent of Participation*, Research Report No. 69, Department for Education and Employment, London.

Meah, A. and P. Thornton (2005), "Desirable Outcomes of WORKSTEP: User and Provider Views", Research Report No. 279, Department for Work and Pensions, London.

Melbourne Institute of Applied Economic and Social Research (2005), "Hilda Survey Annual Report".

OECD (1999), *Economic Survey: Belgium/Luxembourg*, OECD, Paris.

OECD (2001), *Innovations in Labour Market Policies: The Australian Way*, OECD, Paris.

OECD (2003), *Transforming Disability into Ability: Policies to Promote Work and Income Security for Disabled People,* OECD, Paris.

OECD (2004a), *Quarterly National Accounts*, Vol. 4-2003, OECD, Paris.

OECD (2004), *Employment Outlook*, OECD, Paris.

OECD (2005a), *Economic Survey: Spain*, OECD, Paris.

OECD (2005b), *Benefits and Wages 2004*, OECD, Paris.

OECD (2005c), *Ageing and Employment Policies: Australia*, OECD, Paris.

OECD (2006a), *Economic Outlook No. 80,* OECD, Paris, December.

OECD (2006b), *Sickness, Disability and Work: Breaking the Barriers: Norway, Poland and Switzerland, Vol. 1*, OECD, Paris.

OECD (2006c), *Live Longer, Work Longer*, OECD, Paris.

OECD (2006d), *Employment Outlook*, OECD, Paris.

OECD (2007a), *Taxing Wages 2005/2006: 2006 edition*, OECD, Paris.

OECD (2007b), *Jobs for Youth: Spain*, Paris.

Orr, L., S. Bell and K. Lam (2007), "Long-term Impacts of the New Deal for Disabled People", Research Report No. 432, Department for Work and Pensions, London.

Pires, C., A. Kazimirski, A. Shaw, R. Sainsbury and A. Meah (2006), "New Deal for Disabled People: Eligible Population Survey, Wave Three", Research Report No. 324, Department for Work and Pensions, London.

Prime Minister of Australia (2007), *www.pm.gov.au/media/Interview/2007/Interview24247.cfm*.

Productivity Commission (2004), *Review of the Disability Discrimination Act 199, Inquiry Report*, Report No. 30, Australian Government.

Purdon, S., N. Stratford, R. Taylor, L. Natarajan, S. Bell and D. Wittenburg (2006), "Impacts of the Job Retention and Rehabilitation Pilot", Research Report No. 342, Department for Work and Pensions, London.

Sainsbury, R. and J. Davidson (2006), "Routes onto incapacity benefits: Findings from Qualitative Research", Research Report No. 350, Department for Work and Pensions. London.

Sawney, P. and J. Challenor (eds) (2003), "Poor Communication Between Health Professionals is a Barrier to Rehabilitation", *Occupational Medicine,* Vol. 53, pp. 246-248.

Stafford, B. and colleagues (2006), "New Deal for Disabled People: Second Synthesis Report – interim findings from the evaluation", Research Report No. 377, Department for Work and Pensions, London.

The Employers' Forum (2005), *The Disability Standard 2005: Benchmark Report*, London.

Trade Union Congress (2005), "Countering an Urban Legend: Sicknote Britain?", *Economic and Social Affairs*, London.

Waddell, G. and A.K. Burton (2006), "Is Work Good for your Health and Well-being?", The Stationery Office, commissioned by the Department for Work and Pensions, London, September.

Wagener, R. (2003), "The New Benefit Strategy being Implemented in Luxembourg", in B. Marin, C. Prinz and M. Queisser (eds.), *Transforming Disability Welfare Policies*, Ashgate, Aldershot.

Work Directions (2006), "Buying Quality Performance: Procuring Effective Employment Services", United Kingdom.

Zaidi, A. and T. Burchardt (2005), "Comparing Incomes when Needs Differ", *Review of Income and Wealth,* Vol. 51-1, pp. 89-114.

List of Acronyms

ABS	Australian Bureau of Statistics
ACOSS	Australian Council of Social Services
AETR	Average Effective Tax Rate
ALMP	Active Labour Market Programmes
AMC	Administration of Medical Control (Luxembourg)
AUD	Australian Dollar
AW	Average Worker
CBI	Confederation of British Industry
CEAPAT	Natinal Centre for Personal Autonomy and Technical Aids (Spain)
CMP	Condition Management Programme (UK)
CRS	Commonwealth Rehabilitation Service (Australia)
DB	Disability Benefit
DDA	Disability Discrimination Act (UK)
DEA	Disability Employment Adviser (UK)
DEN	Disability Employment Network (Australia)
DEWR	Department of Employment and Workplace Relations (Australia)
DLA	Disability Living Allowance (UK)
DSP	Disability Support Pension (Australia)
DWP	Department for Work and Pensions (UK)
ECHP	European Community Household Panel
EFILWC	European Foundation for the Improvement of Living and Working Conditions
EPL	Employment Protection Legislation
ESA	Employment and Support Allowance (UK)
EULFS	European Union Labour Force Survey
EUR	Euros
EU-SILC	European Union Statistics on Income and Living Conditions
FaCS	Department of Family and Community Services (Australia; nowadays FaCSIA)
FRS	Family Resources Survey (UK)
GBP	British Pound
GDP	Gross Domestic Product
GP	General Practicioner
HB	Housing Benefit
HILDA	Household, Income and Labour Dynamics in Australia
IB	Incapacity Benefit
IBPA	Incapacity Benefit Personal Adviser (UK)
IGSS	Social Insurance Administration (Luxembourg)
IMSERSO	Institute for Migrations and Social Services (Spain)
INSS	National Social Security Institute (Spain)

IS	Income Support (UK)
JCA	Job Capacity Assessment (Australia)
JN	Job Network (Australia)
JSCI	Job Seekers Classification Instrument (Australia)
MA	Mobility Allowance (Australia)
METR	Marginal Effective Tax Rates
MISSOC	Mutual Information System on Social Protection in the EU Member States
MTAS	Ministry of Employment and Social Affairs (Spain)
NDDP	New Deal for Disabled People (UK)
NRR	Net Replacement Rates
NSA	Newstart Allowance (Australia)
PCA	Personal Capability Assessment (UK)
PES	Public Employment Service
PPP	Purchasing Power Parities
PSP	Personal Support Programme (Australia)
RMG	Guaranteed Minimum Income (Luxembourg)
RTWC	Return-to-Work Credit (UK)
SDA	Severe Disablement Allowance (UK)
SDAC	Survey of Disability, Ageing and Carers (Australia)
SSP	Statuatory Sick Pay (UK)
USD	United States Dollar
VR	Vocational Rehabilitation service (Australia)
WHO	World Health Organisation
WTC	Working Tax Credit (UK)

Table of Contents

List of Boxes

List of Tables

List of Figures