effects of big government, labour protection legislation, active labour market policies, universal rights to income maintenance, relatively generous benefits and provision of medical and vocational rehabilitation? The scanty research findings so far suggest that the answer is affirmative.

This evidence suggests that the Nordic welfare regime might be sustainable also in the longer run as long as it is able to provide 'full employment' and high employment among disadvantaged groups. Up to the financial crisis, Nordic countries did quite well in this respect in comparison with other nations; countries belonging to the Nordic regime were effective as well as egalitarian. Thus, the alleged trade-off between these two virtues appear to be somewhat exaggerated. It might be that Nordic social institutions create small income inequalities as well as high employment and economic growth by including also disadvantaged groups in the work force. This broadens the tax base and allows the state to pursue egalitarian goals through comprehensive welfare policies. Welfare policies may be seen as a social investment insofar as it improves living conditions, health and work opportunities for most population groups, including the disadvantaged, whereas an inclusive society is a precondition for economic activity, prosperity, equality and the viability of a universal, generous and service-heavy welfare state.

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Espen Dahl,
Oslo University College, Oslo, Norway

Correspondence: Espen Dahl,
e-mail: espen.dahl@hio.no

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Disability and employment: lessons from natural policy experiments

What is the public health issue?

Across Europe, the situation for working age people not in employment through disability or ill-health is a serious issue for public health and social welfare policy. Why? The scale and upward trend is one reason. In the UK, incapacity benefits are paid to those who are unable to work because of ill-health or disability. The numbers on incapacity benefits trebled during the 1980s and 1990s and now stand at more than 2.6 million people,[1] accounting for 25% of total social security benefit expenditure, corresponding to 1.5% of Gross Domestic Product (GDP).[2]

In the Nordic countries, Sweden has also seen a trebling of the proportion of the population receiving sickness or activity compensation in the past 30 years,[3] with almost 15% of the working age population outside the labour market due to ill-health. Nearly 8% are on disability pensions and the cost of sick leave and disability pensions together corresponds to around 4% of the Swedish GDP. In Denmark and Norway, the proportion of the working age population in receipt of disability pension has risen to 8 and 10%, respectively.

There is recognition across Europe that the ageing of populations will exacerbate these trends: in the near future, it is estimated that there will be eight non-working persons per 10 working persons in the European Union (EU), as a result of the twin trends of the ageing of the population and the increase in the proportions leaving the labour force due to ill-health. These figures are not just about a financial problem for governments, but about opportunities for large sections of the population to participate fully in society as a whole and have a better quality of life.

For public health, the issue is intricately linked to health inequalities. Being in poor health is an important risk factor for non-employment, poverty and social exclusion, recognized as such by the World Health Organization (WHO)[4] and the EU.[5] The exclusion that comes from being outside the labour market relates not only to the work environment, but also to exclusion from close social relationships and the opportunity to participate in society in many arenas. Crucially, the adverse consequences of health problems are not evenly spread across the population, but rather become more severe with decreasing social position. This tendency has the potential to generate further inequalities in health. Helping chronically ill and disabled people return to work can, therefore, be viewed as an important part of a strategy to tackle health inequalities.

Learning from natural policy experiments

Concern for the problem is not enough. We need to find out more about what helps or hinders people return to work when they have ill-health. With the existence of a range of initiatives in different countries to address this issue, theoretically it should be possible to evaluate their effectiveness and glean useful lessons for future actions. In practice, there are major challenges to carrying out such an assessment. Very few interventions have been evaluated using experimental designs. Those that have tend to be relatively small-scale, pilot projects which lend themselves to this approach. In addition, the impact of discrete interventions is often dependent on the wider labour market and macroeconomic policy context, which needs to be taken into account.

One solution is to take advantage of efforts that countries have already made

to help chronically ill and disabled people into work, as these can be viewed as a series of 'natural policy experiments' which offer the opportunity for policy learning. The experiments operate at two levels. First, there are the 'wider labour market policies' that affect the whole of the population but which may have differential implications and impacts for chronically ill and disabled groups within society. Second, various countries have been experimenting with 'focussed interventions' specifically designed to promote employment for chronically ill and disabled people. The contrasting approaches provide fertile ground for assessing what works (or does not work), and for whom, in addressing this pressing issue.

Contrasting labour market policies

The broader, population-wide labour market policies operating in different countries provide striking contrasts in approaches and alternative hypotheses for how they might influence the employment chances of chronically ill or disabled people. Two examples illustrate this point. First, a range of policy on flexibility and de-regulation of the labour market can be seen in different European countries. The UK, for example, has developed one of the most de-regulated labour markets in Europe, while Sweden is at the other end of the spectrum with the most highly regulated. Denmark has developed a unique model of 'flexicurity'. This is a term invented to describe a flexible labour market with liberal hiring-and-firing procedures combined with relatively high social security and active labour market policies—as flexible as the British while offering employees the same level of security as the Swedish labour market. There is debate about what impact flexibility and de-regulation would have on the employment chances of chronically ill and disabled people. On the one hand, there is the argument that a more flexible, deregulated labour market would result in better employment opportunities for those with chronic illness who may prefer to work part-time. On the other hand, it is argued that a more regulated labour market with high employment security may offer greater protection and opportunities for disabled people who would otherwise be in a weak position and be the first to be fired in an economic down-turn.

A second example relates to the considerable cross-country variations in disability-related benefits, which generate contrasting hypotheses about how they might act as incentives or disincentives to work. One argument is that if the levels of disability-related benefits are higher than expected wages, then this may act as a disincentive to working. On the other hand, if the benefit levels are too low to maintain a decent standard of living, then people who are too sick to work will have to take jobs to survive and in so doing may damage their health still further. As public spending increases and the number of people on long-term sickness benefits has increased, more and more countries are experimenting with making eligibility criteria tighter and/or benefit levels less generous. The countries are, however, starting from very different baselines and offer opportunities for comparison.

For both these examples, studies are needed that go beyond academic speculation, to trace what 'actually' happens to sick and disabled people underdifferent labour market policy conditions.

Experiments with focussed interventions

With focused interventions that are specifically aimed at helping sick and disabled people return to work, governments have followed two principal orientations. One has a focus on the employment environment, attempting to make it more 'disability-friendly'. These have included legislation against disability discrimination; initiatives to improve the physical accessibility of workplaces; financial incentives to employers to take on disabled workers; and duties placed on employers and service providers to co-operate in providing a planned return to work.

The second is a focus on the disabled people themselves—attempting to protect their standard of living while not working or to increase their employability. These types of intervention have included financial incentives for employees who return to work; individualized support and advice on locating and obtaining jobs; the provision of education and training opportunities; and the provision of medical rehabilitation or 'health condition management' to reduce impairment and thereby improve an individual's fitness for work.

Over the past two decades, countries have mobilized both responses, but they have differed in the types of strategies employed and how these were combined and prioritized. The Nordic countries, for example, have put more effort and resources into interventions to improve the employment environment, while UK has gone strongly for the individual-focused interventions and has stepped up the intensity of such efforts substantially in the past 5 years.

There is an urgent need, and the opportunity, to synthesize the evidence on the effect of these different types of intervention and to learn from them. When we made a start at doing this,[6] we found there were many pitfalls to reviewing the evidence on social interventions such as these. These included: biased selection of participants into the interventions; measurement of outcomes too soon or inappropriately; hidden stigma associated with some interventions; low awareness leading to low take-up and negligible population impact. All these make it imperative to gain in-depth knowledge of both the implementation of an intervention and the overarching labour market context, to learn more about why an intervention did or did not work.

Conclusion

The issue of disability and employment has been relatively neglected from a public health and health inequalities perspective and this now needs to be the focus of a greater research effort. Very few studies have investigated whether there is a differential impact of either wider labour market policies or focussed interventions for different socioeconomic groups in the population. It is essential for future effectiveness studies to monitor differential impact. Some of the studies that have done so have found that interventions tend to be less accessible to less skilled manual groups, who would need additional support to help them return to work. These are the very groups that epidemiological analyses reveal have the poorest, and declining, employment chances in European countries.[6] The current recession affecting Europe makes it more pressing than ever to address this problem in public health research.

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Margaret Whitehead,
Division of Public Health,
University of Liverpool,
Liverpool L69 3GB, UK

Correspondence: Margaret Whitehead,
e-mail: mmw@liverpool.ac.uk

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