Recent European Trends in Disability and Related Programs

*by Ilene R. Zeitzer**

In most countries and especially in industrialized societies, social insurance disability programs and beneficiaries are often affected by external factors that can exert a profound impact over which there is little control. Among these factors are the effects that recessionary economies and aging populations can have on program financing as well as on application and award rates. Although these factors influence other social insurance programs too, this article particularly examines the impact on disability benefits and other related programs, such as health care and rehabilitation, in 5 European countries—France, Germany, the Netherlands, Sweden, and the United Kingdom—with information on the United States provided for comparative purposes.

---

*Special Assistant to the Associate Commissioner, Office of Disability, Social Security Administration. The article is adapted from a paper presented by the author at the Policy Seminar Series of the United States Council for Inter-national Rehabilitation, January 19, 1994. For more detail on the organization and financing of the disability programs in these European countries (with the exception of France), see "Long-Term Disability Programs in Selected Countries," by Ilene R. Zeitzer and Laurel E. Beedon, *Social Security Bulletin,* Vol. 50, No. 9, September 1987, pp. 9–21.

This article discusses recent European trends affecting disability protection in five countries—France, Germany, the Netherlands, Sweden, and the United Kingdom. (Information is also provided on the United States for comparative purposes.) Foreign disability and related programs are very different from their U.S. counterparts in almost every aspect, including the design of the program, definition of disability, population covered, eligibility requirements, and linkage to other social insurance programs and to provision of rehabilitation. Not only are the foreign programs themselves vastly different from those in the United States, but the whole context in which they operate also differs significantly from the U.S. experience—for example, the relative sizes of the countries compared with the United States, the geater homogeneity of their populations, their demographic picture (particularly with respect to dependency ratios), and their economic situation.

A country's economic situation and the different labor rules and practices all influence social protection. The way individual countries finance, collect revenues, pay benefits, and account for the different social insurance programs, such as disability, varies among the countries discussed. For example, in the United Kingdom one social security contribution, collected from both the employer and the employee and supplemented by governmental contributions, pays for all the various pensions as well as all other benefits under programs such as unemployment insurance and family allowances. In other words, payroll contributions and income tax and other general revenues all go into one fund that is monitored by the Treasury, which in turn moves funds to the programs as needed.

On the other hand, some countries (such as Germany) have defined contribution rates for each of the various programs. Thus, each fund is intended to be self-financing through contributions specifically designated to the fund. Only when payments outstrip contributions does the state make up the shortfall. In the past, the German approach has been to allow insurance contributions to rise as social spending increased, rather than switching part of the burden to the gen-

eral taxpayer. However, that approach may no longer be viable as the German social insurance system struggles to absorb the 17 million former East German claimants who are eligible for full benefits but whose contributions, both in rate and actual value, were considerably less than those of their western counterparts. [1]

The following tabulation shows social protection expenditures as a percentage of gross domestic product for 1990:

Country	Percent
United States	15
Germany	27
France	28
United Kingdom	23
Netherlands	32
Sweden	34

Source: Containing the Cost of Social Security—The International Context, United Kingdom, Department of Social Security, 1993, p. 35, Her Majesty's Stationary Office.

The United States, which has the least comprehensive program, spends the smallest percentage (15 percent). In fact, it is the very comprehensive and universal nature of the European social insurance programs that sets them apart from the American approach.

All of the European countries mentioned have national health insurance programs that provide virtually universal and comprehensive health care for their populations, including, of course, people with disabilities. The problems faced by Americans with disabilities—such as potential loss of employment-linked health insurance if one becomes disabled, difficulties finding new health insurance coverage with a new employer because of pre-existing conditions, or expensive premiums due to risk—are all nonproblems in countries where persons with disabilities are subsumed within a very large risk pool.

Comprehensive health insurance also means that, in addition to doctor visits and hospitalization coverage, persons with disabilities under these foreign programs are provided with whatever prosthetic or orthotic appliances, medical equipment, or adaptive devices they need to improve their lives and promote their independence. This equipment is typically provided at no charge, irrespective of ability to pay or to work. In short, many of the disparities and dilemmas that often complicate the lives of Americans with disabilities are usually nonissues in the European countries under discussion.

The five European countries in this article have, as part of their social insurance structure, cash-sickness programs that act as a natural conduit to the disability program. The general pattern is that after a waiting period of a few days, the person who is off work because of an illness, impairment, or injury begins receiving cash-sickness benefits that replace the income lost due to the condition. In some of the countries, the early weeks are employer paid, but, in all of the countries, the social insurance program eventually assumes financial responsibility for the payments. When well administered, these cash-sickness programs that use the social security numbers of the claimants when paying them benefits, permit early identification of persons whose conditions could profit from early intervention strategies.

With the exception of the United Kingdom, all of the other four countries pay partial disability benefits to persons whose serious impairments have caused a significant loss in their ability to earn. Under these partial disability benefit programs, the disabled individual may still work to the degree possible, but he or she would receive disability benefits to compensate for a percentage of the difference between either pre-disability earnings or the earnings that could be reasonably expected from a nondisabled individual with the same training in the same occupation.

Recent Trends

The general program descriptions mentioned thus far emphasize the differences between the foreign disability models and the U.S. version. However, both models share two aspects that impact heavily on disability programs whether here or abroad: (1) the effects of an economic recession and (2) the impact of an aging society. These factors are discussed next. Presented in each case are some comparative data and recent programmatic changes that show the impact on disability programs of these two significant factors.

First, all disability programs are adversely affected by economic downturns. In other words, in times of recession, applications for disability benefits increase, often dramatically, and this in turn usually results in an increase in the number of benefits granted or in the level of the benefit. For example, under the partial disability benefit system, in good economic times a person may receive only a 50-percent benefit because of being able to work to earn the other half. However, in bad economic times, the first persons laid off are often the marginal workers, so that the net effect is that the disability becomes total despite the person's remaining ability to earn.

The impact of the above-mentioned phenomenon on program trust funds is significant because unemployment means fewer contributors to pay for the increase in the number of recipients. Moreover, recessionary economies impact negatively on all social insurance programs, not just on disability programs. A *Financial Times* article about the member countries of the Organization for Economic Co-Operation and Development (OECD) noted, "Rising unemployment has added to the cost of the welfare state in both unemployment benefits and general family support for low-income families. But it has also helped to push up the budget for sickness and disability benefits, which often offer an escape route into early retirement for older workers." [2]

Table 1 shows unemployment rates in the five European countries and the United States for 1980, 1985, and 1990, and then for 1992 and 1993. Note that nearly all of the European countries have seen a considerable increase in unemployment in recent years, especially compared with 1980 rates.

Furthermore, countries whose economies in the past seemed to have been more immune to recessionary pressures, such as Sweden and Germany, have also fallen prey to dramatic jumps in unemployment. As mentioned earlier, in the case of Germany, the explanation is at least partially attributable to the need to

absorb all of the former East German workers into its labor force. Such full-scale absorption of new workers would be difficult even in the best of economic times. However, in a downturned economy such absorption is not readily achieved.

The general state of the Swedish economy has been declining in the past few years. For example, in 1992, steeply falling property values led to a sharp increase in corporate bankruptcies and heavy loan losses for banks. The rapidly deteriorating public finances and declining output also are contributing to the stagnant economic picture for Sweden.[3]

The conventional thinking is that Swedish employers, who fund the bulk of the social insurance programs with some help from governmental contributions, may no longer be able to afford the high labor costs associated with financing the world's most comprehensive welfare state. Thus, employers are laying off workers—particularly older workers—or encouraging them to take early retirement, while not hiring replacements from the many young unemployed. Swedish employers pay 33.2 percent of payroll for social security contributions, while the worker does not directly contribute at all (table 2).

Although the American unemployment figures have tended to hover around 7 percent for the past 12 years, recently they have been decreasing. The latest indications seem to confirm a possible end to the current recession. Unfortunately, the unemployment figures for the European countries are still going up and reports indicate that the numbers may not yet have reached their maximum. Moreover, as mentioned earlier, there is little doubt that, whatever the statutory pensionable age, most European countries are allowing older workers to take early retirement through their disability programs.

Reactive Changes

Consequently, all of the European countries under discussion have initiated efforts aimed either at scaling back or recasting programs in an effort to reduce costs and/or improve efficiency. Depending on the country, some of these steps have been very substantial and many have serious consequences for beneficiaries, including disability pensioners. The following discussion contrasts two very different approaches taken by the Netherlands and Sweden to show how these program cuts or restructuring will affect disability beneficiaries.

Without a doubt, the European country that has taken the most drastic steps in revamping its disability program is the Netherlands. Currently, Holland has 12 percent of its work force receiving sickness and disability benefits, and many have been on the rolls for 8 or more years.[4] The Dutch Government has long been extremely concerned about the disability situation, and these latest measures come at the end of a lengthy public debate. In an effort to stem this tide toward "retiring onto the disability program," the Government announced a number of steps aimed at both employers and workers.

First, for employers, the Government has established a "bonus-malus" system under which employers receive a bonus if they hire partially disabled employees for a minimum of 1 year. The bonus is 6 months of the gross salary of the hired employee. On the other hand, a malus must be paid if an employee becomes disabled or more disabled than previously. To discourage employers from "offloading" workers to the disability program, the Government is fining employers up to 1 year's salary for each employee who is discharged onto the disability rolls. Furthermore, the employer who retains a disabled worker is eligible for wage subsidies of up to 20 percent of the employee's wages for up to 4 years. Second, to encourage employers to "police" absenteeism more effectively, the Government is imposing higher contributions on employers whose sickness absence rates are higher than the average for the trading sector to which their company belongs.

The new rules aimed at workers make a distinction between those already

Table 1.—Unemployment rates, selected years, 1980-93

Country	1980	1985	1990	1992	1993
United States	7.00	7.10	5.40	7.30	6.95
Germany[1]	2.90	7.10	4.90	7.65	10.10
France	6.30	10.20	8.90	10.20	11.15
United Kingdom	6.40	11.20	6.80	9.90	10.70
Netherlands	6.00	10.60	7.50	6.80	8.50
Sweden	2.00	2.80	1.50	4.80	7.30

[1] Western Germany until 1990; Germany thereafter.

Source: Organization for Economic Co-Operation and Development (OECD), *Economic Outlook*, table 51, June 1992 and table 53, June 1993 (figures for 1993 are partially projections). Rates have been standardized by the OECD based on International Labor Office (ILO)/OECD Guidelines.

Table 2.—Income and social security tax rates for the average worker

Country	Social security contribution rate		Income tax rate		Total tax rate	
	Employer[1]	Employee	Average	Marginal	Average[1]	Marginal[1]
United States	7.7	7.7	11.3	22.6	24.8	35.2
Germany	18.2	18.2	8.7	17.6	38.1	45.6
France	43.8	17.1	1.0	6.7	43.1	47.0
United Kingdom	10.4	7.6	15.5	25.0	30.3	38.9
Netherlands	10.8	10.7	32.5	47.8	48.8	62.5
Sweden	33.2	0	28.0	31.2	46.0	48.4

[1] Percent of average earnings plus employers' social security.

Sources: Adapted from *The Tax and Benefit Position of Productive Workers*, OECD, 1992; and *Taxing Profits in a Global Economy*, OECD, 1991.

on the disability rolls and new disability claimants. Under this legislation, persons who are already receiving disability benefits are still entitled to receive 70 percent of their former salary. However, tighter regulations have been introduced to re-examine claimants, and if claimants refuse to accept the offer of a suitable job, they will lose their right to disability benefits and will have to move to lower benefits under either the unemployment program or basic level social assistance. In addition, the definition of "suitable work" has been extended to include any kind of work that can actually be undertaken by the beneficiary, regardless of levels of education, skill, former occupation, and labor-market conditions.

The legislation also establishes a fixed period during the first 2 years of disability for consultations between the various parties to formulate a plan for reintegration into employment whenever possible. The Dutch Government has also set aside a special training budget to provide increased training opportunities for persons with disabilities and to assist them with reintegration.

To discourage current workers under age 50 from claiming disability benefits so readily, the Dutch Government's legislation reduces the level and duration of benefits for new disability claimants. In other words, the wage-related disability benefit will be awarded on a temporary rather than a permanent basis, depending on the beneficiary's age and previous employment periods. New disability claimants older than age 32 will start with a 70-percent benefit, but benefit levels will be reduced over a period of time, depending on age. For example, persons between the ages of 38 and 42 will receive benefits equivalent to 70 percent of their previous wages for 12 months; persons aged 55 will receive this rate for 3 years. After this period, if the disability still exists, the benefit level will be calculated on the basis of 70 percent of the minimum wage, plus 2 percent of the difference between previous wages and the minimum wage for each year older than age 15.

On the other hand, to provide incentives for employees to cooperate in their vocational rehabilitation, their degree of disability will not be downgraded for 1 year after training even if their employability has increased. If they then become sick after trying to work, they will receive 100 percent of their former wages rather than the normal 70 percent. The additional amount will be paid by the industrial insurance board so that there is no additional financial risk to the employer. Finally, all persons aged 65 or older are now required to contribute to the social security general disability insurance scheme that provides flat-rate, long-term benefits to all disabled residents in the Netherlands.[5]

Though not as chronic or as serious a problem as the Dutch disability situation, the Swedes were also quite unhappy with aspects of their program. Specifically, they had failed to capitalize on their highly efficient computerized tracking system for workers receiving cash-sickness benefits. The information should have allowed them to identify good candidates for early intervention strategies. Years earlier, they were more concerned with the numbers of persons receiving cash-sickness benefits than in disability prevention methods. However, in the past 3 years absenteeism due to illness, once a chronic problem, has fallen sharply from levels where 3 in 10 workers were off "sick" at any time to less than 1 in 10 today. This change is partially due to tightening of the sickness eligibility rules, including better monitoring of absenteeism abuse by the Swedish insurance authorities and employers.[6]

Having reduced their high absenteeism rate, the Swedes turned their attention to improving the rehabilitation prospects for ill or injured workers through a complete overhaul of the way rehabilitation was organized. The new efforts are aimed at early intervention and the strategy is to shift much of the responsibility for rehabilitation onto employers. Beginning in January 1992, employers now have primary responsibility for the rehabilitation of their employees. This change means that it is the employer's duty to chart rehabilitation requirements if:

- The employee has been ill for more than 4 consecutive weeks;
- The employee has been ill on 6 or 7 occasions in the past 12 months; or
- The employee himself or herself requests it.

The employer's rehabilitation report must be delivered within 8 weeks to the Social Insurance Service, which, together with the employee and the employer, draws up a rehabilitation plan containing targets, measures, and financial arrangements. A Working Life Fund was set up in July 1990 to financially support employers in the task of improving the work environment and conducting vocational rehabilitation activities.

In addition, as part of the government's overall plan for revising rehabilitation, the social insurance offices were given financial resources to purchase vocational rehabilitation services directly. In the past, the only option for vocational services was to refer persons to the Employment Service. However, the latter served all unemployed claimants, not just persons with disabilities. Not surprisingly, disabled claimants sometimes had to wait years for services.

The new rules also changed the role of the Social Insurance Service personnel from passive bureaucrats to active liaisons with employers and work places. Under the new setup, Swedish Social Insurance Service employees must have personal contact with every work place and must play an active part in preventive measures as well as encouraging early and active rehabilitation for ill or injured workers. The plan calls for spending less time in the office and more time visiting work places and health centers.

Furthermore, in an effort to improve medical rehabilitation services, the Swedes forged closer cooperation between health insurance and medical services. Specifically, out of the flat-rate compensation paid to county councils from health insurance, the Social Insurance Service is earmarking a large percentage for improvements to medical rehabilitation measures so that sick employees may be rapidly returned to work. The money is available to the county councils only when they have a plan approved by the Social Insurance Service

that details how the money will be spent on direct measures in primary care, on specialist input to support the primary care, on reinforcing resources to eliminate waiting lists for surgery, and on training measures for rehabilitation. Moreover, workers who take vocational rehabilitation will receive a special benefit consisting of 100 percent of their previous earnings plus a grant towards additional expenses incurred because of rehabilitation.[7] Sweden has also instituted cuts in many of its social welfare benefits, but these cuts have been quite mild, especially when compared with those taken in the Netherlands. For example, there is now a 2-day waiting period before payment of cash-sickness benefits, and those benefits are now 80 percent of previous salary instead of the former 90 percent. In short, both countries have undertaken significant changes to their disability programs using both "carrots and sticks" to motivate all involved parties.

The developments concerning disability programs in the other countries have been much more minor. For instance, the Government of the United Kingdom has generally been increasing initiatives for persons with disabilities, while taking steps to address increased expenditures for disability benefits. Essentially, the increases have been to encourage those with disabilities to work by providing more funding for adapted vehicles and by increasing the financial benefits to caregivers who also work outside the home. Concern over increases in disability benefits of nearly 140 percent since 1978–79 has caused the British Government to focus on closer medical examinations and the followup of administrative procedures for persons found capable of work.[8]

Changes in Other Related Programs

The Germans plan to introduce a new, compulsory, long-term (nonmedical) care insurance for the elderly and persons with disabilities, whether they live in their own homes or in residential facilities. At present, such nonmedical home care is financed by local authorities, but the rapid rise in the elderly population has put a nearly intolerable burden on local budgets, so the Government promised to find an alternative system. The Government's solution is to transfer the financing to a system that is funded by contributions from employees and employers as well as from pensioners and persons receiving care. The new insurance will also cover nonemployed spouses and children without their having to pay any contributions.

To appease the employers about the additional costs, the Government has proposed cutting the number of national holidays during the calendar year from 10 to 8, or instead, allowing workers to take a 20-percent pay cut on those holidays. Employers are unpersuaded that such cuts will come anywhere close to covering the additional costs. On the other hand, German workers are angry at having to pay higher contributions because the plan is not expected to result, in the near term, in any improvements in nursing care.[9]

Like the German Government, the French Government is also concentrating its funding cuts on the health care side rather than on the disability program per se, but of course such cuts impact on disabled beneficiaries. The French health care system is the most expensive in Europe, and, among the OECD countries, the system is second only to that of the United States. Under the current French system, patients can choose their doctors and doctors can prescribe whatever treatment they feel necessary. Financial reimbursement is made by the Government which pays patients for 70 percent of doctor's fees, slightly less for prescriptions, and virtually 100 percent for hospital care.

To reign in the costs, the Government has capped the rise in overall health spending to 3.4 percent in 1994 (compared with a 7-percent increase in 1993). The cuts in expenditures will be achieved by ordering hospitals to reduce their spending and, at the same time, by requiring them to pay for new equipment (such as scanners) through compensatory saving in eliminating unnecessary beds. In addition, the French Government is drafting criteria on what constitutes "unnecessary" medical treatment and is threatening financial sanctions on doctors who ignore such guidelines.[10]

Effects of an Aging Population

Finally, the examples of the German and French efforts at budget cutting illustrate the importance of the effect of aging populations on social insurance spending. Though an aged population is not as immediate a concern as the unemployment problem, all of the countries discussed currently have higher percentages of their populations aged 65 or older than does the United States. The strain that the increasing number of elderly will put on social programs can best be seen by relating it to the expected trends in the number of persons of working age. The standard measure for this is called the "age dependency ratio," which is defined as the population aged 65 or older as a percentage of the population aged 15–64.

Table 3 shows the percentage of the population aged 65 or older in 1990 and projections to 2000 and 2020 for each of the five European countries as well as for the United States. Table 4 shows the age dependency ratio for the same six countries in 1990 and in 2020. As can be seen, some of the countries (for example, France and Germany) will be facing much greater pressures from the aging of their populations than will others. Germany is expected to have an age dependency ratio of 34 percent by the year 2020—one person older than age 65 for every three persons between ages 15 and 64. The projections are that by 2040 Germany will have almost half

Table 3.—Percentage of population aged 65 or older in 1990, and projections to 2000 and 2020

[Percentages have been rounded]

Country	1990	2000	2020
United States	12	13	16
Germany	16	17	22
France	14	15	19
United Kingdom	15	14	16
Netherlands	13	15	19
Sweden	18	17	20

Source: Organization for Economic Co-Operation and Development (OECD), *New Orientations for Social Policy*, March 1994, table 15, pp. 112-113.

of its population older than age 65, although the portion will fall thereafter. Age dependency ratios will climb more slowly in the United States and the United Kingdom, with both countries having about four persons of working age to support each elderly person in the year 2020.[11]

Not only are age dependency ratios important to a country's ability to pay for old-age and disability pensions, but they also impact on payment for health care costs and related services (such as geriatric care and social services). Not surprisingly, some countries under discussion are making cost-cutting adjustments to future pensions by raising the retirement age, increasing the numbers of years of contributions for a full pension, changing the benefit formula, or adjusting the indexing. Germany's rapidly declining working age population has led it to progressively raise the retirement age. Currently, it is age 60 for women and 63 for men. It will go to age 65 for both sexes between the years 2000 and 2012. However, the retirement age for disabled persons, or for workers with a 50-percent disability, will remain at age 60.[12]

In addition, since 1992, German pensions that were formerly index-linked to gross salaries are now linked to net earnings exclusive of income tax and social insurance contributions. "The difference is substantial because net earnings have grown much more slowly than gross earnings due to increased taxes attributable to reunifi-cation and higher social insurance charges." The cost-of-living adjustment is computed differently for beneficiaries living in the former West Germany than for those in the former East Germany, because the latter had lower earnings levels that have now sharply increased. In essence, however, the change in the method of indexing means that beneficiaries in the former West Germany will see benefit increases of 2.71 percent rather than the 6.1 percent they would have received had the linkage continued with gross earnings. The benefit increase in the East will be 12.71 percent plus a supplementary benefit not given to beneficiaries in the former West Germany.[13]

A similar change was made in the United Kingdom, which used to link pensions to average earnings, but now adjusts them in line with prices. "The basic pension, currently 15 percent of average earnings, is thus projected to fall to 7 percent of average earnings over 30 years."[14]

Sweden too will raise the pensionable age for both men and women from age 65 to age 66 in quarterly installments from 1994 to 1997. Other Swedish adjustments include freezing the base amount used to calculate most social security pension benefits at 1992 levels and reducing the flat-rate old-age pension by 2 percent.[15]

France has not raised the legal retirement age of 60 but instead extended the contribution period for a full pension from 37.5 to 40 years. In addition, the full pension will be calculated on a person's best-paid 25 years instead of the current best 10 years.[16]

Table 4.—Age dependency ratios[1] for 1990 and 2020

[Percentages have been rounded]

Country	1990	2020
United States	20	25
Germany	22	34
France	21	31
United Kingdom	23	27
Netherlands	18	29
Sweden	(2)	(2)

[1] Population older than age 65 as a percent of the population aged 15–64.

[2] Not available.

Conclusion

In summary, a country's ability to fund disability pensions and related services, such as rehabilitation and training, is directly influenced by many economic and demographic factors over which they may have little control. All too often, good, long-term public policy must be sacrificed to finance the demands of an ever changing economic climate. The European countries discussed in this article are struggling to maintain the established welfare state, while trying to remain globally competitive and to ensure equity for future generations. As U.S. policymakers know all too well, it is not an easy task.

Notes

[1] Quentin Peel, "The Burden Grows Heavier," *Financial Times*, October 25, 1993, p. XI.

[2] John Willman, "Welfare Versus Wealth of Nations," *Financial Times*, October 25, 1993, p. 13.

[3] Organization for Economic Co-Operation and Development, *OECD Economic Outlook*, June 1992, No. 51, p. 113.

[4] United Kingdom, Department of Social Security, *Containing the Cost of Social Security—The International Context*, 1993, p. 19.

[5] International Social Security Association (ISSA), *Trends in Social Security*, October 1992, No. 2, pp. 23–24.

[6] Hugh Carnegy, "Sweden Shows Effects of Painful Cure," *Financial Times*, November 8, 1993, p. 3.

[7] ISSA, *op. cit*, October 1992, No. 2, pp. 27–28.

[8] ISSA, *Trends in Social Security*, August 1993, No. 4, p. 20.

[9] Peel, *op. cit.*

[10] Buchan, David. "French Welfare in Terminal State," *Financial Times*, November 24, 1993, p. 3.

[11] Willman, *op. cit.*

[12] ISSA, *Trends in Social Security*, March 1993, No. 3, p. 18.

[13] Peter Puidak, "Recent Developments in Germany," International Updates, *Social Security Bulletin*, Vol. 55, No. 2 (Summer 1993), p. 78.

[14] Hugh Dixon, "In Search of Fiscal Wisdom for Old Age," *Financial Times*, November 30, 1993, p. 3.

[15] United Kingdom, Department of Social Security, *op. cit.*, p. 66.

[16] D. Buchan, *op.cit.*