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Improving the labour force participation of people on disability-related benefits

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Abstract

Around 5% of the working age population in New Zealand is in receipt of either Sickness Benefit (SB) or Invalid's Benefit (IB) which puts the country slightly below the OECD average disability-related benefit recipiency rate of around 6%. However, as unemployment has fallen in the later 1990s and early 2000s, numbers on SB and IB have continued to rise, so that currently 25% of welfare benefit spending on the working age population is devoted to these two groups. At present, the rate of increase is falling somewhat, though in the 12 months ending in June 2004, SB numbers rose by over 10% and IB numbers by over 5%.

People entering disability-related benefits generally want to re-enter the labour market, and have remediable conditions. There will be a rising demand for their labour as the working age population shrinks as a share of the total in most OECD countries. However, out-flow rates from these benefits are very low in most countries (typically 1-2% per year). Yet there is substantial overlap in health and disability status between people who work and those on sickness or disability-related benefits, indicating that there is scope for raising employment rates among these groups. There is increasing evidence from around the world that activity, including work, is generally positive not only for the incomes of people who were on disability-related benefits, but also for their health, physical functioning and social integration.

It is clear internationally that government policy such as the generosity of disability-related benefit payments makes at least as substantial a contribution to the proportion of the working age population on disability-related benefits as the prevalence of disability in the population or the demand for labour. Until the early 2000s, New Zealand's policy towards people out of the labour market because of short-term sickness or longer-term invalidity had changed little over 20 years despite rising numbers and trends in other OECD countries towards integrating people on disability-related benefits into the wider benefit and employment systems, and adopting more 'activist' approaches to helping them back to work (e.g. intensive case management, early intervention referral for vocational rehabilitation, etc.). By contrast, New Zealand policy was largely 'passive' with a focus on establishing claimants' entitlements to relatively generous benefits, based on the assumption that claimants could not work, with little or no access to rehabilitation for recipients until they had been long term on benefit and with major disincentives to work, particularly for more than 15 hours per week.

However, major changes were announced in February 2005 and a number of reforms are already in progress, designed to strengthen work incentives, improve case management and increase claimants' access to work-focused assistance and health services, with a view to increasing the odds of them returning to work. These reforms are part of an ambitious plan to introduce a single, 'core' welfare benefit which will apply to all beneficiaries including people who would have been on SB or IB in the past. Such people will be treated as far as possible like other unemployed people under the slogan, 'the right job, at the right time, right from the start' which will apply to all but the most severely disabled people. Any extra financial help above the 'core' benefit will be paid to people with disabilities in relation to the extra costs they incur because of their condition and regardless of whether they are in or out of work. There are also plans for increased work incentives for working for more than 20 hours per week. All job-seekers regardless of why they are out of work will be offered an assessment of work-related capability.

Two outcome 'streams' are envisaged: a 'rapid return' (work-tested); and a 'work development and preparation' stream for those deemed likely to return to work more

gradually, together with trials of offering employment-related support from the first day of a claim before benefit entitlement has been determined with a view to preventing any need for benefit receipt. Though the requirements to be placed on claimants in the 'work development and preparation' 'stream' have yet to be determined, these claimants are likely to face regular work-focused interviews as a condition of receiving a benefit. The IB population is likely largely to occupy this 'stream' with more SB recipients in the 'rapid return to work' 'stream'.

The reforms are strongly influenced by the positive employment effects in the US, Canada and the UK resulting from 'active' labour market policies applied to unemployed people and solo parents, and more recently to people on disability-related benefits. The reforms proposed for New Zealand are challenging, but largely in line with research evidence and best practice recommendations from bodies such as the OECD to introduce 'activation' strategies linked to 'mutual obligations' to increase the employment prospects of people on disability-related benefits.

However, the effectiveness and cost-effectiveness of the reform package is likely to depend on the details, yet to be finalised, particularly the nature of the work-related expectations placed on former SB and IB recipients in the second 'stream' and the degree of compulsion (i.e. the sanctions for non-compliance) underpinning the offer of assistance.

New Zealand may also need to investigate the merits of a direct financial incentive for beneficiaries in these groups to return to work, for example, in the form of a tax credit.

Another important implementation issue relates to the resources necessary to train existing case managers and recruit extra staff to provide the more intensive, personalised, job-oriented service required. Additional resources are also likely to be required for clients' needs assessment and their vocational and medical rehabilitation. The risk is that New Zealand attempts to increase employment and realise benefit savings without making the necessary investment in support services and financial incentives to bring this about.

JEL CLASSIFICATION I38 - Provision and effects of welfare programs
J21 – Labour force and employment

KEYWORDS active labour market policies; disability benefits; disabled people; employment programmes; labour force participation; labour incentives; welfare policy

1 Introduction

This paper focuses primarily on how the labour force participation of people with long term ill-health or disabilities is affected by the benefits system and employment services available, and how these systems may be altered to encourage greater participation in these groups of people. Thus the labour force participation of the wider population of people with sickness or disabilities is a secondary consideration in the current analysis. The paper aims to assess recent changes and current policy reform proposals in New Zealand designed to reduce the population entering and staying on Sickness Benefit (SB) and Invalid's Benefit (IB) in light of international policy developments and the evidence of what is likely to work in this area.

Until recent years, there was relatively little attention given in employment policy to people with disabilities or health problems on or applying for disability-related benefits. It was generally assumed that these groups could not, should not and would not want to be helped or encouraged to participate in the labour market. Of late, all these assumptions have been challenged, though only very recently in New Zealand. Indeed, the labour force participation of people with long term health conditions and/or disabilities is central to contemporary thinking about policies to raise levels of labour force participation. The main reasons internationally are that:

- unemployment rates and numbers of people on unemployment benefits have fallen greatly in countries like the US, UK and New Zealand such that increases in labour force participation, if desired, have to come from elsewhere. For example, the current unemployment rate in New Zealand is around 3.5% with one in five firms reporting labour shortages yet one in seven households has no one in work and approximately 300,00 people of working age are in receipt of a welfare benefit;

- people with long term health problems or disabilities are much less likely to be in the labour force and working than their non-disabled peers, and face a number of obstacles and disincentives to participation, many of which can be influenced by government policy and do not relate directly to their underlying condition;

- a high proportion of people who go onto sickness and disability benefits expect to get back to work and appear to have manageable conditions that would seem to make this likely; however, a far lower proportion ever do return to the labour market;

- the association between being disabled and being outside the labour force is far from being a perfect correlation – large numbers of disabled people work and there is substantial overlap in terms of levels of disability between working and non-working disabled people; that is, there is no clear cut-off that separates those who cannot work from those who can, despite the fact that many countries' benefit systems operate as if there is;

- people who are disabled or suffer from long term health conditions and who do not have a job are considerably poorer than their employed counterparts whose financial circumstances are almost as good as those of working people without disabilities;

- though people with long term sickness and/or disabilities are a heterogeneous group, there is increasing evidence that, for the main sub-groups in this population, activity, including work, is largely positive for their health and well-being;

- despite little or no evidence of increasing prevalence of sickness and disability, the numbers of people on long-term sickness and disability benefits, and the share of welfare spending allocated to such benefits, continue to rise in most high income countries, including particularly New Zealand, even when the New Zealand economy was growing, unemployment falling and the demand for labour rising. This leads to concerns about lost production in the economy, the level of spending on benefits and the possibility that features of the benefit system under the control of government could be leading to undesirable exit from the labour market;

2 Challenges in developing labour market and benefit policies for people with long-term health problems or disabilities

Many countries, including New Zealand, provide benefits for people who are unable to work and whose income falls as a result. Disability, accident and sickness can lead to loss of work and related income for people of working age. Disability benefits are a way of helping people manage their risk of losing income due to an uncontrollable impairment or disability, as well as meeting any additional costs of living caused by their disability or health problem which they cannot afford to meet. Without transfers, the burden of impairment would fall solely on people with disabilities and their families. In practice, total compensation is a combination of benefits, self-insurance and income-replacement insurance. Traditionally, entitlement to a sickness or disability-related benefit is assessed in relation to people's ability to work. If they are unable to work because of sickness and disability, they are entitled to a sickness or disability-related benefit. In other words, demonstrated incapacity is the basis of benefit entitlement.

(Burkhauser and Daly 2002) identify a number of hurdles to creating effective, balanced benefit and employment policy for people with disabilities. The first issue is the definition of eligibility. A major challenge is to minimise the costs of not granting benefits to those who need them and granting benefits to those who do not. The lack of an objective test of disability makes this a very difficult task as long as benefit receipt is tied to demonstrated incapacity as it has tended to be until recently in many countries. There are inevitable tradeoffs between equity and efficiency. Targeting disability assistance narrowly will deny benefits to some who need them; while a broad entitlement will award benefits to some who do not.

Some people who receive benefits are capable of work in the right circumstances and many disabled people work. As a result, the population of people with long-term ill-health problems or disabilities is divided into the following groups at any one time:

- those outside the labour force receiving a benefit (e.g. on one of the main sickness or disability-related benefits);

- those outside the labour force not receiving a benefit (e.g. because their spouse is working);

- those in the labour force not receiving a benefit (e.g. people who choose to work and choose not to take up any disability-related allowances);

- those in the labour force receiving a benefit (e.g. to meet the extra transport and living costs of having a disability, or because they only work a few hours per week).

This division occurs because not all sickness and/or disability payments are traditionally made because people cannot work. Some have been related to the presence of disability itself or the presumed additional hardship this creates. For many people disability does not *prevent* work, rather it limits work to a greater or lesser extent. These people may still have some choice over whether to seek a disability-related benefit and/or to keep working. They presumably weigh up what they can earn working and the effort and unreimbursed out-of-pocket costs of working against what they would receive from benefits.

The OECD (OECD 2003) found that the relative employment rate of disabled people across OECD countries was between 50% and 70%, despite very different disability benefit policies. In New Zealand, the relative employment rate is over 70% among people of working age {Jensen, 2004 #3964}. The majority of males with disabilities are in the labour force at all ages up to 55 years. In the 55-64 years age group a slightly higher proportion is outside the labour force.

Secondly, because disability is a dynamic process rather than a static condition and individuals' characteristics and circumstances differ and their responses to the onset of disability and rehabilitation vary considerably, it is difficult to define categorically. This diversity presents a considerable policy challenge, but also an opportunity. There are many reasons for disability, some of them complex and inter-related. Disability status also varies: it can be congenital or work-related, severe, moderate or mild; of sudden or gradual onset, continuous or intermittent; permanent or temporary, progressive or regressive, reversible or irreversible. Disability is thus dynamic and not a "one way street" out of the labour market. Programmes that help the disabled to stay in work or re-enter the labour market need to accommodate a range of disability trajectories (Burchardt 2000). Also, the idiosyncratic and complex nature of disability means that "one size does not fit all." An individualised approach to helping people back into work is needed.

Population ageing presents a further challenge to disability benefit and employment policy. While the risk of disability is well known to rise with age (Maskill, Hodges, Burns and Carroll 2004), older people are also living longer, healthier lives than they did in past generations. At the same time, the ageing population means that the numbers of ageing 'baby boomers' in their fifties and sixties are likely to increase the number of disability-related benefit recipients unless mitigating strategies are developed. Any increase in the age of eligibility for old age pensions is also likely to increase the numbers of people on disability benefits as they choose to retire early on a benefit.

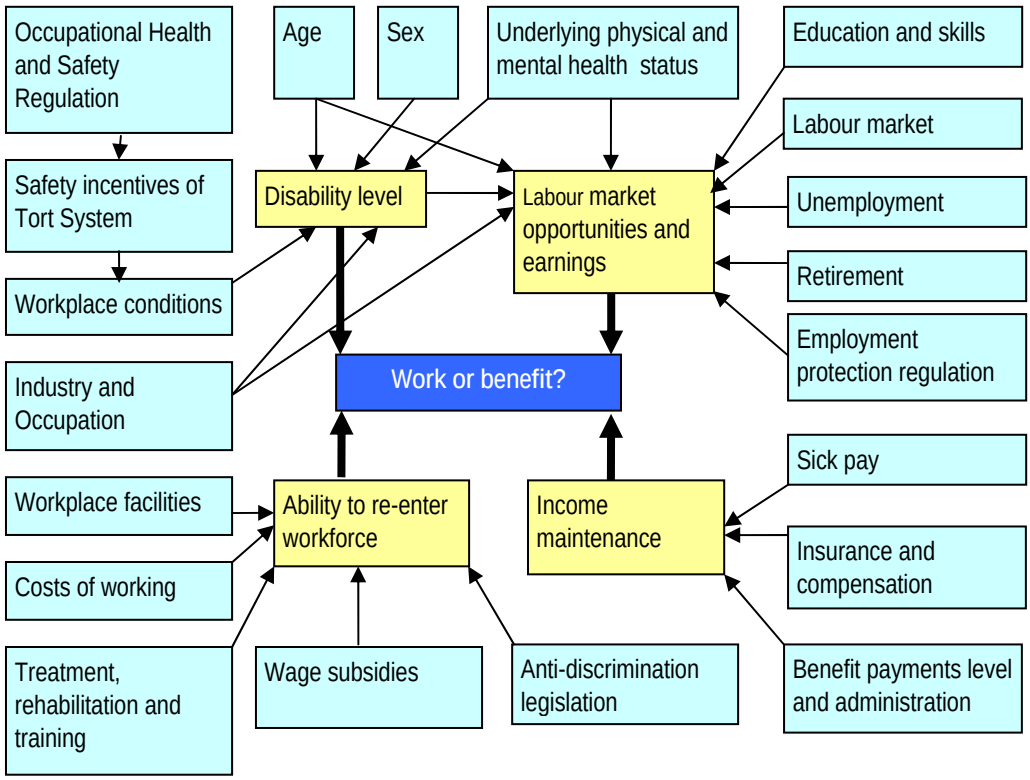
Finally, because it is difficult (if not impossible) to unerringly identify those with disabilities who cannot work, the number of people actually receiving disability benefits will be determined by the impact of disability-related benefit and employment policy on the relative incentives to work or receive benefits.

2.1 A conceptual framework of disability benefit receipt

A typical working-aged person with a disability becomes disabled during working life (Burkhauser and Daly 1996). When health-related impairment affects the ability to work a key issue is whether the worker will remain in the labour force or receive disability

benefits. This decision is influenced by a number of factors: the underlying level of disability; the ability to re-enter the workforce; labour market opportunities and earnings and alternative income opportunities, including disability benefits (see Figure 1) (Curtis, Garian, Gawdiak, Osborne and Solsten 1998).

Figure 1 – Disability work, and benefit receipt



Most economic models assume that when a worker is disabled, the decision is whether to remain in work or to receive a benefit. However, many other factors affect this decision, as described below.

Disability level and type

The underlying level of disability that affects the ability to work is clearly an important factor affecting the decision to work. But a person's health or disability status and the impact of a health problem or disability on the capacity to work is notoriously hard to determine. Disability involving mental illness presents particular difficulties. There is likely to be heterogeneity in the incidence and severity of disability, with variation by age, sex, and type of disability. An individual's underlying mental and physical characteristics can also affect the level of disability in complex ways, so that multiple, interacting factors can impair the ability to work. Mental health problems appear to be an important part of the health and/or disability problems faced by people with ill-health or disabilities outside the labour market and are often present with physical health problems. The type and risk of disability is likely to be affected not only by the industry in which a person works, but also by the safety incentives for the employer and employee incurred provided by regulation and compensation mechanisms. In addition, official definitions of disability change over time and are applied in different ways. As a result, the relation between individual and population prevalence of sickness and disability, and labour force participation is highly variable.

This is borne out in the empirical evidence. While disability status is an important predictor of labour supply behaviour, such predictions are highly sensitive to the measure of disability used (Kreider and Pepper 2002). (Burkhauser and Schröder 2004) compared the levels and trends in the relative employment of working age men with disabilities in Germany and the USA and argued that the decline in employment among disabled people was attributable more to changes in the policy environment (e.g. benefit levels or changes in the assessment of work-related disability) than to any increase in the severity of the work limitations.

There is some variation by sex, with a tendency for more women to be work-impaired than men (Jones, Latreille and Sloane 2003) study of the United Kingdom found that the impact on disability of wages was greater for men than for women.

(Jones *et al* 2003) found in the United Kingdom that the type of health problem also had a significant effect on employment and earnings, with those suffering from mental disability faring particularly badly. They concluded that mental health is both a barrier to getting work and to earning as much as other workers.

People at older ages are more prone to disability, so that an ageing population is also likely to have a greater proportion of people who are work-impaired. (Wilkins 2003) found that in Australia, not only are people more likely to be disabled the older they get, but labour market outcomes are worse the older the person and the older the age of onset. Mature-age onset of disability also involves more severe disabilities, often compounded for people with low levels of education or in manual occupations. (Nadel 2001) reported in the US that while older people are more likely to be disabled, of the three largest categories of disability, musculo-skeletal and circulatory orders increase dramatically with age, while mental disorders do not.

It is often argued that increasing the retirement age could potentially increase the official rate of disability as older workers with some work limitations opted for disability benefits as a form of early retirement. However, there are contrary trends since people are living longer, healthier lives, and are thus less constrained by disability in working for longer than they were in previous generations (Bound 1999)

(Wilkins 2003) also found that single parents are more likely to be disabled than partnered parents. The reasons for this are unclear, but it could be that disability compromises both work and family relations. There appears to have been little research into the relationship between disability, employment and family circumstances.

Ability to re-enter or remain in the workforce

The underlying characteristics of people affect their ability to re-enter the workforce. Because disability is not randomly distributed among the population, but concentrated among the older, less educated and less skilled, they are both more likely to leave a job due to impairment and more likely to find it difficult to re-enter the workforce. People with higher levels of education and skills are less likely to leave a job due to disability and find it easier to get a job after losing it because of impairment ((Hennessey and Muller 1995), see (Nadel 2001)). For example, (Loprest and Maag 2001)) examined the barriers to work among adults with disabilities in the US. They found that more than half of disabled workers, especially those with less education and work experience, faced difficulties in the process of searching for jobs. One third of workers needed special accommodations in the workplace, such as accessible parking or reduced work hours. Few disabled people

used public transport, although it was widely available, and was not seen as a barrier to working.

The changing nature of work as well as individual characteristics affects the ability of people who become disabled to re-enter the workforce. (Rupp and Stapleton 1995) suggest that there are two effects. In the short run, people who work in sectors such as manufacturing may not be able to get jobs in newer sectors such as services, and disability rolls may rise. Economic reforms leading to the reduction in the number of previously protected low-skilled or manual jobs in sectors such as forestry or railways can also have this effect. However, in the longer run, new industries such as IT may produce fewer disabling illnesses and injuries, and the decline in sectors requiring physical exertion will also reduce injuries. At the same time however, the newer industries may require greater cognitive skills, so that mental impairment may have become a more important barrier limiting the participation of people who are less cognitively skilled or who have behavioural difficulties.

Thus the ability of a work-impaired person to enter, re-enter or remain in the workforce depends first on addressing disability and harnessing abilities through health care, rehabilitation and (re)training. A lack of access to health, rehabilitation and training services can limit a person's potential to work. Traditionally, welfare policy towards disabled people has paid little attention to these services on the grounds that long term sick and disabled people could not be helped in these ways. Indeed, the social and private costs of becoming work-ready may always remain too high, and the personal effort too great to make the goal of paid work worthwhile for some people, especially those with severe or acute disabilities. There will always be a proportion of people with long-term health problems and disabilities receiving disability-related benefits for whom work is not a reasonable possibility (estimated at around 25% in the UK), but a larger proportion for whom it is.

Mobility and the ability to get to work can also affect a disabled person's ability to participate in the labour force. Mobility devices, such as wheelchairs and public and private transportation systems that facilitate access can contribute to the ability of the work-impaired to work. Workplaces themselves can affect the ability of the work-impaired to engage in work, through the provision of facilities such as wheelchair ramps (Krause, Dasinger and Neuhauser 1998).

Labour market opportunities and earnings

Being able to overcome impairment does not mean that a disabled person will necessarily be able to get a job. The attitudes of employers towards people with disabilities, whether physical or mental, or both, including outright discrimination, can further hinder their access to paid employment. In response, more direct interventions, through penalties, incentives or mandates are designed to promote the employment of the work-impaired by overcoming these hurdles. They include wage subsidies that seek to overcome the additional costs of employment for those with disabilities, the creation of government jobs for people with disabilities, the imposition of job quotas for the disabled and anti-discrimination legislation.

Discrimination against disabled people is often cited as a reason that disabled workers cannot get jobs and when they do, enjoy lower wages than able-bodied workers. Discrimination can reduce the wages of disabled workers and discourage others from getting jobs. A number of studies have investigated the impact of wage discrimination in the UK ((Kidd, Sloane and Ferko 2000)) and US ((Baldwin and Johnson 1994), (Baldwin

and Johnson 2000)). These studies have generally shown that that productivity differences arising from functional impairments account for around half the wage differential. However, around half the wage differential remains unexplained. The key question is the extent to which this difference represents discrimination due to prejudice. The results suggest that while wage discrimination due to prejudice may be important for a small number of workers, low employment rates are a more serious problem than wage discrimination for workers with disabilities.

Legislation may be passed to reduce discrimination against people with disabilities (among others) that limits their employment opportunities. An important issue is the extent to which it is effective in doing so. The Americans with Disabilities Act was intended to reduce discrimination against people with disabilities. The Act is based on the premise that prejudice creates obstacles to employment and limits wages for people with disabilities. (DeLeire 2000b) and (DeLeire 2000a) attribute the decrease in employment among people with disabilities in the USA in the 1990s in part to this legislation, which, while it increased the duration of employment for those already in work, increased the costs to employers of employing or firing people with disabilities, and thus reduced their incentive to hire them. (Bound and Waidmann 2002) challenge these findings, arguing instead that changes in benefit eligibility meant that workers with disabling conditions rationally chose to leave the labour force and receive disability benefits.

Even if discrimination does exist, it may arise from asymmetric information and uncertainty. Asymmetric information and uncertainty about the impact of an impairment on the productivity of a disabled worker can affect the hiring and firing behaviour of firms (Baldwin 1991).

(Cater 2000) explains the high turnover rates of the majority of impaired workers who initially return to their pre-injury employer and wage as a result of uncertainty. Because the effects of impairment on productivity are initially unknown, employers will retain disabled workers because they are costly to replace, but when they cannot adjust wages to reflect lower productivity, they will fire the worker.

Information asymmetry and uncertainty about the impact of disability on productivity may also underlie the tendency of employers in NZ to retain employees who suffer mental illness, and their reluctance to hire new employees with mental illness (Jensen, Jones, Sathiyandra, Rochford, Krishnan and McLeod 2004a).

A key issue for a worker who becomes disabled relates to the relative income opportunities offered by the labour market and other sources. The higher the relative market earnings, the greater the incentive to try to remain working. In addition to the monetary rewards, there may also be direct effects on health and mobility, psychological benefits and gains from enhanced social inclusion.

Even when people with disabilities can find jobs, however, their possible earnings may be low. Disabled people typically earn less than the able-bodied due, at least in part, to health problems that can limit their productivity in some types of work. The nature of work influences the productivity impact of a given impairment. (see (Baldwin and Johnson 1994) and (Cherlin 2004)). (Cater and Smith 1999) using data from Ontario, conclude that the income effects of disability are less for white-collar jobs than for manual labour, suggesting that education, skills and workplace accommodations can allow workers to adapt to their physical impairments more easily. At the same time, manual workers are more likely to suffer injury than non-manual workers.

The low earnings possibilities for many people with disabilities who can find jobs, particularly the low-skilled, reduce the monetary gain of paid employment relative to disability benefit payments.

Education, skills and experience are important determinants of labour market earnings. People with low levels of eduction and few skills and a disability may enjoy higher income on a disability benefit from than from working. Age can also affect potential earnings, so that an older disabled worked may choose a disability benefit as *de facto* early retirement rather than continuing to work.

People with disabilities however, may have difficulty finding appropriate jobs, especially when demand for labour is weak. It is reasonable to suppose that workers with disabilities are more likely to seek disability benefits during periods of economic downturn and there is evidence of this (Burkhauser, Daly and Houtenville 2001). By contrast, a tight labour market with low unemployment and strong demand for labour is more likely to provide job opportunities for the work impaired, all other things equal.

Income maintenance available

The various unearned income opportunities available to the work-impaired are important determinants of the decision to seek paid work or disability benefits. Income maintenance programmes are intended to provide an income for those who are unable to work due to disability. They include short term measures such sick pay where employers replace lost wages, private income replacement insurance for disability or illness and compensation for injuries. Private insurance provides income maintenance as a proportion of earnings for people who become injured or sick and cannot work. In the US, relatively few workers are covered by private insurance. Typically, highly paid or self-employed individuals take out private insurance. Lower paid workers, who have higher risk of disability given the nature of their jobs, rely on Social Security (Nadel 2001). In New Zealand, disability due to accident is covered universally through the ACC system of social insurance.

At some point, individuals can become eligible for publicly provided social assistance through long-term disability benefit payments. The features of the disability benefit system such as the benefit/wage ratio, eligibility criteria and definitions of disability, access to rehabilitation and training and whether there is a periodic review of long-term disability are probably the most important determinants of the attractiveness of disability benefits relative to paid work. A number of studies have been undertaken examining the effects (Autor and Duggan 2001), (Kidd *et al* 2000). Typically, in high income countries since the Second World War, legal definitions of disability for the purpose of establishing disability benefit entitlements have widened. At the same time, in a number of countries, including New Zealand, relatively high benefit/wage ratios have been established, often at higher levels than unemployment and other benefits. Additionally, there has been a tendency towards limited independent review of long term disability status once it has been determined.

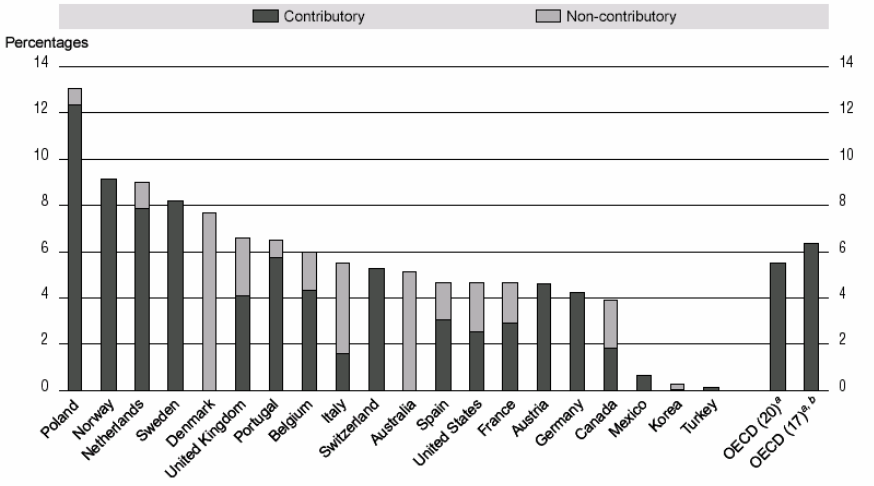
There is strong international evidence (e.g. from the Netherlands) of the interaction between public pensions and disability benefits. Workers who have a disability can choose to retire early by getting a disability benefit. Raising the age of eligibility for pensions increases this tendency, especially as disability increases with age.

3 International rates of employment of disabled people, disability assistance and explanations

(OECD 2003) includes a survey of working-age disabled people, their incomes and degree of economic integration in 16 OECD countries in the late 1990s. Unfortunately, New Zealand did not participate. While showing that the income security of working-age disabled people seemed reasonably high in many countries (particularly Austria, Denmark, Germany, the Netherlands, Sweden and Switzerland), the survey showed that the all-age employment rates of severely disabled people were only about a third of the general population's and for moderately disabled people around 70%. While disabled people are less likely to be in the labour force and employed than non-disabled people in all OECD countries, the relative employment rate of disabled versus non-disabled people varies. The overall employment rate of disabled people ranged from almost 60% in Switzerland to 20% in Poland (New Zealand's comparable percentage would have put it far nearer to Switzerland than Poland – see below). There is approximately a 25% gap on average between the employment rate of disabled people of prime working age (20-49 years) and non-disabled people, but this varies from Switzerland where disabled people are reported as being employed at 87% of the non-disabled rate to Poland where they are reported as having an employment rate only 29% of the non-disabled population. The next lowest rate is in Spain with a disabled employment rate 53% of the non-disabled (Marin and Prinz 2003). The employment rates of disabled people over 50 years of age falls with increasing age far faster than in the non-disabled population suggesting a considerable overlap between disability and early retirement. The relative employment rate of disabled people over non-disabled people is 50% among people over 50 years of age, again with large differences between countries (Switzerland 68% versus Belgium 30% and Poland 35%) (Marin and Prinz 2003) Unemployment rates of disabled people are also high, around 80% higher than those of their non-disabled peers.

Part of these differences between countries is likely to be explicable in terms of the different definitions of disability used in different countries and demography. However, there was no association between disability prevalence from population surveys in each country and employment rates, suggesting that factors other than disability are much more important such as welfare policies. Across OECD countries, there are significant differences in the numbers of people receiving disability assistance (see Figure 2). In the OECD (OECD 2003), the rate of benefit receipt in the late 1990s varied from less than 10 per 1000 people in Korea and Mexico (less than 1% of the working age population) to over 120/1000 in Poland. Rates in the remaining OECD countries lay between Canada (around 40/1000, equating to 4% of the working age population) and the Netherlands and Norway (around 90/1000 equating to 9% of the working age population) with many countries having broadly similar rates (e.g. USA, Austria, Germany, France). The comparable proportion for New Zealand at about the same time was approximately 5% (see below). In a majority of OECD countries, disability-related benefits accounted for a far higher proportion of benefits received by the non-employed than unemployment benefits and constitute the majority of welfare recipients.

Figure 2 - Disability benefit recipiency rate (percentage of 20-64 population) in OECD countries, 1999



Note: The rate is corrected for persons receiving both contributory and non-contributory benefits, except for Canada (unknown).
a) Contributory and non-contributory benefits.
b) Excluding Mexico, Korea and Turkey.
Source: OECD database on programmes for disabled persons, see Annex 1, Table A1.2.

Source - OECD (2003: 48)

Recipients of public disability benefits per 1000 working age people did not seem to be correlated with differences in employment rates between employed and non-employed people except at the extremes (Poland, Korea and Mexico).

It is important to remember that many people on disability benefits do not regard themselves as having a disability, while, at the same time, many people classify themselves as severely disabled, do not work and receive no benefits. The OECD (OECD 2003) survey showed that just under 20% of disabled people of working age in the OECD had neither income from work nor income from benefits in the late 1990s. Only in four countries surveyed (Denmark, Spain, UK and US) did the majority of working age people with a severe disability receive a disability-related benefit. Approximately, a third of disability benefit recipients did not classify themselves as disabled in population surveys.

There has been an upward trend in the number of recipients in most countries because the outflow of people from disability benefits is typically very low, despite the fact that an increasing proportion of work is non-manual. In the USA, for example, this rise coincided with a fall in the total number of welfare recipients (Burkhauser and Stapleton 2004). In the 1990s, the number of people receiving disability benefits increased in almost all OECD countries. By the late 1990s, 4-6.5% of the working age population in most countries were on some form of disability benefit with 8-9% in some countries with comprehensive, high benefits levels and benefits for partial disability.

These trends have induced widespread concern among disability policymakers about the increase in the number of people defined officially as either long-term sick or disabled, the associated fiscal, economic and social costs and consequences of non-participation in the labour market, as well.

Population ageing will have contributed, at least in part, to the number of people receiving a disability benefit, since the prevalence of disability rises sharply after age 50. Also, any increase in the age of eligibility for superannuation would be likely to lead to an increase in the number of older workers on disability benefits. However, these factors are unlikely to explain more than a small part of the large percentage increases seen in the 1990s. A

key question is whether the increases in the number of disability recipients is due to underlying worsening disability, influenced perhaps by demographic change; a reduced ability to re-enter the workforce once disabled, for example, due to worsening discrimination or transportation barriers; changes in labour market opportunities and earnings for people with disabilities (e.g. due to industrial restructuring and/or changing demands for skilled versus unskilled labour); or changes in non-market income opportunities such as changes in eligibility criteria and levels of disability support payments.

However, there appears to be a growing appreciation that the broad benefit policy environment is more important in explaining the trend than increases in underlying disability levels, market opportunities or access to jobs. For example, in the US in the first half of the 1990s, the number of recipients of both contributory and non-contributory disability benefits increased during a period of economic growth and low unemployment because eligibility for unemployment and related benefits was tightened and job search requirements were introduced. As a result, disability-related benefits became relatively more attractive to people who were weakly connected to the labour market.

In the UK, there was a large increase in disability benefit receipt in the period 1980-1995. This trend reversed in the second half of the 1990s related to reforms of the access to benefits (introduction of a personal capability assessment rather than an 'all work' test) and reduction in the generosity of benefit for new claimants. In Italy, radical changes (including means-testing of non-contributory benefits) starting in the mid-1980s took the country from having the highest proportion of people on disability benefits to one of the lowest in the OECD. As a result, unemployed people who had been inappropriately using the disability benefit system were shifted onto time-limited unemployment benefit which paid at a lower rate.

(Preston 2003) summarises the consensus of the range of studies on the main causes of the rise in the dependence on disability benefits in many countries in the 1980s and 1990s, as follows:

- Widened legal and de facto definitions of disability for benefit grant purposes leading to more people becoming eligible for benefits;
- Higher unemployment among people with disabilities – (OECD 2003) estimated that half of all the differences between countries in the employment rate of people with disabilities could be explained by the employment rate of people without disabilities;
- The use of disability benefit schemes as de facto early retirement pension or unemployment benefit (particularly in Scandinavia);
- Low earnings possibilities for many people with disabilities who have low skills as the number of well paid manual jobs fell;
- Relatively high benefit/wage ratios for low skilled people entering disability benefit schemes (e.g. if disability benefits are flat rate they are most attractive to low income earners);
- Limited independent review of long term disability once granted, leading to a low outflow rate;
- Limited rehabilitation resources for people who enter disability benefit systems – many benefit systems were 'passive' focusing on assessing entitlements and paying benefits.

Note that many of these factors relate to the detail of the design of the benefit system and are thus potentially within the control of governments. According to Preston writing in 2003 (Preston 2003: 29), 'New Zealand is almost a text book

example of most of these factors.' The remainder are intrinsic to major, long-term economic trends. Not all these factors were present in all countries, but most were present during the periods of most rapid growth in beneficiary numbers.

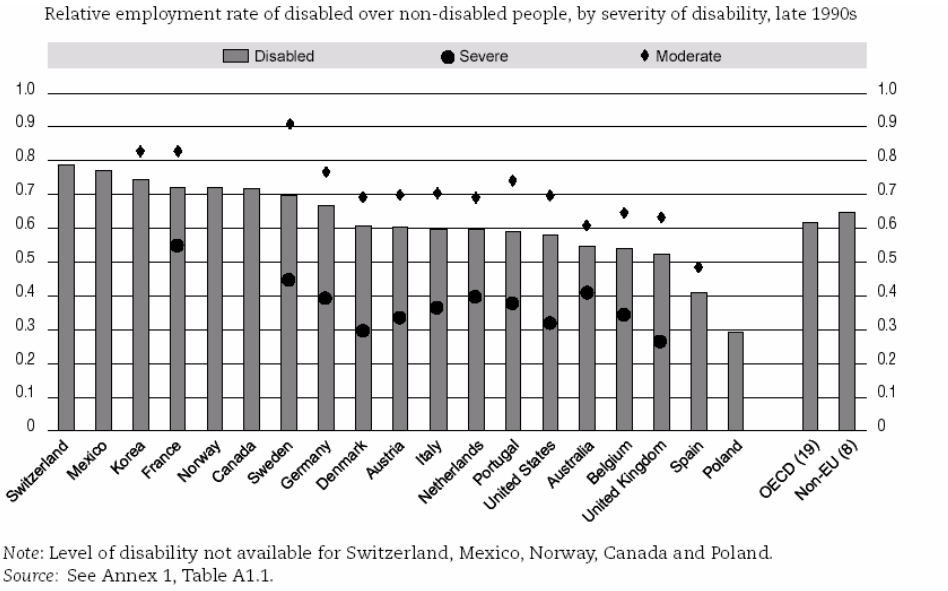
4 New Zealand trends in participation of disabled people, disability assistance and explanations for trends

4.1 Employment rates

The average prevalence of disability in the working age population (20-64 years) from population surveys in OECD countries is around 14% and in the EU 15-16%, after adjustment for differences in survey methods and disability definitions between countries (OECD, 2003). The prevalence in New Zealand in 2001 was 17% (Statistics New Zealand, 2002: Tables 1.01a & 1.02a). This suggests that New Zealand's level of disability is broadly similar to that of other high income countries.

In 2001, 58% of those defined as disabled according to the NZ Disability Survey in the working age group were in employment, with 29% in full-time work. The respective percentages for the non-disabled were 77% and 65%. This gives New Zealand a relative employment rate of disabled versus non-disabled people of 75% which would put it near the top of the OECD on a par with Korea which ranks third out of 19 surpassed only by Mexico and Switzerland. The relative employment rate in most OECD countries is between 50% and 70% (OECD 2003) (see Figure 3).

Figure 3 – Relative employment rate of people with disabilities, OECD countries, late 1990s



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

Source – OECD (2003:34)

The best available comparison of employment outcomes for the disabled population and those without disabilities uses data from the New Zealand Disability Survey, 2001 and the Household Labour Force Survey (HLFS) for the same year to estimate for various sub-

groups of people with disabilities the employment outcomes that would have been expected if they had not had disabilities, but had been the same in other respects (i.e. in terms of age, gender, ethnicity, qualifications, partnered/not and children/not) (Jensen, Jones, Sathiyandra, Rochford, Krishnan and McLeod 2004b). In Table 1, below, the impact of disability on employment is specified as the proportion of people in a category who are employed either full or part-time divided by the 'counterfactual proposition' (i.e. the proportion of those people who would have been employed either full or part-time in the absence of disability).

Table 1 – Impact of disability and disability type on employment outcomes, 2001

	Employed	Full-time employed
Actual rate	59%	29%
Rate if no disability	72%	63%
Impact of disability (actual/ counterfactual)	0.82	0.46
Impact of disability type* (actual/counterfactual)		
Vision	0.62	0.34
Hearing	0.87	0.45
Restricted mobility	0.68	0.35
Restricted co-ordination/dexterity	0.63	0.30
Learning/memory disability	0.69	0.34
Psychological/psychiatric	0.63	0.29

* Categories are not mutually exclusive and were developed empirically for this study. People with more than one disability appear in each relevant type of disability.

Source: Jensen et al, 2004

Table 1 shows that the overall impact of disability is to reduce the employment rate of disabled people to about 80% of what it would otherwise have been had these people not been disabled. In other words, disability has reduced employment by a fifth. The impact on full-time employment is much more pronounced – full-time employment is a less than half of what it would have been. In terms of the impact of different types of disability, hearing limitations have much less impact on employment than other types and vision limitations the most.

(Jensen *et al* 2004b) show the familiar impact of age on employment of disabled people with an impact ratio of 0.74 in the 50-64 age group versus 0.86 in the 25-49 age group and 0.88 in the age group 18-24. Probability of employment was also lower for those with long durations of disability (≥20 years). Likewise, disability had the well-established relatively larger impact on those without qualifications (0.71) compared with those with school (0.90) and post-school (0.88) qualifications. Pacific (0.70) and 'other' (0.61) ethnic groups were significantly more affected by disability than disabled people of Maori (0.85)

or European (0.82) ethnicity. The impact of disability on the employment outcomes of people who were partnered and had children was quite small (0.95).

Not surprisingly, the likelihood of being in any type of employment decreased with increased severity of disability. The impacts of disability were most marked at the highest levels of severity for vision-related disability and least for those with severe hearing disability. However, the impact of severity was much more pronounced when full-time employment was considered, though, again, least for hearing. As before, those with vision limitations were the most affected sub-group at the highest severity levels.

Perhaps the most interesting finding from this study in policy terms is that disability appears to have a relatively modest negative impact on any employment but a large negative impact on the odds of being employed full-time (defined as >30 hours per week). While some types of disability might allow a person to work part-time but not full-time (e.g. because of fatigue), many other types would not restrict a person in this way. This suggests that there may be many people currently working part-time who could potentially work full-time with the right combination of opportunities and incentives. The fact that part-time work is so much more prevalent than full-time work may indicate that the barriers to increased work relate less to the attitudes and practices of employers than to the financial and non-financial rewards to disabled people of increasing their hours of work (e.g. the ratio of extra earned income to loss of benefit payments as income rises). It would be interesting to know more about the circumstances of those people defined as disabled who work part-time including what proportion receive a benefit, their personal and household incomes, their skills, their hourly pay rates and so on.

4.2 Overall trends in disability-related benefit receipt

New Zealand has two principal benefits relevant to people with sickness or disabilities: Sickness Benefit (SB); and Invalid's Benefit (IB). SB is intended for people who are temporarily off work or working at a reduced rate due to sickness, injury, pregnancy or disability. To be eligible claimants must produce a regular medical certificate, have a household income below a certain level and either have had to stop work or reduce hours due to sickness, etc., or unemployed or working part-time, but finding it hard to look for and do full-time work due to sickness, etc. Payment levels after tax vary depending on personal circumstances, but a single person over 25 years of age could expect $168.59 per week and a couple $280.96 in April 2005 (http://www.workandincome.govt.nz/get-financial-assistance/main-benefit/sickness.html). Claimants and their partners are allowed to earn up to $80 per week before tax between them without losing any SB. Over $80, claimants lose 70c of benefit for every dollar of extra earnings.

IB is intended for people who have a permanent injury, sickness or disability that stops them working. To be eligible claimants must produce confirmation of their condition from a doctor and be unable to work regularly for 15 hours or more a week because of a sickness, injury or disability which is expected to last at least two years, or have a terminal condition likely to lead to death within two years and be unable to work 15 hours or more a week, or be blind with a specified level of restriction of field or sharpness of vision. Like SB, claimants may not qualify for IB if they have other sources of income such as a partner's income. People on IB are permitted to work for 15 or more hours per week for an agreed period of six months and still qualify for IB, but have to discuss such plans with their case manager. Depending how much claimants earn during the six months, they may have their IB reduced, though blind people on IB face no deductions. In most

circumstances, claimants and their partners lose no IB if their yearly income before tax is up to $4160. From $4161 to $9360, claimants lose 30c of benefit per dollar of extra income and from $9361 the abatement rate is 70%. Payments depend on personal circumstances, but a single person over 18 years could expect $210.72 per week and a couple $351.22 per week (http://www.workandincome.govt.nz/get-financial-assistance/main-benefit/invalids.html). In addition to both benefits, there is a Disability Allowance for people who have a long-term disability, but need ongoing medical care and help with everyday tasks. It is paid to help meet some of the extra costs faced by this group of people.

In parallel, New Zealland's no-fault accident compensation scheme run by the Accident Compensation Corporation (ACC) generally covers people for treatment of personal injury. ACC helps with the cost of medical or dental treatment, hospital treatment or surgery, and prescriptions or X-rays. The scheme can also provide weekly compensation for earnings lost as a result of injury, and an independence allowance in the event of permanent disability caused by an accident. All New Zealanders qualify for help from ACC, whether or not they are earning an income. It doesn't matter where the injury happens - whether in the home, on the sports field, on the road, or at work. It doesn't matter if the injury is your fault or not, you are still covered by ACC.

Trends in receipt of these benefits in the last three decades largely mirror the growth in the number of people receiving similar benefits in other countries (Wilson, McLeod and Sathiyandra 2004). In 1970-71, New Zealand had extremely low proportions of the working age population on either SB (0.4%) or IB (0.5%) by international standards. These very low rates were partly a product of full employment, but also influenced downward by factors such as the fact that if one spouse or partner were working, the other was normally excluded from receiving a benefit on income grounds. New Zealand has seen significant growth in the SB since approximately 1980 and significant growth in the IB since the early 1970s. By 2001/02 SB rates were 1.4% of the working age population and IB rates had reached 2.5% of the population aged 15 to 64 (about 15,5% of the disabled people in this age group). In terms of numbers of people, there were 40,000 SB recipients in June 2003 and 69,000 IB recipients. By June 2004, there were 44,000 people on SB and 72,000 on IB. As a result of this growth in SB/IB numbers and the decline of numbers of people on UB, the share of working-age benefit spending accounted for by SB rose from 8% in 1990 to 9% in 2003 and by IB from 9% in 1990 to 17% in 2003.

To get a more complete picture of the total number of people supported by the state because of disability, ACC claimants must be added to these figures. At 3 April 2004, there were 15,500 claimants 16-64 years in receipt of weekly compensation lasting 26 weeks or more (Jensen *et al* 2004b).

The growth in SB and IB recipients can only be partially explained by increases in the population, population ageing and raising the age of entitlement to NZ Superannuation during the period. Another possible factor was the reduction in the availability of low skilled manual jobs leading to an increase in unemployment and some shift of the low skilled onto IB. However, UB transfers explain few of the new grants of IB in the later 1990s, though they may well have played a part in the preceding period. It has been argued that the rising numbers are the result of transfers from the ACC system, but, again, the evidence does not bear this out to any great extent. The final set of factors adduced relates to changes to the benefit system itself after 1991 which increased incentives for unemployed people to test their eligibility for other benefits.

Sickness benefits

A decomposition of SB growth from 1991 to 2002, undertaken by the Ministry of Social Development shows that (Wilson *et al* 2004):

- 14.0% of the growth can be explained by growth in the working age population (15-64 years);
- 1.1% of the growth can be explained by the population aging;
- 72.1% can be explained by an increase in the take-up rate of this benefit.

As shown in 2, 12.3% of the 72.1% increase in take-up is due to the 60-64 year age group, driven by the increasing age of NZS eligibility over this period. However, the analysis leaves unexplained the 59.8% increase in take-up by the young to middle age groups

Table 2 – Decomposition of Sickness Benefit Growth (1991-2002)

	Change in beneficiary numbers 1991-2002 resulting from factor in isolation by age group			
	15-29	30-59	60-64	Total
Growth in working-age population	900	1,400	0	2,400
Ageing of working-age population	-1,300	1,500	0	200
Change in take-up rates	1,300	8,700	2,100	12,200
Residual interaction effects	-300	2,200	300	2,100
Total change 1991-2002	600	13,800	2,500	16,900

	Percentage contribution to change in beneficiary numbers 1991-2002 resulting from factor in isolation by age group			
	15-29	30-59	60-64	Total
Growth in working-age population	5.3%	8.5%	0.2%	14.0%
Ageing of working-age population	-7.7%	8.8%	0.1%	1.1%
Change in take-up rates	7.9%	51.9%	12.3%	72.1%
Residual interaction effects	-2.0%	12.8%	2.0%	12.7%
% contribution to change 1991-2002	3.5%	81.9%	14.6%	100.0%

Source – Wilson, McLeod and Sathiyandra, 2004

These decompositions therefore, at best, only explain approximately half of the recent growth in SB due to demographic and policy factors. (Preston 2003) has analysed the growth drivers over the last several decades, broken into discrete time periods, as summarised in Table 3 below.

Table 3 – Drivers of Sickness Benefit Growth (1970-2002)

Period	Sickness Benefit Recipients	Benefit Duration	Annual Grants	Growth Drivers
	Number (Average annual growth rates)	Weeks	Number	Impact (+ve) or (-ve)

1970-1975	5,900-7,800 *(5.9%)*	11.4 – 14.5	36,000-36,000	Employment conditions weakening *(+ve)* Growth in the working age population *(+ve)* Increases in real benefit rates *(+ve)*
1976-1980	9,100-7,500 *(-4.6%)*	14.5 – 20.7	36,000-32,000	Introduction of ACC *(-ve)* Ongoing migration to IB *(-ve)* Introduction of NZS in 1977 *(-ve)* *G*rowth in the average duration *(+ve)*
1981-1991	7,100-20,100 *(11.0%)*	20.7-57.7	31,000-20,000	Reduction in grants *(-ve)* Stagnant real economic growth *(+ve)* Doubling of the unemployment rate (late 1980's) *(+ve)* *E*xplosive growth in the average duration *(+ve)*
1991-2002	20,100-36,500 *(5.5%)*	57.7-47.8	31,000-42,000	Continuation of worsening economic conditions (early 1990's) *(+ve)* Increasing age of eligibilty for NZS *(+ve)* 1991 benefit changes which increase the incentive to migrate from UB to SB *(+ve)*, rates aligned in 1998 *(-ve)*

Source: (Preston 2003)

The years 1970-1975 were the first period of significant growth in the SB since its introduction in 1939. SB increased by 33% over this time, from a little under 6,000 recipients in 1970 to a little under 8,000 recipients in 1975. (Preston 2003) attributes this first growth phase to weakening employment conditions over this time (particularly coinciding with the first oil shock in 1973), growth in the labour force age groups and increases in the real benefit rates resulting from the Royal Commission report that changed the relativity between low earner wages and benefits. In conjunction with these factors, and possibly as a result of worsening employment conditions, the average duration for those on the SB rose by 27%, from 11.4 weeks in 1970 to 14.5 weeks in 1975.

The late 1970s saw a reduction in the number of SB recipients from around 9,000 in 1975 to approximately 7,000 by 1980. At the same time, the average duration on the SB grew by a further 43% from 14.5 weeks in 1975 to 20.7 weeks in 1980. Over this same period the IB rose by a little over 100%. (Preston 2003) points to three reasons why numbers fell over this period. First, the Accident Compensation Corporation (ACC) was established in 1975 and began paying weekly compensation at 80% of previous earnings. This proved to be a much more financially attractive option to those who qualified for ACC and therefore led to a fall in the applications for the SB. Secondly, SB recipients migrated to IB. The final, and possibly the least important reason for the reduction in SB over this period is the introduction of New Zealand Superannuation in 1977.

By 1990 there were 37% fewer grants of SB made than in 1980, with a continuing trend of people flowing to the more generous ACC and IB programmes. However, the period 1980-1990 saw explosive growth in the average duration on this benefit, particularly in the latter half of the 1980s. By 1985 the average duration on the SB had increased to 23.3 weeks from 20.7 weeks 5 years earlier. Within another 5 years this duration would climb another 147 percent to reach 57.7 weeks by 1990. This phenomenon is likely to be correlated with the economic performance in New Zealand during this time. Over the period 1985-1990 New Zealand experienced stagnant real economic growth, a doubling in the unemployment rate, and a 263% increase in the number of Unemployment Benefit recipients (from 38,000 in 1985 to 140,000 in 1990). It is therefore not surprising that SB

recipients, who tend to be more disadvantaged, find it more difficult to return to the labour market once their medical condition improves and therefore the average duration climbs.

The sharp growth seen in the late 1980s continued into the early part of the 1990s as economic conditions continued to worsen. The unemployment rate was to peak at 11% in 1992. However, this growth seemed to be driven more by another surge in grants rather than further increases in the average duration of SB recipients (though duration rose steadily from 1970 to 2002). In the three years between 1990 and 1993 the number of SB grants increased by 117% from approximately 20,000 to 43,000 per year. The average duration on SB fell from 57.7 weeks in 1990 to 42.9 weeks in 1996. Preston (2003) attributes the growth in SB over the 1990s to unemployment, the increasing age of eligibility for New Zealand Superannuation and lastly the new structure of benefits created in 1991, which further increased the incentives for those on the Unemployment Benefit to test their eligibility for the Sickness Benefit. When grants fell by 17 percent in 1999 following the alignment of the SB rates with the Unemployment Benefit (UB) rates, the financial incentive to move from UB to SB was removed.

Invalid's benefits

The Ministry of Social Development's analysis of IB growth between 1992 and 2001 concluded that: (Wilson, McLeod and Sathiyandra 2005)

- 10.3% of the growth can be explained by growth in the working age population (15-64 years);
- 5.7% of the growth can be explained by the population aging;
- 73.2% can be explained by an increase in the take-up rate of this benefit.

As shown in Table 4, 73.2% of the increase is due to the increase in take-up and 25.5% occurs in the 60-64 year age group, largely due to the rising age of eligibility for New Zealand Superannuation from 60-65 over this period. However, most of the increase in take-up (47.7%) that occurs in the young to middle age groups is unexplained.

Table 4 – Decomposition of Invalids' Benefit Growth (1992-2001)

	Change in beneficiary numbers 1992-2001 resulting from factor in isolation by age group			
	15-29	30-59	60-64	Total
Growth in working-age population	700	2,100	100	2,900
Ageing of working-age population	-1,200	2,800	0	1,600
Change in take-up rates	2,200	11,100	7,100	20,500
Residual interaction effects	-300	2,700	600	3,000
Total change 1992-2001	1,500	18,700	7,800	27,900

	Percentage contribution to change in beneficiary numbers 1992-2001 resulting from factor in isolation by age group			
	15-29	30-59	60-64	Total
Growth in working-age population	2.6%	7.5%	0.3%	10.3%
Ageing of working-age population	-4.2%	10.0%	0.0%	5.7%
Change in take-up rates	7.8%	39.9%	25.5%	73.2%
Residual interaction effects	-0.9%	9.5%	2.1%	10.7%

% contribution to change 1991-2001	5.2%	66.9%	27.2%	100.0%

Source: (Wilson *et al* 2005)

Note: The residual interaction effects are caused by the interactions between the three factors.

Preston's analysis of the growth drivers of IB involved an assessment of the whole period 1970-2002 (Preston 2003). He identified a number or drivers: the invalid's benefit rates relative to other benefits; hidden unemployment effects; the fact that initial access to SB only requires a GP's certificate; the lack of rehabilitation in the benefit system; and the age of eligibility for New Zealand Superannuation.

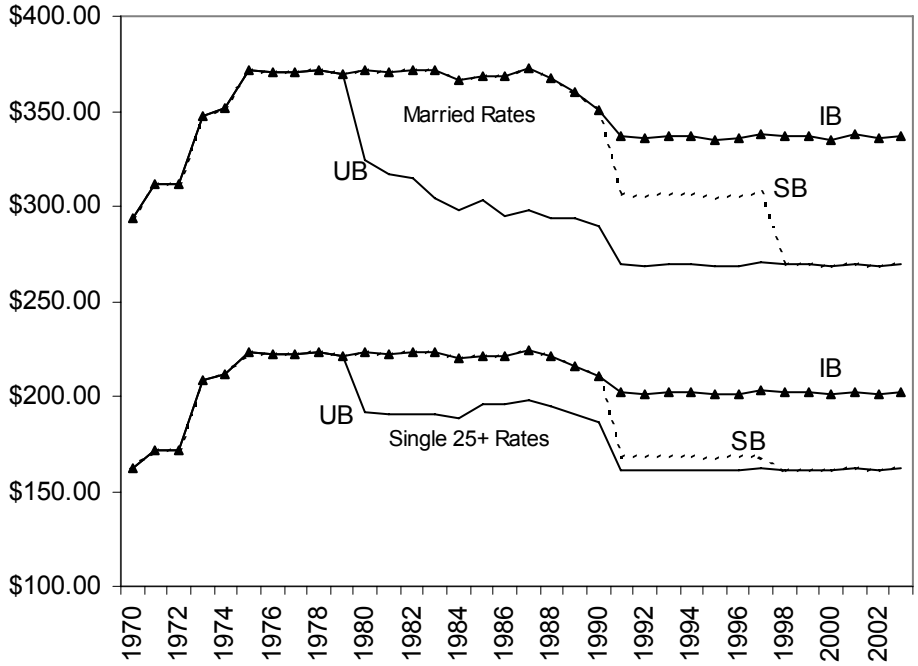
(Preston 2003) was unable to find any evidence that the increase in Invalid's Benefit was due to a rise in the incidence of disability. While the number of self reported disabled persons rose between the 1996 disability survey and the 2001 disability survey (Statistics New Zealand 2002) the rate of disability, at approximately 1 in 5, did not change over this period.

(OECD 2003) identified three features of incapacity or disability benefit levels that are particularly problematic for labour market participation, the second of which was particularly noticeable in New Zealand IB until recently:

- High benefit rates can make it more attractive for low-income earners with disabilities to be on a benefit than in work.
- Rates of benefit higher than other benefits, particularly unemployment benefit, encourage people with disabilities to opt for a disability benefit in preference, from which exit rates tend to be low.
- Flat rate benefit rates, as opposed to earnings related benefits, tend to provide more incentive for low income earners to move onto benefit than high income earners who face higher replacement rates.

The incentive to move from other benefits on to Invalid's Benefits is illustrated in Figure 4. The SB, IB and UB rates were aligned between 1970 and 1980 before the UB rates were reduced. The SB and IB rates remained aligned until the 1991 benefit cuts when the UB rates were reduced again along with the SB rates. Nominal IB rates were not reduced, although real rates fell as they were not CPI adjusted in that year, which left a 3-tier payment structure for UB, SB and IB. This remained until June 1998 at which point the rates of SB and UB were aligned although this only applied to new applicants after this date.

Figure 4 – Real Net Rates of Benefit (1970-2003)



New Zealand's economy is far more open than in the 1970s and 1980s, and less dependent on low and unskilled workers. Before the economic reforms of 1984 firms were able to employ those who were low skilled and/or those with intellectual and physical disabilities because many were sheltered from overseas and domestic competition, but as the labour market has become less highly regulated and tariff protection has been removed a greater proportion of these people have been displaced from the labour market. Further, once displaced from the labour market these people have found it increasingly difficult to become reengaged with the market. Many of these are now in receipt of the IB. (Preston 2003) suggests that this is "hidden" unemployment, as many of these have now left the labour market through lack of skills or after becoming discouraged. He estimates that in 2002 while the officially surveyed unemployment rate was approximately 5%, the rate including those unemployed people on SB and IB and not actively seeking work was nearer 10% of the labour force.

(Preston 2003) identified the lack of rehabilitation in the benefit system as a further driver of IB growth. Apart from some limited referrals to vocational services providers there is currently very limited ability of Work and Income case managers to rehabilitate those on the IB. They also typically have caseloads in the order of 300 plus clients. In contrast, the Accident Compensation Corporation (ACC) is focused on getting injured people back into work. ACC case manager caseloads are around 70 clients. The models used by Work and Income and ACC contrast starkly. Over the period 1996–2002, while the IB grew by 40%, the number on long term weekly ACC compensation fell by 50%. Yet only about 2% of the increase in the number of people on SB and IB, 1998-2002, was displacement from ACC attributable to ACC active case management. It is still possible that there may have been some indirect effects of ACC's more active approach to case management through diverting potential new claimants into SB or IB rather than ACC. Nonetheless, ACC offers a highly relevant model of active case management and client support for other parts of the New Zealand benefit administration system, such as SB and IB, even though the populations served are somewhat different.

The increased age of eligibility for New Zealand Superannuation (from 60 in 1992 to 65 in 2001) led to a large increase in the number of people on the Invalid's Benefit in the 60-64

year age group. In 1992 there were a little over 1,000 recipients of IB aged 60-64, representing an age specific take-up rate of 0.8%. By 2001 this number had risen to approximately 9,000 with an age specific take-up rate of 5.9%. This increase accounted for approximately 28% of the total IB growth between 1992 and 2001.

5 Which policies and interventions are effective in helping disabled people stay in work and return to work?

(Høgelund 2000) undertook a systematic review of the variables that influence work resumption of long-term incapacitated workers with chronic low back pain. Overall, the review did not definitively identify factors which influence return to work. The reviewed literature did not establish whether vocational rehabilitation has a positive effect on return to work. Psychological factors, such as expectations about work resumption and understanding of the condition were found to be important in some clinical studies. Age was strongly negatively correlated with a return to work, while working conditions and work-based interventions, such as light duties, were found to have a positive effect. The details of benefit schemes affect how they are used and the evidence is clear that benefit levels and eligibility criteria do affect the return to work. The review showed that the sooner any steps were taken toward resumption of work, the more likely the former worker was to get back to work and that early return to work was often the best therapy for chronic low back pain.

Stimulated in part by insights from the sorts of studies reviewed by (Høgelund 2000), there has been a general shift in policy in high income countries towards emphasising the mutual obligations (rights and responsibilities) of beneficiaries, including people on sickness and invalidity benefits. This has been linked to moves to integrate disabled people into general labour market programmes with particular emphasis on more 'active' policies. For example, it is increasingly common to find that benefit receipt among the disabled is conditional on participation in a range of work-focused activities explicitly designed to reduce the in-flow of clients onto a benefit and to increase the odds of returning to work of those already on a disability-related benefit.

Overall, it appears that this shift of policy has had positive results in stabilising or even reducing the number of people on disability benefits in a number of countries. This is particularly the case for reducing in-flows onto disability benefits. Outflow rates have been low until very recently. There is relatively little, high quality evidence from evaluations of specific policies and interventions to show which have a strong effect on employment outcomes. Many policies such as rights-based (i.e. anti-discrimination laws), obligation-based (i.e. employment quotas), or incentives-based (i.e. focusing on voluntary action) approaches, tend to protect those disabled people already working rather than offering help to new employees with disabilities. However, there is a weak positive correlation between the amount a country spends in total on 'active' employment programmes including vocational rehabilitation for disabled people (see below) and the employment rates of the disabled (OECD 2003). Given the very large direct costs of disability-related benefits incurred over long periods of time, it appears worthwhile to explore multi-faceted packages of 'active' interventions.

The main policy instruments devoted to improving the employment outcomes of sick and disabled people and/or getting them off benefits are discussed below together with some indication of the effectiveness of each. Most of the evaluations are relatively short term

and lack a wider policy focus. There is some evidence of the positive impact of a very wide range of instruments with the exception of formal classroom training which consistently fails to have positive results, particularly for the most disadvantaged disabled people (e.g. the young and poorly educated with little or no work experience).

5.1 Vocational rehabilitation

Vocational rehabilitation includes a range of efforts to help sick and disabled people become more equipped for work, assist them into work and improve conditions in workplaces so that they are less likely to lose their jobs. It includes an increasing emphasis in many countries on removing age bias in vocational rehabilitation. Most countries have a low percentage of over 45s on such programmes, ignoring the likely greater experience of older people and, therefore, their potential to sustain employment. Another observable trend is an increasing effort to treat disabled people in a similar way to other groups of people currently outside the labour market rather than assuming that disabled people are incapable of work (i.e. helping disabled people so that a new balance can be struck between their rights to assistance and their responsibilities to try to find work which is closer to that facing unemployed people in general).

Different countries have very different approaches to vocational rehabilitation, including how often people can take part, for how long, at what stage (e.g. while still employed or only after job loss or only after going on a benefit and how long after being on a benefit), the level of funding available for rehabilitation, etc. There is also a major division between countries where programmes are voluntary and those which are compulsory before a benefit can be granted. This affects the proportion of people on a disability benefit who receive any form of vocational rehabilitation. This ranged from 160% in Norway (i.e. many disabled people not in receipt of benefits were taking part in programmes) to less than 5% in half of the countries of the OECD in the late 1990s.

Unfortunately, information on the effectiveness of vocational rehabilitation is scarce and often inconclusive according to (OECD 2003) There are relatively few long term studies. Effectiveness studies have to take into account the mix of participants which will, in turn, usually depend on what proportion of disabled people is enrolled in rehabilitation. This is particularly important in non-experimental studies. It is also likely that there is 'cream skimming' in evaluated schemes with more able people more likely to be included for vocational rehabilitation.

In a systematic review, (Franche, Cullen, MacEachen, Frank, Sinclair and Reardon 2004) found moderately persuasive evidence that three components of workplace return to work interventions were effective in reducing the duration of work disability as well as reducing the costs of income replacement and of health care: firstly, early contact on the part of the workplace with the worker; secondly, an offer of work accommodation (i.e. some modification of the pattern or nature of work – see workplace accommodations, below); and thirdly contact between health care providers and the workplace. There was also moderately positive evidence that ergonomic work site assessments, appointment of a return to work coordinator and education of supervisors and managers in the capabilities of disabled people all contributed to reducing off-work disability duration. There was some evidence that the better the coordination between labour and management, the lower the level of work disability reported.

Seven long term pilots are being evaluated in the UK which include new 'condition management' programmes provided by the NHS targeted particularly at people coming

onto invalidity benefit (see Appendix). These programmes are funded by the Department of Work and Pensions to help people manage a range of conditions which are likely to be barriers to work. Programmes aim to improve pain management, improve physical fitness, reduce obesity, improve mood and improve the ability of people with health problems and disabilities to cope with the fear and anxiety associated with long term ill-health. The programmes are not designed to 'cure' or even directly alleviate the underlying conditions, but to assist people to manage them in order to cope more easily with the demands of the labour market. These programmes have much in common with the rehabilitative programmes supported by ACC in NZ. In addition, ACC purchases surgery for its clients if this is necessary to help them get bkc to work whereas Work and Income New Zealand does not routinely do this at present. However, Work and Income has just begun experimenting with purchasing health services for its clients through the PATHS pilots (see below) which have some similarities with the UK pilots.

5.2 Workplace accommodation as part of vocational rehabilitation

Environmental barriers to employment are probably at least as important as the functional limitations experienced by disabled people. Barrier removal such as through 'workplace accommodations' is a significant part of any package to increase participation in this group. Workplace accommodations or changes include things like reduced hours of work, transport to the workplace, adaptations to the physical lay-out of the workplace, alterations in the nature of work expected and so on. Most workplace accommodations are low in cost and many, such as modifications to the work task or rearrangement of the work site, require no additional expenditures. Costs are also minimal when accessibility is built into the design of facilities as opposed to retro-fitting.

(Høgelund 2000) argues that these can be important for sustaining disabled people in work as well as facilitating return to work. An early return to work can reduce the physical, financial, psychological and mental costs of workplace injury. Modified work can be an integral part of rehabilitation, but relatively little is known about is effectiveness or cost-effectiveness. (Krause *et al* 1998) carried out a systematic review of modified work programmes (most of which involved light duties but included measures such as graduated hours and duties; work trials, supported employment and sheltered employment) that allowed an early return to work. While it was methodologically difficult to synthesise the information on programme effectiveness, they found that the modified work programmes were generally effective in facilitating a return to work for temporarily and permanently disabled workers. The best quality studies showed that workers with access to modified work programmes returned to work twice as often as those with no such access. Some studies show savings in direct costs ranging from 8% (taking direct costs into account) and 90% (taking indirect costs into account), suggesting that some programmes for modified work may be cost-effective.

5.3 Active case management

As was shown above, the models and impact of case management typically used by Work and Income and ACC in NZ contrast starkly. The former has traditionally been based on a predominantly 'passive' entitlement verification model, whereas the latter has increasingly embodied many elements of 'active' case management which is attracting increasing attention in many countries. It seems likely that the evidence and lessons from active

labour market policies, in general, are applicable, in broad outline, to people with sickness and disabilities.

The main elements of an 'active' as opposed to a 'passive' approach to the case management of sick and disabled people consist of:

- early intervention and offers of support as soon as a person develops a chronic health problem or disability rather than once disability status and benefit receipt has been established (e.g. help with finding more appropriate work while the client is still in work to avoid the so called 'discouraged worker' effect);

- direct access on the part of the disabled person and/or case manager to a wide range of rehabilitative services (see above) plus training and employment services at the same time as treatment, rather than at a later stage (rehabilitation can even be part of the treatment package);

- eligibility for support, training and rehabilitation services designed to help with return to work *unrelated* to the basis of assessment for benefits and benefit status;

- making benefit receipt dependent on participation in a range of work-focused activities;

- financial incentives to work (see below).

In practice, the traditional and the more active approaches can be made complementary such as when participation in work-focused activities is made compulsory for receiving a benefit.

'Active' case management has major implications for the design of services. For example, in many countries, vocational rehabilitation cannot start until 12 months after a disability or long term condition has been definitively diagnosed. This is generally regarded as too late to maximise effectiveness and the opposite of the 'active' approach. The essence of the active approach is early intervention with case managers having direct access to key resources (e.g. the ability to purchase packages of health care for their clients). Not all active case management approaches entail a separation between assessment of eligibility for a benefit from assessment of needs for work-related rehabilitation, training and support, but such a separation could be a helpful part of any future strategy since it greatly reduces the incentive on clients to either exaggerate their disabilities or to avoid work-related activity in order ensure that they keep their benefits.

Although the cost of 'active' approaches is likely to be greater than more traditional approaches to case management, it is argued that the average cost of case management plus vocational rehabilitation and training is likely to be low relative to the average cost of paying long term disability benefits. If a permanent job is secured, even for a minority of clients, the costs of active case management are recouped. This sort of logic has resulted in an increasing share of spending on disabled people going into active case management and related activities, though the share of total spending is still quite modest. Even in Scandinavia, where active rehabilitation for disabled people is best established, only about 14% of spending is accounted for in this way.

The main evidence underlying the 'active' and early approach to case management for people with long term health problems and disabilities is as follows:

- the likelihood of a person, irrespective of their severity of disability, returning to work from a sickness or disability benefit reduces sharply after six months and even more so after a year on a benefit (e.g. in the UK, the average time on invalidity benefit is eight years for those who have claimed for a year and only one in five return to work within five years) as they lose work-related skills and confidence;

- best practice management of conditions such as back pain and depression which form a substantial percentage of those on long term disability benefits in most countries now stresses the benefits of physical activity and social engagement, including that derived from work;

- most people have manageable conditions when they first claim a disability benefit with a good prospect of a return to work and themselves expect to go back to work in due course (e.g. in the UK around 90% of those going onto invalidity benefit expect to go back to work);

- people with disabilities looking for work perceive significant obstacles, particularly a lack of suitable work locally and a low level of confidence about being able to work. In the UK, only about 40% of invalidity beneficiaries mentioned their health and/or disability per se as an obstacle to getting a job (Secretary of State for Work and Pensions 2002);

- many people who go onto long term disability benefits are already at least partly detached from the labour market before they do so, suggesting that that the process of moving onto a benefit may be influenced as much by declining confidence and motivation as by poor physical health or a disability (this is reinforced by the knowledge that there are large numbers of people with severe disabilities who would be eligible for disability benefits of various types who have never claimed a benefit and have always worked).

5.4 Tighter or different assessment criteria for disability or invalidity

Traditionally, this sort of policy response to climbing beneficiary numbers and/or low labour market participation focuses on restricting the proportion of applicants who can demonstrate the necessary level or severity of disability by adopting a higher threshold for eligibility for disability or sickness-related benefits. A related reform is to shift from assessments based on individual professional judgements and discretion to assessments based on standardised scales and measures, perhaps administered by doctors and others with no previous connection with the claimant rather than relying on the claimants' usual doctors to provide the assessments. Both reforms can reduce the number of new applicants and the number of people going onto benefits, however, neither move does anything for sick and disabled people already on a benefit unless linked to policies such as an increase in the frequency and strictness of review of beneficiaries' health and disability status.

Both tightening assessment criteria and making them more explicit and 'objective' are integral to reforms of systems in which eligibility for a sickness or disability benefit depends on demonstrating a particular level or type of disability which then labels a person as fully unemployable. This approach to eligibility acts as a major disincentive to work and reinforces the 'welfare trap' in which disabled people are worse off in work than

on a benefit. An alternative, more recent approach is to treat sick and disabled people similarly to the unemployed or single parents, determining their eligibility for a benefit on the basis of either the financial consequences for them of not being able to work or the direct additional living costs incurred by having a disability.

Where benefit eligibility has been separated from assessment of a disabled person's work-related support and rehabilitation needs, rather than focusing on 'incapacity', the assessment process can be reformed to focus on the person's degree of 'employability' and the sorts of work that they might be able to be helped to do (not necessarily in their former occupation). Such a shift is consistent with the more 'active' labour market policies discussed above whereas simply tightening eligibility criteria for benefit receipt is in many ways a very different response to 'activation' policies.

5.5 Restricting entitlements to benefits

A wide range of schemes have been implemented in various countries designed to make benefit receipt less attractive and less available. For example, coverage can be reduced by adopting qualifying periods or qualifying insurance contributions, or by increasing the requirements expected of beneficiaries over time. The period of full or any coverage can be reduced by setting life time or periodic time limits. Benefit rates can be cut as in NZ when rates of benefits were reduced in order to sharpen work incentives and curb public spending. In the UK, in the 1990s, the occupational pension of a person was taken into account in calculating their level of disability benefit with a similar intention. Benefit systems can be restructured with the introduction of tiers within the same benefit or by replacing benefits with tax credits.

The most notable contemporary trend in this respect in relation to disability benefits is to make the receipt of a disability benefit conditional on activities such as active job search, taking part in training, attendance at regular work-focused interviews, or even taking any 'suitable' job, thereby linking a potential restriction of entitlement to an 'activation' strategy. This has the advantage of not simply penalizing the beneficiary, but encouraging them to participate in potentially helpful activities. Such requirements can deter people applying for a benefit in the first place as well as raising the cost of staying on a benefit and the motivation to find work. For example, currently in the UK, a person wanting to claim Invalidity Benefit is required to attend one meeting with a personal adviser, known as a 'Work-Focussed Interview' designed to encourage job-seeking or the take-up of training as well as to provide information about the financial help available. There are mandatory follow-up interviews after three years. In the 'Pathways to Work' pilots in seven districts, new invalidity benefit applicants are additionally required to attend eight monthly 'Work-Focussed Interviews' designed to reduce the proportion of new beneficiaries who remain on the benefit beyond the critical 6-12 month threshold after which return to work odds reduce drastically (see Appendix). Of course, for such requirements to have their effect activities of beneficiaries have to be monitored accurately and requirements enforced consistently.

5.6 Financial incentives to beneficiaries to obtain work and/or removing financial disincentives to work

Traditionally in many benefit systems, benefit receipt was dependent on demonstrating incapacity. As a result, there have been strong disincentives in most countries for beneficiaries to demonstrate their capabilities, invest in improving their capabilities and

show an interest in returning to work in case they undermine their claim for income support.

Incentives can have two different objectives: to make it more financially attractive to move off a benefit entirely into work; or to encourage more part-time work while a disabled person remains on a benefit. The latter approach could increase total recipient numbers but would tend to increase each beneficiary's prospects of participating in the labour market, at least for a few hours each week, whereas the former should reduce the total number of beneficiaries. In 1996, in NZ, the income test for beneficiaries was liberalised to encourage more part-time work. A similar change occurred in the UK in 1998. Both objectives are driven, at least in part, by Hogelund's observation (Høgelund 2000) that work can be the best therapy for people with health problems.

Few countries have *sanctions* if beneficiaries fail to cooperate with the goals of more active case management (see above), though in the UK failure to attend the regular work-focussed interviews in the 'Pathways to Work' pilots can trigger a reduction in Invalidity Benefit if claimants cannot show good reason for not attending. It is more usual to have *incentives* for taking up or continuing to work. The Danes have a *permanent* in-work supplement payable to people who enter work from a disability benefit (not yet evaluated). In the Netherlands and the US, there are similar short-run incentives, but only for two months. In selected regions, the UK is currently piloting a new Return to Work Credit that pays £40 per week for up to 52 weeks to anyone moving from invalidity benefit to work of 16 hours a week or more with annual earnings of less than £15,000. Personal advisers are also able to make grants of up to £300 to support return to work activities of all invalidity benefit recipients from day 1 of their claim. It seems likely that incentives need to be long-term such as the 12 months piloted in the UK, particularly if the goal is to encourage people who are likely to be low paid into work or to encourage them to work part-time.

Incentives paid to workers reduce the need to consider paying employers wage subsidies if they hire disabled people (see below).

5.7 Obligations on employers

There are a range of potential obligations that can be placed on employers designed to encourage the take-on, retention or speedy return to work of sick or disabled workers. The best known is the requirement for employers to hire a certain proportion of disabled workers. Another set of rules relates to job protection in which a disabled person may be guaranteed the right to return to suitable work with the same employer after a disabling event.

Attitudinal barriers and lack of information about the capabilities of people with disabilities have been found to be among the biggest obstacles to independent living and to employment. These can result in systemic discrimination and the lack of opportunities for people with disabilities.

The United States experience with the Americans with Disabilities Act has demonstrated that changes in attitudes can effectively follow changes in behaviour when standards and expectations are clearly set out. The provision of clear standards and the availability of technical information and support has led in the United States to increased compliance by employers. However, some analyses indicate that the employment effects have been negative.

All policies which regulate employers have to balance the promotion of employment for disabled people looking for a job with the obligation on employers to keep employees who *become* disabled while working. Over-protective regulation tends to make employers increasingly reluctant to hire people who are or might become disabled in future (e.g. those with degenerative conditions) because of the inflexibility the regulation brings with it. As a result, few countries have mandatory employer involvement in work-related rehabilitation, though there are moves in a number of countries to encourage employers to take more responsibility for rehabilitation of workers who become sick and/or disabled while in employment by, for example, penalising employers with high accident, work-related sickness or disability rates. One way to counter the risk of discrimination against the disabled is to exclude from the requirement critical risk groups such as those who are already sick or disabled, or to prevent employers making detailed investigations into the health of prospective workers. The latter would appear preferable if it can be policed and enforced. This raises another general point with employer obligations – there have to be proper sanctions for non-compliance and adequate instruments to enforce them. Employer quotas, for example, are notorious for non-compliance. Penalties for not fulfilling quotas may help, but do not appear to have been particularly successful in increasing employment among the more severely disabled since they are likely to encourage employers to recruit the least disabled people they can find to meet their quotas (Verick 2004).

Another obligation which can be placed on employers to encourage them to prevent their workers suffering work-related ill-health or disability is to require them to continue to pay wages or meet the costs of benefits during the first period of sickness or disability-related absence as in Germany and Austria. In the Netherlands, employers are liable for the first 12 months of sickness benefit payments and in the UK, for the first 28 weeks. Despite the plausibility of such policies affecting work-related sickness and disability rates, there is little sign in cross-country comparisons that these sorts of employer requirements are associated with lower worker sickness rates and high rates of job retention by people with disabilities. On the other hand, there is evidence from short-run within-country studies that such policies have a positive effect in the period immediately after their introduction.

5.8 Employer subsidies

These include payments made to employers by the state for taking on, or even retaining, disabled workers. There is some evidence that such payments can be successful in helping difficult-to-integrate unemployed people, including those unemployed through sickness and disability, into work

Several countries have a considerable share of their working populations in subsidised employment, particularly Sweden and France, but also Austria, Denmark and Norway. All are countries with relatively high employment rates among prime working age disabled people. Subsidies can be up to full employment costs (as in Norway and Austria) and tend to reduce gradually over time as schemes try to balance the risk of inefficient wage subsidies and of employers shedding disabled individuals when their subsidies come to an end. The available evidence suggests that employer subsidies in this context have large dead-weight costs as well as large displacement and substitution effects, thereby contributing to only small net employment gains (OECD 2003) (Estevão, 2003 Do ALMPs increase employment?). As a result, wage subsidies are not strong policy contenders on cost-benefit grounds, but tend to be justified in equity terms because they can provide jobs for the most vulnerable people in the labour market such as the long-term unemployed. Although the prime focus of this paper is labour force participation to be

justified in relation to macro-economic objectives, there are other goals of employment policy. Equity seems a potentially important consideration when considering the employment of disabled people, especially those whose productivity is likely to be low even after vocational rehabilitation. For relatively severely disabled people whose productivity may be hard to raise, there could even be a case for permanent wage subsidies depending on the value society attributes to participation in the labour force by all social groups.

5.9 Special employment programmes

Like wage subsidies, special employment programmes over and above vocational rehabilitation (discussed above), such as sheltered work, are likely to be most valuable for prospective workers who are *severely* disabled. On the other hand, the evidence suggests that special employment makes little *overall* contribution to the employment rate of disabled people while being important for disabled people who have never worked in the open labour market. It is generally held that special employment programmes should be short-lived to create and/or maintain motivation and skills among programme participants.

Analysts tend to divide special employment into *supported* employment which represents on-the-job support, for instance, through individual job coaches (e.g. in Australia, Austria, Denmark, Germany, Norway, UK and US) and *sheltered* employment in specially established enterprises or segregated employment. Support of the former type is normally phased out over time, though in Denmark it is unlimited and available at a high level. Poland and the Netherlands have a very large amount of sheltered work with approximately 1% of the working age population in sheltered enterprises. In most countries, sheltered jobs are reserved for the more severely disabled such as people with chronic mental health problems or people with learning disabilities since it is increasingly considered inappropriate for most disabled people who want to work to be encouraged to work in sheltered employment. It is also increasingly recognised that sheltered businesses are relatively inefficient. Most countries have policies designed to reduce the amount of sheltered work or replace sheltered work with 'supported' or ordinary jobs in the mainstream of the economy as part of wider efforts to integrate and 'normalise' the lives of disabled people of all kinds as well as raising efficiency. To date, there is little sign of a reduction in sheltered work (OECD 2003).

France, Sweden and Austria have by far the largest percentage of those on disability benefits in special employment programmes as a whole, while the US, the UK, Italy and Portugal have the lowest percentage. As well as whether or not it is appropriate to segregate disabled people within the labour market, there is the risk that disabled people who could work in the mainstream of the economy become trapped in special employment. Thus, like employer subsidies, special employment is probably best viewed as a possible response to the needs of the most severely disabled people in the labour market.

5.10 Administrative changes

These cover a range of reforms to organisations and processes designed in their different ways to increase the focus on work as an option for sick or disabled people in the benefits system. The main organisational change seen in NZ and the UK, for instance, was the bringing together of the agencies responsible for paying benefits with the agencies

responsible for employment services in the shape of Work and Income New Zealand and the Department of Work and Pensions in the UK. Other related changes include recruiting more and better trained disability employment advisers or case managers with a stronger focus on training, rehabilitation and employment than their predecessors (see active case management, above). Another change is to ensure that any medical assessments are undertaken by a doctor other than the claimant's treating doctor, and using 'objective' assessment scales rather than relying entirely on clinician judgement.

5.11 Multi-faceted programmes

For clarity each of the above policies/interventions has been described and discussed separately. However, in reality programmes in different countries designed to help disabled people and people with long-term health problems get and retain jobs do not rely on a single element (e.g. improved access to training for disabled people may well be linked to incentives to employers to take on disabled workers and so on). Thus the centre-piece of UK government initiatives in this field currently are the 'Pathways to Work' pilots and related reforms to Invalidity Benefit (see Appendix). The pilots consist of: a multi-pronged programme of mandatory work-focused interviews for *new* invalidity benefit claimants, except the most severely disabled; improved referral routes from these interviews to existing employment support; and new work-focused rehabilitation programmes provided in collaboration with the NHS; plus a new financial incentive payable on return to work. The pilots began in 2003/04 and run in their original form for 2.5 years until 2005/06 and were funded at the rate of approximately £40m per year. The pilot districts are predominantly 'old' industrial and mining areas where there is likely to be considerable 'hidden' unemployment within the disability benefits system. The pilots are being independently evaluated to try to identify what works best for whom and in what circumstances. More details are given in the Appendix.

Early findings from the first year of the three first wave pilots (Renfrewshire, Derby and Bridgend) based on 58,000 claimants who have entered the pilots suggest that the pilots are getting new invalidity benefit recipients back to work at twice the rate of areas outside the scheme (Department for Work and Pensions 2004b). The cost-benefit analysis has yet to be produced from the evaluation, but it is likely that the approach could lead to significant savings in benefit payments if generalised as well as benefits for the participants themselves. In pilot areas, six times as many people claiming Invalidity Benefit took up support in rehabilitation programmes. Existing claimants were also volunteering to take up the support packages available to new claimants (10% of pilot participants are volunteers).

The early research in the three first wave pilots has also reported an 8-10% point increase in the rate of people coming off Invalidity Benefit altogether after four months of their claim compared to non-pilot areas. This is against a background reduction in the number on such benefits in the second half of 2004.

The personal advisers who conduct the work-focussed interviews have also reported that they were very positive about their new role and had generally received positive feed back from clients about the NHS condition management programmes and particularly the Return to Work Credit. However, they reported that there were some clients whose circumstances they had been unable to make any progress with.

As a result of these promising findings, the UK government has extended the pilots to approximately a third of the UK targeting the most disadvantaged local government areas and those with the largest concentration of Invalidity Benefit recipients. It appears that, subject to satisfactory results in these areas where finding jobs is likely to be more difficult than elsewhere, the general approach will be applied to the entire country. The general approach is also currently being extended to existing as well as new Invalidity Benefit claimants in the pilot areas. In addition, the 'permitted work' rules are being relaxed still further to allow all invalidity benefit recipients to earn up to £78 per week for up to 52 weeks without loss of benefit.

6 New Zealand policy in relation to labour force participation of sick and disabled people

6.1 Major policy changes

During the 1990s a wide range of countries introduced a number of the policies described above, particularly more 'active' labour market policies in relation to sick and disabled beneficiaries. As recently as early 2004, it was fair to say that New Zealand had largely stood aside from this trend. The only substantive change in policy towards those on Sickness and/or Invalid's Benefits for some time had been the decision to reduce the level of SB in 1998 to that of UB as a way of removing a perverse incentive to choose higher rate SB over lower UB. There had been no significant changes in the 1990s to the administration of IB or related employment policies. Although the beneficiary population continued to rise during the 1990s and early 2000s (as recently as the year to June 2004 the annual rise in SB claimants was 10.6% and in IB claimants was 5.6% (Office of the Minister for Social Development and Employment 2004) despite falling unemployment and a tighter labour market), the largely 'passive' policies remained in place. However, as Table 5 shows, current developments and recent policy announcements (columns 2 and 3 in Table 4), which are part of a wider reform of the social welfare system designed to introduce a single or 'core' benefit, indicate that NZ benefit and employment policy in relation to those with sickness and disability is poised for major change in line with cutting-edge, 'activist' thinking internationally. Policy work is still in progress, but it is possible to summarise the main elements as they affect sick and disabled claimants.

Table 5: Comparison of recent, current and proposed policy in relation to SB and IB population in New Zealand

NZ policy to 2003/04	Current/recent NZ policy developments	Proposals under '*Future Directions*' Phase II, 2005-
Largely 'passive' administration of benefits on the assumption that SB/IB recipients are unable to work, by definition. Benefit seen	Reduction of rate of SB to UB level (1998), but IB still higher than UB/DPB/SB	Objective of policy to assist those who are capable into 'the right job at the right time, right from the start'. A small group of severely impaired people will continue

as compensation for impairment rather than related to income loss through being out of work or extra costs of disability. SB/IB paid at higher rates than UB/DPB for long periods		to receive financial support without work expectations, but the ideal is to help people so that they do not need to rely on a benefit. Envisaged fall in IB caseload Single benefit with same core rates for ill-health and disability as other groups. Eligibility based on low income outside labour market rather than e.g. disability status. Benefit paid to all but the most severely disabled on expectation of rapid return to work. Extra financial help for ill-health or disability based on the extra costs incurred not the existence of the condition itself, and available in or out of work. To be known as the Integrated Disability Payment and incorporating current Disability Allowance (DA)
Implicit assumption that SB/IB recipients cannot and do not want to work. Eligibility for IB based on inability to work >15 hours pw in open employment	Six month 'grace' period during which beneficiaries lose no IB if working more than 15 hours pw	Explicit assumption that many people on benefits, including SB/IB want to work and have the potential to do so. Focus on what people can do, not what they cannot do. Medical assessment focused on severity of condition and the extra costs it may impose, but not on the ability to work since many severely affected people work full-time 15-hour rule to be abolished to eliminate sudden loss of income when >15 hrs pw worked. Introduce a 'step' in work incentives for those moving into work at >20 hrs pw (<$80 no abatement; $80-180 30% abatement)
Focus of administration on income support and entitlements. Little or no recognition that clients might be better off in health and financial terms if working	More than 70% of case managers' time still spent on income support issues; only 30% spent on employment issues.	Two outcomes/'streams' envisaged: 'rapid return' (work-tested default) and 'work development' for those returning more gradually, needing p/t or intermittent work or unable to work but able to participate in development activities
Costs of benefits large in relation to amount spent on rehabilitation and training	Trial in 14 sites of enhanced case management focused on potential to work as well as benefit entitlement with reduced manager: client ratios of 1:160. 1:225	

	average elsewhere with aim of 1:150 over time if UB claimants continue to fall. Offered on a voluntary basis to SB/IB clients Extra training for case managers to raise capability and knowledge. Vocational assessment trialled from Oct 2004 for nation-wide use	
Little or no review of cases once entitlement established on the assumption that clients would be long-term on SB/IB and therefore deserving of a higher benefit than UB/DPB		Employment-related support from the start, before people are on a benefit, after basic, initial assessment of circumstances, capacities and expectations to help retain connection with employers. To be trialled from May 2005 in 11 WINZ sites.
Incentives for recipients of SB/IB to distance themselves from labour market since higher rate of benefit paid as long as claimant could demonstrate incapacity to work. Working disabled people locked into part-time work. Almost no financially viable exit from benefit into work		Incentives for work search activities and for work beyond 15 hrs/$180 pw.
Employment-related services not generally available to sick and disabled until they are on SB/IB. SB/IB claimants do not access 'mainstream' employment services	Development of general work-focused assistance available to individuals on SB/IB, but no expectations on them to take this up. Entirely voluntary option. WRK4U seminars to encourage independent job search, targeted mainly at unemployed, long-term job seekers. Jobz4u tool to match clients and employers (job seekers' experience and employers' requirements) also targeted mainly at the unemployed. Low take-up by DPB/SB/IB claimants for fear of jeopardising benefit payments	More flexible active labour market policies and support in the transition to work. SB/IB claimants likely to be required to take part in up-front equivalents of WRK4U seminars and jobZ4u. Assessment of work-related capability to be available to all job-seekers regardless of which benefit they are receiving
Type of employment support related to type of benefit rather than needs of individual disabled person	Providing Access to Health Solutions (PATHS) pilot in Manukau from March 2004 provides SB/IB clients with improved access to health services to enable them to move into work more readily. To be extended to 5 more regions, Oct 2004-June 2005	Access to employment assistance to be made more equitable for SB/IB claimants since no longer tied to type of benefit or duration. Simplification of entitlements to release case manager time to focus on work. Individualised approach to case management and support envisaged, developed in consultation with disabled people and employers

	New employment-focused programmes extending PATHS concept with streams for physical conditions, anxiety, depression, stress, etc., plus services for people with long-term severe mental health problems and severe spinal conditions

Source: ((Minister for Social Development and Employment 2005); (Maharey 2005a); (Maharey 2005b))

From being a somewhat of a laggard in international policy terms, it is proposed that WINZ will trial a substantially new service model in 11 locations around the country from May 2005 based on the assumption that many SB/IB claimants want to work. As the Minister put it in a speech on 10 March 2005, 'New Zealand has seen a dramatic decline in the number of people receiving the Unemployment Benefit over the past five years, ….This huge drop … is enabling us to focus more of our efforts on clients who have not, in the past, received the same level of employment support. This is particularly the case with Sickness and Invalids Benefit clients, a client group that has traditionally been seen as not able to work at all. We now know that this assumption is false. Many Sickness and Invalids Benefit clients do want to work, and can work with the right support. The new Service provides targeted and integrated services that provide support for a return to full-time, part-time, or intermittent work, while still ensuring clients receive their benefits and entitlements.'

The proposed service envisages two distinct 'streams' including a mix of new and old claimants:

- the provisionally titled *'Rapid Return to Work*' stream of clients whose key outcome is a return to full-time work as soon as possible and who will be full-time work tested and expected actively to seek work unless they have a legitimate reason not to seek work immediately. They will be expected to participate in appropriate employment assistance and job interviews and to take up suitable offers of work (whether all of these activities will be made an absolute condition of benefit receipt and any sanctions for non-compliance have yet to be determined). The case managers' approach will be flexible, tailored to the needs of the individual, but clients will be obliged to take part whether their goal is full-time, part-time or intermittent work. Clients' needs will be reassessed from time to time to ensure that the supports in place are appropriate. The rules relating to earnings and retention of benefit in this stream focus on the expected outcome which is return to full-time work and are likely to include the current 70% abatement rate beyond $80 per week which is good for encouraging 20-40 hours of work per week, but poor for encouraging part-time work below this level. It is envisaged that this 'stream' would include most of the current SB claimants, especially those with short-term conditions. Most of this group return to work quickly. Their work test would be suspended while they are ill. The remainder of the SB/IB group is likely to be in the second 'stream';

- the provisionally titled '*Work, Development and Preparation*' 'stream' is likely to cover clients who for a variety of reasons, including ill-health and disability, are likely to make a more gradual transition to work, need to work part-time or intermittently or need to focus on other forms of social participation before returning to work. This group who will not be work-tested, but is likely to face a

requirement to participate in an assessment of the types of employment-focussed assistance from which they might benefit, followed by drawing up a plan for their return to work. Some clients with very severe disabilities in this stream would be exempt even from this. The rules relating to earnings and retention of benefit in this stream focus on an outcome of part-time work. Hence, the plan is to retain the current 30%/70% abatement regime which provides good work incentives up to earning $180 per week which is equivalent to 20 hours at the minimum wage.

It is worth summarising the main differences between the 'new' and 'old' approaches. Whereas the previous approach started employment-focused assistance late in the client's period on a benefit, if at all, the proposed approach will mandate the case manager to start work-related assistance at the outset of the claim. Whereas in the past, eligibility for benefits was assessed *before* any assessment of the client's need for other help, under the new system assessment of eligibility for benefits will take place at the same time as the assessment of the client's other circumstances to assist with the return to work. Whereas under the previous regime support was related to the type and/or duration of benefit received, the intention henceforward is to relate financial support to financial circumstances with a focus on client outcomes (i.e. full-time work, part-time work, intermittent work and/or improved social participation). Whereas the previous system was built on perverse incentives for clients to exaggerate the barriers they faced in participating in the labour market and to avoid working more than 15 hours each week in order to avoid losing out financially, the planned approach attempts to remove or greatly reduce both incentives. Whereas there was no service designed directly to help disabled and long term sick people retain their jobs, there will be a focus in the new service on helping people stay in work or helping them to find a new job if a job is coming to an end before they need to move onto a benefit. In addition, an Integrated Disability Payment is likely to be available to meet the extra costs of disability regardless of whether someone is in or out of work, thereby, theoretically, improving work incentives. This should help with eliminating the incentive for people with disabilities to distance themselves from the labour market in order to access a higher level of support.

The new approach also includes the Providing Access to Health Solutions (PATHS) pilots which are available to SB/IB clients who want to work and for whom access to physical and/or mental health services is judged to be a barrier to employment. A PATHS coordinator and team is charged at local level with facilitating access to existing health services, including those of ACC, or additional services if these are not available through the public health system (e.g. in the timescales needed). The extra services are funded by the Ministry of Social Development (MSD) out of the Employment Assistance budget. The first PATHS pilot in Manukau (South Auckland) was expected to fund mainly elective surgery to enable participants rapidly to return to work. Instead, to date, most participants have had complex, inter-related conditions including stress, depression, anxiety and physical complaints, requiring individual management in primary care. The pilots have assisted clients to use existing ACC and health services more effectively.

It is envisaged that the new employment-focused active approach to case management will be extended beyond the 11 pilot areas progressively during 2006 at which point legislation will be in place for a so called Single Benefit which will be assessed on the basis of financial need and which will replace the existing UB, DPB, SB and IB. Thus the new approach as it affects SB/IB recipients will be fully implemented in 2007. The detailed design of the new service model is currently under development, but there is sufficient information to offer a preliminary assessment in terms of what is known about what works in this policy area and the likely challenges facing the approach.

6.2 Assessment of the proposed direction of New Zealand policy

6.2.1 Consistency with international and domestic evidence

The new approach has the advantage that it is broadly evidence-informed and in line with much contemporary international policy thinking on increasing participation rates among those applying for or receiving disability-related benefits. For example, (OECD 2003) recommended the following potential reform measures all of which are consistent with the recent proposals:

1. Introduce a culture of mutual obligations;
2. Recognise the status of disability independently of the work and income situation;
3. Design individual work/benefit packages for disabled persons;
4. Promote early intervention;
5. Involve employers in the process;
6. Restructure benefit systems to remove disincentives to work;
7. Reform programme administration;
8. Improve co-ordination of transfer schemes.

The reform package in Table 5 has been strongly influenced by the positive employment effects in the US, Canada and the UK resulting from 'active' labour market policies applied to unemployed people and single parents, and more recently extended to people with disabilities and long term health problems. These policies typically comprise features such as early intervention, more active case management, personalised support with job search, changed expectations of clients and work incentives. The OECD notes a correlation between the introduction of 'activation' strategies in Denmark, the Republic of Ireland, the US and the Netherlands, and falling unemployment in these countries. (Burkhauser and Stapleton 2004) suggest that the principal lesson of wider welfare reform in the USA in the recent past is that a three-pronged approach is needed to assist those with disabilities into work: first, more assistance to help the work-impaired stay in their current jobs, or to find a new job if they lose it; secondly, income support, such as the earned income tax credit (EITC) for those who work but have low earnings, to help 'make work pay'; and, finally, for those people who are impaired but able to work, an expectation that they will help to support themselves through work to signal that they should seek work. The proposed approach in New Zealand includes all three elements, though the 'making work pay' component for sick and disabled people relates to changes in the rules on allowable hours worked and earnings rather than an additional tax credit as in the US or UK. On the other hand, disabled people with children are likely to be eligible for the recently introduced In-Work Payment in New Zealand.

While there is considerable evidence supportive of the broad direction of very recent New Zealand policy announcements, it has to be borne in mind that most studies have looked at the effects either of single elements of 'active' policies or simpler combinations of, say, two elements rather than complex packages as proposed in New Zealand or currently being pursued in the UK (see Appendix), so their effects are not straightforward to predict.

For example, both the Canadian Self-Sufficiency Project (Michalopoulos, Robins and Card 2005) and the Minnesota Family Investment Program (MFIP) (Miller, Gennetian, Gennetian, Dodoo, Hunter and Redcross 2000), which are among the best studies of initiatives to assist beneficiaries off benefits, looked only at financial incentives to work with and without case management. In both studies, the combined impact of financial incentives and case management exceeded financial incentives alone in terms of employment rates and earnings over a three to four-year period. Similarly, the US Project Network Demonstration (Kornfield and Rupp 2000) provided a combination of case management and active labour market programmes to recipients of disability-related benefits on a voluntary basis. The project showed a net positive increase in employment rates over two years of about 10% in the intervention group.

In general, there is relatively much less evidence of the impact of specific active labour market policies targeted on long term sick and disabled people than on unemployed people or single parents, as well as relatively little information about the overall impact of a multi-faceted 'package' of inter-related measures as is proposed. For example, there appear to be no studies of the impact of early intervention strategies for people on disability-related benefits. Likewise, while there is a growing body of research on the employment impact of placing higher expectations on prospective beneficiaries (Meyer and Rosenbaum 2000); (Thomas and Griffiths 2004)), there is very little evidence specifically on their impact on people on disability-related benefits. There are major evaluative studies underway in the UK looking at the impact of an activist policy on sick and disabled claimants, but they are at a relatively early stage. The UK 'Pathways to Work' pilots taking place in seven areas require new prospective claimants to attend work-focused interviews and begin to plan their return to work. Early findings show that six times as many people in pilot areas have taken up the voluntary work-related support which follows the initial interviews as in matched areas without pilots (Department for Work and Pensions). The take-up of such support is only 2-3% in non-pilot areas meaning that take up is around 10-12% among new claimants in the pilot sites. This is similar to the impact of work-focused interviews on solo parents (Thomas and Griffiths 2004). While not all those taking up active help will move into work, and many of those who do would have obtained work in any event, there is still likely to be a net positive employment effect. The US Project Network Demonstration produced a 10% net increase in employment rates sustained over about two years from a voluntary programme implying that this might be near the minimum impact likely from a mandatory scheme.

The proposed New Zealand package contains incentives for current IB recipients to increase their income from work through changes to the rules governing hours worked and earnings in relation to abatements. There would also be greater incentives not to claim the IB equivalent than in the past since the IB equivalent will not be paid at a higher rate from other benefits to new claimants in future. There is evidence that a 10% reduction in benefit levels reduces application rates by 5.3% for men and 4% for women over the first two years and by 2% and 1.3% respectively over the life course (Burkhauser, Butler and Gulcin 2003).

The proposed package appears further to be consistent with current evidence of 'best practice' in relation to the management of many potentially incapacitating conditions such as heart disease, musculo-skeletal problems (e.g. low back pain) and mental health problems such as depression and anxiety which form the bulk of the conditions reported by people on disability-related benefits (Secretary of State for Work and Pensions 2002). The best clinical management for back pain is to continue an active life rather than resting until all pain disappears Similarly, an early return to work is now considered a major objective of cardiac rehabilitation for most people of working age and helpful in long-term

recovery. With appropriate treatment people with mental health problems can return to work and working, in turn, aids confidence, motivation and future health. Likewise, there is evidence that inactivity in itself worsens health and reduces the prospect of returning to work

The new approach has also been influenced by, and is consistent with, recent New Zealand experience of initiatives such as the WRK4U seminars. These have reduced the numbers of people coming onto UB by up to 20% through providing links to work before granting benefit, albeit in a favourable economic environment where the demand for labour is very strong. WRK4U also reduced the number of ineligible people who applied by around 26%.

The new approach also draws on early findings from the voluntary SB/IB enhanced case management pilots in 14 sites which showed that from February to September 2004 42% of SB/IB clients in the pilots had opted to receive some form of case management compared with 28% in other places outside the pilots (Ministry of Social Development 2004, p52). However, the definition of 'case management' in the pilots was very broad including as little as a phone call, a letter or a single visit to a client. This raises the question of whether such low intensity intervention is likely to produce significant increases in employment compared with the status quo.

The new approach with its emphasis on early intervention and support is further consistent with New Zealand evidence which mirrors that from other countries such as the UK that the likelihood of exit from SB/IB is lower for people who have spent a long time in the benefit system than for those who have only been on a benefit for a short time (Green and Wilson 2004). Beyond the first year on SB/IB, the rate of exit to employment falls particularly steeply. If this is mainly due to the effect of time on a benefit, it provides a strong rationale for early intervention. On the other hand, it also indicates clearly that it is easier to prevent inflows than reduce the bulk of IB recipient numbers. OECD's most recent study {Prinz, 2005, in press #4679}concludes that very positive results can be expected for the sort of 'activation' policies being developed in New Zealand, but that it is *much* harder to get people off the benefit rolls once they have become established there. Outflows have been close to nil in almost all OECD countries until very recently.

Although it is clear that the wider economic climate influences the effectiveness of programmes designed to increase labour force participation of inactive groups, (Bloom and Michalopoulos 2001) show that even in weak labour markets programmes such as that proposed still have positive impacts. On the other hand, the effects on people who have had limited or no contact with the labour market (such as some SB/IB clients) are likely to be lower overall. However, since these clients have much longer average durations on benefit, the financial savings from them working are likely to be larger though realised over a longer period of time.

6.2.2 Justification for focusing on SB/IB recipients

Moving on from the issue of the robustness and plausibility of the evidence underlying the likely effectiveness of the proposed package, the SB/IB population is rising rapidly, despite the widespread availability of jobs (unlike in, for example, the UK where the main rise in disability-related benefit recipients occurred against a backdrop of low labour demand), whereas the DPB population is falling slowly and the UB population falling rapidly, so it makes sense in purely numerical terms to focus labour market participation policy on the growing number of people who are out of the labour market on grounds of sickness and disability, particularly bearing in mind their long period of benefit receipt and

resultant costs. SB/IB claimants are now the largest group of working age beneficiaries further strengthening the case for focusing attention on this group outside the labour market given the Government's priority to raise labour force participation. For example, in Canterbury and the West Coast of the South Island SB/IB beneficiaries outnumber those on UB by three to one and in Auckland, Waikato, East Coast, Central and Southern Regions of the North Island, there are twice or nearly twice as many SB/IB recipients as people receiving UB. Given that New Zealand has a high rate of labour force participation among older people (50 and over) compared with other similar countries {Hurnard, 2003 #2081}, this suggests that the disability-related non-employment of younger people in New Zealand is likely to be less good assuming that New Zealand's prevalence of disability is around the OECD average (which it appears to be – see above), and that, therefore, there is room for improvement if raising labour force participation is the goal.

6.2.3 Specific strengths and weaknesses of the proposed direction of policy

Table 6 sets out a range of other strengths and potential weaknesses of the proposed package. A particularly sensitive issue relates to the nature of the work-related expectations placed on SB/IB clients in the 'Work development' stream and the degree of compulsion underpinning the assistance offered as part of any set of 'mutual obligations'. A related question is whether the expectations should apply only to 'new' clients or include existing clients over time. Evidence from the US and the UK shows that voluntary participation in employment assistance is low (1-2%) among people on disability benefits ((Department for Work and Pensions 2004a); (Mathematica Policy Research 2004))– hence a degree of compulsion is needed. In the UK 'Pathways to Work' pilots new claimants of Incapacity Benefit attend compulsory work-focused interviews and can obtain NHS rehabilitation support and a Return to Work Tax Credit if they find a job. Early findings indicate that the take-up rate of rehabilitation and training is six times higher in the pilots than in control areas with this mixture of incentives and compulsion (Department for Work and Pensions 2004b). It is important that any binding requirements placed on clients and potential clients in New Zealand are work-focused but not in the form of a traditional work-test, since this would risk a reversion to the previous situation in which people had to demonstrate their incapacity in order to obtain and retain their benefit payments.

Table 6: Potential strengths and weaknesses of the proposed approach to welfare and employment policy for long term sick and disabled people in New Zealand

Potential strengths	Potential weaknesses or risks
Tackles many of the identified weaknesses in current and past policy settings with respect to SB/IB recipients, employment and other outcomes	A major departure from past approaches and relatively innovative in international terms. Hence, likely impacts inevitably uncertain. Not possible to know definitively how many/what percentage of 'new' and 'old' clients will be able to work, with what levels of support, be willing to work, their amounts of work and extent of work available. US and UK experiments with similar groups are encouraging, especially for 'new' clients. Cautious, provisional estimates suggest that the new approach should produce net savings in benefit expenditure excluding gains from higher incomes, enhanced social

	participation, etc Evidence on the impact of 'active' labour market policies on sick and disabled people is less plentiful than for unemployed or single parents. Likely that employment effects will be more modest with sick and disabled, particularly with longstanding claimants, as against new claims Impact on larger number of existing beneficiaries likely to be far more difficult to achieve than reducing inflow rate
Emphasises what people can do and/or can be helped to do rather than the opposite. Separation of benefit eligibility (on the basis of low income) from assessment of disability (what people need help with) is key to focusing on capacity rather than incapacity	New approach requires a new sort of 'active', employment-focused case manager and more intensive work with clients than currently. This raises issues of training and recruitment of more staff, as well as increased costs[1]. New approach could be restricted by case manager capacity for some time
Broadly consistent with international evidence on 'active' labour market policies which shows that people are best assisted into work using active case management, job search assistance and an emphasis on the *requirement* to seek employment, plus monitoring of the job search process	Current proposals are that the 'Rapid return' stream of new claimants likely to include some or most SB clients would be expected actively to seek work, but what this means will need to be made clear to new claimants. Sanctions for non-compliance (e.g. with job search assistance) will need to be determined. Requirements of existing SB/IB clients and similar people in the 'Work Development' stream need to be determined. Evidence is that making benefit dependent on engaging in work-focused activity increases up-take of employment assistance among new and old clients
Broadly consistent with international evidence that most new and old disability-related benefit recipients want to work and with the fact that there is a big overlap in terms of disability between the SB/IB population and those who are at work, including those who have never claimed a benefit	
Consistent with international evidence that activity, including vocational rehabilitation and work, are positive for the health and well-being of two of the largest groups of clients on disability-related benefits – those suffering from depression and anxiety, and those with musculo-skeletal problems	New approach requires a valid, reliable method for determining which small percentage of new (and old) clients should be exempt from any *requirements* to participate in work-focussed planning, activity, job search, etc. though this would be offered (i.e. how to define group effectively outside both 'streams'). This could be by type of condition or impairment, severity of disability, etc.
Consistent with international evidence that there is higher individual satisfaction and quality of life when	The proposals do not currently include a direct inducement to getting a job such as the Return to Work

[1] The Cabinet memorandum from February 2005 that set out the new approach assumed that the additional costs of the new approach would be predominantly one-off related to new systems (para 7). However, this depends, in part, on the ability to manage with roughly the same number of case managers by releasing their time from assessments of benefit eligibility so that it can be devoted to work-focused support of clients.

individuals with sickness and disabilities are able to make use of generic programs and services, including employment programmes, rather than having to use special or segregated programs, and that barriers to the use of mainstream programmes have to be removed	Tax Credit being piloted in the UK (see Appendix). A work incentive element could potentially be developed as part of the Integrated Disability Payment
	Reforms are focused on beneficiaries and prospective beneficiaries not other disabled people who are not on benefits whether in the labour market or not. Medium-term skill and labour strategy may help non-beneficiaries

This suggests that both new and old SB/IB recipients should, over time, be required to engage in some sort of work-related activity, where they are able to do so. The problem then becomes one of determining which clients are fundamentally incapable of fulfilling even the basic requirements, and what it is appropriate to expect a spectrum of people with less severe disabilities to do to enhance their prospects of securing employment. It seems clear that clients placed in the 'Rapid Return to Work' stream will be full-time work-tested and expected actively to seek work.

To date, the New Zealand package does not include a specific financial inducement in the form, say, of a tax credit, designed to reward SB/IB recipients who move into work, though it does include changes in allowable hours worked and amounts earned while retaining benefit. In the UK pilots, returnees receive a 12-month Return to Work Tax Credit. The Credit is a response to the view that previous financial incentives for claimants on disability-related benefits to move into work tend to be low. The £40 per week over 52 weeks payment is designed to help people to afford to move into work and to reassure them that they will have income security when moving from a benefit into work. While this does mean that for a time recipients of the Credit will receive a higher income than people in comparable jobs but who have not moved off a disability benefit and thus there is a small, theoretical incentive to move onto a disability benefit to claim the Credit, the Credit is time-limited, there is a three-month qualification period and the claimant has to go through the medical assessment for the benefit. In addition, like other low income workers people on Invalidity Benefit have access to a Working Tax Credit and the National Minimum Wage.

In the UK 'Pathway to Work' Pilots, to date, existing recipients of disability-related benefits have not been required to participate in mandatory Work Focused Interviews, yet a significant proportion of them have 'chosen' to do so. It may be that this enhanced 'voluntary' response, is due to the presence of the Return to Work Tax Credit. The evaluation of the Pilots currently underway may shed further light on this effect. In the meantime, it suggests that there may be scope for a combination of compulsion to take part in certain employment-related activities and financial incentives to secure a job.

Since policy development is still in progress in New Zealand, it is possible that there will be more explicit work incentives built into the New Zealand package. For example, the proposed IDP is likely to extend support currently available out of work (the current difference between IB and UB) to those in work, in some form, thereby creating an additional work incentive compared to current arrangements.

The implementation of the proposed new approach depends critically on being able to retrain existing and recruit sufficient, sufficiently skilled extra case managers to provide support and guidance to new and old recipients of benefits as well as other disabled people who wish to use employment services including vocational rehabilitation. The UK government is investing in more skilled adviser support and in new work-focused rehabilitation programmes in its pilot areas whereas the outline proposals in New Zealand envisage extensive redeployment of existing case manager time from entitlements to job-related advice and support with the advent of a single core benefit. As a result, New Zealand envisages a relatively low cost path to securing substantial savings on benefit payments. This assumption will need careful testing if the proposals outlined above are to be successfully implemented. It depends on the Single Benefit leading to a significant simplification of the entitlement assessment process, thereby freeing up large amounts of case managers' time without jeopardising clients receiving what they are fairly due.

7 Conclusion

The evidence and experience presented in this paper strongly support major changes in the way that the New Zealand social welfare and employment systems have traditionally managed their relationships with people who are outside the labour force because of sickness or disability and equips similar people in the labour force to remain in work. Although New Zealand has a relatively high labour force participation among people over 50 years of age {Hurnard, 2003 #2081}, the working age population will continue to shrink as a percentage of the total population, as in most OECD countries, making it increasingly important to enable and encourage people with a range of conditions to participate in the labour force. Quite apart from the cost of maintaining people on disability-related benefits and the risk that continuing increases in beneficiary numbers undermine public support for an effective compensation package for those in need {Prinz, 2005, in press #4679}, it is clear that employment generally improves the financial, social and health outcomes of people formerly on disability-related benefits.

It is also clear that benefit policy can make a decisive difference to employment levels and recipiency rates among people with sickness and disabilities. Across the countries of the OECD, there has been a marked trend in the last 10-15 years towards more 'active' or 'integrated' policies designed to ensure that people with health problems and disabilities can find and keep jobs. Perhaps because New Zealand still has slightly below the OECD average percentage of the working age population on health and disability-related benefits, it stood apart from these trends until the early 2000s, continuing with a 'passive', entitlements-based approach in which people on SB and IB were treated very differently from other groups such as the unemployed and, increasingly, people receiving the DPB. Taken together, very recent reforms and major policy announcements in February 2005 aim rapidly to change this situation. New Zealand is attempting an ambitious shift to a far more 'activist' and 'integrated' approach over a two- to three-year period.

The main elements in the reforms as they affect claimants of disability-related benefits are:

- abolition of SB and IB, and replacement with an entitlement to a single, 'core' benefit on the basis of financial need, not health or disability status, and at the same rate as benefits for unemployed people and solo parents;

- any extra financial help above the 'core' benefit to people with sickness or disabilities on the basis of the extra costs they face, not the presence of a specific medical condition or disability;

- more intensive, early stage, personalised case management of claimants based on the goal of, 'the right job, at the right time, right from the start' in order to prevent people establishing themselves on a benefit for the long term (i.e. to break the current risk of progression from SB to IB);

- two 'streams' of clients envisaged: 'rapid return to work' (work-tested); and 'work development and preparation' who are likely to face the requirement to take part in a range of work-focused activities such as vocational rehabilitation and job search in return for a benefit;

- 'stepped' work incentives for those working more than 20 hours per week based on altering the relationship between earnings and benefit abatement rates;

- better access to health and rehabilitative services designed to improve people's ability to obtain and/or retain employment, including mental health services;

- easier access for *all* people with long term health problems or disabilities to employment-related assistance (e.g. training, workplace accommodations), irrespective of benefit status.

The reforms are strongly influenced by the positive employment effects in the US, Canada and the UK resulting from 'active' labour market policies applied to unemployed people and solo parents, and more recently to people on disability-related benefits. The reforms proposed for New Zealand are challenging, but largely in line with research evidence and best practice recommendations from bodies such as the OECD to introduce 'activation' strategies linked to 'mutual obligations' to increase the employment prospects of people on disability-related benefits {OECD, 2003 #1370}.

However, the effectiveness and cost-effectiveness of the reform package is likely to depend on the details, yet to be finalised, particularly the nature of the work-related expectations placed on former SB and IB recipients in the second 'stream' and the degree of compulsion (i.e. the sanctions for non-compliance) underpinning the offer of assistance.

New Zealand may also need to investigate the merits of a direct financial incentive for beneficiaries in these groups to return to work, for example, in the form of a tax credit.

Another important implementation issue relates to the resources necessary to train existing case managers and recruit extra staff to provide the more intensive, personalised, job-oriented service required. Additional resources are also likely to be required for clients' needs assessment and their vocational and medical rehabilitation. The risk is that New Zealand attempts to increase employment and realise benefit savings without making the necessary investment in support services and financial incentives to bring this about.

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Appendix

UK Policy Developments And Thinking Related To Getting People From Incapacity Benefits Into Employment, 2004-05

7.1 Why focus on the population in receipt of Incapacity Benefits (IBs)?

7.1.1 Numbers and trends

2.7 million people of working age were claiming IBs in 2002. This is greater than the combined total of lone parents and unemployed people on a benefit. Currently there are only about 800,000 people claiming the Jobseeker's Allowance (2.7% of the workforce). Yet, about 7.5% of the working age population is on IB. The prevalence of disability benefit receipt in the OECD is concentrated between 5% and 7% of the population.

Numbers have trebled in the UK since the 1970s. 90% of the increase between 1979 and 2002 occurred before the mid-1990s. Just under half of those on IBs are 50 years and over. The vast majority of those between 50 and state pension age receiving a benefit are on an IB.

The main reasons for the increase in the UK have been:

1. macroeconomic instability and industrial restructuring disproportionately affecting older and less skilled workers;
2. increased attention to getting those on Unemployment Benefit back to work, making IBs a more attractive option since recipients tend to have relatively little contact with and support from benefits staff;
3. population ageing leading to more older people with health problems claiming IBs.

Numbers on Jobseeker's Allowance have fallen by 45% since 1997 and numbers of lone parents on Income Support have fallen by 15%, but this has not been matched by people with a health problem or disability. The key difference between IBs and Jobseeker's Allowance is that there is no requirement to look for work in return for the benefit under the former as long as the medical test has been satisfied.

There are three rates of IB, the lowest £55.90, the highest £74.15 which can be increased by various allowances. The average payment is £84.51 (autumn 2004 figures).

7.1.2 Duration on IBs

The numbers on IBs have been on benefit for a very long time compared with people on other benefits. Nearly 50% of IB recipients have been in receipt for over five years compared with less than 5% of the unemployed and 35% of lone parents. Outflow from

IBs is very low. Once a person has been on IBs for 12 months, their average duration of claim is eight years. The numbers leaving IBs for work is very low.

7.1.3 Geographic concentrations

The IB population is locally concentrated in the UK, particularly in localities within cities and in those 'old' industrial areas where the economy has not rebounded after restructuring. This contributes directly to household poverty in these areas. The group most affected in these areas are older men who were displaced and have not found comparable work locally.

7.1.4 Capacity to work

A person on IB is not necessarily incapable of working, rather it is judged that they have a level of incapacity at which it is felt unreasonable to *require* a person to seek work in return for a benefit. This is not a level of incapacity at which work is impossible, but that people are likely to need some support to find suitable work and sustain employment. To satisfy the Personal Capability Assessment (PCA) a person needs to show certain limitations in their personal capacities as a result of their condition, but not that they cannot work in any circumstances. This is because there is no clear cut-off that separates those who cannot work from those who can. Indeed, there are over 3 million people in work in the UK with a long-term disability that substantially limits the type of work they can do. Some will have the same functional limitations as people on IBs and they could claim IB if they were not working.

7.1.5 Severity of health conditions

Most people have manageable conditions when they first claim with a good prospect of return to work, at least objectively (whether they do so is another matter). Nearly two-thirds of IB recipients receive benefits for three main conditions:

- 35% for mental or behavioural disorders (mostly depression, anxiety, other neuroses);
- 22% for musculoskeletal disorders (mostly back/neck pain rather than severe conditions like arthritis);
- 11% for heart, circulatory or respiratory disorders (angina, hypertension, bronchitis).

Only 0.7% have had a stroke, 0.2% tetraplegia and 0.9% have multiple sclerosis. For many, deterioration is not inevitable with effective support and proper management.

7.1.6 Expectations of returning to work

90% of people going onto IBs expect to go back to work in due course, but over 40% will not return and will still be claiming 12 months later. Once people have been on IBs for a year their prospects of getting back to work are very poor (only 1 in 5 within 5 years). The government believes that this is a bad outcome for many since it means that their living standards will remain low.

7.1.7 Work and activity may improve many incapacitating conditions

Best practice management of back pain and heart conditions includes activity and work. People with mental health problems can benefit from return to work. Inactivity can worsen health and reduce the odds of returning to work for many IB recipients. Unfortunately, health professionals do not consistently pursue active, evidence-based strategies.

7.1.8 Significant obstacles to return to work exist and/or are perceived

Among IB recipients looking for work, only 8% report no obstacles to returning to work. 50% report that there are insufficient local jobs for people such as themselves, 49% report a low level of confidence about working, 37% report that they would find it difficult to find work that would suit them, 34% report that they are unlikely to get a job because of their health problems (60% among those not currently looking for work, but who would like to work), 28% report worries about how to manage financially until their first pay day and 18% report worries about managing financially while in work. Only 17% report not having enough qualifications and experience to find the right work (40% of IB claimants have no formal qualifications versus 22% of the unemployed) (Secretary of State for Work and Pensions, 2002). Although health problems are mentioned most commonly as an obstacle to returning to work, around 40% of IB recipients do not mention their health as an obstacle to getting a job.

Another set of obstacles to returning to work relate to being inactive. For many IB recipients, not being at work worsens mental and physical health and further reduces the prospect of returning to work.

Many people claiming IBs are at least partly detached from the labour market, suggesting that the process of moving onto IBs may be influenced as much by declining confidence and motivation as poor health. A third of claimants of IBs had not worked in the two years immediately leading up to the claim, so their skills were already deteriorating before going onto IBs.

Financial incentives to work can be weak even with the Working Tax Credit (which provides additional support to people with a disability) and National Minimum Wage guarantees. Only 25% of IB recipients would be more than £40 a week better off working 30 hours a week.

The benefits system itself acts as a barrier to work because many IB recipients interpret the fact that they are not required to be actively seeking work to qualify for IBs as meaning that they must not do anything to suggest that they might be able to work otherwise their benefit could be withdrawn. Some benefits staff are unaware that because a person satisfies the medical criteria for IBs , this does not meant that they are incapable of work. Words like ‘incapacity’ in IB reinforce this misapprehension. Many IB recipients have little or no knowledge of the opportunities that are available to help them back into work.

Finally, many people with health problems and disabilities, particularly over 50 years (who are half of IB recipients), face discrimination, often because employers do not understand the cost of employing disabled people

7.2 Main planks in the UK strategy to help people move from IBs to work

The main planks are:

- *early and ongoing support* to help people stay focused on their capabilities and expectations before more chronic health problems arise;
- *direct access to a comprehensive range of provision* that tackles the main health- and non-health-related obstacles (see list above); and
- *decent, clear financial incentives* that support the initial steps back to work,

backed up by better information for employers and comprehensive civil rights legislation for disabled people. For example, the employment rights of people who have had mental health problems and face discrimination are to be strengthened. Further legislation is planned for 2006 to outlaw age-related workplace discrimination.

Provision is based partly on employment services available to all people on benefits and bespoke services. In addition, there are extensive plans for further reform of IBs themselves in the longer term (see below).

7.2.1 'Mainstream' provision

Jobcentre Plus

Jobcentre Plus was formed by the merger of the Employment Service and the working age parts of the Benefits Agency to provide a work-focused service to all benefit claimants. Any person wanting to claim an IB is *required* to attend a single meeting with a personal adviser, known as a 'Work-Focussed Interview' to encourage job-seeking or take up of training and to inform people about the financial help available. There are mandatory follow up interviews after three years.

New Deal for Disabled People

This is the main employment programme for people on IBs and is voluntary. People keen to look for work can use a network of job brokers in public, private or voluntary sectors to help them find and retain employment.

New Deal 50 Plus offers a range of extra practical help for the over-50s. Under the programme there was an Employment Credit (EC) providing additional financial support. This payment now forms part of the Working Tax Credit, and is payable for 52 weeks for work of at least 16 hours per week. There is also an in-work Training Grant of up to £1,500 when a person gets a job through New Deal 50+.

Jobcentre Plus employment programmes

These programmes offer help to people to tackle a range of obstacles to work, but take up among IB recipients has been very low as few are aware of it or have been encouraged to use it until recently.

Working Tax Credit

This tax credit, underpinned by the National Minimum Wage, guarantees a minimum income for a person working. This has been increased (April 2003) to improve work

incentives of IB recipients, of whom around 50% as against only 25% previously would be better off in work rather than on IBs.

In addition, *Access to Work* provides subsidies to employers and individuals to meet the costs of adjustments or special aids resulting from a disabled person working.

While the above measures have helped raise the employment rate of disabled people, as well as reduce the rate of inflows to IB since the mid-1990s, there was little evidence until recently that the proportions flowing off IBs had increased or that the overall numbers receiving benefit had fallen as a result of these general measures.

As a result, the government has been testing out new approaches to the IB population since 2002, particularly focusing on giving people the right support at the right time to prevent them becoming long-term dependent on IBs.

7.2.2 Pilots of improved 'Pathways To Work'

The centre piece of government initiatives over the last two years have been the 'Pathways to Work' pilots in seven Jobcentre Plus districts. These consist of a new framework of work-focused interviews within Jobcentre Plus for *new* IB claimants, improved referral routes from these interviews to existing employment support and new work-focused rehabilitation programmes in conjunction with the NHS, plus a new financial incentive payable on return to work. The pilots began in 2003/04 (first wave of three started in October 2003; second wave of four in April 2004) and run in their original form for 2.5 years until 2005/06 and were funded at the rate of approximately £40m per year currently. They have recently been extended and adapted (see below). The pilot districts are predominantly 'old' industrial and mining areas. The pilots are being independently evaluated to try to identify what works best for whom and in what circumstances. The elements are discussed in more detail below.

Mandatory work-focused interviews and support from a skilled personal adviser

Except for the most severely disabled (i.e. people with tetraplegia/paraplegia, registered blind, severe neurological disease, severe mental illness, severe learning disability and terminally ill), once on IB, new claimants in the seven pilot areas face a series of *mandatory,* work-focused interviews roughly monthly with a trained personal adviser at Jobcentre Plus over the first eight months of the claim. The advisers are trained in motivational skills and specialise in disability. The aim of these interviews is to reduce the proportion of IB recipients staying more than 6-12 months on IBs after which time their chances of moving off IBs reduce drastically.

Instead of the first interview at the start of the claim, this is generally after about eight weeks once the client's personal capacity has been assessed and their benefit has been processed and agreed so that the interview can focus on work rather than IBs. IBs are reduced if claimants fail to show up for their regular interviews without good cause. After this early sequence of interviews the normal Jobcentre Plus regime of periodic mandatory follow-up interviews applies. Interviews cover the nature of the benefit and its medical tests, explore options for work-related activity, encourage access to other services, encourage take-up of training in basic skills if needed, explain the range of financial support available to people returning to work, encouraging self-confidence and facilitating returns to work with a previous employer where possible.

Clients and advisers are expected to draw up an action plan together as a result of the interviews. However, beyond attending the interview and drawing up an action plan, there are no other obligatory steps for claimants.

Improved referrals to existing specialist employment programmes

A significant proportion of those on IBs do not see themselves as 'disabled' and do not see disability employment programmes such as the New Deal for Disabled People as relevant. As a result, information is being improved and referral channels simplified in pilot areas to encourage more use of these programmes.

New rehabilitation (condition management) programmes to help people manage their conditions

In pilot areas, DWP is working with the NHS to establish more employment-focused rehabilitation programmes targeted particularly, though not exclusively, at those coming onto IB. Hitherto, in the UK, employment-focused rehabilitation has mostly been limited to employees of large organisations. Programmes do not aim to 'cure' long term conditions, but help with pain management; improving physical fitness and mood; and improving the ability to cope with the uncertainty and fear associated with illness. Initial programmes in the pilot regions cover non-severe mental health, cardiovascular and musculo-skeletal conditions which are the main conditions contributing to IB numbers and the ones which, with the right support, people can manage sufficiently to get back to work, which, in turn, can help their conditions. Programmes are delivered through Primary Care Trusts. They have something in common with NZ ACC programmes.

Given the crucial role of GPs in regulating the flow on and off IB through issuing initial sickness certificates and their advice to their patients in relation to fitness for work issues, it is regarded as important to improve clinical practice in this area. The government has established an interactive website providing on-line training for GPs in occupational health and rehabilitation (see below for more on developing the role and competence of GPs).

New Return to Work Credit

The government is piloting in the seven areas a new Credit that pays £40 per week to anyone moving off IBs into work of 16 hours a week or more payable for 52 weeks. The Credit is payable to anyone whose earnings are less than £15000 per year. The Credit is in addition to the usual tax credits available to low income earners.

As well as the new tax credit, personal advisers are able to make an award of up to £300 to support return to work activities of all IB recipients from day 1 of their claim.

More support for people who move off IBs onto Jobseeker's Allowance (JSA) because of the Personal Capability Assessment (PCA)

People who move from IBs to the normal Jobseeker's Allowance because they no longer meet the requirements of IB, are generally regarded as needing a higher level of support than other JSA clients since research shows that they still have significant medical and non-medical barriers to work. These clients see a specialist adviser to draw up a Jobseeker's Agreement and are eligible for the relevant JSA New Deal without the normal wait of up to 18 months. The PCA report is used as an input to drawing up the Jobseeker's Agreement.

Early results of the 'Pathways to Work' pilots

Early findings from the first year of the three first wave pilots (Renfrewshire, Derby and Bridgend) based on 58,000 claimants who have entered the pilots suggest that the pilots are getting new IB recipients back to work at twice the rate of areas outside the scheme (Department for Work and Pensions, 2004. If this were able to be generalised across the entire country, it should result in substantial benefit savings each year, though the economic analysis to quantify this precisely has yet to be completed. In pilot areas, six times as many people claiming IBs took up support in New Deal and other rehabilitation programmes. Existing IB claimants are also volunteering to take up the support packages available to new claimants (10% of pilot participants are volunteers).

The early research in three first wave pilots has also reported an 8-10% point increase in the rate of people coming off IBs altogether after four months of their claim compared to non-pilot areas. This is against a background reduction in the number on IBs in the second half of 2004.

Personal advisers reported that they were very positive about their new role and had generally received positive feed back from clients about the condition management programmes and particularly the Return to Work Credit. However, they reported that there were some clients whose circumstances they had been unable to make any progress with.

The quantitative data reported to date have been from administrative databases rather than data collected specifically for the evaluation. The impact and cost-benefit parts of the evaluation have not yet reported initial findings.

7.3 Further changes to 'Pathways to Work' pilots and reform of IBs: a more active welfare state?

7.3.1 Extension of pilots to cover a third of the UK from October 2005

Encouraged by the promising early results of the evaluation of the seven pilots, Ministers have decided to extend the Pathways to Work scheme to the most disadvantaged local authority districts and those with the largest concentrations of IB recipients (Department for Work and Pensions, 2004b). This will begin in October 2005. Between October 2005 and October 2006, 14 additional Jobcentre Plus districts will join the 'Pathways to Work' scheme. Including the seven initial pilots, this will bring potential coverage of the scheme to 900,000 IB claimants by October 2006. The seven pilots will continue beyond 2006 to permit more thorough evaluation and to enable them to broaden their focus to include long-term IB recipients (see below).

By 2006, it is planned that *all* Jobcentre Plus districts will have specialist personal advisers capable of supporting people on IBs into work.

The long term intention at present, subject to evaluation and resources, is to be able to offer a service similar to Pathways to Work to the entire country.

7.3.2 Extension of initial work-focused interview to all new IB claimants

From October 2005, all new IB claimants will be required to attend a work-focused interview after eight weeks of their claim in line with the Pathways to Work pilots and to complete an action plan to keep them in touch with job opportunities.

7.3.3 Extension of pilots to longer-term existing IB claimants

It is planned to extend the seven existing pilots gradually to support more, longer-term IB recipients (Department for Work and Pensions, 2004b; 2005a). About 1 in 10 of the current participants in the pilots are long term claimants who have volunteered to take part. About 20% of those who have so far moved into work from the pilots are long-term recipients of IBs. From February 2005, claimants of 1 to 3 year duration will receive a similar pattern of compulsory job-focused interviews (currently they can access these voluntarily), but will also be entitled to a £20 per week Job Preparation Premium to encourage steps towards getting a job.

7.3.4 Changes to 'permitted work' rules

The 'Permitted Work Rules' were introduced in April 2002 and allow most IB recipients to earn up to £78 a week (16 hours at the National Minimum Wage) for a period of up to 52 weeks and continue to receive benefit (people with progressive conditions can continue this indefinitely). They can also earn up to £20 per week indefinitely to help maintain contact with the labour market. Research commissioned by the DWP and published in December 2004 (Dewson, Davis and Loukas, 2004) indicates that for about a quarter of claimants, the Rules have provided a bridge to employment since they found jobs after participating in Permitted Work. This was particularly so for those with musculo-skeletal difficulties and mental health conditions who found that their health problems were not so much of a barrier to work as they had originally thought. Claimants working generally reported that this had been beneficial not just financially but also in terms of self-confidence and independence.

The Permitted Work Rules are to be simplified to allow all IB recipients to earn up to £78 per week for 52 weeks.

7.3.5 Early rehabilitation (pre-IB) and more support for GPs

In 1995, the medical assessments for access to IBs were tightened up and since then a number of initiatives have been taken to inform GPs about the implications of signing people off work due to sickness, the transition to IBs and the consequences for people of eventual long-term dependence on IBs ('to end the sick note culture'). As a result, the numbers on IBs have tended to stabilise, though this is also a result of the wider success of the economy as well as other measures. GPs are now more aware of the health and psychological benefits of activity, including work, for people with long term health problems.

The Public Health White Paper of late 2004 included a proposal to ensure that when GPs signed a person off sick, a rehabilitation course was initiated at the same time, rather than waiting until the person became eligible to apply for IBs.

7.3.6 Scrapping of the name 'Incapacity Benefit' and replacement with two new benefits differentiating those with severe and more manageable conditions

The most recent announcement from the UK government in February 2005 indicates a major change to the structure of benefits in this area by 2008 (Department for Work and Pensions, 2005b). The name 'Incapacity Benefit' will be scrapped on the grounds that it implies that people on IBs are incapable of work. Initially, people will be put on a holding benefit payable at the same rate as Jobseeker's Allowance until they have had a medical assessment which will take place within 12 weeks of their initial claim. The assessment will be accompanied by a new Employment and Support Assessment, based on the current Pathway to Work pilot capability report. This is an important amendment as they will not have JSA conditionality when on the holding benefit.

There are plans for two new benefits: Rehabilitation Support Allowance; and Disability and Sickness Allowance. The former will cover the majority of existing IB claimants, namely, those with more manageable conditions and the latter will focus on the minority with a severe condition. The Rehabilitation Support Allowance will provide a basic level of benefit the same as JSA levels but will build up to more than current IB levels conditional on recipients attending Work-Focused Interviews and then taking other steps towards the labour market.

The most severely affected will receive more money than currently through the new Disability and Sickness Allowance.

The package also includes reference to piloting placing employment advisers into GPs' surgeries on the grounds that the response and support of family doctors is critical to setting claimants on the right direction.[employment advisers was actually announced in the Pre-Budget Report]

7.4 More speculative possible developments in the longer term

There are signs that a third term Labour government in the UK would introduce more compulsion into the administration of benefits, generally, including those applying to the disabled One idea floated by Patrick Diamond, former special adviser at 10 Downing Street, in October 2004 is to place the more able of those on IBs in socially useful work such as park attendants and community wardens as part of their rehabilitation.

In another October 2004 speech to the Institute of Public Policy Research (IPPR), a Left-leaning think-tank, Tony Blair hinted at the possibility of imposing some type of time limit on IBs. It appears that, despite encouraging early signs, the PM does not believe that simply rolling out the Pathways To Work initiative to the whole country will be sufficient to achieve the likely Labour third term target of putting 1.5m economically inactive people into work (equivalent to achieving an employment rate of 80% of the working age population). Hence the recent announcement to make the new benefit payable to those with more manageable conditions dependent on their willingness to take active steps towards the labour market. This approach is likely to be far more acceptable politically than the idea of imposing time limits on benefit receipt. The Five Year Strategy of the Department for Work and Pensions (2005c) noted that: 'Our approach is not about time-limiting or cutting rates of benefit, nor is it about cracking down on those on benefits'.

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