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POLICY STUDIES PAPER NO. 5

DISABILITY OR WORK: HANDICAP POLICY CHOICES

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FOREWORD

Cross-national comparisons of disability programs and disabled populations show that the social environment workers with handicaps face can be as important as their health in affecting their movement into disability. In this context, Richard Burkhauser reviews American disability policy over the business cycles of the past two decades. He finds that strong economic recovery has, in general, overcome the sharp drop in the well-being of people with handicaps brought on by the recession and the reduction in program benefits in the early 1980s. However, the doubly handicapped, those with both health limitations and poor work skills, have not recovered.

Burkhauser's evaluation of policies embodied in the Americans with Disabilities Act of 1990 (ADA) suggests its job accommodation mandates for workers with handicaps could double the time they stay with their employer. However, mandates alone will not dramatically increase employer accommodation. And he argues that the ADA is unlikely to improve either the work chances or well-being of the doubly handicapped. Drawing upon comparisons of programs in other countries, he develops a set of policy suggestions including targeted tax credits that could facilitate the movement of the doubly handicapped into the economic mainstream.

Part of this paper was written while the author was a Fellow in Residence at the Netherlands Institute for Advanced Studies in the Humanities and Social Sciences in Wassenaar, The Netherlands. The author is Professor of Economics and Senior Research Associate, Metropolitan Studies Program, The Maxwell School, Syracuse University.

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February 1992

DISABILITY OR WORK: HANDICAP POLICY CHOICES

The road to disability begins with a health condition, but the transition into disability is greatly influenced by the social environment people with handicaps face. An important institutional component shaping this environment is the disability insurance provided by government. Protection against income loss from a health condition that limits work is a core component of all modern social insurance systems. The structure of that protection and the circumstances under which it is offered vary across countries and over time. But it is universally true that such policy choices greatly determine the size and scope of the population with disabilities.

In this paper the twists and turns of two decades of United States' policy toward people with handicaps are reviewed. It is shown that the strong economic recovery of the 1980s has, in general, overcome the sharp drop in the economic well-being of people with handicaps brought on by the recession and the reduction in the generosity of government programs targeted on them in the late 1970s and early 1980s. However the doubly handicapped, those with a health condition that affects work and who also have poor job skills, have not recovered from the recession.

New policies, as embodied in the "Americans with Disabilities Act of 1990" which have as their goal increasing the employment of people with handicaps, are then reviewed. It is argued that early intervention through accommodation, when a health condition first begins to affect work, will increase the chances that a worker with handicaps will stay with the firm. But it is also argued that the ADA is not a panacea and that it is unlikely to reach the doubly handicapped. Alternative work orientated policies targeted on this group are then outlined.

Two Decades of Handicap Policy: 1970-1989

Definitions of populations with handicaps and disabilities vary. Here those with a health condition that affects their ability to work are considered to have handicaps. The disabled are defined as that part of the population with handicaps that receives government disability transfer benefits.

After a health condition begins to limit work, workers with handicaps may immediately leave the job and move onto the disability rolls. But this is only one of many possible outcomes. The restrictions on work brought on by the health condition will influence this outcome but so will the actions or inactions of employers and government. Thus, work choices by those with handicaps are limited not only by their health but by the social environment they face. The power of social institutions to influence this choice and, thus, the size and composition of the disabled population is most graphically seen in cross-national comparisons. Such comparisons encompass the full impact of a country's social institutions on those with handicaps.

A Cross-National Comparison of Disability Incidence

The importance of public policy on disability is demonstrated in Table 1. This table shows the population receiving transfers from major disability programs per 1,000 workers in the United States and three European countries. All four countries experienced substantial increases in their transfer prevalence rates in the 1970s, with the greatest increases in the Netherlands and the United States. The 1980s saw slower growth in all countries, with the United States and the Netherlands showing the greatest turnarounds.

By 1989 there were 43 disability transfer recipients in the United States per 1,000 workers. In comparison, the German incidence rate was almost 30 percent higher, the Swedish

TABLE 1

DISABILITY TRANSFER RECIPIENTS PER THOUSAND ACTIVE LABOR FORCE PARTICIPANTS BY AGE, IN FOUR OECD COUNTRIES, 1970-1989

	1970	1975	1980	Percent Change 1970s	1985	1989	Percent Change 1980s
Working Age Population:							
Aged 15-64							
United States	27	42	41	52	41	43	5
Germany	51	54	59	26	72	55	-7
Sweden	49	67	68	39	74	78	15
Netherlands	55	84	138	150	142	152	10
Aged 15-44							
United States	11	17	16	45	20	23	44
Germany	7	6	7	0	8	5	-29
Sweden	18	20	19	6	20	21	11
Netherlands	17	32	57	235	58	62	9
Aged 45-59							
United States	33	68	83	152	71	72	-11
Germany	75	64	84	12	103	75	-13
Sweden	66	95	99	50	108	116	17
Netherlands	113	179	294	160	305	339	15
Aged 60-64							
United States	153	265	285	85	254	250	-12
Germany	419	688	1,348	222	1,291	1,109	-18
Sweden	229	382	382	67	512	577	51
Netherlands	299	437	1,033	245	1,283	1,987	92

SOURCE: Aarts et al. (1992).

rate over 80 percent higher, and the Dutch rate over 250 percent higher! It is hard to image how underlying health conditions alone could explain such enormous differences.

This is not to suggest that health does not play some role. Health conditions increase with age; so should the prevalence of disability transfers. This is borne out in Table 1. Prevalence rates rise in the older population in all countries. Yet the startling differences across countries in these rates remain.

With the exception of the Netherlands, prevalence rates are modest for those under age 45. In middle ages, 45 to 59, they rise in all countries with the United States and Germany having similar low rates, Sweden a higher rate, and the Netherlands a rate nearly five times that of the United States. Among the oldest working age group, those 60 to 64, the United States has by far the lowest rate. In Germany there are more people receiving disability benefits than working at this age, and in the Netherlands among those aged 60 to 64 twice as many people are receiving benefits as are working!

The values in Table 1 suggest that to understand the process to disability, it is necessary to know both the medical and the social context in which this process unfolds. One element of this process is the social insurance scheme itself. The greater the share of wage earnings replaced by disability benefits and the easier is access to them, the faster this transition will take place. Burkhauser et al. (1992a) reviews the empirical evidence of this for the United States, and Aarts and de Jong (1991) does it for the Netherlands.

But this is only one aspect of the process. Employer behavior also matters. Deteriorating health can effect job performance, but the willingness of employers to adjust the work environment to reduce or eliminate those aspects of the job that interact with a health condition to reduce productivity can slow the rate of job exit. Burkhauser and Kim (1990) provides evidence of the importance of job accommodation on the tenure of men with handicaps.

Government policy has a more diverse role in the process to disability than is captured by disability insurance rules. Government policy can also retard this process by providing vocational rehabilitation to workers with handicaps to either overcome work impairments or learn job skills that allow for alternative employment. Governments can also provide subsidies to employers to hire or retain such workers or even directly provide them with jobs. In addition, government policy can mandate employers to accommodate people with handicaps or set quotas that require that jobs be provided for such workers.

Broader social policies by governments to counter unemployment or to regulate wages can also affect the process. It has long been observed that disability transfer rates are sensitive to general market conditions. During economic downturns, the distinction between unemployment caused by economic forces and unemployment caused by poor health are often blurred to provide assistance to those who are not working. This same blurring occurs with respect to retirement and disability policy as those with health conditions are often given what amounts to early retirement benefits. Haveman et al. (1984) reviews the disability policies of seven industrial countries during the 1970s in this regard. The net impact of all these government policies can and has at various times increased or decreased the speed at which workers with handicaps move out of the work force and onto the rolls of the disabled.

European policy has differed over time in its use of handicap policy instruments. The Netherlands, more than any of the other countries in Table 1, used transfers as the principle method of treating people with handicaps. In the 1970s and through much of the 1980s full disability benefits, up to 70 percent of gross wage earnings, were provided for those with as little as a 15 percent loss in earnings capacity, if they were unemployed. This lead to explosive growth in the disability population. Reductions in the generosity of the benefits and a tightening of the eligibility rules slowed growth considerably in the 1980s.

Sweden has a transfer structure similar to the Netherlands but requires workers with handicaps to first seek rehabilitation. Only those who do not respond to treatment and return to work in the private sector or to a guaranteed government job are placed on the permanent disability rolls. This emphasis on work has kept disability prevalence rates low in Sweden despite very high benefits. As can be seen in Table 1, the one exception is among those over age 60. Beginning in the 1970s, older people with handicaps were no longer expected to work and became eligible for disability benefits if unemployed.

Germany has more stringent eligibility criteria--one must have suffered at least a 50 percent reduction in earnings capacity--and lower earnings replacement rates than the Netherlands. It also requires all firms with at least 16 workers to employ one worker with handicapped per 16 employees. This combination of less generous benefits and greater job protection accounts for the lower disability incidence rates in Germany.

As is the case in Sweden, Germany has less restrictive eligibility rules for older workers with handicaps workers. Such workers can receive early retirement benefits starting at age 60 if they are unemployed. The earliest retirement age for other men is 63. Aarts et al. (1992) provides a more detailed discussion of policy toward the handicapped in these countries in the 1980s.

A Review of United States Policy

Policy in the United States moved closer to the European countries discussed above in the early 1970s. Social security retirement and disability benefits were raised by over 50 percent during this period (Anderson et al. 1986). Eligibility rules for disability benefits were also relaxed. This was done allowing "vocational characteristics" to enter into the evaluation process. Workers who were poorly educated, worked in physically demanding jobs, or who were older were considered to be less likely to find employment with a given health condition and, hence, were

more likely to be granted benefits. While a strict definition of disability eligibility remained--inability to perform any substantial gainful activity--in practice a looser definition was used.

In 1974 the supplemental security income program merged state programs for the aged, blind, and disabled and raised benefits. This means tested program provides a guaranteed minimum income to those who meet health criteria similar to those of social security disability insurance. As can be seen in Table 2, these changes together with a faltering economy lead to an 76 percent increase in the disability population between 1970 and 1975.

In addition to this substantially increased use of transfer payments, United States policy also directly intervened in the labor market on behalf of people with handicaps. Beginning in 1973 workers who were handicapped due to a health condition or simply by poor work skills were offered government supported jobs. By 1980 over one million such jobs were provided under the Comprehensive Employment and Training Act of 1973 (CETA).

When the jobs provided by this broader program for those with social handicaps are added to more narrowly focused sheltered work jobs and vocational rehabilitation training in Table 2, one can see the enormous increase in government commitment to people with handicaps that occurred in the 1970s. This combination of easier access to benefits and the provision of public service jobs and vocational training for those with social or medical handicaps moved the United States very close to a broad European style system. But such policies were not to last.

The peak for disability transfers for the next decade was hit in 1978 as first the Carter Administration and then the Reagan Administration tightened eligibility criteria. In addition, all public service jobs were ended with the termination of CETA early in the Reagan Administration. Hence, during the worst economic recession since the 1930s, workers with

TABLE 2

PARTICIPANTS IN UNITED STATES PROGRAMS FOR ADULTS WITH HANDICAPS (AGES 18-64), 1970-1990 (in thousands)

Type of Program	1970	1975	1980	1985	1990
A. Disability Insurance	1,493	2,489	2,858	2,657	3,011
Percentage Change[a]		67	15	-7	13
B. Supplemental Security Income	870[d,e]	1,678	1,692	1,851	2,418
Percentage Change		93	1	9	31
C. Total Disability Pensions (A+B)	2,363	4,167	4,550	4,508	5,429
Percentage Change		76	9	-1	20
Narrowly Defined Job Program[b]	100	168	262	200[d]	200[d]
Percentage Change		68	56	-76	0
D. Total Job Programs[c]	100	506	1,096	200[d]	200[d]
Percentage Change		406	116	-82	0
E. Vocational Rehabilitation	876	1,244	1,095	932	938
Percentage Change		42	-12	-15	1
Total in All Programs (C+D+E)	3,339	5,869	6,741	5,640	6,567
Percentage Change		77	14	-16	16

[a]Percentage change over previous five years.
[b]Jobs provided primarily to workers with physical or mental handicaps. This includes those in sheltered workshops and CETA-public service employment (PSE) who are defined as handicapped or disabled veterans.
[c]Also includes those with economic or social handicaps. This includes the entire population of CETA-PSE as well as those in sheltered workshops.
[d]Estimate.
[e]In 1970 this included those adults aged 18-64 receiving Aid to the Blind and Aid to the Permanently and Totally Disabled.

SOURCE: Burkhauser and Hirvonen (1989); U.S. Department of Education (1991); U.S. Departmental Health and Human Services (various years).

handicaps in the United States were faced with stricter disability eligibility rules than in the previous decade and no access to government created jobs.

This retrenchment in government policy is seen in the 7 percent drop in the disability insurance population and in the 16 percent drop in the overall disability program populations between 1980 and 1985. The Courts and then Congress in 1984 limited the ability of the Social Security Administration to remove people from the disability transfer rolls. (See Weaver (1986) for a fuller discussion.) In the second half of the 1980s, the disability transfer program population has once again begun to increase, with the greatest increases in the supplemental security income program. Vocational rehabilitation clients also began to increase during this period after a decade long drop.

The Economic Well-Being of the Handicapped

The twists and turns in American disability policy over the past two decades together with sharp business cycles have had a substantial effect on the economic well-being of the handicapped. Table 3 looks at the relative wage earnings of working age men with handicaps and the economic well-being (pre-tax income adjusted for family size) of the families they head relative to men without handicaps and their families between 1967 and 1987.

These data from the Current Population Survey define the working age population with handicaps as those men aged 18 to 64 who are household heads and who are either receiving transfer benefits from a health related program or who are not working or not working full time because of a health condition. See Burkhauser et al. (1992b) for a fuller discussion.

The relative economic well-being of families headed by men with handicaps rose substantially in the early 1970s despite a drop in their relative wage earnings between 1972 and 1975. Disability benefit increases offset this drop in wage earnings. But in the second half of

TABLE 3

ECONOMIC WELL-BEING OF MEN WITH HANDICAPS AND THEIR FAMILIES RELATIVE TO MEN WITHOUT HANDICAPS AND THEIR FAMILIES ACROSS EDUCATION LEVELS, 1967-1987

	1967	**1972**	**1975**	**1979**	**1981**	**1983**	**1987**
	Family Economic Well-Being of Men with Handicaps Relative to Men without Handicaps by Education, 1967-1987						
Overall	.66	.74	.66	.58	.51	.54	.49
High School Dropout	.62	.67	.36	.46	.29	.32	.30
High School Degree	.77	.75	.65	.62	.44	.57	.64
High School Plus	.69	.85	.93	.70	.64	.71	.72
	Wage Earning of Men with Handicaps Relative to Men without Handicaps, by Education						
Overall	.74	.80	.80	.73	.66	.72	.75
High School Dropout	.78	.81	.78	.75	.70	.72	.71
High School Degree	.88	.84	.84	.76	.69	.74	.91
High School Plus	.78	.83	.89	.79	.75	.83	.89

SOURCE: Derived from Tables in Burkhauser et al. (1992b).

the 1970s and especially in the recession torn early 1980s, further drops in wage earnings resulted in substantial drops in relative well-being.

By 1981 male workers with handicaps had only about one-half the earnings of male workers without handicaps and two-thirds of their family income. The combination of the most serious economic downturn since the great depression and a significant cut in both disability rolls and in government provided jobs had a dramatic effect on the relative economic well-being of people with handicaps.

It is not surprising that a poor economy would have a greater impact on workers with handicaps than on other workers, but it was the view of the Reagan Administration that an economic policy that insured a fast and sustained recovery would in the long run be the best policy for getting all Americans back to work, including those with handicaps. Table 3 provides some support for this view but in a somewhat surprising manner.

The economic well-being of families headed by men with handicaps improved relative to other men after the recession. By 1987 their economic well-being had risen to three-quarters that of families headed by men without handicaps, a level above the pre-recession year value of 1979 but still below the peak years of the early 1970s. Surprisingly this was accomplished despite the fact that the relative wage earnings of men with handicaps did not, in general, recover from the recession.

One explanation of this surprising phenomena is suggested by Table 3 where the relative wages and family economic well-being of male workers with handicaps of a given education are compared to men of that same education level without handicaps. Such a disaggregation provides additional incite on the ability of economic recovery "to lift all boats."

By 1987 the average family income of men with a high school education or better who had handicaps had not only fully recovered from the recession of the early 1980s but the relative

economic well-being of this group was as high or higher than in the peak early years of the 1970s. This was achieved not only by a recovery in the wages of men with handicaps from their recession depths but also by a substantial increase in the wage earnings of other household members. Recovery was a powerful force in improving the economic well-being of these workers and their families.

But for the doubly handicapped, those with health limitations and a poor education, there has been no recovery. Poor education is certainly correlated with other poor employment characteristics and for such fringe workers neither their wage earnings nor their family's economic well-being have lifted with the tide of economic recovery. Workers with handicaps but with good job skills have significantly reduced the difference between their economic circumstances and that of their educational counterparts without handicaps. But this has resulted in a population with handicaps whose employment and economic circumstances are now quite diverse and in which the doubly handicapped have been left behind not only by those without handicaps, but by those with handicaps and good job skills.

Handicap Policy in the 1990s and Beyond

The decline in the disability transfer population which began in 1978 ended in the mid-1980s as Congress limited the power of the Social Security Administration to re-examine the eligibility of those already on the rolls. Since 1985, social security insurance and supplemental security income rolls have increased by 20 percent (see Table 2).

Disability rates are likely to increase for two reasons in the next decades. As we saw in Table 1, disability transfer incidence rates are sensitive to the age distribution and as the baby boom generation ages, health conditions will increase in this cohort. Hence, much of the financial

pressures the baby boom generation will put on the social security retirement program will be visited on the disability program at least one decade earlier.

A second concern will come as an offshoot of the revisions in the social security retirement benefit rules which will effectively reduce the earliest retirement benefit paid at age 62 from 80 percent to 70 percent of what is currently received at age 65. Because disability payments are unaffected by this change, it makes the value of being accepted onto the disability rolls greater relative to early retirement. Both these forces will renew concerns about disability program costs in the coming decades. And they will renew interest in how workers with handicaps can be kept on the job.

The Americans with Disabilities Act of 1990

Keeping workers with health impairments on the job is the major goal of the most recent handicap policy initiative. The Americans with Disabilities Act of 1990 (ADA) requires employers to make reasonable accommodations to workers with handicaps unless this would cause an undue hardship on the operation of business.

This policy thrust follows civil rights legislation of the 1960s in extending protection from employment discrimination to the handicapped. It will eventually extend the standards of discrimination set out in regulations implementing section 504 of the Rehabilitation Act of 1973 to all employers of 15 or more workers (Burkhauser, 1990; Weaver, 1991).

Who Are the Disabled?

Unfortunately, little is known about how successful accommodation is in keeping workers with health impairments on the job or on the ability of mandates alone to insure such accommodation. To estimate the success of this Act in accomplishing its goal of increasing the employment of people with handicaps, it is important to understand the characteristics of the population it is meant to help. Despite the now familiar wheelchair as the symbol of people with

handicaps and the high profile of people with sight- and hearing-impairments in the battle for the ADA, only a small fraction of the population with handicaps are blind, deaf, or wheelchair users.

As can be seen in Table 4, the great majority of those currently on the disability insurance roles suffer from one of four broad health conditions--mental disorders, circulatory diseases (predominately heart problems), musculoskeletal diseases (predominately arthritis), and neoplasms (cancer). And they did not have these handicaps for most of their work life. Approximately three out of five of those on the disability insurance rolls in December 1989 were between the ages of 50 and 64. In addition, over half of new beneficiaries in 1988 were that age. Almost one-half of all older beneficiaries suffers from a circulatory or musculoskeletal condition. A mental disorder is the most common condition for younger age disabled. Two of five beneficiaries under the age of 50 have a mental disorder.

The supplemental security income population is much younger. And like younger disability insurance beneficiaries, those with mental disorders dominate these rolls. Over 60 percent of adult SSI recipients are under the age of 50 and the overwhelming majority suffer from either mental retardation or some other mental disorder.

Hence, one can think of two general groups with handicaps served by disability transfers. The first are middle and older age workers with substantial experience in the work force who either suffer a discrete medical event (i.e., heart attack) or the cumulative effects of a chronic condition (i.e., arthritis). These health conditions lead to work limitation that eventually mean loss of their job and entry onto the disability rolls. The second are younger mentally retarded persons who may or may not have had much work experience and younger workers with mental condition. Such workers are much less likely to have work experience and more likely to end up on the supplemental security income rolls than older workers.

TABLE 4

CHARACTERISTICS OF UNITED STATES DISABILITY INSURANCE AND SUPPLEMENTAL SECURITY INCOME ADULT (AGE 18-64) RECIPIENTS, 1989

	All Beneficiaries[a]			**Newly Enrolled[b]**		
Diagnostic Groups	**Below 50**	**50-64**	**All**	**Below 50**	**50-64**	**All**
Disability Insurance						
Mental Disorders	40.0	17.7	27.7	34.6	9.9	20.9
Circulatory Diseases	6.3	25.4	18.2	8.5	25.0	17.6
Musculoskeletal Diseases	12.4	22.9	18.9	12.7	20.0	16.8
Neoplasms	2.6	3.6	3.3	9.2	16.4	13.2
All Others	38.7	30.4	31.9	35.0	28.7	31.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
Total (millions)	1.10	1.77	2.87	.18	.23	.41
Total (percent)	38.4	61.6	100.0	43.9	56.1	100.0
Supplemental Security Income						
Mental Disorders (other than retardation)	32.7	22.0	28.9			
Mental Retardation	33.5	8.4	24.4			
Circulatory Diseases	3.0	18.6	8.7			
Musculoskeletal Diseases	3.7	16.8	8.5			
Neoplasms	1.1	2.4	1.7			
All Others	26.0	31.8	27.8			
Total	100.0	100.0	100.0			
Total (millions)	1.26	.72	1.98			
Total (Percentage)	63.6	36.4	100.0			

[a]December 1989.

[b]1988.

SOURCE: Derived from tables in the U.S. Department of Health and Human Services (1991), Table 6.C.

The Timing of Policy Intervention

The prognosis for current recipients of disability transfer programs to return to work is not good. Despite some efforts to encourage those on the rolls to reenter the work force by extending the period of eligibility for medicare benefits, only a tiny percent of those who go into these programs ever return to the work force.

Bound (1989 and 1991) show that the prognosis is not all that much better for those who apply for disability benefits but are rejected. Using data from the 1978 Survey of the Disabled, he finds that under 30 percent of rejected applicants in the 1970s were employed in 1978 and only about two-fifths of them were working full time.

Such data suggest that once the transition process to disability has reached the point of either acceptance or rejection for a disability transfer program, a return to work is unlikely. But work orientated policies like the ADA may still prove effective in retarding this transition by intervening much earlier in the process.

The legal process to disability can be a long one. Both those who succeed and those who fail to enter the disability rolls have already travelled a long road. To be eligible for disability benefits a worker must not have performed any substantial gainful activity for at least five months and not be expected to do so for at least 11 months. But this is a minimum. The ultimate eligibility outcome can take several years to unfold as all possible appeals are exhausted. For workers with handicaps who "invest" in not working to improve their chances of program eligibility, a return to work may be quite unlikely even if ultimately they are rejected by the system. (See Parsons, 1991, for a fuller discussion.) But the decision workers with handicaps make to remain on the job after a health condition first begins to effect performance may bear little resemblance to the decision to work of those who have long since left the job they held when their work impairment first began. The hope ADA policy provides is that intervention at the point

that a health condition first starts to affect job performance will delay job exit and disability application.

Does Accommodation Matter?

The 1978 Survey of the Disabled is the most recent economics based national survey of the work experience of the health-impaired population. With these data Burkhauser et al. (1992c) combine the sub-sample of the general population and the sub-sample of persons who applied for disability benefits to test the effect of accommodation on a worker's duration with his firm following the onset of a health condition that begins to effect work. Table 5 summarized these results.

The data are for 1,430 men under the age of 60 at the survey date who were at least 20 years old and employed when their health condition began to limit work. The first row shows the percentage of workers with handicaps who were helped to stay on the job by their employer. The table shows employers accommodated workers long before the passage of the ADA. Over one worker in four was helped. Accommodation rates do not vary much across health conditions.

The next three columns show the marginal effect of accommodation on duration. The first row comes from a hazard model which uses the full sample and controls for differences at onset in economic variables such as: disability insurance replacement rates, education, job tenure, and experience in the work force; as well as in general demographic variables: age, marital status, and race. All these variables are significant at the 5 percent level or better.

The results provide some evidence that accommodation can be an important factor in prolonging the time a worker with handicaps stays on his job. On average, those who were not accommodated stayed a little over two years. Accommodated workers stayed an average of five

TABLE 5

INCIDENCE AND EFFECT OF ACCOMMODATION

Main Health Condition	Sample Size	Percent Accommodated	Expected Duration in Years		
			Accommodated	Not Accommodated	Difference
Total	1430	26	5.0	2.3	2.7*
Heart Attack	164	29	7.6	2.2	5.1**
Other Heart Problems	123	29	3.6	2.2	1.4***
Arthritis	97	29	5.0	2.5	2.5***
Back Problem	133	23	3.2	1.7	1.5***
Emphysema	71	28	4.1	2.8	1.3
Nervous Condition	53	26	3.1	1.9	1.2

*significant at the 1 percent level
**significant at the 5 percent level
***significant at the 10 percent level

SOURCE: Compilation of tables from Burkhauser et al. (1992c).

years. This difference which was significant at the 1 percent level shows that accommodation more than doubles expected duration with the firm.

Sample size constraints prevented an analysis of the influence of accommodation beyond the five largest health condition groups reported in the bottom rows in Table 5. But even across these conditions, the success of accommodation varies widely. Those who suffer heart attacks and receive accommodation have a marginal increase in duration of over five years, nearly twice the average increase. Those with other heart problems, arthritis or back problems, are helped much less by accommodation. Those with emphysema and nervous conditions are not significantly helped. Small sample sizes may account for the lack of significance of these last two groups.

The Power of Policy Intervention

These results suggests that accommodation can prolong work by people with handicaps. But the dimensions of this help must be put in perspective. The average age at onset of a health condition that limits work in the above sample was 38. Smith (1985) reports that the average expected work life of a male that age is approximately 22 years. Hence, while accommodation more than doubles work life with the firm, it is not a panacea. The average duration for accommodated workers with handicaps is still likely to be only about 25 percent of average work life.

In addition, these results are probably an upper bound of the power of accommodation for at least two reasons. It is unlikely that employers randomly choose who they accommodate. They are more likely to accommodate those whose chance of success per dollar spent on accommodation is highest. If successful, the ADA, which requires accommodation unless it places an undue burden on the firm, is likely to widen the scope of accommodation to handicapped workers with more serious conditions and lower expected success rates.

But second and potentially more important is whether the law will in fact significantly increase accommodation, especially to people with handicaps who have not been helped by economic recovery. The ADA's accommodation criteria are far from precise. It will take several years for the courts to decide the operational meaning of "reasonable" accommodation and "undue hardship." This is particularly true since most of the discussion of accommodation surrounding the passage of the ADA has been in physical terms. It is much more likely given the actual health conditions of the handicapped, especially those at older ages, that job flexibility will be a much more important accommodation.

Most recently Oi (1991) has suggested that workers with handicaps are more often constrained by their time and energy than by physical barriers with respect to job performance, since the time and energy they expend in day-to-day maintenance is greater than that of those without handicaps. Future court decisions on the reasonableness of accommodation through more flexible hours or even permanent part-time work are likely to be much more important in shaping the future workplace than decisions on the reasonableness of physical changes.

As we saw in Table 3, economic recovery has lifted the families of well-educated men with handicaps to levels of well-being near their able-bodied counterparts. Recovery has also meant an upsurge in their wage earnings. It is the doubly handicapped with a health condition and poor job skills that recovery has missed. This is the group most in need of government support either through transfers or jobs. Yet it is doubtful that this poor and poorly educated group will be able to use the sophisticated legal weapons provided by the ADA to secure accommodation. The ADA is much more likely to be used by highly skilled workers with handicaps to negotiate with their employers.

Toward a Policy for Keeping People with Handicaps Employed

A return to cross-national comparisons suggests that the goal of full employment for people with handicaps will be at least as difficult to meet as the older and still unattained goal of general full employment. The reform of the Dutch disability system includes accommodation provisions that go well beyond those in the United States. Since 1987 employers who provide accommodation and training to workers with handicaps receive direct government reimbursement. To date few employers have taken advantage of these terms. See de Jong et al. (1990) for a discussion of these reforms.

In Germany employers are reimbursed for training given to workers with handicaps and a quota requires the employment of such workers. But non-compliance results in a small fine. During the 1980s when unemployment rates were at a post-war high, quotas were less likely to be filled than during the better economic conditions of the 1970s and were much less likely to be filled in the private sector than in the government sector. Workers with handicaps who left their employer found it difficult to find another job. For instance, Frick (1990) reports that 90 percent of those included in the official count of workers with handicaps for purposes of the quota were already employed by their employer before being so designated.

Only in Sweden were the employment levels of those with handicaps maintained during the recession of the early 1980s. But this was almost exclusively because of government supplied employment. And these jobs were primarily targeted on those under 60 years of age.

A glance at Table 6 shows that the United States has been more successful in keeping older working age men in the labor force than either Germany or the Netherlands. In 1970 in all three countries about four out of five men aged 55 to 64 were in the labor force. While the labor force participation rates for men this age have fallen in all three countries over the past two decades, they fell least in the United States. Today the United States rates are 18 percent

TABLE 6

LABOR FORCE PARTICIPATION RATES IN FOUR OECD COUNTRIES FOR MALES, AGED 55-64 (in percents)

	1970	1975	1980	Percent Change 1970s	1985	1989	Percent Change 1980s
United States	81	75	71	-12	67	67	-6
Germany	80	68	66	-18	57	57	-14
Netherlands	81	72	63	-22	47	47	-25
Sweden	85	82	79	-7	76	75	-5

SOURCE: International Labour Organization (1970-1990).

greater than Germany and 43 percent greater than the Netherlands. Only Sweden has had consistently higher labor force participation rates than the United States. But since 1980, the declines in these rates in both countries have been modest and almost identical. Note, however, that economic recovery in the second half of the 1980s appears to have stopped the decline in the labor force participation rates of older working age men in all four countries.

This table suggests that while it is possible to keep people with handicaps employed with government regulations and direct job creation, even in these European countries it was done within limits and constrained by overall economic conditions. The economic cycle of recession and recovery remains a powerful force in the labor force participation of people with handicaps and older working age men of all countries.

Unlike the 1970s, United States policy in the 1980s was quite different from that of these European countries. Emphasis was put on developing a strong economy even at the expense of government commitment to people with handicaps through transfers and job creation. This policy was successful but only to a degree and has not helped the doubly handicapped.

The longest recovery of the post-war period has come to an end. If the 1990s are a period of stagnation, then it is likely that people with handicaps will be hurt relatively more than other workers, just as they were in the early 1980s. On the other hand, prolonged recovery from the recession of 1990-1992 is likely to mean that for most people with handicaps, economic integration will continue to occur. But for the doubly handicapped, no current policies are likely to bring economic integration.

The current mood in Washington has prevented the discussion of new handicap policies unless they were costless to the government. This constraint is in large part responsible for the passage of the ADA. But if the doubly handicapped are to be helped, it will only come through targeted government expenditures.

It is unlikely that explicit quotas of the sort used in Germany will ever be a policy option in the United States. It is also unlikely that major job creation programs like those in Sweden will be used, given the lack of support for CETA. But even in the tight budget world of Washington programs targeted on the doubly handicapped should be considered.

A Menu of Policies for the Doubly Handicapped

If economic growth alone will fail to sustain the well-being of the doubly handicapped, if fiscal constraints limit income support measures, and if employment quotas and mandates such as those embodied in the recently passed ADA are likely to be ineffective, what remains? The answers lie in some new and more effective mix of direct transfers, job training, employment subsidies, and deregulation that will begin returning the doubly handicapped to the economic mainstream. It is to the design of such a strategy that public policy should now turn.

Below is a sketch of programs that could begin to integrate the doubly handicapped into American society.

Extending the Earned Income Tax Credit. The least obtrusive means of helping the doubly handicapped is by extending the earned income tax credit now available to workers in poor families with children to workers with handicaps who live in poor families. This would effectively subsidize the kind of low skills work that is within the abilities of many of the doubly handicapped, particularly the young mentally retarded. But this credit could also give poor, older workers with handicaps who could perform part-time work additional income prior to retirement age.

Accommodation Tax Credits. Employers in the European countries discussed above are reimbursed for accommodating workers with handicaps. This recognizes that the economic burden of accommodation need not fall on employers. Rather if employing workers with handicaps is a social goal, society as a whole should finance its achievement.

Jobs Training for People with Handicaps. The Job Partnership Training Act of 1983 replaced CETA as the mechanism for putting the socially or medically handicapped into jobs. While the percentage of successfully placed trainees has been quite high in this program, it has been argued that the most difficult to place have been systematically excluded.

Anderson et al. (1992) provides some evidence of creaming in this program and shows that people with handicaps are underrepresented in the trainee population. Changes in the reward structure for the councils that choose participants could lead to increased use of this program by people with handicaps. Increased funding for vocational rehabilitation targeted on the doubly handicapped would serve the same purpose.

Regulatory Changes. More flexible work schedules may be the single greatest change that accommodation brings to the work place. If so, it will go a long way toward positively restructuring the labor force for workers who are older or have handicaps and desire part-time work. More generally, Gustman and Steinmeyer (1983) argue that constraints on part-time work are a major cause for retirement from full-time jobs. Quinn et al. (1990) provides a detailed discussion of changes in pension and social security rules that would encourage part-time work by older workers.

Changing current Fair Labor Standard Act rules to allowed worker with handicaps who worked part time to receive an equivalent portion of the fringe benefit package would allow for more flexible work contracts and a greater willingness on the part of employers to accommodate workers in this way.

In addition, workers with handicaps are likely to have greater expected health care costs than workers without handicaps. Government subsidization of the added insurance costs of such workers would remove this barrier to employment. For workers with handicaps who are eligible

for Medicare, the ending of the requirement that their employer's insurance pick up the first dollar of health care expenditures would also encourage their employment.

These short sketches of policies targeted on the doubly handicapped are a sample of the kinds of changes in government policy that would increase the likelihood of employment for this group and increase their economic well-being. None of these handicap policies were considered as alternatives to the ADA because they directly affected the government budget.

Policies of the last decade have been successful in both limiting the growth of the disabled population and in restoring the relative economic well-being of people with handicaps from recession year lows. But even if economic growth dominates the new decade, its rewards are unlikely to be shared by the doubly handicapped. Nor is it likely that the accommodation mandated by the ADA will increase their chances of employment. If we are to do something about the doubly handicapped, it is now time to consider the most efficient method of reaching those whom economic growth has left behind.

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