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FOREWORD

Variations in the size of the population receiving disability payments across countries cannot be explained by simple differences in health. Rather, the process to disability is shaped by both social and medical factors. When governments ignore this reality, a policy generated disability epidemic is possible. This paper compares disability policies in The Netherlands, Sweden, Germany, and the United States. It argues that the extraordinary increase in Dutch disability rolls in the 1970s was caused by a general government policy to reduce official unemployment. And that by the end of the 1980s, this policy had left Holland with a hidden unemployment rate that was twice its official rate and three times the unemployment rates in the United States and Germany.

Parts of this paper were written while Burkhauser was a Fellow at the Netherlands Institute for Advanced Study in the Humanities and Social Sciences in Wassenaar, The Netherlands, and while he was a visiting scholar at the Deutsche Institut für Wirtschaftsforschung in Berlin, Germany. It could not have been completed without the assistance of Petri Hirvonen in providing information on the German disability system and Eskil Wadenski in providing information on the Swedish disability system. However, the opinions expressed here are those of the authors.

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A CAUTIONARY TALE OF EUROPEAN DISABILITY POLICIES: LESSONS FOR THE UNITED STATES

An epidemic of dangerous proportion gripped Western industrialized countries in the 1970s. While its symptoms were the same across countries, the curatives used were substantially different, especially in the United States and have had very mixed results over the last decade.

The epidemic is labelled disability. Here we unfold a cautionary tale on the limits of good intentions by contrasting the rise and fall of disability populations in the Netherlands, the United States, Sweden, and Germany over the past two decades.

A Cross-National Comparison of Disability Incidence

As recently as 1970 the ratio of disability transfer recipients to workers in the Netherlands was similar to that in Sweden and Germany. In all three countries there were only about 50 people of working age--15 to 64--receiving payments from the government to offset lost wages due to a health condition for every 1,000 workers in that age group. This modest rate was, nevertheless, about twice that in the United States (see Table 1).

Over the next decade the incidence of disability grew significantly in each of these countries but exploded in the Netherlands. Where once only 14 younger persons (aged 15 to 44) received disability transfers in the Netherlands for every 1,000 young workers, there were 49 in 1980, an increase of 50 percent.

Of course, as we grow older we are more likely to suffer ill-health, so the ratio of disability transfer recipients to workers increases with age. In the Netherlands in 1970 over 100 middle-aged persons (aged 45 to 59) were receiving disability benefits for every 1,000 middle-aged workers and the ratio for older working age persons (aged 60 to 64) was about 300 per 1,000.

TABLE 1

DISABILITY TRANSFER RECIPIENTS PER THOUSAND ACTIVE LABOR FORCE PARTICIPANTS, 1970-1989

	1970	1975	1980	Percent Change 1970s	1985	1989[a]	Percent Change 1980s
Population:							
Aged 15-64							
Netherlands	49	77	126	157	130	139	10
United States	27	42	41	52	51	43	5
Sweden	49	67	68	39	74	78	15
Germany	51	54	59	16	72	55	-7
Aged 15-44							
Netherlands	14	28	49	250	50	53	8
United States	11	17	16	45	20	23	44
Sweden	18	20	19	6	20	21	11
Germany	7	6	7	0	8	5	-29
Aged 45-59							
Netherlands	102	164	269	164	279	317	18
United States	33	68	83	152	71	72	-13
Sweden	66	95	99	50	108	116	17
Germany	75	64	84	12	103	75	-11
Aged 60-64							
Netherlands	274	410	989	261	1,249	1,932	95
United States	154	265	285	85	254	250	-12
Sweden	229	382	382	67	512	577	51
Germany	419	688	1348	222	1,291	1,109	-18

[a]The numbers for the Netherlands refer to 1990.

SOURCE: Updates from compiled tables in Haveman, Halberstadt, and Burkhauser (1984).

But, by 1980 the ratio for the middle-aged population was nearly as high as that of the older population at the start of the decade--almost 269 per 1,000. And by 1980 in the older working population there were almost as many persons receiving disability transfers as there were working!

This explosive growth in Dutch disability incidence slowed substantially in the 1980s. But was still at a record high of 139 per 1,000 workers in 1989, and among older workers, disability transfer recipients outnumbered workers almost two to one.

What plague so debilitated the Dutch work force in the 1970s? What slowed its pace in the 1980s? And, was this a world wide phenomena or endemic to the Netherlands? Table 1 begins to answer these questions. Sweden, Germany, and even the United States experienced substantial increases in their disability transfer populations in the 1970s. But in the United States after a rise in the first part of the decade, disability transfer rates steadied at around 40 per 1,000, well below the European rates at the start of the decade. Growth in Germany has been even more modest. After rising to a high of 72 per 1,000 in 1985, it is back to 1970s levels. Sweden's rates have risen modestly over the past two decades but are still around one-half those of the Netherlands. Importantly in both Germany and Sweden, there has been almost no growth in the disability transfer rates of younger workers. The virulent strain of disability appears endemic to the Netherlands.

Table 1 suggests that the Netherlands and to a lesser extent the other countries experienced a health related phenomena that affected the work of an alarming number of their citizens. But we will suggest that the root cause of the increased incidence of disability over the past two decades had more to do with the policy medicine these countries provided their health-impaired workers than to any change in the underlying health of their citizens. Hence, the cure lay more in the realm of social policy than medical policy.

Disability Labelling

To be labelled disabled, one must have some health condition that limits the ability to work. But disability also has a social context. Work limitations can be offset either by job changes or changes in some of the activities of the job one held at the time of onset of the work limitation. Burkhauser and Kim (1991), for instance, shows that accommodation of this sort by private employers in the United States significantly lengthened the time until their work impaired employees left the firm.

Alternatively, rehabilitation therapy together with government sponsored transition jobs can help overcome work limitations. But social policy can also discourage work and accelerate the disability process. By cushioning the blow of poor health, transfer benefits may also provide a comfortable alternative to work. But this kind of policy medicine has a potentially dangerous side effect. It can encourage the worker to lose the determination to overcome a health impairment and continue working. And like all medicine, an overdose acts like a poison.

To understand the process to disability one must know not only the medical but the social context in which this process unfolds. In general, workers with disabilities were able-bodied for most of their work life. Thus for most such workers, the transition from able-bodied to disabled begins with a health impairment which restricts to some degree their ability to work on a job they hold. At this point, the movement to disability is significantly affected by the options such workers have. The greater the share of wage earnings the disability system replaces and the higher the probability that the worker will meet the criteria for these benefits, the faster this transition will take place.

Employer behavior also effects this decision. Health impairments can effect productivity on the job, and unless accommodations are made, this can result in pressure on the worker to leave. In addition, general economic conditions can lead employers and union officials to

encourage health-impaired workers to leave when layoffs are necessary. This is particularly the case when such workers are near retirement age. Government policy also plays an important role in this decision that goes beyond the level and ease of accessibility to benefits. Health-impaired workers are also more likely to apply for disability benefits rather than unemployment or retirement benefits when they are more generous or longer lasting than these alternative methods of protecting workers. And as we will see in the case of the Netherlands, general labor market policy and the willingness of government to maintain a high wage policy at the expense of high employment may ultimately have more to do with determining the employment of health-impaired workers than specific disability rules.

When the social aspects of the process to disability are ignored by policymakers, a policy inspired disability epidemic is possible. Public policy in the Netherlands in the 1970s allowed everyone to be comfortable in the face of illness and hence to ignore its consequences.

It was comfortable for the worker who received the benefit, comfortable for the employer who no longer had to take responsibility for accommodating the worker, comfortable for the worker's union who saw this as a way of not only protecting a fellow worker but also perhaps opening a new position for an unemployed union member, and even comfortable for the government if it meant the official unemployment rate was lower. Eventually the enormous social burden of this policy was recognized but has not been easily corrected.

The Evolution of Disability Transfer Programs

The substantial movement in the incidence of disability transfer populations over time and across countries can not be explained by shifts in or differences across countries in underlying health conditions. To understand these movements it is necessary to understand the disability policies that caused them. Table 2 contrasts the growth in the major disability transfer programs of the Netherlands, the United States, Sweden, and Germany over the past two decades.

TABLE 2

DISABILITY TRANSFER GROWTH, 1970-1989 (THOUSANDS)

	1970	1975	1980	Percent Change 1970s	1985	1989	Percent Change 1980s
The Netherlands							
All disability pensions	186	322	565		632	706	
Partial disability pensions	44	57	108		130	177	
Total	230	379	673	193	762	883	31
United States							
Disability insurance	1,394	2,489	2,859		2,656	2,999	
Supplemental security income	870	1,723	1,777		1,942	2,210	
Total	2,264	4,212	4,635	105	4,598	5,209	12
Sweden							
Total	188	289	293	56	323	361	23
Germany							
Full disability pensions	812	980	1,237		1,563	1,256	
Partial disability pensions	387	255	182		142	114	
Early retirement for handicapped		17	76		258	255	
Total	1,199	1,252	1,495	25	1,963	1,625	9

SOURCE: See Table 1.

The Netherlands

The first level of protection against income loss in the Dutch system is the sickness benefit. This payment replaces 70 percent of wages for up to one year, but most employees (90 percent) and all civil servants have the rest of net of tax earnings replaced by collective bargaining agreements with their employers. Those who are still receiving these benefits after one year are evaluated to estimate their residual earnings capacity. If they have a chronic condition that causes a reduction in their capacity to perform work commensurate with their job training and work history, they are eligible for disability benefits. Those who are judged partially disabled are eligible for partial benefits, the minimum degree of impairment for eligibility is 15 percent. In the 1970s replacement rates ranged from 9 percent of before-tax earnings to 80 percent for the fully disabled.

The social nature of disability labelling is evident when eligibility criteria are implemented. To determine the level of the disability benefit it is necessary to determine which jobs are commensurate with the workers current health-impaired job skills. But theoretical disability will diverge from actual earnings if the partially disabled person does not become employed in such a job. In this case, it is difficult to disentangle lack of employment due to the health condition from that due to general market conditions, from discrimination or from an unwillingness to work.

A legal measure called the "labor market consideration" had a profound effect on this determination. It was ruled that unless proven to the contrary it would be assumed that lack of employment by a partially disabled worker was the result of discriminatory behavior. As a result, the ensuing administrative practice was that unemployed partially disabled persons were treated as if they were fully disabled. This interpretation of the law made assessment of theoretical earnings

capacity unnecessary since a minimum impairment of 15 percent was sufficient to entitle a person to a full benefit.

The relative generosity of the system increased for another reason in the 1970s. While the 80 percent cap on before-tax wage earnings remained in place over this period, the after tax replacement rate rose because disability recipients did not pay social security taxes on their benefits. These taxes were raised substantially in the 1970s so that while the average real after tax wages of workers rose by only 7 percent, it grew by 16 percent for the average beneficiary over the decade. As can be seen in Table 2, these increases in eligibility and in generosity of the system had a profound effect on the size of the disability transfer population. It nearly tripled over the decade.

The serious recession of the early 1980s and the growing costs of the disability system put enormous pressure on the government to reduce the growth of disability transfers. By 1985 a series of cuts in the before-tax replacement rate had effectively lowered it from 80 to 70 percent of earnings for both new entrants and for current beneficiaries. The cumulative effects of these cuts was a reduction of almost 25 percent in net real income of disabled workers over the first five years of the decade relative to a drop of 10 percent for able-bodied workers. For the median worker, after tax replacement rates dropped from 87 percent at the end of the 1970s to 70 percent at the end of the 1980s.

But this did not totally halt system growth, and after sustained public debate, the Dutch parliament passed additional disability amendments which became effective in 1987. The most important was the abolition of the labor market consideration rule. But as can be seen in Table 2 while the share of partial to full disability pensions has increased slightly in the last five years, 80 percent of disability beneficiaries were still receiving full benefits in 1989.

Despite the legal ban on including labor market considerations in their disability assessments, disability adjudicators still seem to either grant or deny full benefits. Denial rates have remained quite low since 1987. Between 1980 and 1986 denial rates among those who completed their one-year stay on sickness benefit averaged about 5 percent. In 1987 denial rates averaged 8 percent and in 1988 they were 7 percent. So it is likely that this de jure change has not stopped the de facto use of labor market considerations in the adjudication process.

Aarts and de Jong (1990) provides empirical evidence that the Dutch disability system's mix of generous transfer payments and broad eligibility criteria are directly responsible for the rise in disability labelling in the Netherlands. Aarts and de Jong (1991) using a simulation model predicts that, unless current policies are changed, the greying of the post World War II baby boom in the Netherlands will produce an increase of over 80 percent in disability rolls over the next two decades and an increase of from 139 to about 218 disability transfer recipients per 1,000 workers.

The United States

The United States disability policy has substantially more limited goals than Dutch policy. Many workers have sickness benefits as part of their employer's fringe benefit package but some do not. No short-term social sickness insurance programs exist in the United States. Workers whose health impairment is expected to be long lasting, however, are eligible for disability benefits. But in contrast to the Netherlands, eligibility is limited to the fully impaired. That is, to workers who are expected to be unable to perform any substantial gainful activities for at least eleven months. In principle, the definition of activities includes all types of work not merely work related to past training or job experience and whether such work is available. But even in the United States, labor market criteria enter into the disability process.

Despite this strict eligibility criteria, the 1970s were a time of substantial increases in the disability population. One reason for this increase was an increase in the generosity of the system. Congress changed the disability insurance benefit calculation so that the net replacement rate for a disabled worker with median earnings increased from 35 percent at the start of the 1970s to 49 percent at the end with the great majority of that increase occurring in the early 1970s (Haveman, Halberstadt, and Burkhauser, 1984). In addition, in 1974 the federally run supplemental security income program replaced the aid to the aged, blind, and disabled programs run by the states. This program provides a federal minimum income for the disabled regardless of past work history.

But another and more important reason for the increase was that the strict health criteria used to determine eligibility for both programs was liberalized in the early 1970s by increasing the use of an individual's vocational characteristics--age, education, and type of job skills--in such determinations. As was the case in the Netherlands, this allowed market conditions to enter into the disability determination. Hence, fringe workers, those who were older, less educated, or who only had a history of physical labor, and who were less likely to be employed as their health worsened, became more likely to be ruled eligible.

As can be seen in Table 2, growth in these transfer programs slowed in the second half of the decade. The disability program population peaked in 1978 and actually fell over the next five years thanks to the substantial tightening of eligibility standards--especially the reduced use of vocational characteristics--under the Carter Administration and major reevaluations of already eligible recipients in the early years of the Reagan Administration. Thus despite the most serious economic downturn since the 1930s and the pressure this put on the disability system, disability rolls were 10 percent lower in 1983 than in 1980. The widespread reevaluation of those already on the disability rolls ended in 1983 as first the courts and then Congress restricted the power of the Social Security Administration to reevaluate beneficiaries (Weaver, 1986).

Since 1983 the eligible population has increased modestly. Growth in the supplementary security income population followed the same path as disability insurance over the period falling slightly in the first three years of the Reagan Administration but increasing more rapidly over the rest of the decade. Overall growth in the two programs in the 1980s has been a small fraction of the previous decade's growth.

Sweden

Sweden differs dramatically from the Netherlands and the United States in its commitment to keeping work impaired persons in the labor market. So while the first level of protection against income loss in Sweden is the sickness benefit, it is relatively temporary. Workers receive 90 percent of their wage income lost because of sickness. After 90 days the local insurance office investigates to see if rehabilitation is necessary. Only those unable to respond to rehabilitation and work in a private sector or, if necessary, a government provided job are placed on the disability transfers rolls. For those workers who cannot be rehabilitated, eligibility is determined on medical grounds but labor market conditions are also considered.

Replacement rates in Sweden are as generous as in the Netherlands. Benefits for the median worker were about 75 percent of net wage earnings in the 1970s and increased to almost 90 percent in the 1980s. However, disability incidence is substantially smaller than in the Netherlands and the growth in the transfer rolls much lower.

The major reason for this growth in the rolls over the past two decades has been a change in the work requirement for impaired older workers. Starting in the 1970s, workers over the age of sixty could become eligible for benefits owing solely to labor market conditions. For example, long-term unemployed older workers not yet eligible for social security retirement benefits became automatically eligible for disability benefits once their unemployment benefits ran out.

Thus, while Swedish disability rolls have risen 23 percent in the last decade, the great majority of that growth has been among older workers.

Germany

German employers are required by government mandate to provide up to six weeks of fully paid sickness benefits to their workers each year. For workers requiring a longer period, national health insurance replaces 80 percent of their last regular wage income. Eligibility for disability pension benefits is determined on medical grounds but labor market conditions are also taken into consideration.

Workers who are unable to earn a regular income due to reductions in physical or mental capacity are eligible for a full benefit. Workers whose impairment reduces their earnings capacity by one-half when compared with other workers with similar training and experience are eligible for a partial benefit. For those who do not respond to medical or vocational rehabilitation, permanent disability benefits are provided. The net replacement for a full disability pensioner who earned the median wage over his lifetime was about 60 percent in the 1970s and about 64 percent in the 1980s. A partial benefit is exactly two-thirds that of a full benefits.

As can be seen in Table 2, Germany experienced the smallest increase--25 percent--in its transfer population in the 1970s and a 9 percent increase in the 1980s. A major change has taken place in the mix of benefits provided, however. Almost all beneficiaries now receive full disability pensions. This was due to a change in the system, initiated in 1969 and extended in 1975, which provided a full disability pension to unemployed partially disabled workers.

Thus in Germany as well as in the other countries discussed, there has been a blurring of health and unemployment aspects of disability policy. This is especially true for health-impaired older workers. While the earliest retirement age for able-bodied male workers in Germany is

sixty-three, unemployed health-impaired older workers can begin to receive disability related retirement benefits at age sixty. This effective reduction in the retirement age has substantially increased the incidence of disability transfers in the older population over the past two decades.

For younger health-impaired workers, this is less the case. They are offered substantial rehabilitation services and the government attempts to maintain them in the labor force with a quota system. All firms employing 16 or more workers must employ one health-impaired worker for each 16 workers employed.

The Dutch Disease of the 1970s

This brief description of disability policy makes clear that Dutch policy during the 1970s was substantially out of step with its European neighbors as well as with the United States. This explains why its disability rolls rose so much faster than those of the other countries.

Dutch social policy was out of step with Sweden not because it offered more generous benefits but because it failed to emphasize rehabilitation and maintenance of the worker in the labor market. In Sweden, except for older workers, transfers are used only as a last resort after rehabilitation and work in a government sponsored transition job fails. A major reason for Sweden's low transfer rate, despite very high benefits, is that strong social pressure is put on those with job impairments to stick with rehabilitation programs and work rather than accept transfers. And government jobs are provided, at least for younger health-impaired workers, who can not find work in the private sector.

Dutch social policy was out of step with Germany in part because it offers somewhat higher benefits and has less restricted eligibility rules (i.e., both countries provided full benefits for partially health-impaired unemployed workers, but the minimum impairment rate in Germany was 50 percent rather than the 15 percent in the Netherlands), but also because Germany has an active

policy to keep health-impaired workers on the job which includes subsidies to accommodate these workers and a quota system to encourage employers to maintain them in the workplace.

Ironically, Dutch and United States disability policies were the most similar in the 1970s, and not surprisingly, they experienced the greatest growth in their disability transfer populations. The United States started the decade with a substantially lower disability incidence than these three European countries. But as a result of substantial increases in benefits and in the use of vocational characteristics to determine eligibility, its transfer population doubled by the end of the decade and its incidence rate neared these European countries at the start of the decade.

Dutch and American Policy Outcomes in the 1980s

Given these differing policy experiences in the 1970s, it is not surprising that it was in the Netherlands and in the United States that cries for reform of the disability system were most loudly heard in the 1980s. Both governments significantly reduced the growth in their systems during very difficult economic times and, to some degree, at the expense of their disabled populations. The timing of this change in policy is particularly noteworthy because in the 1970s the disability systems of all four countries had been under increasing pressure to consider employment conditions as well as health conditions as criteria for disability eligibility. Thus in the absence of policy changes, one would have expected disability rolls to increase during bad economic times. Yet it was during the deepest world recession since the 1930s that disability rolls were actually cut in the United States and the rate of increase substantially reduced in the Netherlands.

The dramatic shift in disability policy started by the Carter Administration and vigorously pursued by the Reagan Administration was extremely controversial. Purging the disability rolls of those who are capable of doing some gainful activities may comply with the letter of the law but still may put an enormous burden on the families of health-impaired workers, who also may have

poor job skills that put them on the outer fringes of the labor market even in good times. Because such workers are likely to be the hardest hit by recession, it was argued that this policy forced the least able in society to bear the greatest burden of the recession.

A counter argument to this point of view was that in the long run the best government palliative to the health-impaired population was not more access to transfers that discourage work but a strong economy that would provide work for all who wanted it.

The recession of 1983 was followed by seven years of economic growth, and Table 3 provides some evidence on this issue. It looks at the wage earnings of health-impaired men as a percentage of the wage earnings of able-bodied men in the 1970s and 1980s. And it looks at the relative family income for such men over this period. These ratios are also provided within educational classes. The results provide mixed evidence for those who believe that this tough-minded, short-run policy was better in the long-run.

On average, the relative wage earnings of health-impaired men fell in the 1970s, but relative family income rose as transfer benefits became more generous and widespread in the first part of the 1970s. The drop in both benefits and wage earnings in the last part of that decade and in the recession years of the next attests to the increasing relative hardship of this population. By 1987, four years into the economic recovery, the relative wage earnings of health-impaired men had not risen from their recession period low. But the relative family income of these health-impaired men had. In fact, recovery brought faster and greater increases to the families

TABLE 3

FAMILY ECONOMIC WELL-BEING OF HEALTH-IMPAIRED MEN IN THE UNITED STATES RELATIVE TO ABLE-BODIED MEN ACROSS EDUCATION LEVELS, 1967-1987

	1967	1972	1975	1979	1981	1983	1987
Wage Earnings of Health-Impaired Men as a Percentage of Able-Bodied							
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
Family Income[a] of Health-Impaired Men as a Percentage of Able-Bodied							
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

[a]Family income is adjusted for household size by using the official poverty line equivalency scale values.

SOURCE: Compiled from table in Burkhauser et al. (1992).

of health-impaired men than to able-bodied families. In large part, this was a result of increasing wage earnings but not so much that of the health-impaired men as that of their family members.

By 1987 the family income of high school and college-educated, health-impaired workers was at a two decade high relative to their able-bodied counterparts both because their wage earnings had fully recovered from the recession and because of the added earnings of other family members. But this long-run success story was not universal. For the doubly handicapped, men with very poor education (and by proxy those most likely to have poor work skills) as well as a health impairment, there has been no recovery from the recession either in wage earnings or in family income.

Painting the Roses Red

Each society must evaluate the burden that it will permit its citizens to bear when they suffer a health impairment or the loss of a job. And must weigh this against the burden such protection places on able-bodied workers in that society. Cross-national comparisons permits one to look at the outcomes of alternative national policies. This is often as close to a "counter-factual" with respect to what actually happened as policymakers are likely to see. Hence as policymakers in the United States are asked to develop policies for the 1990s in the light of policy outcomes in the 1980s, it is useful to look at how the Netherlands "cured" its disability problem.

Disability transfers are sensitive to the business cycle--down in good times, up in bad times. When jobs are hard to find, using the disability rolls to protect the unemployed is a comfortable way of easing the bad effects of economic downturns. But a policy of labelling the unemployed as disabled is much like the policy of the cards in *Alice in Wonderland* who painted the roses red.

Painting the roses red does little to correct the underlying problem of the rose bush. Labelling unemployed people as disabled does little to correct the underlying problems in the economy and may retard the return of such workers to the work force during recovery.

In the 1970s the Netherlands vigorously pursued a policy of labelling the unemployed as disabled. Table 4 shows that the official unemployment rates in the United States were substantially higher than those in the Netherlands during this period. But if one considers that part of the Dutch unemployed population was hidden in the disability rolls, then "true" unemployment during this period changes substantially.

If one assumes that the true underlying disability rate in the Netherlands was in fact the same as that in the United States during the 1970s--see Table 1--and that all the disabled on the rolls above this baseline were actually hidden unemployed, then the Dutch unemployment rate increases from 1 percent to 3.1 percent in 1970 and from 6 to 13.4 percent in 1980. And when these "truer" measures of unemployment are compared with the United States, the much more serious nature of unemployment in the Netherlands is clearly seen.

Both the United States and the Netherlands drastically changed their disability policies in the 1980s. As we have seen, in the United States this lead to serious short-run problems for the health-impaired population as a whole and long-term problems for the doubly handicapped. But after 1983, the United States also experienced seven years of economic growth and a drop in unemployment to rates near those at the start of the 1970s. And these low rates were not achieved by hiding the unemployed on the disability rolls. In 1989 disability rolls were only slightly higher than at their peak in the late 1970s.

While we have seen that the Dutch began to end their policy of painting the roses red in the 1980s, at considerable cost to the disabled population, they did not end their unemployment problem. Many of the unemployed that would have come onto the rolls during the Dutch

TABLE 4

OFFICIAL AND HIDDEN UNEMPLOYMENT RATES IN THE NETHERLANDS, 1970-1989

	1970	1975	1980	1983	1985	1989
Official Unemployment Rates						
United States	4.8	8.3	7.0	9.5	7.1	5.2
Germany	0.6	3.6	2.9	8.0	7.2	5.6
Netherlands	1.0	5.2	6.0	12.0	10.6	8.3
Dutch Hidden Unemployment Rates						
United States Based[a]	3.1	8.4	13.4	19.0	17.9	16.3
German Based[b]	1.0	7.3	11.9	17.0	15.5	15.4

[a]Adds those on disability rolls above the United States disability prevalence rate to the official unemployed.
[b]Adds those on disability rolls above the German prevalence rate to official unemployed.

SOURCE: Previous tables plus International Labor Organization (1990).

economic recession of the early 1980s did not do so. But they did go onto the unemployment rolls. In 1980 the official Dutch unemployment rate was close to that of the United States. But at the depth of the recession, it had increased to 12 percent--more than 25 percent higher than in the United States. While recovery has also occurred in the Netherlands and official unemployment rates are now lower, they still remain a relatively high 8.3 percent and they are 60 percent higher than in the United States. But if we continue our comparison of hidden unemployment into the 1980s, we see that the story gets considerably worse. In 1989 when hidden unemployment within the disability population is included, the Dutch unemployment rate increases from 8.3 to 16.3 percent, more than three times that of the United States.

Because United States disability rules are considerably tighter and less generous than the Dutch and have excluded all but the most severely health-impaired, using this restrictive definition of disability forces a very high share of the Dutch disabled population into the hidden unemployed. An alternative definition is also considered in Table 4. Assume that the true disability incidence rate in the Netherlands is the same as that in Germany where the partially health-impaired are also granted full benefits if they are unemployed. In this case, the hidden unemployment rate is slightly lower but still shows the tremendous post-recession gap between the United States and the Netherlands. True unemployment in the Netherlands is 15.4 percent in 1989, nearly three times that of both the United States and Germany. What Table 4 suggests is that while changes in Dutch disability policy lessened the dangers of a runaway disability program, the underlying unemployment problem was not corrected.

The Dutch Economic Burden

Dutch social welfare policy guarantees a very high social safety net for all its citizens. The Dutch minimum wage is extremely high relative to that of the United States. In United States' dollars (two Guilder to the dollar) it costs an employer $16,000 per year to hire a full-time (38 hours per week) minimum wage worker. Family welfare payments which are by law universal, are equal to 100 percent of the net of taxes minimum wage. Unemployment benefits are approximately equal to disability payment.

Some consequences of these general labor market policies can be seen in Table 5. Since 1980 the number of employed persons in the Netherlands has increased by 19 percent. But the great majority of this increase is due to the movement into the labor force of women doing part-time work. When employment is adjusted to full-time work years, the decade long gain is only 4 percent. In contrast, the three major transfer programs that provide benefits to people of working age (aged 15-64) all grew enormously in the 1970s and have continued to grow at substantial rates in the 1980s.

In Table 1 we showed the disability prevalence rate per 1,000 workers. In Table 5 we expand this to include the prevalence of all working age transfer receipts per 1,000 full-time workers. Just 20 years ago in The Netherlands there were only 69 working age transfer recipients for every 1,000 full-time workers. Fueled mainly by a runaway disability program and a stagnant work force, that ratio nearly tripled in the 1970s. The disability program was modified in the 1980s, but long-term unemployment due to the recession of the early 1980s resulted in a record high prevalence rate of 333 in 1985. Lackluster employment growth since then means that the Dutch begin the 1990s with three people of working age receiving transfers for every ten full-time workers.

TABLE 5

WORK EFFORT AND SOCIAL WELFARE TRANSFERS IN THE NETHERLANDS, 1970-1990 (THOUSANDS)

	1970	1975	1980	Percent Change 1970s	1983	1985	1990	Percent Change 1980s
Employed Persons	5,204[a]	5,161	5,500	6		8,650	6,550	19
Employed Work Years	4,709	4,670	4,807	2	4,531	4,589	4,980	4
Transfers								
Disability	196	312	605	209	660	695	766	27
Unemployment	58	197	235	305	615	650	526	124
Social Assistance	70	117	117	67	155	183	182	56
Total	324	626	957	195	1430	1528	1474	54
Transfer Recipients (per thousand work years)	69	134	199	188	316	333	296	49

[a]estimate

SOURCE: Compiled from tables in de Jong, Herwijer, and de Wildt (1990).

The tax burden this places on the active work force is startling from a United States perspective. The employer cost of a full-time, minimum wage worker is around $16,000 per year. But 21 percent of that amount is employer based taxes and 20 percent is employee based taxes. The workers net wage is only about $9,600. Put slightly differently the tax burden--shared by both the employer and the employee--of hiring a full-time, minimum wage worker is equal to 70 percent of take-home pay. For higher wage workers the burden is even greater because of the progressive income tax. (See de Jong, Herweijer, and de Wildt 1990 for a fuller discussion of the Dutch social welfare system and its tax burden.)

Policies for the Future

All political parties in the Netherlands are urging major reforms of the Dutch social welfare system. The prime minister has offered to resign if the disability population passes one million. In January 1991 a major blue ribbon commission (Wetenschappelÿke Raad vour het Regeringsbeleid) recommended reforms to parliament which, among other things, will lower the minimum wage and, hence, the welfare benefits that are linked to it, reduce the tax on second earners in a household and, thus, encourage women to enter the labor force in larger numbers, and further restrict eligibility for disability benefits.

In the summer of 1991, the majority center-left coalition responded by agreeing to efforts to reduce the disability population as part of their more general effort to lower taxes through increased labor force participation. They submitted a broad set of measures aimed at maintaining handicapped workers in the labor force. These included the introduction of experience rating for the Sickness and Disability benefits programs; job protection for handicapped workers; and increasing the scope of commensurate work those with handicaps were expected to accept before they could receive disability payments.

In addition, on July 14, 1991, the prime minister issued a highly controversial proposal to limit the duration of the wage-related part of disability benefits for those who received benefits prior to age 50. They would lose their entitlement to these second tier benefits after no more than six years. It is still uncertain how this would effect those currently on the program.

Thus, even a country strongly committed to principles of solidarity and with a longstanding commitment to high guaranteed levels of social welfare has paused to evaluate the results of its social policies over the past two decades.

A review of the Dutch experience and that of the other countries studied here suggests that disability policy is only a part of a broader labor market policy that each country must formulate for itself. In the late 1970s and early 1980s the United States drastically reduced access to disability benefits. This had a significant negative effect on the health-impaired population, but by the end of the decade, strong economic growth had allowed the families of the health-impaired with good job skills to recover. The unfinished work of social policy in the United States is to provide protection to the doubly handicapped--those with both poor health and poor job skills--who have not recovered.

But as we investigate policies to correct these and other problems associated with the widening inequality between wages earned in the United States caused in part by past social policy, it is also important to remember the positive side of that policy--a strong and sustained economic recovery and a growing United States work force. A cautionary lesson of the past two decades of social welfare policies in the Netherlands is how difficult it is to fulfill social welfare promises while maintaining the necessary labor force growth to keep them in the very structured labor markets that such policies help create.

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