CHAPTER 1

Transforming Disability Welfare Policy. Completing A Paradigm Shift

Bernd Marin

I What does disability mean?

Before we address the mainstreaming of disability from sort to self-determination as well as the salience, success and failure of modern disability welfare policies, some thoughts about what disability actually means are at place: How can this most complex phenomenon be defined and measured – and how can people, their needs, hardships and behaviour, their restricted employment opportunities, life chances and their compensation requirements be classified accordingly? What are the problems that these definitions, measurements and classifications involve, and how do these problems impact on disability entitlements?

Problems of definition, classification, measurement – and entitlement

Medical complaints, sickness, illness, chronic disease, impairment, functional limitations, disability, and incapacity to work are ill-defined and complex phenomena. Disability in particular is a slippery and potentially expansive category: it is inherently subjective, ambiguous, fuzzy, elusive and inevitably problematic to define and measure. Disability cannot be observed directly but must be inferred from presumed causes (impairments) with distinct consequences, namely a restriction or incapacity to perform normal work roles. Health impairments causing work disability must be certified
medically, though clinical certification of impairment is necessary but not sufficient for work disability or eligibility for disability benefits.

Assessing disability requires, in addition, a judgement on the severity, curability or irreversibility / permanence of this health condition as well as its limiting consequences for occupational task performance. Assessments are difficult and painful for the claimants concerned and unavoidably subjective: Conceptions of disability – and adequate responses to it and their affordability – change over time, and clinical judgements on which eligibility is based are (apart from highly different individual tastes and social values of the examiners) notoriously unreliable. “Deborah Stone (1985: 133) shows how unreliable clinical judgements are. She cites comprehensive research on the accuracy and consistency of disability determinations in the United States: In one study clinical teams and agency teams independently came to opposite conclusions on more than one-third of a sample of 1,500 cases. In another study comparing different state agencies using the same criteria there was complete agreement on disposition in only 22% of the cases. The limits of diagnostic procedures combined with the biases of doctors, administrators, courts, public opinion, and the uneven political pressures of applicants themselves assure very limited reliability and equity of decisions regarding disability benefits.”1

Impairment may result from disease, accident traumatisms, congenital deformities or prolonged disuse of organs, muscles, senses, and brain functions. The origin of one and the same symptom of incapacity matters a lot when attributed a causation and irrevocability: whether e.g. a failure to concentrate or “learning disability” stems from temporary grief or permanent depression or somatic pathologies can be relevant for invalidity awards. However, it is not only the causal origin and permanence presumed, but also the impact on the work situation which may make the very same impairment or limitation a work disability in one workplace not in another: a flatfoot is likely to disable a postman (if he does not do marathon running in his leisure time) but not a scientist in her laboratory, a seeing limitation a waiter more than a radio reporter or a disc jockey, an even minor hearing problem a member of an orchestra more than the mailman.

Yet, with changing welfare regimes, fiscal resources or labour market conditions, unemployed persons may all the sudden be reclassified as invalid and early retirees without a chance to flexible retirement may find themselves labelled as incapacitated (e.g. in order to prevent actuarial deductions from their pension benefits). Categories identifying persons as “disabled”, “unemployed” or “pre-retired” are frequently hard to distinguish; still, as
the value and the accessibility of benefits usually differ significantly by status categories, membership to the “disability” group often is more attractive than being unemployed or simply in early retirement.

In addition to this generally growing generosity not easily found in other fields of welfare policy and a corresponding magnetic effect of invalidity, an ever-growing share of disability benefits is awarded for mental conditions as well as for musculoskeletal disorders such as lower back pain. These are ailments most difficult to diagnose and objectify in terms of pain, suffering, and work disability – and most difficult to cure. Consequently, we find almost everywhere trends towards inclusion of ever-broader limitations as constituting disability to work; and ever-shrinking probability to get-off the rolls once an invalidity status has been granted. As the average age of first-time claimants is down to 42 years of age in countries like the Netherlands and further life expectancy and survival rates continue to increase strongly in all age cohorts, the duration and permanence of work incapacity continues to grow. Finally, all this expansionary dynamics is further reinforced by another tendency at broadening “disability” categories, namely to take into account labour market conditions and the availability of jobs suited for persons handicapped in one way or another to find jobs at all. With labour slack and mass unemployment, employers, works councils and unions frequently colluded to adopt disability labels available in order to shift costs for dismissals and downsizing to social security.2

Governments usually tend to respond favourably to the claims of the organized aged as their interest associations are frequently very powerful indeed. But even if the old are not well organized, the sheer electoral weight of constituencies nearing in many OECD countries a median voter’s age of 50 or above during this decade makes politicians disproportionately open to demands from so-called older workers and the elderly; as well as to demands from disabled people at all ages – here rather for reasons of higher legitimacy than those of electoral weight. But abusing pre-fabricated tailor-made “invalidity” categories in order to dismiss people into early retirement in their late 40s at public expense as described in Note 2 was overdoing a widely tolerated fiddling with “disability” labels by provocative fraud. Abuse became intolerable only when it was publicly disclosed and documented by the Court of Accounts and not a hidden practice any longer. But even under normal circumstances of regular and legal behaviour, disability assessments frequently are collections of oddities and quite queer decisions.

On the one hand, complex regulations of occupational protection may lead to decisions most difficult to understand: a learned, certified knife shar-
ener with a completed apprenticeship, for instance, who is unable to carry out one single particular turn necessary for his professional performance is entitled to an invalidity pension in Austria, if he has worked in his profession for more than six months; i.e. he is awarded a lifelong work incapacity benefit even in his early 20s on grounds of Berufsschutz, apart from the fact that he may perform many other occupational activities – and he is actually allowed to continue in any other than the learned or Verweisungsberuf full-time with a full salary in addition to his lifelong invalidity rent. Would the knife sharpener be either semi-skilled or unskilled a worker (angelernter Arbeiter oder Hilfsarbeiter) only or a self-employed craftsman (selbständiger Gewerbetreibender) he would not be entitled to such an invalidity pension on the same grounds – even after decades of practice, social security contributions and at an advanced age at which he may objectively be difficult to retrain for another job.

To dismiss such coherent inconsistencies only as unique remnants of on old, corporatist system of professional protection would, however, miss the point. Looking at the most developed, strictly medical or “scientific” attempts at objectifying “abnormalities or losses”, that is impairments causing work incapacity, so-called Baremas, we find an even stranger and more arbitrary variation in assessing particular levels of invalidity. Here too, assessed incapacity varies strongly between countries, within the same countries over time and between different, mostly occupational groups of insured persons for the very same losses or impairments. Such curiosities are less surprising than one would expect; they may understandably be experienced as “unjust”, of which frequent appeals to widespread denials are an indicator, but they are not necessarily or even intentionally unfair, given the complexities involved.

As we have already indicated, chronic illness or disability must not lead to work incapacity, as, the other way round, invalidity benefit award does not have to coincide with self-perceived disability. This incongruence between disability and disability benefits corresponds to the difference between health status and health demand: people may be sick without voicing medical complaints, and medical complaints may vary drastically across comparable prevalence rates between countries; chronic disease may or may not cause impairment, impairment may or may not cause functional limitations, functional limitations may or may not cause disability in terms of incapacity to work.
In short: between health and illness, between the need of medical care or no such need there are fuzzy boundaries; objective health conditions and care requirements on the one hand and subjective health awareness, desire of treatment and take-up of medical services on the other are only very loosely related. Demand for medical care services varies enormously between and within societies; with health status as just one among many determinants of effective health care demand. Effective demand for medical services, thus, only marginally reflects the objective incidence of morbidity within a society – health demand has little to do with health conditions.

_Chronic illness_ of whatever sort may or may not lead to _functional limitations_ in seeing, hearing, speaking, walking, lifting, climbing stairs; and functional limitations may or may not lead to dependence on others in _activities of daily living_ (ADLs) such as eating, getting in or out of bed, dressing and undressing, bathing, using the toilet; and dependence on others in _activities of daily living_ may or may not lead to dependence in _instrumental activities of daily living_ (IADLs) such as household work, laundry, preparing meals, shopping, managing money, using a telephone, etc.

Depending on whom one asks and how, highly different answers and corresponding highly different rates of illness, functional limitations and disabilities will be measured. So far, different disability measures are not at all reconciled with each other. Very little is known so far about their interrelationships. As an unsurprising outcome of this we find that disability measures over time are extremely unreliable, with great statistically unexplainable (“noise”) variations from one period to the next despite very large samples in health statistics; and we find, for instance, 18% of the US population suffering from functional limitations; 10% with a work disability; and 4% of the working age population with a disability benefit (SSDI or SSI).

In addition, things change significantly over time: what used to be a severe impairment that incapacitated for work and full participation in social life a few years ago may have become a minor trivial problem today – severe arthritis, grave depression, strong hearing impairments, heart diseases or hip or knee impairments as cases in point of chronic conditions the better treatment of which has made them of much less concern than a generation ago. Today, technical health aids, assisting devices and adaptations of workplace, housing, and public buildings allow to live independently and without any or comparable limitations with the very same physical condition than years ago – eyeglasses, canes, walkers, electric wheelchairs, walk-
in showers, support rails and handicapped access facilities, special taxi transportation services for disabled people, pre-prepared meals, meals on wheels, home delivery and home help services, all these aids and/or environmental improvements and/or social support systems facilitate life for impaired persons independently from improvements in underlying health conditions or not. High-tech joint replacement of hips and knees, intensive heart surgery, anti-inflammatory drugs for arthritis treatment and other pharmaceutical quick fixes which may help to cope with depression and other mental problems in a way that makes self-perception and general outlook less pessimistic and negative have become frequent applications of medical innovations.

Thus, changes in health conditions or chronic illness rates may stem from true changes in illness prevalence; they may also reflect changes in health behaviour; they may mirror changes in diagnostic practice and capacity detecting illnesses previously undiagnosed or under-diagnosed; they may also result from better medical treatment and longer life with chronic illness so that more people are surviving to report having encountered a specific illness they may not have had a chance to encounter at earlier stages in life; they may also come from changing stigmas, taboos or “fashions” in illnesses (e.g. allergies may be, haemorrhoids or contagious mycosis or cognitive conditions may not be a health status symbol one brags about; blood pressure, certain mental disorders or venereal diseases may have highly different images in different subcultures – thinking of a young writer who felt “not sick enough to be a poet”; alcohol and drug addiction may be rejected quite differently in different milieus) so that different people grossly over- and under-report certain illnesses and health conditions.

Finally, a disease may change in severity, or rather the management and medical control of an unchanged health condition may totally change the objective life expectancy and self-perception of persons, for instance, with hepatitis C or HIV infection where residual life expectancy in all stages has increased significantly over the last decade. Last but not least, class differences and disparities in disability and healthy life expectancy are still very strong, varying from around six years in Nordic countries up to 20 years of differential life expectancy between different socio-economic status groups in the United States; disability risks in OECD countries are roughly doubling with lower educational attainment, lower social status and lower income.
II Mainstreaming disability:  
From sort to self-determination?  
And from “bone-rates” of “abnormality” to normalcy?

The paradigm shift regarding disability that took place during the last few decades changed public perception and policy responses to impairment most significantly. Social protest and successful political mobilization of people with impairments led to an unprecedented degree of organized self-help, campaigning and lobbying, formation of interest associations and NGOs, pressure group activities on governments, legislators and administrators and a resulting new public concern for persons with disabilities. The United Nations acted as a lead agency, declaring 1981 the International Year of Disabled People, proclaiming 1983-1992 as the Decade of Disabled Persons, and setting global standards (the famous 22 Standard Rules on the Equalization of Opportunities for Persons with Disabilities, adopted by the UN General Assembly in its 48th session), including determining the preconditions of equal participation and the target areas, implementation measures and monitoring mechanism. The European Union followed only lately by nominating 2003 “The European Year of People with Disabilities”.

Most important, the World Health Organization (WHO) as the specialized UN-agency dealing with disability, has complemented its International Classification of Disease (WHO 1976) by a new International Classification of Impairments, Disabilities and Handicaps (ICIDH) (WHO, 1981), with a scheme detailing the consequences of disease. WHO distinguished between impairment as loss or abnormality of anatomical, physiological, psychological structure or function, i.e. parts or systems of the body not working properly; disability as any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal, i.e. things that people cannot do, primarily basic skills of daily living; and handicap as disadvantage resulting from an impairment or disability that limits or prevents the fulfilment of a (culturally variable) role. The most recent system adopted by the World Health Organization is called International Classification of Functioning, Disability and Health (ICF, http://www3.who.int/icf/icftemplate.cfm). Before this broader, more complex and dynamic view was adopted, assessment of disability was reduced to measuring impairments in a pseudo-scientific way through so-called Baremas.
Assessing “abnormality or loss”:
The strange world of “bone-rates” or Baremas

Originally, abnormality or loss was restricted to persons who were blind or deaf or paralysed, or without an organ or a leg. These were the heydays of the so-called Baremas, scales for compensating injuries dating back to mediæval ages: Germanic law related money sums for the loss of body parts to the “wergeld” or “manngeld” to be paid as a compensation for killing a free man. Later, the French mathematician François Bareme transposed such scales to percentages, labeled “Baremas”, or (more dramatically in German) “Knochentaxe” (bone-rate). Then, doctors created the equivalent of such a limb-rate (“Gliedertaxe”) also for mental and psychological or “neuropsychiatric disorders”, with even greater fuzziness. A glance at European Baremas and their variation among (even neighbouring, e.g. Scandinavian) countries shows a strange and quite arbitrary codex of particular levels of incapacity, varying a lot between countries – and over time within the same countries, and within the same countries between different, mostly occupational, groups of insured persons, i.e. corporatist distinctions which have nothing to do with residual work capacities or risk structures – for the very same losses or impairments, allowing for a lot of variation and discretionary decision within the same categories of harms, and for strange comparisons across injuries and between corporatist special interest groups.

In the UK in the 1960s, for instance, the loss of fingers and a leg amputated below the knee constituted a 50% disability, while the loss of three fingers and the amputation of a foot or the loss of an eye translated into a 30% incapacity rating; today, the very same lost foot rates for 100% disability in the same country, whereas the amputation of one foot counts for only 30% in Germany, 50% in Belgium as against 100% in England, but both feet only 70% in Italy. Today, an amputation of a lower limb at hip level constitutes 35% incapacity in Iceland, but 90% in England and Belgium, the amputation at ankle level 30% in Denmark but only 9% in Sweden. Within the same country, for instance Austria, the very same physical loss of a limb amputated below the knee counts for 50% degree of the reduction of capacity for remunerative work (Grad der Minderung der Erwerbsfähigkeit) if it happened to somebody during the war, whereas the very same impairment counts for 40% if it happens to a farmer today, but only 30% if it affects either a white collar employee or a blue-collar worker. An infarct or a coronary heart disease makes for a 100% impairment in Italy, but for only between 30 to 60%
in Belgium. Fractures of the vertebral column with neurological consequences rate between 20% (and 25%) and 100% within the same countries Denmark, Norway and Sweden; inflammatory and degenerative phenomena of the vertebral column may vary between 5% and 100% in Belgium, leaving all discretion to medical doctors. Unstable insulin-dependent diabetes mellitus counts for 50-75% in France, 60-100% in Belgium, 30-100% in Lithuania, 51-60% in Italy, 50-80% in Estonia, 75-100% in Ireland, but only up to 40% in Iceland, and a 50% minimum in Germany. A total loss of vision of both eyes makes for 100% impairment in Germany, Denmark, Norway, 95% France, but for only 68% in Sweden. “Severe facial disfigurement” rates as 100% impairment in England, 80-100% in Italy (wolf-mouth, Binder’s syndrome), whereas “visually repulsive” disfigurement counts only 50% in Germany, and between 10 to 100% in Belgium – leaving all the room for discretionary judgements on “ugliness” and the corresponding disability benefits to bureaucrats. France, on the other hand, does not know such repulsive facial disfigurement at all but operationalizes “major impairment” by “disorders seriously hindering or preventing feeding, head carriage, and saliva retention” (50-70%), with dependence on a third party 80%.

Over time, in an international comparison, as well as when comparing injuries with each other, this mechanistic approach of attributing single summary figures for benefits based on Baremas demonstrates its arbitrary and strange character: “The Set Points: how do you compare a fractured leg with schizophrenia … The Paired Organs Problem: what do you do about the one-eyed man loosing his remaining eye; The Whole Body Problem: if loss of a finger is 10%, and back pain is 20%, and depression is 40%, what is the total award for an individual with all three conditions; The Threshold Problem: if benefit is awarded at a threshold (such as 30% for a partial disability pension, and 80% for a full one), how do you decide whether someone falls at 29%, 30% or 31%?”

Sometimes, national Baremas simply reflect long-standing stigmatization or prejudices, if they are shared by the medical profession. In Austria, for instance, around 60,000 persons with schizophrenia are totally excluded from work due to the stigma attached to their health condition, still widely seen, also by medical experts in assessment committees, as equivalent to psychosis (“psychoseadäquat”) and as a mental illness (“Geisteskrankheit”). As first incidence of illness occurs around the age of 20 for men (who, on average, have little if any occupational record at that age), and around the age of 30 for women, most people diagnosed with schizophrenia will be on a life-
long invalidity pension for about half a century – despite the fact that 70% of them are both able and willing to work. Even if the lifetime incidence of schizophrenia of 1% is significantly lower than that of other psychiatric illnesses – who’s share in overall disability benefits is rapidly increasing everywhere in Europe – it is the sort (and exclusion from work and life) of several million Europeans which is at stake with this one mental health condition only; and it will concern dozens of millions of Europeans of all ages when it comes to alcoholism, panic attacks and social phobias, or depression, including very severe ones.

Despite these severe problems with Baremas, they are still widely used for awards of compensation of injuries. This widest possible use of the most problematic and most widely criticized assessment method should be less surprising as it may be at a first glance: it is a very old, well-established system, dating back to centuries; it has an institutional first-mover advantage in that it was established in the early days of disability welfare system evolution; it seems difficult to apply, requiring “scientific” tests and examinations known to professionals only; by assigning numbers to highly complex, multidimensional phenomena, it gives a flair of objectivity (at least to lay persons, while it may be ridiculed as misplaced over-precision by other professionals), comparability and, thus, of social fairness; it is to be used very flexibly for awarding benefits both for impairments and for disabilities arising from impairments, so that either injuries themselves or only disablement resulting from injuries may become compensated, leaving ample room for lawmakers as well as for social administrators to shape and re-shape practices according to changing public moods, fiscal constraints, and political requirements; and the professional autonomy and discretion of both medical doctors and bureaucrats remains extremely high, given the latitude inherent in impairment-based Baremas, so that they keep a monopoly of deciding about the working status of people with disabilities, income, in-kind benefits and service entitlements, in short: a far-reaching control about people’s lives.

Alternative methods of assessing disabilities and handicaps

None of the alternative methods of assessing the legitimacy of a person’s claims to disability benefits does erode the core role of the medical profession. But all of them somewhat undermine its monopoly by creating multidisciplinary
teams in order to integrate a strictly medical examination by a physician into a broader assessment combined with knowledge from vocational rehabilitation, occupational therapy, work organization, labour market, social work, psychology and physiotherapy etc. More complex and widely practiced alternatives to the Baremas include, for instance, the method of assessing care needs (e.g. for home nursing in assessing general attendance allowances), where the amount of the attendance allowance granted varies with the average extent of need for support and care, for instance defining seven levels of disability by qualitative and quantified care requirements between 50 and 180 hours monthly; or functional capacity assessments through individual “ability profiles”, which should allow to identify, compare and match abilities with templates of actual job requirements, in order to facilitate employment opportunities for persons with disabilities (whereas the previous concentration on deficiencies and disabilities instead of abilities will inevitably lead to greater social exclusion). Finally, there is the method of calculating economic loss, referring either to existing or previously held jobs or jobs in general, or anything in between. This method combines a medical examination of impairments and incapacities with a vocational investigation of relevant work opportunities in order to determine the nature of the handicap – and its compensation.

With these broader and more sophisticated perspectives and assessment tools, professional domination of the process is not broken, but even further extended. The former obsessive fixation on anatomical or other “abnormalities” is not fully abandoned but significantly softened: severe injuries such as blindness may or may not fully incapacitate for a given workplace, and formerly often ignored (or rigidly categorized) chronic illness which may interfere with physiological or psychological processes in multiple ways such as arthritis, epilepsy and schizophrenia have been included into a broader definition of impairments leading to disability. In surveys using such a wider scheme, the severity of disability was measured by functional limitations in reaching and stretching, dexterity, seeing, hearing, personal care, continence, communication, locomotion, behaviour and intellectual functioning, and a much larger share of populations was found disabled – about one in seven of the (UK) population, and a third of the more than six million disabled resident population was found in the two least severe disability categories (1-2), about one third in the three middle categories (3-5) and around one third in the five more to most severe categories (6-10).
As a consequence of the authoritative WHO-led broadening of official disability definitions and of practised assessment procedures, as well as of the aforementioned political and intergovernmental activities, a fundamental shift of perspectives came about. Impairment was less and less seen as a personal tragedy of passive “victims” condemned to a life of individual isolation, dependency and assistance from family members and kinship network. Instead, views moved towards those of a more self-determined life assisted by welfare benefits and services tailored for persons with disabilities. Disability was not longer seen as a personal problem above all in need of individual, medical treatment by professional experts who care about a “poor” person with difficulties to adjust to a given environment; but rather as a social problem affecting persons with impairment oppressed by an environment indifferent or even structurally hostile to their specific needs, thereby depriving them of equal opportunities in work and social life. Instead of relying primarily on professional treatment and external expertise, persons with impairments would need to rely on their own experience and to act-up collectively into self-help and political interest organization.

But, paradoxically, in order to strengthen their political position as an interest group, people with impairments had to get disability recognized by professional experts as an issue affecting significant and much higher proportions of the population than previously expected – in the late 1980s, early 1990s, between more than 14.2% (6.2 million UK citizens) and 19.4% (48.9 million US citizens) were reported as persons with impairments in national surveys conducted at both sides of the Atlantic. At this point of the development, the sheer numbers of persons and the shares of the population affected as recognized by professional expertise made for a normalization or mainstreaming of disability.

III The ambiguity of modern disability welfare: Success story or political fiasco?

At first glance, as well as after various in-depth investigations from different perspectives, modern disability policy presents itself quite ambiguous. First, underlying trends with respect to foreseeable problem loads are extremely contradictory and highly puzzling: Is overall disability likely to further increase or decrease? And how come that disability in older age (+65
years) and very old age is declining significantly whereas it increases in working age (20-64 years) (and maybe even for children), despite the uncontested fact that the risk of invalidity rises with age?

Apart from such contradictory developments regarding case-loads, the last decades can be seen both as a remarkable and most obvious success story as well as a kind of certain political fiasco or disaster. The following sections will indicate both undeniable, major achievements on the one hand and equally irrefutable main failures of modern disability welfare policies on the other. But the most plausible, reassuring metaphor from the glass half full or half empty fully misses the point: it is not an intermediate level of success or failure, but the simultaneity of a great and indisputable success in reframing the mind-sets and world views concerning disability, thereby advancing the social rights of people with impairments on the one hand, and an evident failure on the other to consequently pursue and complete this paradigm shift, which started to redefine invalidity from a sinful impairment or stigmatized crippling condition over a tragic individual sort to a disabling environment generating avoidable deprivation and social exclusion.

More specifically, the failure of modern disability policies is not at all accidental but an inevitable and incontestable by-product, an unintended but inescapable consequence of a purposeful and successful social compensation policy. Compensation produces income security for persons with assumed earnings restrictions without a corresponding level of integration offers and activation demands. But as even comprehensive and ambitious integration policies do not matter much, if at all, with regard to employment levels of persons with disabilities, as will be seen, realistic chances to overcome this dilemma may actually be modest, indeed.

**Modern disability welfare salience**

Success or failure of modern disability welfare is in many ways crucial for the future of welfare states or welfare societies. Above all, it is an important component of social expenditures and, thus, of fiscal pressures on and financial sustainability of the welfare state.

A structural feature of modern European welfare states is that the main determinants of public spending are not revenue but entitlements to welfare benefits, for instance to transfers for old-age pensions or pre-retirement, inva-
lidity pensions and disability benefits, unemployment and other social security or social assistance programmes, the provision of health and education, etc. Spending on welfare entitlements cannot be changed according to short-term cyclical fluctuations in the economy and is not even easily adapted over mid-term periods, but is rather driven by long-term population developments, structural and socio-cultural changes: the great expansion of (higher) education beginning in the 1960s responded to the post-war baby boom; increasing expenditures for pensions, medical and care services for the elderly react to population ageing. Both spending developed dynamically and irrespective of the state of the economy. And unemployment expenditures, which are caused by business cycles and the state of the economy and less by demographic factors, were exploding just at the times when job search benefits were most needed while contributions were much weaker, thus reinforcing budgetary crises.

But what do significant increases in invalidity pensions and disability benefits for the working age population reflect under conditions of improved health and more disability-free life expectancy, compression and postponement of morbidity? What does a steep rise in incapacity recipiency rates simultaneously with a reduction of chronic and occupational diseases, accidents and work injuries actually signal? Without a convincing answer to explain these puzzling paradoxes, disability welfare as a kind of garbage can social welfare category will rather continue to contribute to aggravating fiscal pressures than to maintain or restore stability and long-term sustainable welfare.

While overall social policy spending has roughly doubled between 1960 and 1980 and further increased since by more than a fifth, all cuts in order to reduce deficits or taxes have remained soft in terms of slowing down the rate of expenditure expansion and have never been absolute cuts; and they seem to have affected disability benefits less than any other social expenditure so far. Extension of programmes, number of beneficiaries, and amount of expenditures for disability have steadily increased since the late 1960s even if one controls for the changing age structure of societies. Periodic efforts at retrenchment (mid-1970s, 1990s) have succeeded in slowing down recipiency growth rates, but never growth of beneficiaries as such; both the stock of benefit recipients remained high and the inflow rates much higher than outflow. As a consequence, even incapacity benefit expenditures have begun to show reduced inflow rates, i.e. continuing, though slowed-down expansion dynamics so that overall cost containment will be a core challenge in the years to come.
Because disability benefits are generally welcome once the insured risk has occurred (or can be evoked), *incapacity as a potentially catastrophic risk* is much feared and almost every other risk is preferred over impairment, chronic illness, disease and invalidity – except for *death*. Nowadays, everybody seems “to want to die young – but as late in life as possible”, that is dying not prematurely but in longevity and disability-free; though most people most of the time will prefer disability over death, except maybe very young people. But the risk of death is, in the long run by definition, greater than that of invalidity – except for younger people (in wealthy and healthy societies) who rather have incapacitating accidents than die.

Inasmuch as the risk to become incapacitated at all significantly grows with rising age and will become higher (in a non-linear, later almost exponential fashion), the older one is, *invalidity is greater a risk than death, the younger one is*. The risk of invalidity is also *much riskier a risk, the younger one is*: it is much riskier a risk in terms of injuries occurring, the younger one is; it is much riskier a risk in terms of current and future income lost, the younger one is; and it is much riskier a risk in terms of obstacles to benefits eligibility and disability entitlements, the younger one is – for instance, with respect to pre-employment record, necessary waiting periods, capped earnings replacement rates, works and earnings tests, etc. In some countries such as the US in the postwar period, young people, even with previous work records and insurance contributions, were completely excluded from cash disability benefits, as incapacity had not only to be medically examined as leading to death or indefinite duration, but was restricted to workers over age 50 only.

Thus, disability policies are also relevant for those without disabilities today (without that they may know this, though) as much as they are relevant for currently disabled people. They are relevant for non-disabled and young people because, firstly, they may one day in the future become disabled themselves, and secondly, as their own labour market behaviour (more than they may ever realize) is influenced by regulations applying to persons with disabilities and social rights and benefits attached to the status of (partial) incapacity. As “the status of ‘disabled’ typically brings privileges beyond cash and special medical assistance: draft exemption, special education and training, easier access to housing subsidies, a moratorium on debts or extensions of credit” and is generally considered morally worthy and deserving more than other categories of social support, it may attract self-selection into the category more than other welfare benefits. *Disability poli-
cies are, therefore, policies relevant for both disabled and non-disabled people; and they are relevant for all age cohorts in society, though quite differently.

In some developed societies with high non-employment rates, disability welfare plays a major role in depressing labour force participation. Low activity rates imply a low number of persons producing goods and services, and a correspondingly high load to working people of supporting large numbers of persons kept unproductive. Low employment also requires high taxes / social security contribution rates on productive people, which, in turn, discourage these productive strata to work as hard as they otherwise would and rather set incentives for eventually leaving the labour force (temporarily or part-time) for better paid moonlighting, off-the-books businesses and other informal earnings, or even for unpaid activities, leisure, etc. As a consequence, labour market participation drops further and taxes / contributions rise higher, and so forth, so that economies supporting large numbers of people on disability benefits out of work are ever more prone to entrapment in a high taxes and social security contributions / low activity and employment rates trap of socio-economic underperformance, i.e. loss of economic competitiveness and social welfare decay.

This vicious low activity / high tax circle may be caused by any other social policy spending as well, but is particularly likely to be more devastating in case of pay-as-you-go old-age pensions and even more so in case of disability benefits. Both types of benefits lend themselves easier to the temptation of political rent-seeking and manipulation, to using pre-retirement and invalidity pensions schemes for facilitating industrial restructuring or for hiding unemployment, for getting votes instead of making welfare schemes compatible with standards of fairness, competitive requirements and long-term affordability. As with pensions, disability benefits allow for trading short-term political popularity for long-term sustainability. Easier access to early retirement, broader coverage, more generous replacement income, more relaxed screening of eligibility and assessment of claims buy immediate satisfaction of interest groups and voters, whereas fiscal burdens of non-funded liabilities are shifted to later generations of working populations, without easily discernible relationships with the goodies distributed in earlier periods.

But in contrast to political leniency with respect to regular old-age pensions, thoughtless generosity regarding disability benefits instead of giving wisely changes the behaviour not only of current invalidity beneficiaries and that of potential claimants, but that of non-disabled employees,
their employers and that of social administrators and all other interest groups as well. As with sickness and health insurance, moral hazard in disability welfare may become contagious, spreading over to others, demoralizing previously innocent bystanders watching what they may consider malingering at their own expense by free-riding recipients – and possibly give-in to the temptation to use incapacity schemes that are easier and cheaper a way to deploy surplus workforce than regular dismissals.

Thus, enterprises frequently find themselves in the paradoxical situation to complain about a rise of non-wage labour costs which they themselves have previously produced by abusing pre-retirement and invalidity pensions schemes to offload large proportions of middle-aged workers at public expense. In a situation where up to half of all social spending is spent for pensions, where up to 90% of new retirement is pre-retirement before the legal retirement age, and where invalidity often is the single most important determinant of pre-retirement, nothing less than a full turnaround will be indispensable. Sticking to the mind-blowing political double-bind message that both work and early retirement are intrinsically desirable, and to the hypocrisy or self-delusion that disability is a soft and painless way-out of labour market problems for redundant middle-aged workers cannot be upheld any longer. But it is still open how a new, reformed disability welfare would look like.

For without compassion, compensation and solidarity, the burden of incapacity would have to be shouldered exclusively by persons with impairments themselves, their family, kinship, partners, friends, and potential charitable sponsors. Loss of earning following loss of health and work capacity; additional expenses for medical care or mobility not fully covered by social security; additional costs of care attendance for household members or relatives and their necessary adjustments, even in terms of working time and corresponding employment opportunities and income foregone; all these and other external effects of incapacity would be most harmful to the people concerned and could be destructive for society at large without solidarity and compensation. They help to re-internalize some of these extra costs of widespread individual sufferance by collective pooling and absorption of individually devastating or catastrophic risks.

But are there no other, better solutions of risk insurance for disability than traditional social security arrangements? Truly alternative options, apart from hybrid forms frequently found, are either free private insurance market solutions or judicial liability assignments and procedures. But generally they are
held as being *too costly alternatives to public disability welfare*, either in terms of health, welfare, fairness and social cohesion foregone in case of free market disability insurance; or in terms of tort costs, i.e. of potentially endless costs of legal litigation in case of legal liability judicature.

*Juridification of disability programmes* is most advanced in the United States. This does not protect US disability development from a trend towards broadening definitions of disability, looser eligibility criteria, rising recipiency rates, and from corresponding cost expansion as more advanced and generous welfare states. To the contrary, an interaction of growing interest organization of disabled people, media populism, and the self-interests and eigendynamics of professional groups and the judiciary through its District Court rulings, which ever more reversed benefit denials ever more appealed to by rejected claimants, together these forces led to constraining all attempts at cost containment and retrenchment. Efforts to improve management of disability programmes and to speed-up adjudication procedures actually increased generosity of awards, as it made judges more inclined to approve of claims and to grant awards in case of doubt in order to improve their records towards less appeals.

As a consequence, the social security administration operating the Social Security Disability programme ran “the largest system of administrative adjudication in the world”\textsuperscript{8} with *excessive tort costs*: already at the time of President Reagan’s massive efforts of rollback of disability benefits and beneficiaries, year by year 1,250,000 disability claims plus 250,000 previously denied applications were reviewed by 5,600 examiners, and around 150,000 subsequent appeals to denial decisions were adjudicated by 625 administrative law judges at the state and ultimately at the federal level. As a consequence, the intended reduction in rolls of disability recipients failed, whereas the unintended and undesired mobilization of political and judicial action against administrative decisions flourished. Countervailing pressure group dynamics, the juridification of claims, a system open to media populism and legal litigation in a battlefield of medical and legal disability specialists, liberal judicial rulings, this mix of American exceptionality actually produced similar outcomes and overall tendencies of bureaucratization and expansion as classical state welfarism – at somewhat lower direct overall costs but much harsher conditions for the handicapped.

*Unregulated market insurance* against loss of earnings caused by disability would inevitably leave large groups without affordable insurance, as necessary risk-rating would automatically exclude “bad risks” and poor
people by disabling them from even purchasing a private disability insurance; it could not cover pre-existing disabilities, thus excluding for instance people with congenital impairments or already workless due to a previous accident; and it is inevitably extremely costly in terms of assessments and monitoring pre-onset behaviour of insured and post-onset behaviour of beneficiaries. Not even regulation of private insurance markets by, for instance, mandatory insurance through legally fixed standard contracts can solve the problem of social exclusion; it would still require public intervention and compensatory arrangements.

In view of this market failure for disability insurance, most countries have, therefore, organized disability insurance through social security – as mandatory, public monopolies, with universal coverage, uniform conditions, solidary premium rating (flat-rate or earnings-related instead of risk-rated contributions), and pay-as-you-go financing mechanisms. Risks are pooled and shared collectively, though the degree of risk-pooling and interest aggregation may vary from the level of economic sectors to society as a whole; and all other parameters of disability insurance, from eligibility requirements to benefit calculation rules, are regulated by law. Despite these common traits, public disability welfare schemes differ a lot with respect to how they organize their functioning as an insurance, i.e. managing claims, assessing eligibility, calculating fees and benefits, organizing collection of contributions and payment of transfers, instituting prevention, rehabilitation and curative efforts. Monitoring of behaviour of the insured and of beneficiaries and controlling potential moral hazard, however, plays much less of a role than in private insurances.

Consequently, no or little moral hazard makes social insurance arrangements significantly less costly than private insurance market products: Contracts are uniformly standardized, obligatory, and covering everybody, no competition does not require marketing, and largest possible numbers of insured make for maximum economies of scale. But if moral hazard arises under these circumstances, there are little to no incentives – and mechanisms compatible with social insurance – to contain harmful opportunistic behaviour, i.e. social insurance may actually loose its comparative cost advantage and become more costly than private market insurance. Thus, whether the potential comparative cost advantage of social insurance systems can actually be realized or not depends largely on their capacity to contain moral hazard or abuse of benefit arrangements.
Whereas experience rating may still be an option at the level of economic sectors or even large firms, it could not be applied on lower levels of aggregation. Risk-rating, bonus/malus schemes rewarding careful behaviour by lowering premiums, cost-sharing schemes shifting part of the losses incurred to the patient or the disabled person, or exclusion clauses excluding certain claims based on subjective complaints which cannot easily or at all be checked medically from insurance coverage, all these control instruments of private insurers may be used within a social security system either not at all, or with utmost prudence only. Thus, in a system of socialized disability welfare not only individually unbearable risks, but abuse, fraud and waste also tend to be socialized – making for rising costs (and contribution requirements) of the overall system. This expansion dynamics can only be contained by benchmarking and overall cost/benefit comparisons and controls.

Modern disability welfare is most salient a social policy for a number of other unique features as well, such as, for instance: Above all, it “is the most difficult social program to administer. And it is the most resistant to cost containment. Medical or clinical judgements on which eligibility is based are notoriously unreliable.” (Wilensky, a.a.O.). There are most tricky problems of defining, classifying, and measuring disability, of assessing severity, curability or irreversibility of health conditions and of their occupational impact and social consequences not found in any other classical field of social welfare such as labour market policy and unemployment benefits, social assistance, family or pensions policy. Discretionary decisions make room for almost unavoidable unequal treatment by programme administrators. Fuzzy risks allow for influencing the actual probability of incurring a harm and its degree of disability by the patient’s own subjective perception, his/her willingness to work, motivation to succeed in rehabilitation etc. It is also torn between archaic legacies in (subliminal) perception or cultural codes and hypermodernity of some of the diagnostic and treatments methods, and between moral values, moralizing postures and amoral self-seeking interests. It contains elements of incomparable institutional and technical complexity, cross-sectoral inter-penetration, and ethical dilemmas. In short, modern disability welfare is a kind of laboratory for all modern welfare problems and failures – from variability of incidence to mismatches of service supply and demand, from overclaim to social exclusion problems and unrecognized non-take-up; from paradoxes of targeting or anti-discrimination policies over perverse incentives to long-term welfare dependency; from discrepancies between health and health demand to those between disabil-
ity prevalence as a medical condition, disability as a labour market prospect, and disability as benefit recipiency.

**Modern disability welfare success**

In several most advanced countries, disability policies have been a remarkable success during the last decades of the twentieth century. It may be summarized as a, probably irreversible, process of *emancipation* of people with disabilities, as a *trend towards integration and normalization, to independence and self-determination*. Traditional segregation of persons with disabilities into homes, special schools or sheltered employment sites has been partly overcome through *integrated schooling* and *assisted employment* which allows even severely impaired persons to work together with non-disabled people in the regular labour market; and *new forms of housing* have helped to move away from nursing homes to smaller housing units or single apartments with ambulant care services.

Together with integration and normalization grew the awareness that persons with disabilities are not pitiable creatures to be patronized by well-intended professionals, but that they are able to speak and act for themselves. Thus, it has become accepted that persons with disabilities including mentally disabled persons may take care of themselves, live autonomous lives, represent their own interests and may co-determine or help in designing the service at their disposal. For this purpose, a number of new instruments have been developed during the last decades: *care attendance allowances*, personal assistance, particularly widespread in Scandinavian countries, which allow even most severely impaired persons to live autonomously, *interest group associations* such as the “Centers for Independent Living” or the “Selbstbestimmt Leben Bewegung”, disabled persons organizing themselves and not, as traditionally, through their parents; umbrella or peak associations such as “Save Our Security”, organizing grass-root organizations; or specialized lawyers associations such as the US National Association of Disability Claims Representatives. Social services are ever more set up for *user involvement* which allows people with disabilities to influence the services established to support them and to end their previous forced infantilization.

Furthermore, the impact of human-built environmental factors that often incapacitate persons with or without impairments (preschool children,
young mothers with small children, frail elderly as much as wheelchair users) has been recognized and thus the (co-)causation and not just the social construction of disability. While disability was previously seen as a static feature of persons with impairments which must be accepted and can not, in principle, be changed significantly, the social definition of handicap allows for identifying the social and physical barriers which limit the opportunities of full participation in society for those with illness and impairments and trying to shape these contextual barriers. Mobile early childhood developmental support, measures to adapt workplaces, communication facilitators such as general availability of sign language or large type, screen magnifiers and voice synthesizers built into the basic design of computers and other widespread technologies, as well as legal regulations to guarantee equal access to public buildings (such as the Americans with a Disability Act) are cases in point of this new approach.

Non-discrimination and mobility support outside the home by equal accessibility of public buildings may be a most visible example of a disability welfare policy success, though it has been achieved only partly so far. Once the principle of general and equal – and equally easy – accessibility of buildings, shops, transports and communications will have been generally accepted and ramps, lifts, moving staircases will be safely useable for every human and animal companion including Seeing Eye dogs, automatic doors, adaptable buses, trains, plane gangways, tramways and underground metros have been introduced, not only persons with impairments such as wheelchair users, but everybody more or less fragile without impairments – from small children to young mothers with strollers or little children to frail elderly persons to healthy middle-aged people with buggies, trolleys or heavy luggage or cyclists or roller-skaters – everybody benefits from the fact that design features of equality of access and comfort have become a pure public good. To the extent that the full range of abilities of potential users is taken into account, no – potentially discriminating and stigmatizing – selection and identification of those with disabilities for special treatment in distinction from able-bodied others is necessary any longer.

Equal and easy public accessibility is a best-practice case in point of success of a modern disability policy. While its non-identification or anonymity as well as the non-rivalry in consumption features even avoid to set some people apart by classifying those users as “disabled”, these ideal qualities do not extend to all measures established in support of persons with impairments: paradoxically, a child with mental retardation or an adult with
physical impairments must first be identified (and even be certified) as such before measures necessary to guarantee his/her support and non-discrimination could effectively be taken; and any measure taken in more traditional social policies such as health and medical care, education, personal care and social services will rival in consumption with other claims for uses of public funds (whereas accessible buildings, once built, are useful investments not consuming further scarce funds depending on their actual usage, rather the opposite: the more frequently they are used, the more useful the outlet proves to be).

Anti-discrimination has become an indispensable key feature of modern disability policy. But the less persons with impairments are automatically viewed as handicapped or disabled and in need of compensation, but just in need of equal access and equal opportunities and non-discrimination, the less they can count on automatic support, affirmative action or reversed discrimination – as an effective anti-discrimination policy and positive discrimination measures require selective identification (as against full anonymity). It is one thing to systematically take stock of discriminatory measures – such as the prohibition of blind persons to act as witnesses to a marriage only recently eliminated in an advanced welfare EU-country – in order to eliminate them and another to think that effective anti-discrimination and equalizing personalized services can be provided without selective delivery.

The widely unacknowledged core paradox of non-discriminatory anti-discrimination and equal opportunity disability policy is, of course, that strictly universalistic public policies are attractively anonymous and non-discriminatory, but cannot guarantee effective non-discrimination, as they must disregard individual needs and personal circumstances of people discriminated against structurally. In addition, they may actually even lead to a reduction of resources available to persons with disabilities. Social compensation policies of an affirmative action kind for impaired persons in order to make up for barriers encountered by them, on the other hand, may improve their resource endowment and lead to a reversed, positive discrimination, but at the expense of more “discrimination”, i.e. more intrusive, “policing” investigations and bureaucratic and medical professional assessments of disadvantages resulting from these impairments – or even the gravity and credibility of the impairments themselves. But even if an inevitable discrimination for the purpose of positive discrimination may be unobtrusive and not stigmatizing, a predominance if not monopoly of medical pro-
fessionals in assessing people as disabled will prevail in order to allow for most legitimate ("objective") classifications and easy administration of benefit provision and to protect programme administrators as well as claimants against charges of malingering.

Disability right campaigners object to this medicalizing and individualizing approach, without being able to say how identification of beneficiaries could credibly be done without professional dominance, either of medical doctors or of discretionary social case workers. Obviously, the dilemma between the values of integrity, privacy, anonymity and non-discrimination on the one hand and well-targeted help on the other is not easily balanced out. But there are far more troublesome problems of modern disability welfare than some inherent inconsistencies of underlying values and paradoxes in implementing these guiding principles.

**Modern disability welfare failure**

The very expansion of disability welfare may not be a sign of more overall welfare and well-being of disabled people, but of an administrative incapacity to provide welfare and cater it well enough to the persons with impairments in need. In short: disability welfare expansion as a potential welfare failure, rather than an unquestionable welfare increase and success of social policies. As with spending on unemployment, hospitals, prisons, pharmaceuticals etc., more spending on sickness, accidents, work injuries and disabilities may signal less welfare for each disabled person and for society at large.

Indeed, the very expansion of pension dependency of persons in working age and the (partly very steep) increase in disability expenditures over the last decades – apart from a puzzling misallocation of disability benefits – contrast sharply to a series of generally favourable social and health conditions. Most puzzling queries arise: How is it to be explained that disability recipiency rates for working age populations and costs expand in spite of improved health and increased life expectancy?

....... despite declining disability of population groups at higher disability risk such as the elderly beyond working age 65?

....... despite a simultaneous compression rather than extension of morbidity?

....... despite the reduction and postponement of morbidity at ever-later age beyond working age?
Transforming Disability Welfare Policy

...... despite the growing concentration of between a third and half of all health costs over the life cycle to the ever-later last 12 months in life?
...... despite a significant reduction of incapacitating chronic diseases?
...... despite much fewer work injuries?
...... despite less traffic and other accidents?
...... despite less exposure to infectious and contagious diseases (some of which have virtually disappeared or have been strictly contained such as rheumatic fever, typhoid fever, syphilis) and to hazardous substances such as asbestos and other carcinogens, dust, etc.?
...... despite the fact that they should actually fall proportionately to the extent that all populations are becoming more educated, as chronic illness and disability rates are highly correlated with low education (they roughly double with lower education)?
...... and despite the remarkable progress in medical treatment and health care institutions?

How is it, at the level of single welfare societies, to be explained that without any evidence of health deterioration, government spending for sickness and disability has, in the UK for instance, quadrupled over the past two decades, and 40% of working-age recipients of state benefits now claim sickness and disability compensation? How can small countries like Austria or the Netherlands, despite most advanced medical and health care systems, nevertheless face hundreds of thousands up to a million persons of working age on disability (pension) benefits, with an overall increase of invalidity pension recipiency rates up to 86% between 1980 and 1997 and of up to 555% for age cohorts 55/56 years within a few years only? How can disability pensions expand sharply exactly in those middle years of working age where up to 90% of workers quit work prematurely but permanently, but where overall disability-related care attendance requirements are on average about half, and median to severe care requirements only around 27% to 17% of the overall population care requirements and only 3 to 7% of disability care requirements of elderly persons above 80 to 85 years of age? And how is it possible that in small neighbouring countries of similar population size and economic structure Switzerland, for instance, has 10% to 12% the number of invalidity pensioners in the middle-aged cohorts from 55 to 65 years than Austria? (Despite or because of the fact that the latter country accepts full invalidity pensions [with more than 50% inability to participate in remunerative work] only, whereas Switzerland has quite a differentiated – and generally generous – IV system of awarding a quarter benefit for less
than 40% income loss, half a benefit for minus 50% and a full benefit for minus 66% income loss after injury?)

Modern disability policies are based on a so-called “social model” of disability: socio-environmental handicaps are seen as incapacitating people with (anatomical, physiological, psychological) impairments into a disability of performing “normal” activities or fulfilling conventional societal roles properly. While such an interactionist, dynamic perspective makes much sense and certainly more sense than an individualistic, strictly medical conceptualization of disability, it also makes by its very nature for fuzzy and ever shifting boundaries between disabled and non-disabled persons. As an inevitable consequence, it lends itself to systematic overclaims and waste, and even invites chronic overuse, abuse, opportunistic behaviour and moral hazard as well as inclusion and exclusion errors in assessment.

Thus, the deficiency of modern disability welfare is a triple failure:

• Firstly, the failure to contain the case load, the inclusionary auto-dynamics and the corresponding fiscal burdens at “reasonable” and that may just be traditional, previous levels of disability prevalence and disability costs or at benchmarked levels of comparable, advanced welfare societies – overall disability-related programme expenditures as a percentage of GDP, or of total public social spending, or aggregate contribution rates to disability insurance as the only prices signalling overdose, waste and abuse;
• Secondly, the failure to deliver the kind of benefits most needed by needy disabled persons, be they in-kind assistance or service offers, be they monetary transfers to substitute for income losses or earnings restrictions due to disability-related employment constraints, without constraining present or future employment and income opportunities; and
• Thirdly, the failure to focus and target disability benefits on those disabled people most in need of support, in particular severely disabled people, instead of wasting them on either non-deserving persons often neither poor nor needy or on persons in need but deserving and being better helped by other than disability benefits.

Quite obviously but surprisingly, disability policy does reach none of the main goals and objectives of disability welfare. Yet the failure, so the hypothesis, of modern disability policies is not at all accidental but an inevitable by-product, an unintended but unavoidable consequence of a purposeful and successful social compensation policy. Compensation produces income security for persons with
assumed earnings restrictions without a corresponding level of integration offers and activation demands.

While the generous support and compensation policies now in place in the majority of countries investigated have not only helped disadvantaged people to live decent lives despite disabilities as far as income maintenance is concerned, it has also frequently contributed to their social exclusion from the labour market. But without gainful employment persons of working age in job-holding societies are also excluded from full participation in social life. They have, on the other hand, generated a proliferation of beneficiaries of disability transfers, many of whom are not only considered able-bodied and perfectly capable of work by their environment but many of whom do consider themselves being “not disabled” at all. The OECD study Transforming Disability into Ability reports that on average one in three (between one in six and one in two) disability benefit recipients do not classify themselves as disabled.\textsuperscript{11} Millions of Europeans, self-declared not disabled, are using the disability track as the easiest or most attractive exit-path from the labour market under conditions of chronic stress, dissatisfaction at work, job insecurity, threatening structural unemployment – or, ever more so, under revealed preferences for lasting leisure among mature, middle-aged and more or less healthy employees not yet qualifying for regular or early retirement without (actuarial) deductions from pension entitlements.

The conspicuous gap between successful income compensation and failed employment integration, together with an impressive inflow of successful new claimants to invalidity entitlements, has, on balance, generated an uncontrollable expansion (and in some cases an explosion) of disability benefits and costs over the last decades. Social expenditures on disability are totalling now several times the social costs of unemployment, even under adverse conditions of very high unemployment rates: in 19 out of 20 OECD countries investigated (with the exception of Belgium), disability costs were significantly higher than the costs for unemployment, on average more than double the costs (2.17 times), up to 11.9 times the unemployment costs in Norway (\textit{a.a.O.: Tab. 2.1}). European underemployment malaise seems to have shifted from mass unemployment to a massive non-employment, of which widespread invalidity has become a major current.

Above the age of 50, in particular, the relationship between unemployed and economically inactive persons, many of them on disability benefits, is now 1:8. The average male is outside the labour force for more than 10 years during working age, the average woman for 22 years, of which the average
person is likely to be unemployed or on job search for not more than two years – unemployment (while still quite high) becoming a minor problem as against overall non-employment. Whereas one-in-five adult men of working age is now outside the labour force and another one-in-ten-to-twelve is not working because of unemployment, male unemployed are less than a third of the male non-employed in Europe today … the proportion of women outside the labour force is six times greater than the proportion unemployed.\textsuperscript{12}

Obviously, invalidity accounts for only one faction, though an important and growing one, of overall growing non-employment of adult Europeans of working age. And labour market hypotheses for explaining the rise of disability welfare and related non-employment are all the more plausible, as no demographic explanations could be accepted as a possible alternative (they play no role for the working age population, as could be seen already in the first paragraph); and as all medical experts agree that there is no increase in invalidity prevalence and, therefore, no medical or epidemiological explanation for this steep increase in invalidity pensions and invalidity expenditures. Aarts and De Jong,\textsuperscript{13} in a quantitative study of determinants of change in disability recipiency shares in the Netherlands in the 1980s concluded that only a third of the variance in inflow into disability status is explained by medical factors, two thirds by non-medical determinants, above all benefit generosity and unemployment rates.

At the same time and despite boosting incapacity benefit expenses, not just a few handicapped persons but an unbelievable majority of those severely disabled and most in need of support (despite the fact that some of them may actually work) may have been deprived of the necessary support (OECD, 2003: Chart 3.8, Tab. 3.7). One could, expressed somewhat sloppy, speak of the forgotten many, the disabled majority of people with (severe) impairments. Current invalidity policies, thus, not only tend to overspend scarce public funds but to divert generous disability funds towards recipients either not in need at all or in need of other re-integration measures than incapacity benefits, while leaving many of those in need of protection without social protection. And it seems to be the very expansion of disability welfare and its inclusionary auto-dynamics that feeds this widespread misallocation of benefits awarded frequently at the expense of excluding most of the needy. But are all these millions of invalidity beneficiaries who declare themselves as being not disabled, and these millions of invalidity beneficiaries who
receive awards despite their ability to work, do they both also constitute *so many million non-deserving invalidity benefit recipients*?

Certainly not, *inclusion problems are much more complicated* than that. By no means, for instance, is the lack of a full overlap or identity between those who are disabled to work (or not), and those who receive disability welfare benefits (or not), caused mainly by either bureaucratic ignorance or cruelty of programme administrators, or by malingering of claimants of disability awards. Manifold are the reasons to explain this most *crucial mismatch*. Though disabled persons are mostly treated as if they were unable to work, the opposite assumption would be more realistic, sound and productive. But even today, with an incapacitating compensation philosophy still widespread, *many welfare recipients are able and interested to continue to work despite a partial incapacity*. More precisely, *one in three recipients of a disability benefit works*, ranging from 10% in Australia to 68% in Sweden (*a.a.O.*: Chart 3.7); and it may just be the income supplement which allows them to integrate not just into the labour market but economically as well on a level of equal consumption opportunities as people without constraining incapacities. Thus, their benefit recipiency is well-targeted and fully effective. Others who declare that they are not disabled and still receive disability benefits may be among those particularly brave and unusually painless and tough people who state their health status as either good, or bad but good enough of not being “moderately or severely hampered in ... daily activities by (this) chronic physical or mental health problem, illness or disability” (so the disability definition of the OECD study), thus simply understating their handicaps.

Institutional factors rather than personal toughness may also explain why disability benefits must not have been unjustly awarded to persons declaring themselves as not disabled, for instance when benefits are given to persons with a temporary condition extending beyond the mandatory waiting period (an earnings “sacrifice” asked for as a kind of proof of serious disability before long-term or permanent incapacity to work benefits are granted) before claims are adjudicated. And *wrong inclusion assessment* may also be due to overly lenient, patronizing attitudes or misguided social or labour market considerations of decision-making bodies and not to misrepresentation of the health condition by claimants.

Inversely, many denial decisions may only correctly identify hypochondriac persons who tend to overstate their condition of impairment and dis-
ability, thus justly excluding unjustified claims. The significantly high denial rates – of an OECD average of 39%, and up to 69% in several countries – as well as the relatively small share of successful appeals among rejected applicants of an OECD average of only 16% in 1999 (a.a.O.: Tab. 4.13) somewhat corroborates this hypothesis of widespread overclaims (if one dismisses the alternative assumption of an overly and well-synchronized, orchestrated strictness by administrators, medical examiners, and independent judges alike). But overclaim (or careless risk behaviour) would be less of a problem – apart from ever rising assessment costs and tort costs, the costs of legal litigation – could it effectively be contained through improved assessment procedures and mechanisms constraining moral hazard (such as, for instance, co-insurance and close monitoring of care-taking behaviour). Erroneous admission or false inclusion, on the other hand, if it occurs, is more typical for a public disability scheme and very costly, but less damaging for the persons concerned than the opposite screening error of erroneous denials or unjustified exclusion.

While unjust exclusion is expected to happen more systematically within private insurance schemes, its occurrence in public disability welfare systems, reputed for maximizing inclusion, but minimizing exclusion errors of unjustified benefit denial, would seriously undermine their legitimacy in an unexpected way. But empirical evidence of widespread exclusion and misallocation errors in disability determinations are all too strong to be easily ignored or interpreted away: If between 53.3% and 56% of people who state their illness conditions and sufferance such that they feel “severely disabled” do nevertheless not receive any disability-related benefit (a.a.O.: Tab. 3.7); and if, in addition, 35% of those disabled and therefore also non-employed do not receive any disability benefit income at all (a.a.O.: Chart 3.8, Panel B); and if of those disabled and non-employed who do receive some welfare benefit less than 54% receive a genuine disability benefit while others are dependent on unemployment, social assistance, retirement pension or some other type of differently targeted benefit (a.a.O.: Tab. 3.8); then the assumption of frequent award exclusion errors and, therefore, of millions of disabled people either unjustly denied compensation or so discouraged that they have given up even to apply for it any longer, will be difficult to falsify and dismiss. And if erroneous exclusion from benefit recipiency is so widely claimed, even unjustly, then there is a real problem of misallocation of awards – or of lack of legitimacy, at least – for an inherently subjective state of affairs such as health, medical and other care needs.
In short: it is the inherently subjective, ambiguous, fuzzy, elusive nature of disability which makes for almost inevitable shares of non-disabled persons with benefits on the one hand and of disabled people without benefits on the other; but it is the very size of both these shares which determines the quality scale or failure rate, i.e. the overall performance of the disability welfare system. And the recent OECD report (OECD, 2003) shows quite impressively that, according to whatever standards one would refer to, the mismatch is nothing less than shocking, when a clear majority of severely disabled people is not awarded an incapacity benefit whereas more than 40% of disability recipients are self-declared non-disabled.

In sum, modern disability policies have been so successful that they have become self-negating and self-destructive: They attract literally millions of seemingly non-deserving beneficiaries while depriving neediest disabled non-recipients from disability benefits. They allow for a conspicuous gap between successful income compensation (a.a.O.: Chart 3.2) and failed employment integration (a.a.O.: Chart 3.6). They allow work wither away for people with disabilities and to make it pay less for them than for people without impairments, despite the fact that work through gainful employment only guarantees a full and equal participation in social life in job-holding societies. They award many more people permanent pensions than they place in rehabilitation (a.a.O.: Chart 5.1) or employment programmes (a.a.O.: Chart 5.2). They are not able to effectively create employment through activating programmes. Everywhere, they exclude exactly those persons most in need for occupational re-insertion, i.e. above 45 years of age where inflow rates are highest, most systematically from return to work programmes (a.a.O.: Table 5.5) – the great age-mismatch between disability inflow and vocational rehabilitation offer (a.a.O.: Table 5.6). Thus, they are completely writing-off broad middle-aged cohorts of persons with partial impairments and whole generations of so-called elderly workers having gone through longer spells of unemployment. They invite massive claims for invalidity pensions and illness-related pre-retirement for ever-younger cohorts and frequently even grant early retirement under false disability labels. They have resigned that invalidity expenditures and non-employment costs for disabled people within generally more healthy populations have become many times the un-
employment expenditures. They have accepted widespread paid non-employment of employable persons with (partial) disabilities. They take it for granted that extremely low outflow rates for even partial disability tend to make invalidity benefits, once granted, a lifelong welfare dependency. They even tend to channel social problems of long-term unemployment, social assistance and non-employment through the invalidity track, thus making disability a major entrapment for surplus labour populations. They thereby not just misallocate resources at a grand scale but misdirect and reduce energies and work capacities at large. They demoralize and misguide – to the extent these mismatches become widely visible and publicly debated – disabled and non-disabled citizens alike, corrupt norms of solidarity and reciprocity by inviting opportunistic behaviour and widespread abuse of social rights, and threaten to undermine the legitimacy of welfare entitlements and welfare state arrangements altogether.

Though disability welfare policies obviously have done much good, they certainly could do much better in terms of welfare value for programme money spent, both from the point of view of persons with disabilities, in particular those with severe impairments, and from the perspective of society at large.

IV Towards an employment-oriented equal opportunity model: A second or a completed paradigm shift?

As a consequence, the radically ambiguous paradigm shift which has occurred during the last decades must be followed-up by a shift towards a more coherent employment-oriented equal opportunity model. Whether this is to be seen either as an evolutionary development, as a consequent continuity and completion of the social model or rather as another radical break, another paradigm shift – away from a system which is becoming unsustainable both in terms of fiscal affordability as well as in terms of social effectiveness, fairness and legitimacy – towards a new synthesis is a minor question of interpretation. What is crucial is that the normalization and mainstreaming of disability inherent in the social model finally moves away from modelling disability benefits primarily according to a lifelong retirement pension scheme without return
option, and moves instead more towards job search, job return and other (re-)start programmes.

The philosophy underlying these re-insertion and re-integration programmes will value economic independence and full social integration of persons with impairments. It will make all efforts for providing regular employment opportunities for disabled people, and, above all, to make them as equal as possible. As a consequence, today’s large numbers and population shares of disability income benefit recipients (in working age!) will simply not be tolerated and seen as a collective welfare failure to be remedied – a failure of public health care and prevention, of social services, of accident prevention, of labour market and of disability policies – and not as a sign of welfare success.

This applies even more so to the (on average) two thirds majority of persons receiving (partial) disability benefits who are excluded from the world of work: with the exception of Sweden, Mexico and Korea, a majority of welfare beneficiaries in 20 countries investigated does not work, and whereas more than two thirds of disability recipients are active in Sweden, an opposite two thirds is inactive or unemployed in the other OECD countries. The currently very low (38% less) employment (a.a.O.: Chart 3.6. and Table 3.3.) and extremely high (81% higher) unemployment rates (a.a.O.: Table 3.5) of persons with health impairments compared to non-disabled persons would have to become totally unacceptable: less than minor differences, measured by the relative (un)employment rate of disabled over non-disabled, at least for those moderately disabled, could just not be taken for granted any longer.

Two groups currently out of work could be targeted for new employment opportunities in particular: people with a partial disability or a disability not preventing them from doing any productive work at all, but whose impairment prevents them from finding work at the prevailing wages and working conditions; and those people able to find gainful employment at given income and work environment, but who opt for being defined as disabled since preferring to receive replacement income through incapacity benefits and lasting leisure – or possibly significantly higher overall income through additional undeclared income in the informal sector – over accepting available jobs may be by far the most rational choice from an individual point of view.

Here, re-designing incentive structures will be indispensable: for instance, by de-coupling disability and benefit awards, recognizing impairment as a condition independent from eligibility for or actual receipt of benefits or em-
employment status (OECD, 2003). Other than today, invalidity recipients could then take the “risk” of taking up a job without knowing whether they will turn out to be fully fit for work in general or that work in particular, without loosing both the return-to-non-work and replacement income option, and without being taxed away all extra income from gainful employment in a confiscatory way (at a 100% marginal tax rate). Furthermore, one would have to ensure people of all disability-related services available according to personal needs and health requirements and irrespective of work status, insurance, and benefit receipt.

As with care attendance allowance, disability benefits should rather compensate for additional expenses due to the impairment, such as extra costs for medical treatment, personal care services, mobility, or education and training. Tax allowances plus in-kind services plus in-work benefits may produce better conditions for people with disabilities than the current cash benefits, which are most frequently awarded to substitute for work income, instead of supplementing (restricted or even unconstrained) income from work. Benefits for disabled persons will not end (or fall drastically) with taking-up work or gaining income from work, thus being neither conditional upon non-work, nor on low income irrespective of work (means-tested), nor on no or low income from work, i.e. being taxed away for reasons of work.

Specific measures which could be meaningful in principle such as, for instance, the Disability Working Allowance (DWA) introduced in 1992 in the UK and which since has been replaced by the Disabled Workers Tax Credit (DWTC) programme, would have to be radically re-designed in order to make them more effective. This bonus for finding a job was denied to 90% of all 20,000 claimants asking for it within half a year of its introduction because of means-testing results or because the job was not yet in hand. The lesson to be drawn from this failure is obvious: Paradoxically, restricting the number of eligible recipients for return-to-work support policies too much implies to continue the trend to expand the number of incapacity beneficiaries and claimants instead of reducing them. Narrow time limits (of six months) and strict low-income limits, unrelated to the size of the disability benefits, undermine the efficiency of employment vouchers. But for getting people on disability benefits (back) into work, the size of employment vouchers would have to depend exclusively on that of the incapacity benefits awarded, so that the more money is currently spent on maintaining incapacitated persons out of work, the more incentive it offers the disabled person to become employed. Only a generous, uncapped, positive relationship
between the value of employment vouchers and disability benefits will make vouchers “buy” incapacitated people into regular employment, whereas an all too stingy flat-rate conception ceiling-off their exchange value will not do the job of getting most persons with disabilities constraining their employability on the job. But employment vouchers will have to remain in place and disabled persons will continue to qualify for them even after they have found employment, though not necessarily for the original employer. This innovative employment-oriented approach towards getting disability beneficiaries into employment suggests to give the recipients of incapacity benefits the – voluntary! – option to use a portion of these benefits to provide employment vouchers for employers that hire them. It is to be found in a recent paper by Orszag and Snower.14

The aforementioned and other prerequisites of a successful Incapacity Benefit Transfer Programme (IBTP) are modelled after the Unemployment and Training Accounts (UTAs) and the Benefit Transfer Programmes (BTPs)15 and represent a new approach to employment initiatives, tailor-made for disability benefit recipients. It claims that (under specified premises) “it is always possible to stimulate employment through self-financing employment vouchers” and that “for plausible values of the autonomous separation rate and the rate of displacement – they constitute a large fraction of the existing incapacity benefits” (a.a.O.: 4). The positive-sum quality of the IBTP game consists in raising “the take-home pay of the newly recruited (previously incapacitated) workers, while at the same time reducing their cost to the employers. The difference between what the employees receive and what the employers pay is the fraction of the incapacity benefit that has been transferred to employment vouchers. When people draw incapacity benefits, the government bears the cost of supporting them single-handedly. But when they transfer their incapacity benefits to employment vouchers, the government shares this cost with the firms that hire them. Since the amount that the government spends on the employment vouchers is set so as not to exceed what would have been spent anyway on incapacity benefits, the reduction in incapacity and consequent increase in employment can be achieved at no extra budgetary costs.” (a.a.O.: 3). In addition, the absence of relevant deadweight for disability beneficiaries allows designing self-financing employment vouchers for incapacitated persons more generous than other employment subsidies for non-employed people.

Creative thinking to create new and better employment opportunities for people with disabilities starts on the premise that it is just not good enough
a disability welfare practice and outcome if the relative average income of disabled over non-disabled persons or households with a disabled person does not fall back behind too much (OECD, 2003: Chart 3.2). It is much more important that comparable income stems from work, as, once disabled people do find work, the income from gainful employment already today is little different from that of non-disabled members of the labour force (a.a.O.: Chart 3.4). In short: work pays and non-work burdens both disabled and non-disabled persons – though (and that is a core policy design problem) not quite alike: the relative average personal income of those not working over those working is almost everywhere (with the exception of Belgium, Italy and Norway) significantly better for disabled as against non-disabled persons, this comparative income protection advantage of disabled people paradoxically making work pay relatively much better for non-disabled persons over disabled people (a.a.O.: Chart 3.5). The big variation in income according to working status is even bigger for non-disabled persons and, therefore, rewards them significantly higher for working efforts than people with impairments.

In the end, societies will always get more of what they pay more for collectively. Where unemployment benefits last long, unemployment lasts long, and long-term unemployment may even prevail over short spells of involuntary job turnover. When paying disabled persons an income compensation largely apart from work efforts and not as in-work benefits in order to compensate earnings restrictions through income supplements, social security will produce the expectable though undesired result, namely much more disabled persons out of work than both the people concerned and the society at large may wish for. The effects of disability benefits on the labour market may be similar to those of unemployment benefits, which may actually reinforce the very problem the consequences of which they are intended to mitigate: they may prolong or even fully discourage job search, or taking a job when offered in order not to loose transfers and other, transfer-related entitlements to necessary services; they put upward pressures on wages and induce both workers and employers to opportunistic behaviour such as taking greater risks of dismissals, etc. If you pay for inactivity, that is what you get; if you pay for incapacity, that is what you get.

If you pay for inactivity caused by incapacity or impairment / disability conditioning non-employment, that is what you get. The empirical correlation between compensation generosity and beneficiary numbers supports this assumption and basic political wisdom: the more generous (and broader in terms of coverage) the disability entitlements, the higher not only the welfare recipiency
stock, but also the new beneficiary inflow rates (OECD, 2003: Charts 6.4-6.6). And certain restrictions of welfare benefits during the last decade have been accompanied by an overall decline in the total number of new disability recipients, i.e. in inflow rates 1999 over those 1995 as against those in 1990 (a.a.O.: Table 4.5). Thus, cutting back on welfare generosity – not in terms of pay granted but in terms of strings attached to grants awarded! – may, quasi automatically, also cut back the numbers of new disability recipients. It may also – in the longer term, once that new policy orientation has become generally known if not accepted – reduce the number of new claimants of entitlements. But studies also show a discouragingly long time lag for institutional changes to trickle down to the persons affected – legislative changes normally take five years before the population at large and not just a few people most concerned take note of the new situation.

Given the alternative of long-term if not life-long non-employment invalidity entrapment, conditioning benefit payment on increasing employability is actually without serious alternative. As with long-term unemployment, all measures preventing it, as well as measures improving skills and thereby employability, are preferable at almost any cost, as the costs of failure are inevitably even higher. In principle, persons with disabilities must be made attractive to employers, be it through active help with motivation and job-finding, be it through specific skill formation, be it through a flexible system of wage differentials and either income supplements or employment vouchers for persons with earnings restrictions due to impairment.

If society gets too much inactivity caused by incapacity because that is what it pays for, there are two alternative solutions: either cutting off disability benefit payments, or continue to keep paying them, but after a period of non-employment payment only for activity rather than inactivity. This will eliminate long-term or life-long disability welfare dependency – the more serious the more long-life societies will become. Long-term incapacity dependence is as terrible a waste and social ill as long-term unemployment, as, after a while, long-term non-employed persons become practically unemployable and long-term non-employment prevents employment from rising which in turn causes ever long non-employment. The answer, therefore, is to prevent disabled people entering long-term non-employment in the first place, a policy priority that has been formulated in the EU guidelines adopted at the Luxembourg Summit in 1997 with respect to effectively combating long-term unemployment.
Generosity of disability benefits *per se* will not only not *undo* non-employment of persons with impairments, but rather co-produce it. The crucial factor is how society treats people with disabilities: whomever it allows to be discriminated against, discrimination will effectively take place against these vulnerable groups; and whatever it subsidizes, it gets more of it, both inactivity and activity. In order to prevent long-term if not life-long inactivity of people with disabilities, a better use of the benefit money is – to subsidize jobs. If there is anything which can be done to reduce non-employment and unemployment of persons with incapacity, it is offers of work, or training, retraining, work practice, vocational rehabilitation or other measures of creating employability for the non-employed disabled persons at the earliest possible stage in order to break a pattern of life in a culture of dependence.

*Long-term non-employment*, thus, more than unemployment is an *invalidity trap of first order* with next to no return opportunities: the longer someone is out of work, the lower the chances of re-entry into the labour market. As with unemployment, its long-term (over one year) duration becomes the single most important determinant of continued unemployment – so-called *hysteresis* – and a stigma in itself. Employers having a choice will always prefer people with short spells of job search as against long-term unemployed however better their qualifications may be. Long-term joblessness is even more stigmatizing and makes people even more *unemployable* in employers’ perception if the persons concerned may be attributed other comparative disadvantages such as disability or having stayed not only out of specific jobs or work but out of the workforce altogether by even given-up job search and labour market availability at all. Publicly *subsidizing non-employment of previously and potentially employable persons with handicaps* – instead of subsidizing all efforts at job maintenance or rapid re-insertion and upgrading their employability – is a *core entrapment* of many disability welfare policies.

Consequently, *timing of preventive action and sequencing of return-to-work and activation measures* is crucial. This requires occupational health and safety investment to reduce occupational hazards and risks of work injuries; early intervention to prevent pathological conditions from illness or accidents turning into impairments; rapid and sound medical rehabilitation to correct impairments by medical treatment, aids or appliances in order to prevent them from becoming chronic or even leading to functional limitations; and vocational rehabilitation, or workplace accommodation, and work as-
Assistance for strengthening offsetting capacities in order to prevent functional limitations turning into prolonged or irreversible work disability. Everything will have to be done to prevent exit from work in working age in general and to block the disability exit-path – often after long-term unemployment or social assistance or long-term sickness – in particular.

While everybody will agree in principle with this focus on early intervention in order to prevent long-term benefit dependency from arising at all, much time is lost in practice by inadequate timing of activation. In many countries vocational rehabilitation, for instance, if it exists at all or not just formally (such as, e.g. in the United Kingdom where until recently – till about the year 2000 – rehabilitation efforts were virtually nil and the Employment Rehabilitation Service was meant to be privatized), starts only when a person is potentially entitled to or even already paid a disability benefit (OECD, 2003). By this practice, the long and critical period of sickness absence is irrevocably lost for re-integration – and the potential and initial motivation to return to work may be withered away after one year or more out of work with up to the full previous income. As a counter-intentional result of these perverse practices widely prevailing, it is less the very nature of the initial health condition, or the impairment stemming from it, or the objective severity of functional limitations, but the permanency of the work-disabling condition of a prolonged stay out of work artificially produced by delayed re-insertion measures which transforms unused abilities into disability and dependence.

The crucial difference and strategic institutional deficiency at stake, thus, is not income but job discrimination and adverse self-selection into non-employment. And it is this, partly politically induced, option for non-employment and the, partly politically accepted, job discrimination of employers that will have to be overcome. The same applies for overall absenteeism due to health conditions which is not monitored systematically and comparatively so far: anything more than a few percentage segments in every working age population which are so acutely sick or ill or injured or incapacitated that work is actually completely impossible, could be critically screened, surveyed and regularly reviewed for its causes and assessed against comparative benchmarks. The fact that overall absenteeism rates, sickness and disability benefits and costs vary that strongly not just between countries of different socio-economic development – and probably very different underlying health conditions of the population and health care capacities – but vary also equally strongly between similarly advanced, similarly wealthy
and similarly healthy populations shows impressively that institutions and policies do matter, and matter a lot. Differences in health and disability welfare institutions, as well as differences in labour markets and social policies, make for far more difference in disability prevalence socially accepted as work-disabling than the differences in subjectively perceived and “objective” health status.

Absenteeism from work is a good case in point of how institutional arrangements may or may not first invite moral hazard and, after its occurrence or not, require policy change in order to contain opportunistic behaviour – or not. Some of the most advanced welfare states such as Sweden or Germany by the very generosity of their sickness benefit conditions first invited widespread abuse of sickness insurance and then introduced harsh measures in order to cut down on sickness pay – by reduced income replacement rates, waiting periods (“Karenztage”), differential replacement rates by lowering substitute income for the first two or three months of absence, increased employer’s cost-sharing for sickness payments, etc. Sweden, after taking recourse to waiting periods punishing short-term absence from work and illness by income losses, succeeded to cut absenteeism from an average of about 27 workdays annually by almost half; it then found itself at the same level of illness-related absence from work as Austria without any such punitive action and with the same level of generosity of benefits as Sweden before. Welfare generosity obviously requires a collective containment of moral hazard.

By the very nature of sickness, work-related accidents, occupational diseases or other forms of disability, moderate and therefore partial disablement would be expected to prevail over total work disability, and temporary incapacity should prevail over lifelong and irreversible one. But empirically, the opposite is true: outflow rates from disability benefits, even for partial disability, are extremely low, i.e. around 1% (!) in 80% of the countries investigated (a.a.O.: Chart 4.1), so that benefits once awarded are an almost irreversible way into long-term welfare dependency, regardless of the underlying health conditions. Those countries investigated that offer partial benefits (a quarter of them even partial disability at several gradations), also happen to be among the countries with the highest recipiency rates. The existence and availability of partial benefits seems not only not constraining but rather expanding overall disability recipiency, demonstrating that preventing partial benefits creeping into full or permanent dependency is a major challenge in offsetting disability welfare spread. Currently, even in countries provid-
ing partial benefits, only one in three awards is for partial disability, whereas the great majority of benefits is for full incapacity.

Furthermore, in contemporary welfare systems more people are awarded a disability benefit than receive vocational rehabilitation services (a.a.O.: Chart 5.1) and ten times more people are on benefits than in special employment programmes for disabled people (a.a.O.: Tab. Chart 5.2). Despite the fact that the employment value for active programme money seems to be quite doubtful, given the weak correlation between employment rate and expenditure on active employment-related programmes for disabled persons (a.a.O.: Chart 5.4), it certainly is an indication of societies which have not got their priorities right, namely towards return to work measures.

In a paper for the European Centre,17 the editor of this book and main author of the OECD report summarizes the – rather disenchanting – relationship between “policy and employment outcome” such: “Differences in employment population ratios are apparently not explained by differences in countries’ employment and rehabilitation policies … The relationship between the two variables is virtually zero. One could argue that this result is a consequence of the fact that current employment outcome is determined by yesterday’s rather than today’s policy… However, correlating late 1990s employment rates with pre-1990 activation policies does not affect the conclusion. High employment rates are found in countries with strong as well as weak employment and rehabilitation policies, and vice versa. To be more precise, none of the ten integration policy sub-components is correlated with employment outcome. These results hold for absolute employment levels as well as for employment rates of disabled people relative to those of their non-disabled peers. Hence, the general employment level – as an indicator of social and economic status – does not explain this non-relationship between employment rates and the integration component either.” (a.a.O.: 11; for the integration policy sub-components see OECD, 2003: Table A2.2).

Still, prioritizing re-insertion implies complementing strictly medical rehabilitation by vocational rehabilitation. Quite obviously, crunches and wheelchairs, artificial limbs or artificial hips may be necessary for restoring body functioning sufficiently in order to be able to move or walk again without too much impairment; but they are far from sufficient in guaranteeing full work capacity again, except in a few well-practiced routine cases. If around one million artificial hips for an annual cost of about 20 billion Euro are implanted each year worldwide with the purpose of letting a million persons not become disabled but enable them again to walk normally, the so-
cial value added of these medical expenditures is far from obvious and different welfare philosophies and health practices prevail. Whereas in the United States, for example, patients spend five days in hospital under the premise “a good surgical intervention does not need any follow-up treatment” and are then left to themselves for a privately covered reconvalescence period, the very same hip implantation will take six weeks in Austria; 21 days of hospital treatment plus another 21 days of nursing care and rehabilitation under the premise that “the patient will leave after six weeks of comprehensive care completely healthy and capable to work”.

Nevertheless, encompassing comparative cost-benefit analysis of different rehabilitation strategies – such as covering the 5 : 42 difference in days of supported invalidity after an artificial hip implantation surgery described in the paragraph above – are greatly lacking. Furthermore, in his theoretical introduction to this volume Philip R. de Jong points at a number of “problems surround(ing) rehabilitation policy”, namely the inherent complexity of assessing the rehabilitative potential (“as complex as screening for partial disability is”), the set-up of an adequate individualized rehabilitation programme, and the unclear character of their efficacy. And all experts from all disciplines stress the crucial role of subjective motivation, as if the faith in one’s own recovery could actually remove mountains of physical impairment, whereas giving up hope and confidence in successful rehabilitation is as good as its programmed failure. This demonstrates vividly how in cases of medically defined risks and disabilities the insured patient himself – and other parties with interests of their own – may influence the occurrence as well as the degree of invalidity.

In sum, an employment-oriented equal opportunity disability policy model would emphasize activation, customized early intervention, tailor-made work assistance, seasoning, vocational training and occupational rehabilitation, removal of disincentives to work and employment; it would develop schooling, training, job placement and assistance services, subsidize or otherwise compensate employers for competitive disadvantages eventually stemming from disabled members of the workforce, and support disabled people working by in-work benefits and a rights-based approach of effective anti-discrimination legislation. It would try to develop a culture of mutuality. Within this new social contract between society, people with disabilities and their employers, every party will have more rights and more obligations at the same time, as the OECD report claims as well. Recipient’s obligations will match their rights as beneficiaries; and employers will be more
obliged than they currently are to accommodate the workplaces for persons with disabilities. Disabled persons will be entitled to a tailor-made, personalized assistance for re-integration into work – and income supplements to the extent of their failure only – and not above all to replacement income benefits. And employers in an employment-oriented disability policy will be mandated to accommodate workers with disabilities, take and retain them and be compensated for that, instead of massively using or abusing disability entitlements to discharge surplus workforce at public expense and contributing to widespread, costly, and absolutely unnecessary non-employment of the overwhelming majority of non-employed people with disabilities, as is currently the case.

Thus, employers too will have new rights and new obligations under this new deal. Above all, external costs generated by using disability benefit schemes as a workforce management tool will have to be re-internalized by some form of experience rating – employers producing more accidents, occupational diseases, work injuries, sickness, disability and pre-retirement will on some intermediate level of risk pooling (enterprise, sector, region) be held responsible for their decisions. They will have to become actively involved in prevention, rehabilitation and re-integration – and to be publicly supported in sharing and carrying-out public functions and compensated for “undue hardship” undermining their competitive edge. If, for instance, employment quotas for persons with handicaps are used as a policy instrument, non-compliance with legal obligations and free-riding at the expense of competing enterprises will have to be prevented by cost-sharing arrangements and fines reflecting realistic costs. But more than guaranteeing fairness in burden-sharing, public authorities will have to make sure that companies willing to retain or recruit persons with disabilities will be technically assisted to actually do so: workplace and job adjustments usually are not expensive financially, but complex and demanding socially throughout the process of problem assessment over developing an intervention strategy to evaluating outcomes of the accommodation process.

Public authorities too will have to re-direct their policies, for reasons both of social cohesion impact and effectiveness of disability welfare as well as its cost-efficiency. In an employment-oriented equal opportunity disability policy model, a much greater share of overall expenditures on disability welfare will have to go to active programmes instead of passive benefit transfers. Activation is not only promising in terms of long-term sustainability of funds allocated, both vocational rehabilitation and training programmes are
actually less expensive than benefit transfers without return option. Sheltered employment, in contrast, is not only frequently inappropriate and most problematic for its ghettoizing segregation effects and its permanence, it is also much more expensive not only than activation programmes but even than passive disability benefits themselves. It is the more surprising that sheltered employment mostly remains as important as ever before and that its replacement by supported employment initiatives in the regular labour market does not advance as one could rationally expect it to do.

But without individualized participation offers, work re-integration packages, personal job coaches and help in work-related and extra-occupational activities, normalization and integration of people with disabilities into regular labour markets and work opportunities is doomed to fail. Worst of all, the striking age-mismatch between disability inflow and vocational rehabilitation offer will have to be ended: currently, there is almost no participation in active programmes of those most in need, namely above age 45, whereas younger people have an attendance far above their disability prevalence requirements (a.a.O.: Chart 5.6). And, as was shown repeatedly throughout this chapter, disability benefits will have to be re-designed by public authorities, policy-makers, legislators and programme administrators in such a way that incentives, including strong financial incentives for both firms and their handicapped employees, will be reoriented towards return-to-work incentives instead of their current out-of-work bias.
Normalization or mainstreaming of disability do not imply that rationality, fairness and equality in treating people with disabilities exist. Rather, collective compassion is distributed quite unevenly and arbitrarily, though not accidentally – but with serious consequences for the categories of handicapped persons concerned. This graded or unequal compassion for various types of disability has been observed by scholars like Wilensky and tried to explain as “a hierarchy of sympathy”: “a blind colleague briefed me on the amazing array of benefits the state supplied to the blind, even the partially blind. I then inquired into state benefits for the deaf, for paraplegics, and other groups. They were nowhere near what had already been achieved by organizations of and for the blind, with the possible exception of polio victims, whose plight had been dramatized by FDR and the immensely successful National Polio Foundation … One would be hard put to say that a partially blind person is worse off than a paraplegic. A psycho-political explanation for the differences in state largesse might go like this: A well-dressed blind person with a tapping cane and a handsome guide dog is as appealing on the street as the picture of the smiling child on crutches in the Polio Foundation posters. But a paraplegic in a wheelchair is less mobile. If she appears in public, she makes the passer-by uneasy. And unlike the blind, the paraplegic cannot readily make her way up the Capitol steps or the state capitol offices to lobby for her particular group as the blind person and his dog can. All this began to change in the 1960s as other groups became more militant and better organized …, began to coordinate political action across types of disability, and acquired better technology and support.”

Furthermore, normalization or mainstreaming of disability do not mean that earlier attitudes of indifference and rejection, that even hostility and discrimination are completely overcome and do not persist. But underlying currents can neither prevail overtly, nor are stigma and stereotypes and unequal access and opportunity any longer politically tolerable. This is important enough to notice against the background not just of the ultimate horrors of systematic mass killing of “life unworthy of living” (lebensunwertes Leben), often simply ill people who could not be healed and had no prospect of recovery within a regime which saw itself as a healing movement, or people of “inferior races”, by the Nazis. It seems absolutely unimaginable...
ble today that only somewhat over half a century ago, two to three decades ago before the recent paradigm shift towards mainstreaming and integration of people with impairments occurred, it was still considered a “volksschädliche” disability worthy of forced internment in special asylum institutions, against the will of the persons concerned and that of their parents, when children were stigmatized as “asozial” in their behaviour, or used to be even only bed-wetting or nail-biting. This may be less surprising in view of the fact that people were even killed for “crimes” such as “disobedience”, not denouncing a hidden Jewish friend, carrying felt boots, not respecting the law prescribing shop closing hours, the possession of carrier pigeons and the illegal slaugther of animals, owning radios in some occupied territories and the unauthorized hearing of BBC, or occasional black labour or black market trading of say, cigarettes.20

It may have been this ultimate insanity of Nazi sanitarianism, the ultimate cruelty and grotesqueness of the obsession with sanitizing society, biopolitically conceptualized as a Volkskörper in need of eliminating everything defined as “insane”, of coercive health, trimming, fitness, rejuvenation, cleaning and purification which should have once for ever discredited the discrimination of people with impairments and disabilities. Sanitarianism made great efforts at controlling all public health-relevant action and population development – from sexuality, generative behaviour over lifestyle, dietary practices, drinking etc. to low-cost dying. It aggressively propagated, for instance, breast-feeding, cancer prevention and nutrition therapies, wholemeal bread and soja bean, raw diet, vegetarianism, clean air, and crusaded against cancer, asbestos, food colouring and conservation matter, pesticides, alcohol and nicotine (including a ban on sports-related and erotic marketing of tobacco), against “decadent” make-up, marketing of baby food stuff, obesity, abortion, homosexuality, vivisection, etc.21

Though attacks on impaired people or their overt discrimination may never again be tolerated, contemporary societies, unfortunately, have by no means finally overcome all other biopolitical and eugenic temptations. They range from grounding politics not in socio-economic interests, but in inherited, “natural” identities; over perfecting the human race through genetic screening to eugenic manipulations; to policing, sanctioning, finally eradicating “unhealthy” behaviour of all sorts, stigmatized as contagious or only dangerous for oneself, but irresponsible and costly to society. The Nazi Hitler youth movement propagated “Du hast die Pflicht, gesund zu sein!” – you are obliged to be healthy; or “Ernährung ist keine Privatsache” – nutrition is not a
private matter. But biopolitics and eugenics have not only preceded but also survived Nazism and have, as does euthanasia, recently had a surprising revival in modernized and humane form in several Western societies.22

Mid twentieth-century Nazism has peaked in the utmost possible perverse way a long history of cruelty or ruthlessness towards persons with disabilities. Whether intolerance of deviance and diversity (difficult to cope with and challenging otherwise not challenged persons), what Jacques de Goff called “the inner demons” of European history will have been finally overcome once and forever is still to be seen. History, anthropology and ethnology teach us an incredible diversity of what constituted “impairment” and “disability” across time and space – and what did not do so; and what behaviour was socially accepted or not, what was disapproved or even stigmatized and what norms and obligations towards persons with disabilities – and by them – were prevailing.

Cultural diversity is actually striking: Many societies fully integrated people with what today is perceived as a severe physical impairment or a grave mental disorder, or as social deviance or deprivation, such as being insane and/or being homeless, being unable to hold down a job or unable to read and write, being dirty and unkempt, or simply being obese and still appear in public; while other societies strongly stigmatized traits (or behaviour) considered normal or fully acceptable in our societies such as being infirm or ugly or infertile, living alone unmarried, or having no children, or having children with congenital impairment, or drinking alcohol, or being HIV positive; with “ugliness” as an impairment starting with a crooked nose, excessive freckles, or flabby or small buttocks.

Judeo-Christianity oscillated between interpreting impairments as warranting healing, charity for the sick and support on the one hand and as signs of wrongdoing, justifying the separation of people supposedly unclean and ungodly on the other. In the Old Testament, it was the incapacity to pray in the community of others and not that to work which constituted disability: people with crooked noses, sores, missing limbs, leprosy, skin diseases and crushed testicles displayed human impairments precluding them from participation in religious rituals. Throughout the Middle Ages, truly Dark Ages of stigma for persons with disabilities, the Church and some of its Saints such as St. Augustine continued to interpret impairment as punishment for sin and people with impairments as living proof of Satan’s existence and power over ordinary mortals. Disordered minds, in particular, were attributed to demonic forces. An impaired infant was seen as a “changeling”, the Devil’s
substitute for a human child or the product of the mother’s involvement with sorcery and witchcraft. Birth of an impaired child was a proof of parents’ involvement with witchcraft, sinful practices or wickedness, impairment was a *shameful stigma* provoking fear, ridicule and mockery, if not isolation, ostracism and even persecution. In normal periods of everyday life, in contrast, people with impairments and mental disorders were tolerated and integrated into families and into domestic and agricultural labour, before capitalist industrialization pushed ever growing numbers of “the aged and the infirm“, “the sick“, “the insane” and “the defectives“ and others unable to meet the pace of factory production into segregation in workhouses, asylums, and later into residential homes or sheltered employment institutions.23

History, anthropology and ethnology also teach us that it always was and is less the physical or psychic impairment as such but the *meaning* of disability within the social order and production process that determines societal reactions to incapacity. If a congenital impairment, for instance, is seen as caused by nature or God, individuals cannot be blamed for it – as they often are, more or less openly, in modern Western societies. In several contemporary Central African cultures, in contrast, *impairment is not at all stigmatized, while ugliness or childlessness are*. Physically impaired persons may work and marry, become parents and participate in community life to the best of their abilities, whereas “faults“ of “ugliness“ such as “excessive freckles, protruding navel, absentmindedness, and flabby or small buttocks” may make it difficult if not impossible to marry.24

It is easy to think of functionally equivalent forms of “ugliness“ stigmatized in modern and post-modern societies, with different “faults” actually disapproved, ranging from disadvantageous to acutely disabling in occupational and private life, acting as barriers to careers at professional work, to marriage and conviviality, though in a much more hidden, inauthentic, self-denying – and therefore also more difficult to combat and to overcome – manner. In contrast to *handicaps caused by physical impairment*, *incapacities resulting from social deprivation* such as being poor, looking poor, being low-skilled, clumsy, extremely timid, speech deficient, functionally illiterate, having ticks or ridiculous habits, being homeless, unable to hold down a job, unwashed and unkempt in public, or having social phobias or panics (at least as long as they are not recognized in medical terms as a health condition or mental illness) and their consequences frequently lead to joblessness and social isolation, but with (almost) no entitlements to income or other benefits.
Generally, it is less a physical impairment as such which defines disability but its interpretation. In traditional societies, it is less the ability or disability to perform certain tasks, but the place of a person in cosmology and thus its personhood which defines disability; then, the primary focus is less on improving the situation of an impaired person, but on interpreting the fault. The fault is best interpreted such that divine intervention – or sort in modern, secularized societies – plays more of a role than any kind of failure, failure of parents to respect food or sex taboos, bad family relationships leading to sorcery, lack of respect for ancestors – or unhealthy, even risky lifestyle in our societies. Traditionalism stigmatizes *childlessness* and even denies personhood to persons without children: “In many traditional societies…. The key ‘disabling’ condition is failure to have children: parenthood is the key to adult status. Those without children of their own … are sometimes given children by other members of their family, so that they can acquire full personhood …” (a.a.O.: 15).

The WHO study on “Disability and Culture. Universalism and Diversity” demonstrates impressively that archaic conceptions are not restricted to traditional tribes such as the Masai, Punan Bah, Songye or Tuareg. Rather, intolerance against deviance from mainstream patterns of behaviour and moralizing of unhealthy lifestyles as harmful if exercised by disapproved marginal groups prevails in many contemporary post-industrial societies: “someone who is dirty and unkempt” should not appear in public and tried to be stopped”, even less so than “someone with a chronic mental disorder who ‘acts out’ “. Even infertility is assigned a minor “disabling effect” of health conditions (a.a.O.: 270). Childlessness may continue to meet disapproval in important segments of many so-called modern Western societies, as traditionalist groups are trying to establish childlessness as the result of a kind of sinful, egotistical, irresponsible, and that is sanctionable and stigmatized behaviour. Superficially, declining birth rates and corresponding population shrinking and its consequences are taken as reasons for increasing the salience of this issue and to politicize it. But the scapegoating of childless persons as embodiment of a collectively disabling and harmful condition is even more puzzling in view of the facts: first, the share of women without children in today’s Western societies of around 15 to 20% is significantly below, often around only a half of that of the times of their grandmothers at the early twentieth century when childlessness was above 30% of the female population; and secondly, not only has childlessness fallen and not increased in a secular perspective, it also contributes much less to declining birth rates than the falling fertility of women who do have children,
but on average significantly less than at times before demographic maturity.

Furthermore, blaming the victim for congenital impairment in particular is far from being overcome in folklore and broad popular sentiments and resentments. Intolerance against deviance and less calculable behaviour is still deep-rooted though rarely expressed openly nowadays. Thus, even obviously “innocent” outsiders such as physically impaired persons, brain-damaged children, mentally ill or infirm old people may not just be discriminated against by avoiding contact but may see themselves being prejudiced through moralizing attribution of self-infliction and culpable behaviour. A study reporting opinion poll survey results in Germany in the late 1960s demonstrated as supposedly “most important causes of physical impairments: medicament abuse by parents (73%), alcohol- and nicotine abuse (62%), hereditary transmission (55%), attempts at abortion (42%), venereal diseases (37%)“. Crippling of the child was attributed to a culpable behaviour of its parents.

Underlying such a pitiless stigmatization of disabled people may be a hidden since forbidden desire of annihilation. Another study in the mid-1970s analysing anonymous protest calls to the Austrian Broadcasting Corporation ORF found many anonymous protests to complain about the “disgusting” appearance of severely impaired children in public TV, some of which even asked for an “elimination“ of such “burdening” creatures. But hostility which stops short of demands for physical elimination and asks for displacement and segregation of disabled people “only” frequently does not even hide behind anonymity: Law suits have been filed – and rejected – for “spoiled vacation pleasures” or “having to see” greater numbers of guests with severe disabilities in tourist recreation sites; and local communities mobilized against the establishment of sheltered workshops and residential housing for disabled children and youth in their neighbourhood.

Apart from the fact that the “hereditary disease” these persons actually suffered from may have been the remnants of their or their ancestors’ Nazi-past and its Herrenrassen ideology, it also proofs how easily political correctness of speech codes and norms of decency may wither away under conditions of “permission” through either unsanctioned anonymity of expression or through socially approved instigation to hatred or contempt or political mobilization – or self-righteous moralizing. Then, hidden and suppressed wishes of strongly prejudiced persons at destruction of provoking
diversity which makes feeling insecure will become the more open, the weaker and more helpless the secretly detested and disdained objects of prejudice actually are.

It is not difficult to imagine, how little it would take in order to again stigmatize people with (congenital or acquired) impairments, or their parents, could it be proved scientifically (or only credibly be asserted) that some extremely dangerous or contagious or costly or repellent or publicly rejected diseases were caused by a behaviour to be blamed for its occurrence or spread, such as, for instance, drug or alcohol or nicotine abuse, unconventional sexual practices or promiscuity, unhealthy lifestyle, non-compliance with compulsory vaccination requirements risky for public health, costly negligence of medical treatment prescriptions or (in the future maybe) the non-take-up of genetic screening facilities, whether voluntary or not.

Under these circumstances, even objectively harmless but cumbersome disruptions of public order (such as a frequent occurrence of incontinence or vomiting of drug dependent persons in public places or spaces) or widespread small “survival” delinquency by ill and destitute “junkies” may evoke deeply hostile popular reactions. The popular stigmatization of HIV infection in the early period of the pandemic, which was most skilfully contained in later stages, shows, nevertheless, the potentially explosive dangers of blaming the victim for self-inflicted disease, disability, and transmission of risk. And even after the successful medicalization and normalization of HIV/AIDS, heavy social disapproval or stigma against persons infected persists in almost all countries27 – despite the astonishing fact that HIV infection was found to be the most variable health condition in the study, being ranked from the most disabling of all health conditions in Egypt and Tunisia to the third-least disabling condition in Luxembourg (a.a.O.: 271) but with almost identical disapproval ranking in these countries. Thus, it is not just the infectiousness and danger of a potentially deadly disease which arouses stigma but the moral indignation and social disapproval as such – alcoholism and drug addiction were most strongly stigmatized almost everywhere despite their being less dangerous for public health.
Notes


2 Occassionally, this strategy went as far as in a number of large semi-public enterprises in the course of their privatization in Austria. Between 1998 and 2002, post, telecom, public bus and public railways dismissed thousands of their employees into early retirement via disability pensions. Obvious irregularities and conspicuous regularities generated a suspicion of abusive patterns and led to an investigation by a special commission of the Federal Office on Crime (Bundeskriminalamt). After screening the first third of the files documenting the early retirement practices, inquiries confirmed not only the suspicion of widespread abuse but detected refined forms of exploiting a legal situation where regular early retirement would be at the expense of companies whereas incapacity-related pre-retirement must fully be covered by public schemes: if an equivalent job to the one somebody is unable to carry out is not available, pre-retirement is foreseen at public expense by the law regulating civil service. In searching systematically for reasons given for invalidity with the help of computer programmes, investigators found out that early retirees (of an age 45 and lower) always displayed exactly those illnesses and impairments which made them unable to work exactly but only at the position they were holding before: most chauffeurs retired because of back pain not allowing for prolonged sitting; postmen mostly had a prolapsed disc incapacitating them from lifting or carrying heavy things; employees working on computers had almost always seeing impairments preventing them to continue working on screens; office workers were most frequently diagnosed with mental and psychological problems which did not allow them to concentrate on their work that, therefore, had to be given up. Thus, whereas practically none of the around 4,500 diagnosed “invalids” sent into pre-retirement up to more than two decades before legal retirement age was attested a general disability to work, all of them were finally defined as disabled to work – as they were diagnosed as unable to work at their previous workplaces and seen able to work in all those other areas where no work was available. Each enterprise and each category of disability to work had a special group of medical examiners issuing the medical assessments. The Chamber of Physicians (Ärztekammer), a mandatory corporatist interest representation of medical doctors, which had previously complained with some of the companies that several of their members were put under pressure to hand-out benevolent clinical expertises refused to help the criminal investigations and to collaborate with the judicial authorities in order to protect those of its members which had collaborated with business companies in falsely diagnosing tailor-made “disabilities to work” (status as of early Fall 2002).

3 Wolff, M. et al. (1995) Where We Stand, pp. 122, 123, documenting the Number of Medical Complaints per 1,000 People over a Three-Year Period found, for instance, that Germans seek 23 times more often treatment against back pain than US-Americans and 2.5 times so often than French; they consult physicians 10 times more frequently than Americans and 3 to 4 times more often than French regarding heart problems; when it comes to bronchitis, Germans see doctors 15 times more often than Americans and 5 times the French; whereas French people seek treatment of depressions around 15 times more often than Americans; nervousness gets the French 4 times more frequent to the doctor than Americans and twice as often as Germans; insomnia makes French clients seeking help
239 times more often than Americans and 4 times the neighbouring Germans, while Germans complain 11 times more frequent about skin problems than US citizens and 4 to 5 more often than the French.


7 Wilensky, op. cit., p. 550.


Bernd Marin


