



Helping chronically ill and disabled people into work: what can we learn from international comparative analyses?

- In the UK, employment rates for people with a chronic illness and disability are low and show a social gradient, with less skilled manual workers suffering the most.
- This project aimed to identify and synthesise evidence on policies and interventions that might help chronically ill and disabled people into work in five highly developed welfare systems: Canada, Denmark, Norway, Sweden and the UK.
- Comparing these five countries in relation to *macro-level policies*, the problematic employment situation in the UK for people with limiting illness and low education may in part be a consequence of adverse long term macroeconomic conditions combined with a relatively low level of active labour market policies.
- In relation to *focused interventions*, a typology of eight different types of intervention was developed and studies reviewed within each category. Some intervention types produced promising results in terms of improved employment chances for participants. Influential factors in terms of impact included intensive personal support and substantial financial incentives.
- There are many pitfalls to interpreting the evidence on social interventions including: biased selection of participants into the interventions; take-up of universal initiatives by those for whom they were least intended; measurement of outcomes too soon or inappropriately; hidden stigma associated with some interventions; low take-up leading to negligible population impact. All these make in-depth knowledge of the intervention/system context and the incorporation of evidence from qualitative studies a necessity.
- Very few studies investigated whether there was a differential impact of the interventions for different socio-economic groups. It is essential for future effectiveness studies to monitor differential impact. Some of the studies that did, found that specific interventions were less accessible to less skilled manual groups, who would need additional support to help them return to work.
- These are the very groups that our epidemiological analyses reveal have the poorest, and declining, employment chances in all five countries, with the situation in the UK being of particular concern. The current recession in all the countries make it more pressing than ever to address this problem.

Background

Chronic illness and impairment can have high social and economic consequences for individuals, their families and society. Disability is one serious consequence, when individuals experience disadvantage resulting from barriers to educational, employment and other opportunities that have an impact on people with ill health or impairment.

In the UK, employment rates for people with a chronic illness and disability are low and 2.6 million chronically ill or disabled people are on incapacity benefits. As chronic illness, disability and non-employment are socially patterned, with increasing risk with decreasing socio-economic position, these trends have the potential to generate further social inequalities in health. Other comparable countries are facing similar problems and this provides an opportunity for policy learning.

The aim of the project was to identify and synthesise evidence on policies and interventions that might help chronically ill and disabled people into work in five highly developed welfare systems: Canada, Denmark, Norway, Sweden and the UK.

Methods

In-depth analysis for each country included three main components:

- Policy review and analysis to understand the range and types of policies and interventions that have been implemented in each country that may influence employment chances for chronically ill and disabled people, and where the main emphasis lies.
- Epidemiological studies of employment-related trends over time for chronically ill people from different socio-economic groups during which time selected policies have been introduced, changed or taken away.
- Synthesis of evidence from the selected countries on evaluation studies of the impact of the identified policies and interventions.

Full details of the review methods can be found on the PHRC website (www.york.ac.uk/phrc/).

Key findings

How have chronically ill and disabled people fared in the labour markets in different countries?

There were marked differences in the employment rates of people with limiting longstanding illness across the five countries. The UK had the lowest employment rates for both men and women. Nearly 60% of British men with limiting longstanding illness were employed, compared with rates of over 70% for their Danish and Norwegian counterparts. Half of British women with limiting longstanding illness were employed, compared with rates of over 64% for their Norwegian and Swedish counterparts. The highest employment rates for individuals with limiting longstanding illness were observed in Denmark and Norway for men (71% in both countries) and Sweden and Norway for women (65% and 64%).

Differentials between the employment rates of healthy and chronically ill individuals were largest in the UK, where the employment rates of men and women with limiting illness were 37% lower than those of their healthy counterparts.

Social inequalities in employment chances for people with chronic illness were substantial. Those who had a low level of education were hardest hit in all five countries, but this effect was particularly pronounced for chronically ill men in the UK. The same was true for women in Denmark and men in Norway. Considering the trends over the past twenty years, there was a marked deterioration in the employment chances of people with limiting illness who had low education, even during most recent periods of economic recovery.

What has been the influence of macro-level policies?

Contrasts in policy on flexibility and de-regulation of the labour market are stark and may potentially have differential impacts for chronically ill and disabled people. The UK now has one of Europe's most de-regulated labour markets, while Sweden has maintained one of the most highly regulated. Canada is nearer UK and Norway nearer Sweden on this spectrum. Denmark, however, has developed a unique model of "flexicurity", a term invented to describe a flexible labour market with liberal hiring-and-firing

procedures combined with relatively generous social security and active labour market policies. There are opposing hypotheses about whether a flexible labour market is good or bad news for people in ill-health, as outlined in **Box 1**.

Another significant contrast at the macro-level is the degree of economic security for individuals outside the labour market. Sweden, Norway and Denmark have a high level of generosity and entitlement to welfare benefits when not working, while the UK and Canada have much lower levels. There are contrasting hypotheses about how the level of welfare benefits may act as incentives or disincentives to work for people who are chronically ill. **Box 1** summarises the main hypotheses about the influence of macro-level policies for chronically ill and disabled people.

The secondary data analyses on the effects of macro-level policies found:-

No support for hypotheses 1 and 2 relating to the effects of unregulated/flexible labour markets and the discouraging effect of more generous welfare benefits: the countries with the most generous benefits also have the highest employment rates among chronically ill people. Likewise, hypothesis 4 - the "Business cycle" notion of increased employment-related polarization between healthy and ill people during periods of high unemployment - is not supported. Denmark and Sweden have had the largest variations in unemployment but still very high employment rates among chronically ill people.

Hypothesis 3 – on active labour market policy impacts - is partially supported. Higher employment rates among chronically ill and disabled people were observed for the countries with high spending on active labour market policies such as vocational rehabilitation.

Hypothesis 5, concerning the post-industrialisation effects (i.e. the structural transformation from manufacturing to the service and education sectors, and the associated trend towards higher demands on labour) is partially supported. We observed growing employment polarization between healthy and ill groups which were mainly independent of short-term economic fluctuations.

Comparing these five countries, it seems as if the problematic employment situation in the UK for people with limiting illness and low education is a result of adverse long term macroeconomic conditions combined with a relatively low level of active labour market policies.

What kind of focused interventions have been introduced?

With focused interventions, governments have followed two principal routes. One has a focus on the employment environment, attempting to make it more "disability-friendly". The second is a focus on the disabled people themselves – attempting to protect their standard of living whilst not working or to develop their skills, education etc. in order to increase their employability. See **Box 2** for eight distinct types of intervention.

Over the past two decades, all five countries have followed both routes in an effort to promote return-to-work for chronically ill and disabled people, but they have differed in the types of strategies employed and how these were combined and prioritised. It is clear that the Nordic countries have put more effort and resources into active labour market policies over the years and have tended to put more emphasis on interventions to improve the employment environment, compared with the UK and Canada. Conversely, the UK in particular, has gone strongly for the individual-focused interventions and has stepped up its' intensity of efforts substantially in the past five years.

What is the evidence on the effectiveness of focussed interventions?

86 studies that fitted our inclusion criteria were identified for the review (26 from the electronic databases and 60 from the grey literature). In addition we included 14 studies from our previous review of UK interventions on the same subject, as well as the review itself. There were examples of evaluations of all the intervention types in **Box 2**. Key conclusions include:

There is a big gap between the large volume of interventions that we identified in our policy review and the small volume of evaluations carried out. There is need for more and better assessment studies. The qualitative studies were invaluable in helping to understand the reasons why an intervention did or did not work.

Some interventions produced promising results in terms of improved employment chances for participants. *Resting disability pension* was a remarkable example from Sweden, where people who had been retired on disability pension for several years were enabled to return to work. This was an example of a **Type 5** individual-level intervention – a financial incentive offered to pensioners to take up work. Influential components of the intervention appeared to be the substantial size of the incentive offered to disability pensioners and the safeguards for their pension if they wished to go back to their pensioner status within the first year. It was, however, an example of an intervention that had a differential impact, with a greater uptake among non-manual, educated disability pensioners.

The level of incentive also appeared to be a crucial factor in **Type 3** work environment interventions – offering financial incentives to employers. Earlier UK experiments to offer financial incentives to employers to take on disabled workers, for example, appear to have been at too low a level to act as a realistic incentive. The Danish *flexjobs* scheme, on the other hand, offered support in the region of 50-65% of the employee's salary. Employment in *flexjobs* has increased dramatically since the introduction of the scheme: from 6700 in 1999 to 40,600 in 2006. The Danish scheme, however, illustrates another problem: there are indications that the *flexjobs* might increasingly have been assigned to chronically ill people who have no reduction in work ability who might otherwise have obtained a job without the scheme – thus crowding out those for whom the scheme was intended.

Type 6 individual-level interventions, offering personal case management and job search assistance, were implemented in all five countries and demonstrated improved likelihood of employment for participants under some of the schemes. Schemes showing positive results included the *Canadian Opportunities Fund for Persons with Disabilities (OF)*; the *Danish Case Management Interviews (CMI)* and the UK *New Deal for Disabled People and Pathways to Work*. The qualitative studies on the UK interventions flagged up the importance of building supportive and trusting relationships between claimants and case managers, to overcome concerns and build confidence. There were, however,

some indications of selection into the programmes of people who were seen as easier to place (cream-skimming), particularly by private and voluntary sector providers. This is an example of a generic problem in reviewing social interventions of this nature, as the following outlines.

Lessons for systematic reviewing of social interventions:

There is a danger of misleading evidence from evaluations due to biased selection of participants into the interventions. Some interventions selected the easier cases (cream-skimming). Conversely, others were focussed on the hardest cases, seen as in greatest need of the service. This emphasises the importance of always considering selection into interventions when interpreting results.

Some evaluations may measure outcomes too soon or inappropriately. This was a potential danger with some of the evaluations of vocational rehabilitation, where the time spent on the rehabilitation programme meant that any possible uptake of employment was delayed until they finished the programme.

Some interventions may actually be counterproductive, which highlights the necessity of evaluating all initiatives for harmful effects. The possibility was also raised of stigma being attached to a particular form of rehabilitation that may cause employers to avoid participants from it.

Some interventions had very low uptake or population coverage, so they could not be expected to have a measurable effect when assessed at the population level.

Conclusions

Very few studies investigated whether there was a differential impact of the interventions for different socio-economic groups in the population. It is essential for future effectiveness studies to monitor differential impact. Some of the studies in this review that did, found that specific interventions were less accessible to less skilled manual groups, who would need additional support to help them return to work. These are the very groups that our epidemiological analyses reveal have the poorest, and declining, employment chances in all five countries, with the situation in the UK being of particular concern.

Box 1: Hypotheses about the impact of macro-level forces on employment chances of chronic ill and disabled people

1. **Unregulated/flexible labour markets** with low employment protection will leave the labour force more unprotected against macroeconomic forces, but, *conversely*, might at the same time make it easier for individuals with lower education and reduced work ability to get employment.
2. **Policies with generous welfare benefits** have made it possible for workers with reduced work ability to leave the labour force without serious economic consequences, leading to lower employment among these groups.
3. **Active labour market policies** including vocational rehabilitation might on the other hand draw workers more actively back into the labour force after periods of sickness, disability or unemployment, and might in particular be beneficial for less qualified groups.
4. **Economic fluctuation and the business cycle hypothesis** predict increased employment-related polarization between healthy and ill people during periods of high unemployment as entry and exit processes are likely to be more health selective under such circumstances.
5. **Post-industrialisation** i.e. the structural transformation from manufacturing to the service and education sectors, and the associated trend towards higher demands on labour (e.g. higher demands for flexibility, skills, credentials, performance, capacity and productivity). Under such conditions, people with less education and those suffering from poor health will be particularly vulnerable to labour market exclusion because they are less able to meet these demands and requirements. Those suffering from the double burden (low education + chronic illness) would be exposed to the highest risk.

Box 2: Typology of focused interventions

focus	Type of intervention	Examples of interventions
work environment	1 Legislation against disability discrimination	Disability Discrimination Act 1995 UK
	2 Improving physical accessibility of workplaces	<i>Access to Work</i> scheme (UK); Work Environment Act 1977 (Swe)
	3 Financial incentives to employers to employ disabled workers/job creation	Opportunities Fund (Can); <i>Job Introduction Scheme, Work Trial</i> (UK); <i>Icebreaker, Flexjob</i> (Den)
	4 Require employers and service providers to make provision for planned return to work and to cooperate	<i>Active Sick Leave</i> (Nor). <i>Finsam, Socsam, Frisam</i> (Swe),
individual	5 Increase motivation to gain employment through financial incentives to disabled people or reducing benefits	Tax credits (Can, UK) <i>Return to Work Credit, Job Preparation Premium</i> (UK); <i>Resting Disability Pension</i> (Swe)
	6 Individualised support and advice and locating and obtaining work	<i>New Deal for Disabled People, Pathways to Work</i> (UK)
	7 Education, training and work trial to increase "employability"	<i>Residential Training</i> (UK); Vocational rehabilitation (Swe, Den, Can)
	8 Preventive approach: provide medical rehabilitation and/or health management advice to reduce impairment	<i>Dagmar</i> (Swe), <i>Condition Management Programme</i> (UK)

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