Disability and Welfare in Iceland

in an International Comparison

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I. Introduction

The aim of this research monograph is to give an account of the extent, characteristics and development of disability in Iceland, by way of an international comparison. The work also deals with the financial situation of the Icelandic disabled population, services of the welfare state, societal conditions and the policies of Icelandic governments towards the handicapped and disabled. The major goal is to explicate the contemporary situation of this social group, learn from the experience of other Western nations and pave the way for further discussions and policy-making in this area of the welfare state.

The general conclusions are that Iceland does not rank with the countries which do best, according to various OECD measures of income security and integration. Lagging behind the other Nordic countries in this field is something of a disappointment since Iceland generally prefers to be on level with those neighbouring countries as regards the level of living of its citizens.

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Kolbeinn Stefánsson sociologist translated the monograph into English from the Icelandic original.

II. Handicap, Disability and the Welfare State

2.1. Defining disability

Over the last decade we have seen a growing body of research and writing on disability. At the same time universities have established courses and research centres on disability studies and organisations representing the interests of disabled people have grown stronger and more visible. This flurry of activity is reflected in a new understanding of handicaps and disability in the industrialised countries which has, in turn, altered the circumstances of disabled people, from being regarded as outsiders occupying the margins of society to a growing understanding that handicapped and disabled people are entitled to full human rights and equal access to society. However, these new perspectives have not found their way into the public discourse in Iceland to the same extent as they have in other industrialised countries, even though interest groups have been very active, and even though the volume of teaching and research have grown considerably.[1]

The Icelandic National Dictionary defines disability as "considerable or total reduction of work capacity on account of accident or illness, e.g. paralysis". Insofar as the dictionary reflects the common usage of the term in Iceland we can say that this definition reflects a rather limited understanding of the term, especially when we consider developments in the neighbouring countries. The Icelandic social security system also employs a definition of disability based on work capacity. However, since 1999 the definition is increasingly based on a medical criterion. In academic work a distinction is usually drawn between handicap and disability and the consequences of the two.

In a recent report, *Transforming Disability into Ability* (2003), OECD recommends that authorities abandon definitions of disability based on loss of work capacity. They argue that such perspectives treat the work capacity of disabled people as one-dimensional whereas it is actually varied and multidimensional. Policies

[1] See for instance the extensive information on the website of the University of Iceland Institute of Disability Studies (http://www.fotlunarfraedi.hi.is). See also the following publications: Traustadottir (2003), *Fötlunarfræði* (Reykjavík: Hákólaútgáfan); Flovenz (2004), *Réttarstaða fatlaðra* (Icelandic Human Rights Office and the Memorial Fund of Johann Gudmundsson); and Margeirsdottir (2001) *Fötlun og samfélag* (Reykjavík: Iceland University Press).

should be directed at enabling disabled people to make use of what work capacity they have. This shifts the emphasis of the welfare state from passive support, in the form of subsistence payments for disabled people, towards active welfare policies, both in the labour market and in society.

This shift in policy emphasis is reflected in how definitions of handicap and disability have evolved over time. Handicap has, for the most part, been defined according the "medical" model of disability. According to that model disability is regarded as the consequence of handicaps, resulting from unusual (sometimes abnormal) structure of functioning of the body or the mind, either since birth or because of illness or accident. Such handicaps can be temporary or permanent, limited or extensive. Either way it can cause a long-term reduction in the capacity to lead a "normal" life (Johnstone 2001, p. 10; Barnes, Oliver and Barton 2002). Reduced capacity to lead a normal life is usually what the term "disability" refers to.

Handicaps and disability are seen as a misfortune from the perspective of the medical model. These misfortunes call for caring, nursing, and whichever treatment that is available at any given time. Disability, the reduced capability for participation in society (work and ordinary life), is often been seen as leading almost inevitably to an existence at the margins of society, where the life of the handicapped person is for the most parts under the control of others (their families or nursing staff), without much independence or active participation. Adding the limited income support in some countries means that disabled people have to cope with poverty on top of everything else they must endure on account of handicap and illness (OECD 2003, chapter 1; Harpa Njáls 2003).

The "social" model is an alternative to the medical model. The popularity of that alternative has been growing. The social model traces its origin to the establishment of the Union of the Physically Impaired Against Segregation (UPIAS) in Britain in 1976. UPIAS made the case that handicaps and disability aren't only the responsibility of handicapped and disabled people. On the contrary, disability is seen as resulting from social and economic barriers in both the labour market and in society that exclude the ill and the handicapped from social participation and normal life. In other words, the labour market systematically excluded disabled people and society accepts that they are pushed to the margins of society where they live in abject

poverty. It might be said that the disabled are denied opportunities equal to other citizens, or even that they are held down by an oppressive social environment that is not concerned with their needs (UPIAS 1976; Finkelstein 1993; Barnes 2000). Disability is thus understood in the context of democracy and human rights (Marshall 1964).

What the social model of disability in fact does is to turn the causal relationship between disability and society on its head. Instead of accepting that limited capacities, on account of handicap or illness, lead automatically to exclusion from society, it is argued that society is responsible for the disability of people by failing to eliminate barriers and by failing to accommodate handicapped people in social life. This perspective became the foundation of the struggle of handicapped people for increased rights and consequently it became influential in public discussion in many of our neighbouring countries.

To clarify what this means we may consider the experience of deaf people on Martha's Vineyard, an island close to the city of Boston in the United States. The island is a popular tourist spot and a summer resort, and it is well known that many wealthy and influential people have summer houses there, including the Kennedies. In addition to the guests there is a core population that lives there all year round. For genetic reasons an unusually large proportion of the inhabitants were born deaf. Consequently knowledge of sign-language became wide-spread among the island's population, to the extent that the communication barrier between the deaf and the hearing was almost completely overcome. In fact, the success of sign-language was such that older residents had trouble recalling which people had been deaf and which had been hearing, when they were reminiscing about old time (Groce 1985). Deafness became relatively unimportant in the daily lives of the people in this community.

Considerable progress has been made on various rights issues that have been advanced by the advocates of the social model of disability. For instance, the World Health Organisation (WHO) has altered its definition of disability to include both the medical and the social model. Other international institutions have followed suit, for instance the OECD, the International Labour Organisation (ILO) and the European Union have all developed programs aimed at improving the rights of handicapped and disabled people through equal opportunity initiatives. This includes a strong emphasis

on improving access to the labour market, improving facilities for mobility, housing provisions, incomes, and general social participation.[2] These issues will be covered in more depth in the last chapter of this report.

Following this discussion it may be helpful to look at the relationship between handicap, disability, and society, as is done in figure 2.1. In line with common practices in this field of research the terms handicap, disability, and social environment are considered separately as are their consequences for the living standards and the circumstances of the groups in question. In this context the term "handicap" refers to physical or psychological limitations people must live with, regardless of why. Disability is a direct consequence of such limitations and is reflected in reduced capacities that limit the opportunities of the handicapped in the society, i.e. their capacity for work and social participation.

Figure 2.1
The relationship between handicap, disability, and social environment

Handicap >>>	**Disability >>>**	**Social environment >>>**	**Living conditions**
Primary Cause:	***Direct Consequence:***	***Welfare State Adjustment:***	***Quality of Life:***
Physical and psychological limitations on account of illness, accident or inborn traits	Limited capability Limited opportunities Limited work capacity Limited capacity to participate in society	Social insurance Rights, access, adaptation Support for employment. Support for participation in society.	Living standards Equal opportunities Labour market participation Participation in society

The consequences of disability are largely dependent on the social environment. The welfare state and other aspects of the social environment can mitigate or amplify the problem. All things being equal we would expect the quality of life and opportunities for the handicapped to be closer to those of the general population in countries where measures to improve the living standards and

[2] See for instance the new definitions of WHO (1997), ILO (2002a), Disability and Poverty Reduction Strategies, ILO (2002b), Managing Disability in the Workplace: ILO Code of Practice (website ILO), Council of the European Union (2003), Equal Opportunities for People With Disabilities – A European Action Plan. See also Deborah Mabbett (2005), The Development of Rights-Based Social Policy in the European Union: The Example of Disability Rights (JCMS 43(1P, pp. 97-120) and a report by the European Foundation for the Improvement of Living and Working Conditions (2003), *Illness, Disability and Social Inclusion* (Dublin: EF).

conditions of pensioners, such as the disabled, are more extensive (Hvinden 2004). A larger proportion of handicapped and disabled people experience exclusion, isolation and poverty in countries where measures are less extensive. Social policies directed at the disabled are therefore very important. On the basis of that we can analyze the consequences of both the primary causes of disability and the social environment on the circumstances of people whose capacities for participation in society and the labour market is reduced.

2.2. Disability and the welfare state

Handicaps and disability have been receiving growing attention by all Western welfare state over the last two decades, in part because of new attitudes towards the human rights of minority groups. The emphasis on equal opportunities and better living standards for people who are not capable of earning a living through paid work has gained prominence in rich countries. This reflects both growing ambitions and growing demands for reform in a policy area that is felt by many to be important. Such views have been amongst the driving forces of the development of welfare states since their inception in the first half of the 20th century and have been the cause of much of the welfare state's expansion, especially up to 1980 (Olafsson 1999). Furthermore, the number of disabled people has been growing in most modern societies over the last few decades. The disabled are now more numerous than the unemployed in most countries, and far more numerous than the recipients of sick pay benefits or the clients of municipal social services. The disabled are therefore an important and growing social group in all modern welfare states.

The generosity of disability benefits and the quality of services for disabled people have been rising in Western countries, in the long-term. In other words, social support for this group has improved and more of their needs are being met. However, the growing number of disabled people and the rising generosity of benefits have put a strain on the funding of pensions systems. This has lead to concerns about future increases in expenditures. Such concerns became widespread in public discussions in many Western countries in the 1990s.

Such concerns, along with new political perspectives, lead to policy shifts in most of the OECD countries. The new emphasis was on active social policies instead

of focusing exclusively on providing pension payments (i.e. passive social policy). This involves making the labour market more accessible for disabled people and other pensioners (mostly the long-term employed and other inactive people) and increasing their participation in society. The goal is to reduce the social exclusion of specific groups in society as well as to promote viable ways of life. This is believed to reduce public welfare spending by enabling people to earn a living in the labour market, in so far as they are able to. This became the predominant policy approach in the OECD countries in the 1990s, though countries differed in how far they have moved in this direction as well as in how they implement these new policies (OECD 2005).[3]

There were other pressures that lead to these policy shifts. Many countries had attempted to reduce unemployment by pushing older people (mostly people aged 55 and above) out of the labour market in order to make space for younger people who were beginning their labour market career. This was done through providing the older workers with early retirement pensions or disability benefits (lowering the requirements to include wear from work and various physical and mental deviations, the prevalence of which rises with age). This raised the expenditure burden from pension payments substantially. These developments were reflected in falling employment rates of people aged between 50 and 65 in most Western countries. This problem became an increasing concern when governments also became aware of the so-called pension crisis, which was foreseeable because of the proportional increase in old age pensioners relative to the working population. That development was thought to call for a considerable increase in future taxation, especially since it went hand in hand with a falling birth-rate, disrupting the balance between the generations (Stefán Ólafsson 1999)[4].

A final contributing factor was the growth in unemployment in Western societies after 1973 which lead to further increases in welfare expenditures, which amplified the problem and provided a further impetus for the above mentioned shift in

[3] OECD (2005), Extending Opportunities: How Active Social Policy Can Benefit Us All (París: OECD) and OECD (2003), Transforming Disability into Ability: Policies to Promote Work and Income Security for Disabled People (París: OECD). See also European Foundation 2003 og Gallie og Paugam 2004.

[4] This is discussed extensively in part II in Olafsson (1999), *Íslenska leiðin: Almannatryggingar og velferð í fjölþjóðlegum samanburði* (Reykjavik: Iceland University Press and the State Social Security Institute).

social policy. This is the general context of the developments that affected the disabled in the 90s.

2.3. Differing paths and different effects of welfare states.

Having described the general context of social policy development above it must be pointed out that these developments have not been identical in all Western countries. The resources devoted to social policy has obviously been of importance as have the different paths taken by individual states.

The welfare systems of the affluent societies have had two primary roles when it comes to the handicapped and the disabled:[5]

- Securing a livelihood for the disabled that enables them to share the living standards regarded as normal in their society. This objective has often been defined as providing the disabled with a minimum income that approaches the average incomes of the general population.
- Promoting the social integration of handicapped people so that they can enjoy real opportunities for active participation in society. In this role the welfare state seeks to equalise opportunities and to realise the human rights of all citizens.

The impact of welfare systems on the living standards of citizens depends on the emphasis that the authorities have put on public welfare provision. It is well known that there are well established differences and in the last few decades extensive comparative research have revealed that these different approaches vary in their effectiveness as well as in outcomes. Figure 2.2 provides an overview of characteristics and outcomes of nations representative of some of the main models of welfare state development. The overview is based on a summary of some of the most influential research in recent decades.

[5] These roles are explained in the report by OECD (2003), *Transforming Disability into Ability*.

Figure 2.2
Overview of Characteristics of Different Welfare Regimes
United States, Germany, Scandinavia, and Iceland

Welfare System:	**United States**	**Germany**	**Scandinavia**	**Iceland**
Characteristics:				
Role of Government	Small	Considerable	Large	Rather large
Public Insurance Coverage	Limited	Extensive	Extensive	Extensive
Living Standards of Pensioners	Low	Class dependent	High	Rather low
Public Welfare Services	Limited	Limited	Extensive	Extensive
Poverty Rates	High	Considerable	Low	Rather low
Income Equalisation	Limited	Considerable	Extensive	Considerable
Gender Equality	Limited	Limited	Extensive	Extensive
Reduction of Class Differences	Limited	Limited	Extensive	Considerable

Based on Esping-Andersen 1990, 1999 and 2002; Scharpf og Schmidt 2000; Pierson 2001; Stefán Ólafsson 1999; OECD 2003.

The American and the Scandinavian models are in a number of ways opposites. Americans have been reluctant to give the government a large role in shaping the living standards of their citizens, preferring instead to rely on the private sector and self-sufficiency of individuals and their families (Wilensky 2002). Consequently the government plays a smaller role in the United States than it does in European countries, especially when compared to the Scandinavian countries. The market thus has a greater effect on people's living standards in the United States than in Scandinavia.

The American welfare system is smaller, cheaper and offers less extensive rights to the public. This is reflected in the less extensive public insurance coverage enjoyed by the American people, which is most noticeable when it comes to medical insurance. Pensions are usually limited, the amount is small, and public welfare service provision is small. The consequences for public welfare are that the living standards of those who must depend on the welfare system (old age pensioners, disability pensioners, the unemployed, single mothers, and people with low incomes) are poor in comparison to those of the general population and in comparison to similar groups in the countries of the European Union. The extent of poverty is also unusually high in the United States, especially considering how wealthy the nation is (GDP). The equalising effect of the government is also small. Thus the effects of social class are not mitigated to the same extent as they are in Scandinavia (Esping-Andersen 1990, 1996 and 1999; Wilensky 2002; Kenworthy 2004).

The policies of the Scandinavian countries contrast with those in the United States. The role of the government in the areas of welfare and living standards is large, despite leaving an important role for the market when it comes to business and employment. This is more in line with the mixed economy model than the American model, and the Scandinavian model is in fact known for its uniqueness in the developed world. In the Scandinavian countries rights are based on citizenship, they are extensive and without barriers for those who need support from the welfare system. Benefit levels are relatively generous and welfare services are wide-ranging and of high quality. Public insurance coverage is widespread and active, and the living standards of pensioners and support recipients are relatively high in comparison to other countries. Poverty rates are generally by far the lowest observed in modern societies and the effects of social class and gender are alleviated through the public welfare and taxation systems. The Scandinavian countries are thus more effective in equalising opportunities than most other modern states. The Scandinavian model therefore has considerable impact on the living standards of the population as well as on social conditions.

The German model, which is common in the north-western parts of continental Europe, can be described as a compromise between the American and the Scandinavian models, though they are closer to the Scandinavian model. Rights are based on employment, i.e. they depend on employment histories, and public welfare services are limited. Public insurance coverage is extensive but women are at a disadvantage, both because they tend to be less active in the labour market than their Scandinavian and Anglo-Saxon counterparts, and because the system is based on the male breadwinner model. The entitlements and living standards of pensioners depend on past employment and therefore on past incomes. Those in the middle and upper income groups generally enjoy generous pension entitlements. The equalising effect of the welfare state is small in comparison to the Scandinavian systems. However, poverty rates tend to be much smaller than those observed in countries that have adopted the Anglo-Saxon model. Poverty rates are nevertheless higher in nations that have adopted the German model than in the Scandinavian countries. Social class and gender differences in opportunity are also greater in the German model.

The Icelandic model shares characteristics with both the Scandinavian and the Anglo-Saxon models. Its Anglo-Saxon characteristics are more in line with the version of that model applied in England and New Zealand than with that of the United States. Thus the Icelandic welfare state differs in important respects from the Scandinavian welfare state model (Olafsson 1999, Kildal og Kuhnle 2004). The role of the government is somewhat smaller in Iceland (e.g. the important role played by occupational pension funds, charities, the sickness benefit funds of labour unions and from collective agreements, as well as because of long-term high employment rates and prevalent ideology of self-help). The Icelandic social security system, however, is based on the Scandinavian model, i.e. rights are based on citizenship rather than employment.

There is broad social insurance coverage but pensions from the social insurance system have for the most part been flat-rate, low, and subject to severe means-testing which lead to a rapid reduction in pensions if people have incomes from other sources. This feature of the welfare system, which is the feature most related to the Anglo-Saxon model, has frequently resulted in low living standards for pensioners, though the Icelandic system is more effective in promoting equality. Welfare services in Iceland, on the other hand, have been very similar to those in Scandinavia, with a wide range of high quality services in such areas as health, social services and education.

Thus it may be said that even though the Icelandic welfare system is similar to the Scandinavian model in many respects, it also has some important characteristics from the Anglo-Saxon model, especially when it comes to pension payments. As a consequence the Icelandic system does not promote the same degree of equality as do the Scandinavian systems. The living standards of people with low incomes and pensioners are not as good in Iceland as they are in Scandinavia, and poverty rates are somewhat higher. Yet poverty rates are low in Iceland in comparison to other Western countries, such as those in North American and in continental Europe (Olafsson 1999). The Scandinavian countries have the lowest poverty rates in the developed world.

2.4. The Scandinavian approach to handicap and disability

Because the handicapped and the disabled have been disadvantaged for a long time relative to other groups, they are of special interest for welfare state research. Their disadvantage stems from a certain narrow mindedness when it comes to this group. Furthermore, there has been a lack of awareness of their situation in terms of rights and entitlements, as was stated earlier in this chapter. Thus it is important to examine the circumstances that different welfare states produce for this group, especially the Scandinavian welfare states.

It seems clear that the Scandinavian countries have provided the best living standards and opportunities for the disabled in recent years (Kautto et al 1999 and 2001). If the ideals and goals of the Scandinavian model were to be followed to the letter we could expect that the following would describe the circumstances of the disabled in the Scandinavian societies (Hvinden 2004):

1. *Income support.* Everyone who suffers a handicap or reduced capacity for work and social participation would have access to social security that provides generous pensions in line with average incomes in society.
2. *Participation in paid employment.* A strong emphasis on measures intended to promote participation in paid employment; both by assisting people who aren't employed to find suitable jobs and helping those employed keep their jobs, despite lowered productivity resulting from handicap and disability.
3. *Participation in society.* A wide range of social services would be available that would enable people with physical or psychological impairments to enjoy independence in their daily lives without having to rely on their family or on charity to satisfy their needs. Another way to go about this would be to provide the handicapped with money to purchase such services from private providers.
4. *Access to society.* A permanent systematic effort to ensure that people with impaired mobility and other restrictions gain access to all areas of social life and to all regular services and opportunities. The design of the environment, of buildings, transportation, of markets for goods and services, of

communications and information system, would be adapted to the needs of all citizens.

5. *Integration of measures.* All support systems for the handicapped and the disabled would be integrated and coordinated so that they would complement and support each other. This would maximise their success in integrating this group into society. Pensions and incomes from work would complement each other as to provide incentives for the disabled to take up paid work rather then living of pensions alone. Access to education and the labour market would also have to support each other, as would for example transport and mobility/access issues.

2.5. How successful are the Scandinavian societies in fulfilling their policy ambitions?

The fact is that no country has ever been able to fully realise this ideal about a social environment favourable to handicapped and disabled people. The Scandinavian nations have however approached some aspects of this ideal.[6] Other countries have also been successful in specific areas. Lets take a closer look at the achievements of the Scandinavian and other European countries in terms of these ideals. This discussion will be in general terms but the analysis and comparisons in the later chapters of this report will use empirical data to illustrate the different achievements of countries in specific policy areas.[7] In the later chapters we will also examine Iceland's position in comparison to both the Nordic countries and other Western countries.

1. *Income support.* Expenditures on disability pension are higher in the Scandinavian countries than in the other European countries, which are higher than in the North American countries. Yet there are differences within the

[6] Here and elsewhere in this report the term "Scandinavian nations" is taken to refer to Denmark, Finlands, Norway, and Sweden.

[7] The discussion here is primarily basesd on Björn Hvinden (2004), but also on reports from OECD (2003 and 2005a, 2005b); NOSOSKO 2002 og 2005 og Eurostat, "Disability and Social Participation in Europe" (2001).

Scandinavian countries. Norway spends the most and Finland spends the least. The Scandinavian countries, along with the Netherlands, have the highest proportion of people of working age receiving disability pensions. Thus there is strong evidence that the Scandinavian countries provide the best living standards for people suffering handicaps or illness, relative to average incomes in these countries.

2. *Participation in paid employment.* The Scandinavian countries spend the largest proportion of their GDP on special labour market measures for handicapped and disabled people. Finland spends smaller amounts on such measures than the other Scandinavian countries. OECD statistics suggest that employment rates of handicapped and disabled people in Denmark, Sweden, and Norway are in the vicinity of 50%, i.e. about half of them are in paid employment. The proportion is between 22 and 45% in the other European countries.
3. *Participation in society.* Expenditures on services for handicapped and disabled people are generally higher in the Scandinavian countries than in the other European countries and in North America. Denmark and Sweden spend a higher proportion of their GDP on such services than Norway and Finland. A part of these objectives is related to the ideology of the *Independent Living Movement*, which originated in the United States. It is difficult to find reliable data on the diffusion of such ideas but they have played a larger role in Sweden than in the other Scandinavian countries. This involves the service recipient choosing services and service providers for him or herself. The authorities provide money to pay for the costs, up to a certain limit. In general it may be assumed that countries that spend more money on pensions and services for handicapped and disabled people are more successful in creating conditions that enable them to function independently within society.
4. *Access to society.* Hvinden (2004) claims that the Scandinavian countries haven't been very successful in using design, planning and transportation systems to secure the access of handicapped people to buildings, institutions, and services. However, recent comparative research on the access of handicapped people to society in Denmark, Sweden, the Netherlands, Britain,

and the United States indicates that the situation in Denmark and Sweden is not worse than it is in the other three countries (Ramböll 2005). It is difficult to assert anything further about comparisons in this area, but the high employment rates of disabled people in the Scandinavian countries suggests that access to workplaces is less of a problem there than in other European countries.

5. *Integration of measures.* It is difficult to compare the achievements of different countries in this area. This is a complicated topic and there is a serious lack of data addressing it. Pension systems have not adjusted to the policy shift that took place over the last decade, aimed at getting more disabled people into employment. Consequently the pension systems often fail to provide incentives to take up a paid job. Pension systems that are marked by extensive income testing, like the Icelandic one, are especially problematic in this context. For most Western countries this is probably the one area that needs most reform in the future.

Overall it seems that the Scandinavian countries are at the forefront of welfare provision and integration of their citizens into society, both in the areas of handicap and disability as well as many others. Yet there are policy differences between the Scandinavian countries as they emphasise different things. But overall they compare favourably with other countries. That does not mean, however, that the goals of the Scandinavian model have been met, as disabled people are in many ways a group that has been neglected in these societies, though a lot has been achieved in recent decades. This will therefore be a policy area which most Western countries will have to review in the coming years.

2.6. Raising well-being and rising expenditures: Economic perspectives

While there are good reasons to improve the living standards, entitlements and services for handicapped and disabled people it must also be kept in mind that the costs of doing so might be considerable. Governments are concerned that financing such measures through taxation is becoming increasingly difficult, especially in an

environment marked by globalisation, privatisation and increasing competition (Olafsson and Stefansson 2005, chapter 8).

The conventional wisdom in economics is that if pensions are too high relative to the lowest wages, i.e. if they are at least equal to minimum wages, then people will be tempted to drop out of the labour market, i.e. that there is an incentive to choose a life of idleness sponsored by the welfare state rather than a life of self-sufficiency in the labour market (Herbertsson 2005; Haveman and Wolfe 1999). Consequently economists often argue that pensions must be kept at a minimum. Pensions should not approach the average incomes in society since that is held to produce what the advocates of the market call a "moral hazard", i.e. the temptation for healthy individuals to give up paid work for life as a pensioner (Herbertsson 2005, chapter 2, especially sections 2.4-2.8). The other side of the coin is that those who are unable to function in the labour market are condemned to a life in abject poverty.

This is a faulty perspective. Empirical research indicates that the assumption that people will prefer a life of idleness over paid employment is not sustainable. People value employment for reasons other than income and positive orientation to work is an important value for most people, especially in Iceland (Olafsson 1996; Rose 1988; Gallie et al 1998). The fact is that most people want to work. Employment is a key component of people's participation in society, to their life-styles, and their self-esteeem. Employment is even important for people's mental health (Jahoda 1982). This is particularly evident for people who have suffered unemployment and people who are at the margins of the labour market (Gallie and Paugam 2004). Thus it is highly unreasonable to base policy on the assumption that people will prefer a life of idleness over employment simply because disability and unemployment benefits approximate the lowest wages in the labour market.

Income is not the only reason why people value work. This is reflected by the fact that most people prefer jobs over unemployment, even if the wages are lower than the unemployment benefits. This is because there are non-financial rewards from work. There is also the possibility of career advancement over time. Also, receiving benefits is often associated with negative labelling which deters people from taking advantage of their entitlements. This is reflected in survey data from EU member countries that show that between one third and one half of those who have some sort

of a handicap or disability, physical or mental, do not claim disability benefits. In most cases these are people with lower levels of disability and those who are able to do some paid work despite their disability (OECD 2003; European Foundation 2003).

On the basis of the above mentioned perspective of economists, governments tend to focus on the costs of welfare measures rather than on the gains they produce. This also applies to expenditures on disability. However, welfare measures create jobs for people and improve the living standards of pensioners, the unemployed, the handicapped and the ill. Such measures can therefore produce benefits for society as a whole. Furthermore, there are often great social costs from leaving people who have difficulty functioning in the labour market at the margins of society. This risk is greater in countries where welfare systems are weak. A milieu of poverty leads to a deterioration of human capital and social problems become endemic. Children who grow up in such environments are in danger of loosing their footing. Social stability is also more fragile. Such costs tend to be ignored when we focus exclusively on the costs of welfare. This is a grave mistake (Barr 1993; Wilensky 2002). The fact that the Scandinavian countries compare favourably with other countries in terms of economic competitiveness strongly suggests that a strong welfare state is far from antithetical to a strong economy (Olafsson and Stefansson 2005).

In chapter IX we will consider the possibility that disability benefits are providing an incentive for people to drop out of the labour market, i.e. that the increase in the number of disabled people in Iceland can be explained in terms of overly generous pensions that allegedly produce a “moral hazard”.

III. Who are the Disabled?

– Review of studies from other countries –

There is no single accepted method of estimating the total number of disabled people in Western societies. There are however two methods that are most commonly used.

On one hand there are questionnaire surveys where people are asked about limitations on daily activities stemming from illness or handicap. Such data can be analysed for different subgroups and circumstances. It is also possible to analyse the relationship of different variables to living standards and participation in the labour market and society. This is the approach most widely used in Western countries, mostly because of its analytical possibilities.

On the other hand we can count the number of people who are registered as disabled and receive disability benefits at any given time. This may seem like a quick and an effective approach. The problem is that different countries rate disability according to different standards. Rules on entitlements to disability benefits differ as well. Furthermore, the disability benefits systems of different countries have diverse functions. In some countries disability benefits play a smaller role than sick pay schemes, unemployment benefits, and income support from municipalities. In other countries the disability benefits system plays a larger role whereas the other systems mentioned are more marginal. Thus it is obvious that counting disability benefit recipients is not a reliable measure of the number of disabled people in society.[8] For instance, OECD published a large report on disability in 2003 where they use both kinds of data, though survey data plays a larger role in the report when it comes to estimating the extent and characteristics of disability in the OECD countries. Research by the European Union also relies more heavily on survey data to analyse the number of disabled people and their circumstances.

In Iceland there exists data on the number of disability benefit recipients that is collected by the State Social Security Institute. Unfortunately there is, however, a conspicuous lack of survey data on the frequency of disability as well as on the circumstances of handicapped and disabled people. Consequently we will rely primarily on data from the Social Security Institute.

[8] See Richard H. Burkhauser, Mary C. Daly et al (2002), "Self-Reported Work-Limitation Data: What They Can and Cannot Tell Us", in *Demography* 39(3), pp. 541-555.

The two kinds of data often produce different result. Survey data tends to indicate a higher prevalence of disability than does data on disability benefit recipients. The reason is that many of the people who suffer limitations because of illness or handicap do not receive disability benefits. In the OECD countries there are also some instances of people receiving disability benefits without reporting any limitations. This is partly a matter of response error, known as social desirability bias (some people may for instance not want to admit that they have health problems, others may not want to admit that they receive disability benefits because they feel that it is a source of negative labelling in society). Different surveys also produce different estimates of the prevalence of disability within the same society. This is because of different definitions of disability and question wording. Thus careful analysis is needed before we compare numbers on the prevalence of disability in different countries.

In this analysis we will rely on data from the OECD, which has attempted to harmonise the quality and comparability of data on the prevalence of disability and its development over time. References to the work of academics will also be made to support our analysis.

3.1. How prevalent is disability in Western societies?

In general about 14-15% of people living in the European Union are disabled (handicapped or suffering physical or mental limitations because of illness, accident or birth defects). This is also the average for 18 OECD countries, according to recent figures from the OECD (2003).[9] About a third of these people are severely disabled, the rest suffering moderate disability. These numbers are based on people's own evaluations. The countries where disability is most prevalent are Sweden, Portugal, the Netherlands, Denmark, Britain, Germany, Norway, and Canada. The lowest frequencies are found in the United States and Italy.

[9] What follows is based mainly on information from the OECD (2003), *Transforming Disability into Ability*; Burchardt (2003), "Being and Becoming: Social Exclusion and the Onset of Disability" (London School of Economics, Center for Analysis of Social Exclusion, CASE Report 21); EIM (2001), "The Employment Situation of People With Disabilities in the European Union" (report produced for the Departments Employment and Social Affairs of the European Commision); and an EU report (2001), "Disability and Social Participation in Europe" (Luxemburg: Eurostat, Key Indicators 2001).

Figures for 17 OECD countries indicate that on average about 6% of their populations received disability benefits in 1999. It is likely that a larger proportion of this group suffers from severe disability than those observed in the survey data discussed above, other things being equal. The same countries tend to have relatively high disability rates whether we use survey data or data on benefits recipients, with the exception of Germany and Canada that have relatively few disability benefit recipients (many older disabled people in Germany are on early retirement schemes).

On average about 17,5% of people living in the United States report some form of handicap or health problem that affect their daily activities, compared to approximately 14% in the European Union as a whole (EF 2003, p. 6). Around 6% of people living in the European Union receive disability benefits, compared to approximately 4,5% in the United States (OECD 2003, p. 48). These figures suggest that entitlements to disability benefits are more restricted in the United States or that the disabled receive support through other parts of the welfare system (though that seems rather unlikely). Thus the figures may reflect differences between the welfare systems of the United States and the European countries, which were discussed in the preceding chapter, i.e. the United States is more restrictive when it comes to public welfare provisions.

In 1999 about 5,2% of all 18-64 year olds in Iceland received full disability benefits (75% disability or above). If the recipients of rehabilitation benefits and disability allowance (50-65% disability) are included the proportion of people receiving all kinds of disability support reaches 6,1%.[10] In the first instance it thus seems that the prevalence of disability in Iceland was equal to or less than what it was in the OECD countries at the turn of the century. However, early retirement pension schemes, which are common in many Western countries, are generally not available in Iceland. Early retirement pensioners, aged 55-66 years old, are often not included in estimates on the prevalence of disability. The only options available to such people in Iceland are disability and unemployment benefits. Including early retirees in the comparison would show that the prevalence of disability in Iceland is well below the OECD and EU averages. The prevalence of disability in Iceland and other Western

[10] The proportions for Iceland are calculated from raw data from the State Social Security Institute and Statistics Iceland.

countries, given the different functions of their disability benefit systems, will be discussed in more detail in the next chapter.

Generally speaking the prevalence of disability has been rising in Western countries during the last 25 years. However, the growth rates have slowed down in many countries following their adoption of new policy measures intended to encourage and support the labour market participation of disabled people as well as their participation in society. The evidence indicates that these developments occurred later in Iceland than in the neighbouring countries, i.e. the rising prevalence of disability that occurred in most Western countries between 1980 and 1995 started later in Iceland (mostly after 1990). Also, it seems that Iceland has been late to adopt policies that support the labour market and social participation of disabled people; as such policies reached Iceland approximately 10 years after they became established in the neighbouring countries. This will be discussed later (see chapter XI).

3.2. The Causes of Disability in Europe

The European Community Household Panel is the dataset that contains the richest information on disabled people in Europe. The survey was carried out annually in most of the EU countries over the last decade. Most of the sample is re-interviewed annually. This makes it possible to track changes in people's circumstances over time (i.e. panel survey). The panel structure of the data makes it possible to analyse people's circumstances prior to them becoming disabled and hence which circumstances lead up to that event.

Table 3.1 shows how disabled people in the EU countries are distributed according to the causes of their disability, i.e. to what extent disability is caused by birth defects, accidents, illness, or other reasons. This is a useful way to assess the characteristics of disability on the basis of its causes. Apparently the disabled are a very heterogeneous group.

The most interesting thing that this table shows is that only a small proportion of disability is caused by birth defects, or fewer than 10%. Many people believe that this is the most common cause of disability. It turns out that diseases that occur sometime over the life-cycle are by far the most frequent cause of disability, either acute conditions or slow and protracted afflictions. Disease is the cause of nearly two

thirds of all disability. Those who are injured in accidents (at home, at work, or in traffic) are only about 14% of all disabled people in Europe, which is lower than what many people assume. Most people in Europe have one or two handicaps or health problems, but about a third of all disabled people have more than two problems, i.e. multiple disability, which makes their circumstances even more difficult (Burchardt 2003, p. 15; see also EF 2003).

Table 3.1
General Causes of Disability in the EU Countries in 1999
Women 16-59 years of age and men 16-64 years of age

Sources of disability:	% of the disabled
Birth defects	9
Accident leading to immediate health problems	10
Accident leading to long-term health problems	2
Accidents, other	2
Acute disease	40
Long-term disease	26
Other (temporary health problems, etc.)	11
Total	100%

Source: Burchardt 2003 og OECD 2003.

The fact is that most disability is caused by illness or other life-event that happen at some time over the life-cycle, often while people are of working age. In fact most disability occurs after people reach working age. This suggests that preventative measures and the promotion of public health care measures can be effective in lowering the prevalence of disability in society, as would measures to prevent work- and traffic accidents.

These results show that the disabled are a very heterogeneous group and indicates how diverse their circumstances and needs really are. Standardized measures and services – whether they involve living standards, support systems, or education – are consequently less effective than in other areas of social policy. Consequently, welfare services for the disabled tend to be flexible and highly individualised.

3.3. The Demography of Disability in Europe

Age Groups

The risk of disability grows with age. This is reflected by the fact that the prevalence of disability is highest for people between 60 and 64 years of age, i.e. during the last years of working age.

On average approximately 1,5% of people aged between 20 and 34 are disabled, about 3% of people aged between 35 and 44, approximately 7% of people between 45 and 54, and about 14% of people between 55 and 59 years old. The countries with the highest prevalence of disability in the youngest age-group are Poland, Norway, the Netherlands, Sweden, Denmark, Portugal, and Austria. On average two out of three disabled people in Europe are over 45 years of age (EIM 2001, p. 36).

There are variations between countries in how much the prevalence of disability rises with age. Survey data indicates that the prevalence of disability for 60-64 year olds can be anywhere from three to ten times higher than the prevalence for 16-19 year olds. In the EU countries the prevalence of disability for the older group is approximately five times higher, on average, than it is for the younger age group.

That fact the risk of disability rises with ages suggests that, given the current trends and the rising average age, the prevalence of disability will continue to rise in Western countries. Social policy is important in this context. Both the extent of services available for disabled people (pensions, health care, and social services) and the support they receive for labour market and social participation are of central importance. The growing emphasis on active social policies has clearly slowed the increase in the prevalence of disability in these countries. It is likely that most countries will continue to pursue such policies.

The OECD argues against the perspective that we should expect the prevalence of disability to rise further because of population ageing on the grounds that the rise observed so far occurred largely because of new attitudes and increased demands for rights (OECD 2003, p. 27). That may certainly be a part of the story and if that is the case the relative importance of these two effects in the coming years will certainly be important. However, the association between the risk of disability and age is so systematic that there is bound to be a growing pressure towards a rise in the

prevalence of disability. Changes in welfare provision and/or changes in social attitudes must occur if we are to counter that pressure.

Sex

The proportion of people who are disabled tend to be quite similar for the sexes in the EU countries, though it tends to be slightly higher for women overall (though that varies between countries). Disability is more prevalent for women in countries where the welfare state is based on universal rights than it is in countries where entitlements are based on employment. The latter kind of systems is primarily found in continental Europe (the countries that adhere to the German model). In those countries women who have not been active in the labour market have limited or no entitlements to disability benefits. Instead they must rely on sick pay benefits or municipal income support (Olafsson 1999).

The Scandinavian countries, much like Iceland and Britain, have a system based on citizenship and universal entitlements. The prevalence of disability for women is higher in countries with such systems. This suggests that the characteristics of entitlement systems affect how many people register disabilities and apply for disability benefits. It may even affect whether people with moderate levels of disability regard themselves as disabled.

Education and Occupation

Disabled people have lower levels of education attainment on average than the population as a whole. Conversely, the prevalence of disability varies with educational level. About 19% of those who have only completed the lowest level of education are disabled in 19 OECD countries on average. In contrast only about 11% of those who have completed some kind of a university education are disabled in these countries on average. There are two main reasons for this. Some disabled people suffer limitations that affect their ability to study, or at least require them to overcome higher barriers in order to complete their education. This applies in particular to people who have been disabled since birth. In case of people who become disabled later in life it is well established that those who only complete lower levels of education are more likely to end up in jobs that involve greater risks of accident or

illness, i.e. people's risk of disability varies inversely with their level of education. This relationship also holds when we control for age, i.e. the risk of disability varies inversely with educational level for all age groups.

This is also the case with low-income jobs. People in low income jobs have a higher risk of disability than do people with higher incomes and better living standards (EF 2003, chapter 1). In some cases, however, causality may run in the other direction as people's careers often founder when they become disabled, causing their living standards to fall dramatically. This means that the risk of falling into poverty following loss of health and ability is higher in countries that provide less support through the welfare state than it is in more generous countries.

Civil Status

It is interesting to note that the marital rates of severely disabled people are similar to those of people who are not disabled. Approximately 67% of people with severe disability were married in the EU countries in the latter half of the 1990s. The proportion was 73% for the moderately disabled and nearly 78% for the non-disabled. However, it was more common for the severely disabled to have experienced divorce, i.e. 19% compared to 10% of those who were not disabled. This is an important indicator of disabled people's opportunity for social participation as well as their ability to live in an independent family.[11]

Participation in the Labour Market

The employment rates of disabled people are considerably lower than the employment rates of other citizens in the EU countries. This is hardly unexpected as the term "disability" implies reduced capacity to work. Approximately 40% of all disabled people in the EU have a paid job of some sort. Approximately 25% of severely disabled people and around 50% of moderately disable people have a job. The employment rate of the non-disabled is around 70% (OECD 2003, p. 35). Disabled men generally have higher employment rates than disabled women ((EU - Disability and Social Participation in Europe, p. 34-5). The low employment rates of disabled

[11] This discussion refers to people aged between 30 and 64 years old. The numbers reported are averages for the EU countries.

people have lead the OECD and many governments to promote policies that are designed to get disabled people and other inactive citizens into jobs, for their own good as well as to reduce government spending on pensions.

Those who advocate improved rights for disabled people have also made much of the lower employment rates of disabled people, interpreting them as an indication that they are systematically excluded from and discriminated against in the labour market. They argue that this discrimination must be overcome and that we must change the organisation of work, work places, and society as a whole in order to enable handicapped and disabled people to participate in employment and be full members of society (Barnes 1999; Robert 2003, p. 136-159; Barnes and Mercer 2005).

There are many policy measures which can raise the employment rates of disabled people. In fact many Western governments have been implementing such measures over the last 10 years or so. These measures include ensuring the availability of suitable jobs and establishing support systems that enable handicapped employees to contribute in the workplace. This will be discussed further in chapter XI.

Disabled people that are employed tend to work nearly as many hours as do fully employed people without disability. Their distribution across occupations is also similar to that of other workers. Approximately 26% of severely disabled people and 49% of moderately disabled people have some earnings from employment, compared to 64% of non-disabled people. These figures obviously correspond closely with the figures on employment rates (EU - Disability and Social Participation, p. 47, 54 and 59). Younger disabled people and those with higher levels of education are generally more active in the labour market.

Along with lower employment rates disabled people are also more likely to experience unemployment than other people. During the latter half of the 1990s the overall unemployment rate of the European Union was approximately 10%. Approximately 30% of severely disabled people and 16% of moderately disabled people were unemployed over the same period. It is therefore clear that disabled people are hit harder by unemployment than the rest of the population. These numbers also suggest that there are many disabled people who want to work despite being

inactive in the labour market. It is especially common in Sweden and Denmark that employed disabled people receive earnings from both pensions and wages. That suggests that the welfare state in these countries provides strong support for the employment of disabled people in the form of work incentives (OECD 2003, p. 37-8).

IV. The Prevalence of Disability in Iceland in a Comparative Perspective – Trends over Time

In this chapter we will examine how the prevalence of disability, i.e. the number of people receiving disability benefits each year, has changed over time in Iceland. We will describe the social characteristics of the disabled and consider various factors that explain the development. The development in Iceland will be compared to experiences in the neighbouring countries. We will compare the total number of disabled people and the prevalence of disability as a proportion of the population, both for specific age-groups and the population as a whole. A special attention will be paid to incidence of disability, i.e. the registration of first-time claimants.

4.1. Rising Prevalence of Disability – Explanatory Hypotheses

It is well established that the number of disabled people in Iceland has grown considerably in recent years. This was the subject matter of a recent report published by the Ministry of Health and Social Security (Herbertsson 2005). There are good reasons to examine this development more closely, especially in an international comparative perspective. A number of causal hypotheses can be proposed on the basis of Herbertsson's report:

1. The Icelandic population is growing. In fact population growth rates have been higher in Iceland than in the neighbouring countries over the last decade. Population growth will – ceteris paribus – raise the absolute number of disabled people.
2. The Icelandic population is ageing, i.e. the average age of the population is rising. This ought to raise the prevalence of disability given that the risk of disability increases with age. Also, Iceland has a relatively young population compared to the neighbouring countries. This suggests that the prevalence of disability has been comparatively low in Iceland. It also suggests that we may expect the prevalence of disability to rise in Iceland in coming years, as it has been doing over the last decade. Population ageing thus partly explains the growing prevalence of disability.

3. Social conditions can also affect the prevalence of disability. Growing unemployment (especially long-term unemployment) can lead to a higher prevalence of disability. So can increased pressure in the labour market. There is evidence that both these factors had an effect in Iceland during the 1990s. Unemployment rates rose considerably (though they are still relatively low compared to other Western countries). Heightened international competition and demands for higher profits have lead to demands for increased productivity of the labour force. This can have adverse effects on people with reduced work capacity. These factors will be examined more closely in chapter VI.
4. The disability benefits system is only one part of the welfare state. Other systems, such as sick pay benefits, unemployment benefits, and municipal social services (the last links in the safety net) deal with related issues. The division of labour between these systems differs between countries. If benefit amounts are low within one or more of these systems, relative to the others, then people who require support because of illness, unemployment or handicap, may have an incentive to turn to the more generous systems. Herbertsson (2005) presents interesting data that indicates that imbalances between different support systems in Iceland have produced unusually strong incentives for people to apply for disability benefits rather than applying for unemployment benefits or turning to the municipal social services. In addition to the systems discussed so far we should also consider social security sick pay benefits. The division of labour between these two systems will be examined later in this chapter.
5. The accessibility of disability benefits can also affect the prevalence of disability. It seems reasonable to expect the prevalence of disability to be higher in countries where getting disability benefits is relatively easy, so long as there are real financial incentives to apply for disability benefits (such as the disability benefits being more generous than benefits from other systems, e.g. unemployment benefits, sick pay benefits, and municipal income support). In 1999 Iceland adopted a new disability rating standard, the British PCA. It

has been suggested that this standards has caused an increase in the prevalence of disability. That hypothesis will be examined later in this chapter.

6. Many economists, especially in the United States, believe that disability benefits and unemployment benefits must be inferior to the lowest wages obtainable in the labour market. The belief is that "overly" generous benefits will entice people to give up paid labour in favour of life of idleness (assuming that it is easy for healthy people to get disability benefits). It has been argued that this occurred in Iceland during the 1990s and in recent years. This hypothesis will be scrutinised in chapter IX.

There are a number of other plausible hypothesis that might explain the growing prevalence of disability in Iceland. In the final chapter we will propose a holistic set of hypotheses and support them with the data presented in this report as well as with references to other research. For now, however, we concentrate on analysing the prevalence of disability in Iceland over time, in comparison to the neighbouring countries.

4.2. Prevalence of Disability in Iceland – Trends Over Time

Figure 4.1 presents an overview of the absolute number of disability benefits recipients in Iceland between 1986 and 2004. It also gives the numbers separately for each sex from 1993 onwards. The figure shows a substantial increase in the number of disability benefits recipients, though it differs from one period to the next. In 2004 there were approximately 12.000 disability benefits recipients, up from 2.600 in 1986. This seems like a considerable increase. More women than men received disability benefits in 1993 (5.509 against 2.454). The number of disabled women grew by 108% during the period in question whereas the number of disabled men grew by 92%.[12]

[12] Source: State Social Security Institute.

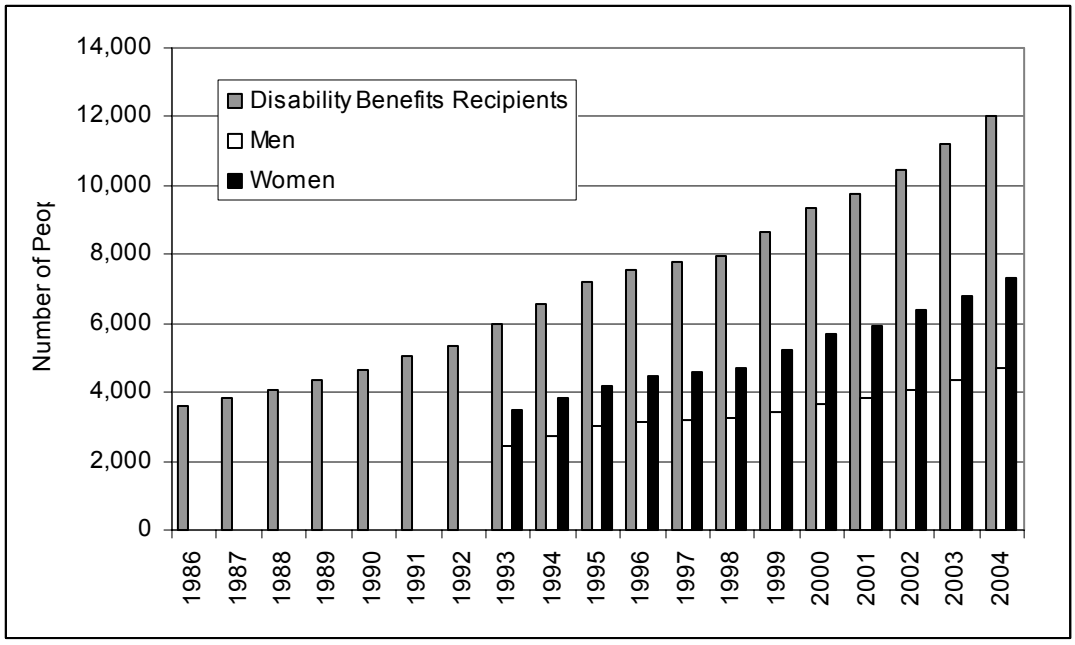

Figure 4.1: Absolute number of disability benefit recipients – Iceland, men and women, 1986-2004.

Figure 4.1 shows the absolute number of disability benefits recipients from 1986 to 2004. It does not reveal how rapid the increase has been, nor how much it has varied from one year to the next. That information is given in figure 4.2.

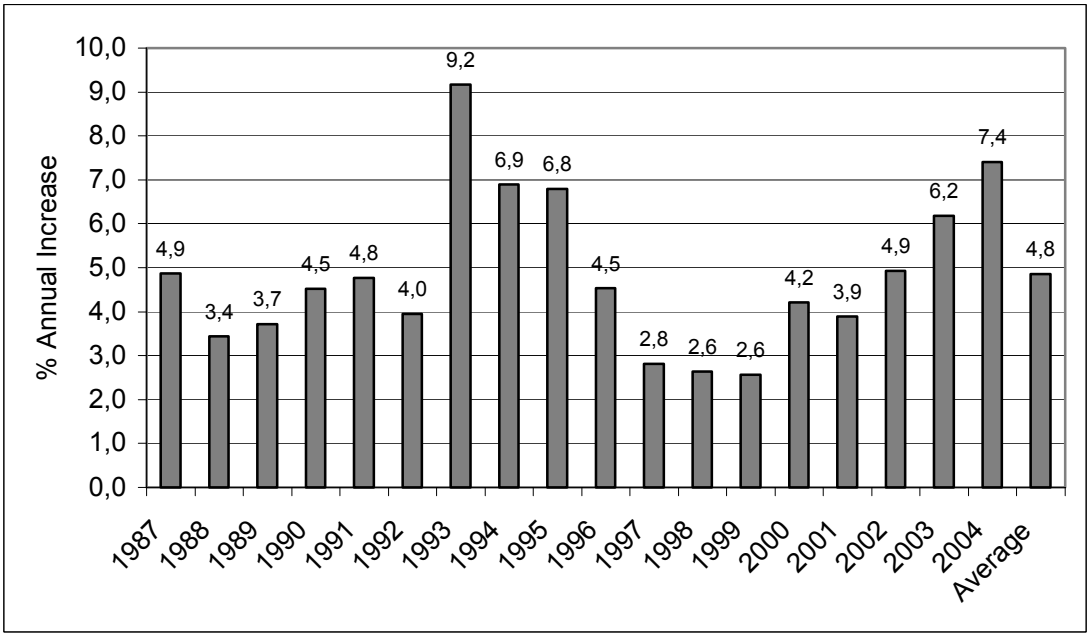

Figure 4.2: Annual increase in the number of disability benefits recipients and disability allowance recipients in Iceland, 1987-2004.

In figure 4.2 we see clearly that the proportional increase in the absolute number of disabled people (both those with 75% disability or more and those with 50-65% disability) has varied considerably from one year to the next. The trend is marked by two peaks, the former in 1993-1995 and the latter in 2003-2004. We would expect the proportional increase to be fairly constant from year to year if the number of disabled people in Iceland was growing on account of population growth, population ageing, inborn handicaps, or by disease, as all these factors tend to change slowly and steadily. The same would apply if the increase was being caused by incentives produced by the welfare state itself; as such effects tend to operate in a systematic way (given that the system did not undergo radical changes during the period in question). If the increase was brought about by new disability rating standards or by other variable factors (such as variations in unemployment levels, natural disasters, or warfare) we would expect considerable variations in the proportional increase from one year to the next.

Since the figure shows that the increase has varied considerably from one year to the next, from 2,6% to 9,2%, we have good reasons to suspect that the number of disabled people in Iceland was affected by external factors, i.e. social and economic circumstances, in addition to more stable demographic factors, during the period in question. This will be considered further toward the end of the report on the basis of this analysis as a whole.

4.3. Numbers of Disability Benefits Recipients - A Detailed Analysis

Figure 4.3 reveals an important part of the development in Iceland. The number of people with partial disability (50-65% disability) has fallen considerably from 1986 to 2004, or by 59%. At the same time there has been a large increase in the number of people with full disability (75% disability and above), or by 232%. It is clear that people have been shifted from partial disability rating to full disability rating. Focusing exclusively on the number of people with full disability thus exaggerates the increase. It is difficult to determine the cause of this shift with any certainty. It may be that differences in benefit levels between full and partial disability benefits have had

an effect (i.e. meagre benefits for partial disability have created an incentive to seek a full disability rating).

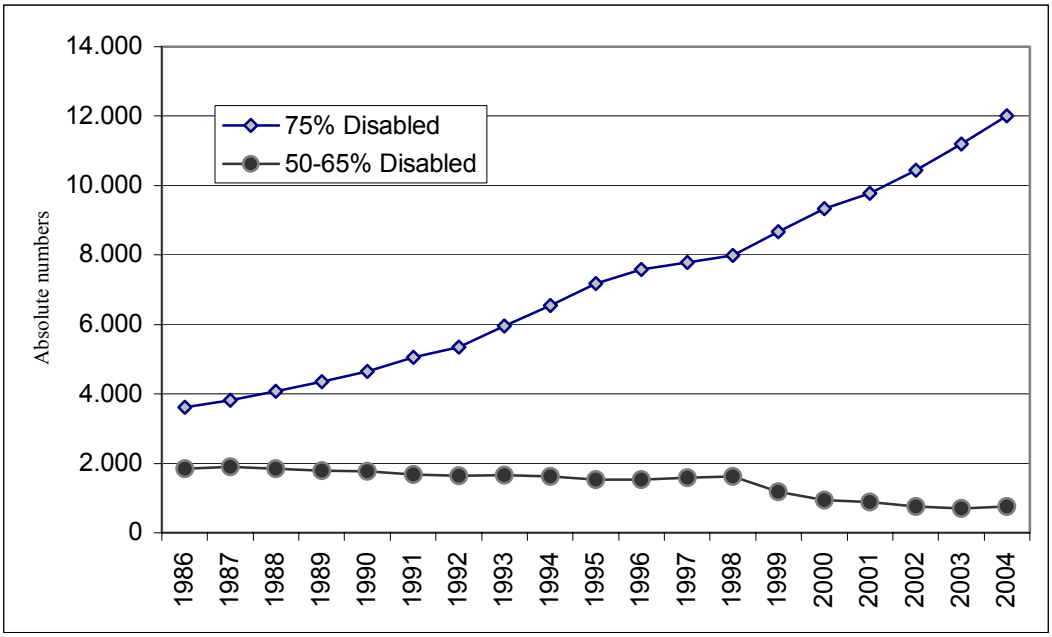

Figure 4.3: Number of disability benefit recipients (75% and above) and disability allowance recipients (50-65%). Iceland 1986-2004.

Another thing that stands out is that there was a noticeable acceleration of this trend in 1999, which has persisted ever since. That year Iceland adopted a new disability rating standard which meant that disability ratings were granted solely on a medical basis rather than on the basis of mixed medical, social, and financial criteria. It is quite possible that the new disability rating standard affected this development, i.e. that people with partial disability were more likely to receive full disability rating than before. This applies especially to women. It has become less frequent that people receive a lower disability rating because they enjoy favourable social and economic circumstances.

A part of the increase may thus have resulted from improved services within the disability benefits system. Some, however, might argue that this suggests that people are receiving too much support. That should not be a cause for concern if we consider the structure of pension entitlements in Iceland. Extensive means testing in the public pensions systems ensures that benefits are sharply reduced if disability benefits recipients receive incomes from other sources.

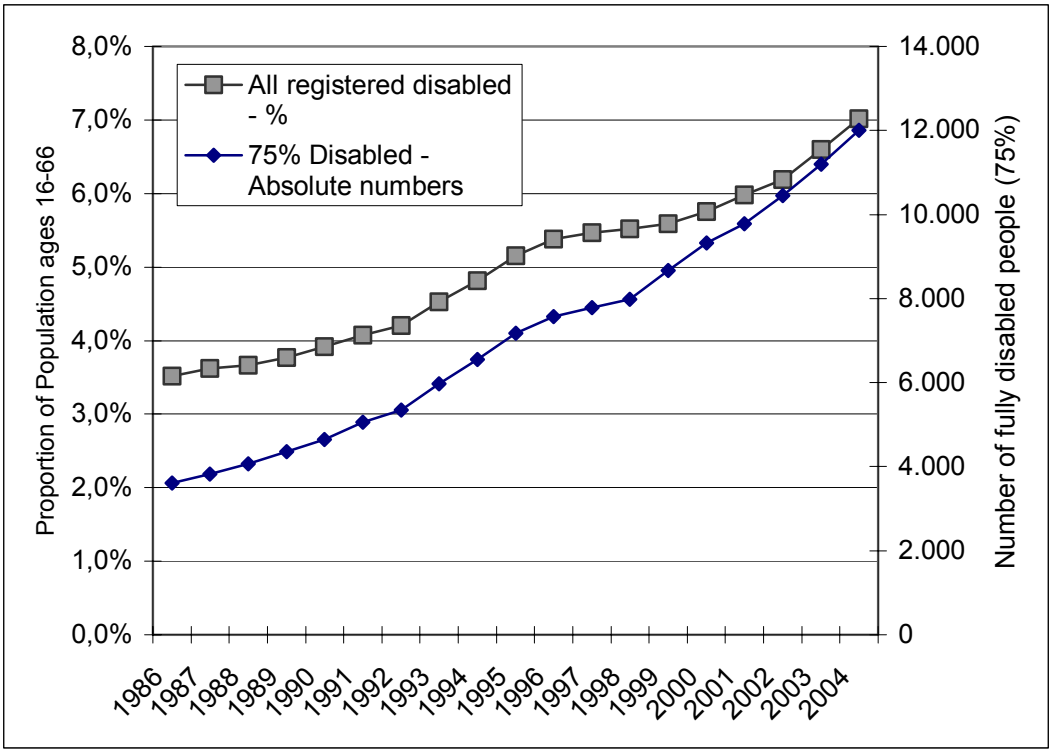

Figure 4.4: All registered disabled (50-75% disability) as a proportion of population aged 16-66, and fully disabled only (75% disability) in absolute numbers. Iceland 1986-2004.[13]

In figure 4.4 we see how the prevalence of disability in Iceland, i.e. the number of disabled people as a proportion of the population aged between 16 and 66 years old, has developed over time. The trends are shown simultaneously for all disabled people (those receiving disability benefits and those receiving disability allowances) and for people with 75% disability or above exclusively (those receiving disability benefits). This figure shows that prevalence of disability has grown faster than the population in Iceland. If we consider all people who receive some form of disability benefits we find that they made up about 3,5% of the Icelandic population aged between 16 and 66 years old in 1986. This proportion had doubled by 2004. Population ageing and other demographic variables mentioned above may have affected this process.

It is important to distinguish between the absolute increase in the number of disabled people in all categories and the proportional increase, as we do here. The proportional increase can nevertheless result from gradual changes (such as would

[13] All disabled includes disability benefits recipients (75% disability), disability allowance recipients (50-65% disability) and people receiving rehabilitation benefits.

occur on account of demographic changes) and from socio-economic factors external to the disability benefits system (e.g. pressure in the labour market and incentive created by the welfare state).

The figure also shows the trend for people with full disability exclusively. During the period in question we observe a more than threefold increase in the prevalence of full disability, i.e. people with full disability. This increase is explained, at least partly, by the shift from partial disability benefits to full disability benefits discussed above. This shows that focusing exclusively on increases in the number of people who receive disability benefits (75% disability) and overlooking the decrease in number of people receiving disability allowance (50-65% disability) leads to exaggerated claims about the growing prevalence of disability in Iceland.

4.4. Growing Prevalence of Disability in Iceland – Comparative Focus

It is clear from the discussion above that the prevalence of disability grew substantially in Iceland between 1986 and 2004, though the proportional increase is not as large as the absolute increase might suggest. OECD data shows that there was a rapid growth in the prevalence of disability in Western countries after 1980. That trend lasted until 1995. After 1995 the growth slowed down (OECD 2003, p. 61). This development started about a decade later in Iceland and it didn't really take off until after 1992. The lower average age of the Icelandic population may be one of the reasons for this, as are changed social and economic circumstances after 1990, such as changes in the labour market. This will be discussed further in chapter VI.

Table 4.1 shows the proportional change in the number of disability benefits recipients in the Nordic countries from 1990 to 2002, broken down by age-groups. This gives a clear overview of the nature of the increase, i.e. the extent to which it occurs among young or older people of work age, and of the pattern in Iceland as compared to the other countries.

Table 4.1

Number of Disability Benefit Recipients in the Nordic Countries 1990-2002

Proportional changes over the period, by age-groups.

Age-Groups:	Denmark[14] %	Finland %	Iceland %	Norway %	Sweden %
16-19	72	-53	-5	-19	47
20-29	12	-16	35	16	52
30-39	25	-23	61	31	57
40-49	22	-6	115	35	47
50-59	29	-5	68	55	63
60-64	-2	-16	14	8	1
16-64 yo total	19%	-11%	57%	32%	35%

Source: NOSOSKO 2004, bls.144

The table shows a considerable decrease in the number of disabled people in Finland during the period in question. Around 1990 Finland experienced very high unemployment rates that fell again from 1995. Thus it seems that there was a connection between the extent of unemployment and the prevalence of disabled people in Finland in the 1990s. The prevalence of disability grew when unemployment was at its highest levels but fell again when unemployment went down. The proportional increase in the number of disabled people was highest in Iceland in the years after 1990, followed by Norway and Sweden.

It is noteworthy that the prevalence of disability in the youngest age-group, 16-19 year olds, fell in Iceland between 1990 and 2002. This runs counter to claims made in previous research where it is claimed that the largest increase in disability had occurred among young people (Herbertsson 2005, p. 4).[15] Furthermore, the prevalence of disability is also lowest in the youngest age-group.

[14] It must be kept in mind that the figures for disability benefits recipients in Denmark presented here do not cover everyone who would be included in the disability benefits systems of Iceland and the other countries. Some of the disabled people in Denmark receive early retirement pensions or sick pay benefits, or receive support through from other parts of the welfare system. This will be discussed further later in this chapter.

[15] Note, however, inconsistencies in Herbertsson's conclusions about the increase within specific age-groups (see pages 4, 37, and 73). In the abstract on page 4 he states: "It is disquieting that that the biggest proportional increase in disability has been among young people. The increase has been so rapid that it is bewildering". On page 37 he states: "It is disquieting that that the biggest proportional increase in disability has been among middle aged people. The increase has been so rapid that it is bewildering". On page 73 he presents a graph that clearly shows that the biggest increase has occurred among older people.

The prevalence of disability grew most among 40-49 year olds, followed by 50-59 years olds, and then by 30-39 year olds. Thus, the largest increase in the prevalence of disability in Iceland occurred among people aged between 30 and 60 years old. That development is similar to the developments in most other European countries that occurred some years before, as was discussed in chapter III. Indeed, the prevalence of disability is highest for the older age-groups in most European countries. On the other hand, it is interesting how little the prevalence of disability has grown for 60-64 year olds in Iceland. The employment rates of this age-group are also unusually high in Iceland (OECD 2005). The developments in the other countries are not identical. It is noticeable that the number of young disabled people has grown in Denmark and Sweden, while it has fallen in the other three countries. The increase in disability prevalence in Sweden is rather even in all age-groups except for the oldest. In Finland instances of disability also decreased the least in the oldest age-group.

The following is a summary of how the prevalence of disability developed in Iceland from 1990 to 2002:

- The biggest increased occurred among people aged 40-49
- The second biggest increased occurred among people aged 50-59
- The third biggest increase occurred among people aged 30-39
- The youngest age-group (16-19 years old) experienced a decrease of about 5%
- Overall the increase was substantially larger in Iceland than in the other Nordic countries. This stems from the fact that the rise in the number of disabled people experienced by most other Western countries between 1980 and 1990 occurred later in Iceland. The biggest growth period in Iceland was during the 1990s and again from 2002 to 2004.

The Incidence of Disability as a proportion of the working age populations (16-64 or 16-66 years old) is an important indicator of how the occurrence of disability has developed over time. The incidence of disability reflects the number of newly registered disabled people as a proportion of each age-group. This isolates the effects of population growth on disability. This can be seen in figure 4.5 and table 4.2.

If the number of disabled people is growing because of specific circumstances, such as deterioration of population health, employment conditions, changes is the welfare state (e.g. considerable increase in disability benefits generosity) or because of other conditions in society, then those effects should show up in figures on

incidence of disability. The picture shows that the incidence of disability grew slowly from 1986 to 1989, but as of 1993 there was a substantial increase. Then there was a large drop from 1995 to 1998. There was a sharp increase in incidence of disability in 1999, when the new disability rating standard was adopted. The incidence fell again in 2001, though not to previous levels, and rose again in 2002 and 2003.

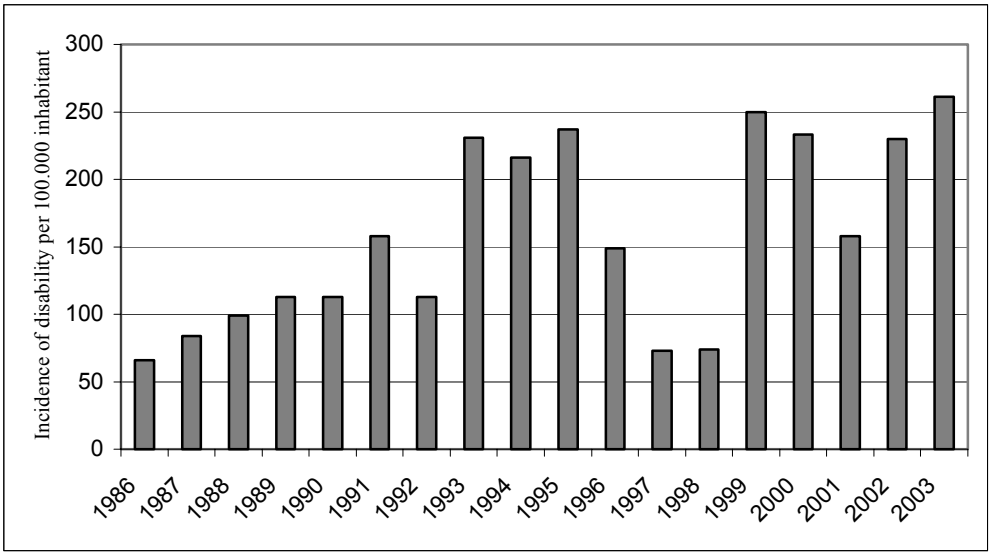

Figure 4.5: Incidence of Disability per 100.000 inhabitants. Iceland 1986-2003.[16]

What is interesting about figure 4.5 is that the increase in number of disabled people is neither regular nor constant. Those who are familiar with figures on unemployment during this period will notice that this development corresponds closely with that of the unemployment rates. This will be examined further in chapter VI. In chapter IX we will examine the association between the incidence of disability and how the earnings of disabled people have developed over time, relative to the earnings of people who are employed.

Table 4.2 shows the incidence of disability in Iceland in comparison to 9 EU countries and the average disability incidence of those countries (column labelled "Europe"). This gives an interesting picture of the extent of disability and the increase

[16] The Incidence of Disability reflects the number of first time disability recipients per population of 100.000. The total number of disabled people also falls because of mortality and because some people give up their disability benefits. The net outcome is the real change in the number of disabled people. These figures reflect the fully disabled (75% disabled and above), unlike figure 4.2 above, which reflects all recipients of disability support.

in its prevalence in an international context and shows where Iceland is situated in the process.[17]

If we look at the average of the European countries we see clearly how the incidence of disability falls from 1995 to 2000 but rises again in 2001-2. The fall is strongly associated with the implementation of various measures intended to increase the labour market participation of disabled people as well as other "inactive" citizens of the EU countries. What is particularly interesting is that in 2002 the incidence of disability in Iceland was less than half of the European average. In those years when the incidence of disability was the lowest it was only about a quarter to one fifth of what it was in the other countries.

Table 4.2
Incidence of Disability per 100.000 Inhabitants
1986-2003

	Austria	Finland	Iceland	Ireland	Netherlands	Norway	Poland	Russia	Sweden	Switzer-land	Europe
1986	403	708	66	...	...	615	...	...	598	...	...
1987	398	742	84	...	...	840	...	...	615	...	...
1988	438	672	99	131	...	748	...	...	641	...	...
1989	389	696	113	139	...	744	...	...	612	...	...
1990	370	745	113	192	777	697	...	517	589	...	...
1991	373	661	158	174	768	597	...	614	575	...	...
1992	375	633	113	123	657	491	...	750	673	...	600
1993	304	583	231	171	679	461	...	778	716	...	612
1994	195	589	216	156	511	541	...	765	552	...	586
1995	184	576	237	154	470	580	...	916	444	335	628
1996	167	...	149	124	533	569	...	798	443	...	543
1997	179	...	73	115	565	643	...	781	465	...	535
1998	185	...	74	139	763	751	...	776	389	...	537
1999	189	...	250	156	671	751	429	723	445	...	509
2000	219	477	233	...	735	663	277	767	554	...	524
2001	267	494	158	...	735	560	221	834	641	...	557
2002	284	521	230	...	668	590	204	...	714	...	561
2003	271	...	261	...	501	631	...	...	...	...	...

Source: World Health Organisation 2005 (website)/Icelandic Directorate of Health.

If we consider the Nordic countries in the table, Finland and Sweden, we see that the incidence of disability (new disability claimants per 100.000 inhabitants) is considerably higher than it is in Iceland despite the fact that the overall proportion of

[17] Sources: International data comes from the World Health Organisation (WHO) and the data on Iceland comes from the Icelandic Directorate of Health. The data can be found on the WHO website.

disabled people has grown more rapidly in Iceland, as was shown in table 4.1. This suggests that despite a considerable increase in the number of disability benefit claimants, the financial burden imposed by disability on the welfare state is smaller in Iceland than it is in most European countries, including Finland and Sweden. The falling number of disabled people in Finland is also reflected in falling rates of incidence of disability after 1990.

Even though the incidence of disability in Iceland is smaller than the average of these European countries, there are some countries whose disability incidence is similar or even lower. According to these figures Austria and Poland have similar incidence rates and Ireland has lower incidence rates than Iceland.

4.5 The Disabled as a Proportion of Working-Age Population

The incidence of disability shows how many people are registered as disabled for the first time each year, as a proportion of the population. The prevalence of disability, on the other hand, shows the total number of disabled people at any given time as a proportion of the working age population. Figures on the prevalence of disability are given in figure 4.6 and in table 4.3.

Figure 4.6 shows how the prevalence of disability has developed in the Nordic countries from 1995 to 2002. The figure indicates that Denmark has the lowest proportion of its population receiving disability benefits, followed by Iceland. It must however be noted that the low numbers for Denmark stem from the fact that a considerable proportion of their disabled pensioners are registered with the retirement pensions system (early retirement schemes – førtidspension) and some of them receive sick pay benefits from the medical insurance system, rather than receiving disability benefits. In Iceland most such people would receive disability benefits. Such discrepancies will be discussed later, but let us first look at the patterns that appear in the figure.

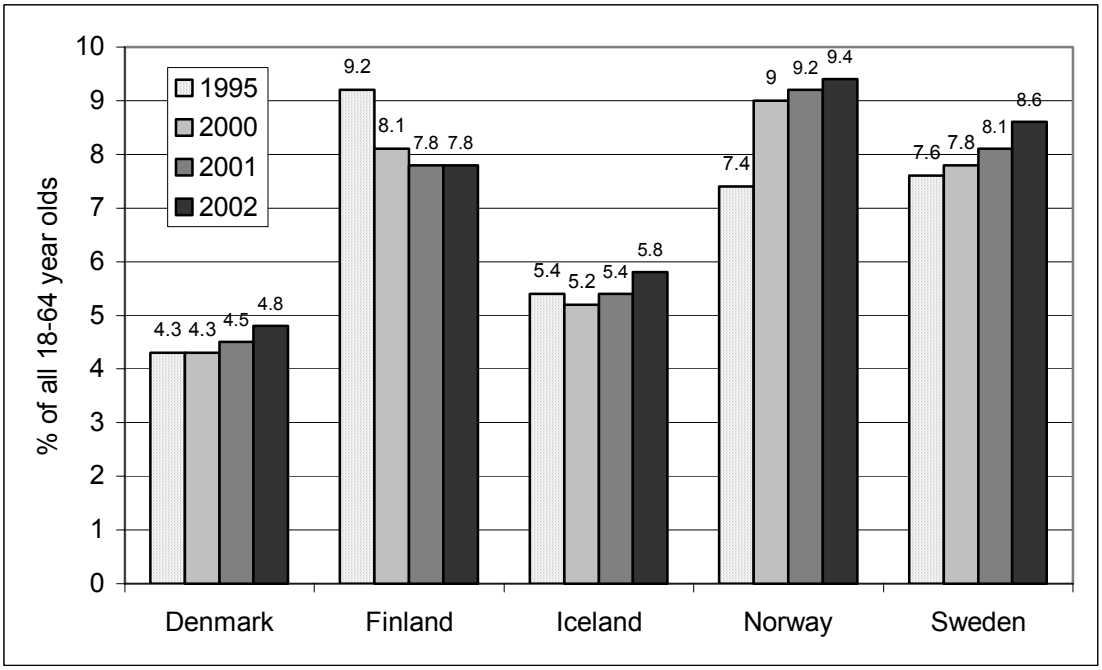

Figure 4.6: Prevalence of disability (disability benefit recipients) as % of the working age population (18-64 years of age). The Nordic Countries - 1995, 2000, 2001 and 2002.[18]

It is clear that the prevalence of disability fell in Finland between 1995 and 2001. At the same time it rose in Norway and Sweden. The disability prevalence fell in Iceland between 1995 and 2000, but rose again in 2001 and 2002.

It is interesting to consider the prevalence of disability in EU countries, given in table 4.3, while keeping in mind that disabled people are often registered with different schemes in different welfare states. The prevalence rate is rather low in Iceland, e.g. 3.430 against an average of 4.801 out of 100.000 inhabitants in the European countries in 2001. On the other hand we must note that the prevalence of disability has doubled in Iceland since 1985. The prevalence of disability has thus risen faster in Iceland than has the average of the European countries.

[18] Source: NOSOSKO 2004.

Table 4.3

The Prevalence of Disability per 100.000 Inhabitants

European Countries 1986-2003

	Belgium	Denmark	Finland	Germany	Iceland	Italy	Netherlands	Norway	Poland	Sweden	Switzerland	Europe
1985	...	...	5329	...	1431	...	...	4527	...	3864	...	...
1986	...	...	5495	...	1487	...	...	4659	...	3924	1810	...
1987	...	...	5664	...	1555	...	...	4952	...	4007	1834	...
1988	...	...	5748	...	1629	...	...	5156	...	4112	1859	...
1989	...	...	6059	...	1724	...	...	5395	...	4183	1911	...
1990	1669	3128	6239	...	1823	...	5891	5525	6894	4222	1941	4054
1991	1788	3149	6310	6716	1959	...	5989	5596	...	4259	1988	4102
1992	1830	3174	6347	...	2049	...	6008	5511	...	4420	2029	4243
1993	1868	3177	6341	7864	2260	1655	6023	5389	...	4612	2101	4447
1994	1947	3210	6330	...	2458	1752	5813	5388	...	4676	2205	4571
1995	1982	3295	6280	7955	2684	1795	5565	5420	8787	4756	2273	4635
1996	2001	3286	6110	...	2817	1791	5507	5464	...	4737	2353	4812
1997	1981	3264	5963	8069	2870	1742	5539	5596	...	4780	2443	4853
1998	2000	3243	5813	...	2914	1725	5760	5824	9132	4763	2526	4882
1999	2062	3233	5686	8081	3128	...	5834	6047	9147	4797	2624	4868
2000	2101	3210	5569	...	3318	...	5982	6254	8984	4936	2732	4809
2001	2090	3301	5401	8151	3430	...	6098	6322	8677	5135	2825	4801
2002	2105	3346	5377	...	3631	...	6149	6439	8422	5474	3003	...
2003	2138	3527	5363	...	3875	...	6037	6598	...	5662	3235	...
2004	...	3518	...	...	...	...	...	...	...	...	...	...

Source: World Health Organisation-WHO, 2005 (website)/Icelandic Directorate of Health.

Finland, Germany, the Netherlands, Poland, and Sweden all have higher disability prevalence rates than Iceland. Switzerland and Denmark have similar rates (note however the abovementioned qualification about the Danish numbers). Belgium has lower prevalence rates than Iceland (though many people there receive early retirement pensions). Overall the evidence suggests that the prevalence of disability is rather low in comparison to the other Nordic and European countries.

In table 4.4 we finally take into consideration what was said above about disabled people being registered in different schemes in the pension system. It is a well established fact that a large part of the increase in disability in Europe after 1980 was amongst elder people. These people either received disability benefits or early retirement pensions. This was, among other things, done to make space in the labour market so as to reduce unemployment among young people, which was a serious problem in many countries.

Table 4.4
People of Working Age that Receive Some Kind of Pension.
Nordic Countries, 2003

A. Disability Benefits Recipients Only
Proportions of Age-Groups

Age-Groups:	Denmark	Finland	Iceland	Norway	Sweden
16-19[1)]	0,2	0,3	1,2	0,6	1,0
20-29	1,2	1,4	3,0	1,3	1,6
30-39	2,6	2,6	4,8	3,4	3,3
40-49	5,3	5,4	7,1	8,3	7,8
50-59	9,4	14,6	10,0	18,6	16,2
60-64	12,4	29,9	17,0	35,2	29,8
% of 16/18-64 yo:	5,0	7,8	6,2	9,5	8,9

[1)] Denmark and Norway: 18-19 year olds

B. All Pensioners, % of People at Working Age
(Disability enefits, early retirement, sick pay, etc.)
Proportions of age groups

Age-Groups:	Denmark	Finland	Iceland	Norway	Sweden
16-39	1,8	1,7	3,5	2,3	3,5
40-49	6,5	5,4	7,1	8,3	8,2
50-54	10,7	11,4	8,7	14,7	14,3
55-59	16,0	20,5	11,6	22,5	21,2
60-64	60,0	69,1	17,0	43,4	39,7
% of 16/18-64 yo:	**10,7**	**11,7**	**6,5**	**10,2**	**11,2**

Source: Nososko 2004, p. 132 and 153.

The upper half of table 4.4 presents figures on disability benefits recipients as a proportion of different age-groups and the population as a whole. The figures correspond with the figures in table 4.6. The lower half, on the other hand, presents all pensioners (disability benefits, early retirement, sick pay, and rehabilitation benefits) as a proportion of different age-groups and the overall population. It is particularly interesting to compare Iceland to Denmark in both halves of the table. The first part of the table suggests that the prevalence of disability is lower for each age-group in Denmark than it is in Iceland. This seems unlikely (considering information from other sources, e.g. from OECD and information about expenditures on disability benefits). The explanation for the low prevalence of disability in Denmark is that many of the people who are registered as disabled in Iceland would be registered with

other pensions systems in Denmark, such as early retirement, sick pay, rehabilitation schemes, and unemployment benefits or with the municipal social services.

The lower half of the table is thus a more valid representation of the actual number of disability benefits recipients and other pensioners as a proportion of the working age population. The prevalence of disability rises with age and it is highest by far for the oldest age group, 60 years old and above. It is interesting that Iceland is the country with the highest prevalence of disability in the youngest age-group (16-39 year olds), yet the prevalence of disability is lower in Iceland for all the other age-groups. The main reason is that young people in the other countries who are unemployed or disabled are assigned to various educational and rehabilitation programs as early as possible. The emphasis on such activation measures has been growing in Europe over the last decade. Iceland lags behind in that development, as will be discussed in chapter XI.

These wider and more realistic figures reveal that about 6,5% of people of working age in Iceland received pensions of some sort in 2003, compared to 10,7% in Denmark, 11,7% in Finland, 10,2% in Norway, and 11,2% in Sweden. Iceland is therefore the country that has the lowest proportion of its working age populations receiving benefits of any kind, whether it is disability benefits or any other pensions. This is also in accordance with the figures from the World Health Organisation about the prevalence of disability in Europe that were presented in table 4.3.

These results indicate that Iceland spends less on disability benefits and other kinds of labour market inactivity than do the other Nordic countries. This is partly because early retirement and transition schemes are not available in Iceland. Such schemes are common in the Nordic and the European countries where many people aged between 55 and 65 years old who suffer health problems or are worn out from work received early retirement pensions over the last two decades. People who have lost their health due to long-term unemployment have also been allowed to transfer from unemployment benefits to such pension schemes. Disability benefits are the only pension scheme that is available for such people in Iceland.

In addition it seems that the disability benefits system in Iceland plays a larger role than similar systems do in the Nordic and the other European countries. In these countries there are great many people who receive sick pay because of long-term

illness or other kinds of pensions than disability benefits. Because of that a larger proportion of income support is channelled through the disability benefits system in Iceland than in the other countries. This will be examined more closely in the next section of this chapter.

4.6. Overloading of the Icelandic Disability Pension System?

4.6.1. The Dwindling Role of Sick Pay, Unemployment Benefits and Municipal Income Support

As was discussed above, in section 4.4, some of the schemes, such as early retirement schemes, that are available in the neighbouring countries, both the Nordic countries as well as the countries in continental Europe, are not available in Iceland. People who are on such schemes in the other countries would be put on disability benefits in Iceland. Other things being equal this should mean that the proportion of the population receiving disability benefits in Iceland should be higher than in the other countries. This is however not the case, as was shown in section 4.4 of this chapter.

But the Icelandic welfare state differs from those of the other countries in other important respects. For instance, public sick pay has a relatively small role to play, as does income support from municipalities and unemployment benefits. Herbertsson's report (2005) clearly shows that there has been a growing imbalance between different pension systems in terms of benefit amounts. This also applies to sick pay. For instance, unemployment benefits were equal to disability benefits for singles in 1996 but had fallen behind to about 80% in 2005. Income support from Reykjavik social services for singles was slightly more generous than disability benefits in 1996, but by 2005 it had fallen to 70% (Herbertsson 2005, pp. 65-66). This should, all things being equal, create an incentive for people with income problems to apply for disability benefits rather than other kinds of income support. In most cases there is a considerable consistency between different kinds of benefits in Europe, e.g. unemployment and disability benefit amounts are usually quite similar (OECD 2003).

Consequently it makes sense to ask whether this growing imbalance between the abovementioned schemes is among the factors that explain the growing prevalence of disability in Iceland over the last decade or so. Is it a deliberate policy

to have the Icelandic disability pensions system play a bigger role than is generally the case in the neighbouring countries?

According to information from the State Social Security Institute the role of the sick pay system in Iceland has played an ever decreasing role in supporting those suffering from long-term illness. Most of those who are in paid employment are entitled to retain their wages during spells of illness, most often for duration of one to three months, depending on tenure with current employer. After that people must rely on sick pay from the State Social Security Institute and/or limited grants from Labour Union sickness funds. It is not unusual that those who turn to the State Social Security Institute are first granted rehabilitation benefits only to be transferred to the disability benefits system if the problem turns out to be permanent.

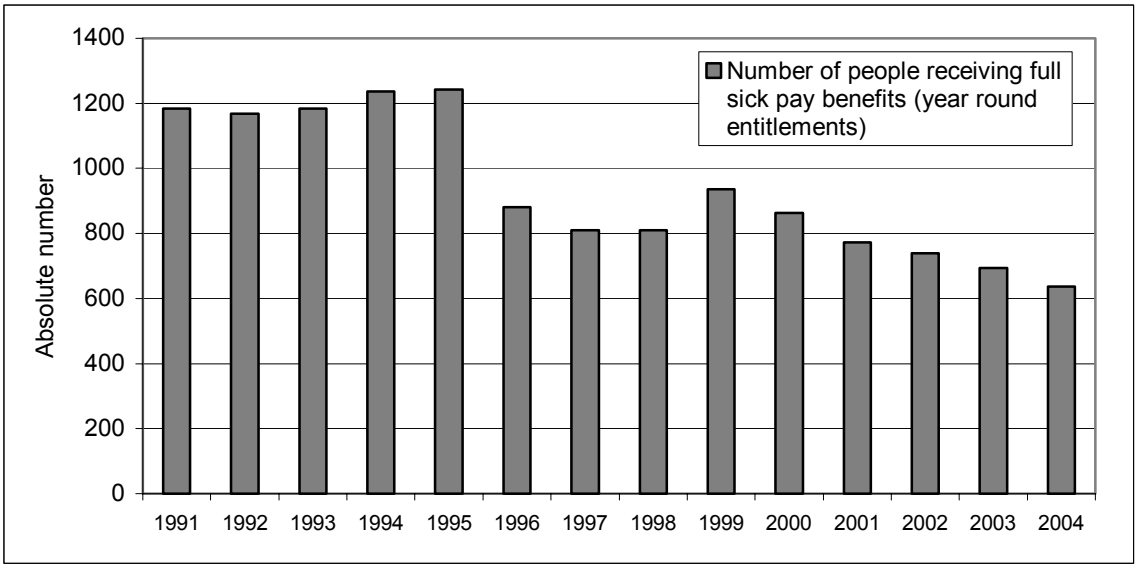

Figure 4.7: Indicators of the use of public sick pay, 1991 to 2004.[19]

Figure 4.7, which is based on data from the State Social Security Institute, indicates how sick pay benefits have come to play a smaller role. Funding for the sick pay system has decreased in absolute terms during the last decade and if funding is divided by the amount that people's entitlements to year-round support give, as is done in the figure, we get an indication of the ever smaller part played by this part of the welfare system, which may have increased the pressure on the disability benefits

[19] Source: State Social Security Institute. Expenditures on sick pay benefits are divided by the number of (heilsársnotendur). The real expenditures on sick pay benefits have diminished over time.

system. That alone should have led to an increase in the number of disability benefits recipients in Iceland, beyond what is common in the neighbouring countries.

Figure 4.8 indicates considers the same question in terms of incentives, i.e. the incentives those entitled to sick pay from the SSI have to apply for such benefits. In the figure, sick pay is given as a percentage of minimum wages in the labour market. In 1988 it was about 35% of minimum wages. By 2002 it had fallen to about 25%. That year sick pay benefits were approximately 25.000 ISK per month, with a small supplement for each dependent child. Sick pay benefits were not this low in any of the countries that enjoy a similar level of prosperity as Iceland (see comparison of entitlements to sick pay benefits in Appendix I). This amount falls so far short of any minimum sufficient to support an individual in Iceland that people suffering long-term illness have a strong incentive to get seek other sources of support. This situation has been getting worse for the long-term sick, as can be seen from the figure.

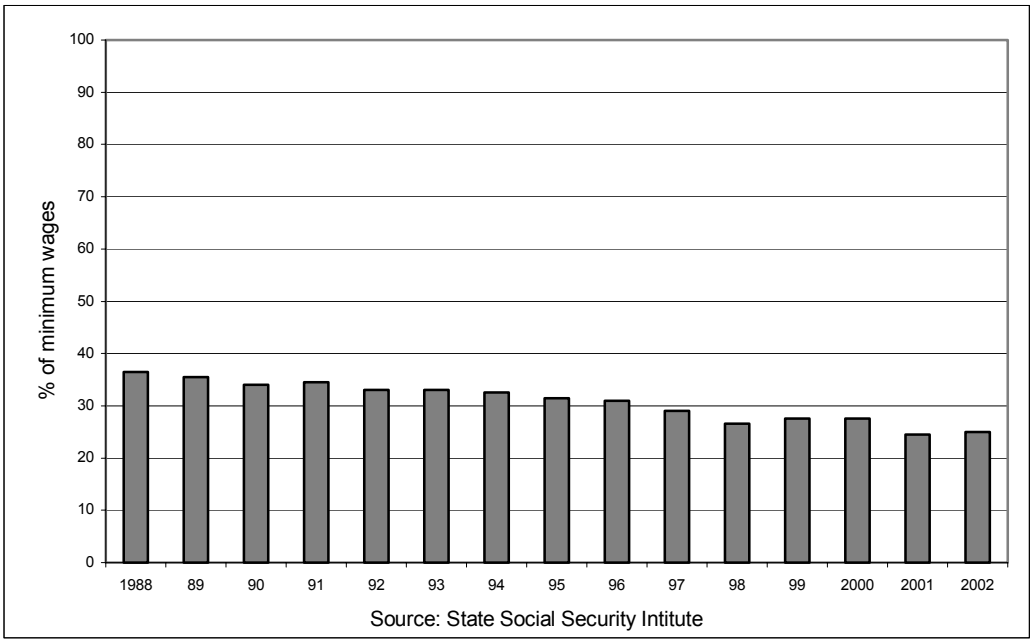

Figure 4.8: Sick pay as percentage of the minimum wage of manual workers, 1988 to 2002

Employed people in the other Nordic countries are usually entitled to sick pay that covers between 70 and 100% of previous wages. In Sweden there is no time limit on entitlements, but there is a one-year time limit in the other countries (NOSOSKO 2003, p. 87). That social security sick pay benefits are so unusually low therefore implies that this part of the welfare system is only meant to serve a very limited

purpose. This is bound to increase the pressure on other support measures, such a municipal income support and unemployment benefits, or in this case the disability pensions system.

4.6.2. The Declining Role of Municipalities

One option in the Icelandic welfare system is for people suffering long-term illness to seek financial assistance from municipal social services. Data on the reasons given for seeking municipal income support, e.g. from the capital city region, doesn't indicate that doing so is particularly common (see for example the Annual Report of Reykjavik Social Services, various years). Comparative figures on the number of individuals making use of this option in the Nordic welfare states, such as those displayed in table 4.5, indicate that this option is used considerably less in Iceland than in the other countries.

Table 4.5
People who Receive Income Support from Municipalities
% of ages 16/18 and above. Nordic countries 1990-2001.

	Denmark	Finland	Iceland	Norway	Sweden
1990	5,8	5,9	2,6	5,5	4,8
1995	4,7	10,9	3,5	5,6	6,6
2000	4,1	8,3	2,6	4,4	4,9
2001	4,0	8,0	2,6	4,2	4,4

Nordic Statistical Yearbook, various years

This is clear from the fact that in 1990 about 2,6% of people 18 years old or older had received such support in Iceland, compared to 4,8 to 5,9% in the other countries. This proportion grew in 1995, after unemployment rates had increased considerably. Unemployed people make up a large proportion of the applicant group, and the number of applications varies considerably with the unemployment rate. This is a clear indication that the amount of unemployment benefits is below the poverty line. The proportion fell again in Iceland after 1995, as unemployment went down, and in 2001 it was about 2,6%, compared to 4,0% to 8,0% in the other Nordic countries in that year.

This information can either reflect less need for such support in Iceland than in the other countries, or weaker incentives to seek such support considering the small

amounts granted (cf. Herbertsson 2005), or simply that some of those who would otherwise be entitled to this kind of support are already within the disability benefits system. Employees of the Social Security Institute have indicated in interviews that this may well be the case. This situation is unfortunate as the likelihood of getting stuck in the pension system increases substantially once people have been granted disability benefits. Channelling people onto disability benefits also runs counter to the goals of the welfare state.

4.6.3. The General Role of the Disability Benefits System

Unemployment benefits are also important to this analysis, as it is well established that unemployment benefits and disability benefits systems are strongly interconnected in the neighbouring countries, especially in continental Europe (OECD 2003, chapters 4 and 5).

Table 4.6
Unemployment in the Nordic Countries
% of the Labour Force 1995-2003

	Denmark	Finland	Iceland	Norway	Sweden
1990	8,8	3,4	1,8	5,2	1,6
1995	7,0	15,5	4,9	4,9	7,7
2000	4,6	9,8	2,3	3,4	4,7
2002	4,7	9,2	3,3	3,9	4,0
2003	5,5	9,1	3,4	4,5	4,9

NOSOSKO 1998 and 2004

Since the end of the Second World War unemployment rates have generally been lower in Iceland than in other European countries. Table 4.6 shows that Iceland and Norway had similar unemployment rates in 1995. In Iceland unemployment grew to unprecedented levels from 1992 to 1995. Unemployment rates were still higher in Sweden and Denmark, and much higher in Finland which had a serious unemployment problem after 1990. Survey research on employment participation and unemployment in Iceland often show higher levels of unemployment than do the unemployment registries that are used for the administration of unemployment benefits. When survey data shows higher levels of unemployment it is often an indication that some unemployed people are completely without income support from

the welfare state or that they receive support from other parts of the system, including the disability benefits system. However, this deviation is generally small in Iceland. The relationship between unemployment and disability will be examined more closely in the chapter on employment conditions and the frequency of disability.

In table 4.7 we analyse the expenditures on disability benefits, sick pay, and unemployment benefits in 1998, i.e. those parts of the welfare system we have reasons to assume to be highly related in terms of the flow of clients between systems. Data in table 4.7 give indications about expenditures on disability in different countries, but the emphasis is on the different weights of these three parts of the welfare system.

If we first take a look at Iceland we see that about 1,5% of the GDP was spend on disability benefits that year while public expenditures on sick pay were only about 0,1% of the GDP, and expenditures on unemployment benefits were about 0,4% of the GDP. Expenditures on disability benefits were close to the average of the OECD countries that year but the expenditures on sick pay were only about one sixth of the same average. Norway spend about 1,5% of its GDP on sick pay, Sweden spent about 1,1%, Denmark 0,7% and Finland 0,4%. It is interesting how much more the other Nordic countries spend on sick pay. In Iceland employers pay for a substantial part of sick pay (generally 1 to 3 months of pay are retained) while the share of the Social Security system in this task is obviously very small.

The countries in the table below are ordered according to their total expenditures on these three aspects of the welfare state (column 4). Iceland is the seventh country from the bottom, i.e. our total expenditures on pensions are unusually small. The countries that spend less are Canada and the United States, which are known for limited spending on such measures. Japan also spends less than Iceland, but these sorts of expenditures are to a large extent paid for by employers in Japan. Finally there are countries with unusually underdeveloped welfare systems, such as Turkey, Korea, and Mexico. The countries topping the list are the Netherlands and the Scandinavian countries, as well as Poland which has had unusually high rates of disability. It is noteworthy that in 2003 Sweden intended to transfer all disability benefits recipients onto the sick pay system, which further underlines how interrelated these two parts of the welfare system can be.

Table 4.7

Expenditures on Disability Benefits, Sick Pay and Unemployment Benefits

% of GDP 1998. OECD-countries.

	Disability Benefits	Sick Pay	Unemployment benefits	Total
Netherlands	2,4	1,0	2,6	6,0
Denmark	1,8	0,7	3,4	5,8
Finland	2,8	0,4	2,6	5,8
Poland	4,0	1,2	0,6	5,7
Sweden	2,1	1,1	1,9	5,2
Norway	2,8	1,5	0,5	4,8
Belgium	1,3	0,4	2,5	4,1
Spain	1,3	0,9	1,5	3,8
New Zealand	1,0	1,2	1,6	3,8
Slovakia	2,0	1,2	0,6	3,8
Switzerland	2,2	0,5	1,0	3,7
France	0,9	0,5	1,8	3,2
Ireland	0,7	0,7	1,7	3,1
Portugal	1,9	0,5	0,8	3,1
Britain	2,6	0,1	0,3	3,1
Luxemburg	1,8	0,7	0,5	3,1
Austria	1,9	0,2	0,9	3,0
Czeck Republic	1,7	0,9	0,2	2,8
Germany	1,0	0,3	1,3	2,7
Greece	1,1	0,8	0,5	2,4
Italy	1,0	0,7	0,7	2,4
Australia	1,2	0,0	1,1	2,4
Iceland	1,5	0,1	0,4	2,0
Canada	0,5	0,1	1,0	1,5
United States	0,9	0,2	0,2	1,3
Japan	0,3	0,1	0,5	0,9
Turkey	0,2	0,0	0,6	0,9
Korea	0,1	a	0,2	0,3
Mexico	0,0	a	0,0	0,0
Average	1,5	0,6	1,1	3,1

Source: OECD (2002), *Society at a Glance*.

Following from the discussion above about the relatively large role played by the disability benefits system in Iceland it seems apparent from this analysis of expenditures that there is a considerable pressure on the Icelandic disability pension to take on a bigger role than is generally the case in the neighbouring countries. In those countries sick pay, municipal social services, unemployment benefits, and

rehabilitation benefits have a much larger role to play. Consequently a heavier burden is placed on the Icelandic disability benefits system. Yet, despite this bigger burden on the Icelandic disability benefits system the proportion of people of working age receiving disability benefits is generally smaller than in Europe. This suggests that the problems that swell the rank of disability benefit recipients are smaller in Iceland than in the other countries. Considering the importance of the Icelandic disability benefits system Iceland should, ceteris paribus, be close to the top of the list of countries when it comes to the prevalence of disability. The growing number of disabled people in Iceland over the last decade does however still leave Iceland with a rather low rank in the European disability prevalence league.

V. Employment Participation

5.1. Employment Rates at Ages 55 to 64

We noted earlier that people in other Western countries frequently withdraw from the labour market before reaching legal retirement age. In some countries this has been the intentional outcome of labour market policies intended to make space in the labour market for unemployed young people. Unemployment has been a serious problem in many European countries, especially after 1980. This development has affected disability benefits systems in some countries as some early retirees, that is older people that have been granted disability status on account of worse health that comes with higher age, receive pensions from those systems.

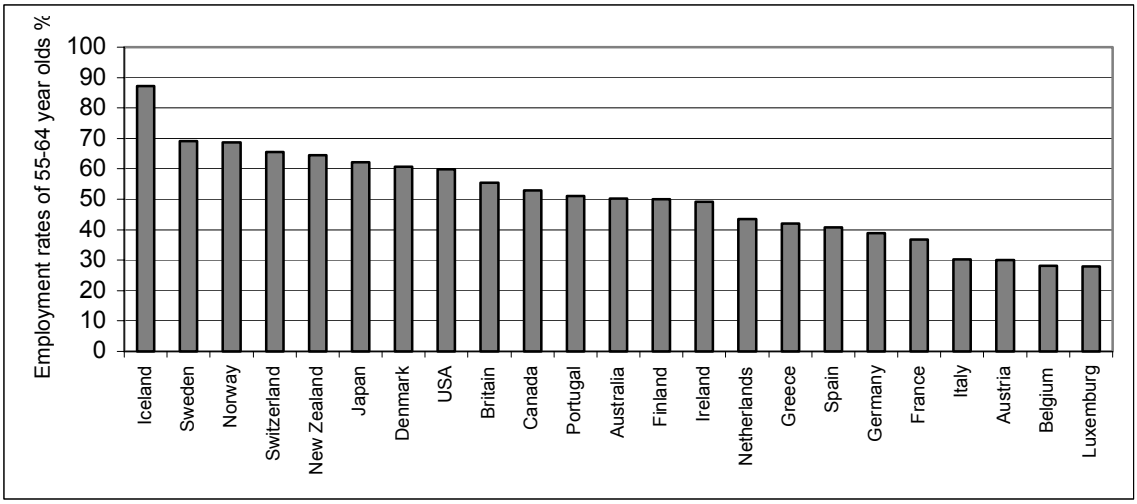

Figure 5.1: Employment participation at ages 55-64. OECD-countries 2003.

There are generally no early retirement schemes in Iceland (two notable exceptions are fishermen that are entitled to retire before the age of 67; and civil servants who have a combined age and career length of 95 years or more can retire before the public retirement age). The reason is probably that Iceland has not experienced a serious long-term shortage of jobs that might have led to the development of such measures. The disability benefits system is generally the only provision that tends to people that drop out of the labour market before legal retirement age. Figure 5.1 shows the employment rates of 55-64 year olds. This is the age group that has often

been dropping out of the labour market in many European countries in recent decades. The employment rate of this age group in Iceland is unusually high. In fact it is far above what prevails in other Western countries.

It appears that the older generation in Iceland is unusually active in the labour market. The countries closest in this respect are Sweden and Norway. It is interesting that both these countries are among those generally held to be quite generous with disabled people that, according to some economists, should entice people to drop out of the labour market. The fact is, however, that the employment rates of older citizens are in keeping with the fact that employment rates are generally high in the Scandinavian welfare states. Denmark also scores high on this list but Finland, which has experienced the highest levels of unemployment of the Nordic countries, is further down the list.

Switzerland, New Zealand and Japan follow the three Nordic countries in terms of employment rates of 55-64 year olds, then followed by the United States, Britain, and Canada. Both North American countries restrict their people's access to disability benefits and early retirement (Myles 1996). Britain, on the other hand, has a high number of people on disability benefits.

If we compare employment participation in Iceland and the other Nordic countries, then labour market surveys for the year 2003 imply that 13% of the Icelandic working age population (16-64 year old) are outside the labour market. The proportion in the other Nordic countries is 21-26% (NOSOSKO 2004, p. 75). Employment participation is unusually high in Iceland. Correspondingly, the burden imposed by the Icelandic pensions system is unusually small in comparison to other Western states.

5.2. Employment Rates of Disabled People

Figure 5.2 shows the employment rates of disabled people, which is important for all policy making on disability. The figure is based on OECD survey data (wider definition of disability) for the year 1999.

The employment rates of disabled people are everywhere less than those of the general population. This is what we expect given that the term disability refers in large part to limited capacity to work. The highest employment rates are is

Switzerland and Norway, about 60%, followed by Canada, Sweden, Denmark, the United States, France, and Germany. There may be different reasons for the high employment rates of disabled people in the countries in question. In the United States the high participation rates are most likely caused by low pensions and limited entitlements, i.e. more disabled people are pushed into the labour market. The United State government tried to accomplish this effect with so-called "workfare" measures during the 1990s, with considerable success we might add. However, various people have criticised the fact that the circumstances of disabled people and single mothers, which the measures were mostly targeted at, have actually gotten worse (Cowling 2004). The Scandinavian countries and some of the other European countries use both support measures and incentives to achieve the same objective, though the consequences tend to be more beneficial for the disabled (Zeitlin and Trubeck 2003; OECD Employment Outlook 2003).

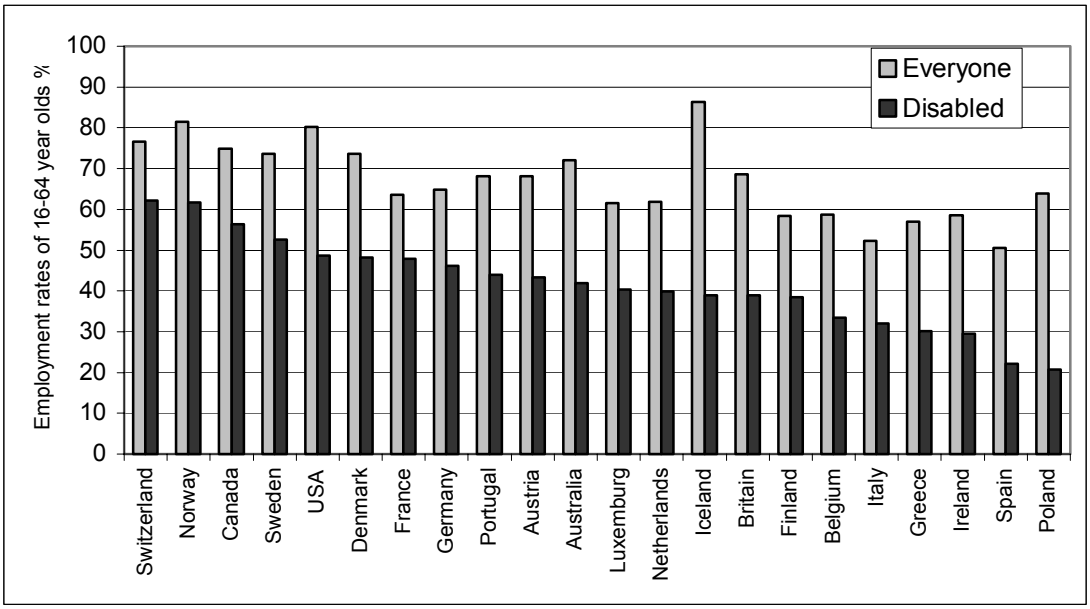

Figure 5.2: Comparison of the employment participation rates of the disabled and all individuals of working age. OECD countries 1999, ages 16 to 64.

The Mediterranean countries, which have rather underdeveloped welfare systems, have the lowest employment rates for disabled people, as do Ireland, Italy, and Belgium. The same goes for Finland, but Finland has experienced a long-term unemployment problem and consequently the opportunities for work have been unfavourable to the disabled.

The employment participation rate for disabled people in Iceland was about 38%. That figure comes from a report published by the National Economic Institute.[20] According to that report 37,8% of disabled people in Iceland had some earnings from employment in 1997. This percentage is rather low when we consider the generally high employment rates in Iceland and also when we consider the employment rates of disabled people in countries that top the list in figure 5.2. This probably stems from the fact that Iceland has not adopted active labour market policies to the same extent as have these other countries. This will be examined further in the chapters on expenditures on disability and activation measures and occupational rehabilitation.

Finally, in figure 5.3 we show a final indication of high employment rates, low prevalence of disability, and unemployment rates together.

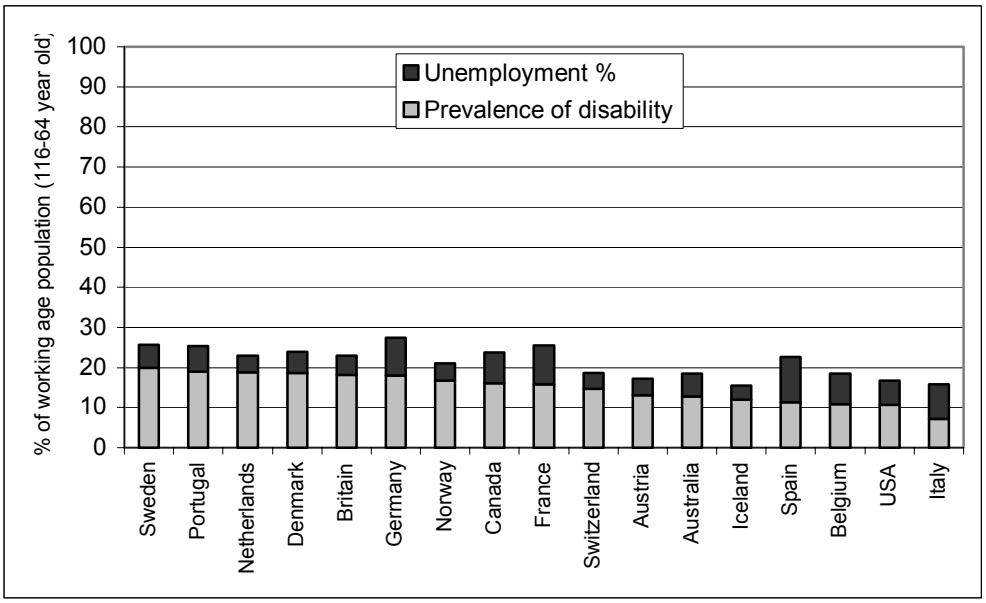

Figure 5.3: The prevalence of disability and unemployment together.[21]

Most of the evidence suggests that Iceland has indeed a small burden from both unemployment and disability by European standards.

Despite high employment rates in Iceland, low unemployment rates compared to other Western countries, and relatively low frequency of disability, there is ample cause to consider the relationship between employment conditions and disability in

[20] "Prime minister's report on the circumstances of the disabled" – Parliamentary document 1136/123.
[21] Disability is estimated from OECD survey data (the estimates for Iceland are estimated from the average difference between the number of disability benefits and the prevalence of disability in Europe as estimated from survey data).

Iceland further. There is evidence that conditions in the Icelandic labour market changed during the 1990s, e.g. increased unemployment and increased pressure at work, and this may have influenced the growing prevalence of disability over the last decade. This is the subject of the following chapter.

VI. Employment Conditions and Disability

A Close Relationship

6.1. The Effects of Growing Unemployment

In 2004 the author of this report, in collaboration with Sigurdur Thorlacius and Sigurjon Stefansson, published an article on the relationship between unemployment and the incidence of disability in Iceland 1992-2003 in the *Icelandic Medical Journal* (Læknablaðið).[22] This was the first time that evidence on the association between unemployment and the prevalence of disability was presented in Iceland. There was a strong relationship between the incidence of disability and unemployment, which varied a lot during the 90s.

This chapter follows up on this research from 2004. Figure 6.1 shows how unemployment has developed over time, from 1957 to 2004. What is striking about this picture is that unemployment levels rise to unprecedented levels during the 1990s, i.e. it tripled from what it had been during most of the post-war period.

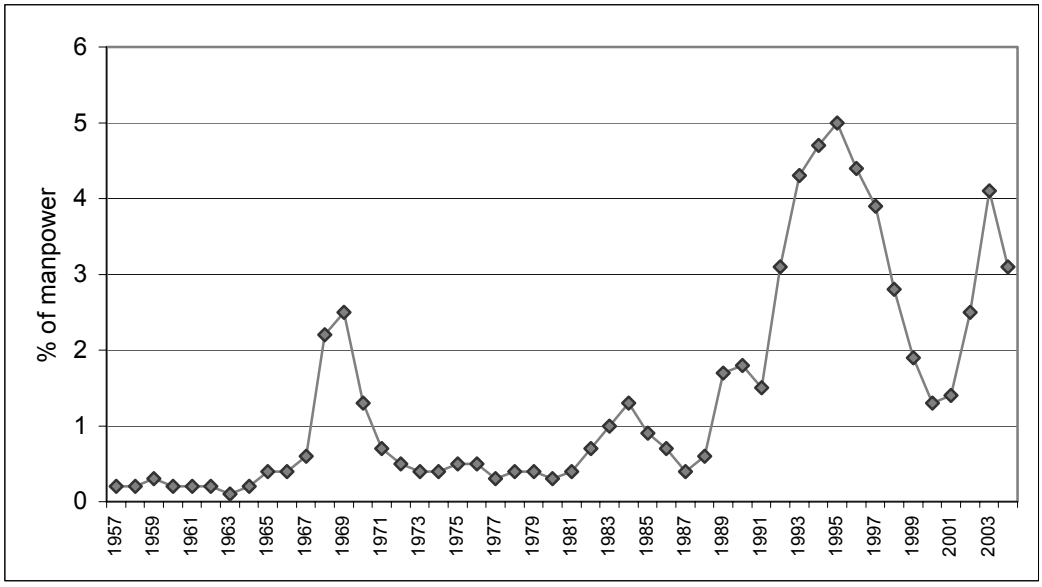

Figure 6.1: Unemployment in Iceland, 1957-2004.
Registered unemployment, as a proportion of working age population.

[22] Thorlacius, Stefansson and Olafsson (2004), "Tengsl atvinnuleysis og nýgengis örorku á Íslandi 1992-2003", *Læknablaðið* 2004; 90: pp. 833-6.

Unemployment had usually only been a temporary situation. Unemployment rose primarily during the economic recession following the collapse of the herring stock in 1968-1969, and again during the 1983-1984 recession. Still, these peaks were far below the unemployment levels observed during most of the 90s. Another feature of the development during the 90s is that the unemployment rate fluctuated considerably. This creates an excellent opportunity to study the effect of unemployment on the prevalence of disability. The highest unemployment rates were observed from 1992 to 1995, when it fell again, though not to the level of the post-war years. Then unemployment rates grew again after 2001, quite rapidly in fact from 2002 to 2004. It fell considerably again in 2005.

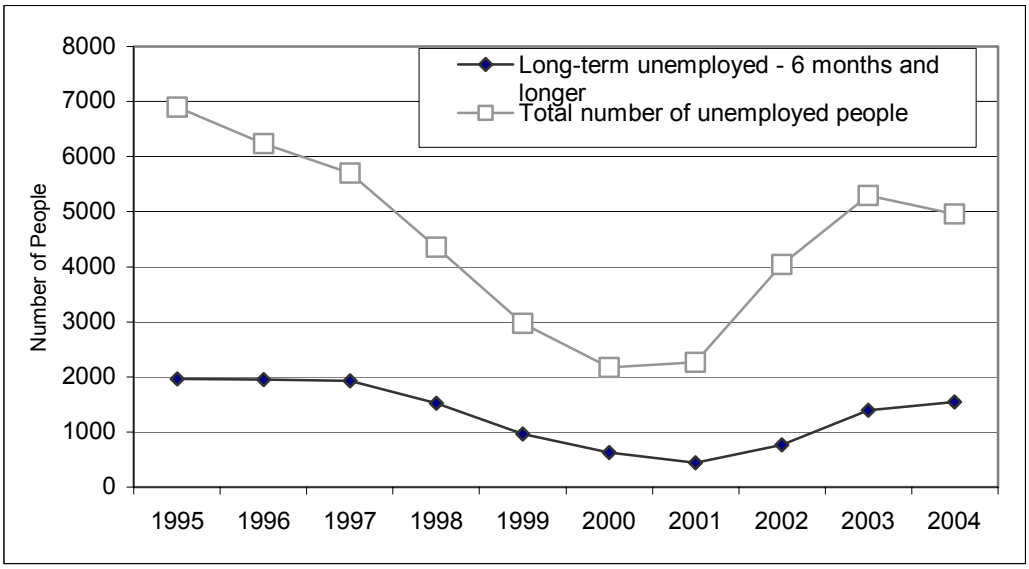

Figure 6.2: The relationship between the overall number of the unemployed and long-term unemployment specifically, 1995-2004.

Figure 6.2 shows that long-term unemployment rates co vary with the overall unemployment rate. This is important because long-term unemployment is generally thought to be associated with worse health, both physical and mental (Jonsdottir and Olafsson 1993; Halvorsen 1994, Jahoda 1982). Between 1990 and 2004 we observe two periods of high unemployment, including long-term unemployment, as figures 6.1 and 6.2 clearly show. Between these two periods there is a brief spell during which unemployment falls noticeably.

But how are these changes in the unemployment levels related to the prevalence of disability in Iceland? Indications of a relationship between unemployment and the incidence of disability are given in figures 6.3 to 6.5.

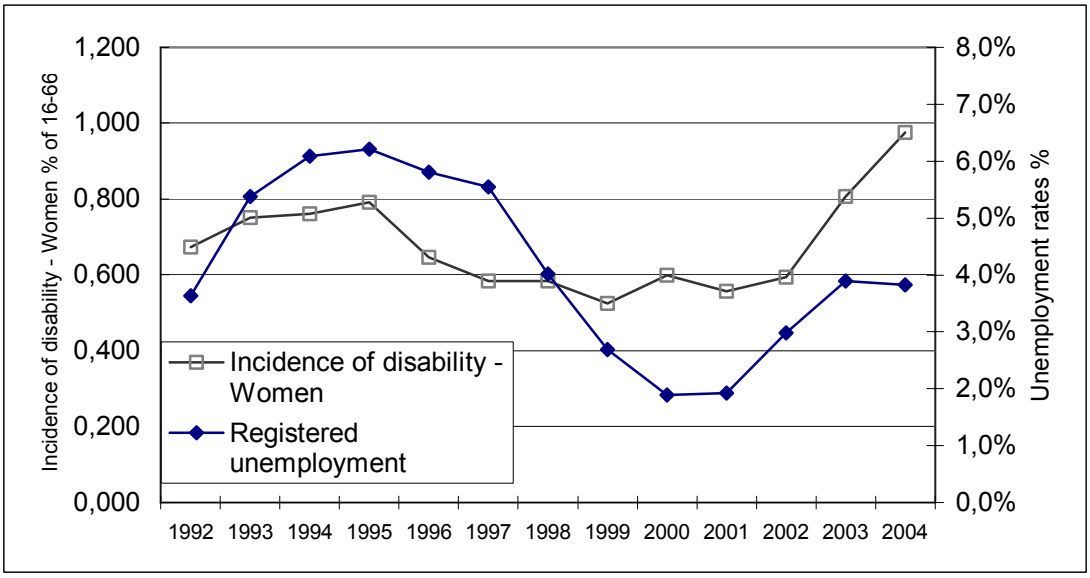

Figure 6.3: Relationship between women´s incidence of disability (50-75%) and the unemployment of women.

It was shown earlier that the increase in the prevalence of disability in Iceland has occurred in waves rather than in a steady and a regular manner. Thus it is especially important to consider how the incidence of disability is affected by external conditions because the part of the increase that stems from population growth and ageing is more regular. Figure 6.3 shows how the incidence of disability varies with the unemployment rate (the unemployed as a proportion of people in the labour market) over the period from 1992 to 2004.

It is clear from the figures that the incidence of disability moves quite closely with the unemployment rate. The incidence of disability grew considerably during both periods of high unemployment (1992-1995 and 2002-2004). Note, however, that the incidence of disability does not fall as much as we might expect between 1999 and 2001, given the fall in unemployment rates. The new disability rating standard adopted in 1999 may have had an effect here, as fewer applications for disability status seem to have been turned down for a short while afterwards (Herbertsson 2005, p. 99). Disability allowance recipients (50-65% disability) were also transferred to disability benefits (full disability, 75% or more), as was discussed above in chapter

IV. This change in the disability rating standard may therefore have lead to a temporary increase in the incidence of disability during this period (1999-2001). It is, however, unclear whether the change has had the effect of permanently raising the prevalence of disability.

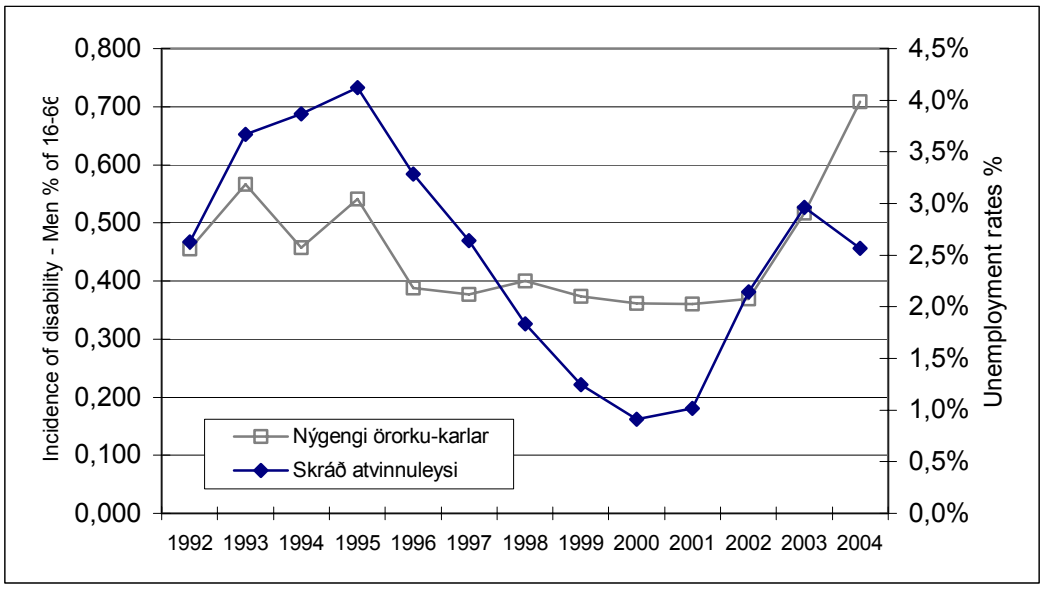

Figure 6.4: Relationship between incidence of disability for males (50-75%) and the unemployment rate of men.

Figure 6.4 shows this relationship for men. The results are similar though there are small differences in the fluctuations. In 2004 there was a considerable decrease in unemployment, especially for men. This fall in unemployment is not reflected in a corresponding fall in the incidence of disability in that year. However, the incidence of disability for men fell during the first 8 months in 2005. The number of disabled women is also increasing at a slower rate. This is an indication of a lagged relationship.[23] The regularity of the relationship is nevertheless such that we can safely conclude that higher levels of unemployment are likely to result in a considerable increase in the prevalence of disability in Iceland. The evidence for 2005 indicates that the incidence of disability is falling in the wake of declining unemployment rates. Indeed, this relationship is well established in some other

[23] See recent news on the incidence of disability on the website of the Icelandic State Social Security Institute, www.tr.is, August 2005.

countries (OECD, Employment Outlook 2003 and Jobs Study 1994; Högelund 2002; European Foundation-Linking Welfare and Work, 1999).[24]

Finally, figure 6.5 shows a more comprehensive presentation of the relationship. In this figure it is examined as the correspondence between employment conditions (level of unemployment) and the overall increase in the prevalence of disability. The figures for unemployment come from labour market surveys.[25] The overall increase in the prevalence of disability is a different measure than the incidence of disability (inflow into disability every year). Its advantage stems from the fact that it takes into account both the inflow and the outflow from the disability registry, i.e. net increase in the prevalence of disability. The figure reveals a strong relationship between these factors. The relationship is even more regular than it is in figures 6.3 and 6.4.

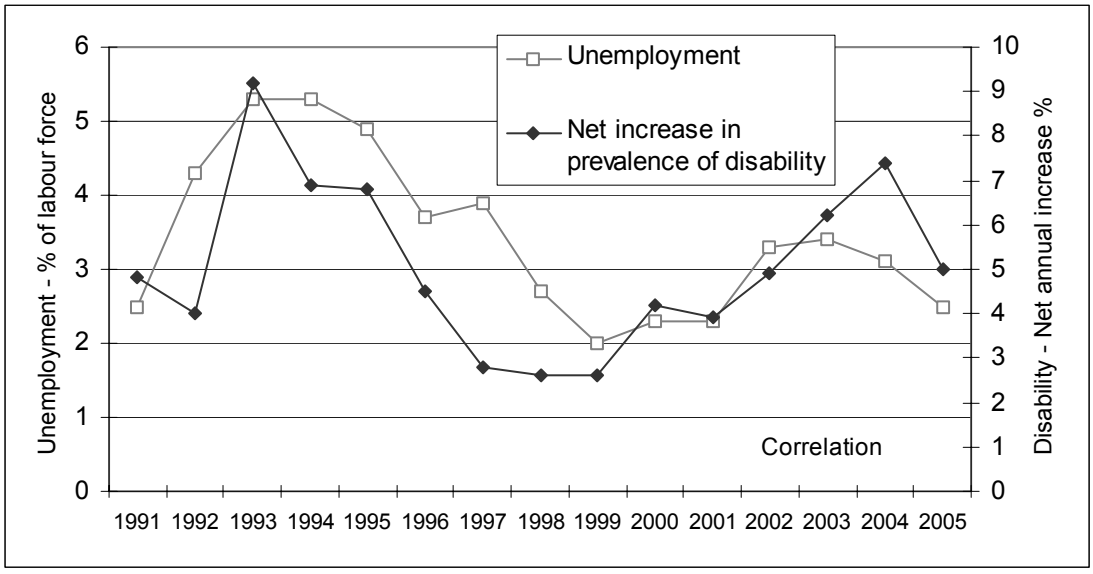

Figure 6.5: Relationship between extent of unemployment and the overall increase in numbers of disabled people.

The figure covers the development for up to the first nine months of 2005. The correlation is 0,65, which is considerable. There is therefore at hand evidence that

[24] That was the experience in Finland after 1990, when unemployment increased considerably, i.e. the prevalence of disability grew also considerably. When unemployment went down again after 1995 the prevalence of disability fell as well (see discussion of the incidence of disability in chapter IV).

[25] The data on unemployment presented in figures 6.3 and 6.4 refer to registered unemployment, which behaves somewhat differently than data on unemployment from labour market surveys. Thus it is useful to use both kinds of data, both on unemployment and on disability.

indicates there may be a causal relationship running from unemployment to disability in Iceland.

In figure 6.6 we show the relationship between long-term unemployment and the incidence of disability for both sexes. This figure covers the period from 2001 to 2003, during which there was a considerable increase in unemployment.

The number of people suffering long-term unemployment grew markedly from 2001 to 2003. The incidence of disability grew considerably as well. The frequency of disability, however, grew faster than unemployment in 2004 (not shown) which indicates a lagged relationship, which is to be expected. The Pearson correlation for the relationship is 0,85.

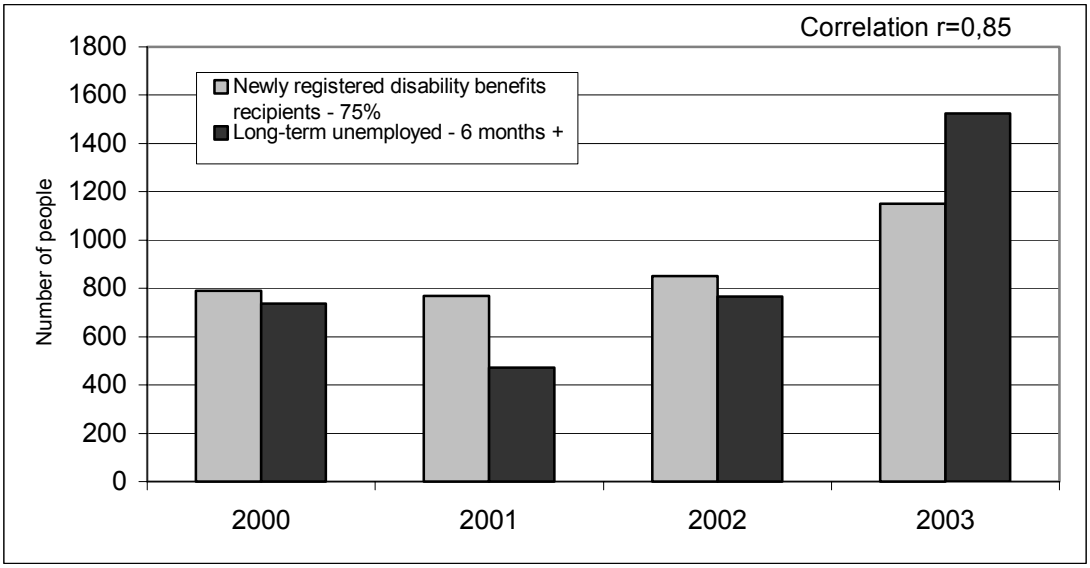

Figure 6.6: Number of people suffering long-term unemployment (6 months or more) and the incidence of disability (75% disability or more).

Thus it seems that higher unemployment rates during the 1990s and from 2001 to 2003 are associated with a higher incidence of disability and a net increase in the number of disabled people. Though correlation does not establish causation there are strong reasons to expect there to be a causal relationship between these variables, though other factors are also likely to be involved.

6.2. Growing Pressure in the Labour Market

The Icelandic labour market underwent a historical transformation during the 1990s. It is likely that this has created circumstances that increase the risk of disability. The

risk of unemployment increases pressure on people in itself, especially those who are disadvantaged in the labour market, e.g. because of bad health or various limitations. Those who are more likely to suffer health problems may be harder hit by a tighter labour market, which may in turn facilitate their transition to disability status.

But increased pressures can also stem from different sources. During the 1990s the Icelandic labour market underwent a change, in part in reaction to economic stagnation from 1988 to 1994. New approaches to management were introduced, and increasing emphasis was placed on reducing personnel and increasing competitiveness by business restructuring for increased efficiency (Gudmundsdottir 2001; Edvardsson 2003).

During this period new management practices, such as quality management, the re-engineering of work, downsizing, and other such measures were widely adopted in Iceland. Their application entailed an increasing emphasis on efficiency, improved productivity, and to attain the same results with a smaller staff than before. One of the consequences was a higher unemployment rate. It is clear that these changes in work and management practices clearly lead to increased pressure in the workplace.

Table 6.1
Pressure in the labour market
Evidence from Survey Data 2003

A. Has pressure increased or decreased in your workplace over the last 12 months?

	Increased	Unchanged	Decreased
Results:	44,3%	45,0%	10,7%

B. How much pressure do you experience at work?

	A lot	Neither/nor	Little
Results	70,5%	23,2%	6,3%

Source: Gallup – Buying time, October 2003 (www.hgj.is).

It is generally thought that pressure in the labour market has grown in Western countries because of globalization (Olafsson and Stefansson 2005). This also applies in Iceland as it is largely subject to the same social and economic forces as other developed countries. The data in table 6.1 support this. It comes from a questionnaire survey that was conducted by Gallup for a project named “Hið gullna jafnvægi”

(Striking the Ballance Between Work and Family Life). The survey includes a measure on whether respondents feel that pressure has increased, remained unchanged, or decreased over the last 12 months (from 2002 to 2003). The results are decisive as about 44% claim that pressure has increased, 45% say that it has remained unchanged, and little under 11% say that it has decreased. The overall conclusion is that about four times as many report that work pressure has increased as report that it has decreased.

The period from 2002 to 2003 was a time of relatively high unemployment in Iceland. Consequently the survey also taps the effects of higher unemployment rates. There is therefore strong evidence of increased pressure at this time. Unfortunately there exists no survey data that measure work pressure in the early 90s, but it is likely that higher unemployment rates and new management practices at that time may have led to increased pressure for employees and managers. It is highly likely that such circumstances have a particularly adverse effect on those who are disadvantaged in the labour market, e.g. because of handicaps, bad health, or disability (EF 2003, chapter 5).

Research from other countries indicates that the abovementioned effects tend to follow from unemployment and increased pressure in the workplace. Shields and Wheatley (2001) review recent research on the negative effects of unemployment on health, and there seems to be a general consensus on this within the research community (EF 2003, p. 21). Work accidents and bad conditions at work also affect the probability of experiencing disability, especially for manual workers in industry. Askenazy (2001) found a substantial correlation between the adoption of work organisation that increased flexibility and pressure in the United States, and the health of employees. Quality control and the other abovementioned management practices appear to increase the risk of work related accidents and health problems, especially mental health (strain, anxiety, etc.). Similar research in the EU member countries has produced similar conclusions (EF 1999a). This development towards increased pressure in the labour market may also be associated with a higher prevalence of disability on account of various kinds of mental disorders, which has been a growing problem in many Western societies in recent years.

Thus there is strong evidence that unemployment and increased pressure in the labour market have raised the prevalence of disability in Iceland, either in the short-term or the long-term. Higher unemployment rates appear to amplify this effect.

VII. Social Profiles of the Disabled in Iceland

The social characteristics of disabled people in Iceland are very similar to what they are in other Western societies, though the gender difference is rather large as it is in the other Nordic countries as well as in Britain. The welfare states in these countries are founded on the principles of citizenship rights and thus grant women the same entitlements to disability benefits as men, unlike in the countries that tie entitlements to employment (e.g. many countries in continental Europe).

In Iceland about 7,7% of women aged 16-66 received disability benefits in 2000. The percentage for men was 4,8%.

Table 7.1
Disability benefit recipients
By sex and age in 2004

	Proportion of population in each age-group	
Age	Men	Women
16 - 19 year olds	1,2%	1,1%
20 - 24 year olds	2,1%	1,9%
25 - 29 year olds	2,4%	3,3%
30 - 34 year olds	2,6%	4,3%
35 - 39 year olds	3,7%	6,4%
40 - 44 year olds	5,0%	8,0%
45 - 49 year olds	6,1%	9,1%
50 - 54 year olds	6,4%	10,9%
55 - 59 year olds	8,4%	14,2%
60 - 64 year olds	12,3%	21,1%
65 - 66 year olds	15,6%	26,4%
Total 16 - 66 yo	**4,8%**	**7,7%**
Numbers	4.709	7.302

Source: State Social Security Institute

The prevalence of disability grows steadily with age. This pattern is similar to that observed in other countries, though the prevalence of disability in the older age-groups is considerably lower in Iceland than in the OECD countries, generally speaking. In Iceland in 1999 about two-thirds of disabled people are 45 years old or older, compared to an average of 76% in 19 OECD countries. In the countries with the highest prevalence of disability for people over 45 every 9 out of 10 disabled people are of that age. Such countries include Austria, Germany, Italy, Mexico, Portugal, and Spain. The lowest proportions are observed in Switzerland, Australia,

and Iceland, which has among the lowest frequency of disability for people of working age (16-64/66 years old) (OECD 2003, p. 79).

On the other hand it seems that the prevalence of disability is rather high in the younger age-groups in Iceland, in comparison to the other OECD countries (OECD 2003 p. 80). Table 7.2 shows this distribution for the Nordic countries in 2003.

Table 7.2
Age-distribution of disability benefits recipients in 4 Nordic countries - 2004

	Finland	Iceland	Norway	Sweden
16-19 years old	0,3	1,2	0,6	1,0
20-29	1,4	3,0	1,3	1,6
30-39	2,6	4,8	3,4	3,3
40-49	5,4	7,1	8,3	7,8
50-59	14,6	10,0	18,6	16,2
60-64	29,9	17,0	35,2	29,8
Total 16-64 yo	7,8	6,2	9,5	8,9

Source: NOSOSKO 2005. Data on Denmark is not fully comparable.

The prevalence of disability for people under 39 is higher in Iceland than in the other Nordic countries shown in the table, while the proportion of disabled people over 39 is considerably lower, even if people on early retirement in the other countries are not included in these figures. This higher prevalence of disability in the younger age-groups has been interpreted as evidence of faster growth of the number of young disabled people in Iceland than in the other Nordic countries. That is not the case, as we showed in table 4.1. The number of disabled people aged from 16 to 19 years old actually fell between 1999 and 2002.

There is an important difference between Iceland and the other Nordic countries. More young disabled people in the other Nordic countries are mobilised for occupational rehabilitation and employment through support measures than there are in Iceland (this will be discussed in more detail in chapter 11). Such support measures for employment and social participation result in a higher proportion of young disabled people having paid jobs or being registered with other parts of the welfare system (such as in job rehabilitation or on sick pay). The high prevalence of disability among young people thus reflects the fact that Iceland is a laggard when it comes to

measures that support the rehabilitation and employment for this group rather than this group being larger in Iceland than it is elsewhere.

In table 7.3 we show the proportion of disabled people who are married or cohabiting. The table shows that the proportion of disabled people that are married or cohabiting is smaller than that proportion of the overall population. This contrasts with the general pattern in the EU countries. Nevertheless, some might expect that this difference was even greater, i.e. that an even smaller proportion of disabled people would be married or cohabiting. It must be kept in mind that the average age of the disabled is considerably higher than that of the general population. Because of that we would expect that a higher proportion of the disabled would be married or cohabiting, all other things being equal. Thus, if we were to control for age, the marriage and cohabitation rates of the disabled would be far below that of the general population.

Table 7.3
Civil status of the disabled and the general population
18 years of age and above

	Disabled	Population
Married or cohabiting	42%	61,2
Single	58%	38,8
Total	100%	100%

Source: Estimates of a committee on the interplay between social security, pension funds and taxes 2001, and Statistics Iceland "Landshagir"

Since about 42% of all disabled people are married or cohabiting it is also interesting to note that marriage and cohabitation is far more common for newly registered disabled people than it is for the group as a whole, or two out of every three according to a recent survey of newly registered disabled people that was conducted in 1996 (Olafsson and Thorlacius 1997). This suggests that the proportion of disabled people with families is growing. This is to be expected if we consider that disability most often follows illness or accidents that occur while people are of working age. What's more, the largest increases in disability rates occur among people aged between 40 and 55 years old. In 1999 approximately 28% of disabled people had a dependent child. This underlines the fact that the largest proportion of disabled people in Iceland leads a "normal" family life. This fact is frequently overlooked in discussion about the circumstances of disabled people. That is obviously important for the perspective that

disabled people should be treated in the same way as other citizens, both in terms of rights and in terms of objectives and services (Flovenz 2004; Traustadottir 1998).

The education level of newly registered disabled people in Iceland, as well as in other countries, is much lower than that of the general population. This can be seen in table 7.4.

Table 7.4
Education level of newly registered disabled people and the general population over 18
Education completed. Survey of 1997.

	Disabled	Population
Primary school or below	56,1	35,0
Vocational training	14,2	12,4
Craft	15,0	20,1
Academic secondary education	9,8	16,3
University education	4,9	16,2
Total	100%	100%

Source: Thorlacius, Stefansson and Olafsson 2001a.

Approximately 56% of all newly registered disabled people either completed only primary education or no education at all. This contrasts with 35% of the general population. The proportion of disabled people that have some sort of vocational training is slightly higher than that of the general population. About 15% of disabled people have completed a crafts-apprenticeship compared to 20% of the general population. It is mainly in academic secondary education and university level education that the proportion is substantially smaller for disabled people than for the general population.

There are a number of explanations for the lower educational attainment of the disabled. For one thing the average age of the disabled is higher than that of the general population (older age-groups tend to have lower levels of education overall). For another thing it is clear that some disabled people have difficulties studying because of health or handicaps and because the education system is not sufficiently sensitive to their needs and doesn't offer options that suit them (EF 2003, chapter 12).

It is clear that more disabled people should be able to take up and complete academic secondary education as well as education at a university level. Thus it seems

obvious that Iceland can make a great deal of progress in that direction in the years to come.

Table 7.5 shows the occupational distribution of newly registered disabled people compared to the occupational distribution of the general population. A higher proportion of the disabled come from manual occupations, i.e. labour workers, farmers and fishermen. Correspondingly a lower proportion of the disabled come from the higher classes, e.g. managers and specialists.

Table 7.5
Occupations of newly registered disabled and the general population
18 years of age and above
Primary job after completing education. Survey of 1997.

	Disabled	Population
Managers	0,9	8,2
Professionals	4,2	11,0
Technicians and white collar	15,3	13,8
Services and retail	18,3	17,1
Crafts	11,5	11,3
Labour workers	28,5	17,4
Farmers and fishermen	15,7	6,1
Not in paid employment	5,6	15,1
Total	100%	100%

Source: Thorlacius, Stefansson and Olafsson 2001a.

The differences in the occupational distribution of disabled people and the general population reflects a greater risk of disability for people in the lower occupational categories where work conditions are worse and wages are lower. In other countries lower wages tend to go with a higher risk of illness, accidents or other traumas that can lead to disability during work life. This thus reflects the higher risk that is associated with lower wages and worse conditions at work (Wagstaff 2002; Rahkonen et al 2002; Lindholm et al 2001).

VIII. Mental Illness: The New Cause of Disability

Thorlacius, Stefansson, Olafsson, and Rafnsson (2001) studied the prevalence of disability from 1976 to 1996 and published their results in the Icelandic Medical Journal. Their results indicated that the overall prevalence of disability (50-75%, i.e. all disabled people, age-standardised) was approximately 5,1% in 1976 and 5,7% in 1996. In recent discussion it has been suggested that the prevalence of disability has been growing considerably. In fact the prevalence of disability grew considerably from 1992 to 1996, as was shown in chapter 4. In that light it is curious that the prevalence of disability in 1996 was similar to what it was in 1976. Also, in 1962 Gudnason found that the prevalence of disability was about 4,7% of all people of working age (16-66 years old).

We can thus conclude that the prevalence of disability has not grown much, on the whole, over these last few decades. However the number of part-disability pension recipients (50-65% disability) has fallen over the period while the number of full disability benefit recipients (75% disability or more) has risen. That is also the trend in recent years, i.e. since 1996, as was shown in chapter 4.

The first thing to note is that the risk of disability from disease, all diseases taken together, was smaller in 1996 than it was in 1976. The risk ratio standardized for age is 0,95 for women and 0,93 for men. The relatively small increase in disability that occurred between 1976 and 1996 is therefore primarily due to population ageing and growth.

In this context it is interesting to take a closer look at the standardized risk ratios of specific diseases in table 8.1, comparing the ratios for 1976 and 1996. If the risk ratio in the table is 1,0 then the risk is the same in 1996 and in 1976, if the ratio is above 1,0 then the risk has increased, but if it is below 1,0 then the risk has decreased. The table also shows the 95% confidence intervals (upper and lower limits). If both the upper and the lower limit are on the same side of the number 1 then the risk ratio is statistically significant at the .05 level, i.e. there is more than 95% probability that the results are reliable.

Table 8.1
Probability of Disability in 1976 and 1996,
Sorted according the the International Classification of Disease (ICD).
Standardized for age.

	Women		Men	
Disease:	Standardized Risk Ratios	95% Reliability (CI)	Standardized Risk Ratios	95% Reliability (C I)
Infectious and parasitic disease	0,08	(0,05;0,11)	0,08	(0,06;0,12)
Malignant neoplasms (cancer)	1,23	(0,99;1,53)	3,61	(2,44;5,33)
Endocrine, nutritional and metabolic	1,00	(0,79;1,26)	1,76	(1,29;2,47)
Mental disorders	1,09	(1,00;1,18)	1,19	(1,08;1,31)
Nervous system and sensory organs	0,99	(0,87;1,13)	0,82	(0,70;0,96)
Blood, coronary and circulatory system	0,77	(0,68;0,87)	0,67	(0,58;0,77)
Respiratory system	1,14	(0,92;1,41)	1,32	(1,04;1,67)
Digestive system	0,33	(0,24;0,44)	0,40	(0,27;0,61)
Skin and subcutaneous tissue	3,16	(2,05;4,87)	5,62	(3,13;10,09)
Musculo-skeletal and connective tissue	1,20	(1,09;1,31)	0,97	(0,87;1,09)
Birth defects/congenital	1,57	(1,24;1,99)	1,70	(1,29;2,24)
Injury and Poisoning	1,25	(1,02;1,53)	0,69	(0,56;0,86)
Other	0,50	(0,41;0,61)	0,86	(0,65;1,12)
All disease together	**0,95**	**(0,91;0,99)**	**0,93**	**(0,89;0,99)**

Source: Thorlacius, Stefansson, Olafsson and Rafnsson (2001b), p. 208.

The risk from infectious diseases has decreased considerably, as has risk from diseases of the digestive system and coronnary diseases. This holds for both sexes. For men the risk from disease of the neural and sensory system, from injuries and poisonings has also decreased over the period. The risk from skin disease has increased for both sexes and the risk from cancer and the risk from digestive and endocrinal, nutritional and metabolic diseases has increased for men. Birth defects are a little more frequent for both sexes, but otherwise the risk ratios have changed very little over the period. There is a slight increase in risk of disability from mental illness for men, but for women the increase in negligible.

Following from this analysis it is interesting to look at the development over the last decade or so. Table 8.2 shows data on the proportional distribution of the primary causes of disability in 1992 and 2004, along with the proportional change between these years. What is most noteworthy is the proportion of disability caused by mental illness. That proportion grew from 15% to 28,7% for women, and from 17,8% to 37,8% for men. This is a big increase for both sexes. The proportion more than doubles for men.

The proportion of disability caused by cancer has fallen considerably for both sexes, but the frequency of disability from coronary and circulatory disease fell more for men, from 24,9% to 10,7%. Otherwise changes in the frequency of different causes of disability are rather small.

Table 8.2
Main cause of disability (50-75%), 1992 og 2004
% divisions and changes.

	----------Females--------			----------Males--------		
	1992	2004	Change	1992	2004	Change
Genitourinary system (cancer)	13,1	7,4	-5,6	14,5	5,8	-8,6
Nutritional and Metabolic	3,7	1,5	-2,2	1,3	2,7	1,3
Mental disorders	15,0	28,7	13,8	17,8	37,8	20,0
Nervous system and Sensory organs	6,8	8,0	1,3	6,4	9,8	3,4
Coronarry and circulatory system	5,6	4,3	-1,4	24,9	10,7	-14,2
Respiratory system	5,4	2,1	-3,2	3,4	1,3	-2,0
Musculo-skeletal	33,9	37,1	3,2	19,2	17,3	-1,9
Injury and Poisoning	4,9	5,3	0,4	5,7	8,7	2,9
Other	11,7	5,4	-6,2	6,7	5,8	-0,9

Source: State Social Security Institute

That the proportion of disability caused by mentall disorders grew so much as it did calls for an explanation, especially in light of no similar changes taking place from 1976 to 1996. The fact that disability from mental illness increased as much as it did during the 1990s is therefore a recent development.

How has this development been in other Western societies? It is common in the OECD countries that between a quarter to one-thirds of disabled people (both the prevalence and incidence of disability) are due to mental illness. In countries where the OECD has data on the incidence of disability for 1999 about 32% of newly registered disabled people sufferred from mental disorders. This group has been growing significantly after 1990. The figures for Iceland are somewhat lower than those for the neighbouring countries, but the increase observed in recent years is moving us closer to their average. The main explanations emerging from OECD research are as follows (OECD 2003, chapter 4; also EF 2003, p. 25-27):

1. People are more willing to seek help for mental illness than before, when such matters were a cause of embarrasment and were hidden in society. The OECD

believe that this is supported by, among other things, a big increase in the number of psychiatrists and therapists of all sorts.

2. New diagnostic methods are also thought to have made the detection of mental illness easier.
3. Increased pressure and demands in the labour market are also thought to have increased the risk of mental illness and stress related diseases. This is related to long-term unemployment which has been shown to increase the risk of suffering mental illness.
4. Growing instability in family arrangements in the more prosperous countries, divorces and increasing numbers of single mothers, can also increase risk of mental illness.
5. Finally, it is generally the case that mental illness is more common as a cause of disability for younger people and consequently we may expect an even larger increase in incidence of disability on account of mental illness in the future.

It is clear that a large part of the increase in disability on account of mental disorders is the result of different attitudes toward such diseases as well as of better services for families with mentally ill members. These changes can be likened to an awakening. This awakening has been reflected in the founding of associations presenting the interests of the mentally ill. In the past isolation and exclusion were frequently the lot of people suffering from mental illness. The services that have now become commonplace were not fully utilized or sought after and neither was disability status. Work rehabilitation is, for instance, a very imporant factor in this field, and must be improved. The increased importance of mental illness is in line with developments in the neighbouring countries, except that it occurred later in Iceland. We can expect that the rise in the number of disabled people suffering mental illness will abade once their proportion has reached the average levels of the neighbouring countries.

There are thus reasons to think that disability from mental illness is one of the major forces driving the increase in disability in Iceland, from 5,7% of the working age population in 1996 to 6,2% in 2003.

IX. The Financial Situation of the Disabled

9.1. Pensions and employment earnings

In this chapter we discuss the financial circumstances of disabled people in Iceland. This discussion is divided into five parts. In the first part we compare how the earnings of disabled people have developed compared to the earnings of the employed during the 19990s and up to 2004. In the second part we compare the earnings of disabled people more directly with other social groups. In the third part we present data on different components of the earnings of disabled people. In the fourth part we examine the tax load of disabled people, and finally we compare the earnings of disabled people in Iceland with those of disabled people in other Western countries.

It is important to examine how far the pensions and earnings of disabled people have kept up with earnings in the labour market. It reflects the circumstances of the disabled relative to others during the economic upswing that has prevailed since 1995. It is also an important test of the hypothesis that the growing prevalence of disability is caused by the improved financial circumstances of disabled people, i.e. the assumption that high benefits pose a moral hazard tempting healthy individuals to drop out of the labour market and seek disability pension (Herbertsson 2005).

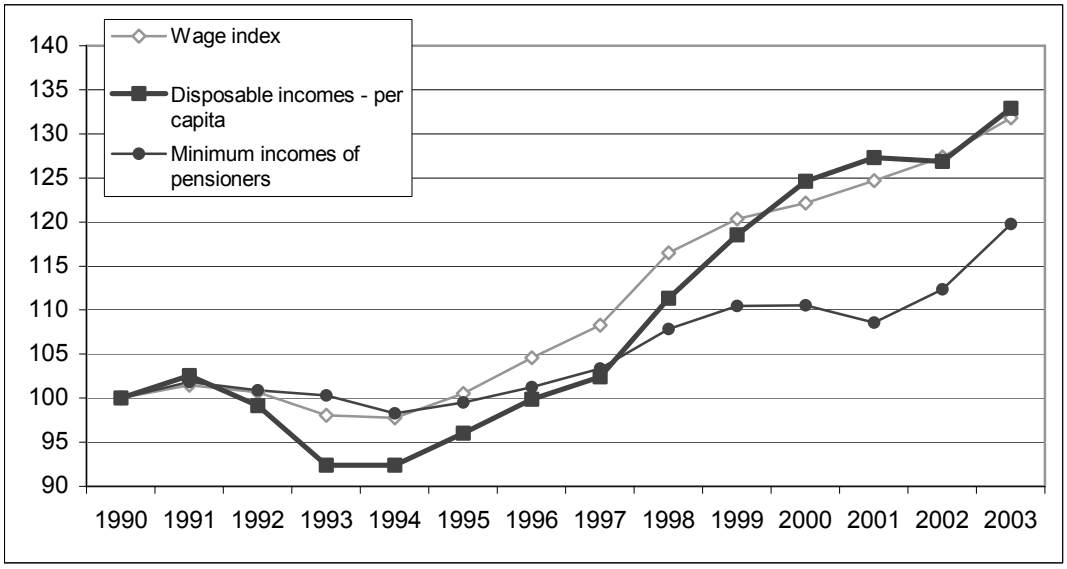

Figure 9.1: The development of minimum pensions from the State Social Security Institute, disposable incomes per capita, and the wage index, 1990 to 2003. (1990=100)

The earnings of disabled people would presumably need to have improved considerably relative to labour market earnings in order to increasingly tempt able-bodied people to drop out of the labour market and seek disability status. In what follows we present some evidence that this has not occurred in Iceland over the last 10 years. On the contrary, the earnings of the disabled have risen less than the earnings of employed people.

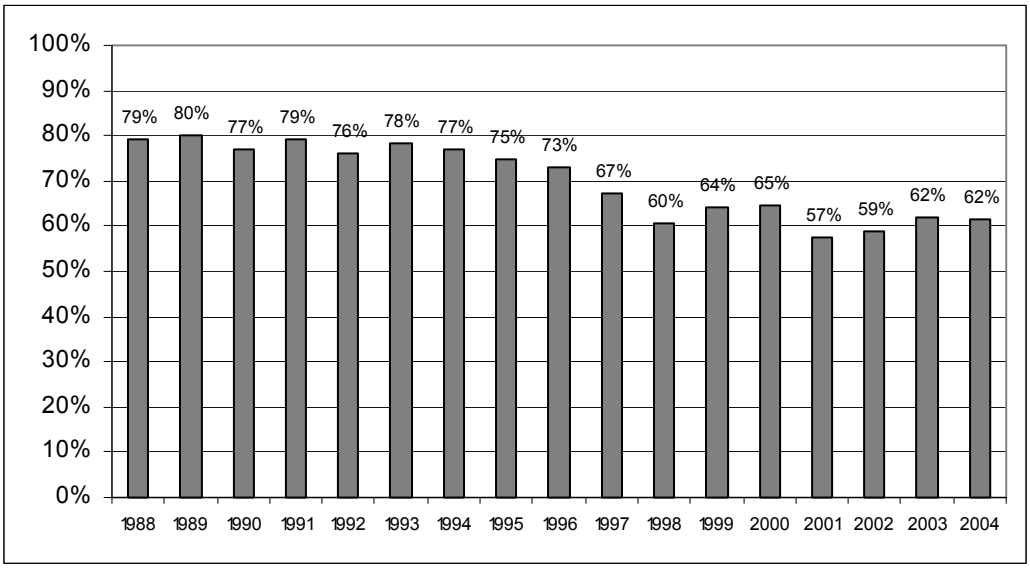

Figure 9.2: Basic pensions and income supplement, plus a minor lump sum, as a percentage of the minimum wage 1988-2004

Figure 9.1 shows the amounts paid through those components of social security pensions that most pensioners receive (base line pensions, income supplement, plus a minor lump sum) have developed from 1990 to 2003, in comparison to the wage index and the per capita disposable income.[26] Pensions fell less than disposable incomes during the recession from 1992 to 1994 but during the boom, from 1995, this basic core of the pensions system grew noticeably less than disposable incomes. Figure 9.2 shows this development from another perspective, i.e. pensions as a proportion of minimum wages. The difference is also important in terms of the alleged moral hazard brought about the welfare state. If the theory that life as a

[26] In 2004 approximately 92% of disability benefits recipients received full basic pensions, but little under 50% received the income supplement, while just over 20% received the household supplement and nearly 12% received the additional income supplement. Thus it is clear that approximately half of all disabled people do not enjoy the components of the pensions shown in the figure. Those with lower incomes from other sources often receive full basic pensions and the incomes supplement (Social Security Statistics 2004).

disability pensioner tempts people who receive low wages in the labour market has any basis in reality, then we would expect the temptation to be stronger the higher pensions are relative to the minimum wage.

As figure 9.2 shows the gap between the components of pensions that most people receive from the SSI and the minimum wage in the labour market has widened after 1995. This suggests that there should have been reduced temptation to drop out of the labour market. Figures 9.1 and 9.2 thus indicate that the temptation for people to opt for disability benefits has hardly increased. It is in fact more likely to have decreased, if such temptation exists at all (which has however not been proven).

In chapter 2.6 we criticized the theory that disability benefits produce a moral hazard. That criticism suggests that the risk of temptation is generally exaggerated in discussions and criticisms of social security. Most people prefer to work if they possibly can and the negative labelling that is often associated with disability status is likely to deter many people from seeking disability benefits, especially able-bodied people, though this is also likely to affect those who suffer partial disability as well. In fact, at any given time there is a sizeable proportion of disabled people that do not make use of their entitlements to disability benefits, because of such deterrence among other things (OECD 2003). Deterrence should affect healthy people even more strongly. Nevertheless, we should not overlook the risk of moral hazard completely as there is always a possibility that some people would like to abuse disability pensions, as well as other parts of the welfare system. Thus we will consider a number of things suited to test the relevance of the "moral hazard" hypothesis before we draw conclusions about whether improved financial circumstances of the disabled explain the growing prevalence of disability.

The component of the pension that most people receive is not the only thing that matters in this context. Therefore, in figure 9.3 we show how the maximum pensions payable to disability benefits recipients has evolved as a proportion of the average earnings of all taxpayers in Iceland, i.e. everyone who is 16 years old or older.

The maximum pensions that a disabled person can get from the State Social Security Institute is composed of basic pensions, income supplement (tekjutrygging), income insurance supplement (tekjutryggingarauki), household supplement

(heimilisuppbót) and the age related supplement (aldurstengd uppbót), which is paid in full if the person in question is 18-19 years old when he is granted disability status. This component falls gradually with higher age of entry into disability status. If a person becomes disabled around the age of 40 the age related supplement is down to 10%. The age related supplement was introduced in 2004, in accordance with a special agreement between the Organization of the Disabled in Iceland and the government in 2003.

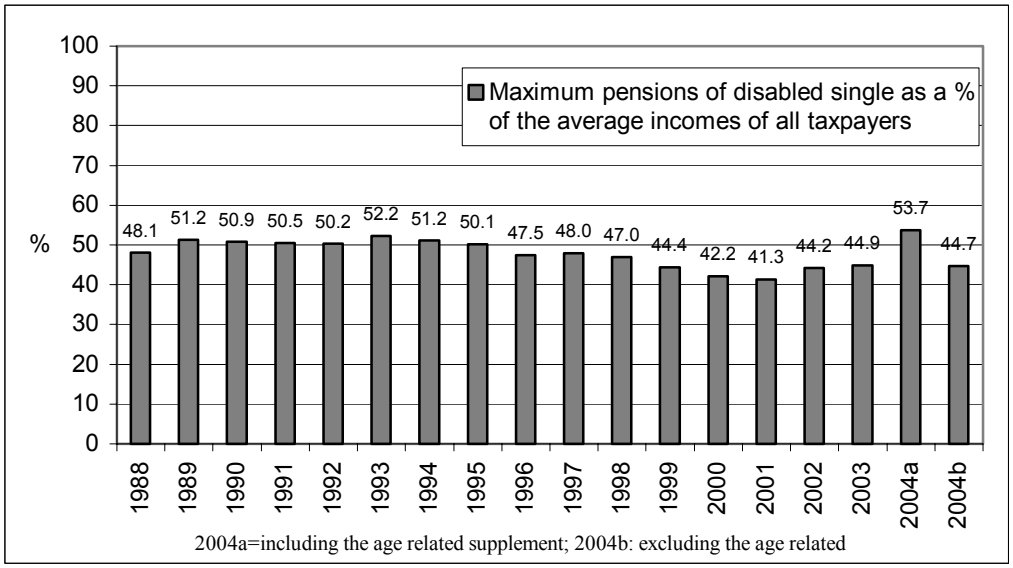

Figure 9.3: Maximum payable disability benefits from the SSI, as a percentage of the average earnings of all taxpayers, 16 years and older, 1988-2004.

Furthermore, some disabled people are entitled to a supplement to cover additional costs rising from their disability (to cover the costs of medicine, medical services, transportation etc.) Such supplements are generally lower than the actual costs and therefore we don't include them in our earnings measure. Recent research in Britain on the additional costs incurred by the disabled because of their illness or handicap concludes that such costs are strongly associated with the seriousness of the disability, but on average it appeared to be around 35%. Research from other countries has reported a lower proportion of additional expenses, but most often it is estimated to be between 15-30% of pensions (Burchardt 2003, chapter 6).

This means that disabled people must receive earnings that are between 15-30% higher than those of the non-disabled if they are to be on equal footing. The most common supplementary benefits paid by the SSI, however, are approximately 4% of

the maximum payable pensions, or about 2% of the average earnings of all taxpayers. Thus, research from other countries on additional expenses because of disability thus suggests that this element of the pensions system leaves a lot to be desired.

Figure 9.3 shows that in the years from 1988 to 1995 the maximum disability pension paid by the SSI was around 50% of the average earnings of all taxpayers in Iceland. In 1995 the rules were changed so that the annual increase in pensions was indexed to general pay rises in society and to prices, whichever was higher. Before that pensions were linked to minimum wages. From that time onwards the disability benefit fell further behind the earnings of all taxpayers in Iceland. In 2001 it had fallen to 41% of average earnings. Thus the earnings of people who had to rely solely on social security had fallen far behind those of the general population. Following that, and after the interest groups of disabled peopled applied considerable pressure on the government (including a lawsuit against the government) the proportion rose to 44% in 2002-3. The age related supplement was introduced in 2004, which brought a substantial increase to those disabled at a young age, as the bar for 2004a shows. Those who were 18-19 years old at the time of their transition to disability status (and had no other earnings) could receive up to 53,7% average earnings of all taxpayers in that year. This proportion fell already by 5% at the age of 20 and if people became disabled around the age of 40 they only receive about 10% of this supplement (i.e. little over 2000 krónur per month).

Since about 72% of disabled people in Iceland are over 40 years old it seems likely that the maximum benefit most disabled people can receive from the SSI falls between 45-50% of average earnings (see bar 2004b on figure 9.3). As the risk of disability rises with age it seems apparent that the age related supplement only benefits a small part of the disabled people fully, though it is of considerable importance to people who become disabled at an early age or have congenital disability.

Thus the maximum benefits most disabled people could expect to receive from the SSI in 2004 was a lower proportion of the average earnings of taxpayers than it was in 1998 and had been over the 10 years before that. Given these facts we should expect that the temptation caused by the disability benefits should have decreased over the last decade, if such a temptation existed in the first place. It is most likely

that such temptation is the exception rather than the rule. The considerable gap that exists between the maximum pension and the average earnings of taxpayers in Iceland, disadvantaging the disabled, hardly supports a different conclusion.

However, some disabled people have other earnings than pensions from the Social Security Institute. Some of them are entitled to pensions from occupational pension funds (if they had careers prior to becoming disabled). In 2004 about 50% of single disabled people and about 73% of disabled people who were married or cohabiting were entitled to at least some pensions from pension funds.[27] In addition some disabled people have earnings from the labour market. It is therefore important to examine the total earnings of disabled people. That is done in table 9.1. These total earnings are composed of everything they receive through social security, occupational pension funds, and paid labour.

Table 9.1
Total earnings of the disabled compared to the total earnings of all taxpayers, 16 years old and above.
Development from 1995 to 2003; single, single parents, and married people.

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	% increase 1995-2003
All taxpayers	1.289	1.396	1.516	1.683	1.876	2.074	2.322	2.453	2.625	2.827	119,3
Disabled: Single	870	902	952	1.041	1.123	1.263	1.352	1.494	1.643	1.829	110,2
Disabled: Single parents	1.305	1.294	1.395	1.557	1.726	1.867	2.076	2.222	2.342	2.634	101,9
Disabled: Married	2.313	2.446	2.623	2.949	3.218	3.547	4.124	4.203	4.581	4.869	110,5

Based on data from Statistics Iceland on tax returns and Landshagi 2005.

This table compares the actual total earnings of taxpayers and three categories of disabled people: single, single parents, and married. The last column shows the percentage increase for each group from 1995 to 2004. The average earnings of all taxpayers increased by about 119,3%, but the average earnings of disabled people

[27] Source: Statistics Iceland, analysis of tax reports, extracted for this report.

grew between 101,9 and 110,5%. It is clear that the results are of the same order here as they were in figures 9.1 to 9.3.

When we consider the total earnings of disable people, whether they come from social security, pension funds, or employment, the conclusion is that their total earnings have fallen behind the earnings of all taxpayers. As was shown in figures 9.1 and 9.2 the pensions that most people receive through social security have fallen considerably behind the earnings of the employed. By including the whole population of taxpaying age, those in paid employment and those who aren't, in the taxpayer average (as we do here), we lower the average earnings for the all taxpayers. If we were to compare how the earnings of the disabled have developed compared to those of people who are fully employed, we would most likely find the gap to be even wider. Our estimates of how far the earnings of the disabled have fallen behind those of other citizens over the last decade are thus a cautious estimate and probably underestimate the difference.

Finally we make a similar comparison from yet another angle, the purchasing power of disposable incomes, and show how it has developed for the three categories of disabled people and for the general population (figure 9.2). This comparison involves the same underestimation that was noted above, but it is also an important indicator of the development as disposable incomes are that part of people's earnings that they retain for their own use, after paying taxes and dues.

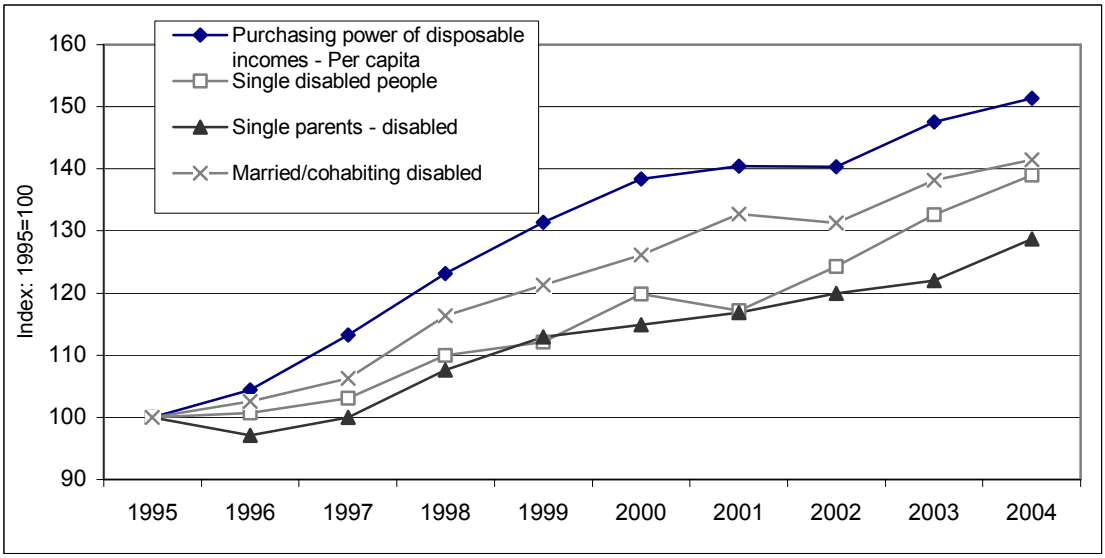

Figure 9.4: Purchasing power of disposable incomes.
Disabled individuals and the general population. Index: 1995=100.

This figure tells the same story, i.e. that the purchasing power of the disabled has grown less than that of other groups in society. The married disabled come closest to the general population, but the gap for disabled people who are either single or single parents is noteworthy.[28] The purchasing power of the disposable incomes of disabled people has not kept up with the purchasing power of the disposable incomes of the general population. Far from it.

All things considered it seems apparent that the earnings of disabled people, both from social security and from other sources, have grown less than the earnings of the general population. Thus it seems likely that this development has deterred people from dropping out for the labour market and seeking disability benefits. The credibility of the moral hazard theory is consequently rather limited. Even though the maximum benefits paid through social security grew from being 50% to about 55% of the average earnings in society we would hardly expect such a moral hazard to arise. The difference in total earnings of the disabled and the fully employed is so large that such a fluctuation would be trivial in terms to overall financial circumstances. Thus there are strong reasons to reject the theory advanced in the Ministry of Health's report that the growing prevalence of disability is due to their financial circumstances having improved above and beyond those of the general population (Herbertsson 2005).

How the earnings of disabled have developed between 1995 and 2004 is also important for other reasons. The objectives defined in the laws that were adopted in 1992 are to secure equality for disabled people and living standards comparable to those of other citizens, as well as to create conditions that allow them to lead normal lives.[29] When the earnings of disabled people fall as far behind the earnings of employed people, as they have in recent years, it seems obvious that the circumstances of the disabled have moved further away from the objectives of the law. This is a serious problem for this group of people. We can also ask whether it isn't a serious development when a government disregards the objectives of a law they themselves passed, especially during a period of economic prosperity when the

[28] The figures on per capita disposable incomes come from the Ministry of Finance, October 2005 (http://www.fjarmalaraduneyti.is/Utgefid-efni/thjodarbuskapur/nr/4712), but the figures on the disposable incomes of disabled people come from Statistics Iceland (extracted for this report).
[29] The law is available on Althingi's website: http://www.althingi.is/lagas/nuna/1992059.html.

government has more means to accomplish these objectives than they had at the time the law was passed. Government decisions are the key determinant of how the earnings of the disabled develop.

In the following section we will take a closer look at the earning difference between disabled people and other citizens. We will also consider the effect of different income components, as well as how taxation affects the earnings of disabled people in Iceland.

9.2. Earnings gaps between the disabled and non-disabled

Figure 9.2 presented evidence of the earning gap between disabled people and all taxpayers, i.e. for all people 16 years old and above who filed a tax report. That figure shows that a disabled person who received maximum pensions from the State Social Security Institute from 1989 to 1995 received approximately half the average earnings of all taxpayers. After 1995 that proportion fell as far as down to 41% but rose again, though it did not rise fully to its previous levels. This result does not apply to all disabled people. It only applies to people who depend solely on social security and who have no other earnings. This group includes fully disabled people who have been handicapped since birth, disabled people who are no longer employed, as well as people that have no entitlements to pensions from occupational pension funds. All things considered these results may apply to about a half of all disabled single individuals and a considerably larger proportion of disabled single parents. It is difficult to estimate how large a proportion of disabled people who are married/cohabiting depend only on social security, as many of them benefit from the earnings of their spouses. Thus it is clear that the earnings of a large proportion of disabled people, many of whom have the worst financial circumstances, are less than half the average of the total earnings of all taxpayers.

In figure 9.5 we consider the total earnings of disabled singles (the sum of social security benefits, pensions from occupational pension funds, labour market incomes, etc.) and compare them to the average earnings of people who are employed, i.e. everyone who filed a tax report between the age of 25 and 65. This is in many ways the most important comparison of earnings of disabled people and other social

groups because the age bracket excludes old age pensioners. In addition most people over 25 have completed their education and entered the labour market. Thus this comparison is primarily between the incomes of disabled people and people most of whom are employed.

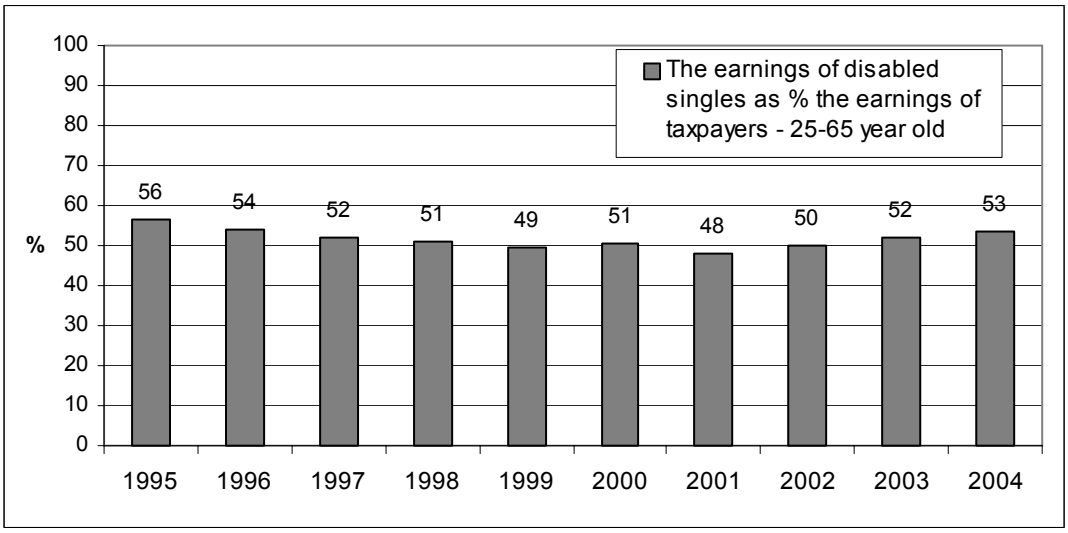

Figure 9.5: Total earnings of single disabled people as a proportion of the earnings of everyone who filed a tax report. 25-65 years old, 1995-2004.

The figure shows that the average earnings of disabled singles have ranged from 48% to 56% of the average earnings of all taxpayers aged 25-65. The proportion was highest during the first part of the period. It fell until 2001, when it rose again (on account of the disabled stepping up their struggle for improved conditions, among other things). This pattern is the same as that observed in the other time series that we have examined. In 2004 the earnings of disabled people had reached 53% of the average earnings of the reference group. Previously it had been highest in 1995, i.e. 56%. This is the general difference between the earnings of disabled people and people in the labour marked and shows how poor the financial circumstances of disabled people can be. In figure 9.6 we take the comparison even further by comparing the average earnings of disabled people to the average earnings of taxpayers with a comparable marital status: single people and people who are married/cohabiting.

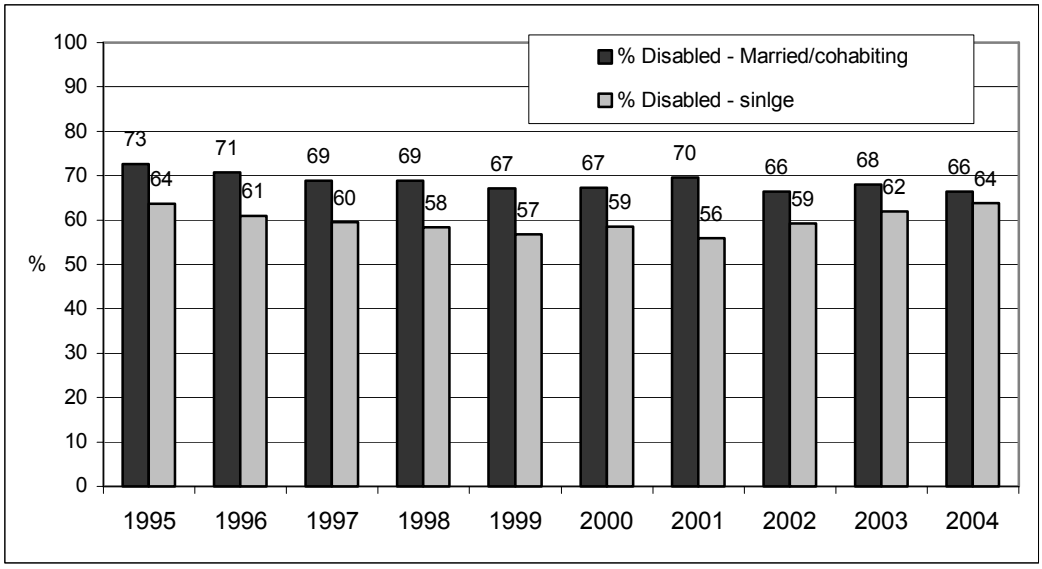

Figure 9.6: The earnings of the disabled as a proportion of the total earnings of other citizens, 1995-2003.

The earnings of disabled singles are closer to the earnings of all other singles than they are to the earnings of the general population. The reason is that people who are married or cohabiting tend to have higher earnings than do people who are single. Thus it is probably more appropriate to compare the earnings of disabled singles to employed singles. That comparison brings the single disabled up to 56-64% of the average earnings of their reference group. Married disabled people have an even higher proportion of the average earnings of employed people who are married, ranging from 66 to 73%, lowest in 2004 and highest in 1995.

In a report on the circumstances of disabled people from 2003, the OECD concludes that the earnings of families with handicapped or disabled members are similar to the average earnings for the population as a whole in many OECD countries (OECD 2003, p. 8). The figures reported above suggest that Iceland falls short of OECD standards. Finally we show a more direct comparison of the earnings of disabled people and different groups of employed people in 2003 and 2004 (table 9.2).

The column furthest to the right gives the proportional difference between the earnings of people who receive maximum pensions from the State Social Security Institute (without the age related supplement) and other groups. There we see that the earnings of people who are 18-19 years old when they become disabled (who receive the full age related supplement) rise by approximately 20% (maximum benefits).

Table 9.2

Maximum benefits that single disabled people receive from the SSI, the average earnings of the disabled, taxpayers and people fully employed in the labour market, in 2003 and 2004

Comparison of earnings

	2003	2003	2004[30]	2004	2004
	Kronas	Difference	Kronas	Difference	Difference
Maximum SSI benefits, single disabled	98.185		105.298		100,0
Maximum benefits with age supplement	98.185		126.547		120,2
Average earnings of single disabled, total	136.917	100	152.417	100	144,7
Average earnings of all taxpayers 16+	218.750	159,8	225.312	147,8	214,0
Average earnings of taxpayers 25-66 years old	221.250	161,6	227.888	149,5	216,4
Average earnings of the fully employed	254900	186,2	272400	178,7	258,7

Source: SSI, Statistics Iceland (tax reports data) and *Landshagir*.

The average disabled person, however, have earnings that are about 44,7% above the maximum social security benefits, i.e. the outcome when all single disabled people are taken together and their earnings from all sources are counted. A disabled person that receives the maximum social security benefits would have to raise their earnings by about 114% (more than double their earnings) to reach the average earnings of all taxpayers and the average of labour incomes in Iceland. If we use the earnings of the fully employed as a basis of comparison (the last row) a disabled person would have to raise his earnings by 158,7% of the maximum benefits from the Social Security Institute. This comparison applies to those that rely solely on social security and don't receive the age related supplement (were over 45 years old when they became disabled).

A more realistic comparison, in the sense that it applies to more single disabled people, is to base the proportional difference on the average total earnings of the single disabled (total earnings: i.e. pensions from the State Social Security Institute and pension funds, labour incomes, and other things), as is done in columns 2 and 4. Those columns show that the earnings of the average disabled person would have to rise by about 48-49% to match the average earnings of all taxpayers, of taxpayers aged between 25 and 64, or taxpayers with average labour incomes in 2004. The earnings would have to rise by about 79% to match the average earnings of fully employed people. The difference is larger than it was in 2003.

[30] The average earnings of tax payers grew by the same proportion as labour incomes between 2003 and 2004 (i.e. 3%).

This generally means that disabled people are overrepresented in the lowest income groups. Their financial circumstances therefore increase the risk of social exclusion and limit options in a market society where access to most things depends on purchasing power. This explains why the disabled have been so numerous among those who seek income support from charities and municipal social services (Njals 2003).

9.3. Composition of the earnings of the disabled

There were not any significant changes in the composition of the earnings of disabled people between 1995 and 2004. Labour incomes make up a slightly larger proportion of the total earnings of disabled singles, remained stable for single parents, and fell slightly for married/cohabiting people (table 9.3).

Table 9.3
Changes in how the earnings of the disabled are composed
1995-2004

	1995 % of total	2004 % of total	Increase 1995-2004
	Single		
Labour incomes	14,7	15,6	224
Social security pensions	59,4	56,3	199
Pension funds	18,8	17,7	198
Other incomes	7,1	10,4	309
Total earnings	100,0	100,0	210
	Single parents		
Labour incomes	8,1	7,9	197
Social security pensions	37,7	42,4	227
Pension funds	15,6	10,8	140
Other incomes	38,6	39,0	204
Total earnings	100,0	100,0	202
	Married/Cohabiting		
Labour incomes	61,7	60,5	206
Social security pensions	16,9	16,4	204
Pension funds	13,6	13,3	205
Other incomes	7,7	9,9	271
Total earnings	100,0	100,0	211

Source: Statistics Iceland

Labour incomes make up about 15% of the total earnings of disabled singles on average, about 8% of earnings for disabled single parents, and approximately 60% of

the earnings of disabled people who are married or cohabiting, as they often benefit from the earnings of their non-disabled spouses. Pensions from the SSI make up about 56% of the earnings of disabled singles. This proportion has fallen slightly. Pensions from pension funds represent little under 18% of their total earnings and other incomes are about 10%, and this is the proportion that has grown the most since 1995. Labour incomes make up the smallest proportion of the total earnings of single parents (approximately 8%), which we might expect as caring for children probably affects their ability to do paid work, besides the possibility that there are insufficient incentives for labour market participation.

Pensions from the SSI make up about 42% of the total earnings of single parents and other incomes (child allowance, interest relief, child benefits make up about 39% of their earnings. The largest proportion of the earnings of married or cohabiting people comes from labour incomes. In many cases these incomes are the labour incomes of a fully employed spouse. Social security pensions are a small proportion of their earnings, or about 16%, pensions from pension funds make up about 13%. The fastest growing component of the earnings of this group is incomes from other sources, making up about 10% of their total earnings.

Table 9.4 shows the proportion of disabled people that have some earnings from each of these sources (column 3), the average amounts for those who have such earnings (column 2) and the average amount for each component for all disabled people (column 1). Almost everyone receives something from the State Social Security Institute (at least the basic pension) and the average amount is noticeably smaller for married people. About 38% of singles have some labour incomes and this can also be taken as an indicator of their labour market participation. The corresponding figure for single parents is smaller, or about 35%. Most married people (88%) have labour incomes, either their own or from their spouse, or both.

It is interesting that the employment rates of disabled people has fallen for singles since 1995 (from 42,4% to 38,5%) and for single parents (from 36,7% to 34,9%). This development is exactly the opposite of what it is in most European countries where employment rates of disabled people have been rising, in large part because of a growing emphasis on that as an objective in itself and because of the

introduction of support measures intended to do just that (OECD 2003; EF 2003). The employment rates of married people have remained almost constant.

Table 9.4
Composition of the earnings of disabled people in 2004

Singles			
	Average earnings [1]	Average-earning [2]	Proportion receiving each kind of income
Labour incomes	285,4	741,3	38,5%
Social security	1.029,0	1.030,4	99,9%
Pension funds	324,2	639,7	50,7%
Other incomes	190,7	382,3	49,9%
Total earnings	1.829,4	1.829,4	100,0%
Single parents			
	Average incomes [1]	Average incomes [2]	Proportion receiving each kind of income
Labour incomes	207,7	596,0	34,9%
Social security	1.115,5	1.121,1	99,5%
Pension funds	284,5	600,4	47,4%
Other incomes	1.026,1	1.034,7	99,2%
Total earnings	2.633,8	2.633,8	100,0%
Married/Cohabiting			
	Average incomes [1]	Average incomes [2]	Proportion receiving each kind of income
Labour incomes	2.943,6	3.343,0	88,1%
Social security	797,0	797,8	99,9%
Pension funds	646,3	886,4	72,9%
Other incomes	482,3	803,1	60,1%
Total earnings	4.869,2	4.869,2	100,0%

Explanations:
[1] Calculated on the basis of total number of disabled people.
[2] Calculated in the basis of the number of people receiving each kind of income.

Amount reported in thousand ISK
Source: Statistics Iceland (tax report data)

The average sum that disabled singles with such entitlements received from occupational pension funds in 2004 was approximately 640 thousand ISK, or around 53.000 ISK per month. Similarly all disabled singles received approximately 85.800 ISK per month from the SSI. This is quite similar for single parents, though they get similar amounts from other sources (child allowance, child benefits, etc.).

9.4. Taxing of earnings of the disabled

In this section we will examine how taxation affects disabled people and how their tax load has developed over the period from 1995 to 2004. This data was processed by Statistics Iceland for this report. What is being analysed are the earnings of the three categories of disabled people that we have discussed above: singles, single parents, and married/cohabiting. The information refers to total earnings, interest relief, child allowance, and taxation (gross and net) and to disposable incomes. Finally we compute the purchasing power of disposable incomes for each year (see table 9.5). These base figures have been used in various ways above, as in other parts of this report.

The last column in the table shows the percent increase of each item between 1995 and 2004. It is interesting to note that the item that has grown the most is taxes. Taxes have grown from two to four time more than total earnings and the tax base. At the same time deductible elements, like interest relief and child allowance, have risen considerably less than total earnings, so that their contribution to earnings has fallen proportionally. As a consequence the net tax burden (total earnings plus interest relief and child allowance, minus direct taxes) has grown more than the gross taxation. This means that the disposable incomes have grown less than earnings before taxation. The smaller value of deductible elements and higher taxation (especially because the proportion of earnings exempt from taxation has fallen, as the personal tax allowance has not kept up with changes in pay levels during the period) have heavily increased the tax burden of disabled people over this period.

Thus the government gives less support through interest relief and child allowance than it did in 1995. At the same time they have increased the tax load of disabled people by taxing a larger proportion of their earnings. This has eaten up much of the financial gains that were made by raising the basic pensions and other earnings. Thus it is clear that the earnings of disabled people would have grown considerably if it weren't for less support and greater taxation.

Table 9.5

Earnings and taxes of the disabled 1995 to 2004

Singles, single parents, married and cohabiting

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	% increase 1995-2004
Singles											
Total earnings	870	902	952	1.041	1.123	1.263	1.352	1.494	1.643	1.829	110,2
Tax base	835	865	907	981	1.075	1.147	1.270	1.364	1.467	1.674	100,5
Taxes	74	83	99	116	149	169	210	226	257	330	345,9
Mortgage interest relief (deducted from tax)	9	10	12	13	15	16	16	19	17	18	95,3
Child allowance (deducted from tax)	–	–	–	–	–	–	–	–	–	–	
Net taxes	65	73	87	103	134	153	194	207	240	313	382,5
Disposable incomes	806	829	864	938	989	1.110	1.158	1.287	1.403	1.517	88,2
Purchasing power of disposable incomes, 1995 =100	100,0	100,7	103,1	110,0	112,1	119,9	117,2	124,3	132,7	139,0	39,0
Single parents											
Total earnings	1.305	1.294	1.395	1.557	1.726	1.867	2.076	2.222	2.342	2.634	101,9
Tax base	864	849	889	971	1.090	1.208	1.354	1.373	1.476	1.690	95,6
Taxes	82	78	94	110	149	181	231	223	252	329	302,1
Mortgage interest relief (deducted from tax)	52	53	57	63	70	71	72	73	66	67	28,8
Child allowance (deducted from tax)	276	272	255	257	270	292	305	320	328	331	19,9
Net taxes	-246	-247	-218	-209	-192	-182	-147	-170	-142	-69	356,5
Disposable incomes	1.551	1.541	1.614	1.766	1.918	2.049	2.223	2.392	2.484	2.703	74,3
Purchasing power of disposable incomes, 1995 =100	100,0	97,1	99,9	107,6	113,0	114,9	116,9	120,0	122,0	128,7	28,7
Married and cohabiting											
Total earnings	2.313	2.446	2.623	2.949	3.218	3.547	4.124	4.203	4.581	4.869	110,5
Tax base	2.147	2.234	2.386	2.651	2.871	3.145	3.709	3.762	4.074	4.291	99,8
Taxes	346	382	442	512	587	674	892	864	981	1.058	205,7
Mortgage interest relief (deducted from tax)	30	33	36	37	41	45	47	56	51	52	72,1
Child allowance (deducted from tax)	35	35	31	28	27	29	28	34	34	32	-8,6
Net taxes	281	314	376	446	520	600	816	774	896	974	246,6
Disposable incomes	2.032	2.131	2.247	2.503	2.699	2.947	3.308	3.430	3.686	3.895	91,7
Purchasing power of disposable incomes, 1995 =100	100,0	102,6	106,2	116,4	121,3	126,2	132,7	131,3	138,2	141,5	41,5

Source: Statistics Iceland (special analysis from all tax reports of the disabled, 1995-2005).

Disabled singles and disabled single parent were hit harder by the net increase in taxation, on average, than were disabled people who are married or cohabiting. Disabled single parents, however, receive child benefits, which are exempt from taxation (thus being deducted from their tax base, which is a substantially lower proportion of the total earnings of this group than of the other disabled groups). This is a considerable benefit for disabled single parents.

The disposable incomes of disabled singles have grown by about 88% during the period, by 74% for single parents, and by 92% for the married or cohabiting. This is expressed in terms of each year's price levels. When we correct for changes in price levels and calculate the purchasing power of disposable incomes we find that it grew least for disabled single parents (28,7%), which is a lot less than the rise in the average purchasing power of the overall population. The purchasing power of disabled singles grew by about 39% and by 41,5% for those who were married or cohabiting.

The purchasing power of disabled people grew considerably over the period, though it must be kept in mind that it started from a lower base than that of the overall population (thus contributing less in terms of financial circumstances than we might expect on the basis of average earnings in society). The earnings of most employed people in Iceland grew considerably between 1995 and 2003, but the earnings of the disabled did not keep up with that development, as was shown in the first section of this chapter. A larger tax load contributed to that outcome.

In figure 9.7 we see the size of the tax load and how it has developed from 1995 to 2004. The tax load is measured as net tax payments, as a proportion of total earnings. The figure thus shows the proportional tax burden of each group for each year and thus gives a clear picture of how the tax load developed for these groups over the period.

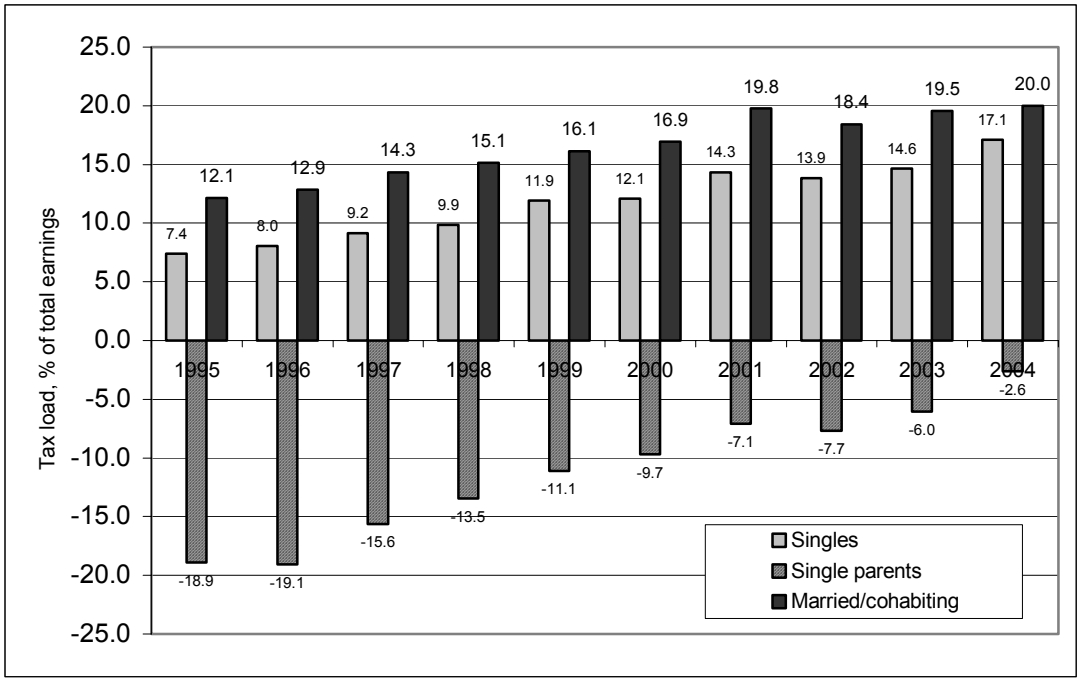

Figure 9.7: The tax load of the disabled 1995 to 2004.
Singles, single parents, married and cohabiting.[31]

The figure shows that the tax load of these groups has grown considerably for all the groups. The tax load of disabled singles rose from 7,4% of total earnings in 1995 to 17,1% in 2004. The tax load of disabled people who were married or cohabiting grew from 12,1% to approximately 20% during the same period. Single parents, however, had a negative tax burden, i.e. they receive more from the government than they paid. At the beginning of the period their negative taxation was -19% but fell considerably and by the end of the period it was down to -2,6%. For the most part these numbers reflect child benefits and interest relief. It is also important that a considerable portion of their earnings (child benefits) are exempt from taxation.

The fact that the tax load of particular groups (and the falling negative taxation of disabled single parents) would probably be met with astonishment in the neighbouring countries as it is highly unusual. This is even more remarkable when we consider the fact that the government's policy during this period was to reduce taxation. The government has lowered tax rate (e.g. the withholding tax rate went from 41,93% in 1995 to 38,55%

[31] Definition of tax load: Total earnings plus interest relief and child allowance, minus income and property taxes, calculated as a proportion of total earnings.

in 2003). At the same time the government reduced the proportion of earnings exempt from taxation by not letting the personal tax credit follow changes in pay nor price levels. Consequently a larger portion of people's earnings was taxed and taxation moved further down the income distribution hitting low-income groups, such as the disable, hard. Thus tax increases resulting from government policy are larger than tax rate cuts, such that there was a net increase in the tax burden of low and average income groups.

Table 9.6 shows the extent of the net increase in the tax burden of the disabled during the period.

Table 9.6
Increased tax burden of the disable 1995 and 2004
Change in total tax burden.

	1995 %	2004 %	Increase, percent points	Increase, proportional
Singles	7,4	17,1	9,7	131,1
Single parents	-18,9	-2,6	16,3	256,5
Married and cohabiting	12,1	20,0	7,9	65,3

Source: Statistics Iceland (tax data, as in table 9.5).
Tax burden= net tax payments as a percentage of total earnings.

Changes in the tax load can be shown both as an increase in percent points (column 3) and as a proportional increase (column 4), the proportion of earnings taxed in 2004 relative to the proportion of earnings taxed in 1995. The increase in percent points was shown in the figure above but the proportional increase was 131% for singles and 256% for single parents (where the change was reflected in smaller negative taxation, which also reduces earnings, as does the rising taxation of the other groups). Finally the increase was smaller for married couples, or about 65%, which must nevertheless be considered a big increase in taxation.

It is clear that disabled people with the lowest earnings (e.g. those who only receive pensions from social security) paid no taxes during the first part of the period under consideration. An 18 years old disabled person that is entitled to full disability pensions from the SSI can expect to receive 127.497 ISK (in 2005) at most, including the new age related supplement (a total of 21.993 ISK). From these earnings the person in question would pay a total of 19.784 ISK in taxes. It is interesting that it should be

considered necessary to tax such low earnings so heavily, earnings that were exempt from taxation in the past. It is also of interest that the new age-related supplement which was negotiated with the Organization of Disabled in Iceland shortly before the 2003 election is now in its second year already largely eaten up by the heavier tax load (the gain from this supplement for the disabled person in question is currently only about 2000-3000 ISK, or about 10% of the maximum age related supplement itself).

The maximum that a 40 year old newly disabled person that has no other sources of income receives is 107.703 ISK from the SSI (his age related supplement is only 2.199 ISK) and he pays 12.315 ISK in taxes. He therefore retains 95.388 ISK.[32] This shows the size of the effect that taxes have on his income.

In all cases there was a considerable change in the financial circumstances of disabled people. Disposable incomes actually fell. We can also ask whether this change hasn't had negative effects on the employment rates of disabled people, which were already low in Iceland, as was shown in chapter 5. Unlike in many of the neighbouring countries the employment rates of disabled people have not grown in Iceland over the period. It is possible that the greater taxation of the disabled may have discouraged employment.

9.5. Earnings of disabled people in Western countries

Finally we try to estimate the earnings of disabled people in Iceland in comparison to those of disabled people in other OECD countries. All such comparisons are complicated because it is not possible to ensure the comparability of the data completely. Over the years the OECD has done a lot of work on harmonising data and in their big report on the circumstances of the disabled from 2003 they present data that shows the earnings of disabled people as a proportion of the earnings of other social groups in 1999 (OECD 2003, chapter 3; see also *Society at a Glance* 2002 and 2005). We do not have access to more recent data on the subject and thus we will present data on Iceland that is as comparable as possible in order to show how the circumstances of the disabled in Iceland

[32] The figures used in these examples are all taken from the website of the State Social Security Institute in Iceland (www.tr.is), November 24, 2005.

compare to those in other countries. The first table in the appendix to this report describes entitlements to disability pensions in the OECD countries, including Iceland. This serves as an indication of the characteristics of this part of the Icelandic welfare state.[33] Figure 9.8 compares the earnings of disabled people in Iceland to the earnings of disabled people in other OECD countries.

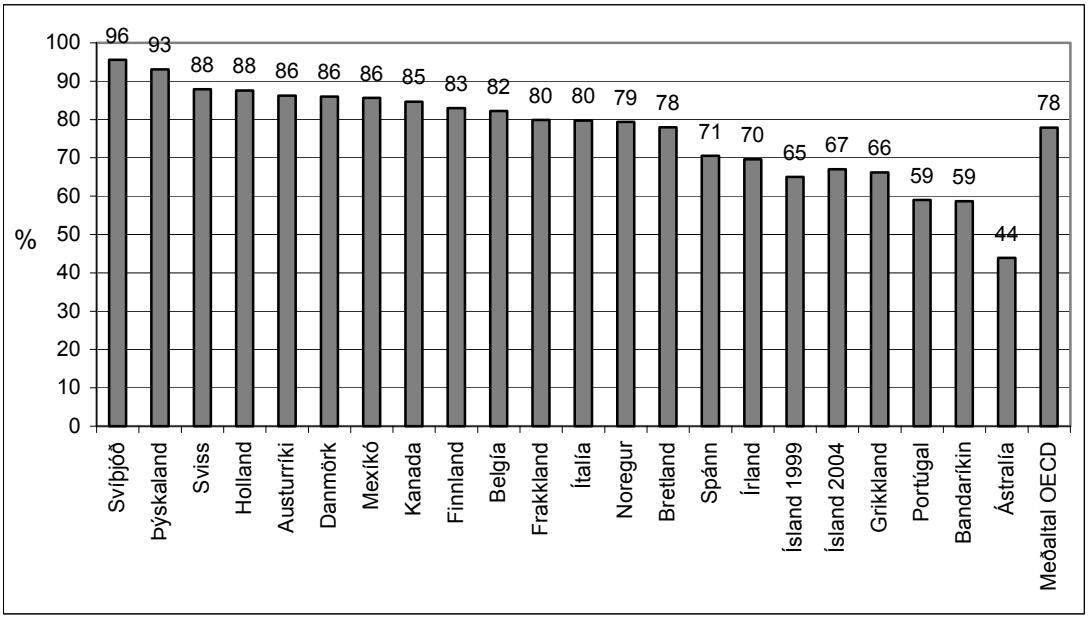

Figure 9.8: Earnings of disabled people as a proportion of the earnings of all other citizens, 20-64 years old.
OECD countries, year 1999.

The earnings of disabled people in Iceland were about 65% of the average earnings of all taxpayers. The OECD average was about 78%. Iceland ranked fifth from the bottom of the 22 countries in 1999. Australia and the United States are at the bottom, along with Portugal and Greece. Australia and the United States keep their disability benefits rather low, as do other Anglo-Saxon countries (Canada, Ireland, Britain, and New Zealand). Portugal and Greece, however, have relatively underdeveloped welfare states in this respect (Esping-Andersen 1990 and 1999).

[33] The figures for Iceland are calculated as follows: The information extracted by Statistics Iceland on the earnings of disabled people in 1999 and 2004 are calculated as average earnings (the earnings of married disabled people are divided evenly between spouses) and those average earnings are then calculated as a proportion of the average earnings of taxpayers aged between 25 and 64.

The highest proportions are reported for Sweden, Germany, Switzerland, the Netherlands, Austria and Denmark (from 86% to 96%). The OECD also calculates the family earnings of families with disabled members as a proportion of the earnings of families without disabled members. These same countries score the highest in that comparison, i.e. the average earnings of families with disabled members are close to 95% of the average earnings of families without such members in these countries (OECD 2003, p. 28-29). According to this comparison in figure 9.8 Iceland lags far behind when it comes to securing earnings for disabled people that approximate the average earnings in society. In fact the generosity of disability benefits and other sources of incomes of disabled people in Iceland are small when we consider how prosperous the nation is, measured as GDP per capita. If this were a comparison of national economic prosperity Iceland would rank much higher.

In figure 9.8 we also show what the proportion had become in Iceland in 2004. The proportion had risen slightly, or from 65% to 67%, though that didn't affect Iceland's ranking among the nations.

It must be kept in mind that when we make such comparisons based on averages that different groups will have different outcomes. One rule seems to be that the earnings of disabled people who must rely solely on social security (State Social Security in Iceland) tend to be considerably lower than the earnings of those who receive pensions from occupational pension funds and those who receive labour incomes on top of their pensions (OECD 2003, p. 76). As was reported above in figure 9.3 the maximum social security pensions a disabled person can receive from the SSI are approximately 46% of the average earnings of taxpayers. These are often people who have had high levels of disability from an early age. Their earnings thus fall below the poverty line.

The gap between the earnings of this group and of the other groups of disabled people seems to be quite large in Iceland, compared to the other OECD countries (OECD 2003, p. 29). This gap tends to be larger for countries like the United States and other countries that have weak welfare systems. An obvious priority in Iceland is to free these people from poverty by raising social security pensions substantially, as these people have no other sources of incomes. If that is not done we may expect this group to be regular visitors to various charities and municipal social services. It is an embarrassment

for the welfare systems of a modern and prosperous nation to offer such limited support that many of its citizens must rely regularly on charity to get by.

It seems that in the OECD countries those disabled people who are employed have earnings close to the earnings of other employed people, i.e. those who aren't disabled. Thus there are considerable opportunities for raising the living standards of the disabled by increasing their employment participation, which is generally low in Iceland as was discussed in chapter 5, though employment rates for the non disabled are amongst the highest in the world. Stronger employment incentives for the disabled in a stronger support system for employment participation could be a considerable step in the right direction, both for those disabled people that can work as well as for the pensions systems in Iceland which could thereby save a part of their expenses.

It must be kept in mind, when considering the earnings of disabled people in Iceland, that the social security system is characterised by heavy means-testing. Countries that have similar system (the Anglo-Saxon countries in particular) generally provide leaner pensions and lower living standards for disabled people than the other OECD countries (OECD 2003, p. 53). The income threshold is generally very low in Iceland and the curtailment of benefits is very steep once recipients start receiving other incomes (see "Álit vinnuhóps um endurskoðun almannatrygginga og samspil þess við skattkerfið og lífeyrissjóði" (2001), as well as report by Herbertsson 2005; and Olafsson´s book of 1999) This characteristic of the Icelandic disability benefits system can easily operate as a poverty trap (Njals 2003) and reduces the gains from employment for disabled individuals. Increasing the employment rates of disabled people is a big policy priority for Western countries nowadays. There is a lot to be gained from introducing measures in that direction.

Overall the earnings of the disabled have not kept up with the earnings of other citizens since 1995, contrary to the objectives established by legislation on the conditions of the disabled, passed by the Althingi parliament in 1992. The primary reason is that pensions from social security have not been increased sufficiently and the tax load of the disabled has increased drastically from 1995 to 2004.

X. Expenditures on disability pensions and services

International Comparison

National expenditures on disability are determined by the number of disabled people in a country, the generousity of the benefits they receive, as well as the scope and the quality of the services provided for disabled people. Analysis of expenditures on these issues can therefore strengthen our conclusion from the analysis that we have presented so far in other parts of this report as well as illustrate further differences between nations.

Table 10.1

Expenditures on disability in the Nordic Countries

	Denmark	Finland	Iceland	Norway	Sweden
Expenditures on disability, as % of GDP:					
1995	3,5	4,7	2,2	4,0	4,3
1999	3,5	3,7	2,3	4,7	3,8
2000	3,4	3,4	2,7	4,1	3,7
2001	3,6	3,4	2,7	4,2	3,8
2002	3,7	3,4	3,0	4,6	4,3
2003	4,1	3,5	3,4	4,5	4,6
Expenditures on disability benefits and services for the disable per capita (in Euros corrected for purchasing power):					
1997:					
Disability benefits	527	652	335	781	506
Services for the disabled	236	148	147	299	264
Total expenditures per capita	**763**	**800**	**482**	**956**	**770**
1999:					
Disability benefits	575	577	376	929	495
Services for the disabled	288	159	177	260	288
Total expenditures per capita	**863**	**736**	**552**	**1118**	**783**
2001:					
Disability benefits	647	581	422	1011	510
Services for the disabled	297	182	238	281	348
Total expenditures per capita	**944**	**763**	**659**	**1292**	**858**
2003:					
Disability benefits	728	586	545	1222	694
Services for the disabled	328	202	281	264	453
Total expenditures per capita	**1056**	**788**	**826**	**1486**	**1146**
Growth of expenditures per capita 1997-2003:					
Disability benefits (%)	38	-10	63	56	37
Services for the disabled	39	36	91	-12	72

Source: NOSOSKO, various years

In table 10.1 we compare expenditures on disability in the Nordic countries for the period from 1995 to 2003. In the top part of the table we see that Iceland spent about 2,2% of its GDP on disability in 1995 while the other countries were spending between 3,5% and

4,7%. There were thus considerable differences in expenditures and the share of GDP spent in Iceland was quite small. In chapter 4 we showed that the prevalence of disability has grown faster in Iceland than in the other Nordic countries in the last ten years or so. However, the total number of disabled people was smaller in Iceland. Thus we would expect expenditures on disability to have grown faster in Iceland than in the other countries. The figures in table 10.1 show that to be the case. Yet Iceland still had the lowest expenditures in 2003, though it was drawing closer to the other countries, especially Finland which has decreased its expenditures following a fall in the number of disabled people resulting from improved employment conditions in recent years.

In the lower part of the table we examine the expenditures from another perspective, as total expenditures per capita for each country (in Euros corrected for purchasing power in the relevant countries). The expenditures are also broken down by whether they are on pension payments or services.

We can see that in 2003 per capita expenditures on benefits were lowest in Iceland (545 euros), followed by Finland, while Norway had the highest expenditures by far. These numbers are affected by the strong exchange rates of the Icelandic krona (ISK) in recent years. Indeed the difference was much larger during the early years of the period, to Iceland's disadvantage. Thus Iceland clearly had the lowest expenditures on disability benefits for all the other years. On the other hand, expenditures on services for disabled people in Iceland were comparable to those in the other countries. This is in line with the prevalent characteristic of the Icelandic welfare state, which is that expenditures on benefits tend to be small while expenditures on services are often comparable to those in the Scandinavian countries (Olafsson 1999). In 2003 both Finland and Norway spent less than Iceland on services for the disabled. This was the first year that Norway spent less than Iceland on this policy area. Total expenditures were lowest in Finland in 2003, followed by Iceland. In 1997 there were considerable differences between Iceland and the other countries in terms of expenditures on such measures.

Expenditures on disability grew fastest from 1997 to 2003, not least because of imporved services for the disabled. Even though the strong exchange rates of the Icelandic currency explains a part of this development it is also clear that there was a real increase as well, as can be seen from the proportional figures in the first part of the table

as well as from the fact that the number of disabled people has grown faster in Iceland than in the other countries during the period. Expenditures on disability also grew considerably in Norway, Denmark, and Sweden. It must also be kept in mind that the other countries also have higher expenditures than Iceland on disabled people who are supported by other parts of the welfare system.

Table 10.2

Expenditures on disability in the OECD countries 1990 to 2001.

Proportion of GPD 1990-2001

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Poland	3,5	4,9	5,9	6,1	6,1	6,0	5,9	6,0	6,0	5,9	5,5	5,5
Sweden	5,6	5,4	4,8	5,4	5,2	5,1	4,7	4,5	4,7	4,7	4,8	5,2
Norway	4,8	5,1	5,0	4,9	4,7	4,7	4,7	4,7	5,0	5,2	4,7	4,8
Netherlands	6,9	6,8	6,8	6,6	6,0	5,3	4,7	4,5	4,3	4,3	4,1	4,1
Denmark	3,3	3,3	3,3	3,5	3,6	3,7	3,7	3,6	3,8	3,8	3,7	3,9
Finland	4,3	5,0	5,5	5,6	5,4	5,1	5,0	4,6	4,2	4,1	3,9	3,9
Switzerland	2,3	2,4	2,7	2,9	3,0	3,1	3,3	3,4	3,6	3,6	3,6	3,8
Luxemburg	3,6	3,5	3,5	3,4	3,4	3,6	3,6	3,5	3,2	3,7	3,3	3,6
Belgium	3,2	3,3	3,4	3,8	3,7	3,4	3,4	3,4	3,3	3,4	3,2	3,3
Czeck Republic	2,5	2,4	2,4	2,4	2,6	2,7	2,8	2,8	2,7	2,7	3,0	3,0
EU-15	3,2	3,2	3,2	3,3	3,3	3,1	3,1	3,0	2,9	2,9	2,8	2,9
Iceland	1,6	1,7	2,0	2,2	2,2	2,4	2,3	2,4	2,4	2,4	2,8	2,8
New Zealand	3,0	3,1	3,2	3,1	2,9	2,8	2,8	3,0	2,9	2,8	2,8	2,8
Hungary	m	m	m	m	m	m	m	m	m	2,7	2,6	2,7
OECD-23 countries	2,7	2,7	2,8	2,9	2,8	2,7	2,7	2,6	2,6	2,6	2,6	2,6
Austria	2,1	2,2	2,2	2,3	2,5	2,5	2,5	2,5	2,6	2,6	2,6	2,5
Portugal	2,5	2,7	2,7	2,8	2,8	2,5	2,5	2,5	2,5	2,4	2,5	2,5
Britain	2,1	2,3	2,5	2,7	2,7	2,8	2,8	2,8	2,7	2,5	2,5	2,5
Spain	2,3	2,5	2,6	2,7	2,6	2,6	2,6	2,4	2,4	2,3	2,4	2,4
Australia	1,9	1,8	2,0	2,2	2,1	2,3	2,3	2,2	2,3	2,2	2,3	2,3
Germany	1,8	1,8	2,0	2,1	2,1	2,2	2,4	2,4	2,4	2,3	2,3	2,3
Slovakia	m	m	m	m	m	2,3	2,5	2,5	2,7	2,6	2,4	2,3
France	2,5	2,5	2,5	2,6	2,5	2,1	2,2	2,1	2,1	2,1	2,1	2,1
Italy	2,7	2,5	2,6	2,6	2,6	2,4	2,4	2,3	2,2	2,2	2,2	2,1
Greece	2,3	2,1	1,9	1,9	1,8	1,7	1,6	1,6	1,7	1,8	1,8	1,8
Ireland	1,9	2,0	2,0	2,0	1,9	2,1	1,8	1,6	1,5	1,4	1,4	1,4
United States	1,0	1,1	1,2	1,2	1,2	1,2	1,2	1,1	1,1	1,1	1,1	1,1
Canada	1,1	1,1	1,2	1,2	1,1	1,0	1,0	0,9	0,9	0,9	0,8	0,8
Japan	0,6	0,6	0,6	0,6	0,6	0,6	0,6	0,6	0,6	0,6	0,6	0,7
Korea	0,3	0,4	0,4	0,4	0,4	0,4	0,4	0,5	0,5	0,4	0,4	0,5
Mexico	0,1	0,1	0,1	0,1	0,1	0,1	0,1	0,1	0,1	0,1	0,1	0,2
Turkey	0,2	0,3	0,4	0,3	0,3	0,2	0,2	0,3	0,3	0,4	m	m

Source: OECD, Social expenditures data base

But how does Iceland stand compared to other Western countries on this issue? Table 10.2 shows the total expenditures on disability in general (as % of GDP) fro 1990 to 2001.

Here we see that the average expenditures of the OECD countries have remained stable over time and the EU average has fallen. Over the same period expenditure grew faster in Iceland than in the other countries. Expenditures in Iceland, however, were far below the average of the two groups of countries in 1990 (EU and OECD) and Iceland was still below the EU average and slightly above the average of the OECD countries in 2001. In the last two years expenditures in Iceland have grown even more, so Iceland has moved up the list.

The countries with the most developed welfare systems, the Scandinavian countries, are far above Iceland in 2001, along with the Netherlands, Switzerlands and Poland (which has an unusually extensive disability benefits system, probably because of long-term employment which has shifted the burden of unemployment on to the disability benefits system). The countries below Iceland are the Anglo-Saxon countries that tend to restrict expenditures on disability benefits and social services, along with other countries with underdeveloped welfare states. Germany and France are significant deviations in this respect as both have lower expenditures than Iceland.

Table 10.3 shows an interesting breakdown of expenditures on disability and related parts of the welfare system, i.e. those parts of the system that stand closest to the disability benefits system and often share the burden of the disability benefits system, albeit in different ways in different countries.

In section 4.5 we showed that the Icelandic disability benefits system plays a relatively large role in comparison to related parts of the welfare system. This means that the burdens of the sick pay system, unemployment benefits system, and the municipal social services fall partly on the disability benefits system, which consequently becomes larger and more expensive. Thus it is necessary to consider the expenditures on disability benefits in the context of expenditures on related systems, i.e. to add up the expenditures of these different systems to get a wider and more realistic picture.

Table 10.3
Expenditures on disability benefits and related parts of the welfare system
% of GDP 1998

	Disability benefits	Accident insurance	Sick pay	Services for elderly and disabled	Active labour market policies	Unemployment benefits	Other	Total 1-7	Total welfare expenditures
Sweden	2,1	0,3	1,1	3,7	2,0	1,9	0,9	12,1	31,0
Denmark	1,8	0,1	0,7	3,0	1,7	3,4	1,1	11,7	29,8
Netherlands	2,4	x	1,0	1,3	1,3	2,6	1,3	9,9	24,5
Norway	2,8	0,0	1,5	3,4	0,9	0,5	0,7	9,8	27,0
Finland	2,8	0,2	0,4	1,5	1,4	2,6	0,6	9,5	26,5
Poland	4,0	0,8	1,2	0,3	0,4	0,6	0,3	7,5	22,8
Switzerland	2,2	0,8	0,5	0,7	0,8	1,0	0,5	6,4	28,1
Belgium	1,3	0,4	0,4	0,1	1,4	2,5	0,3	6,3	24,5
France	0,9	0,2	0,5	0,7	1,3	1,8	0,4	5,8	28,8
Germany	1,0	0,3	0,3	0,7	1,3	1,3	0,6	5,6	26,0
Ireland	0,7	0,1	0,7	0,4	1,2	1,7	0,6	5,4	15,8
New Zealand	1,0	0,8	1,2	0,0	0,6	1,6	0,1	5,3	21,0
Canada	0,5	0,4	0,1	a	0,5	1,0	2,8	5,2	18,0
Slovakia	2,0	a	1,2	0,4	0,0	0,6	0,9	5,1	13,6
Austria	1,9	0,4	0,2	0,9	0,4	0,9	0,3	5,1	26,8
Spain	1,3	x	0,9	0,3	0,6	1,5	0,1	4,9	19,7
Luxemburg	1,8	0,6	0,7	0,5	0,2	0,5	0,2	4,7	22,1
Iceland	1,5	0,0	0,1	2,2	0,1	0,4	0,4	4,7	18,4
Austria	1,2	0,9	0,0	0,8	0,4	1,1	0,1	4,5	17,8
Britain	2,6	0,0	0,1	0,8	0,3	0,3	0,2	4,5	20,8
Portugal	1,9	a	0,5	0,3	0,7	0,8	0,3	4,4	18,2
Czeck Republic	1,7	0,1	0,9	0,5	0,1	0,2	0,4	3,9	19,4
Italy	1,0	x	0,7	0,2	0,7	0,7	0,0	3,2	25,1
Greece	1,1	n	0,8	0,3	0,2	0,5	0,2	3,1	22,7
USA	0,9	0,1	0,2	0,1	0,2	0,2	0,6	2,2	14,6
Japan	0,3	0,2	0,1	0,3	0,2	0,5	0,2	1,8	14,7
Turkey	0,2	0,0	0,0	0,1	0,1	0,6	0,3	1,4	11,6
Korea	0,1	0,2	a	0,2	0,5	0,2	0,2	1,4	5,9
Mexico	0,0	0,0	a	0,0	0,1	0,0	0,5	0,7	8,2

OECD, Society at a Glance 2002

In this way we get the total expenditures on all the main parts of the welfare system that might be covering the disabled, the injured and the long-term sick, in addition to the unemployed. Because these systems are differently organized there is often an overlap between different parts of the systems that affects comparability. For instance, it is not correct to compare the expenditures on just disability benefits in Iceland to expenditures on just disability benefits in the other countries, if the role of the disability benefits

system is larger in Iceland than it is in the other countries, and the role of the other systems consequently smaller.[34]

The table supports our conclusion from section 4.5. Icelandic expenditures on disability benefits are not that far from the average of the other countries, but the expenditures on sick pay, on the other hand, are very low in Iceland, or about 0,1% of the GDP. Sweden spends about 1,1%, Denmark spends 0,7%, Norway spends 1,5%, and Finland spends 0,4%. The neighboring Nordic countries therefore spend between four and five time more of their GDP on sick pay than Iceland. This means that the sick pay systems of these countries shoulder a considerably larger part of the disability burden than it does in Iceland. Other things being equal the Icelandic disability benefits should be more expensive than the comparable system of these other countries. Yet this is not the case.

When we add up all these related parts of the welfare system, as we do in column 8 in table 10.3, we see that Iceland ranks rather low on expenditures. This means that Iceland has a relative small burden from disability, accidents, injury, illness and unemployment, when compared to the other OECD countries. The countries that have smaller total expenditures on these issues are the Anglo-Saxon countries and countries with underdeveloped welfare states.

[34] Unfortunately the most recent disaggregated data we have is from 1998, from an OECD report of social indicators (2002) *Society at a Glance*.

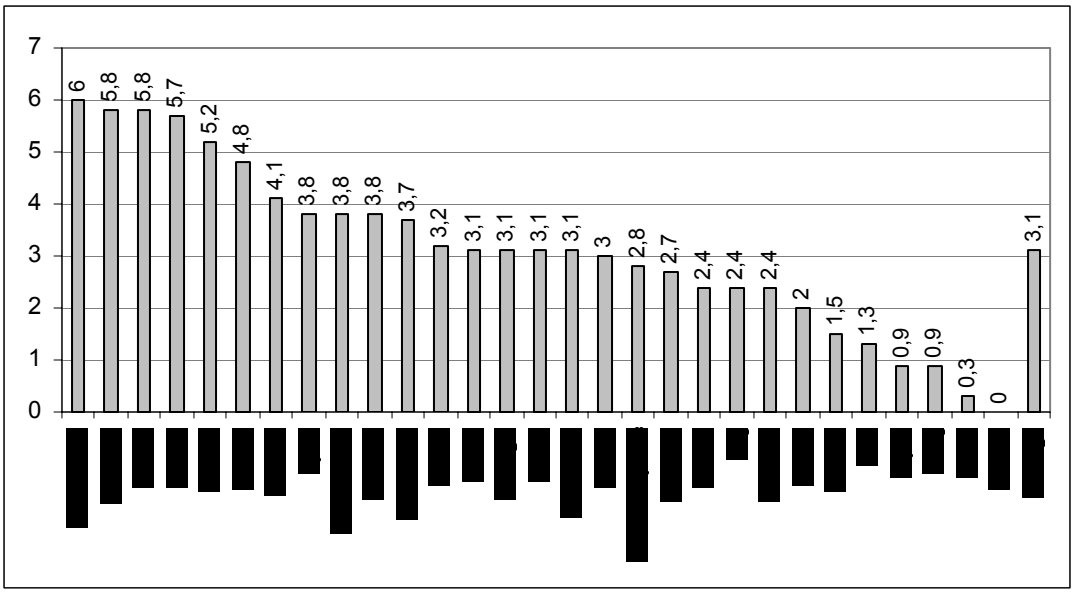

Figure 10.1: Aggregate expenditures on disability, sick pay, and unemployment benefits. OECD countries 1998.

In figures 10.1 and 10.2 we show two different two different versions of aggregate expenditures on disability and related issues. Figure 10.1 show the total expenditures on disability, sick pay and unemployment benefits. There Iceland ranks seventh from the bottom. Canada, the United States, Japan, Turkey, Korea and Mexico are below Iceland.

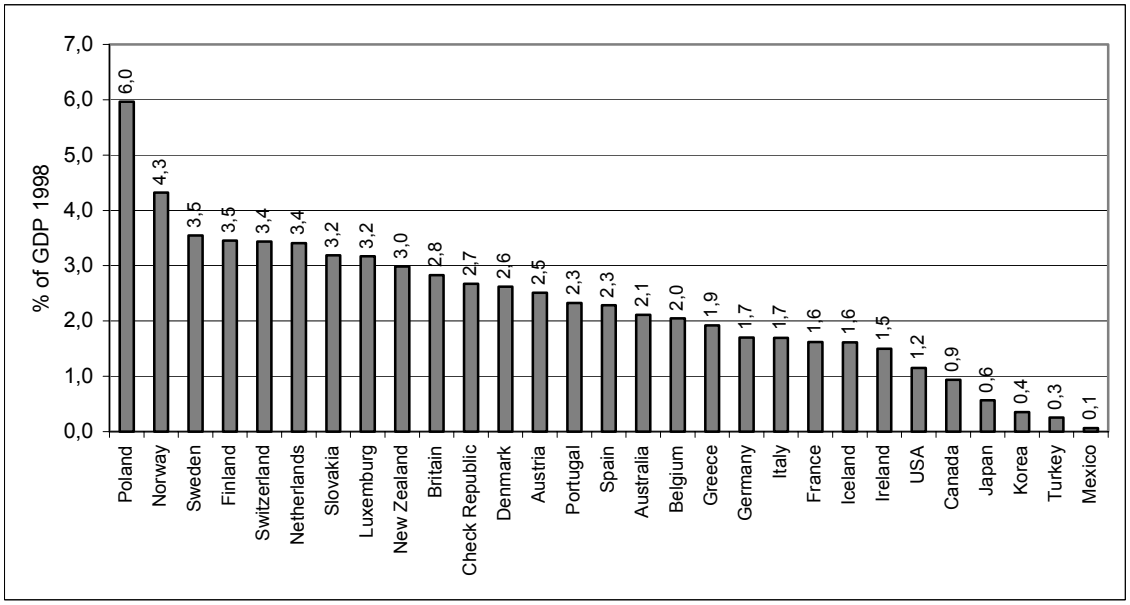

Figure 10.2: Total expenditures on disability benefits, accident insurance and sick pay. OECD countries 1998.

In figure 10.2 we have left out expenditures on unemployment benefits, which role is probably least similar to the role of disability benefits. On the other hand we have added accident insurance. These three policy areas are undoubtedly closest to the disability benefits system, i.e. there is most overlap. Iceland moves up one place in the ranking while Ireland fell one place.

All things considered it is clear that Iceland has rather lean expenditures on disability and related parts of social security. Iceland is not far below the average of the European countries when disability benefits and services are considered in isolation, though our expenditures are well below those of the other Nordic countries, despite the fact that expenditures have risen considerably in Iceland in recent years.

XI. Disability Policy in Western Countries

XI.1. From Social Exclusion to Integration

The objective of disability policy in most Western societies is twofold:

- Ensuring that the disabled have acceptable living standards so that they can participate in the ordinary life of their society, regardless of handicaps, reduced capacities, and physical functioning.
- To counteract the social exclusion of disabled people so that they can be full members of society; in the labour market, in education, as well as in recreation and the cultural life of their community.

There are many ways by which such objectives may be accomplished and consequently social policy on disability differs considerably between countries. So does government spending on such measures. Over the last few decades we have also seen the adoption of new measures in most industrialised countries. The policy emphasis has shifted from providing the disabled with some minimum level of pensions to activation measures, especially measures for getting disabled people into paid employment and education.

Such measures have been emphasised by organisations representing the interests of handicapped and disabled people. One of the reasons for their implementation is that such organisations have become more visible and more active over the last few decades. International organisations, such as the OECD, the ILO, the WHO, and the EU, have also emphasised such measures.

Handicapped and disabled people are at a greater risk of social exclusion than most other citizens. Social exclusion results from mutually enforcing disadvantages. Disabled and handicapped people suffer physical or mental problems that impede full participation in society, education, employment, and access to the living standards that are customary in their societies. They also face prejudice and ignorance. On top of that the pensions provided by many modern welfare states are insufficient to secure acceptable material living standards, which further limits their integration into modern market societies. Thus physical, social, and economic barriers operate together to thwart the social participation of handicapped and disabled people. The risk of social exclusion is greater for those who suffer such multiple disadvantages than it is for the population in general.

Being disabled thus increases one's risk of isolation and exclusion at the margins of society, thus being deprived of the quality of life enjoyed by most "ordinary" people. Many Western countries have introduced new measures supporting the social integration of disabled people, especially measures to get them into paid employment (OECD 2003, chapter 6). As the needs of disabled people are many and varied, depending on the cause of their disability, such measures must often be individualised and flexible. The implementation of these new measures has rarely been accompanied by a reduction of pensions. In most cases the emphasis has been on supporting employment and on active labour market policies. Still, in some countries such measures have been accompanied by new restrictions on entitlements to disability benefits, e.g. in the United States, as the authorities have felt that the number of disabled people had been growing too fast or because of suspicion that able-bodied people have been lured out of the labour market by overly generous benefits (Handler 2003). Apparently it is easy to convince people that such abuse is widespread, though it is rarely backed up by credible evidence. Nevertheless, the possibility of abuse exists and that can undermine the legitimacy of the welfare state in the eyes of the general public.

Thus we must be wary of exaggerated claims about such abuses. The fact is that in Iceland no one is granted disability benefits without cause, unless the physicians employed by the State Social Security Institute fail in their obligations, as they are not authorized to grant disability benefits to people who do not meet pre-defined requirements (i.e. suffering disability, though the level of disability may vary). In most Western countries disability benefits are usually granted on the basis of specific criteria with a number of people being involved in the evaluation process (see Appendix I). It is also common that a person's disability rating is reappraised regularly. Thus it is unlikely that abuse is widespread as that would require widespread carelessness on behalf of the physicians and staff of social security institutions. The administration of disability benefits, however, is so tightly regulated that we have little reasons to expect this to be the case.

The Western countries that spend the most on improving the circumstances of the disabled are the Scandinavian countries, the Netherlands, Switzerland, and Luxemburg. This is consistent with the strong emphasis placed on welfare issues in these countries,

especially the Scandinavian countries. The United States generally have low expenditures on disability benefits and services for the disabled. Consequently they have failed to secure adequate living standards for their disabled citizens. On the other hand the United States pioneered progressive legislation on disability with their 1990 "Americans with Disabilities Act" (ADA). Margeirsdottir (2001, p. 96-97) has described this reform as follows:

> "The law covers all categories of disability, i.e. the handicapped, the deaf, the visually impaired, the mentally disturbed, etc. The core of the law is made up of provisions on access, transportation, employment, information technology and telecommunications. This last provision provides, among other things, people who are mute or hearing impaired with special equipment, such as text telephones and other communications equipment.
>
> The laws also contain various provisions on the employment of disabled people in order to prevent discrimination in the labour market. These provisions cover issues such as work hours, unlawful dismissals, and perks and other things that the disabled often miss out on. Employers are mandated to secure access to the workplace at their own expense as well as to provide necessary support and equipment. In turn employers are entitled to tax deductions to cover these costs. Equal rights authorities have emphasised the employment rights of the disabled and issued detailed instructions for employers on access and work place organisation suited for disabled employees.
>
> The National Institute on Disability and Rehabilitation Research has established centres for rehabilitation and special support equipment that provide assistance and advice with regards to the employment of the disabled. The objective is to enable most disabled people to work in the regular labour market, but also to ensure that those who are not able to do so have access to sheltered workplaces, which are usually run by voluntary organisations and private enterprises.

These laws also contain clear provisions about the access of handicapped people to public transport, services and institutions. Goods that are available in the market must also be adapted to the needs of disabled people. As was discussed above, in chapter 2.4, the Scandinavian countries generally have similar objectives with regards to the social integration of disabled people as well as their access to market goods. In fact, the idea of normalisation, i.e. the integration of disabled people into society, was first elaborated in the Scandinavian countries. The Scandinavian welfare states have provided reasonable living standards to ensure that financial limitations do not prevent disabled people from

leading ordinary lives. The responsibility of each sector of society for ensuring the integration of disabled people is emphasised both in Scandinavia and in the United States.

In the United States the costs resulting from such obligations are born by employers, but in the Nordic countries these costs are born by the state. Thus rights and entitlements in Scandinavia are more universal than they are in the United States, as it may be difficult to ensure that companies and employers provide such measures. It is also difficult to ensure that the quality of the measures is adequate and universally available. Thus the main achievement of the American model is to improve the access of disabled people to society rather than providing them with earnings in line with the average earnings in society. In that respect the Scandinavian countries have a distinct advantage (Hvinden 2004, OECD 2003, EF 2003). Appendix I gives, among other things, an overview of entitlements regarding the employment of disabled people and provisions against discriminations in the labour market in Western countries.

XI.2. Disability and Human Rights

In 2004 Brynhildur Flovenz, an Icelandic law researcher, published a detailed appraisal of the legal status of disabled people in Iceland. She makes a distinction between positive and negative human rights. Negative human rights protect people's freedom to act within reasonable limits and limit the power of the state. Positive human rights are intended to guarantee people's access to specific goods, such as social support, income support, education, health care, etc. Positive human rights thus commit the state to implement certain measures. How well these measures are implemented is up to the government (Flovenz 2004, p. 33). The rudimentary rights of disabled people are guaranteed by the constitution and various international agreements to which Iceland is a signatory, as well as by various laws and regulations on the issue of disability, such as laws number 59 from 1992.

Disabled and handicapped people are not mentioned specifically in the Icelandic constitution, neither in article 76, which contains a declaration on fundamental human rights, nor in article 65 which contain a statement of equal rights and treatment for all citizens. Nevertheless, it is clear that these articles apply to disabled people. On the other

hand it is striking that neither the constitution nor Icelandic law contains articles prohibiting discrimination against disabled people, neither in society nor in the work place. Such articles can for example be found in legislation in the United States and in Sweden. Brynhildur Flovenz also claims that the definition of disability in Icelandic law is primarily based on the medical model, unlike in Denmark and Sweden where disability tends to be defined in terms of the social model. The social model makes demands on the government to foster social arrangements that take account of the needs of disabled people, in order to accommodate social diversity.

The Legal Status of Disabled People in Sweden

Disabled people do not have the same legal status in Denmark as they do in Sweden. Swedish law has incorporated most of the rights included in the *Americans with Disabilities Act* from 1990. Furthermore, the government guarantees that these rights are implemented and provides for sufficient income support for handicapped and disabled people. The Swedish government also established an office of ombudsman for handicapped people whose role it is to protect the rights and pursue the interests of handicapped people in Sweden, for instance by making sure that legal and administrative barriers to social integration are removed. This office oversees the implementation of goals that have been established by legislation, i.e. equal rights and social integration. In 1999 the Swedish parliament passed laws that prohibited discrimination against disabled people, both in the workplace and in society, which were in line with the American ADA laws. The office of ombudsman enforces these laws. The Swedish state has thus acknowledged its responsibility for increasing the access of disabled people to society and information. This policy uses the guidelines of the United Nations as a yardstick (Flovenz 2004 and Margeirsdottir 2001).

The Legal Status of Disabled People in Denmark

The rights of disabled people in Denmark are based of the underlying principles. Firstly, society must be organised in such way as to meet the needs of people who suffer limitations, such as handicap or disability. This is referred to as disability due to the

social environment (*miljörelaterade handicapbegreb*). That concept is based on the social model of disability (see chapter 2 and Traustadottir 2003).

Secondly, there is the principle of compensation (*kompensationsprincippet*) which requires society to offer services or funds to those who suffer disabilities to counteract the resulting limitations or to make up for them in some way. Such benefits should be independent of incomes or property and granted free of charge.

Finally, it is assumed that actors within specific sectors of society are responsible for securing equality for handicapped people within that sector. For example, the educational authorities are responsible for equality within the school system, and the health care authorities have similar responsibilities for health care services (Flovenz 2004, p. 84).

Denmark has not adopted special laws on disability as it is held that such laws would serve primarily to differentiate disabled people from other groups in society. The Danish approach is to extent provisions for equal rights to include handicapped and disabled people. That is also the reason why Denmark has not passed laws banning discrimination against handicapped people (as was done in the United States). The Danish welfare state is based on the principle that all citizens should contribute according to their ability while being entitled to support according to their needs. That principle is the basis of the mutual insurance system that is the welfare state. Municipalities and regional authorities administer services for the disabled. The goal is one of mainstreaming, i.e. integrating the interests of disabled people into universal social policy. There is also a strong emphasis on consultation with associations representing the interests of disabled people, rather than leaving the protection and pursuit of the interests of disabled people to civil servants, as is done in Sweden. Similarly, the idea in Denmark is to seek the voluntary cooperation of employers when it comes to the employment of disabled people, rather than compelling them by legislating to abide by disability quotas when recruiting personnel, as is done in many countries (see appendix I, tables 12 and 13).

In 1980 a council on disability issues was established, with an equal number of representatives from the government and the disabled. This council monitors the social circumstances of disabled people and offers recommendations to the government, in

addition to initiating reforms in specific policy areas. In 1993 Denmark established an equal rights office. This office monitors inequalities between disabled people and the general population, gathers information and carries out research, and provides information to the government about existing inequalities (Flovenz 2004, p. 82-85).

The Legal Status of Disabled People in Iceland

Margeirsdottir (2001) provided an overview of how the rights of disabled people have developed in Iceland in recent decades. It is clear that there has been a lot of progress since 1980, both in terms of rights and attitudes towards disabled people. The laws passed in 1992 introduced some of the policy innovations that many of the neighbouring countries had adopted at the time. Since then, however, there have been significant developments in this area of social policy in many Western countries. There has been a growing emphasis on social integration and employment as well as the strengthening of other rights.

Flovenz's (2004) appraisal of the legal status of disabled people in Iceland, with reference to laws in other countries, policy goals, and international agreements, reveals that the legal status of disabled people in Iceland leaves a lot to be desired. Here we will review some of her findings.

According to Flovenz the administrative procedures of disability policy are insufficient in terms of securing the rights of disabled people. This is because different tasks, such as consultation, protection of interests, and the provision of services, are all provided by the same agency, i.e. the regional offices of the municipal social services. The employees of such agencies are therefore often faced by contradictory demands and allegiances. This suggests that it is necessary to establish an independent body that provides consultation and guidance, as has been done in Sweden. Such an institution would be independent of the agencies that provide services for the disabled. Brynhildur Flovenz also states that it would be a significant step forward if all services for disabled people were to be provided by the municipalities.

Issues of access are not really dealt with in Icelandic legislation. The objectives of the law on disability that was passed in 1992 are to provide disabled people with equal right, living standards comparable to those of other citizens, as well as providing social

conditions that enable them to lead ordinary lives. So despite considerable progress a lot remains to be done if we are to integrate disabled people into various domains of social life. The authorities responsible for implementing these goals ought to establish realistic targets and devise plans of implementation. For example, earlier this year the British government published an ambitious plan on the integration of handicapped and disabled people into society, including plans for implementation and annual progress appraisals.[35] It is also important to adopt a broad view on accessibility issues, such that they are understood not only in terms of physical access to buildings but in terms of the goods and services available in society.

Flovenz compares the situation in Iceland to the principles of equal opportunity established by the United Nations. This comparison suggests that Iceland falls short of providing disabled and handicapped people with full access to society. It is also important that associations representing the interests of disabled people are consulted on issues affecting their constituents. It should be noted however that the present minister of social affairs has pledged reforms in this area.

On the upside it does seem that disabled people's access to the lower levels of the education system is reasonably secure, through a wide range of support measures. On the other hand data on the education attainment of disabled people (see chapter 7) indicates that their access the higher levels of the education system is still too restricted. This suggests a need for more effective measures supporting disabled people in both secondary education and at the university level. Improving the access of disabled people to education will benefit the disabled as well as society as a whole.

XI.3. Vocational rehabilitation, support and employment

Iceland has no laws on vocational rehabilitation for disabled people but the laws on disability from 1992 and a ministerial directive on the employment of disabled people contain provisions for such measures. Unfortunately these provisions are fragmented and unsystematic, as was noted in the final report of a task group on vocational rehabilitation

[35] The plan is called "Improving the Life Chances of Disabled People". It was written by the Prime Minister's Strategic Unit and it was presented in January 2005. The duration of the plan is until the year 2015. (http://www.strategy.gov.uk/downloads/work_areas/disability/disability_report/pdf/disability.pdf).

that was appointed by the Minister of Health and Social Security (Thorlacius, SSSI, published on February 14th, 2005).

The workgroup concluded that it was necessary to strengthen vocational rehabilitation in Iceland, and to establish a national rehabilitation centre to oversee the projects. It is also necessary to reform the administration of occupational rehabilitation as it currently falls under the purview of three different government ministries. Flovenz (2004, p. 163) also notes that Iceland does not have a plan of implementation for vocational rehabilitation, as is required by the UN's rules on equal opportunities. Nor is there a plan of implementation for health care for disabled people.

Figure 11.1 shows the extent of occupational rehabilitation in Iceland in 2003 compared to the other Nordic countries.

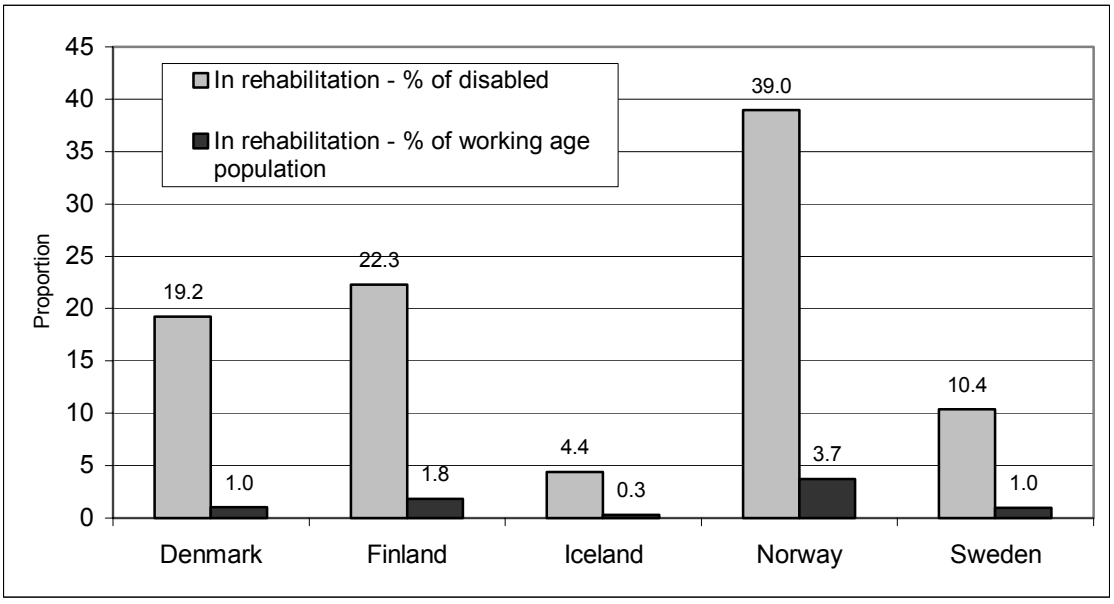

Figure 11.1: Individuals receiving vocational rehabilitation, as % of all disabled people as well as % of the working age population (ages 18-64)[36]

This figure supports the conclusions of the abovementioned workgroup, i.e. that it is necessary to increase the availability of vocational rehabilitation measures in Iceland, as much fewer people receive such training in Iceland than is the case in the other Nordic countries. The difference is very large and it is clear that Iceland lags far behind its neighbouring countries. It should be noted that the other countries have been making

[36] Source: Calculated from figures presented in NOSOSKO 2005, p. 148 and p. 29.

considerable progress in this policy area over the last decade. It seems that Iceland has not kept up with that development. Further evidence is presented in table 11.1.

Table 11.1
Expenditures on active labour-market policies in the OECD countries
Proportion of GDP 1990-2001.

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Denmark	1,1	1,3	1,4	1,7	1,7	1,9	1,8	1,7	1,7	1,8	1,6	1,5
Netherlands	1,1	1,2	1,3	1,3	1,2	1,1	1,2	1,3	1,4	1,5	1,5	1,5
Sweden	1,7	2,3	2,9	2,9	2,9	2,2	2,2	2,0	1,9	1,7	1,3	1,4
Belgium	1,2	1,2	1,2	1,2	1,3	1,4	1,5	1,2	1,4	1,3	1,3	1,3
France	0,8	0,9	1,0	1,2	1,3	1,3	1,3	1,3	1,3	1,4	1,3	1,3
Germany	1,1	1,4	1,9	1,5	1,2	1,3	1,3	1,1	1,2	1,2	1,2	1,1
Finland	1,0	1,4	1,8	1,7	1,6	1,5	1,7	1,5	1,4	1,2	1,0	0,9
European Union-15	0,8	0,9	1,1	1,1	1,0	1,0	1,0	1,0	1,0	1,0	0,9	0,9
Norway	0,9	0,9	1,0	1,1	1,3	1,3	1,2	0,9	0,9	0,8	0,7	0,8
Spain	0,8	0,7	0,7	0,5	0,5	0,5	0,5	0,5	0,7	0,8	0,9	0,8
Ireland	1,4	1,3	1,3	1,4	1,6	1,6	1,6	1,3	1,1	0,9	0,8	0,7
OECD-23 countries	0,7	0,8	0,9	0,9	0,9	0,8	0,9	0,8	0,8	0,8	0,7	0,7
Portugal	0,6	0,7	0,8	0,8	0,7	0,8	0,8	0,7	0,7	0,8	0,6	0,6
Austria	0,3	0,3	0,3	0,3	0,3	0,4	0,4	0,5	0,4	0,5	0,5	0,5
Hungary	m	m	0,6	0,7	0,6	0,4	0,4	0,4	0,4	0,4	0,4	0,5
Italy	0,2	0,2	0,2	0,1	0,2	0,2	0,4	0,4	0,5	0,5	0,5	0,5
New Zealand	0,9	0,8	1,1	0,8	0,7	0,7	0,7	0,7	0,6	0,6	0,6	0,5
Switzerland	0,2	0,2	0,3	0,4	0,4	0,5	0,5	0,8	0,8	0,7	0,4	0,5
Australia	0,3	0,3	0,7	0,7	0,7	0,8	0,6	0,5	0,4	0,4	0,5	0,4
Canada	0,5	0,6	0,6	0,6	0,6	0,6	0,5	0,5	0,5	0,5	0,4	0,4
Slovakia	m	m	m	m	m	0,8	0,8	0,6	0,4	0,2	0,3	0,4
Japan	0,3	0,3	0,3	0,3	0,3	0,3	0,3	0,3	0,3	0,3	0,3	0,3
Korea	0,0	0,0	0,0	0,1	0,0	0,0	0,0	0,1	0,5	0,7	0,5	0,3
Britain	0,6	0,5	0,6	0,6	0,5	0,4	0,4	0,4	0,3	0,4	0,4	0,3
Czeck Republic	m	0,2	0,3	0,2	0,2	0,1	0,1	0,1	0,1	0,2	0,2	0,2
Greece	0,4	0,4	0,4	0,3	0,3	0,3	0,4	0,3	0,2	0,2	0,2	0,2
USA	0,2	0,2	0,2	0,2	0,2	0,2	0,2	0,2	0,2	0,2	0,2	0,2
Iceland	0,0	0,0	0,0	0,1	0,1	0,1	0,1	0,1	0,1	0,1	0,1	0,1
Luxemburg	0,3	0,2	0,2	0,2	0,2	0,2	0,3	0,3	0,3	0,1	0,3	0,1
Mexico	0,0	0,0	0,0	0,0	0,0	0,1	0,1	0,1	0,1	0,1	0,1	0,1
Poland	0,0	0,0	0,4	0,6	0,5	0,4	0,5	0,5	0,4	0,3	0,2	0,1
Turkey	0,0	0,0	0,0	0,0	0,0	0,0	0,1	0,1	0,1	0,1	m	m

Source: OECD, Social expenditures data base

Here we see expenditures on active labour market policies in different countries as a proportion of their GDP. Such measures reduce unemployment rates and are well suited to raise the employment rates of people who are inactive for various reasons, such as

illness, social circumstances, or because of handicaps and disability. The OECD promotes such measures on the grounds that it improves the functioning of labour markets.

The Scandinavian countries have long been at the forefront in this policy area. This is reflected by that fact that they have the highest expenditures on activation measures. In fact Sweden pioneered such policies already in the 1950s. However, nowadays this is an important policy area in many of the more prosperous countries, especially those with extensive welfare states (Esping-Andersen and Regini 2000). Denmark and Sweden have the highest expenditures in table 11.1, while Finland and Norway have somewhat lower expenditures. Other countries with high expenditures are the countries in North-Western Europe. Sweden and Finland increased their expenditures following higher unemployment rates during the first half of the 1990s. Their expenditures fell again when their labour markets began recovering. The countries with the lowest expenditures on active labour market policies are the less developed countries (Turkey, Poland, and Mexico) along with two more affluent nations (the United States and Luxemburg). Iceland also belongs to this group. The Anglo-Saxon countries, which generally have low welfare expenditures, spend little on active labour market policies.

It appears that Icelandic expenditures on active labour market policies were unusually low in the 1990s as well as in recent years. One of the reasons may be that there hasn't been a perceived need for such measures as employment conditions in Iceland have for the most part been very good. However, as we showed in chapter 6, the Icelandic labour market changed fundamentally after 1990 leading to higher unemployment rates and a higher prevalence of disability. There are therefore strong reasons to place more emphasis on such policies than is currently done. The same goes for occupational rehabilitation. These are policy measures that the OECD promotes, for instance in a recent report on active social policies,[37] and governments in Western countries are increasingly adopting.

The OECD also addresses different methods for raising the employment rates of handicapped and disabled people. The main ones are the following:

[37] OECD 2005, *Extending Opportunities: How Active Social Policy Can Help Us All* (Paris: OECD).

- **Accommodated work**. Regulation that helps disabled people retain their jobs and that mandates that work facilities are adapted to the needs of disabled employees. Financial support for amelioration and adaptation.

- **Subsidised work**. Subsidies for labour costs or financial incentives (e.g. tax incentives) to compensate for lower productivity of some disabled people.

- **Supported work**. Support or counselling in work places, occupational rehabilitation, help with finding jobs. Such measures are in the form of personal support for the disabled person in question, either temporarily or permanently.

- **Sheltered work**. Special workplaces for handicapped people, either to provide attachment to the general labour market or as a permanent workplace (especially for the severely disabled).

- **Reserved work**. Jobs in specific areas of the labour markets are reserved for special groups, e.g. by imposing quotas.

- **Vocational rehabilitation**. Vocational training and rehabilitation to help people find their way back into the labour market. Takes place either in ordinary workplaces or in special institutions.

Many of these measures have been made available in Iceland. However, their implementation is recent and funding is limited. Consequently there are very few people who benefit from vocational rehabilitation and active labour market policies. This explains in part why the employment rates of disabled people are so low in Iceland in comparison to the neighbouring societies. Another reason is that the social security system does not provide sufficient incentive for disabled people to take up paid work. The means-testing built into the system severely reduces the financial gain from employment for this group. It is hardly a reasonable objective for a social security system to trap disabled people in poverty, regardless of whether they are employed or not. Disabled people should enjoy the same opportunities as other citizens.

There are therefore good reasons to reduce the means-testing of disability benefits (either temporarily or permanently) and/or to provide tax incentives for disabled people who work, as is done in the United States.[38] The financial gain from employment must be increased and the support system for the employment of disabled people must be improved.

[38] For more information see Appendix I, especially the tables on entitlements based on employment.

Tables 19 and 20 in Appendix I present a comparison of entitlements, the earnings, and support for employment in OECD countries, as they were at the turn of the century. The conclusion is that Iceland lags behind the Nordic countries, as well as many other European countries, when it comes to the entitlements and earnings of disabled people. We lag even further behind if we compare our standing on active labour market policies to that of the other countries (see table 20).

The conclusion is therefore that even though Iceland has a relatively good legal framework defining the rights and entitlements of disabled people, in comparison to the neighbouring countries, it hasn't kept up with most recent developments. This is most apparent when it comes to legal protection against discrimination in the workplace as well as in society more generally. Nor does Icelandic legislation guarantee disabled people access to various areas of social life (higher education, health care, vocational rehabilitation and training, product and service markets, information, culture, entertainment, and family life). It must also be remembered that formal rights of access to key areas of social life are not sufficient in themselves. Disabled people must have the purchasing power necessary to make use of such rights. Legal reforms must therefore be supported by systematic measures to raise the earnings of disabled people if we are to meet the policy objectives laid down in the laws from 1992, i.e. that disabled people should enjoy living standards comparable to those of other citizens and be able to lead as normal lives as possible.

XI.4. Who are the Champions? Evaluating disability policies in OECD-countries

Each of the dimensions of disability policy that have been discussed in this report tell a story about the policy emphases and achievements of different Western countries. Thus the real comparison is spread throughout the report. Welfare states are diverse, yet social policies vary systematically so that there is a limited range of welfare state models. This also applies to disability policy. Therefore it is also useful to look at the bigger picture and consider how different welfare states affect disabled people.

In chapter 2.3 we described the main welfare state models that are found in Western countries. We also examined the end results of different welfare state

arrangements for the living standards of citizens in these countries. The Scandinavian welfare state is superior when it comes to improving the living standards of the majority of all citizens, followed by the welfare states in the northern parts of continental Europe. The American welfare state and the Southern European ones have the smallest impact. Inequality and poverty is generally greater in these countries than it is in Scandinavia and the North-Western parts of the European mainland. In the conclusions we will summarize the outcomes in specific domains, focusing on how Iceland compares to the other countries. In this section we consider the overall impact of different welfare state model on the quality of life of disabled people in terms of the two widely established policy goals:

- Securing acceptable living standards for disabled people
- Ensuring the integration of disabled people in society

It is not immediately obvious how to summarize all the information that has been presented in this report. If this were an extensive research project we would develop scales for specific aspects of the welfare state that affect disabled people. These would then be weighted according to their importance. Finally we would merge these separate scales in an overall index of disability policy. This is beyond the scope of this report. Fortunately however the OECD constructed such an index for its report on disability in 2003 (*Transforming Disability into Ability*). The OECD methodology is open to debate, but the index does provide a useful starting point.

Appendixes I and II contain detailed overviews of policy measures that affect the living standards of disabled people and their integration into society. It should be noted that the OECD defines social inclusion primarily on the basis of employment. It does not examine the education system or culture and recreation, to name some important dimensions of social inclusion not considered. Nor does it include information on access to buildings and institutions. Access to employment is important but it is not the only thing that matters in the context of disability. But even given these reservations about the OECD index it must be admitted that it is a very useful tool to examine how Iceland compares to other countries on the dimensions that it does measure. Appendix II contains information on the standards that the OECD uses to determine the characteristics and the

quality of the income support and social inclusion systems in its member countries. The results are shown in figure 11.2. Figure 11.3 approaches this same issue from a slightly different angle.

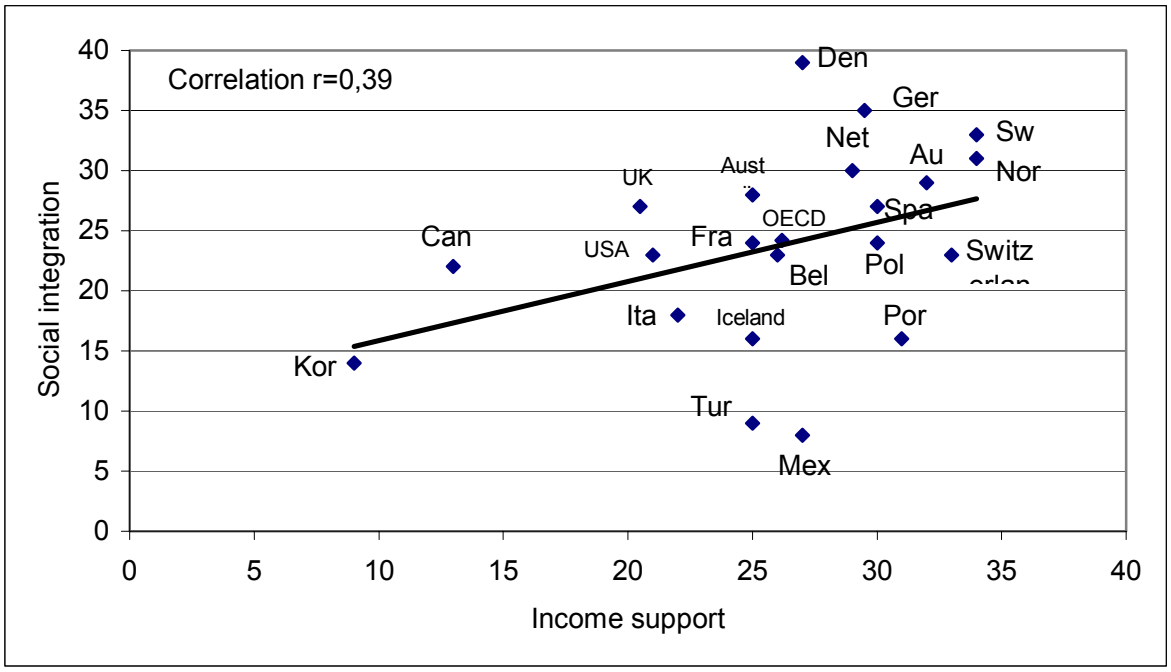

Figure 11.2: The OECD evaluation of the quality of the income support and social integration measures for disabled people, 2000.[39]

The countries furthest to the right (the income support axis) have better income support systems, according to the OECD. That does not only mean that these countries provide disabled people with higher incomes. This is a composite index including the regulation of benefits, benefit generosity, and the administration of disability benefits (where stricter administration is considered better). The duration of benefits entitlements is also included in the index (shorter duration is considered better), as well as are the amount of sick pay benefits and unemployment benefits in addition to the duration of such entitlements. Countries that provide generous benefits but have lax administration, by the standards of the OECD, do not score as high as benefit amounts would otherwise indicate.

[39] Source: OECD 2003, chapter 6 and appendixes. Appendixes I and II contain much of this information. Iceland has been evaluated using these same methods and inserted into the tables to facilitate comparisons. Tables in appendix II contain the outcomes for specific aspects while figure 11.2 presents the overall results.

Conversely, countries with low benefit amounts but strict administration of benefits can receive a high rating on this scale.

The countries furthest to the right in the figure have systems that are characterized by both generous benefits and strict administrative processes. These countries also have a relatively high number of disability benefits recipients, which can be interpreted as an indication of better services for the disabled (OECD 2003, p. 133). Sweden and Norway appear to have the best income support systems, according to this index. Sweden has the highest income security level for disabled people, as was shown earlier in this report (chapter 9.5).

The emphasis on social integration (especially employment) is rated on the other axis. The higher up that a country is on this axis, the more it pursues social integration. Denmark tops the list, followed by Germany, Sweden, and Norway.

In terms of both objective, social integration and income support, it is better to be as close to the top and as far to the right side of the figure as possible. The correlation between the two objectives in the figure indicates that countries with good income support systems tend to have good measures for social integration as well. Still, there are significant deviations such as Turkey and Mexico whose integrative measures tend to be underdeveloped while providing fairly generous pensions for those that have such entitlements. Denmark is also a deviant case as it places an unusually strong emphasis on active labour market policies (Högelund and Pedersen 2002; Kvist 2003), many of which were developed during the 1990s.

Korea, Canada, Turkey, Mexico, Italy and the United States are the countries with the worst outcomes in this comparison. These countries are either relatively poor or have underdeveloped welfare systems, or both. But this group of countries also include the affluent Anglo-Saxon countries, such as the United States, which are known for placing little emphasis on public welfare measures.

The evidence shows that Iceland scores slightly below the OECD average when it comes to income support and far below that same average when it comes to social integration. This combination of characteristics means that Iceland is among the nations that are somewhat behind in fulfilling the double objective of acceptable living standards and social integration. However, we should be careful when interpreting Iceland's

outcome on the social integration scale as it refers primarily to active labour market policies. Iceland has established a legal framework for many of the measures included in the index.[40] What Iceland lacks is effective vocational rehabilitation, effective measures supporting employment, and stronger financial incentives for disabled people to seek work.

The OECD index for income support is somewhat imprecise. Therefore we also consider the relationship between the earnings of disabled people, on the right axis in figure 11.3, and the OECD scale for social integration, on the left axis. This provides an important insight into the functioning of those aspects of the Icelandic welfare state that affect the living standards of disabled people. The numbers on earnings are the same as were presented in figure 9.8.

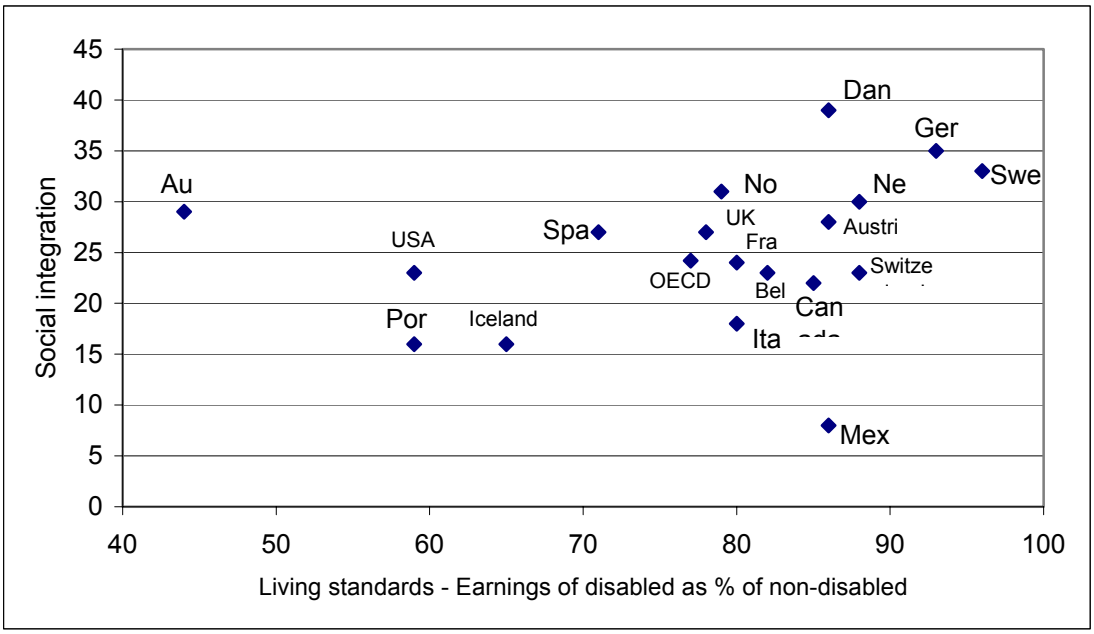

Figure 11.3: Earnings of disabled people and social integration measures for disabled people.

Sweden, Germany, Denmark, the Netherlands, Austria, and Switzerland have the best outcomes according to this measurement. The countries in which the earnings of disabled people are closest to those of the average earnings of other citizens also tend to emphasize employment measures for the disabled. However, Iceland has a worse

[40] E.g. Laws on Disability no. 59/1992 and ministerial directive on the employment of disabled people (195/1995)

outcome according to this measurement than the one presented in figure 11.2. This is because the earnings of disabled people as a proportion of the average earnings of all taxpayers aged between 25 and 66 are rather low in Iceland, in comparison to the other countries.

Iceland is well below the OECD average on both measures. Our outcome is similar to that of countries like the United States, Portugal, Australia, and Spain. There is a considerable difference between Iceland and the other Nordic countries. The evidence suggests that public policy and its implementation in Iceland lags far behind developments in the Scandinavian countries. Iceland is below the OECD average on both of the objectives currently emphasized by most Western countries, as measured by these scales.

Finally we present the OECD's classification of different disability systems (see tables in the appendixes). The OECD defines six groupings of nations. In academic research in this field it is more common that countries are sorted into 3-4 groupings. Nevertheless, the OECD classification corresponds closely with the classification most often used in academic research. The OECD classification is as follows:

- **The Anglo-Saxon model** (United States, Canada, Britain, Ireland). They have dual pension systems (social security or occupational entitlements). Disability rating is based on the medical model, i.e. on people's ability to do any type of work (does not depend on work experience or education), and administrative procedures are strict. Sick pay and disability benefits are small (generally lower than unemployment benefits). Entitlements to vocational rehabilitation are varied and inconsistent. So are disability rating procedures (the demand for vocational rehabilitation is not met). Employers carry a lot of responsibility. Support measures for the employment of disabled people are innovative (supported employment). Measures for vocational rehabilitation are weak. A strong emphasis on "forcing" people into the labour market by keeping disability benefits small and by providing addition incentives for employment (e.g. the earned income tax credit in the United States).

- **The Scandinavian model** (Denmark, Norway, Sweden, and also Finland). Everyone is entitled to disability benefits (based on citizenship). Disability allowances play an important role for those who do not have full work capacity. Disability ratings are strict and involve evaluation of work capacity. Disability benefits are generous and often granted on a permanent basis. There is a strong emphasis on measures supporting employment (subsidized work). Vocational rehabilitation is effective and people may be forced to join such programs, for

instance by depriving them of disability benefits (replacing them with rehabilitation benefits).

- **The German model** (Germany and Austria). Characterised by entitlements based on employment. Disability benefits are quite generous but usually only granted on a temporary basis. Disability rating is based on the ability to take up jobs that are similar to past jobs or the kind of jobs the person has been trained/educated to do. Employees retain their wages for some time during sickness. A strong emphasis on all kinds of employment measures and on vocational rehabilitation.

- **The Latin or the Catholic model** (France, Italy, Portugal, Poland, Spain, and Belgium). Dual disability benefits system (social security and occupational entitlements). Disability rating is based on a strict medical model but occupational entitlements are based on the capacity to do "one's own job". Employers have some responsibility. There is a strong emphasis on financial support for employment (also a strong emphasis on sheltered work in Poland). These countries tend to have limited measures for vocational rehabilitation, except Poland and Spain.

- **The Mixed model** (the Netherlands, Switzerland, and Australia). Everyone is entitled to disability benefits (based on citizenship). The means testing of benefits (curtailment of benefits because of other incomes) is prevalent in Australia and to some extent in the Netherlands. Partial benefits are available for fairly small reductions in work capacity. Measures to increase employment rates are integrated and well organized. Employers have considerable responsibilities in this area (less so in Switzerland) and there is a strong emphasis on sheltered work (less so in Australia). As this is a residual category there are considerable variations between the countries included in it. Consequently benefit amounts and measures for vocational rehabilitation vary a lot between them.

- **Underdeveloped welfare states** (Turkey and Mexico). Only few people are entitled to disability benefits. Sick pay and disability benefits are small. No measures to promote the employment of disabled people. No vocational rehabilitation.

We conclude that the Scandinavian welfare states are in many respects at the forefront of dealing with disability. Extensive reform is required in Iceland, both in the area of income support and in active integration policies, if Iceland wants to belong to the Nordic group of nations when it comes to supporting disabled and handicapped people.

XII. Conclusions

12.1 Disabled People and the Welfare State

Many disabled people are among those who live at the margins of society in the prosperous modern states. When physical and psychological limitations that prevent social participation interact with ignorance and prejudice towards the group, and with low incomes that limit the freedom of choice in market societies, the risk of social exclusion and isolation increases substantially. The disabled are therefore currently a special risk group. They are also a large and unusually diverse group. On average, about 14% of the population of Western countries suffer limitations that lead to some level of disability. Different welfare states vary in their approaches as well as in how well they meet the needs of the group. The disabled are covered through disability benefits systems, sick pay systems, accident insurance systems, through early retirement and through unemployment benefits.

The general goals of policies on disability tend to be twofold:

- To secure an acceptable minimum income level for the disabled that enables them to lead as ordinary lives as possible. This is usually taken to mean that the living standards of the disabled should be similar to the average living standards of the general population.
- The secure equal rights and social participation for disabled people in order for them to enjoy the benefits of family life, education, employment, markets for services and commodities, as well as of culture and recreation. This creates scope for a real diversity in society.

Icelandic laws on disability from 1992 establish that the objective of the government is to "secure equal rights for the disabled and living standards comparable to those of other citizens, as well as to create conditions that enable them to lead normal lives". This objective is in line with the twofold policy goal mentioned above, which are shared by most Western nations. The United Nations, the World Health Organization (WHO), the International Labour Organisation (ILO), the OECD, and the European Union have adopted these goals, as have many governments in the developed world.

It is interesting and important, in light of the objectives described above and the special circumstances of the disabled in modern societies, to analyse and explain the financial situation and the living standards of disabled people in Iceland. This is the main objective of this report. The subject is approached from an international comparative perspective.

There has been very little research on the disabled people in Iceland and it is important to amend that. Also, the unique position and the diversity of the disabled make them a very interesting group from a social scientific perspective. Furthermore, the disabled pose a special challenge for the modern welfare states, an acid test of the quality and the compassion of a society. If we take modern ideas about human rights, freedom, equality, and solidarity seriously then each member of society is entitled to the goods associated with these ideas. Everyone should be a full member of the national community and enjoy as equal opportunities as possible.

In contrast, those disable people who have lived closest to the margins of society have generally received less than their fair share of social goods. Many areas of social life have been closed off to them and the attitudes of other citizens have often been unable to accommodate the distinctiveness and the diversity of the disabled. It is thus an ambitious a far reaching task to organise society so as to accommodate everyone.

What is the disability situation like in Iceland? Have we been able to accommodate everyone? Have we made progress or are we standing still?

The welfare state plays a key role in achieving such objectives. Those countries that have more ambitious welfare systems tend to provide better support for this group. The Scandinavian countries have some of the most effective policies but other European countries have also been quite successful in various policy areas. In this report we focus on the aspects of the Icelandic welfare state that affect the disabled and ask how they compare to those in the neighbouring countries. We use public data from Western countries, survey data, and data on rights. In addition we gathered new data on the incomes of disabled people from tax reports. That data was processed by Statistics Iceland. We have also relied on other academic research publications.

In what follow we sum up the main conclusions.

12.2 The Causes and Characteristics of Disability

Two out of three disabled people become disabled because of illness or the consequences of illness, either in the short-term or long-term. The second largest group are those who become disabled through accidents. Those who are disabled from birth are usually less then 10% of the disabled. This means that disability is an event that occurs for most people while they are of working age. Two out of every three disabled persons are over 45 years old.

Disability is somewhat more common among women than among men in Iceland. It is also more common for those who have physically taxing and dangerous jobs than for those who enjoy "better" employment conditions and have higher earnings. The probability of disability rises with age. The disabled have lower levels of educational attainment than the general population. This is a consequence of the constraints they face, both because of their disability and because the education system does not accommodate to their special needs, meaning that education is simply less accessible to them. Most disabled people in Europe are married or cohabiting and a sizeable proportion has dependent children. This varies with both kind and degree of disability.

Approximately 40% of disabled people in Europe have a paid job, varying with the level of disability. About 25% of people with higher levels of disability, and nearly 50% of people with lower levels of disability, are employed. This description of disability in the European countries applies for the most part to Iceland as well.

12.3 The Prevalence of Disability

Approximately 14% of the working age population in Western countries suffers some disability. Not all of these people receive pensions from the welfare state. Somewhere between 5-7% of the working age population receive disability benefits and some disabled people receive sick pay, early retirement pensions, or unemployment benefits. About 6% of the working age population in Iceland receives disability benefits. On the other hand there are no general entitlements to early retirement in Iceland, and the sick pay system is very weak and the unusually low incomes that it provides for the long-term ill act as a deterrent. The unemployment benefits system and the municipal social services have also pushed

people indirectly (through incentives) towards the disability benefit system (Herbertsson 2005). This means that the disability benefits system in Iceland plays an unusually big role compared to similar systems in the neighbouring countries. Similarly, the sick pay system and related systems play an unusually small role. Other things being equal there should be far more people receiving disability benefits in Iceland than in the neighbouring countries. This is however not the case.

- In 2003 about 6,5% of the working age population in Iceland received some form of pensions (mostly disability benefits). This compares to 10,7% in Denmark, 11,7% in Finland, 10,2% in Norway, and 11,2% in Sweden.
- The Incidence of disability per 100.000 inhabitants is relatively low when compared to the European countries, according to figures from the WHO.
- The prevalence of disability per 100.000 inhabitants is also relatively low in Iceland when compared to the other European countries.
- The prevalence of disability began to rise considerably after 1980. This increase began to subside during the latter half of the 1990s, especially on account of various activation policies directed at the disabled.
- The increase in the prevalence of disability began later in Iceland than in the neighbouring countries, i.e. after 1990. That is the reason why the prevalence of disability has been growing faster in Iceland than in the other countries. Another reason is that Iceland is a laggard when it comes to developing activation measures for the disabled and other people who are inactive in the labour market.
- The biggest increase in the number of disabled people in Iceland occurs in the age-group between 40-49 years old, followed by 50-59 year olds, with 30-39 year olds in the thirds place. The number of disabled people within the youngest age-group (16-19 years old) has actually fallen from 1990 to 2002. The claim advanced by Herbertsson (2005) that the number of disabled people in the youngest age-group has been growing at an unusually high rate is simply wrong.

12.4 Explaining the Increasing Prevalence of Disability

Approximately 4,7% of the working age population in Iceland (16-66 years old) had disability status in 1962. That proportion went up to 5,1% in 1976, and by 1996 it had

reached 5,7%, correcting for the age composition of the population. Thus the prevalence of disability has grown slowly in Iceland over these decades. If we look at figures for specific years closer to the present we see that the prevalence of disability has grown from 3,5% in 1986 to almost 7% in 2004, i.e. it has doubled in little less than 20 years (not correcting for age composition). A part of this increase is the result of the rising average age of the population. A part stems from people with partial disability (50-65%) that have been transferred to full disability status (75% disability and above). Such transference increased temporarily, it seems, following the adoption of a new disability rating standard in 1999. There is no compelling evidence that it has become more difficult to refuse people status since the adaptation of the new standard. However, the new standard allows that people with demonstrable disabilities, who can nevertheless earn a living, be granted full disability status (75% or more). This does not mean that they receive full disability benefits as these benefits are greatly reduced because of incomes from other sources, by way of the prevailing income-testing rules.

The risk of disability because of specific disease has generally decreased or remained constant, but the risk of disability from mental illness has increased considerably after 1990. There has been an awakening amongst families of mentally ill people so that these people are now more likely to seek services from the welfare state than they were before. This explains a large part of the increase of disability prevalence after 1990.

It is also clear that the increase in the number of disabled people has neither been constant nor steady. It has varied a lot from one year to the next. For instance, the incidence of disability grew considerably from 1992 to 1995. It fell after 1995 and grew again from 2002 to2004. The incidence of disability fell again in 2005. These fluctuations call for an explanation. In this report we demonstrate that these fluctuations follow changes in the unemployment level closely. When unemployment grows (especially long-term unemployment) the incidence of disability grows shortly afterwards. When unemployment levels go down the incidence of disability falls as well. Higher unemployment levels, as well as heightened competition and new management practices, raise pressure in the labour market. Thus more pressure in the labour market must be included among the causes of higher disability rates. Finally it seems obvious that the disability benefits system doesn't

provide enough incentives for the disabled to seek employment, as was discussed in the chapter on employment participation.

When we sum up the conclusions of this report it is clear that the rising prevalence of disability can be explained by the following factors:

Causes of the Rising Prevalence of Disability

Explanatory factors:	What they explain:
• Population growth/population ageing	Explains gradual increase
• Awakening concerning mental illnesses	Increase over the last 10-15 years
• Increased unemployment	Fluctuations in incidence of disability
• Weakening of related pensions systems[41]	Gradual increases since 1990
• Increased pressure in the labour market	Gradual increases since 1990
• New disability rating standard	Transfers 50-75% disabled onto 75% disability
• Disability benefits too high relative to wages	No explanatory value

Herbertsson (2005) proposes six explanatory factors in his report for the Ministry of Health and Social Security. These are: 1. Changes in the age composition of the population; 2. More demands for profitability in the labour market; 3. Disability benefits too high relative to labour market incomes; 4. Insufficient incentives for the labour market participation of the disabled; 5. As disability benefits have risen more than unemployment benefits and municipal income support there is an incentive to seek disability benefits rather than the other kinds of pensions. 6. New disability rating standard since 1999 which has made it easier to grant more people disability status.

Explanations 1, 2, 4, and 5 advanced by Herbertsson are supported by the present analysis. On the other hand, explanations 3 and 6 are falsified. Herbertsson's theory that the maximum disability benefits have become as generous as to tempt able bodied with low incomes to drop out of the labour market is rejected on the grounds that the income gap between disabled people and people in the labour market has widened rather than narrowed. Furthermore, the disabled have fewer possibilities for earning an income than do other people. Consequently it is unlikely that life on disability benefits would tempt many people, even if the pensions/income gap had narrowed.

[41] Related systems refers to sick pay, municipal income support, and unemployment benefits. People who should be supported through these systems are often channelled into the disability benefits system. That was a growing trend over the last decade.

It must be added that Herbertson's explanation rests on the assumption that it is easy for able bodied people to get disability status. There is no evidence whatsoever that able bodied people are flocking into the disability benefits system. Refusals rates of applications for 75% disability status are very similar in 2001 and 2004 as they were in 1992 (Herbertsson 2005, p. 98-99), i.e. they are similar as they were before the number of applications for disability status began to grow in the wake of rising unemployment. This means that it is no more difficult to reject applications in 2002 with the new standard than it was in 1992 with the old standard. Thus it is not self-evident that the new disability rating standard is more lax when it comes to granting disability status. What the new standard has done, however, is to facilitate a higher disability rating for the partially disable, i.e. people with 50-65% disability are granted 75% disability status.

Of course it is important that the disability rating process is professional and rigorous, but we must also provide disabled people with good services so that those who have a demonstrable disability get an accurate rating and thereby become entitled to disability benefits. The risk that their living standards become "too good" is negligible, as pensions for this group fall as soon as incomes from other sources rise, due to the income-testing mechanisms in the Social Security system.

The causes of rising prevalence of disability since 1990 are thus multiple and natural. The prevalence of disability in Iceland, following the increase in recent years, is not unusually high. On the contrary, it is rather low compared to other European countries. The most important causal factors behind the increase are new attitudes towards mental illness as well as changing social circumstances (especially higher unemployment levels). Other causal factors explain slow and steady increases which have had less impact overall. It must be pointed out that recent reform of the unemployment benefits system, undertaken in connection with a review of collective wage settlements (kjarasamningar), will probably lighten the burden of the disability benefits system, as incentives to transfer from unemployment benefits to disability benefits are weakened.

12.5 Employment Participation

- Iceland generally has the highest employment rates of all Western countries. This also applies to people aged between 55 and 64 years old. In the

neighbouring countries that age-group makes up a large portion of disability benefits or early retirement pensions recipients.

- Overall the proportion of Icelandic people who receive disability benefits and unemployment benefits is lower than in any European country. This is in line with the unusually high employment participation rates in Iceland as compared to other European countries.

- A much smaller part of the population in Iceland is outside the labour market than in the other Nordic countries, or about 13% in Iceland compared to 21-26% in the other countries.

- The employment rates of disabled people in Iceland, however, are only about 38%, which is considerably below the European average. The disabled have higher employment rates in, for example, Scandinavia, as well as in North America and Switzerland.

- The employment rates of disabled people have fallen in Iceland between 1995 and 2004, especially among disabled singles and disabled single parents. This runs counter to the objectives adopted by most Western states, i.e. to increase the employment rates of disabled people.

12.6 The Financial Circumstances of the Disabled

Incomes

- The objectives established by the laws on disability from 1992 are that the living standards of handicapped and disabled people should approximate the average incomes of the general population. As the incomes of disabled people have generally been much lower than those of other citizens, they must rise faster than the incomes of the general population, if these objectives are to be met.

- Prior to 1995 social security pensions had been indexed to minimum wages. In 1995, however, this was changed to the effect that the minimum social security pensions have grown less than the wage index of Statistics Iceland and per capita disposable earnings.

- The basic social security pensions plus the income supplement (tekjutrygging) went down from 75% in 1995 to about 62% of minimum wages in 2004.

- The maximum disability benefit from the State Social Security Institute was highest as a proportion of the average wages, 53,7%, of the average for all taxpayers in Iceland in 1993. It was lowest in 2001 when it was approximately 41%. After that it rose to about 45% in 2004.

- The new age supplement means that the maximum disability benefits received by someone who becomes disabled at the age of 18-19 can reach 53,7% of average taxpayers incomes. Most of the people who benefit from the age supplement receive between 45 and 50% of average taxpayers' incomes.

- In Western countries it is generally estimated that disabled people require between 15-30% higher incomes than other citizen in order in order to be on equal level of living footing. This is because of additional costs for medicine, medical services, transportation, training, etc., that stem from their disability. Grants from the SSI covering such expenses are only approximately 4% of maximum disability benefits or close to 2% of average incomes in the country.

- The total incomes of disabled singles (social security pension, pensions from pension funds, and labour incomes) grew by about 110% between 1995 and 2004. At the same time the average incomes of all taxpayers grew by 119%. The total incomes of disabled single parent grew by 101,9% (current prices).

- The purchasing power of per capita disposable income in Iceland grew by approximately 50% between 1995 and 2004. The purchasing power of disposable incomes of disabled singles and married/cohabiting disabled people grew by almost 40% over the same period. The purchasing power of disabled single parents grew by nearly 30%.

- The incomes of disabled people have thus grown considerably less between 1995 and 2004 than the incomes of the general population in Iceland. The circumstances of the disabled have moved further away from the objectives about equalising their incomes with those of the general population, established by the laws from 1992

Income Differences

- In 2004 the total incomes of disabled singles amounted to 53% of the average total incomes of taxpayers aged between 25 and 65 years, down from 56% in 1995.

- The total incomes of disabled singles amounted to 64% of the average total incomes of all taxpayers in 2004.

- The total incomes of married/cohabiting disabled people amounted to 66% of average total incomes of all taxpayers in 2004, down from 73% in 1995.

- A disabled person with the average incomes of all disabled in 2004 (152.417 ISK, in total) required an increase of 78% to reach the average incomes of fully employed people. A disabled person who only had incomes from social security would require an increase of 158% to reach parity with the average fully employed citizen.

The Composition of Incomes

- In 2004, on average about 56% of the incomes of disabled singles came from the Social Security Institute, approximately 18% came from pension funds, and little over 15% came from paid employment.

- Disabled single parents have lower employment incomes and lower incomes from pension funds. They have higher incomes from other sources (child pensions, child benefits, etc.).

- Around 42% of disabled single persons had employment earnings in 1995. This percentage had fallen to 38,5% in 2004.

- Approximately 37% of disabled single parent had some employment earnings in 1995. This had fallen to 35% in 2004.

The Tax Burden of the Disabled

- The tax burden of the disabled has grown considerably from 1995. Furthermore, they receive less support though child allowance.

- The disabled with the lowest incomes paid no incomes taxes at the beginning of the period from 1995 to 2004. Now they pay considerable incomes taxes, mostly because the real value of the personal tax credit has decreased (the tax-free bracket).

- In 1995 7,4% of the incomes of disabled singles went to taxes. By 2004 this had risen to 17,1%. The tax burden rose each year except in 2002.

- The tax burden of married/cohabiting disabled people (which is affected by the incomes of their spouse) grew from 12,1% of their total incomes to 20% over that same period.

- Disabled single parents have a negative tax burden, i.e. they receive support from the tax system, mostly on account of child allowance and mortgage interest relief. In 1995 their support was 18,9% of total earnings but by 2004 it had fallen to 2,6%. This is the equivalent of a very sizable increase in tax burden.

- The tax burden of disabled singles grew on average by about 131,1% between 1995 and 2004. The tax burden is calculated as the total taxes of the disabled in proportion to their total earnings.

- In November 2005 an 18 year old single disabled person who receives maximum benefits from the SSI, but has no other incomes, can receive up to 127 thousand ISK per month (including the age-related supplement, 21.993 ISK). He receives 2.000 ISK more than a person in comparable circumstances before the age supplement was

introduced. Yet, without the age-related supplement his circumstances would be even worse than before, though his real improvement is only about 10% of the supplement.

- In November 2005, a 40 year old person, who has recently become disabled, whose incomes come solely from social security, receives at most 107.703 ISK from the SSI (his age-related supplement was 2.199 ISK). He pays a total of 12.315 ISK in taxes and thus retains 95.388 ISK.

This increase in tax burden over the last decade has therefore made the financial circumstances of the disabled considerably worse. Overall, the development of incomes between 1995 and 2004 has been unfavourable to the disabled. The objectives of the laws from 1992 have therefore not been met. The main reasons are that the social security pensions have not risen sufficiently and the tax burden of the disabled has grown considerably.

The Incomes of Disabled People - Comparative Perspective

- On average, in 1999 the mean incomes of disabled people in the OECD countries were 78% of the average incomes of the non-disabled (people of working age).

- The disabled had the highest incomes in Sweden, or approximately 96% of the average incomes of the non-disabled.

- Other countries where disabled people have relatively high incomes are Germany, Switzerland, the Netherlands, and Denmark.

- Disabled people have the lowest incomes in Australia (44% of the average incomes of the non-disabled), the United States (59%) and Portugal (59%).

- On average, the incomes of the disabled in Iceland are about 65% of the total incomes of all taxpayers aged between 25 and 64 years old. Iceland thus ranks low in the income ladder within the OECD.

Expenditures on Disability

- The disability benefits system has a relatively large role to play in Iceland, in comparison to the sick pay system and other parts of the welfare state. Yet expenditures on disability aren't unusually high in Iceland, as we might expect. Total expenditures on disability and related systems (sick pay and accident insurance) are well below the European average.

- If we focus exclusively on disability benefits we see that Iceland has had the lowest expenditures of all the Nordic countries for a number of years. As the prevalence of

disability has grown in Iceland its expenditures have moved closer to those of the other countries. Yet Iceland still had the lowest expenditures of the Nordic countries in 2003.

- The highest expenditures were in Norway and Sweden, 4,5-4,6% of the GDP, followed by Denmark, 4,1%. Expenditures in Finland were 3,5% of the GDP, and 3,4% in Iceland. In addition the other countries have additional expenditures on disability through other parts of their welfare states. Such expenditures are much lower in Iceland.

- Per capita expenditures (in Euros corrected for purchasing power) on disability were lower in Iceland than in the other Nordic countries from 1997 to 2003 (despite Iceland benefiting from a favourable currency exchange range, for the purpose of comparison).

- In 2001, the total expenditures on disability benefits in Iceland were approximately 2,8% of the GDP, or close to the EU average. Expenditures in Iceland had grown from 1,6% in 1990, but at that time they were far below the EU average.

- Icelandic public expenditures on sick pay were unusually low, as a large part of the people who would be supported through that system in other countries receive support through the disability benefits system. Expenditures on sick pay were about 0,1% of the GDP in Iceland in 1998. In comparison the expenditures were 0,7% to 1,5% of the GDP in the Scandinavian countries.

- On the whole it is safe to say that Iceland has low expenditures on disability compared to other European countries, as the disabled are neither very numerous nor are their pensions particularly generous.

12.7 Disability Policy

From Exclusion to Social Inclusion

- Considerable progress has been made in many Western countries in the last couple of decades when it comes to the rights of disabled people. They human rights situation has improved, partly because of clearer provisions in laws against discrimination in the labour market and in the wider society. The administration of disability policy has been changed, with a clearer division of labour when it comes to protecting the interests of the disabled and closer consultation with associations representing the interests of disabled people in implementing reforms. Furthermore, new approaches and more effective measures have been implemented to increase the social participation of the disabled, both in employment and in other spheres.

- An office of ombudsman for the disabled was established in Sweden some years ago. In Denmark they recently established an equal rights council for disabled people that

monitors the implementation of laws and reforms, in addition to proposing reforms on issues that affect the handicapped and the disabled.

- Brynhildur G. Flovenz, an Icelandic lawyer who has researched the legal status of disabled people in Iceland, argues that there are strong reasons to reform the administration of these issues in Iceland. Among important measures would be to strengthen the representation of disabled people in the public arena and separate it from the consultative role of the regional offices. Laws on access must also be strengthened by introducing a plan of implementation, with measurable indicators of achievements.

Active Labour Market Policies

- There are fewer disabled people receiving occupational rehabilitation in Iceland than in the other Nordic countries. There are between three and ten time more people of working age that are in some sort of occupational rehabilitation in the other Scandinavian countries than there are in Iceland.

- Iceland spent approximately 0,1% of its GDP on active labour market policies in 2001 while the other Nordic countries spend from 0,8% to 1,5% of their GDP on such measures, which benefit both the unemployed, the disabled, and other people who are outside the labour market. Such measures reduce the burden of the disability benefits system and improve the living standards and the incomes of the disabled.

- There is a legal framework for such measures in Iceland but the implementation of occupational rehabilitation is imperfect, fragmented, and lacks coordination. It is important to increase the options for occupational rehabilitation for the unemployed, the disabled and other people who suffer some form of disablement.

- It is also important to provide the disabled with stronger incentives to work by making employment more profitable by reducing the income penalty in the social security system, through tax incentives, or by other measures.

- It is important to strengthen the support system for the employment of disabled people, by helping them find jobs, support in the workplace, by subsidising labour costs, and through other measures that have been implemented in the neighbouring countries over the last decade. Supported employment in the regular labour market (AMS) should have priority over sheltered workplaces.

Which Country is the Best? – Evaluating Disability Policy in the OECD Countries

- In its appraisal of the situation of disabled people in Western countries in 2003 the OECD evaluated the quality and the implementation of public measures directed at the disabled. The evaluation was based on the twofold objective, of securing

sufficient incomes for the disabled and strengthening their social participation. This summary is based on that evaluation. In addition Iceland is evaluated according to the same standard. That evaluation is compared to OECD's conclusion (2003).

- Evaluation of the income support systems of the OECD countries covers the scope of disability pension's entitlements, rules and procedures for disability rating, as well as the characteristics of entitlements in related parts of the welfare system, such as sick pay and unemployment benefits. The evaluation of measures to increase social participation refers primarily to active labour market policies directed at the disabled. It is based on the administration of such measures, the evaluation of work capacity, the responsibilities of employer for implementation, and the scope of specific measures (support system for labour market participation, sheltered workplaces, the organisation of occupational rehabilitation, and the use of financial incentives to increase employment rates).

- Iceland scores slightly below the average of the OECD countries in this quality assessment of the income support system but far below the average when it comes to measures for social participation. Thus it seems clear that Iceland lags behind the neighbouring countries when it comes to the implementation of measures that increase the employment rates of the disabled, both when it comes to using financial incentives and in terms of direct support measures for employment.

- When we compare how successful the OECD countries have been in securing adequate incomes and social participation for the disabled the results are even worse for Iceland. In that evaluation Iceland performs at the same level as Spain, Portugal, and the United States, i.e. far below the OECD average on both measures. The other Nordic countries and some of the countries in continental Europe perform far better.

It is therefore clear that Iceland has not kept up with the developments in disability policy that have taken place in the neighbouring countries over the last ten years or so. There is a lot that remains to be done when it comes to improving the financial circumstances of the disabled and their social participation. There are good reasons to take legislative steps to secure the rights of this group, for example by implementing provisions for equal rights and against discrimination, by establishing an office of ombudsman or establishing an equal rights council for the handicapped and the disabled, as well as by reforming the administration of disability policy and increasing consultation with associations representing the interests of disabled people. It is most important to implement measures to raise the living standards and social participation of the disabled. There ought to be a plan of implementation with measurable objectives and regular status assessments, in order to monitor whether we

are making progress towards the established goals. It is sensible to seek cooperation between public and private actors when implementing such reforms.

There are no reasons why a country as prosperous as Iceland should provide a worse living for the disabled, relative to fully employed people, than the other Nordic countries and the countries in continental Europe, i.e. countries that in many cases are less prosperous than Iceland. It is unacceptable that members of this group are forced to become regular customers of charitable organisations because of limited support from the welfare state. Furthermore, the curtailment or reductions of benefits once people have incomes from other sources means that there are rapidly diminishing returns from employment for the disabled. Such curtailments often operate as a poverty trap, in this case within the welfare system itself. This must be changed in order to increase the employment rates and social participation of the disabled. It is also important to establish and strengthen measures to support the participation of disabled people in the labour market.

Not enough progress has been made on issues concerning the disabled in Iceland over the last decade, neither in terms of financial support nor social participation. Decisive reforms are needed to bring the circumstances of disabled people in line with the circumstances of comparable groups in similarly prosperous countries. Iceland should aspire to be on equal footing with the other Nordic countries within 5 years.

Appendix I

Rights and Disability Policies
in Iceland and other OECD-Countries

Table 1: Regulations on sickness and disability benefit levels[42]

	Maximum disability benefit level	Sickness cash benefit level
Australia	Means-tested flat-rate benefit depending on family status, benchmarked at 25% male average earnings (most household income sources are considered, but with generous thresholds)	Means-tested flat-rate benefit depending on family status, about 87% of the disability benefit (no statutory benefit duration)
Austria	60% of covered pensionable earnings, remaining years partially credited	100% of earnings for 6-12 weeks (subject to contract duration), then 60% of covered earnings (up to 52 weeks in total)
Belgium	40% of lost wage if single between small minimum-maximum margin, else 65% (i.e. remaining years implicitly credited); flat-rate benefit for self-employed	100% of earnings in first month (one waiting day), manual workers 86% except for first week then 60% of earnings (singles 55%) and flat-rate benefit with 3-month waiting period for self-employed (one year in total)
Canada	Around 30% of covered earnings at average income up to CAN$ 935 per month, consisting of a flat-rate basic amount and 75% of the corresponding retirement pension (with dependant's supplements)	55% of weekly insurable earnings, with a family supplement for low income earners (up to 15 weeks in total)
Denmark	Flat-rate benefit with several components (some of which own income- or also partner income-tested) depending on disability, age and marital status – up to about 150% of average income maximum	Up to about 100% of maximum unemployment benefit – i.e. 88% of the highest disability benefit – depending on wage and contractual working hours (up to 52 weeks within any 18-month period)
France	50% of covered earnings (i.e. remaining years implicitly credited), 30% for partial disability, low income supplement	50% of earnings, possibly topped up by collective agreements, raised to 66.66% after 30 days if three or more children (up to three years in total)
Germany	58% of pensionable lifetime earnings, remaining years partially credited	100% of earnings for up to six weeks, then 70% of covered earnings (up to 78 weeks in total within each 3-year period)
Iceland	Means tested flat rate benefits that are determined according to family circumstances. Indexed to consumer prices (since 1995; indexed to minimum wages before that). The income threshold is low and some components of the pensions do not have an income threshold at all. Those who contribute to occupational pension funds accumulate entitlements to disability pensions from such funds. Such pensions curtail disability benefits to some extent. The most common benefits are 60% of minimum wages, and in 2005 the maximum social security benefits were approximately 99% of the minimum wages of labourers, but only about 56% of the average earnings of the fully employed.	Fixed amount, 876 ISK per day, or little over 26.000 ISK per month, or nearly 25% of the minimum labour wages (2003) or approximately 10% of average earnings of the fully employed (2004). Granted if a person has been unable to work for three weeks, from the 15th day of being absent from work. After entitlements to wages during illness have expired (usually after 1-3 months) the worker can apply for support from the sick pay funds of his labour union. These entitlements vary between unions.
Italy	80% of pensionable earnings (defined-contribution), remaining years credited for full benefit only, minimum pension offered	50% of last earnings (with 3-day waiting period which may be covered at 100% via collective agreements), increased to 67% after day 20 (up to 180 days in total)
Korea	Mature system: 60% of covered earnings, remaining years not credited; currently: 30% of earnings; minimum also 30%	No sickness cash benefit programme (for work-related sicknesses, covered by work injury scheme, 70% of earnings)
Mexico	40.25% of pensionable earnings regardless of age and contribution period, with family supplement of 15% of the benefit	60% of earnings with 3-day waiting period (up to 52 weeks, or 78 weeks if incapacity remains beyond the first 52 weeks)

[42] The material in these appendices is from OECD (2003), *Transforming Disability into Ability*, and the description for Iceland is prepared by the author of the present report.

Netherlands	70% earnings for up to 3-6 years, subject to age (for first year usually topped up to 80-100% through collective agreements); thereafter partly calculated in relation to minimum wage, i.e. reduction depending on age and wage; flat-rate benefit for self-employed and youth handicapped	70% of earnings, which is for nearly all employees topped up by collective agreements to 100% of net wage (for up to 52 weeks)
Norway	Around 65% covered earnings with average income (considerable redistribution); supplementary payments via collective agreements common for higher incomes	100% of pensionable income (up to 52 weeks); self-employed either 65% or, with additional voluntary coverage, also 100%
Poland	76% of pensionable earnings (57% for a partial benefit), remaining years credited but with reduced accrual rate	80% of earnings, topped up in some collective agreements (100% if work-related or if pregnant), generally 100% from day 91 onwards (up to six months in total)
Portugal	80% of pensionable earnings (or up to 92% according to the new formula); remaining years not credited, but minimum of 30% and absolute minimum (65-100% of minimum wage) subject to work record	65% of earnings during first year (waiting period of three days for employees, 30 days for self-employed and other voluntarily insured), and 70% thereafter (for up to three years in total)
Spain	85% of last eight years' earnings (i.e. remaining years implicitly credited); and 47% for own occupation disability	51% of last eight years' earnings (3-day waiting period, topped up in some collective agreements), increased to 64% after first three weeks (up to 12-18 months in total)
Sweden	Around 70% covered earnings with average income (considerable redistribution); plus almost universal coverage with occupational pensions	80% of earnings (one waiting day), generally topped up by another 10% via collective agreements (benefit payable for an unlimited period, but usually about one year)
Switzerland	Around 60% of covered earnings (public first pillar, which guarantees subsistence income, plus mandatory second pillar); a means-tested supplement can be granted for those with a half or a full disability benefit	Generally 80% of previous earnings, both for continued wage payment (between three weeks and six months subject to contract duration) and for private insurance (up to 720 days in 900-day period)
Turkey	60% of average earnings in last five years (i.e. remaining years implicitly credited)	67% of earnings for out-patients, 50% for inpatients (2-day waiting period), 100% for Civil Servants (up to 6-18 months in total)
United Kingdom	Flat-rate benefit (but not means-tested) paid at three different rates; long-term rate 20-25% average earnings (plus family supplements), first six months 75% and second six months 89% of that	Flat-rate benefit paid at the middle rate disability benefit (3-day waiting period); supplemented by occupational sick pay up to full wage, which is operated by 85% of employers (up to 28 weeks in total)
United States	Around 35-40% of covered earnings at average income up to US$ 1,700 per month (plus supplements for dependants and free Medicare coverage)	100% of wage via leave accrual plans (for a very short period), 50-70% with up to 7-day waiting period via temporary disability benefits (up to 13-52 weeks in total)

Table 2: Regulations on coverage of public disability-related benefit schemes

	Sickness cash benefits	Contributory or earnings-related disability benefits	Non-contributory disability benefits
Australia	Non-contributory means-tested scheme for those employed or in full-time education above age 21	No such system	Universal means-tested programme (residents currently present in country); ten years of residence for pre-arrival disability
Austria	All employees	Labour force plus voluntarily insured with five years of contribution in last ten years (more if over age 50, less if under age 27); former labour force with 15 years	No such system (only ordinary means-tested social assistance available)
Belgium	Labour force with minimum amount of contributions and 6 months of insurance, including 120 days of paid or credited work and insurance in the last quarter		Own- and partner's income-tested income supplement for those over age 21
Canada	Employees with 600 hours insurable earnings in last 52 weeks	Labour force with four years of contribution in last six years (more flexible in Quebec)	No federal system; special means-tested benefit in three provinces, otherwise general social assistance
Denmark	Labour force with (generally) 120 hours of work in last 13 weeks	No such system	Universal "pre-pension" programme (residents aged 18-65); main components are not income-tested
France	Employees and unemployed with work record of 800 hours in last 12 months; 200 hours paid work in last three months for sick pay entitlement for the first six months; special scheme for self-employed		Means-tested supplemental allowance below certain income thresholds
Germany	All employees	Labour force plus voluntarily insured with five years of contribution, three of which in last five years	No such system until now; new means-tested system for fully disabled persons as of 2003
Iceland	Employees are entitled to retain their wages during illness for 1-3 months (depends on tenure, 3 months after 5 years with the same employer). People over the age of 16 who have been resident in Iceland over 6 months are entitled to sick pay benefits through social security (for 52 weeks every 2 years). Many workers are entitled to support from labour union sick pay funds once they stop receiving wages.	Everyone in the labour market who has been employed for at least 2 years and has experienced a loss of income on account of disability (minimum 50% disability). Mandatory insurance. Contributions are credited if a person has 3 years of contributions over the last 4 years (minimum 6 months over the last year)	Everyone at ages between 16 and 67 that has been resident in the country for a minimum of 3 years. Full basic pensions are only granted after 40 years of residence. No premiums. Depends on disability rating. Means tested benefits that are cut when people receive incomes from other sources.
Italy	All employees	Labour force plus voluntarily insured homemakers with five years of contribution, three of which in last five years	Own income-tested benefit for Italian residents and EU citizens with longer-term resident card
Korea	No such system (some collective agreements, e.g. for government officials)	Employees with one month of contribution	Means-tested disability allowance for severely or multi-disabled persons
Mexico	Employees and unemployed with four weeks of contribution preceding illness	Employees with 250 weeks of contribution (150 weeks if 75% incapacitated)	No such system
Netherlands	All employees and unemployed	Labour force without requirements, self-employed with 52 weeks contribution	Youth handicapped persons without requirements (not means-tested)

Norway	Entire labour force	Universal (all residents aged 18-67 with three years of residence or contribution)	(non-contributory component for those people not in the labour force)
Poland	Employees with 30 continuous days of insured employment	Labour force with five years of contribution if over age 30 (less if younger); special scheme for farmers	Social pension for youth handicapped persons not covered by any other system (not means-tested)
Portugal	Employees with six months of insurance, including 12 days of insured work in last four months (voluntary insurance for self-employed)	Self-employed and employees with five years of contribution (special schemes three years, voluntarily insured six years)	Own and partner's income-tested benefit for persons in a situation of need and over age 18
Spain	Labour force with 180 days of contribution in last five years (no minimum for work injuries/ accidents)	Labour force with five years of contribution, one-fifth (full) or half (partial) of which in last ten years; former labour force with 15 years, one-fifth of which in last ten years	Means-tested benefits for those not meeting the contribution requirements
Sweden	Entire labour force	Universal (all residents aged 16-65 with three years of residence or contribution)	(non-contributory component for those people not in the labour force)
Switzerland	No public system; continued wage payment for employees plus voluntary private insurance	Universal (resident or working in the country), with one year of contribution	Extraordinary benefit if less than one year of contribution (not means-tested)
Turkey	Employees with 120 days of contribution in last 12 months	Employees with 1 800 days of contribution, or five years at 180 days each, or with old-age pension entitlement	Means-tested benefit for needy, frail and destitute persons not covered by social insurance
United Kingdom	Employees with contract for more than three months (currently about to change to all employees); access to short-term incapacity benefit if fulfilling conditions shown in next column	Labour force with six months paid contribution in last three years and 12 months paid or credited contribution in last two years	(1) non-contributory severe disablement allowance until 2001; (2) means-tested income support (i.e. social assistance) with special disability premiums
United States	No public system; temporary disability insurance in six states, relatively broad coverage with employer-provided programmes (e.g. short-term disability benefit)	Labour force with 5-10 contribution years in last ten years if over age 31 (less otherwise); youth handicapped can become eligible with three-year work period	Means-tested supplemental security income for blind and disabled people with no or low income

Table 3: Regulations on re-testing of disability benefit entitlements

	Type and frequency of re-testing of benefit entitlements
Australia	Temporary; medical review every two or, usually, five years; randomised review of income and assets via a questionnaire on changes since last review
Austria	Temporary for up to two years (repeated renewal), continuation of payment if no health improvement; permanent if 100% disabled (about 20-25% of the inflow)
Belgium	Granted indefinitely, with flexible examinations (in most cases, several control examinations); after three years usually permanent
Canada	*de facto permanent*
Denmark	Permanent if rehabilitation failed (no re-tests)
France	Temporary subject to flexible re-evaluation
Germany	Temporary for up to three years if reasonable prospect for improvement, with repeated renewal; partial entitlements that are paid as full benefits because of poor labour market (concrete labour market perspective), always temporary
Iceland	Benefits granted permanently by the SSI, when disability is obviously permanent and severe (applies to approximately 50% of disabled people). Others get temporary assessment and are subject to review every 1-5 years if work capacity is expected to increase over time. It is possible to require recipients to engage in rehabilitation before benefits are granted.
Italy	Permanent for full permanent disability; up to three years, temporary for partial benefit, i.e. partial disability (after six years benefit becomes permanent)
Korea	Flexible; periodic review of not completed diseases
Mexico	Temporary for renewable periods (with periodical examinations in the first year) if there is recovery potential; usually permanent after two years
Netherlands	Temporary up to maximum of five years; regular re-tests but – due to lack of personnel – generally only via questionnaire to the benefit recipient
Norway	Basically permanent; no regular review of the disability status (work ability improvement could only be derived from tax authorities' income records)
Poland	Flexible (depending on chances of improvement), temporary benefits withheld after expiration of payment period (beneficiary must provide new evidence)
Portugal	Permanent but not definitive, i.e. re-test every three to ten years, although by an evaluation commission – revision test – is possible any time (and common after three years on sickness benefit)
Spain	Permanent, but for temporary disability a long-term sickness benefit can be paid for up to 30 months (after that, benefit becomes permanent)
Sweden	Flexible but de facto mostly permanent; a temporary benefit can be awarded for long-lasting but non-permanent incapacities
Switzerland	*de facto permanent but re-test every three to ten years, although possible any time (either on request of the benefit recipient or ex officio)*
Turkey	Permanent
United Kingdom	Generally temporary as long as the personal capability assessment threshold is met; review frequency assessed at each new assessment
United States	In most cases de facto permanent, but subject to continuing disability review (but authorities have to prove that health conditions have improved)

Table 4: Regulations on the definition of disability and on waiting periods

	Definition of disability	Mandatory waiting period
Australia	Two criteria: having a disability that results in a score of at least 20 points on the impairment tables, and continuing inability to work 30 hours or more a week or be re-skilled for work at full wages within the next two years	None (but mandatory waiting period of ten years for people who acquire their disability before moving to Australia)
Austria	50% work-capacity reduction (earnings-capacity reduction for unskilled workers); critical role of court decisions due to imprecise legal definition	None, but health restriction must have lasted six months
Belgium	66.6% earnings-capacity reduction in the usual occupation	One year
Canada	Severe and prolonged disability that prevents doing any work on a regular basis	None
Denmark	50% work-capacity reduction (over age 50, such reduction can be due to social reasons only)	None, but rehabilitation must be completed
France	66.6% earnings-capacity reduction, but full benefit also requires loss of work capacity	None, if condition has stabilised, but often only after three years
Germany	25% work-capacity reduction; partial disability determined in relation to hours a person can work (0-3 hours or 3-6 hours)	None, but disability must have lasted 26 weeks
Iceland	75% reduction in work capacity entitles people to full disability benefits. Requires a minimum score on a disability rating standard (the same as is used in the UK). 50-65% reduction in work capacity entitles people to disability allowance, which is substantially lower, or approximately 20% of full disability benefits.	None, but it is possible to stipulate rehabilitation before granting benefits.
Italy	66.6% work-capacity reduction (for partial benefit referring to suitable job)	None
Korea	Medical criterion (four precisely defined degrees of disability)	Waiting period of about 50 days (sickness benefits not available)
Mexico	50% earnings-capacity reduction in previous job	None
Netherlands	15% earnings-capacity reduction (25% for self-employed and disabled youth); degree of disability determined as the wage in job matching the functional limitation relative to pre-disability wage	One year
Norway	50% work-capacity reduction; but earnings-capacity reduction determines the benefit level	None (after completion of proper vocational rehabilitation)
Poland	Temporary or permanent work-capacity reduction (for benefit for partial disability referring to the usual occupation)	None
Portugal	66.6% earnings-capacity reduction in the usual occupation	None, but in practice usually after three years (end of long-term sickness)
Spain	33% work-capacity reduction in usual occupation for a partial lump sum benefit; inability to carry out “usual”/”any” work for “total”/”absolute” disability	One year (but earlier claiming for clearly permanent cases possible)
Sweden	25% work-capacity reduction; degree of partial disability determined in relation to daily hours a person can work (0-2/2-4/4-6 hours)	None (after proper vocational rehabilitation)
Switzerland	40% earnings-capacity reduction; for inactive persons, degree of disability is determined in relation to the current activity (e.g. housework or education)	One year
Turkey	66.6% work-capacity reduction, with a strong medical focus	None

United Kingdom	Limitations in everyday activities that are relevant to work (i.e. predominantly medical “personal capability assessment”); but own occupation test for first 28 weeks (sickness benefit receipt)	28 weeks
United States	Earnings-capacity reduction: inability to engage in substantial gainful activity (i.e. to earn US$ 740 per month)	Five months (not always covered by short-term benefits), and 24 months period for Medicare coverage

Table 5: Description of the assessment procedure for disability benefit claims

	Medical assessment	Benefit decision-making	Vocational assessment
Australia	Medical reports by treating doctors; with independent medical examinations in 65% of all cases	Single Centrelink officer based on a prescriptive set of criteria	Impairment tables refer to work in general; labour market conditions considered in assessing whether persons aged 55 and over can be re-skilled for work in the next two years
Austria	Team of insurance doctors; privately submitted medical certificates have no effects	Responsible insurance officer (in local or central insurance office)	Strict own-occupation assessment for skilled workers and unskilled workers over age 50
Belgium	Insurance doctor (in addition to follow-up of nominated reporting doctor)	Medical commission of insurance authority (decision by central commission)	Reference to equivalent worker
Canada	Insurance staff (doctors and nurses)	Single insurance officer	All jobs (own occupation for age 60-64 in Quebec)
Denmark	Treating doctor and assessing specialists contracted by the municipality	Caseworker of the municipality	Any job; rehabilitee has influence on vocational plan
France	Insurance doctor	Team of experts at the insurance authority	Reference to previous earnings (but not as regards remaining work capacity)
Germany	Social-medical consultants; through examination or on basis of medical files (e.g. after in-patient treatment); treating doctor's certificate taken into account but usually not sufficient	Insurance officer assesses the impact on work capacity and verifies availability of a part-time job (on the local labour market) in case of partial disability	Own-occupation assessment abolished 2001, except for cohorts born before 1961; concrete labour market view (full benefit granted if proper part-time work is not available)
Iceland	The State Social Security Institute physician. Based on a certificate by a doctor, a questionnaire, and evaluation by the SSI doctors.	The SSI physician.	Assessed by the SSI, though the SSI can turn to private parties (physicians contracted for such work)
Italy	Specialised insurance doctor	Assessment team (head doctor monitors all assessments)	Suitable job for partial, any work for total incapacity
Korea	Consulting doctors committee of the National Pension Corporation	Officer of the National Pension Corporation	All possible jobs taken into account
Mexico	Insurance doctor (based on a table of percentages for specified diseases)	Insurance officer	Strict own-occupation assessment (referring to pre-disability job)
Netherlands	Insurance doctor assesses functional limitation	Doctor together with vocational expert	All jobs theoretically available (though rehabilitation is voluntary)
Norway	Treating doctor (consulting doctors can be involved)	Regional officer based on assessment by local officer	Any job; actual labour market conditions may influence evaluation of return-to-work possibilities
Poland	Single certified social insurance doctor	Insurance officer in one of the regional divisions	Any job for full disability, commensurate job for benefit for partial disability
Portugal	Reporting doctor appointed by regional social security centre	Verification commission (three technically independent experts)	Reference to one's usual occupation
Spain	Team of experts at the insurance institute	Provincial director of insurance institute on basis of recommendation issued by disability evaluation team	Usual occupation for partial (33%) and total disability, any occupation for absolute and severe disability

		(which is a separate body)	
Sweden	Insurance doctor on basis of medical files (other experts can be involved)	Insurance officer	Any possible occupation (normal job has priority)
Switzerland	Treating doctor; increasing involvement of additional medical experts	Interdisciplinary team at the cantonal disability authority	Job with reasonable income; relates to theoretical balanced labour market
Turkey	Reports issued by medical boards or health commissions of health establishments or hospitals	Insurance officer in the headquarters of the insurance authority	Refers to any work
United Kingdom	Treating doctors provide medical evidence; PCA by contracted and approved medical services doctors	Non-medical personnel in the local benefits agency	Own occupation in first 28 weeks; any occupation in PCA for disability benefit
United States	Treating doctors or consulting doctors	State disability officers (work in teams, usually not medical doctors)	Substantial gainful activity is related to any work that exists

Table 6: Age-specific regulations in the disability benefit programme

Selected regulations that affect age groups in different ways

Australia	Benefit level: years until retirement irrelevant (means-tested and flat-rate); availability of suitable jobs effectively taken into account for persons aged 55 or above as a consequence of different eligibility criteria
Austria	Benefit level: remaining years only credited until age 56; own-occupation assessment: covers also unskilled workers over age 55
Belgium	Benefit level: years until retirement implicitly fully credited, because number of insurance years is not taken into account
Canada	Benefit level: years until retirement implicitly fully credited, because number of insurance years is not taken into account; assessment: own occupation perspective for persons between 60 and 65 (only in Quebec)
Denmark	Benefit level: years until retirement implicitly credited, because number of insurance years is not taken into account, and slightly reduced benefit for those who have the pension awarded over age 60 (not eligible for pre-pension supplement equal to 7.5% of maximum benefit); assessment: for persons over age 50, eligibility is created by work-capacity reduction induced by severe social problems
France	Benefit level: years until retirement implicitly fully credited, because number of insurance years is not taken into account (and supplement tops up low income)
Germany	Benefit level: remaining years until age 55 fully credited, plus one-third of the period 55-60; own-occupation assessment for cohorts born 1960 or earlier
Iceland	In 2004 an age related supplement was introduced for people with 75% disability. The amount is the same as for the basic pension component of disability benefits (21.993 ISK in 2005). Falls to 95% of that amount if a person is 20 years old when becoming disabled, and by further reductions for every 2 years above that. If a person is 40 years old when becoming disabled the age related supplement falls to 10% and 5% at the age of 44, and 3% (550 ISK) if people become disabled after the age of 49. Intended to raise the living standards of those disabled at a young age.
Italy	Benefit level: years until retirement fully credited for full benefit, but not credited for partial benefit, hence, majority of new claimants rely on minimum pension
Korea	Benefit level: years until retirement age not credited, entitlement to basic benefit if less than 20 insurance years (30% replacement rate at average earnings)
Mexico	Benefit level: years until retirement implicitly credited, because number of insurance years is not taken into account
Netherlands	Benefit level: wage-related duration of benefit payment, with 70% of earnings, increases with age – from ½ year if age 33-37 to three years if age 53-57, six years if age 58 and until age 65 if 59 or older; similarly, reduction of benefit level during subsequent period, in which benefit is partially related to minimum wage, declines with age – at average earnings, the reduction would be about 35% if age 30 but only about 10% if age 55
Norway	Benefit level: remaining years until age 67 (statutory retirement age) are fully credited if coverage conditions are met
Poland	Benefit level: years until retirement credited as non-contribution years, i.e. with accrual rate of 0.7 rather than 1.3%
Portugal	Benefit level: years until retirement not credited, hence, most younger claimants will receive (earnings-related or absolute) minimum
Spain	Benefit level: benefit for total own occupation disability increased by 20% if aged 55 or older; years until retirement implicitly fully credited, because number of insurance years is not taken into account
Sweden	Benefit level: remaining years until age 65 (statutory retirement age) are fully credited if coverage conditions are met
Switzerland	Benefit level: years until retirement are fully credited, and in addition for younger benefit applicants (i.e. under age 45) a career factor is added to the reference income, which gradually declines from 100% if under age 23 to 5% if 39-44
Turkey	Benefit level: years until retirement implicitly fully credited, because contribution record is not taken into account
United Kingdom	Benefit level: years until retirement implicitly credited, because number of insurance years is not taken into account (flat-rate benefit)
United States	Benefit level: years until retirement implicitly credited, because number of insurance years is not taken into account (only income during insured period)

Table 7: Regulations on disability-related benefit suspension and work incentives

	Benefits suspensions	Other work incentives
Australia	Up to two years in case of full-time work	Part-time work is compatible in line with means-test conditions (no benefit cuts below the "free area" of AUS$ 200-230 per month; only above 70% average earnings entire benefit is foregone)
Austria	Not possible; and no incentives to resume the original occupation	Work in a different job permitted (benefit cut of 30-50% above certain ceiling)
Belgium	Up to three months for trial work; sickness benefit suspension for up to 14 days	Some additional income allowed
Canada	Possible without time limitation; "fast track" re-application process	Three months paid work trial without loss of benefits
Denmark	"Letting the pension rest" is possible during trial work and vocational rehabilitation	Special in-work supplement for people with at least two-thirds reduced vocational ability if foregoing the disability benefit
France	Not possible	Income up to pre-disability level (in first six months even above) allowed
Germany	Up to six months; immediate resumption if trial work unsuccessful for health reasons	Benefits (also partial benefits) compatible with work beyond pre-disability earnings: benefit may be reduced to ¾, ½ or ¼
Iceland	Generally not possible to suspend benefits, but earnings from other sources curtail benefits automatically because of extensive means-testing	The means-testing of disability benefits reduces work incentives as labour incomes do not raise the earnings of disabled people above benefit amounts, unless these other earnings are substantial
Italy	Not possible	Partial benefit fully compatible with earnings up to four times the minimum pension, and partially also with higher earnings
Korea	Not possible	Earnings totally irrelevant for benefit entitlement
Mexico	Not possible	Work in a different occupation does not affect the benefit
Netherlands	Up to three years during periods of work	Benefit payment continued for up to six months with trial work
Norway	Up to three years for trial work; sickness benefit suspension in rehabilitation phase	Low additional income allowed
Poland	Not possible	Benefit for partial disability fully compatible with earnings up to 70% of average wage, and partly with earnings up to 130%
Portugal	Only in case of sheltered work	Earnings allowed up to reference wage (with subsidy for contributions payments up to this level of income)
Spain	Not possible	With partial or total own occupation disability benefits, work in different job suitable for health condition is allowed
Sweden	Up to three years during trial work (only one year without new application); wage subsidy suspension up to three years; sheltered work break up to one year	Limited additional income allowed
Switzerland	Not possible	Income up to pre-disability level allowed
Turkey	Not possible	Disability-related benefits not compatible with work; income tax abatement for workers with disabilities (granted according to three levels of work-capacity reduction)

United Kingdom	Up to one year to try work (linking rules) and up to eight weeks during first 28 weeks (i.e. short-term incapacity); two years if entitled to disabled person's tax credit	Benefit compatible with work of less than 16 hours per week (permitted work rules; since April 2002, permission by a doctor no longer required)
United States	Extended period of eligibility of three years during which benefits are paid for each month with earnings below substantial gainful activity (SGA) if medical condition has not improved; application within five years without new waiting period	Full benefit during trial work period up to nine months (which can be spread over five years); full Medicare coverage during extended period of eligibility plus three more months

Table 8: Attempts to prevent benefit application: some policy examples

	Measures aimed at preventing sickness and disability benefit application
Australia	Disability reform package: tighter eligibility criteria, clearer benefit structure (1991); tightening of assessment process for disability and sickness benefits, revised impairment tables (1998); introduction of independent work capacity assessments (2002); planned: tightening of eligibility criteria (mid-2003)
Austria	Disability benefits granted temporarily (1996); special early retirement due to reduced work capacity abolished (2000); work income reduces benefit (2001)
Denmark	No direct application for disability benefits but only for social benefit, i.e. municipality decides whether disability benefit could be appropriate (1998) together with reduced reimbursement rates for municipalities (1990s); stricter review of sickness status (1997); planned: abolition of partial disability benefit (2003)
Germany	Work income reduces benefit (1996); disability benefits always granted temporarily, own-occupation assessment abolished for cohorts born after 1960 (2001)
Iceland	Disability benefits from social security have grown less than the minimum wages since 1995. The taxation of disability benefits has grown considerably since 1995. It is not clear whether this development was intended to reduce applications for disability benefits. Employers are responsible for sick pay during the first few weeks of illness. Greater demands that recipients undergo rehabilitation.
Italy	New partial disability benefit (about 90% of inflow) which is granted temporarily, without crediting of remaining years (1984), work capacity criterion replaces earnings-capacity criterion, own-occupation assessment (except for partial benefit) and concrete labour market perspective abolished (also 1984); no combination of disability and work injury benefit for the same cause (1995)
Netherlands	Concrete labour market perspective abolished (1987); disability benefits granted temporarily, own-occupation assessment abolished, long-term benefit level reduced subject to age, review of benefit stock below age 45 with reclassification in 30% of all cases (1994); responsibility for sickness benefits partly (1994) and later on fully shifted towards the employer (1996), with private re-insurance; introduction of experience-rated premium rates for disability benefits (1998)
Norway	Tighter medical criteria for disability benefit receipt and for statements of treating doctors, abolition of own-occupation assessment, higher demands on regional mobility (1991); tighter medical criteria for sickness benefit receipt, judgement from insurance authority required after 12 weeks on sickness (1993); however: 1991 regulations on tighter medical disability benefit criteria had to be largely annulled after a verdict of the Social Security Court (1995)
Poland	Sickness costs shifted partly to the employer, harmonisation and reduction of sickness benefit level (1995); new disability assessment procedure with new criteria and clearer responsibilities, stricter handling of temporary entitlements (1997); better control of sickness status (1999)
Portugal	Implementation of the Verification of Permanent Incapacity System (1987); extension to sickness status assessment (1992); creation of the Verification of Incapacity System with a new assessment of disability and sickness status with more objectivity and consistency (1997)
Spain	Contribution requirements for disability benefits increased (1986); stricter control of sickness status, reduction of long-term sickness benefit level, usual occupation replaces own job assessment (1997)
Sweden	Employer has to cover first 14 days of sick leave (1992); labour market reasons as basis for disability benefit entitlement over age 60 abolished, one waiting day for sickness benefits introduced (both 1993); tighter medical criteria including abolition of the so-called elderly rules, i.e. milder enforcement for older disability benefit applicants (1997)
United Kingdom	Responsibility for sickness benefits shifted towards the employer (1986) with reimbursement rate reduced to 80% (1991) and abolished altogether (1995), though with private re-insurance; reduction in contributory benefit level through abolition of the earnings-related component (1995); tighter disability benefit access through a new all work test (1995) which was later replaced by personal capability assessment (2000)
United States	Reduced replacement rate, greater use of continuing disability reviews (1980) but tighter administrative control had to be relaxed after political outcry (1984)

Table 9: Important aspects of the unemployment benefit scheme

	Unemployment benefit level	Unemployment benefit duration
Australia	Means-tested flat-rate benefit, identical to sickness benefit, i.e. about 87% of the disability benefit (depending on family status)	No time limit; payable as long as actively seeking work or satisfying an activity test (exemptions from activity test for periods of temporary illness or incapacity)
Austria	55% of covered previous net income (with flat-rate supplements for dependants), means-tested unemployment assistance 92-95% of the preceding benefit	Minimum 20 weeks, increases to 30/39/52 weeks if employed during 3/6/9 years in last 5/10/15 years and over age –/40/50; then unlimited unemployment assistance
Belgium	55% of former earnings (60% with dependants) in first year, thereafter reduced to 44% if single (no reduction if household head with dependants)	Indefinite duration regardless of insurance period; if sharing a household with other income sources present, benefit reduced to 22% of the minimum (flat-rate)
Canada	55% of weekly insurable earnings, with a family supplement for low income earners (identical to sickness benefit)	Up to 45 weeks, depending on individual employment history and regional unemployment rate
Denmark	90% of wage up to a certain maximum (which is about 88% of the maximum disability benefit), minimum for full-time employees 82% of this maximum	Up to four years; during the benefit period (one year or, if under age 25, six months), no requirement to accept job offers, during activation period jobs must be accepted
France	57.4% of former earnings (or 40.4% plus flat-rate amount) in initial period, reduced in steps for each further six-month period (but not lower than 70% of minimum), income-tested unemployment assistance	7-60 months subject to contribution period and age (< 50/ > 50), divided in two periods; then unlimited unemployment assistance if worked five in last ten years, higher benefit if age 55/57.5 and insured 20/10 years
Germany	60% of covered previous net income (67% with a dependent child), means-tested unemployment assistance 53%/57%	Minimum six months, 12 months with two years employment in last seven years, increases up to 18/22/26/32 months if fulfilling contribution requirements and age 45/47/52/57; then unlimited unemployment assistance
Iceland	Fixed amount set by the government. Supplement for dependent children. In 2003 the amount was 73.000 ISK, or approximately 30% of the average earnings of fully employed people	recipient must be actively seeking employment. Must have been in paid employment for at least 10 weeks during the last 36 months.
Italy	30% of earnings (7-day waiting period); but up to 80% through special unemployment schemes (e.g. in industrial crisis)	Usually 180 days, sometimes up to one year; special schemes have a longer duration, usually around two years
Korea	50% of last wage	90-240 days depending on age (under 30, 30-49, 50 +) and insurance period (maximum with ten or more insurance years); generally 240 days if disabled
Mexico	No unemployment insurance; labour law requires employers to pay dismissal indemnity, which is a lump sum of three months pay plus 20 days pay for each year of service	
Netherlands	70% of last wage up to a maximum; follow-up benefit, which is not means-tested, equal to 70% of minimum wage (or 70% of last wage if this is less than that)	Benefit period depends on age and employment record in last five years – gradually increasing from six months to five years (if age 58); follow-up benefit for a further period of two years (or until age 65, if age 57½ when becoming unemployed)
Norway	62.4% of last year's income	Up to three years, if income exceeds two times the base amount (and for all persons over age 64), otherwise one and a half years
Poland	Flat-rate (but not means-tested) depending on employment record: 80/100/120% of PLN 446.7/month with < 5/5-19/20 + years	Varies with local unemployment rate: below average six months, above average 12 months, twice the average rate and 20 years of employment 18 months

Portugal	65% of earnings (between one and three times minimum wage), means-tested flat-rate social unemployment benefit 80% of minimum wage (100% for a family)	12-30 months, depending on age (30 months over age 45), followed by social unemployment benefit for half of this duration; if not entitled to contributory benefit, means-tested benefit for 12-30 months
Spain	70% of earnings (60% after 180 days) within 75% and 170% of minimum wage (100%/220% with dependent children); means-tested non-contributory unemployment benefit 75% minimum wage	Up to 720 days maximum with six contribution years; non-contributory benefit usually payable for 6-18 months (various groups, e.g. contributory benefit exhausted and children, no contributory benefit, over age 45 with additional conditions, over age 52)
Sweden	80% of daily earnings up to a maximum (5-day waiting period) for regular benefit, flat-rate 40% of this maximum for basic benefit (i.e. not fulfilling insurance criteria)	Up to 300 days, or 450 days if age 57-64 (for both basic and regular coverage)
Switzerland	80% of covered earnings with dependent children or low earnings or if disabled, and 70% otherwise (5-day waiting period)	150 days if under age 50, 250 days if age 50-59, 400 days if age 60 or over, and 520 days if recipient of partial disability benefit
Turkey	50% of daily net earnings up to net minimum wage	180-300 days, depending on days of contribution (300 with 1,080 contribution days)
United Kingdom	Flat-rate benefit payable at three rates: similar to low-rate disability benefit if age 25 or over, 80% of that if age 18-24, 60% of that under age 18 (3-day waiting period)	Up to 182 days in any job-seeking period, irrespective of length and level of contributions, followed by means-tested jobseeker's allowance up to 100% of the regular benefit for unlimited period
United States	About 50% of wage (state-specific insurance with some differences)	Up to 4-26 weeks (in two states 30 weeks) depending on labour force attachment in first four of last five quarters; possibly followed by extended benefit programmes or emergency benefits

Table 10: Overview on characteristics of early retirement schemes

	Important features of (the) early retirement programme(s)
Australia	As of age 55, i.e. 10/6.5 years earlier for men/women, via mandatory funded occupational pension scheme (superannuation guarantee) if permanently retired; as of age 60 with special unemployment allowances and no recent work experience (mature age allowance and partner allowance, which are being phased out and will be closed to new entrants mid-2003)
Austria	3.5 years before statutory age with either i) long insurance record (37.5 years) or ii) long-term, i.e. one year, receipt of unemployment or disability-related benefit in last 15 months and 20 insurance years in last 30 years
Belgium	Pre-pension supplement to unemployment benefit if age 58, eligible for unemployment benefit, made redundant and having 25 years of employment
Canada	Five years earlier with reduced benefit (only for the earnings-related component, not for the universal basic flat-rate benefit)
Denmark	Seven years before statutory age of 67 via voluntary early retirement insurance with 25 years unemployment fund membership and – with mature scheme – 30 years with special contribution payment (note: part of the equally voluntary unemployment insurance, with special contributions introduced in April 1999)
France	No option in public scheme (statutory retirement at age 60), but more generous rules for older unemployed workers; various private bridging-pension schemes
Germany	Two years earlier with long insurance record (35 years); five years earlier if i) long-term, i.e. one year unemployment in last 78 weeks or 24 months elderly part-time and 15 insurance years, or ii) women with 15 insurance years and ten contribution years after age 40, or iii) severely disabled and 35 insurance years
Iceland	Early retirement is not available in Iceland. This creates pressure for the long-term unemployed older workers and the partially disabled to apply for disability benefits.
Italy	No age limit for seniority pension, which required 35 insurance years or many fewer years in public sector (currently increased to 40 years, or 35 years and age 57, and phased out altogether by 2010)
Korea	Five years earlier (statutory age currently 60 years) with ten years of contribution
Mexico	Five years earlier with corresponding benefit (from individual accounts) if 1,250 weeks with contributions (new system for those entering the labour force in 1997); ten years earlier with 15 years of service for public employees
Netherlands	No early retirement in the public pension scheme; typically five years earlier according to collectively bargained regulations which cover 70% of all employees and 100% of all civil servants
Norway	No early retirement in the public pension scheme (except for special age limits for certain professions); five years earlier according to the collectively agreed AFP programme if currently employed, 10 years of contribution since age 50, and income exceeding two base amounts (covers 60% of the working-age population)
Poland	Five years earlier for women with 30 years of insurance, war veterans, recipients of a work injury or disability benefit; special ages for certain professions; no age requirement if unemployed with 35/40 years of insurance (women/men); pre-retirement unemployment pension with an employment record of 25/30 years
Portugal	Flexible retirement ten years earlier with 30 years registered earnings with benefit reduction; five years earlier if long-term unemployed (ten years earlier with 20 years registered earnings, with benefit reduction); special age limits for certain professions; ten years earlier non-permanent pre-retirement (can precede early retirement if in business in crisis situation)
Spain	Five years earlier with considerable actuarial reduction (with 15 insurance years); one year earlier if employer concludes replacement contract; special ages for certain professions; special arrangements in some collective agreements
Sweden	Old system: advance retirement five years earlier with reduced benefit, or partial retirement four years earlier; new system: flexible retirement, also with reduced benefit (contribution-defined), up to four years earlier
Switzerland	Advance retirement 1/2 years earlier (for women until 2004/for women as of 2005 and for men) with reduced benefit in the first pillar, and up to five years earlier in the second pillar, also with a reduced benefit
Turkey	Statutory age 50/55 for women/men with minor contribution requirements; no age limit with 25 years of insurance (average age at retirement of 47-48 years, currently being phased out and mandatory retirement ages re-introduced)
United Kingdom	No early retirement in the public pension scheme; advance retirement via voluntary occupational schemes or also voluntary permanent health insurance (the latter usually provides a bridging-benefit of 50% salary for a period of ten years after retirement on ill-health grounds)
United States	Advance retirement three years earlier with reduced benefit (with ten years covered employment); up to ten years earlier in many private pension plans (defined-benefit or defined-contribution) with certain service requirements

Table 11: The legislative framework shaping employment promotion

	Most important legislation influencing employment of disabled people
Australia	(1) Commonwealth Disability Discrimination Act: rules out dismissal on the grounds of a person's or his/her associates' disability, defines standards in employment; (2) Disability Services Act: outlines the rules on disability service provision (supported employment, vocational rehabilitation); (3) Workplace Relations Act: regulates employment subsidies in the open labour market
Austria	(1) Disabled Persons Employment Act: mandatory employment quota for registered disabled people, dismissal (after first six months of a new contract) only with the consent of a regional committee for disabled persons; (2) Austrian Constitution: general non-discrimination article
Belgium	(1) Social Rehabilitation Act, which formed the basis of new legislation promoting equal opportunities in each of the communities; (2) Labour Legislation: rules out discrimination in hiring on the basis of, among other things, disability
Canada	(1) Canadian Charter of Rights and Freedoms: guarantees equal rights before and under any legislation without discrimination on the grounds of disability; (2) Canadian Human Rights Act and provincial human rights acts: regulate employer obligations; (3) Employment Equity Act: requires that the composition of the federally-regulated workforce reflects the population composition
Denmark	(1) Social Model of Disability: principle of compensation (disabled people have to be compensated by society to enable the use of their abilities) and principle of sector responsibility (every sector of society is responsible for its own matters); (2) generally, policy is based on voluntariness and information
France	(1) Disabled Persons Orientation Act: promotion of equal opportunities for people with disabilities; (2) Employment of Disabled Workers Act: mandatory employment quota for disabled people, longer notice period for dismissal
Germany	(1) Severely Disabled Persons Integration Act: mandatory employment quota for severely disabled persons, dismissal (after six months of contract) only with approval by the public welfare office, various employer obligations; (2) Social Code: social right of integration (legal basis for rehabilitation); (3) new law on equality of opportunity for people with disabilities (effective as of May 2002)
Iceland	1) Ministerial directive on the employment of disabled people. Based on the right of disabled people to work, according to the laws from 1992. Entitlements to supported work. No quotas for disabled employees. General entitlements to rehabilitation. 2) Constitution: Discrimination against disabled people is not explicitly forbidden, though general provisions against any kind of discrimination are held to apply to disabled people
Italy	(1) Framework Law on the Assistance, Social Integration and Rights of Disabled People: lays down (integration) policy principles and prescribes a series of rights; (2) Regulations for the Right to Work of Disabled People: mandatory employment quota for registered disabled people, disability up to 60% and work-disability up to 33% does not constitute grounds for fair dismissal
Korea	(1) Act on Employment Promotion and Vocational Rehabilitation of Disabled Persons: prohibits discrimination, minor mandatory employment quota for disabled people; (2) Labour Standard Act: dismissal only with justifiable reason; (3) Welfare of Disabled Persons Act: prohibits discrimination by employers and employment protection institutions
Mexico	(1) Federal Labour Law: states the right to work and protects all workers from unjustified dismissal; (2) Organisation of American States Convention for the elimination of all forms of discrimination by disability (recently ratified)
Netherlands	(1) Re-integration of Disabled Workers Act: aims to prevent labour market outflow of disabled employees and regulates employer responsibilities; (2) Dutch Civil Code: rules out dismissal because of sickness for a period of 2 years
Norway	(1) Working Environment Act: regulates employer obligations towards disabled employees; (2) Anti-Discrimination Act: prohibits discrimination on grounds of disability
Poland	(1) Vocational and Social Rehabilitation and Employment of Disabled Persons Act: mandatory employment quota for registered disabled people; (2) Labour Code: rules out discrimination in employment relations by reason of disability
Portugal	(1) Basic Act on Prevention, Rehabilitation and Integration of Disabled People: defines national policy, aims to ensure implementation of constitutional rights; (2) Portuguese Constitution: same rights and obligations for disabled people, dismissal without a justified cause prohibited; (3) Act which defines the role of the Institute of Employment and Vocational Training (support to promoters of programmes for the vocational rehabilitation of disabled people)

Spain	(1) Act on Social Integration of Handicapped Persons: mandatory employment quota, special protection to former employees receiving disability pension; (2) Workers Standing Rule: prohibits discrimination against disabled job applicants; (3) Spanish Constitution: provision on non-discrimination
Sweden	(1) Discrimination Act: prohibits discrimination against disabled people in working life; (2) Working Environment Act: regulates employer obligations; (3) Act on Support and Services for Persons with Functional Limitations: regulates obligations of the municipalities and counties
Switzerland	(1) (New) Swiss Constitution: general anti-discrimination clause; (2) generally, the system is not based on legal mandates but on voluntariness and incentives
Turkey	(1) Labour Law: mandatory employment quota for disabled people; (2) Regulations on Employment of Disabled Persons: criteria for definition of disability
United Kingdom	(1) Disability Discrimination Act: protects disabled people in all aspects of employment, prohibits dismissal for reason of disability, mandates mainstreaming of services (to be fulfilled by employers with at least 15 employees)
United States	(1) Americans with Disabilities Act: prohibits discrimination against qualified individuals with disabilities in all aspects of the employment process (to be fulfilled by employers with at least 15 employees); (2) Rehabilitation Act (to be fulfilled by federal government and organisations receiving federal funding): empowers people with disabilities, ensures that federal government plays a leadership role in promoting employment of disabled people

Table 12: Details on (mandatory) employment quota schemes

	Quota	Fulfilment	Sanction	Use of levy
Australia	–			
Austria	4% (with double counting), public and private employers with over 25 employees	64% of all quota places filled; one in four employers fulfils entire quota	Levy of € 200 per month for each place not filled (0.4% of payroll)	Employment programmes for disabled persons and/or their employers
Belgium	2-2.5% in public sector, no quota for private sector	rather high	–	–
Canada	–			
Denmark	–			
France	6% (with double counting, *e.g. in first two years* of contract), public and private sector with over 19 employees	67% of all quota places filled; four in ten employers fulfil entire quota and more than one in three disregards it	300-500 times hourly minimum wage, 25% penalty for failure to pay (€ 150-250 per month, 0.45-0.75% of payroll)	Training, job retention and employment measures for disabled people, run by a statutory body (AGEFIPH)
Germany	5% (double/triple counting), public and private employers with over 19 employees	57% of all quota places filled; one in eight employers fulfils entire quota and one in three disregards it	€ 100-250 per month for each place not filled, depending on fulfilment (0.25-0.65% of payroll)	Range of integration services for disabled people (55% managed by provinces, 45% by ministry)
Iceland	No quotas. Disabled people have precedence for public sector jobs, if they are at least as qualified as other applicants	Regional offices can require a written explanation if they suspect disabled applicants have been discriminated against	–	–
Italy	7% for public and private sector with over 50 workers, one / two places for 15-35/36-50 employees	no statistics since new law was introduced (2000), but about 50% of quota fulfilled during 1986-1998	€ 52 per work day (€ 1 075/month) for each place not filled (one-fourth if no appropriate candidate (4% or 1% of payroll)	Regional programmes for disabled people (i.e. regional funds)
Korea	2% for public sector and private sector with over 300 employees	72% fulfilment in public, 46% private sector; one in six employers fulfils entire quota	65-75% of minimum wage, depending on fulfilment ($ 324 per month for each place not filled, 0.5% of payroll)	Employment promotion projects for disabled people (subsidies, equipment, guidance, research)
Mexico	–			
Netherlands	Legal authorisation to impose a quota system as ultimate solution			
Norway	–			
Poland	6% (double/triple counting) for private employers with at least 25 full-time employees; 2% for public sector	limited available data indicate a quota fulfilment of around 33%	Levy of 40.65% of average wage per month for each place not filled (2.4% of payroll)	Rehabilitation and employment programmes for disabled people, run by a special state fund (PFRON)
Portugal	5%, but only for new recruitment in public sector	–	–	–
Spain	2% for private sector with over 50 employees and entire public sector	25% in private and 30% in public sector (non-fulfilment seen	No sanctions; obligation to report disabled employees	Employment activities carried out by NGOs and non-profit

		as serious offence)	and verification by labour inspection bodies	organisations
Sweden	–			
Switzerland	–			
Turkey	3% for public and private sector with over 50 workers	no statistics on quota fulfilment available	$ 410 per year for each place not filled (around 0.2% of payroll)	Almost only vocational rehabilitation and training measures
United Kingdom	(3% quota for employers with over 20 workers abolished 1996)	(rapidly declining quota compliance until 1996)	–	–
United States	–			

Table 13: Major obligations for the employer

	Regarding work	Regarding rehabilitation	Regarding sick pay
Australia	Employer obliged to accommodate work or workplace, unless this would impose unjustifiable hardship (rigid interpretation of the term "unjustifiable")	No employer obligations	Continued wage payment during first days of sick leave (5-8 days per year for blue-collar, 8-20 days for white-collar workers)
Austria	Take the state of health of disabled employees into account (no sanctions, but considered in dismissal procedure); contribute "reasonably" to the adaptation of the workplace	No employer obligations	Continued wage payment for 6-12 weeks (depending on length of employment); no re-insurance possibility
Belgium	Only for some high-risk sectors of the economy: reassign or adapt job after absence of four weeks due to illness or accident	No employer obligations	Continued wage payment for one month for salaried employees; manual workers: 100% in 1st, 86% in 2nd, 26% in 3rd/4th week
Canada	Duty to accommodate workplace conditions (i.e. eliminate discrimination resulting from a rule, practice or barrier) except for cases of undue hardship (with fines in case of non-compliance)	No employer obligations	no employer obligations, i.e. no period of continued wage payment
Denmark	None; emphasis on encouraging social responsibility of employers (social index, social accounting)	No employer obligations	Continued wage payment for two weeks (if employed for 13 weeks, and no increased risk of sickness); longer periods (collective agreements) with sickness benefit reimbursement
France	Guarantee ease of access (to work, toilet, eating facilities), should adapt work station; adapt work or working time for victims of work injuries/accidents	No employer obligations	no obligation, but several collective agreements top up low sickness benefits
Germany	Provide employment according to skills and abilities, preferential selection for training within company, support to attend training elsewhere, examine vacancies for potential for disabled persons	No employer obligations	Continued wage payment for first 6 weeks; without re-insurance possibility
Iceland	No employer obligations	No employer obligations	Continued wage payments for 4-12 weeks, depending on tenure with current employer
Italy	Assign equivalent tasks or lower-graded tasks but under old conditions, make necessary adaptations to work organisation	No employer obligations	No obligation, but several collective agreements bridge the waiting days
Korea	Should – with technical guidance – offer employment in line with abilities (but no sanctions)	No employer obligations	Collective agreements can include regulations on sickness-related payments (e.g. government officials)
Mexico	No employer obligations	No employer obligations	No employer obligations, i.e. no period of continued wage payment

Netherlands	Rehabilitation obligation can include work accommodation and working hours reduction; prohibition of medical checks during hiring process	Employer ought to submit a plan on rehabilitation measures after 13 weeks of sick leave (only minor sanction, most employers do not feel responsible); responsibility remains for entire first year as long as employee may be able to return to the employer	Sickness benefit payment during entire 52-week period (except for work disabled persons during first five years of employment), but employers can re-insure with a private insurer; obligation to contract with sickness absenteeism management service
Norway	Ensure suitable work (but dismissal possible after 6-12 months), arrange work conditions in general so as to enable employment of people with disabilities	No employer obligations	Continued wage payment during the first 16 days
Poland	Ensure workplace accommodation and access; for work injuries: arrange for suitable workplace if employee declares readiness to return to work	Disabled employees have a right to special breaks for rehabilitation exercises	Sickness benefit payment during first 35 days
Portugal	Only for work injured: adapt workplace, offer compatible job and part-time work	Again, only for work injured: offer vocational training and leave to train for other employment	No obligation; moreover, topping up sickness benefits is not permitted
Spain	Former employees on disability benefit who recover have absolute priority for filling a suitable vacancy; or (after partial benefit) must be offered same or similar job, possibly with up to 25% reduced wage	During promising rehabilitation process, employer must keep post for two years	Sickness benefit payment from day 4 to day 18
Sweden	Provide reasonable suitable accommodation if the employee or job applicant is sufficiently qualified (e.g. purchase tools and change working environment, work organisation, work tasks and working hours); provide, if possible, a different, job in the company	Employer is responsible for submitting a rehabilitation analysis to the regional insurance office within first eight weeks of sickness also for repeated short-term sickness (no sanctions, only 35% do so); and for taking rehabilitative measures that can be conducted in the company(not against the will of the employer, and again no sanctions)	Continued wage payment during the first 14 days (except for first day)
Switzerland	No employer obligations (protection against dismissal during period of continued wage payment)	No employer obligations	Continued wage payment at reduced level (80% of the wage) for between three weeks and six months, subject to contract duration
Turkey	Work-injured workers are given a priority right; civil servants have the right to ask for a suitable job	No employer obligations	Continued wage payment for civil servants borne by state as employer
United Kingdom	Employer has to make reasonable adjustments, e.g. adjust premises, reallocate duties, alter working hours, provide different workplace, modify equipment, provide supervision (mostly financial and compensatory sanctions)	No employer obligations except for allowing rehabilitation absences	Sickness benefit payment during entire 28-week period (reimbursement possible where costs exceed 13% of total social security contributions), but employers can re-insure with a private insurer

United States	Provide reasonable accommodation (e.g. adjust equipment, make facilities accessible, modify work schedules) unless this would be undue hardship(sanctions include, e.g. back and front pay, attorney fees, accommodation, re-instatement, job offers)	No employer obligations	Voluntary employer-paid benefits like leave accrual plans(paid sick leave up to 12 days per year or balance of 6-12 weeks, paid time off up to 20 days per year or balance of 4-6 weeks) or short-term disability benefits (cover first 13-52 weeks)
Portugal	Only for work injured: adapt workplace, offer compatible job and part-time work	Again, only for work injured: offer vocational training and leave to train for other employment	No obligation; moreover, topping up sickness benefits is not permitted
Spain	Former employees on disability benefit who recover have absolute priority for filling a suitable vacancy; or (after partial benefit) must be offered same or similar job, possibly with up to 25% reduced wage	During promising rehabilitation process, employer must keep post for two years	Sickness benefit payment from day 4 to day 18
Sweden	Provide reasonable suitable accommodation if the employee or job applicant is sufficiently qualified (e.g. purchase tools and change working environment, work organisation, work tasks and working hours); provide, if possible, a different, job in the company	Employer is responsible for submitting a rehabilitation analysis to the regional insurance office within first eight weeks of sickness also for repeated short-term sickness (no sanctions, only 35% do so); and for taking rehabilitative measures that can be conducted in the company(not against the will of the employer, and again no sanctions)	Continued wage payment during the first 14 days (except for first day)
Switzerland	No employer obligations (protection against dismissal during period of continued wage payment)	No employer obligations	Continued wage payment at reduced level (80% of the wage) for between three weeks and six months, subject to contract duration
Turkey	Work-injured workers are given a priority right; civil servants have the right to ask for a suitable job	No employer obligations	Continued wage payment for civil servants borne by state as employer
United Kingdom	Employer has to make reasonable adjustments, e.g. adjust premises, reallocate duties, alter working hours, provide different workplace, modify equipment, provide supervision (mostly financial and compensatory sanctions)	No employer obligations except for allowing rehabilitation absences	Sickness benefit payment during entire 28-week period (reimbursement possible where costs exceed 13% of total social security contributions), but employers can re-insure with a private insurer
United States	Provide reasonable accommodation (e.g. adjust equipment, make facilities accessible, modify work schedules) unless this would be undue hardship(sanctions include, e.g. back and front pay, attorney fees, accommodation, re-instatement, job offers)	No employer obligations	Voluntary employer-paid benefits like leave accrual plans(paid sick leave up to 12 days per year or balance of 6-12 weeks, paid time off up to 20 days per year or balance of 4-6 weeks) or short-term disability benefits (cover first 13-52 weeks)

Table 14: Approach to vocational rehabilitation

	Approach to vocational rehabilitation
Australia	Voluntary (except for unemployment beneficiaries and people with injuries acquired in the workplace or through motor vehicle accidents); services can include initial needs assessment, disability management and post-placement support; eligibility assessed on the basis of severity of disability (with required minimum of 50 Work Ability Tables), impact on work capacity, and potential to gain from a programme; Centrelink, the government's key social service centre, refers potential clients to providers; services are delivered and access determined by the Commonwealth rehabilitation provider, which receives government funding under an annual service level agreement with predefined performance targets and reporting requirements, and under a new quality assurance framework; there are no established programme guidelines for voluntary vocational measures; intervention possible any time (e.g. at the client's request, during benefit receipt or review), but acceptance into a programme unlikely during sickness benefit receipt
Austria	Compulsory (benefit claim treated as a request for vocational rehabilitation) and also a right; aims to restore or improve the work capacity of the insured; implemented if present job cannot be resumed but prospect that another job commensurate with the person's qualifications can be carried out; persons are eligible who meet or are soon likely to meet the requirements for a disability pension; far-reaching training and occupation measures (can include university curriculum); operated by insurance authorities in collaboration with the labour market service and financed by insurance contributions; secure benefit income (disability pension or special transitory allowance)
Denmark	Compulsory for access to systems run by the municipalities, i.e. disability benefits as well as subsidised jobs and sheltered employment; entitlement, which requires possibility for full or partial self-reliance, settled by a caseworker in the municipality (based on medical and vocational information); recently, encouragement of voluntary primary rehabilitation within firms; rehabilitation process consists of pre-rehabilitation phase (clarify vocational aim, draft vocational plan) and rehabilitation phase; implemented according to the principle of "the earlier the better" after stabilisation of medical condition, but possible when already on disability benefits; secure benefit income (special rehabilitation benefit if not entitled to any other benefit); municipalities' cash expenses reimbursed from the federal budget at a rate of 50% (compared with 35% for disability benefits)
France	Optional; financed by sickness/disability insurance bodies and offered by specialised centres for vocational rehabilitation; eligibility assessed by COTOREP, the departmental commission for assessing work capacity (but stabilisation of medical condition required); strong incentives to enrol due to generous rehabilitation benefit (100% of former salary up to a ceiling, or 30% of ceiling if not previously employed)
Germany	General right for all disabled people – without any restrictions – to the extent this is necessary to maintain, improve or restore work capacity and secure integration into the labour market; quasi-compulsory (agreement of the disabled person required, but benefit suspension possible); early intervention and efficient and prompt implementation; far-reaching measures; financed and operated by insurance authorities and the federal labour authority (which is responsible for co-ordination); also health insurance has to check the necessity for vocational rehabilitation before, during and after medical rehabilitation; secure benefit income (usually special transition or education allowance)
Iceland	Rehabilitation is not mandatory, but the Social Security Physician can require people to undergo rehabilitation before granting benefits. Everyone has the right to apply for rehabilitation, but demand for rehabilitation is not being met. A task group with the SSI estimates the likelihood of success of rehabilitation and determines which rehabilitation measures should be used. The SSI makes service contracts with parties running rehabilitation measures. The Reykjavik Office of Disability is contracted for supported employment. Vocational rehabilitation falls under the purview of three different government ministries and there is a serious lack of coordination and integration of measures. Social security employment contracts are intended to facilitate the employment of disabled people, e.g. subsidised work. There is a fund that covers some of the costs for work place adaptation. There is sheltered work for severely disabled people. There are rehabilitation benefits (equal to basic disability benefits and the income supplement) for up to 18 months during rehabilitation. Employment measures are generally inadequate.
Netherlands	Voluntary programme because work motivation is seen as vital factor for success, but disabled person is expected to follow the rehabilitation plan; early intervention should (in theory) be assured and offered by the employer, who has to prepare a rehabilitation plan after 13 weeks of sickness and who keeps responsibility during the entire one-year sickness benefit period; rehabilitation plan has to be approved by the national institute for social insurance, which becomes responsible after the first year (i.e. also for all those people who have been granted a disability benefit), or earlier if the disabled person is not able to return to the employer or if the employer does not assume responsibility; consequently, attendance of vocational rehabilitation programmes often starts only in the second year; the plan is implemented by the national institute,

	but contracted out to private service providers, which are currently being created
Norway	Not mandatory, but in principle rehabilitation should be tried before benefit award; everybody classified as vocationally disabled (definition of the public employment service – PES) or eligible for social security benefits (social insurance definition) is eligible for vocational rehabilitation; PES bears responsibility for setting up an individual training plan and for funding vocational rehabilitation; traditionally implemented before disability benefit award, but increasingly both early intervention for people with shorter sickness spells – with suspension of sickness benefit – and also late intervention for people on disability benefit; secure benefit income (special allowance if no other benefit entitlement)
Poland	Voluntary, but a right; meant to help disabled persons – who are registered as unemployed or as job-seekers – to get adequate employment and promotion at work through vocational counselling, training (up to 36 months) and job placement services; includes special assessment of inability to work; financed from contributions to compensatory levy fund and other state budgets; secure benefit income (training pension) during six months up to a maximum of 36 months
Portugal	Voluntary, although legislation favours vocational rehabilitation before compensation pay; far-reaching programmes offered by various public and private institutions; accessible for everybody (with strong focus on mainstreaming); eligibility assessed by expert teams in the Institute for Employment and Vocation Training (IEFP); vocational training typically divided into three phases: pre-training (up to one year), training/qualification (up to two years) and apprenticeship in an enterprise (up to one year); usually offered after receipt of sickness benefits (i.e. often at a rather late stage); secure benefit income through training allowance of 70% of minimum wage (in addition to other benefits)
Spain	Compulsory for persons entitled to disability-related benefit (payment conditioned on follow-up of plan); insurance authority responsible for determining a recovery plan and programme, and funding, with early intervention; special subsidy (75% of sick pay) available to workers on sick leave not entitled to sick pay; rehabilitation services voluntarily accessible by other groups (funded from government revenues, responsibility of public employment service and social services)
Sweden	Compulsory, i.e. disability pension cannot be granted if there is still a possibility that the person will be rehabilitated; training must also be accepted for inferior jobs; eligibility only requires that the person be considered in need of rehabilitation by the national insurance office; employer is responsible for submitting a rehabilitation analysis, while the national insurance office is responsible for funding, making a rehabilitation plan and co-ordinating various measures; vocational rehabilitation is usually provided by special employability institutes (Ami), while training is offered by labour market training centres; measures are taken whenever need is identified – also after short sickness spells (though rarely during first eight weeks), preventively while still working, or late intervention when already on disability benefits; rehabilitation is always connected with a special rehabilitation allowance, which is higher than the sickness benefit
Switzerland	Compulsory (integration-before-benefits principle is applied since introduction of invalidity insurance in 1960); vocational rehabilitation is granted if work capacity could be improved or maintained, and until the person can be re-integrated; eligibility also requires the person being declared disabled in line with the Invalidity Insurance Act (or in case of an impending disability); insurance authorities are responsible for eligibility assessment and for setting up an individual rehabilitation plan; measures are financed by statutory contributions and government subsidies of invalidity insurance; wide range of rehabilitation measures; rehabilitation often starts at a relatively late stage (permanent or long-lasting work-capacity reduction); authorities have no information about the need for rehabilitation during sickness absence, because there is no duty to register during periods of continued wage payment or receipt of sickness cash benefits from a private insurer; secure income through daily allowance that is higher than a disability benefit

United States	Voluntary, but everybody has the right to submit an application; eligibility requires that rehabilitation services are needed to achieve an employment outcome; assessment is made by a rehabilitation counsellor or case manager, who also has to approve the plan; generally, clients themselves have to seek out services; systematic outreach only during disability benefit application and review; broad range of services with emphasis on the client's preferences; focus more and more shifted towards assisting severely disabled people without any work experience; flexible and individualised, but difficult to enter and – notwithstanding the substantial budget – lacking funding to serve the needs of all; matching federal-state funding for public rehabilitation services and reimbursement by social insurance authority for benefit recipients; very limited subsidies to rehabilitation clients but SSA benefit recipients usually retain their benefit; several new forms of consumer-directed services (individual training accounts, ticket to work voucher) through which the client can choose and contract with an approved provider, and new outcome-based funding procedures

Table 15: Good practice subsidised employment programmes

	Subsidised employment: examples of good practice
Belgium	Both through collective agreements (CCT 26, 50% of labour costs) and through regional regulations (with lower subsidy level, e.g. 30% sector-specific minimum wage in Flanders), subsidies are granted for reduced productivity of a disabled worker; most of these subsidies, including CCT 26, are renewable and can thus become permanent; claimants have to enrol with the regional disability agency, loss of productivity is assessed by a doctor, external multidisciplinary teams make recommendations to the responsible authority (the federal inspectorate of labour for CCT 26, regional administration for other subsidies)
Denmark	Flex-job scheme: subsidy to the employer according to three levels of work-capacity reduction, equal to one-third, half, or two-thirds of the minimum collective wage; eligibility requires permanent work-capacity reduction, completion of vocational rehabilitation and impossibility to work in a normal job or under social chapter employment (which is special employment with reduced wage under collective agreements); subsidies are granted for an unlimited duration; flex-jobs must always be full-time jobs and, hence, cannot be combined with disability benefit payments; for the future, considerable increase in the number of flex-jobs offered is planned (from 9 000 to something like 40 000), thereby gradually replacing partial disability benefits (the ability to handle a flex-job will be introduced as the major criterion for determining disability benefit eligibility)
Korea	Employment subsidies for any disabled worker for a period of three years (with declining subsidy rate) have been abolished in 1999, and replaced by far more generous subsidies, with unlimited duration, only for employment in excess of the mandatory employment quota; the new subsidy varies with the degree of disability and gender – the basic rate is 100% of the minimum wage, topped up by another 50% if severely disabled and another 25% if female
Sweden	Flexible wage-subsidy scheme, mainly for new recruitment: subsidy covers up to 80% of wage costs up to a maximum level (empirical average is 60%) depending on the degree of, and changes over time in, reduction in work capacity; assessment of eligibility and work-capacity reduction (on the basis of a medical certificate and the type of work the person shall carry out) is done by the employment agency; funded by he labour market authorities; subsidy is payable up to four years, with regular adjustment of the subsidy level, and can be resumed within three years after having started non-subsidised work

Table 16: Good practice supported employment programmes

	Supported employment: examples of good practice
Austria	Vocational counselling (Arbeitsassistenz) aims at obtaining jobs in the open labour market, and at securing jobs at risk by means of mediation; it is provided by non-profit organisations and qualified social workers, psychologists or other specialists; it is financed by rehabilitation authorities; it consists of five phases: i) contact with the disabled person, ii) preparation of an occupational or training plan, iii) information and entrance phase (reconcile employer and employee needs), iv) follow-up assistance (few weeks or months) and v) crisis intervention whenever needed; tasks of Arbeitsassistenz involve: developing profiles of skills, identifying and minimising obstacles on the way to employment, finding the right job, introduction at the workplace, psychological and social assistance at the workplace, developing personal working methods and organisational structures, installation of working aids, establishing communication, exchange of information between the disabled person, their colleagues and supervisors, conflict management, and crisis management in case of a pending dismissal
Denmark	Personal assistant can be hired to assist in practical occupational functions arising from specific employment; this type of assistance is granted unlimited in duration, and for up to 20 hours per week for a full-time job of 37 hours per week; the subsidy is given to the employer (or the self-employed disabled person), because the assistant is a regular employee; assistant must be approved by the disabled person; similar type of assistance can also be granted in work-related education and during vocational rehabilitation
Germany	Accompanying support, financed from the compensatory levy fund, can be granted to severely disabled people unlimited in duration (also for temporary jobs and part-time employment of at least 15 hours per week) in order to make full use of skills and capabilities and secure full integration; in addition, recently there is a right to support by work assistance for a period of up to three years (this is granted and financed by the rehabilitation authorities)

Table 17: Good practice sheltered employment programmes

	Sheltered employment: examples of good practice
France	Two main types of sheltered employment: (1) centres for help through work for severely disabled people with more than two-thirds work-capacity loss (zero transition rate), and (2) sheltered workshops for people with less than two-thirds capacity loss (1.5% transition into open employment each year); both types offer permanent employment; eligibility is assessed by COTOREP; workers in centres for help, which are run by not-for-profit bodies, must be paid at least 5% of the minimum wage ("SMIC", which is about € 900 per month) and are guaranteed 55-110% of SMIC via top-up payments; workers in workshops, which operate as commercial enterprises, must be paid at least 35% of SMIC and are guaranteed a minimum income of 90-130% of SMIC (also via subsidy)
Netherlands	A strong focus on sheltered employment has existed since the 1950s, with introduction of more business-like management and in 1989 more attention on the transition to open employment; in 1998, significant programme re-orientation took place in order to increase efficacy: responsibility was fully shifted to the municipalities, which are obliged to provide sheltered labour market opportunities, and which receive a central government subsidy for every disabled person employed in sheltered employment; three subsidy levels depending on the severity of the disability; per person subsidy to encourage the creation of sheltered workplaces in a regular work environment or of so-called guided work (regular job with guidance from a special institution); sheltered employees work in competitive enterprises, with regular labour conditions and statutory collectively agreed wages; permanent employment is still possible, though only with renewable temporary contracts
Norway	Labour market enterprises with strong focus on the transition into the open labour market; these sheltered employment entities consist of three distinct phases: phase 1 – testing the training prospects, phase 2 – testing the transition prospects, and phase 3 – permanent employment; unusually high percentage makes the transition into the open labour market (around 30%); at any stage, at least 50% of the workforce has to be in phase 2, which cannot last more than two years; phase 1 usually takes place while being on sickness benefits, while during second and third phase standard wages are paid

Table 18: Access to different employment programmes

	Anti-discrimination, employment quota	employment	Supported employment	Sheltered employment
Australia	Anti: disability that presently exists, previously existed, may exist in the future or is imputed to a person	Eligibility is assessed on the basis of support needs; all persons with a disability can in principle qualify, and they can also approach service providers directly		
Austria	Quota: "registered disabled", i.e. long-lasting disability of at least 50% (strictly medical)	Registered supportable disabled, i.e. at least 30% disability, unable to find job without such measures	Severely disabled, most with mental or sensual disabilities or psychological disorders	Registered disabled whose output matches at least 50% of that of an average productive worker
Belgium	Public quota: long-term limitation in opportunities for social or professional integration	Similar to quota and registered with the regional disability agency; some regions in addition require a minimum incapacity level depending on the type of disability		
Canada	Anti: previous or existing disability, including disfigurement and drug or alcohol dependence	Provincial programmes, often with differing definitions; federal wage subsidies target unemployed persons having difficulties finding work; supported employment focuses on people with intellectual or developmental disabilities		
Denmark	Principles: apply to all disabled persons	Reduced work capacity, normal employment impossible, vocational reduced functioning	Severe visual or hearing impairment or severely rehabilitation completed (permanent help needed)	Severely reduced functioning, unable to access any other employment programme
France	Quota and employment subsidies and support: registered with COTOREP (commission for assessing disability status) or work injury victim or disability benefit recipient or war veteran			Degree of work-capacity loss determines type of programme
Germany	Quota: "registered severely disabled", i.e. disability of at least 50% or equal status (e.g. 30-49% and unable to obtain a job)	Same as for quota and registered as unemployed	Same as for quota	Extent and type of disability makes open employment impossible, but able to do some productive work
Iceland	Laws prohibiting discrimination: only general provisions. No laws of quotas for the employment of disabled people	SSI employment contracts allow for subsidising of work, up to 75% of basic wages as defined by collective wage agreements	An experimental project in Reykjavik	exists. In 1994 there were 15 sheltered workplaces. Becoming increasingly marginal
Italy	Quota and the few available employment programmes: "registered disabled", i.e. 45% general work-ability reduction or 33% work-related ability reduction or military service disability or visual/hearing/speech impairment ("compulsory placement list")			
Korea	Quota, anti-discrimination and subsidies: considerable restriction in working life caused by disability for an extended period of time (medical definition)		Severely disabled or judged to have difficulty in finding proper work/need on-site support	Severely disabled living in the community who are difficult to employ
Mexico				
Netherlands	–	Classified as work disabled: current or former disability benefit recipient or on sheltered employment waiting list or passed the work disability test, which is valid for five years and renewable		Severe disability, i.e. can only work under adapted circumstances
Norway	–	Classified as vocationally disabled by	Classified as severely vocationally disabled by the responsible authority, the public	

		the PES	employment service(PES)	
	Quota and all employment programmes: disability assessment carried out by local assessment teams – to determine degree of disability and identify appropriate training and employment measures; note: assessment obtained to receive social insurance benefits is also recognised			
Portugal	New quota: disability of at least 60% and able to perform the job	Difficulty in securing or retaining a suitable job	Disabled in training at work (initial integration phase)	Inferior productivity, unable to work in open employment registered with department
Spain	Quota, grants for workplace accommodation and for employers, and employment programmes: assessed to be handicapped, i.e. certified degree of handicap of at least 33%			Same as for quota and registered as unemployed
Sweden	Anti: any lasting impairment resulting from an injury or disease	Registered vocationally disabled at regional employment office	Registered as severely vocationally disabled	Registered; can work half-time but cannot obtain any other work
Switzerland	–	Declared disabled along with the invalidity insurance act		Subsidy to institution requires 50% disability
Turkey	Quota: disability identity card, *i.e. 40-70% work-capacity* reduction	No such programmes		
United Kingdom	Anti: substantial and long-term disability with adverse effect on ability to carry out ADL	Blurred boundaries between programmes: nature and severity of disability prevents person from finding job in open employment (open employment must be considered first and shown not to be feasible)		
United States	Anti: qualified person (i.e. able to perform the job) with disability that limits one or more major life activities	Disability-label neutral, *i.e. access is determined by* programme characteristics	Eligibility varies with the funding agency	State programmes use their own configurations and criteria

Appendix II

Evaluation of Disability Policies
in Iceland and OECD-Countries

Table II.1

Scores for sub-dimensions of income support typologies in 2000

Comparing Iceland and OECD countries

	Coverage	Minimum disab.level	Level of full disability	Benefit generosity	Permanence of benefits	Medical assessment	Vocational assessment	Sickness ben. level	Sickness ben duration	Unemployment benefit level	Sum
Australia	5	5	5	1	2	4	2	1	5	2	32
Austria	2	3	4	2	1	1	5	3	2	2	25
Belgium	3	2	3	1	4	2	4	3	2	2	26
Canada	1	1	1	1	4	1	0	2	1	1	13
Denmark	5	3	1	4	4	3	1	2	2	2	27
France	3	2	1	3	1	2	4	2	5	2	25
Germany	2	5	3	2	1	3	3,5	4	4	2	29,5
Italy	3	2	0	3	1	1	3	3	3	3	22
Korea	0	3	0	1	2	1	0	0	1	1	9
Mexico	0	3	4	0	3	2	5	2	3	5	27
Netherlands	4	5	2	5	3	1	1	3	3	2	29
Norway	5	3	0	5	5	5	2	5	2	2	34
Poland	2	3	4	4	2	2	3	4	2	4	30
Portugal	3	2	3	5	4	1	4	2	5	2	31
Spain	3	4	1	4	5	0	3	2	4	4	30
Sweden	5	5	1	5	3	3	1	4	4	3	34
Switzerland	5	4	3	4	4	4	2	4	2	1	33
Turkey	2	2	3	2	5	3	0	2	3	3	25
Britain	3	1	2	1	2	3	1,5	1	2	4	20,5
United States	3	1	2	3	4	4	1	2	0	1	21
OECD average	3,0	3,0	2,2	2,8	3,0	2,3	2,3	2,6	2,8	2,4	26,2
Iceland	5	3	2	2	4	3	1	1	2	2	25

Source: OECD (2003) and own assessment of Iceland

Table II.2

Scores for sub-dimensions of social integration typologies in 2000

Comparing Iceland and OECD countries

	Coverege consistency	Assessment structure	Employer responsibility	Supported employment	Subsidised employment	Sheltered employment	Rehab. programs	Rehabilitation timing	Benefit suspension	Work incentive	Sum
Australia	4	4	4	2	2	3	1	3	4	2	29
Austria	2	3	1	4	4	2	5	4	0	3	28
Belgium	3	3	2	1	5	2	2	3	2	0	23
Canada	1	0	4	3	2	2	1	0	5	4	22
Denmark	2	5	2	5	5	2	5	5	3	5	39
France	5	2	2	2	5	2	1	2	0	3	24
Germany	4	0	3	5	4	3	5	5	3	3	35
Italy	4	2	4	1	1	2	0	2	0	2	18
Korea	0	0	1	2	3	2	1	2	0	3	14
Mexico	2	2	0	0	0	0	0	1	0	3	8
Netherlands	4	2	3	2	1	5	2	2	5	4	30
Norway	4	2	3	2	4	3	5	3	5	0	31
Poland	5	2	2	0	4	4	2	2	0	3	24
Portugal	3	2	2	1	2	2	1	1	1	1	16
Spain	4	3	3	1	3	3	4	4	0	2	27
Sweden	3	3	5	2	4	2	5	4	5	0	33
Switzerland	4	3	1	1	1	3	5	3	0	2	23
Turkey	3	2	0	0	1	0	2	1	0	0	9
Britain	2	2	4	3	1	2	1	3	4	5	27
United State	0	0	4	5	1	2	1	1	5	4	23
OECD average	3,0	2,1	2,5	2,1	2,7	2,3	2,5	2,6	2,1	2,5	24,2
Iceland	2	1	1	1	1	3	2	3	2	0	16

Source: OECD (2003) and own appraisal of Iceland

References

Askenazy, P. (2001), "Innovative Workplace Practices and Occupational Injuries and Illnesses in the United States", in *Economic and Industrial Democracy*, vol. 22, pp. 485-516.

Álit nefndar um samspil almannatrygginga, lífeyrissjóða og skatta (Report on social security, pension funds and taxation)(2001), webpage: (http://forsaetisraduneyti.is/media/Skyrslur/nefndaralitpdf.pdf).

Árelía Guðmundsdóttir (2001), Sveigjanleiki á íslenskum vinnumarkaði á umbrotatímum 1992-1997 (Flexibility in the Icelandic Labour Market 1992-97) (Háskóli Íslands, félagsvísindadeild doktorsritgerð).

Barnard, C., Deakin, S. and R. Hobbs (2001), "Capabilities and Rights: An Emerging Agenda for Social Policy?", in *Industrial Relations Journal*, vol. 32, no. 5, pp. 464-479.

Barnes, C. and G. Mercer (2005), "Disability, Work and Welfare: Challenging the Social Exclusion of Disabled People", in *Work, Employment and Society*, vol. 19, no. 3, pp. 527-545.

Barnes, C., M. Oliver og L. Barton (eds.)(2002), *Disability Studies Today* (Cambridge: Polity Press).

Barnes, C. (2000), "A Working Social Model? – Disability, Work and Disability Politics in the 21st Century", in *Critical Social Policy*, vol. 21, no. 4, pp. 441-457.

Barnes, C. 1999; "Disability: A Choice of Models" (text on: http://www.leeds.ac.uk/disability-studies/publish.htm).

Barr, N. (1993), *The Economics of the Welfare State* (Oxford: OUP).

Bergeskog, A. (2001), "Labour Market Policies, Strategies and Statistics for People with Disabilities: A Cross-National Comparison", in IFAU – Office of the Labour Market Policy Evaluation, Working Paper no. 13.

Burchardt, T. (2003), "Being and Becoming: Social Exclusion and the Onset of Disability" (London: LSE Center for Analysis of Social Exclusion-CASE Report 21).

Brynhildur G. Flóvenz (2004), *Réttarstaða fatlaðra* (Rights of the Disabled in Iceland)(Mannréttindaskrifstofa Íslands og Minningarsjóður Jóhanns Guðmundssonar).

Burkhauser, R. V. and Mary C. Daly (1998), "Disability and Work: The Experiences of American and German Men", in *FRBSF Economic Review*, no. 2, pp. 17-29.

Burkhauser, R. V. and Mary C. Daly et.al. (2002), "Self-Reported Work-Limitation Data: What They Can and Cannot Tell Us", in *Demography*, árg. 39, no. 3, pp. 541-555.

Council of the European Union (1997), "Council Resolution of 20the December 1996 on Equality of Opportunity for People with Disabilities", in *Official Journal*, no. C 12, from 13. January.

Cowling, S. (2004), "States of Dependence: Lessons from the US Road from Welfare to Work". (CofFEE – Center of Full Employment and Equity, Working Paper nr. 04-14).

EF - European Foundation for the Improvement of Living and Working Conditions (2003), *Illness, Disability and Social Inclusion* (Dublin: EF).

EF - European Foundation for the Improvement of Living and Working Conditions (1999a), "Employment Status and Health". Luxembourg: Official Publication of the European Communities.

EF - European Foundation for the Improvement of Living and Working Conditions (1999), *Linking Welfare and Work* (Dublin: EF).

EIM (2001), "The Employment Situation of People With Disabilities in the European Union". (Report for Employment and Social Affairs section of EU).

EIM (2002), "Active Labour Market Programmes for People with Disabilities: Facts and Figures on Use and Impact". Report of EIM for Employment and Social Affairs section of EU, August 2002).

Esping-Andersen, G. (1990), *The Three Worlds of Welfare Capitalism* (Cambridge: Polity Press).

Esping-Andersen, G. (ed.)(1996), *Welfare States in Transition: National Adaptations in Global Economies* (London: Sage).

Esping-Andersen, G. (1999), *The Social Foundations of the Postindustrial Economy* (Oxford: OUP).

Esping-Andersen, G. (ed.)(2002), *Why We Need a New Welfare State* (Oxford: OUP).

Esping-Andersen, G. og M. Regini (2000), *Why Deregulate Labour Markets?* (Oxford: OUP).

EU, Framkvæmdanefnd Evrópusambandsins (2003), Equal Opportunities for People With Disabilities – A European Action Plan (homepage EU).

EU, Framkvæmdanefnd Evrópusambandsins (2001), Disability and Social Participation in Europe (Lúxemborg: Eurostat, Key Indicators 2001; also at á www.eurostat.org).

Finkelstein, V. (1993), "Disability: A Social Challenge or an Administrative Responsibility?", in J. Swain o.fl. (ed.), *Disabling Barriers – Enabling Environments* (London: Sage).

Fjármálaráðuneytið (2005), Endurskoðuð þjóðhagsáætlun, október (http://www.fjarmalaraduneyti.is/Utgefid-efni/thjodarbuskapur/nr/4712).

Fötlunarfræði: heimasvæði, http://www.fotlunarfraedi.hi.is.

Gallie, D. (ed.) (2004), *Resisting Marginalization: Unemployment Experience and Social Policy in the European Union* (Oxford: OUP).

Gallie, D. and S. Paugam (2004), "Poverty and Social Isolation: An Assessment of the Current State of Exclusion Theory", in Gallie (ritstj.), *Resisting Marginalization*.

Gallie, D. et.al. (1998), *Restructuring the Employment Relationship* (Oxford: OUP).

Gallie, D. (ed.)(1988), *Employment in Britain* (Oxford: Blackwell).

Gallup – "Að kaupa sér tíma" (Buing time), survey for "Hið gullna jafnvægi", October 2003 (www.hgj.is).

Groce, N. (1985), *Everyone Here Spoke Sign Language: Hereditary Deafness on Martha´s Vineyard* (Cambridge Mass.: Harvard University Press).

Guðbjörg Andrea Jónsdóttir og Stefán Ólafsson (1993), *Atvinnuleysi á Íslandi 1993* (Unemployment in Iceland 2003)(Reykjavík: Félagsvísindastofnun HÍ).

Hagstofa Íslands (Statistics Iceland) (various years), *Landshagir* (Reykjavík: Hagstofa Íslands).

Hagstofa Íslands (2005), Special tax data on earnings and taxes (Stefán Þór Jansen, October).

Hagstofa Íslands (2005), various data from website (www.hagstofa.is).

Halvorsen, K. (1994), *Arbeidslöshet og arbeidsmarginalisering – levekaar og mestring* (Oslo: Universitetsforlaget).

Handler, J. F. (2003), "The Big Experiment", in Zeitlin og Trubek (2003), *Governing Work and Welfare in a New Economy* (Oxford: OUP).

Harpa Njáls (2003), *Fátækt á Íslandi* (Poverty in Iceland) (Reykjavík: Borgarfræðasetur).

Haveman, R. og B. Wolfe (2000), "The Economics of Disability and Disability Policy", in A. Culyer og J. Newhouse (eds.), *Handbook of Health Economics*, vol. 1a (Amsterdam), pp. 995-1051.

Hvinden, Björn (2004), "Nordic Disability Policies in a Changing Europe: Is There Still a Distinct Nordic Model?", in *Social Policy and Administration*, vol. 38, no. 2, pp. 170-189.

Högelund, J. og J. G. Pedersen (2002), "Active Labour Market Policy for Disabled People in Denmark" (Kaupmannahöfn: Socialforskningsinstituttet; WP nr. 18).

Högelund, J. (2001), "Work Incapacity and Reintegration: A Literature Review", in Frank S. Bloch og Rienk Prins (eds.), Who Returns to Work and Why: International Social Security Series. Bindi 5 (New Brunswick: Transaction Publishers); (also at http://www.sfi.dk/).

ILO (2002a), "Disability and Poverty Reduction Strategies" (homepage ILO, www.ilo.org).

ILO (2002b), "Managing Disability in the Workplace: ILO Code of Practice" (homepage ILO, www.ilo.org)

ILO (2004), "CBR – A Strategy for Rehabilitation, Equalization of Opportunities, Poverty Reduction and Social Inclusion of People with Disabilities" (Joint Position Paper of ILO, UNESCO og WHO; at www.ilo.org).

Ingi Rúnar Eðvarðsson (2003). *Labour Market Performance in Iceland.* (HA, WP03:01).

Jahoda, M. (1982), *Employment and Unemployment* (Cambridge: CUP).

Johnstone, David (2001), *An Introduction to Disability Studies* (London: David Fulton Publishers).

Kautto, Mikko et.al. (eds.)(1999), *Nordic Social Policy: Changing Welfare States* (London: Routledge).

Kautto, Mikko et.al. (eds.)(2001), *Nordic Welfare States in the European Context* (London: Routledge).

Kenworthy, L. (2004), *Egalitarian Capitalism: Jobs, Incomes and Growth in Affluent Countries* (New York: Russell Sage Foundation).

Kildal, N. og Stein Kuhnle (ritstj.)(2004), *Normative Foundations of the Welfare State: Scandinavian Experiences* (London: Routledge).

Kvist, Jon (2003), "Scandinavian Activation Strategies in the 1990s : Recasting Social Citizenship and the Scandinavian Welfare Model ". (Kaupmannahöfn: Socialforskningsinstituttet; RFAS nr. 4-2003).

Lindholm, C. o.fl. (2002), "Class Differences in the Social Consequences of Illness?", in *Journal of Epidemiol Community Health*, árg. 56, bls. 188-192.

Mabbett, Deborah (2005), The Development of Rights-Based Social Policy in the European Union: The Example of Disability Rights. *JCMS*, árg. 43, nr. 1, bls. 97-120.

Mabbett, D. og H. Bolderson (2002), "Definitions of Disability in Europe" (Brunel University/European Commission, 30. June 2002).

Margrét Margeirsdóttir (2001) *Fötlun og samfélag* (Reykjavík: Hákólaútgáfan).

Marshall, T. H. (1964), *Class, Citizenship and Social Development* (Chicago: UC Press).

Norðurlandaráð (various years), *Norræna tölfræðihandbókin* (Kaupmannahöfn: Nordic Council).

NOSOSKO (various years), *Social Security in the Nordic Countries* (Kaupmannahöfn: Norræna tölfræðiráðið).

OECD (2005a), *Extending Opportunities: How Active Social Policy Can Benefit Us All* (París: OECD).

OECD (2005b), *Society at a Glance* 2005 (París: OECD).

OECD (2002), *Society at a Glance* 2002 (París: OECD).

OECD (2003), *Transforming Disability into Ability: Policies to Promote Work and Income Security for Disabled People* (París: OECD).

OECD (2003), *Employment Outlook* (París: OECD).

OECD (1994), *Jobs Study* 1994 (París: OECD).

OECD, Social expenditures data base (www.oecd.org).

Oorschot, Wim van og P. Abrahamson (2003), "The Dutch and Danish Miracles Revisited: A Critical Discussion of Activation Policies in Two Small Welfare States", in *Social Policy and Administration*, vol. 37, no. 3, bls. 288-304.

Oorschot, Wim van og Kees Boos (2000), "The Battle Against Numbers: Disability Policies in the Netherlands", in *European Journal of Social Security*, árg. 2, nr. 4, bls. 343-361.

Oorschot, Wim van og Björn Hvinden (2000), "Introduction: Towards Convergence? – Disability Policies in Europe", in *European Journal of Social Security*, árg. 2, nr. 4, bls. 293-302.

Pierson, Paul (ritstj.)(2001), *The New Politics of the Welfare State* (Oxford: OUP).

Rahkonen o.fl. (2002), "Determinants of Health Inequalities by Income from the 1980s to the 1990s in Finland", in *Journal of Epidemiological Community Health*, árg. 56, bls. 442-443.

Ramböll (2005), "Disability policy in 5 Countries/Services Offered to Disabled People" (http://www.ramboll-management.dk).

Rannveig Traustadóttir (2003), *Fötlunarfræði* (Disability Studies) (Reykjavík: Hákólaútgáfan).

Rose, M. (1988), "Attachment to Work and Social Values", in Gallie (ritstj.), *Employment in Britain*.

Russell, M. (2002), "What Disability Civil Rights Cannot Do: Employment and Political Economy", in *Disability and Society*, árg. 17, nr. 2, bls. 117-135.

Scharpf, F. og V. Schmidt (ritstj.)(2000), *Welfare and Work in the Open Economy*, Vol. I and II (Oxford: OUP).

Shields, M.A. og Wheatley, P.S. (2001), "Exploring the Economic and Social Determinants of Psychological and Psychosocial Health". Discussion Paper nr. 396, IZA, Bonn.

Sigurður Thorlacius, Sigurjón B. Stefánsson og Stefán Ólafsson (2001a), "Menntun. störf og tekjur þeirra sem urðu öryrkjar á Íslandi árið 1997" (Social Conditions of New Disability Pensioners), in *Læknablaðinu* 87, bls. 981-985.

Sigurður Thorlacius, Sigurjón Stefánsson, Stefán Ólafsson og Vilhjálmur Rafnsson (2001b), "Breytingar á algengi örorku á Íslandi 1976-1996 (Change in Prevalence of Disability), in *Læknablaðinu*, árg. 87, nr. 3, bls. 205-209.

Sigurði Thorlacius, Sigurjón Stefánsson og Stefán Ólafsson (2004), "Tengsl atvinnuleysis og nýgengis örorku á Íslandi 1992-2003" (Unemployment and Disability), in *Læknablaðinu*, 12. tölublað, árg. 90, bls. 833-836.

Sigurður Thorlacius o.fl. (2005), "Lokaskýrsla starfshóps um starfsendurhæfingu á Íslandi" (Report on Vocational Rehabilitation) (Handrit, 14. febrúar, TR).

Sigurður Thorlacius, Sigurjón Stefánsson, Halldór Baldursson og Haraldur Jóhannsson (2004), "Endurhæfingarlífeyrir eða örorkulífeyrir? – Aldur, kyn og sjúkdómsgreiningar við fyrsta mat tryggingalæknis", in *Læknablaðið*, árg. 90, bls. 681-684.

Sigurður Thorlacius, Sigurjón Stefánsson og Stefán Ólafsson (2005), "Disability due to Psychiatric Disorders in Iceland", í *Disability Medicine*, árg. 5, nr. 2, bls. 57-61.

Stefán Ólafsson (2005), "Normative Foundations of the Icelandic Welfare State: On the Gradual Erosion of Citizenship-Based Welfare Rights", in Kildal, N. og Stein Kuhnle (ritstj.)(2004), *Normative Foundations of the Welfare State: Scandinavian Experiences*

Stefán Ólafsson og Kolbeinn Stefánsson (2005), *Hnattvæðing og þekkingarþjóðfélag* (*Globalization and Knowledge Society*) (Reykjavík: Háskólaútgáfan).

Stefán Ólafsson (1999), *Íslenska leiðin: Almannatryggingar og velferð í fjölþjóðlegum samanburði* (*The Icelandic Welfare Model*) (Reykjavík: Tryggingastofnun ríkisins og University of Iceland Press).

Stefán Ólafsson og Sigurður Thorlacius (1997), "Social Conditions of Newly Registered Disability Pernsioners" (Félagslegar aðstæður nýskráðra öryrkja)" (Reykjavík: Félagsvísindastofnun HÍ).

Tryggingastofnun ríkisins (ýmis ár), "Statistics on Social Security (Staðtölur almannatrygginga)" (Reykjavík: TR/www.tr.is).

Tryggvi Þór Herbertsson (2005), "Fjölgun öryrkja" (Increase of Disability Pensioners) (Reykjavík: Heilbrigðis- og tryggingamálaráðuneytið).

UK Prime Minister´s Strategy Unit (2005), "Improving the Life Chances of Disabled People", á netfanginu: http://www.strategy.gov.uk/downloads/work_areas/disability/disability_report/pdf/disability.pdf.

UPIAS. 1976: Fundamental Principles of Disability. London: Union of the Physically Impaired Against Segregation (Einnig aðgengilegt á netsvæðinu: www.leeds.ac.uk/disability-tudies/archiveuk/index.)

Wagstaff, A. (2002), "Poverty and Health Sector Inequalities", í *Bulletin of World Health Organization*, árg. 80, bls. 97-105.

WHO – World Health Organization (2005), Gögn af heimasíðu (www.who.org).

Wilensky, H. (2002), *Rich Democracies* (Berkeley: UC Press).

Zeitlin, J. og D. M. Trubek (2003), *Governing Work and Welfare in the New Econom: European and American Experiments* (Oxford: OUP).

National Economic Institute (Þjóðhagsstofnun) (1999), “Skýrsla forsætisráðherra um stöðu, aðbúnað og kjör öryrkja” (Prime ministerial report on the conditions of the disabled)– parliamentary document no. 1136 at 123. session.