MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

Evidence Brief

Tightening entry criteria to benefits for disabled people

2012

Author

Centre for Social Research and Evaluation, Ministry of Social Development.

Disclaimer

The views and interpretations in this report are those of the researcher and are not the official position of the Ministry of Social Development.

Readers should note that this report has not been through the Ministry's full publication quality assurance process but is being published as it may be of value and interest to the social services research community and others. The report has been edited and proof read, but the layout and content has not been reviewed or updated since the report was finalised. Web links for references have been updated where possible.

Date of publication

This report was completed in 2012, and published in the MSD Research Archive website in September 2019.

ISBN

Online 978-0-9951240-3-5

Contents

Current situation

Key points

- Changes to the eligibility criteria for incapacity benefits may have some effect in reducing the number of people on these benefits but this may lead to substitution into other benefits as much as employment.
- Recent reforms include efforts to assess a person's work capacity rather than incapacity in assessing eligibility to the benefit system.
- Those who are relatively less impaired are substantially more likely to return to work if denied benefits.
- Medical reassessments based on stricter access criteria can result in lower incapacity benefit recipiency in the short term, although the effect may not be long lasting.
- More frequent reassessment of incapacity status, based on the same medical criteria as the initial assessment, has shown little or no impact on outflow.
- Efficiency in programme operation, consistency in processing benefit applications and control of administration during the screening process might substantially decrease the number of applicants receiving an incapacity-related benefit.
- Positive results have been documented for countries that have strengthened requirements to participate in work-related activities.

Incapacity-related beneficiaries constitute a major proportion of benefit recipients in New Zealand, consistent with overseas experience. In New Zealand, as of September 2011, the number of working age people receiving the Sickness Benefit and Invalid's Benefit were 85,000 and 59,000 respectively, representing almost 44 percent of working age beneficiaries (MSD 2011). An increasing proportion of such beneficiaries are being recorded as those having mental health problems.

Internationally, there is concern that the provision of relatively generous disability benefits may encourage people in low-paid work to enter the disability benefit programme (Gruber 2002, cited in Kemp et al 2006). In addition, disability benefits at a young age seem to steer people into benefit dependence (OECD 2010). The Organisation for Economic Co-operation and Development (OECD) recently reported that between one-third and one-half of all new disability benefit claims are for reasons of mental ill health, and among young adults that proportion goes up to over 70 percent (Prinz 2011). Over the past two decades, various countries have implemented, or are starting to implement, reforms that incorporate tighter eligibility criteria to the benefit system.

The table below summarises criteria and impact of these tighter eligibility rules internationally.

Impact summary table

Country	Tightening criteria	Impact	Reference
Netherlands	Reassessment under the new rules after 1993 reform	Fifty percent of full benefits being converted into partial awards or terminated in the first year after the reform	Howard 2004
Netherlands	Reassessment of entire caseload of beneficiaries under age 45 in 2005–09	Forty percent found to be fit for work or having lower disability level	OECD 2010
Netherlands	Implementation of stricter rules for assessment of disability	Twelve percent less benefits claimants between 2002–04	Netherlands Country Memo 2007
Netherlands	Review of all recipients in the general disability scheme[1] below age 45 based on stricter access criteria between 1994–98	– Thirty percent of cases reclassified to another benefit or moved off benefit completely – Many successfully reapplied during the following years. After 5 years, beneficiaries were back to the same level seen before the reform	OECD 2003; 2008
Australia, Canada, Netherlands, Switzerland, Luxembourg, Poland	Strengthened requirements to participate in work-related activities	Falling disability benefit inflow	OECD 2006; 2010; Carcillo and Grubb 2006
United States	Eligibility to the Social Security Disability Insurance (SSDI)[2] and Supplemental Security Income (SSI)[3] requires the person to be unable to work	Increased employment and earnings but no effect on caseload size	Rangarajan et al 2008
Canada	Canadian Pension Plan Disability Benefit administration tightened up with respect to initial assessments, reassessments and tracking of clients	Over 40% of reviewed cases resulted in stopped benefits within 2.5 years	Torjman 2002

1 The Dutch disability scheme covered work-related injuries and permanent benefits. It has been replaced by a new benefit scheme (WIA) since 2006 that emphasises residual capacity instead of compensating incapacity irrespective of the cause of impairment.

2 The Social Security Disability Insurance (SSDI) is the federal insurance programme of the United States Government and is intended to replace lost income for people suffering from a disability that is likely to cause substantial long-term losses in earnings. The insurance is targeted at individuals who suffer a long-lasting impairment that prevents them from engaging in a minimum level of work activity, defined by the social security administration as earning more than USD$12,000 annually in 2011. SSDI does not give partial ratings: individual applicants are deemed either able or unable to work (SSDI 2011).

3 The Supplemental Security Income is a federal income supplemental programme funded by general tax revenues. It is designed to help aged, blind and disabled people who have little or no income and provides cash to meet basic needs for food, clothing and shelter (http://www.ssa.gov/ssi/).

What has been done

In most countries, eligibility for benefits is based on an incapacity to undertake gainful work, which is modified by individual circumstances affecting the likelihood of employment, such as age, education and prior work experience (Bloch and Prins 2001). Recent reforms to tighten access to benefit systems have included the use of more objective medical and stringent vocational criteria, changes to benefit payments and stronger monitoring of the sickness absence phase (OECD 2010).

Tightening medical criteria

Several countries have tightened medical criteria used to determine disability benefit entitlements. For example:

- most countries undertake **medical reassessments** to determine medical condition or functional capacity of people on sickness benefits, to help identify potential disability cases (CSRE 2010)
- some countries, which used to rely on general practitioners, have now moved to a **more uniform evaluation**. In **Spain**, for instance, disability is assessed by benefit administrators based on a medical assessment performed by the institute's own doctors. In **Switzerland**, an increasing number of medical assessments are performed by the special regional medical services (OECD 2010). In **New Zealand**, a revised medical certificate is used to determine eligibility for the Sickness and Invalid's benefits. People who are expected to be able to work part time in the next two years receive the Sickness Benefit rather than Invalid's Benefit. Case managers can seek advice from regional health and regional disability advisors when making decisions regarding benefit eligibility, reviews and renewals for financial assistance and services and interventions for people with ill health or a disability (Ministry of Social Development website[4]). The case manager may seek a second opinion regarding the client's eligibility by referring to a designated doctor
- many countries disallow reassessments on the basis of new entitlement criteria, such as a new minimum entry threshold or changed assessment procedures or criteria. Australia has started **assessing new clients under new rules** leaving the old entitlements untouched. Few countries have ever done widespread reassessments of large parts of the beneficiary caseload. In the Netherlands, when the entire caseload of beneficiaries under the age of 45 was reassessed according to the new rules, almost 40 percent were found to be fit for work or have a lower disability level than before, younger recipients in particular. Cohort evaluation of reassessed beneficiaries suggests that about one-third moved into work within 18 months, partly with special reintegration support offered for this group (OECD 2010)
- countries such as the **United States tightened criteria with the intent of removing substance abusers from the benefit rolls**. In 1997, the US Government changed entitlement criteria to federal disability benefits so that anybody with drug or alcohol addiction as their primary incapacity had their benefits terminated. Proponents of the policy change estimated that 75 percent of former Supplemental Security Income Drug Addiction and Alcoholic beneficiaries would re-qualify for Supplemental Security Income (SSI) benefits under another disability

[4] www.workandincome.govt.nz/community/forms-and-brochures/changes-to-the-sickness-benefit.html (note: website content no longer available)

category, but only 35 percent of this population retained their SSI benefits (Hogan et al 2011). Some people not qualifying for federal benefits may qualify for state benefits (eg, General Assistance (GA)). Not all states have GA programmes but where they do claimants receive financial assistance if they have a temporary incapacity, are low income and not eligible for any other public assistance. Access to GA may be conditional (Pennucci et al 2009).

Work capacity assessment and more stringent vocational criteria

There has been a move away from assessing someone for their *fit with their usual occupation* to a broader assessment with a *fit with all jobs*. Often, this shift is complemented with a shift in responsibilities, with decisions increasingly being taken by case managers of benefit authorities and taking into account not only the medical file but also clients' abilities and work aspirations (OECD 2010). Some countries have included requirements to participate in work-related activities.

- In the **Netherlands**, eligibility for benefits after the 1993 reform is calculated on the basis of '**generally accepted work**' in regard to the person's remaining work capacity, which is not related to education, work history or acquired status. More jobs were regarded as being 'available' to the disabled, thus making it more difficult for any worker to be assessed as incapacitated (Oorschot 2010). The job-matching process is, however, based on hypothetical jobs in the economy, not actual jobs available (OECD 2010).
- In **New Zealand**, new applicants from May 2011 have a part-time work obligation if assessed as being able to work at least 15 hours a week. Three medical certificates are needed during the first eight weeks of Sickness Benefit after which a medical certificate will have to be produced every 13 weeks. If a client is still receiving Sickness Benefit after 52 weeks, they may be required to complete the 12-month reassessment process. The 12-month reassessment will ensure that clients receiving a Sickness Benefit are on the right benefit for the right amount of time and help case managers determine what steps can be taken to help Sickness Benefit clients into work. Those with work obligations will not be punished for not getting a job, but their benefit may be reduced or stopped if they do not try to find suitable work (MSD website[5]).
- In **Australia**, people with an ability to work 15 to 29 hours per week are classed as unemployed and are required to find part-time work (OECD 2010). From 1 July 2011, the Employment Services Assessment (ESAt) assesses the jobseeker's circumstances to determine work capacity and the most appropriate service, where one or more medical conditions are identified. ESAts are similar to the previous Job Capacity Assessments for potentially highly disadvantaged jobseekers with disability, injury or illness (DEEWR 2011).
- The **United Kingdom** introduced Work Capability Assessments, which distinguish between those who could work, those who could work at some point with the right support and those who cannot work (OECD 2010). The assessments have been criticised for not dealing well with clients with multiple or fluctuating conditions. The rate of appeals amongst customers against decisions using the Work Capability Assessment has been high (Barnes et al 2010).

[5] www.workandincome.govt.nz/community/forms-and-brochures/changes-to-the-sickness-benefit.html (note: website content no longer available)

- In **Germany**, since 2001, labour market authorities have been responsible for employment measures. Eligibility is measured in terms of the person's capacity for a general job in the market and not solely on their own previously chosen profession. The incapacity to work in own chosen occupation, however, was kept for all insured people older than 40 years at the time of the reform and people entitled to a partial benefit who do not find suitable part-time work based on their own assessment continue to receive a full disability benefit (OECD 2010).

Changes in benefit payment

Reforms that aim to tighten access to the benefit system have sometimes included changes in the duration of benefit payment, levels of benefits and the level of disability required for benefit entitlement (OECD 2010).

- Some countries have started **treating people with partial capacity as unemployed**. In the **Netherlands**, those with a 15–34 percent capacity no longer get disability benefits. If the earning loss is less than 80 percent, the temporary benefit is primarily a wage subsidy scheme because it covers 70 percent of the difference between the new wage and the pre-disability wage. For those who are without work, the unemployment insurance rules apply and the temporary disability benefit shrinks eventually to one based on the minimum wage (Jong 2008). In **Luxembourg**, people with remaining work capacity who were receiving sickness benefits were shifted onto job-search support in the form of a clearly defined 'redeployment' procedure. This can have two outcomes: i) employment with a permanent payment to compensate for any difference between previous and new earnings; or ii) unemployment in which case they receive a waiting allowance set at the level of disability benefit but with availability requirements just like every other unemployed person.
- Some countries, such as the United Kingdom and the Netherlands **treat those with a permanent and full incapacity differently from those who have partial work capacity**. The former receive a permanent benefit at a higher rate with no activation requirements (OECD 2010). This is comparable with the New Zealand system where Sickness Benefit recipients face work obligations whereas those on an Invalid's Benefit do not. In the Netherlands, if the capacity loss is more than 80 percent and there is no foreseeable potential for any degree of recovery, the applicant is awarded full and permanent disability benefit. But if the capacity loss is anywhere between
  35–80 percent or more, with prospects of recovery, they are entitled to partial or temporary disability (Jong 2008). In the first year after the 1993 reforms in the Netherlands, reassessments under the new rules led to 50 percent of full benefits being converted into partial awards or terminated (Howard 2004).
- More countries have moved to **providing disability benefits for a temporary period**. Countries such as Austria, Germany and Poland where disability benefits were in effect permanent have now become strictly temporary, except in cases of full disability in Austria and Germany.
- Canada recently extended the length of time that people with a disability can put their benefit on hold for while they are trying to work so, if need be, they can return to the benefit without reassessment.

Stricter sickness absence monitoring

For the people in work, sickness absence is the period during which much could be done to monitor their health and manage their return to work. **Sickness absence rates have been found to be co-related with disability beneficiary rates in most of the OECD countries**. Several countries have started addressing the issues of **long-term sickness absence monitoring** as a measure to tackle the number of people claiming disability benefit. Employers, public authorities and doctors involved have roles in such monitoring, which is found to vary among countries implementing the initiative (OECD 2010).

- In the **Netherlands**, employers are responsible for sickness pay for up to two years. This is implemented rigorously in combination with strong financial incentives for employers to follow these regulations, and sanctions for those who do not follow.
- The **Netherlands** and **Sweden** have detailed medical guidelines for general practitioners' sick leave certificates for a range of diagnoses, to ensure that sick workers do not stay out of work for longer than is necessary.
- In **Spain**, the National Institute of Social Security was created in 2004 with the sole purpose of better monitoring and reducing absence rates. A new monitoring tool with daily updated complete individual sickness absence histories allows online selection of cases for reviews on the basis of longer than expected recovery phases. A general absence control was put in place for more than 6 month's absence.
- In **Denmark**, municipalities are given incentives to monitor absence rigorously and introduce steps for early intervention. The sickness monitoring process includes the categorisation of sickness into various categories (three) with more work relevant focus and closer follow-up rules being applied for the category most at risk.

What works?

Tightening the eligibility rules for disabled people has been successful in reducing the inflow into the benefit system (Howard 2004). In the Netherlands, the stricter rules for assessment of disability alone were responsible for 12 percent less benefit claimants between 2002 and 2004 (Netherlands Country Memo 2007). Such changes may have some effect in reducing numbers, but this may lead to **substitution** as much as employment. In Denmark, for example, the inflow to early retirement seemed to relate strongly (inversely) to entrants to disability benefit. Such substitution might reduce the chances of work as well as increase administration costs (Howard 2004).

Strengthened requirements to participate in work-related activities have shown positive results. Switzerland, for example, has moved to a more binding rehabilitation principle instead of a benefit principle. Sanctions are applied for non-compliance. In Luxembourg,[6] people with partial work capacity are now obliged to enrol in training and reintegration measures. Both countries have seen falling disability benefit inflow rates recently (OECD 2010).

[6] Individuals assessed with continuing work incapacity can remain on a sickness benefit (OECD 2007).

A recent study undertaken by the RAND Center for Disability Research has found that, in the United States, those who have impairments that are on the margin of allowance for the Social Security Disability Insurance (SSDI) would not go to back to work if they were awarded benefits (RAND 2011). **The evidence shows that compulsory participation in labour market programmes or job-search requirements for people with partially reduced capacity for work can be effective**.

- Work requirements have been effective in reducing benefit caseloads and enhancing welfare-to-work transitions in Australia, Canada and, to some extent, the Netherlands (Carcillo and Grubb 2006).
- Work-focused interviews in the United Kingdom contributed to the positive impact of the Pathways to Work programme for short-term incapacity benefit clients (Carcillo and Grubb 2006).

Efficiency in programme operation, as well as uniform and consistent processing of benefit applicants, might substantially decrease the number of applicants receiving incapacity benefit. A recent study in the United States using data from the entire population of SSDI programme applicants has identified inefficiencies and inconsistencies in the evaluation of cases, leading to a significant amount of work capacity among a subset of current beneficiaries. Half of the applicants who were awarded benefits were accepted by a disability examiner in the initial phase, while the other half were first rejected by an examiner (because they were considered capable of work) but later allowed on appeal (RAND 2011).

Control of administration and general practitioner (GP) certification behaviour can have a significant effect on the number and duration of incapacity benefit certificates issued (CSRE 2010). The potential of stricter administrative procedures for doctors, however, will only be achieved if compliance with these strict rules is monitored and non-compliance sanctioned (OECD 2010).

- Inflow into incapacity benefits started to fall sharply after stricter rules for the issuing of sickness absence certificates, and more control of GP's decisions, were introduced in Poland. Major changes responsible for this decline are a new incapacity assessment procedure and a more restrictive approach to granting permanent disability benefits. Over the same period, the unemployment rate increased and inflow into early retirement increased rapidly (OECD 2006).
- Administration of the Canadian Pension Plan Disability Benefit was tightened up with respect to initial assessments, reassessments and the tracking of clients. A disability reassessment project, conducted between May 1993 and November 1995, saw over 40 percent of reviewed cases resulting in stopped benefits. In 1997–98, new tracking mechanisms were introduced to identify individuals no longer eligible for benefits. Reassessments in 2000/01 fiscal year resulted in a 23 percent cessation of benefits (Torjman 2002). The movement of those beneficiaries who lost entitlements has not been documented.
- The certificates issued by GPs may be influenced by non-medical factors such as: the GP's desire to maintain good rapport with their patients, the number of patients the GP has and costs of certification (Dunstan 2009; Hussey et al 2003).

Disability benefits at a young age seem to steer people with disability into benefit dependence (OECD 2010). A study by the RAND Center for Disability Research in the United States found that the marginal applicants who were denied benefit during initial assessment were younger, more likely to have mental disorders and more likely to have low earnings before they became disabled (RAND 2011). There is increasing

recognition that granting a disability too early in life is counterproductive. This is supported by the fact that countries that require labour force experience before people can access the main disability programme have much lower disability benefit rates for 20–34 year olds. The Netherlands, Australia and Norway have introduced activation measures for young people on disability benefits (OECD 2010).

Getting the right services to the right people at the right time is important (OECD 2010). Activation measures **such as vocational interventions and work experience approach, together with restricting access to benefits, are found to reduce disability benefit recipients**.

- A return-to-work initiative for low-income mothers with disabilities in the United States led to an increase in employment and earnings and a decrease in numbers receiving benefits. The initiatives included vocational support (eg, job placement and job placement assistance) and work-based educational and language barriers to work (Rangarajan et al 2008).
- Work experience, on-the-job training and job placements for claimants 18–40 years old with intellectual disabilities in the United States achieved increases in employment and earnings and slight reductions in the number of people receiving benefit (Rangarajan et al 2008).
- Unpaid work trials in the United Kingdom moved one-third of the participant incapacity beneficiaries into sustained employment within three months of registration (OECD 2007).

What doesn't work?

Sickness, disability and incapacity constitute various human experiences, rather than just well-defined clinical conditions. **Assessing incapacity involves much more than formal rational decision making** (Agnes et al, 2007). Evidence from epidemiological and clinical research shows that long-term sickness absence and incapacity depend more on individual and work-related psycho-social factors than on medical factors or the physical demands of work (OECD 2006).

More frequent reassessment of incapacity status, based on the same medical criteria as the initial assessment, has been introduced in several countries with little or no impact on outflow (CSRE 2010). Increased focus at the application phase on remaining work capacity on one hand and the continued rather strong medical approach taken for reassessments on the other does not work. Improved work capacity despite an unchanged medical condition could be quite frequent, for instance, as a consequence of being better able to manage the condition – for example, a mental health condition – and maybe also because of better knowledge on how best to handle conditions in the workplace (OECD 2010).

Medical reassessments based on stricter access criteria may result in lower incapacity benefit recipiency outflow in the short term. However, the effect is not long lasting, and the people who move off incapacity benefit tend to transfer to other benefits such as the Unemployment Benefit (CSRE 2010). When the Netherlands reviewed all recipients in the general disability scheme below age 45 based on stricter access criteria, between 1994–98, 30 percent of cases were reclassified to another benefit or moved off benefit completely (OECD 2003). Many of those who lost their

entitlement successfully reapplied during the following years. During 2002–03, benefit recipiency rates were back to the same level seen before the reform (OECD 2008). Many of those removed from the scheme transferred to the unemployment rolls where they were eligible for either unemployment or temporary benefits (Dean, Rienk & Veerman 2004, cited in CSRE 2010). This strongly suggests that strict medical criteria alone do not help reduce benefit recipiency.

Restricting access to disability benefits without opportunities for part-time employment does not work.

- Although the number of long-term disability benefits is dropping in the Netherlands, and increasing emphasis has been placed on what disabled workers can do instead of what they cannot do, the actual labour participation of all disabled workers has gone down. Also, there was marginalisation of disabled workers, indicated by an increased proportion of them working in small part-time jobs (Oorschot 2010).
- Policymakers should be honest about what job opportunities can be offered to incapacitated workers, and, in some cases, it might simply prove impossible to find appropriate work (Livermore and Stapleton 2010; OECD 2003).

Providing temporary benefits with either fixed or flexible frequency of testing has been found to be ineffective. Reasons for this could include that the reassessments for testing are not taken seriously and the reassessment criteria are too narrow. Usually the benefit can only be withdrawn if the medical condition improves. Most people on temporary payments go on to receive permanent payments (OECD 2010).

Taking a piecemeal approach to changes to health and disability policy does not work. The OECD (2010) has indicated that unless all the actors, including benefit recipients, workers, employers, medical practitioners and service providers, have incentives to increase employment opportunities for individuals with health problems and/or disability, the progress will be less effective (OECD 2010).

What we don’t know

Robust quantitative data on the impacts of tightening entry to the disability benefit system is lacking. We do not know enough about what works for beneficiaries (or those with increased likelihood of being beneficiaries) with mental health problems, which are on the rise in most developed countries. Also, better evidence on the impact of the measures taken to tighten access for young people with remaining work capacity and to encourage them to the labour market is required.

Much remains to be done in terms of moving those already on incapacity benefits into work and more generally raising employment opportunities and labour force participation of workers with chronic health problems and disability (OECD 2010).

References

Agnes, M, Anja K and Rein V (2007). Judging without criteria? Sickness certification in Dutch disability schemes, *Sociology of Health and Illness*, 29(4): 497–514.

Barnes, H, Aston, J and Williams, C (2010). *Employment and Support Allowance: Customer and staff experiences of the face-to-face Work Capability Assessment and Work-Focussed Health-Related Assessment*. Research Report No. 719. A report of research carried out by the Institute for Employment Studies on behalf of the Department for Work and Pensions. London.

Bloch, F and Prins, R (Eds) (2001). *Who Returns to Work and Why? A Six-Country Study on Work Capacity and Reintegration*. Transaction Publishers, New Brunswick, NJ.

Carcillo, S and Grubb, D (2006). *From Inactivity to Work: The role of active labour market policies*. OECD, Social, Employment and Migration Working Papers 36. OECD Publishing, Paris.

CSRE (2010). *Medical reassessment for recipients of incapacity benefits to decrease numbers of beneficiaries receiving sickness benefit*. Evidence Brief, Centre of Social Research and Evaluation, Ministry of Social Development, Wellington.

DEEWR (2011). *Employment Services Assessments*. Department of Education, Employment and Workplace Relations, Australian Government. Canberra.

Dunstan, D A (2009). Are sickness certificates doing our patients harm? *Australian Family Physician*, January/February 2009.
www.racgp.org.au/afp/200901/200901dunstan.pdf

Hogan, S R, Unick, G J, Speiglman, R and Norris, J C (2011). Gender-specific barriers to self-sufficiency among former Supplemental Security Income Drug Addiction and Alcoholism Beneficiaries: Implications for welfare-to-work programme and services. *Journal of Social Service Research*, 37(3), 320–337.
www.tandfonline.com/doi/pdf/10.1080/01488376.2011.564071

Howard, M (2004). *Technical Commission on Social Security Research, Trends in disability benefit recipiency rates in post-industrial societies: Preliminary results of an ISSA research project.* ISSA, Geneva, Switzerland.

Hussey, S, Hoddinott, P, Wilson, P, Dowell, J and Barbour, R (2003). Sickness certification system in the United Kingdom: Qualitative study of views of general practitioners in Scotland. *British Medical Journal 2004, 328*(88).
www.bmj.com/content/328/7431/88

Jong, P R (2008). *Recent Changes in Dutch Disability Policy*.
www.ape.nl/include/downloadFile.asp?id=102

Kemp, P A, Sunden, A and Tauritz, B B (2006). *Sick Societies? Trends in disability benefits and post-industrial welfare states*. International Social Security Association, Geneva, Switzerland.

Livermore, G and Stapleton, D (2010). *Work Activity and Use of Employment Supports Under the Original Ticket to Work Regulations: Highlights of the Fifth Ticket to Work Evaluation Report.* Mathematica Policy Research Inc, Washington. www.ssa.gov/disabilityresearch/documents/TTW5_highlights_rev.pdf

MSD (2011). National Benefit Factsheets, Ministry of Social Development.

Netherlands Country Memo (2007). *Sickness and the Disability Schemes in the Netherlands*. Netherlands Country Memo as a background paper for the OECD Disability Reviews, November 2007. www.oecd.org/social/soc/41429917.pdf

OECD (2003). *Transforming Disability into Ability: Policies to promote work and income security for disabled people*. OECD Publishing, Paris. www.oecd.org/employment/emp/transformingdisabilityintoability.htm

OECD (2006). *Sickness, Disability and Work: Breaking the barriers (Vol. 1): Norway, Poland and Switzerland*. OECD Publishing, Paris.

OECD (2007). *Sickness, Disability and Work: Breaking the barriers (Vol. 2): Australia, Luxembourg, Spain and the United Kingdom.* OECD Publishing, Paris.

OECD (2008). *Sickness, Disability and Work: Breaking the barriers (Vol. 3): Denmark, Finland, Ireland and the Netherlands*. OECD Publishing, Paris.

OECD (2010). *Sickness, Disability and Work: Breaking the barriers. A synthesis of findings across OECD countries*. OECD Publishing, Paris.

Oorschot, W V (2010). Disability Benefit Reforms in the Netherlands 1980–2006, Retrenchment and reconstruction. In Kautto, M and J Bach-Othman (Eds) *Disability and employment: Lessons from reforms*. Finnish Centre for Pensions, Helsinki.

Pennucci, A, Nunlist, C and Mayfield, J (2009). *General assistance programme for unemployable adults*. Document No. 09-12-4101. Washington State Institute for Public Policy, Olympia, WA.

Prinz, C (2011). *Reconciling Mental Ill-Health and Employment: Summary and conclusions of the evidence report in the context of OECD's "Mental Health and Work" review*. OECD DELSA/ELSA(2011)11. OECD Publishing, Paris.

RAND (2011). Do Disability Benefits Discourage Work? *Insights, Emerging Research on Disability*, RAND Centre for Disability Research, August 2011, Number 1.

Rangarajan, A, Wittenberg, D, Honeycutt, T, Brucker D (2008). *Programmes to Promote Employment for Disabled People: Lessons from the United States*. Research Report No. 548. Department of Work and Pensions, Norwich, UK.

Social Security Disability Insurance (2011): See https://www.ssa.gov/planners/disability/index.html

Torjman, S (2002). *The Canada Pension Plan Disability Benefit*. Caledon Institute of Social Policy, Toronto. www.crwdp.ca/sites/default/files/Research%20and%20Publications/Enviornmental%20Scan/2.%20Caledon%20Institute/3.%20The%20Canada%20Pension%20Plan%20Disability%20Benefit.pdf