Disability and employment: the importance of the diagnosis

Chronic illness and disease may have adverse social and economic consequences, and may limit the opportunities among people of working age to participate in gainful employment. Health-related exclusion from the labour market is a costly problem to society and has been recognized as a major issue in many OECD countries.¹

Not least is it a considerable problem for the affected individual and his/her family. Participation in the labour market involves several dimensions of individual daily life, including structuring daily life regarding time and purpose, income and economic standard of living, sense of participation in society, in the social network in the workplace, and a sense of identity. Hence, losing one’s job and being excluded from the labour market has a profound impact.

The risk of health-related exclusion from the labour market varies between men and women, between social classes and between countries, and may be one important mechanism for contributing to health inequalities. Women have become more affected by health-related exclusion than men, lower socioeconomic groups more than higher socioeconomic groups, and rates of exclusion are higher in the UK than in Sweden.²

Yet another factor of importance is the specific diagnosis. In many countries, including Sweden, the major causes of long-term sickness absence and disability pension include musculoskeletal diseases, psychiatric diseases and cardiovascular diseases. The possibilities to reconcile chronic illness and disease with gainful employment vary widely across different diagnoses. In previous studies following up persons admitted to hospital in Stockholm County Council for specific diagnoses, we found reduced rates of employment 5 years after admission in all groups, compared with rates in the general population. However, rates of employment were considerably higher among persons admitted for musculoskeletal disease³ and coronary heart disease⁴ compared with persons admitted for psychiatric diagnoses. The lowest rates of employment were found among persons admitted for psychotic disorders (unpublished results).

The likelihood of employment of an individual with a chronic illness is the result of an interaction between the individual’s severity of disease and capacity to work on the one hand, and the opportunities for adequate rehabilitation, work and work adjustment on the labour market, on the other. Studies using multidisciplinary investigations among persons on long-term sick leave have found high prevalence of comorbidity of psychiatric and somatic diagnoses. About 80% had more than one diagnosis, the vast majority had a psychiatric diagnosis, 55% both a psychiatric and a somatic diagnosis.⁵ However, only one-sixth were assessed to have no working capacity. Patients with psychiatric diagnoses with or without concomitant somatic diagnoses may need medical rehabilitation or medical/vocational rehabilitation to a greater extent than those with somatic diagnoses only, adapted to their needs.

Having gainful employment serves many functions, not least it provides an opportunity to earn one’s living, but also to participate in society. The low rates of employment among persons with a chronic psychiatric illness are disturbing for several reasons. The onset of chronic psychiatric illness is usually at a much younger age than that of chronic somatic diseases, affecting the possibilities for an individual to complete an intended education or training. Furthermore, chronic psychiatric disease may lead to disability pension at an early age. Social insurance systems are usually based on the premises that individuals work and contribute to the insurance for a long time; that if disease strikes, it will be later in life. Persons with chronic psychiatric disease, however, will not to the same extent be protected by the social insurance and usually have a low income level, even in a welfare state as Sweden. Patients admitted for different diagnoses in Sweden usually experience a decline in income in the subsequent 5 years, but to a greater extent among patients admitted for psychiatric diseases. They also run a higher risk than persons with other diagnoses needing social assistance.⁶

In a recently started international project funded by the Nordic council, we will investigate whether health-related exclusion from the labour market has a social gradient, a diagonal gradient, whether it differs across different welfare states, and whether the Nordic model, with its extensive and comprehensive welfare state arrangements, makes a difference. Another objective is to study aspects of living conditions among persons who for health reasons are outside the labour market in different countries. Previous studies have indicated differences in rates of employment among similar groups of persons with limiting long-standing illness in different countries. The Nordic countries have had more emphasis on active labour market policies, legislation to protect the right to employment of the individual, and more comprehensive and generous social security nets than many other countries, which might explain the differentials. However, times and policies are changing, the Nordic countries differ in many aspects of social and labour market policy and the countries are not entirely homogeneous. What are the trends in recent years, and does the Nordic model still make a difference? The Nordic model is represented by Norway, Denmark and Sweden, and findings will be contrasted against other types of welfare states represented by the UK, Canada and Germany. Hopefully, this project will increase the evidence base for policy makers trying to limit health-related exclusion from the labour market.

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References

There is a need to integrate comparative welfare state studies with public health and health inequality research. Up to now, these two research disciplines have been apart and separated by institutional and disciplinary boarders within and between countries. This is now about to change. This is an important step forward as it entails the potential to shed new light on one of the hottest issues related to the future of the welfare state: employment problems and worklessness, especially among disadvantaged groups. In many countries, the fear of dwindling labour force participation is a cause of great political concern since it threatens the economic fundament of the welfare state, especially in the Nordic countries. This is a serious threat to all modern economic systems, but in particular to the Nordic model. The defining features of the Nordic model are: generous and universal welfare benefits; and free or cheap social and health services. In order to pay for such comprehensive public welfare provision, it relies on relatively high tax rates and a broad tax base—i.e. high employment; the Nordic model is hardly sustainable without a high rate of labour market participation. Over the past 15 years the Nordic countries have performed quite well, and contrary to common economic thinking, they have been able to achieve both economic growth and equality. Labour statistics from the OECD covering the past 15 years or so and up to the financial crisis, show that the Nordic countries have succeeded in creating relatively high employment, particularly among groups otherwise marginalized in the labour market, i.e. women and elderly.

As research on ‘social determinants of health’ has eloquently demonstrated, inequality in people’s living conditions has a strong influence on health. The WHO Commission on social determinants of health phrases this view like this: ‘These inequities in health, avoidable health inequalities, arise because of the circumstances in which people grow, live, work and age, and the systems put in place to deal with illness…’ The conditions in which people live and die are, in turn, shaped by political, social and economic forces. It follows from this perspective that welfare policies that have a positive impact on people’s living conditions throughout their life course, e.g. childhood conditions, housing, human and social resources, and work environment, will also improve the health of individuals, reduce health inequalities, and hence boost the health of nations. Social policy that provides people with welfare resources to cope with and control their lives, and which enables people to participate in the labour market and to be respected members of the society, will thereby improve people’s health and wellbeing, directly and indirectly. There is little doubt that the Nordic countries perform very well on income inequality: despite an increase in the Gini coefficient over the past decades, it is still smaller than in most other countries. Small income inequalities are likely to be translated into a more equal distribution of most kinds of living conditions and hence health. However, comparative research on public health and health inequalities across welfare regimes does not unequivocally confirm the hypothesis that Nordic egalitarian countries have narrower health inequalities than less egalitarian ones, at least not in relative terms.

Looking beyond these controversies, it is evident that research on the social consequences (i.e. the sickness dimension as opposed to disease and illness) of health inequalities is rather meagre, especially in terms of labour market participation. There is a mutual relationship—an interaction—between social welfare, individual and public health and the structure of the labour market. An important question to be addressed is whether welfare arrangements and welfare regimes influence labour market attachment among citizens with lower socio-economic positions who suffer from health problems. It is generally recognized that health is a precondition for social participation. In EU’s programme to combat social exclusion, ill-health is identified as one of the crucial factors causing marginalization and social exclusion. Research, also from the egalitarian Nordic countries, shows that ill-health is a barrier against participation in the labour market, a barrier that is higher for people with lower socio-economic status. A consequence of non-employment is most often decreased level of living and wellbeing. The reduction in work capacity, and labour force participation, that ill-health often entails, is therefore one of the major obstacles for social inclusion, for eradicating poverty and for promoting social equality. However, less attention is paid to the fact that such adverse social consequences of ill-health are socially stratified and may vary across countries.

Recent comparative research suggests that people with low education and poor health struggle with low employment rates also in the Nordic welfare states. However, the participation rates among the disadvantaged, i.e. lower occupational classes and lower educated people, appear to be significantly higher than in the UK for example. This prompts the question whether the institutions of the Nordic regime are conducive to high levels of labour force activity not only among the general population, but also among more disadvantaged groups. One might even ask whether there are positive employment...