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**Social security and social protection for people  
with disabilities or incapacity for work**

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# Social security and social protection for people with disabilities or incapacity for work

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**Summary.** *This paper discusses the distinctions between disability and incapacity for work, from both a theoretical and an operational perspective. Disability refers mainly to a functional limitation in ordinary activity; incapacity for work concerns people who are unable to work because of a medical condition. Although the terms overlap, they are conceptually distinct, and people can be disabled without being unable to work, and unable to work without being disabled. Clarifying these distinctions is important for the development of policy: social security benefits for disability are given on different principles from benefits for incapacity.*

This paper has its origins in work done for an EU PHARE project in the Former Yugoslav Republic of Macedonia, concerned with the development of systems for the protection of people with incapacities. It rapidly became apparent that the focus of concern was not incapacity, but disability in people of working age. The two issues, while closely related, are distinct, and the pattern of responses which is appropriate required are very different.

Although the paper is conceptual, the detailed illustrations are mainly drawn from social policy in the United Kingdom.

## **Disability**

Disability is a complex term. The World Health Organisation distinguishes impairment, disability and handicap. An *impairment* is an anatomical, physiological or psychological abnormality or loss. This definition is used only in a limited context. An example from the UK is the system used for assessing compensation for Industrial Injury Benefits. It includes, among many others, ratings like these:

Very severe facial disfiguration	100%
Absolute deafness	100%
Amputation below shoulder	80%
Loss of a hand	60%
Loss of four fingers	40%
Loss of all toes	20%
Loss of part of big toe	3%

The 'percentages' in this scale represent judgments of value, rather than any precise statement of functional ability or capacity.

*Disability* refers to a functional limitation in ordinary activity. The test is not the impairment, but how impairments or chronic physical conditions affect behaviour. The term "80% disabled", widely used in

Europe, refers to a loss of 80% of physical or mental capacity, judged by medical examination; blind people are taken to be 100% disabled. (There is still some ambiguity as to how far the measure of disability can be taken on the basis of impairments, and how far it should consider functional capacity. The UK schemes mix both criteria. In France, the 80% test used to be based on the scales introduced in 1919, which were concerned principally with impairment; since 1993 they have been based on a test of functional limitations.<sup>1</sup>)

*Handicap* was intended by the WHO to refer to the social issues surrounding disability - the production of the social status of a 'disabled person'. The UN defines handicap as "the loss or limitation of opportunities to take part in the life of the community on an equal level with others. It describes the encounter between the person with a disability and the environment."<sup>2</sup>

The term 'handicap' is now considered unacceptable by many people with disabilities, and the idea of a 'social model of disability' has been adopted in its place, but the condemnation of the WHO definition found in some recent texts<sup>3</sup> is unjustified: the term 'handicap' was clearly intended to refer to the same issues as the social model of disability. The primary emphasis in services based on this model has been 'normalisation'<sup>4</sup> (not 'independence', but the promotion of autonomy and 'social role valorisation') and 'empowerment'<sup>5</sup>.

### **Disability and the labour market**

Disability is commonly thought of in Central and Eastern European countries as referring to people who have partly or wholly lost the capacity to work. Poland's Law on the Rehabilitation of the Disabled, for example, defines disability as "a physical, psychological or mental state which permanently or temporarily makes difficult or impossible performing social roles, especially an ability for employment."<sup>6</sup> Much disability, however, is not relevant to the labour market, because disability is in large part a problem of older people. According to the European Commission, the proportion of older people over 65 is likely to be 35% to 45%<sup>7</sup>, but this is subject to a range of definitions of disability. In the UK, research has shown that over two-thirds of the people who might be assessed as disabled are above working age.

The fullest accounts of the position of disabled persons in the UK stems from two major surveys undertaken by the Office of Population Census and Surveys in the 1980s<sup>8</sup>. Previous surveys had

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<sup>1</sup> A Deveau, 1995, Un nouveau barème, Informations sociales 42 pp 40-6.

<sup>2</sup> United Nations, 1994, The standard rules on the equalization of opportunities for persons with disabilities, New York: United Nations, p.9.

<sup>3</sup> e.g. M Oliver, 1996, Understanding Disability, London: Macmillan; P Abberley, 1998, The spectre at the feast, in T Shakespeare (ed) The disability reader, London: Cassell.

<sup>4</sup> W Wolfensberger, 1972, The principle of normalization in human services, Toronto: national Institute of Mental Retardation.

<sup>5</sup> P Ramcharan, G Roberts, G Grant, J Borland 1997 (eds) Empowerment in Everyday Life, Jessica Kingsley.

<sup>6</sup> J Szmagaliski, 1999, Policies for disabled persons in Poland, paper for EU/PHARE consensus programme in the Former Republic of Macedonia.

<sup>7</sup> DGV (European Commission). n.d., Mainstreaming disability within EU employment and social policy: a DGV services working paper, p.5.

<sup>8</sup> J Martin et al., 1988, The prevalence of disability among adults in Britain, London: HMSO.

estimated that there were some three million people with disabilities in the UK<sup>9</sup>; the 1988 survey, using a broader definition of disability, identified 6.2 million adults.

The age distribution was as follows:

Age Group	Number of disabled adults (thousands)	No. and % of adults in higher severity categories
16-19	76	31 (41%)
20-29	264	95 (36%)
30-39	342	99 (29%)
40-49	453	126 (28%)
50-59	793	192 (24%)
60-69	1334	318 (24%)
70-79	1687	519 (31%)
80 and over	1254	622 (50%)
Total	6202	2002 (32%)

For many people disability substantially increases in severity over the age of 70. This has important implications for services:

- ! services aimed at the whole population with disabilities are likely to be used primarily by elderly people.
- ! services related to employment and the workplace do not provide for the majority of adults with disabilities.

The same survey method, repeated in 1996/7, showed 8.6 million disabled adults.<sup>10</sup> The bulk of the increase concerns self-identification of limitations in ability by older people; there is some foundation for an increase, because there are growing numbers of very elderly people, but the increase far exceeds what might be expected given the health of the population. The questions for the 1980s study were tested at the time for reliability and validity, and on the face of the matter it is difficult to see why large numbers of people should have begun to complain of problems of locomotion, bending stretching and so forth. The most plausible explanation is that the responses reflect, to an unexpected degree, the economic circumstances of the respondents. During the 1990s, many unemployed people - more than a million - were reclassified as being incapacitated. Many were older people with little realistic prospect of regaining work in Britain's depressed economy. Such respondents may well legitimise their dependent position by reference to their incapacity.

#### *Provision in the labour market*

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<sup>9</sup> A Harris et al, 1971, *Handicapped and impaired in Great Britain*, London: HMSO.

<sup>10</sup> R Berthoud, 1998, *Disability benefits*, York: Joseph Rowntree Foundation.

People with disabilities may be able to work, but they suffer from two principal disadvantages: limited opportunities for employment, and limited earnings when they are in employment.

*Opportunities for employment.* Disabled people are part of a labour market. The demand for labour depends on a range of factors, including cost and productivity; disabled people, in competition with other workers, may be disadvantaged in both respects. They may entail greater costs for employers in circumstances where special facilities are required, or where replacement workers have to be appointed and trained to cover periods of interruption in service. They may be less productive either because of interruptions in service, or because of physical capacity (e.g. capacity for sustained exertion, or speed of operation).

There are several potential responses to this disadvantage.

! *Costs.* Employers or employees can be subsidised in order to alter the calculation. This can be done through grants or benefits.

! *Increasing capacity.* It may be possible to increase the capacity of the disabled person; training programmes, or the provision of special tools and equipment.

! *Alternative forms of employment.* Sheltered workshops are one example; grants for disabled people to set up independent businesses is another.

! *Changing employment practice.* The use of a quota is probably the best known example, though it is difficult to see how, and in what circumstances, a quota could achieve the desired effect. Quotas have general deficiencies in principle - they imply selection on non-relevant criteria, and if they have any force they become ceilings, reinforcing discrimination.<sup>11</sup> The main alternative is the establishment of anti-discrimination law (see box 1).

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**Box 1: Disability discrimination.**

In the UK, the 1995 Disability Discrimination Act gives disabled people rights of redress against employers who have discriminated against them. People are treated as disabled if four conditions are satisfied:

- ! there is an impairment
- ! the impairment has an adverse effect on normal day-to-day activities,
- ! the adverse effect is substantial, and
- ! the effect is long-term.

This definition excludes, then, seasonal complaints, allergic conditions, and some behavioral disorders. The position of a number of conditions which lead to periodic incapacity, like depression and back pain, have proved difficult to categorise.

Discrimination is held to occur if the person has been negatively treated because of disability; the treatment is different from other people who are not disabled; and the employer's action is not justified. Employers can be considered to discriminate if they fail to make reasonable adjustments in their policies for their employees, such as offering alternative locations, modifying assessment tests and supervision, or allowing time out for medical treatment. To date, there have been about 3,000 cases taken in Industrial Tribunals: although there have been some very high settlements (the highest being over ,100,000), the compensation for successful actions in 1997 generally fell in the range of ,700 to ,4250, and the median figure is ,2000.

Main source: P Winfield, 1999, *Where are we now?*, Adviser no 74 pp 31-35.

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<sup>11</sup> J Elster, 1992, *Local justice*, Cambridge: Cambridge University Press.

*Limited earnings.* People with disabilities are liable to limited earnings for some of the same reasons as they are liable to be excluded from employment: limited capacity, and the combination of discrimination and limited competitiveness. Where capacity is limited, it has been possible to subsidise employment: the main benefit in the UK which does this is the Disabled Person's Tax Credit, which offers a means-tested supplement to wages, declining as income increases. The issue of limited competitiveness is much more problematic, because low earnings on the basis of competitiveness depends on the structure of salaries in the economy as a whole. The main response of disability campaigners has been to say that the problem is exaggerated; relatively few jobs in a modern economy have wages which depend directly on production, and once issues of discrimination have been addressed, much of the reason for disadvantage in earnings will have been removed.

### **Incapacity for work**

Incapacity for work concerns the situation in which a person is unable to work by reason of a medical condition. The terms 'disability' and 'incapacity for work' are not used consistently, but they should not be seen as equivalent. A person may be disabled and able to work, and there is some arbitrariness in the attribution of 'incapacity' to people with disabilities. The structure of the labour market means that people with limited capacity are treated as less employable than others, and are liable to receive lower wages when they are employed. It is debatable, though, whether many people are truly 'unemployable', in the sense of having no capacity for work of any kind: this would be true only for the relatively small number of people with severe multiple disabilities. What happens, rather, is that people with disabilities are treated as less desirable employees, and are likely to find employment only where labour is in short supply. This is particularly true of people with psychiatric illnesses like schizophrenia; the symptoms may be intermittent, but incapacity is taken to be long-term. Many provisions for people with disabilities are concerned to secure them a place within the workforce; this would be unnecessary if they were incapacitated.

Conversely, a person who is incapacitated may not be disabled. Incapacity arises when the effect of the person's condition is to prevent that person from undertaking employment. This might mean either that someone is unable to undertake the employment which he or she would usually do, or that he or she is unable to do any work at the time. Although benefit regulations tend to refer to the broader definition of incapacity, most incapacity - and most disability - relates to functional ability in a specific context; different standards apply to a surgeon, a bus driver and a clerical worker. In France, the test of incapacity is whether or not a person is able to earn two-thirds of a previous wage (a much more liberal test than that applied to disability).

The most basic distinction made falls between short-term and long-term incapacity. Short-term incapacity covers most episodes of interruption of work and earnings; there is a presumption that the person who is incapacitated in the short term will return to work subsequently, in an equivalent position. 'Incapacity' has to be understood in the context of the person's own occupation. Sickneses such as influenza or backache do not usually imply an inability to do any sort of work; they offer a legitimate reason for temporary interruption of employment, which is not inconsistent with performing at full capacity overall. In the short term, people are encouraged to enter the 'sick role'. Parsons defines four principal features.

1. The sick person is discharged from ordinary social obligations. He is not expected to do the same as someone who is healthy.
2. The sick person must not be sick by choice. A malingerer or a hypochondriac is someone who tries to manipulate the sick role, rather than someone who is genuinely of it; the fact that the illness is voluntarily assumed breaks expectations and alters the obligations of others towards the sick person.
3. Though the sick role is an undesirable status, it is accepted as a legitimate one.

4. The sick person must seek help in an attempt to get better.<sup>12</sup>

Long-term incapacity occurs either when the interruption disrupts work and employability, or when the incapacitating condition is of a kind which is liable to produce such an effect. The borderline between the two is fuzzy; in the UK, incapacity is treated as short-term for six months, while transfer to an invalidity pension in France takes place formally after three years, the point when entitlement to earnings-related sickness benefits expires. Long term incapacity has two implications. One is that the sick role is eroded, and the allowances which are made for sickness cease to apply. The second is that the point of reference alters. Illness may impair a person's ability to do a task without necessarily preventing performance altogether: people who are unable to work in a role they previously filled may still be able to work in other roles.

**Box 2: The assessment of incapacity in the UK**

Incapacity Benefit, effectively a long-term sickness benefit, is awarded in the UK on a points scheme. The categories under which points are assessed are:

Physical problems		Mental problems
walking on level ground walking up and down stairs sitting in an upright chair with no arms standing rising from chair reaching	speech hearing continence vision consciousness bending and kneeling manual dexterity lifting and carrying	Completion of tasks Daily living Coping with pressure Interaction with others

The criteria mean that

- some people without disabilities would be accepted as incapable for work. Mental capacity, social behaviour and the ability to cope with stress are factors in capacity.
- people with disabilities may not be treated as incapable for work. A person with several low-level disabilities (e.g. inability to walk more than 800 metres, to climb stairs and to sit comfortably) would not necessarily have enough points to qualify.

Long term incapacity shades into disability, because duration is one of the principal defining features of a disability. If there is a distinction, it is that there are limiting long-term illnesses which are not permanent, and to which the sick role can still validly be applied. Stroke (cerebro-vascular accident) is one of the principal causes of disability and incapacity in the UK, accounting for about half of all cases of people in the 50-60 age bracket. Many victims of stroke, however, recover over time: they are incapacitated but not necessarily disabled. Some benefits require that the disabling condition must have lasted for a period months prior to claim; others that the condition must be likely to last for a period subsequent to claim. To receive Disability Living Allowance in the UK, claimants must have been disabled for three months before claiming, and the condition must be likely to last for at least six months. The total period of nine months excludes many strokes from which people are likely to

<sup>12</sup> T. Parsons, 1958, "Definitions of health and illness in the light of American values and social structure", 165-187 of E.G. Jaco (ed.), *Patients, physicians and illness*, Glencoe, Illinois: Free Press.

recover. (Exemptions from this kind of provision are made for people who are diagnosed as being terminally ill.)

Unlike disability, incapacity legitimates withdrawal from the labour market. More than half the claimants of Invalidity Benefit in a 1993 survey in the UK considered that they would not work again, or described themselves as retired.<sup>13</sup>

### **The principles of distribution**

Benefits for disabled people are given on a number of principles.

1. Compensation for disability. Industrial disablement or action in the courts assume that people should be paid if something unpleasant happens to them. This does not extend to those who simply become ill or to those born with disabilities. (Part of the rationale for compensation is preventative: penalising those who are responsible is assumed to encourage more responsible action. Prevention is not, however, a primary aim of benefits in themselves.)
2. Special needs. Allowances can be made for example for personal care, transport, and medical goods.
3. Desert. War pensions are the obvious example.
4. The protection of carers. People caring for a disabled person may be limited in their capacity to seek work and to earn.
5. Rehabilitation. Benefits may be concerned to change the status of the disabled person - for example, through training or the provision of special equipment.
6. Promoting employment. A number of benefits are geared specifically to the promotion of employment for disabled people, as a desirable end in itself. They do so principally by altering the calculation of costs and benefits made by disabled people or by employers.
7. Improving low income. Low income may reflect incapacity or disadvantage in the labour market. Many disabled people on low incomes rely on forms of social assistance benefits, for others who are poor. Support for disabled people on low earnings is another example.
8. Equal opportunity. Rehabilitation and the promotion of employment can both be seen as means to further equality of opportunity for people with disabilities. This is an express objective of the UN World Programme of Action concerning Disabled Persons.<sup>14</sup>
9. Participation in society. This is, again, a declared objective of UN policy. It encompasses rehabilitation, employment and income support; it is also a justification for a range of benefits in kind intended to promote social inclusion for people with disabilities, including housing, transport, leisure, cultural and educational benefits.
10. Market-based and voluntary provision. With the exception of insurance-based social protection (below), the role of non-governmental organisations (NGOs) in this field is overwhelmingly geared to disability, not to incapacity *per se*. State intervention which is based on support of the voluntary sector necessarily reflects to some degree the principles which inform voluntary action. The voluntary sector has a wide range of objectives, including humanitarian, religious, mutualist and commercial aims. In the special case where market-based criteria apply, it is worth noting that the services provided are mainly services for elderly people; commercial services develop according to economic demand rather than abstract principles. So, for example, the private market for mobility aids, nursing care or help with domestic tasks is primarily a market for old people.

The principles on which incapacity is provided for are related, but different. They include

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<sup>13</sup> S Lonsdale, C Lessof, G Ferris, 1993, Invalidity benefit, Department of Social Security.

<sup>14</sup> United Nations, 1994.



1. Social protection. The principle of social insurance is intended to cover changes of circumstance and needs which might arise. This extends to cover for medical care, the incurring of unexpected costs and income maintenance (which follows).
2. Income maintenance. People wish to protect themselves from circumstances in which their income might be interrupted. This is sometimes done through social assistance but more typically it affects people who have previously been earning, and so it will be done through an insurance-related benefit.
3. Economic efficiency. Part of the rationale for incapacity benefits is based, not in the circumstances of the incapacitated worker, but in economic processes. Employers wish to maximise the productivity of the workforce. This is less likely to be achieved if workers are unable to function adequately - and less likely still if a worker with a short-term illness like influenza infects everyone else. Rules relating to short-term incapacity allow for restoration of full capacity; rules relating to long-term incapacity allow for removal of less productive workers from the labour market. (Note that there is a potential tension between this principle and the desire, in relation to people with disabilities, to promote increased participation in the labour market.)
4. Early retirement. A scheme for incapacity benefits may become in effect a surrogate scheme for early retirement. Because it legitimates withdrawal from the labour market, it makes it possible for those who hope to retire a means of doing so.
5. The functioning of medical services. The balancing of medical priorities has been an important element in the administration of incapacity benefits: part of the purpose of sickness benefits has been to facilitate and encourage medical consultations, but the routine certification of sickness has proved burdensome and (in some systems) ineffective as a means of prioritisation.

Although there is some overlap between the two issues, it mainly happens in so far as disability implies incapacity, or incapacity includes disability. A disability is a functional limitation of ordinary activity, and if the ordinary activity refers to the ability to work, the terms become equivalent. There are, though, disabilities which do not impair the ability to work, and problems which incapacitate people - like frequent illness, backache and stress-related disorders - which are not usually described as disabilities. A person who is disabled does not need social protection or income maintenance solely on account of the disability; a person who is incapacitated without disability does need social protection, but is not necessarily disadvantaged in terms of equality of opportunity or participation in society.

The distinction between disability and incapacity is not crucial; in many cases, people of working age who are disabled will be protected by provision for incapacity, and vice-versa. There remain, though, many who are not: most adults of working age with a disability (nearly three-quarters, on the UK figures) are in less severe categories of disability. Conversely, people with disabilities who are disadvantaged in the labour market are not necessarily protected by provision concerned with incapacity.

### **Schemes for incapacity and disability in less developed countries**

The options available for the extension or generalisation of less developed social security systems are usually described in terms of 'Bismarckian' and 'Beveridgean' schemes. Bismarckian schemes are insurance based, financed by contributions, and particular to the individuals or groups who contribute to them. Beveridgean schemes are universal and rights-based.<sup>15</sup> Neither option is necessarily helpful for a less developed economy. Universal coverage tends to dilute the level of protection which it is

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<sup>15</sup> See e.g. B Majnoni d'Intignano, 1993 *La Protection Sociale*, Editions de Fallois, Paris; D Lenoir, 1994 *L'Europe Sociale*, Editions la Découverte, Paris; P van Parijs, 1994, 'Au delà de la Solidarité', *Futuribles* 184, February, pp 5-30.

possible for a less developed country to afford; the needs of people in poorer countries tend to be greater, but the ability of their economy to meet those needs is less. Insurance-based schemes can protect only a limited number of people - those in the position to contribute. The pattern which tends to develop is that of a limited group with adequate protection, a sizeable number of others with inadequate coverage, and a substantial remainder with none.

This work was undertaken following a programme in the Former Yugoslav Republic of Macedonia, where the system of social security is still relatively underdeveloped. Many of the main concerns proved to be not about incapacity for work, but severe disability - especially in circumstances where disability required full-time care, effectively removing the carer from the labour market. Few of the principles applying to incapacity are applicable to the circumstances of severe disability. The mechanisms which are most directly associated with protection against incapacity - income maintenance, social protection and insurance - are unlikely to be effective for disabled people, because of the inability of disabled people to contribute. They are potentially more effective for carers, because often carers will have contributed before having to leave the labour market, but conventional schemes for incapacity do not necessarily address those issues.

The identification of discrete principles of operation has the advantage of making a more informed selection possible. Should provision be concerned with (for example) support for social protection, need, desert or economic efficiency? Each answer implies a different structure of priorities, and so of benefits. At first sight, the strongest impetus may seem to come from the salaried, better off employees, concerned to protect their position, to obtain health care and to maintain their income. Such people are also generally able to contribute to an insurance-based scheme, and in many countries professional and mutualist associations precede state intervention in this field. The development is not, however, self-evident. "Desert" may seem at first to be the least compelling reason for provision, but in practice war pensions have often been among the first forms of social security offered in developing systems. The same is true of industrial compensation schemes.<sup>16</sup>

The scope for applying any of these principles is limited in practice, because the capacity of the economic system is limited. Less developed systems are likely to be heavily dependent on the work of NGOs, which have their own priorities and methods of work. This implies that, whatever the aspirations of a government, policy is likely to develop incrementally, with a gradual extension of solidarity. (This approach has been central to the development of social security policy in parts of Europe<sup>17</sup>, and currently it is the policy of the European Union.<sup>18</sup>) Because incremental development is subject to political negotiation, and often dependent on activity beyond the state, this implies that provision will be made over time according to a range of principles, rather than a unitary plan.

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<sup>16</sup> P Flora, A Heidenheimer, 1981, *The development of welfare states in Europe and America*, New Brunswick: Transaction Books.

<sup>17</sup> P Baldwin, 1990, *The politics of social solidarity*, Cambridge: Cambridge University Press.

<sup>18</sup> Y Chassard, O Quintin, 1992. "Social protection in the European Community: towards a convergence of policies", paper presented to the International Conference on Social Security 50 years after Beveridge, University of York.