Erasmus Universiteit Rotterdam

Statistics Netherlands

Back to work following an incapacity benefit [*)]

Erik Snel (Erasmus University Rotterdam)[§]

Frank Linder (Statistics Netherlands) [§§]

Contents

[*)] Paper prepared for the ILP conference Innovating Labour Market Policies; Transitional Labour Markets and Flexicurity, Amsterdam, Netherlands, November 30 – December 1, 2006.

[§] Department of Sociology (EUR), e-mail: snel@fsw.eur.nl.

[§§] Department of Social and Spatial Statistics, Socio-economic state, e-mail: flnr@cbs.nl.

The views expressed in this paper are those of the authors and do not necessarily reflect the policies of Statistics Netherlands.

1. Transitional labour markets and social exclusion

The notion of transitional labour markets (TLM) indicates that as a result of a complex constellation of both economic and social developments, workers in advanced western economies are increasingly being confronted by transition in their labour careers (Schmid 1998a,b, 2000, 2002a,b). These may be both transitions within the sphere of paid employment (from one job or 'working hours regime' to another) and transitions from employment to other social activities (care, education, leisure, but also temporary unemployment and illness). TML theorists argue that labour market transitions as such are both inevitable and on the whole rather positive, as they provide employees with opportunities for training and balancing their professional career with changes in their private lives. However, there is always a danger that labour market transitions that were meant to be temporary unintentionally become permanent, and result in lasting exclusion from the labour market. Schmid refers to this aspect of TLM as 'critical transitions':

> "Some of these transitions are critical in a sense that they may lead to downward spirals of job careers ('exclusionary transitions'), ending in recurrent unemployment or (finally) in long-term unemployment, poverty, discouraged inactivity or violent protest" (Schmid, 2000:93)

> "Critical transitions are always like exit doors that close behind the back whereas opening doors in front are still uncertain. Thus, the danger is great that they kick off processes of social exclusion" (Schmid, 1998a: 9)

Others distinguish three kinds of transitions. *Maintenance transitions* where people already in work maintain this status by changing job or working hours regime. *Integrative transitions* are transitions of people not in employment (unemployed, in education or training, carers) who return to paid work. And e*xclusionary transitions*, which are moves out of the labour market to permanent non-employment or unemployment, possibly with intermittent periods of part-time or temporary employment. (Cebrian, Lallement & O'Reilly, 2000; Muffels, 2002). In our opinion, the vocabulary of integrative and exclusionary transitions provides a new and promising perspective on questions of labour market dropout. The question is not why some people become unemployed or incapacitated for work, but rather why some people manage to resume work from a situation of unemployment or incapacity while others in the same situation do not. This is, then, the issue this paper focuses on.

To our knowledge the literature on TLM contains only a few reflections on why temporary transitions out of employment (unemployment, illness, caring, etc.) are followed by resumption of work in some cases, but result in a permanent exclusion from the labour market in others. In general terms, Buitendam (2001) argues that the results of labour transitions depend both on individual *transition capacities* and on existing *transition facilities* of employers, but also on social security

systems. He claims that social competences and certain personal characteristics (independence and flexibility) are increasingly important to achieve and retain a good position in contemporary labour markets. These individual transition capacities can be defined as:

> "..the cognitive and social capacities that people need to make the transition from one position to another (internal labour market) or from one job or company to another (external labour market). Buitendam argues that transition capacities must be developed to enable people to make smooth transitions" (Nagelkerke & Wilthagen, 2002: 167)

Generally speaking, the more human and social capital (education, work experience, informal social contacts that provides access to job opportunities) an employee has, the more possibilities he has to return to and even improve his position on the labour market; similarly, he will have a lower risk of being excluded from the labour market. In fact, De Koning et al. (2003) found that low-skilled unemployed persons indeed have fewer chances of resuming work than those with higher skills.

The odds of labour market reintegration after temporary employment interruptions also depend on the transition facilities, i.e. all the technical, organizational and institutional arrangements in place on the employers' side and social security systems related to work resumption. Examples of transition facilities are organizational or technical arrangements at the workplace that allow workers to combine employment with childcare, or enable workers with physical or mental disabilities to work, but also regulations and incentives in social security systems that support the return to work. As various authors have pointed out, the Dutch social security system was originally - and still is partly - outspokenly passive, aimed more at income support of benefit claimants than at labour market reintegration. For a long time this resulted in high and persistent unemployment and social benefit dependence in the 1980s and 1990s (Therborn, 1986; Engbersen, 1993; Nagelkerke & Wilthagen, 2002).

In the last decade, successive Dutch cabinets have tried to reform social security from a passive system aimed at income support to a more active structure aimed at encouraging people to work. As the number of benefit claimants in the Netherlands fell rapidly in the 1990s (also because of the economic recovery in these years), these reform polities appeared to be rather successful. However, despite the social security reforms the number of incapacity benefits in the Netherlands stabilized at a very high level (at least until recently[1]). This article focuses specifically on employees claiming incapacity benefit (Dutch acronym: WAO) in the Netherlands, and thus on one specific labour market transition: from employment to illness and vice versa. Even more specifically, we shall concentrate on the question of resumption of work after an interruption of employment because of medical reasons. How many incapacity benefit claimants in the Netherlands manage to return to work? And also: are there any differences in this respect between native Dutch and ethnic minority workers? Our *research*

questions are twofold: 1) is there a difference in resumption of work between native Dutch and ethnic minority incapacity benefit claimants? And 2) if so, how can these differences be explained (with particular respect to differences in human capital)?

We shall answer these questions by using large-scale empirical data from Statistics Netherlands' Social Statistics Database (SSD). This unique database combines information from several large-scale surveys with administrative data from various Dutch policy institutions, including the organization responsible for carrying out incapacity benefits. In the remainder of this paper we first take a closer look at the issue of incapacity in relation to ethnic minority workers in the Netherlands (section 2), we then give some further information about the empirical sources and statistical measures used in our analysis (section 3), before we go into the outcomes of the analysis, which consist of a descriptive (section 4) and an explanatory part (section 5). We conclude with a short discussion of the main findings (section 6).

2. Incapacity benefits and ethnic minority workers in the Netherlands

For many years discussions of the Dutch system of incapacity benefits have touched a raw nerve in Dutch social politics. When the WAO (Disablement Insurance Act) was founded in the mid-1960s, it was intended for a limited number of employees who were unable to work because of medical reasons. However, with the industrial restructuring in the 1970s and 1980s things got out of hand as many workers in the traditional sectors of industry were made redundant and ended up not with an unemployment benefit, but with an incapacity benefit. For the workers themselves and for the trade unions, an incapacity benefit appeared to be an attractive alternative for being unemployed.[2] For the employers this route enabled them to reorganize without too much resistance from workers and unions. 'The Netherlands is ill', claimed Lubbers, Prime Minister at the time, when the number of people claiming incapacity benefit approached one million (of a labour force of less than 5 million). Since the mid-1980s, successive Dutch cabinets have carried out a number of drastic reorganizations of the Dutch incapacity insurance scheme. However, initially these reorganizations did not have the desired effect and by the mid 1990s, the number of incapacity benefits again rose to nearly one million (which is apparently a symbolic threshold in political discussions on this topic). Even in the second half of the 1990s, when the Netherlands experienced an unprecedented period of economic growth and job increases, the number of incapacity benefits did not decrease. Observers referred to this paradox of continuous economic growth on the one hand, and high health-related labour market dropout rates on the other as 'the dark side of the Dutch miracle' of those days (Gorter, 2002; Muffels et al., 2002; *cf.* Visser & Hemerijck, 1996). Only recent changes in the Dutch incapacity benefit regulations (in 2004)

seem to be resulting in a reduction of benefit claimants. These recent policy changes are outside the scope of our paper, however.

In general terms, the successive revisions of the Dutch incapacity benefit regulations aimed both to reduce the inflow into the system (more selective and conditional access) and to increase the outflow (reduction of the amount and duration of benefits as financial incentives to encourage work, activating benefit claimants) (Teulings, et al., 1997; Aarts, et al., 2002; Van der Veen, 2005). The latter aspect in particular – activating policies and stimulating work – is relevant for our discussion. According to Wilthagen, the Dutch system of incapacity benefits is a typically reactive form of social security. It compensates for income loss for medical reasons, but "..it takes risks and hazards more or less for granted and is at most only indirectly geared towards prevention and change" (Wilthagen, 2002: 274). This reactive social security was adequate for traditional social risks like unemployment because of company closure or disability as a result of heavy work, i.e. social risks with external causes that those involved have no influence on.

Contemporary social risks, however, are often 'manufactured risks', i.e. (unintended) consequences of human action (Giddens, 1994). As an example, Wilthagen points out the large numbers of workers incapacitated for mental reasons (stress, burn-out), partly resulting from heavy workloads or unresolved conflicts at work.[3] These social risks are related to the attitude and behaviour of those involved (employees, bosses, employers, etc.). This situation would benefit more from a proactive social security scheme, oriented not primarily towards income compensation, but towards coping with and controlling social risks ('risk management'). In the case of incapacity, a proactive system would aim to activate sick employees and benefit claimants, and get them back to work. However, the Dutch system of incapacity benefits originally[4] was far from this ideal. According to Nagelkerke & Wilthagen (2002: 168) there are only few arrangements "..facilitating certain maintenance transitions within companies or within work situations. These transitions could be preventive ('opting out') while at the same time – for disabled persons – offering the possibility of reintegration".

Because of the reactive social security system in the Netherlands, all too often illness, stress and incapacity result in complete and permanent labour market drop-out – the opposite of the ideal of TLM. This paper specifically focuses on immigrant workers in the Netherlands and the Dutch system of incapacity benefits. Previous research has shown overrepresentation of some categories of non-western immigrant workers in the Netherlands among the incapacity benefit claimants. Taking into account the size of their labour force, workers with a Turkish background are twice as likely to claim an incapacity benefit as native Dutch workers. The number of incapacity benefits for workers with a Moroccan background is 1.5 times that for native Dutch workers. This overrepresentation of Turkish and Moroccan workers is not limited, as may be expected, to men with a history of heavy work in the

traditional industries (the former 'guest workers'). Young Turkish and Moroccan workers, too, and especially women, are overrepresented among incapacity benefit claimants. In 1999, not less than one in four female Turkish workers received an incapacity benefit (Snel, 2002). Other non-western immigrant groups are not overrepresented – or even underrepresented – in the Dutch incapacity schemes. Further analysis showed that the generally low levels of education of these migrant workers partly, but not completely explain the overrepresentation of Turkish and Moroccan workers in the Dutch incapacity schemes (Snel, 2002).

Seen from a dynamic perspective, the overrepresentation of Turkish and Moroccan workers among the incapacitated can be explained by either a large inflow or a relatively small outflow of these migrant groups in the incapacity schemes (or, of course, both). Previous research has shown that the inflow into the incapacity benefit scheme is 2.5 times larger for Turkish and Moroccan workers than for native Dutch workers. Again Turkish women have an exceptional position: they are 4 times as likely as native Dutch women to claim an incapacity benefit (Copinga & Selten, 2003). Whether these higher inflow figures of workers with Turkish and Moroccan backgrounds result from the lower educational levels of these groups is unknown. In other words: we do not know whether the higher inflow of Turkish and Moroccan workers in the Dutch incapacity benefit system is primarily a social issue, or whether other factors (discrimination, culture, etc.) also play a role.

Little is known so far about the outflow from incapacity benefits in the Netherlands, although the general impression is that it is hard to break out of the system (Snel, 2002). Linder (2005) first substantiated this impression. He showed that of all 850 thousand incapacity benefit recipients[5] in September 1999, only 70 thousand (8 percent) resumed work within 3 years to some extent (including people who earned an income from labour alongside their incapacity benefit). The present paper builds further on Linder's initial analysis and focuses on possible differences in work resumption and other outflow from incapacity benefits between native Dutch and non-western immigrant workers.

Once we have established ethnic differences in the outflow from incapacity benefits, the next question is what causes these differences. The (scarce) literature on this issue distinguishes both general and specific ethnic factors that influence the odds of work resumption. The following general factors are mentioned (Aarts et al., 2002; Hoff & Jehoel-Gijsbers, 2002):

- *Severity and nature of health limitations*: incapacity benefit claimants with less serious health problems and with mental limitations (as opposed to physical health problems) more actively look for work and are more likely to resume work;
- *Age*. Young benefit claimants experience fewer serious health problems, look for work more actively and are more likely to resume work;
- *Economic sector and employer*. In some occupational sectors (cleaning, manufacturing) people who receive incapacity benefit have a small chance of going back to work. Claimants in these sectors relatively often remain on the benefit;

- *Perception of illness and resumption of work.* In addition to the objective situation, the subjective perception of illness and possibilities of going back to work are crucial for actual resumption of work. Benefit recipients who see few possibilities, do not actively look for work and are consequently less likely to find new work;
- *Motivation* is also crucial for the chance of work resumption. Motivation has various aspects, such as the significance of work for the person concerned, financial aspects (benefit claimants are less likely to look for new work if there is another income earner in the household), and the relationship with the employer. Conflicts or discrimination experiences at the workplace reduce the chance of work resumption;
- *Socio-economic status (educational level).* Available research gives no clear indications that the socio-economic status of benefit recipients is of influence on the odds of resumption of work.

These general factors give us some indication that incapacity benefit recipients with an immigrant background are less likely to resume work than native Dutch benefit claimants. They are more likely to have serious health problems, to work in occupational sectors where there is a lower probability of work resumption, and to experience conflicts and discrimination at work (Snel, 2002). These factors do not stimulate benefit recipients to go back to work. However, the more subjective aspects (perception, motivation) may be of greater influence. Several qualitative studies on sick workers and incapacity benefit recipients with an immigrant background claim that ethnic-specific or cultural factors greatly restrict the odds of work resumption (Snel, 2002; Heijmans van den Bergh, 2002; Kamphuis et al., 2003). It is claimed that migrant workers have little interest in resuming work before they have completely recovered from their illness. This 'absolute illness role' impedes fast work resumption. The same goes for the alleged tendency of migrant workers to deny mental health problems. As undiagnosed mental problems are not treated and thus not cured, this also hinders fast work resumption. However, other researchers maintain that the ethnic-specific or cultural factors often cited as the reason for low work resumption rates of migrant workers have never seriously been researched in quantitative terms. In fact, we do not know whether these alleged cultural traits are typical for (specific categories of) migrant workers or for any worker *with a social background of low-skilled work* (Meershoek et al., 2005 and 2006).

Using large-scale statistical data, this paper first describes whether there are differences in the chance of work resumption between incapacity benefit recipients with a native Dutch and an immigrant background. We shall subsequently examine a variety of factors that may explain these observed differences. However, the empirical data used in the analysis only enable us to examine the effect of the general factors mentioned above. The alleged ethnic-specific or cultural factors cannot be included in the analysis, although indirectly our analysis also reflects the possible effects of these factors. If the

observed differences in work resumption between ethnic groups can be explained completely by the general factors in the analysis, no room is left for the alleged ethnic-specific or cultural factors.

3. Empirical data and methods

The empirical data used in this article to analyse transitions from incapacity to work are obtained from Statistics Netherlands' Social Statistics Database (SSD) (Arts and Hoogteijling, 2002 and Bakker, 2005). The SSD is a large database that contains coherent and consistent detailed statistical information on persons, households, jobs and social benefits. The information comes mainly from administrative registers, such as the tax and social security administration, and where necessary is supplemented by data obtained from business and household sample surveys, such as the Dutch Labour Force Survey. The SSD is the end result of a micro-linkage and micro-integration process of all the data sources used. The linking procedure is not only performed on a cross-sectional but also on a longitudinal basis. The latter makes the SSD ideal for analysing labour market transitions, such as the transition from incapacity to work and other outflow from incapacity benefits. The advantage of micro-integrated data is that they are believed to provide far more reliable results because of the combination of information from several sources.

Our statistical analysis proceeds in two successive steps. The first step is descriptive and traces labour market transitions for everyone receiving a WAO incapacity benefit (WAO-IB)[6, 7] at the end of September 1999; in total 688 thousand persons. We trace what their labour market position is after three years, at the end of September 2002. Some recipients in 1999 will still be receiving an incapacity benefit in 2002, either with or without a job.[8] Others will no longer receive the benefit and will have resumed work, will have retired or will have died. It should be kept in mind that someone who receives an incapacity benefit at the end of September 1999 as well as the end of September 2002 may have worked temporarily between these two moments. However, this does not happen very frequently (Linder, 2005). In our statistical analyses we use separate dependent variables, transitions from full and from partial incapacity benefits. Furthermore, we examine the differences in these transition patterns between native Dutch incapacity benefit claimants and claimants with various non-western immigrant backgrounds.

Official Dutch statistics define ethnic origin by the country of birth of both the person concerned and his or her parents. A person is defined as having an immigrant background if he or she was born abroad, and at least one parent was born abroad, or if he or she was born in the Netherlands and both parents were born abroad. People with immigrant backgrounds thus include both first and second-generation immigrants. In our analysis we distinguish four non-western immigrant categories: two former guest workers groups (Turks, Moroccans), post-colonial Caribbean immigrants (from Suriname, Netherlands Antilles and Aruba) and other non-western immigrants. We compare the labour

market position of these non-western migrant groups with that of the native Dutch. We shall not look into the category of immigrants from western countries (EU, USA, Canada, etc.), as the labour market position of these groups generally does not differ much from that of the native Dutch.

The second step in the analysis is of an explanatory nature. We use multiple regression analysis to examine whether the observed differences between population categories in their outflow from incapacity benefits can be explained by relevant individual characteristics and by characteristics of their incapacity benefit. The other variables involved in the analysis (besides labour market position in 1999 and 2002, and ethnic origin) are: gender, age, household composition, educational attainment, degree of incapacity (full or partial), nature of incapacity (physical or mental), duration of the benefit, and economic sector of the former job, or for those who continue to work (mostly part-time) the sector during the incapacity period.

4. Descriptive analysis: outflow from incapacity benefits

The first part of our statistical analysis focuses on resumption of work and other outflow from WAO-incapacity benefits, and possible differences in this respect between the native Dutch population and various non-western immigrant groups. We start by establishing transitions away from incapacity benefit. What was the labour market position in 2002 of people receiving incapacity benefit in 1999? Were they still receiving a (full or partial) incapacity benefit, had they returned to work, or was there another change in their situation?

Table 1. WAO-Incapacity benefit recipients of 1999 and their socio-economic position in 2002 (in absolute numbers and in %)

	WAO-Incapacity benefit recipients in 1999	Socio-economic position in 2002 in %:					
		Demographic outflow		Situation unchanged + other outflow			
	All (x 1,000)	Retirement (age 65+)	death/ migration	WAO-IB	WAO-IB plus work	Only work	Other outflow
Overall	687.8	10.9	3.9	58.6	20.0	5.3	1.4
Only WAO-IB	483.5	14.7	4.4	73.2	**4.2**	**2.2**	1.3
WAO-IB plus work	204.2	1.8	2.7	24.0	57.3	**12.7**	1.5

bold = work resumption

Source: Statistics Netherlands, Social Statistical Database (SSD)

Table 1 shows the labour market position in 2002 of all 688 thousand WAO incapacity benefit recipients in 1999. The table distinguishes between persons who only have income from an incapacity benefit (484 thousand) and recipients who have additional income from labour (204 thousand). The table clearly shows that for the large majority of people claiming incapacity benefit in 1999, the

situation did not change in the subsequent three years: for 73.2 percent of all persons having only an incapacity benefit in 1999, the situation was the same three years later. The same is true for 57.3 percent of all recipients in 1999 who had additional income from labour. Incapacity benefit claimants thus appear to be a very stable category (Linder, 2005). Furthermore, table 1 distinguishes between two types of outflow: demographic outflow and other outflow. Demographic outflow consists of people whose incapacity benefits is discontinued because they retired at the age of 65 (10.9 percent of all incapacity benefit recipients in 1999) and people who have died or emigrated (3.9 percent of all incapacity benefit recipients in 1999) [9,10]. Three different situations can be seen as resumption of work:

- Someone with only an incapacity benefit in 1999, and an incapacity benefit plus labour income in 2002 (4.2 percent of all cases with only an incapacity benefit in 1999);
- Someone with only an incapacity benefit in 1999, and only labour income in 2002 (2.2 percent of all cases with only an incapacity benefit in 1999); and
- Someone with an incapacity benefit plus labour income in 1999, and only labour income in 2002 (12.7 percent of all incapacity benefit recipients with additional labour income in 1999) (figures marked bold in the table).

We can conclude from this that resumption of work after having received an incapacity benefit is quite an exceptional phenomenon. Only 8 percent of all people claiming incapacity benefit in 1999 had resumed work in 2002 (figure not in the table). Table 1 describes two more types of outflow. Someone may have had incapacity benefit with additional labour income in 1999 and only an incapacity benefit in 2002. This transition ('relapse to only an incapacity benefit') occurs for no fewer than one in four of all incapacity benefit recipients with additional labour income in 1999.[11] Lastly, there is some miscellaneous outflow: in some cases when incapacity benefits are terminated people are eligible for an unemployment benefit or for income support, in other cases people are no longer eligible for any form of social security.[12] Just over 1 percent of all incapacity benefits paid in 1999 were terminated for these miscellaneous reasons. The figures in table 1 are not yet broken down into ethnic categories. These figures are presented in Appendix 1.

Our main descriptive research question is whether there are ethnic differences in resumption of work and other outflow from incapacity benefit. To answer this question we re-arranged the figures from table 1 and distinguished five ethnic categories (table 2). The table shows three remarkable findings. First, incapacity benefit recipients again appear to be a very stable category. For at least two-thirds of all incapacity benefit recipients in 1999, the situation had not changed in 2002. In both years they had either only a benefit or a benefit with additional labour income. The table also shows the differences between various ethnic categories. The proportion of benefit recipients whose situation did not change between 1999 and 2002 is even larger for Moroccans and Turks (no change for 74 and 78 percent respectively) than for the other ethnic categories (native Dutch, post-colonial migrants from Suriname, Netherlands Antilles and Aruba, and for other non-western immigrants). We can conclude that

although outflow from incapacity benefits is generally very low, this is even more true for Turkish and Moroccan incapacity benefit claimants than for other groups.

Table 2. Socio-economic position in 2002 of WAO-incapacity benefit recipients of 1999, by ethnic origin (in %)

	Situation unchanged[1)]	Demographic outflow[2)]	Resumption of work [3)]	Relapse to only an incapacity benefit[4)]	Other Outflow[5)]
Native Dutch	68.1	14.9	8.4	7.3	1.2
Moroccan	74.2	11.0	5.7	5.6	3.5
Turkish	78.0	8.8	5.8	4.3	3.2
Surinamese, Antillean/Aruban	69.1	9.7	11.0	7.3	2.9
Other non-Western origin	67.5	8.5	11.6	7.7	4.7

1) WAO-IB in both 1999 and 2002, or WAO-IB plus labour income in both 1999 and 2002
2) Outflow because of retirement, death or emigration
3) WAO-IB in 1999 and work or WAO-IB plus labour income in 2002, or WAO-IB plus labour income in 1999 and only labour income in 2002.
4) WAO-IB plus labour income in 1999 and only WAO-IB in 2002
5) Outflow because of reasons not mentioned before

Source: Statistics Netherlands, Social Statistical Database (SSD)

Subsequently table 2 distinguishes between the four types of outflow from an incapacity benefit that we explained previously. The most common type is the demographic outflow (because of retirement, death or emigration). Demographic outflow is highest for native Dutch benefit recipients: almost 15 percent of all native Dutch recipients in 1999 left the scheme for demographic reasons. For all immigrant categories, demographic outflow fluctuates between 8 to 11 percent. This difference can be explained by differences in the age composition between native Dutch and immigrant incapacity benefit recipients. Native Dutch incapacitated are older on average and therefore more often retire than claimants in other groups. The next most common outflow from incapacity benefits is resumption of work, our main topic of interest. As explained above, we define three different outflows as resumption of work (from benefit alone to benefit with additional labour income, and from benefit with additional labour income to only labour income). Table 2 shows very clearly that resumption of work occurs least often in the Turkish and Moroccan groups: less than 6 percent of all Turkish or Moroccan incapacity benefit recipients in 1999 had resumed or partly resumed work in 2002. The proportion of work resumption is higher for the native Dutch group (8.4 percent) and highest for all other non-western immigrant groups (between 11 and 11.6 percent).

The fourth column in table 2 shows what we have labelled as relapse to only an incapacity benefit, i.e. when incapacity benefit recipients had additional labour income in 1999, but only a benefit in 2002. Fewer Turkish and Moroccan incapacity benefit recipients lose additional labour income than claimants in all other groups, although it should be kept in mind that relatively few Turkish and Moroccan incapacity benefit recipients had additional labour income at all in 1999. The large majority of Turkish and Moroccan claimants in 1999 had only income from their benefit (see Appendix 1). The fifth column in table 2 shows the miscellaneous outflow. This outflow is three times as common for Turkish, Moroccan and other non-western immigrant groups as for the native Dutch group; for the Surinamese and Antillean groups it is twice a high as for the native Dutch.

With this information we can now answer our descriptive research question. Our main finding is that the population of incapacitated in the Netherlands is an extremely stable social category. For the large majority of all incapacity benefit recipients in 1999 the situation did not change in the subsequent three years. The main reasons for discontinuation of incapacity benefits were of a demographic nature: because the claimant had retired, died or emigrated. Resumption of work after incapacity is rather exceptional: only 8 percent of all incapacity benefit recipients in 1999 had resumed work to some extent in 2002 (sometimes in addition to receiving an incapacity benefit). Having said this, we did observe some ethnic differences in the outflow from incapacity benefits. Demographic outflow is most common for native Dutch incapacity benefit recipients, presumably because they are generally older than claimants with an immigrant background, and therefore more likely to retire. Resumption of work is least common for Turks and Moroccans, and most common for claimants with a Surinamese, Antillean/Aruban, or other non-western immigrant background. Native Dutch benefit recipients take a position between the two. Relapse from benefit with additional labour income to only an incapacity benefit is least likely for the Turkish and Moroccan groups. Lastly, other outflow affects all immigrant groups significantly more than native Dutch benefit recipients.

5. Explanatory outcomes: how can these differences be explained?

The question then is how these observed ethnic differences in outflow patterns from incapacity benefits can be explained. The scarce literature on this topic suggests both general and ethnic specific explanations for these differences in outflow. The most important general explanations for differences in work resumption are differences in the degree and nature of incapacity, age and socio-economic status (educational level). If such general factors completely explain the observed differences in resumption of work between ethnic groups, the differences are not an ethnic issue but the result of the specific composition of the migrant groups in question (this is also referred to as a composition effect). Qualitative research suggests there are also ethnic specific explanations for the limited work resumption of Turkish and Moroccan incapacity benefit recipients, such as the (real or alleged) differences in the perception of illness, poor communication between sick employees and incapacity benefit claimants on the one hand and medical professionals on the other, or conflicts and discrimination experiences on the work floor that obstruct a return to work, etc. The empirical data used in our analysis do not enable us to test these ethnic specific explanations for the observed differences in work resumption. We can only test the more general explanations. This, however, also gives some indication of how much room there is for the ethnic explanations of the differences in resumption of work.

Table 3. Transition[1)] from WAO-IB or from WAO-IB plus work in 1999 to a new situation in 2002; reference category: situation unchanged (odds ratios OR)

	Transition from WAO-IB to: (N=391.270):							Transition from WAO-IB plus work to: (N=195.020):						
	Sig. main effect	WAO-IB plus work OR	Sig.	Work OR	Sig.	Remainder OR	Sig.	Sig. main effect	Work OR	Sig.	WAO-IB OR	Sig.	Remainder OR	Sig.
Ethnic origin (ref: Native Dutch)	**							**						
Moroccan		0.523	**	0.811	**	2.649	**		1.889	**	3.088	**	5.919	**
Turkish		0.556	**	0.842	**	2.303	**		1.604	**	2.632	**	5.475	**
Surinamese, Antillean/Aruban		0.942		1.708	**	2.259	**		1.902	**	1.560	**	3.123	**
Other non-Western origin		1.182	*	1.890	**	4.055	**		1.776	**	1.655	**	4.140	**
Western origin		0.837	**	0.986	**	1.106	**		1.074	**	1.279	**	1,411	**

** significant at 1% level / * significant at 5% level
1) Demographic outflow not included

Source: Statistics Netherlands, Social Statistical Database (SSD)

Table 3 again describes the actual differences in outflow from incapacity benefit between the various ethnic categories. It is a so-called multinomial logit-regression model that analyses the probability for different types of outflow from incapacity benefit against the probability of remaining on the benefit. The left-hand part of table 3 describes outflow from a situation of incapacity benefit alone, the right-hand part describes the outflow from incapacity benefit plus additional labour income. Differences in demographic outflow are not taken into account in table 3. Furthermore we should point out that table 3 compares transitions of various non-western immigrant groups among incapacity benefit recipients with transitions of the native Dutch reference category. The figures in table 3 are odds ratios (OR). An OR indicates how much larger or smaller the probability of one kind of outflow is for a specific migrant group compared with the probability of the same kind of outflow for the native Dutch group. An OR of 1 implies that the probability of this type of outflow for the migrant group in question equals the probability of the same type of outflow for the native Dutch category. An OR of 0.5 (for instance, when we compare the transition from incapacity benefit alone to incapacity benefit with additional labour income for the Turkish and Moroccan groups with that for the native Dutch reference category) implies that for Turkish and Moroccan claimants, the probability of this specific transition is half that for native Dutch claimants.[13]

Although the situation did not change for the large majority of incapacity benefit recipients in 1999, we can observe some significant differences in outflow. Resumption of work from a situation of incapacity benefit alone in 1999 (to work alone or incapacity plus work in 2002) occurs significantly less often in the Turkish and Moroccan groups than in the native Dutch reference category (OR<1). The transition from incapacity benefit alone in 1999 to only work occurs significantly more often in the Surinamese, Antillean and other non-western groups than in the native Dutch group (OR>1). The third type of work resumption (from incapacity plus work in 1999 to only work in 2002) occurs

significantly more often in all migrant groups than in the native Dutch group (OR>1). The largest differences between all migrant groups on the one hand and the native Dutch reference category on the other can be observed for the other kinds of outflow.

The crucial question is, however, to what extent these observed differences in outflow result from divergent characteristics of native Dutch and migrant benefit recipients, or from characteristics of the benefit they receive. To answer this question we carried out two regression analyses. For each type of outflow two models are tested. In the first model only the ethnic background of benefit recipients is taken into account (table 3). The second model shows the effect of various personal characteristics of benefit recipients and of the benefit they receive (tables A.2 and A.3 in the Appendix to this article). Table A.2 describes transitions from only incapacity benefit; table A.3 describes transitions from incapacity benefit plus income from work. In our discussion of the findings, we first describe the influence of all independent variables on the outflow. Subsequently, we examine the effect of adding all these independent variables on the initial differences in outflow. If an observed difference in one kind of outflow between a migrant group and the native Dutch reference group (model 1) disappears when all variables are added (model 2), we can conclude that the initial difference can be explained completely by the new factors in the model. If not, other factors are apparently at work that have not yet been analysed. [14]

Gender appears to be an important factor for resumption of work, although only from incapacity benefit alone. The probability of resuming work (from incapacity benefit alone in 1999 to only work or benefit plus work in 2002) for men is double that for women. For the transition from benefit plus work to only work there are no differences between men and women. All other kinds of outflow from incapacity benefit occur more often for women than for men.

Age is even more important than gender. For the younger age categories (15-35 years), the probability of work resumption is 3 to 7.7 times larger than for the oldest category (50-65 years). Also the intermediate age category (30-50 years) has significantly better probabilities of resuming work than the oldest age group. Remarkably, other outflow also occurs more often in the youngest than in the oldest age group. One explanation for this may be that incapacity benefits of younger claimants are more often discontinued (bigger chance of being declared fit for work after medical examination), without resumption of work. In such cases, a person may become eligible for unemployment benefit.

Position in the household has some effect on outflow. Single parents with an incapacity benefit have a larger probability of resuming work than the reference category (partner in a couple without children). Single parents also have a larger probability of other outflow (termination of benefit without new employment) than both couples with and without children (only for other outflow from only incapacity

in 1999). In general, we can say that age and gender differences have a larger effect on outflow than differences in household position.

The next factor is the *educational level* of incapacity benefit recipients. As may be expected, the probabilities of work resumption vary with the educational levels of benefit recipients. This is especially true for the highest qualified benefit recipients: their probability of work resumption is twice that of the lowest educated benefit recipients (only primary education). However, there are two limitations on the influence of educational level on the probability of work resumption. First, education only effects resumption of work for those claimants with incapacity benefit only. Secondly, education favours especially those with the highest qualifications. The differences between benefit recipients with only primary education and those with a secondary education level are not very large. In general, the effect of education on outflow is smaller than can be expected in theory.

A next series of factors are characteristics of the incapacity benefit. First the *degree of incapacity*. Obviously, benefit recipients who are only partially incapacitated manage to resume work much more often than those who are completely (i.e. 80-100 percent) incapacitated. Other outflow from an incapacity benefit only is also relatively more common for recipients who are only partially incapacitated.

The next characteristic is the *nature of incapacity*. We have seen that previous analyses were inconclusive on whether mental or physical illness implies a larger probability of work resumption. Our analysis shows that there is indeed not much difference. The only significant difference between benefit recipients with mental and physical disabilities is that the latter have a greater probability of moving from only incapacity benefit to only work. Generally speaking, however, the nature of incapacity is of little influence on outflow.

The *duration* of the incapacity benefit has a large influence on outflow probabilities. The shorter the period of dependence on an incapacity benefit, the greater the chances of resumption of work. The probability of the transition from only incapacity benefit to work is eight times larger for recent benefit recipients (up to 1 year) than for long-term claimants (receiving a benefit for at least five years). But recent benefit recipients also have a higher probability of other outflow than long-term recipients. This would imply that quite a lot of incapacity benefits are terminated in the first year, even if there is no new employment.

To conclude the *economic sector* of the job, which the benefit claimant had before incapacity or which he still has alongside his incapacity benefit, has some effect on the outflow. On the average there is not so much difference in outflow probabilities between the economic sectors. There are a few exceptions:

for example benefit recipients with a (former) job in the economic sector of Education definitely have a smaller probability of other outflow than in other sectors.

The final question is what the inclusion of all these background characteristics adds to the initial differences in resumption of work and other outflow between native Dutch recipients and those with an immigrant background. To answer this question we compare the outcomes of model 1 and model 2 in tables A2 and A3 (in the appendix). To what extent do the newly added characteristics in model 2 explain the observed differences in outflow in model 1? As far as resumption of work is concerned, we have visualized the differences between both models in figure 1.

Figure 1: Transitions from WAO-IB or WAO-IB plus work to work (1999-2002) for people of non-western origin (reference category: no transitions) (odds ratios; native Dutch = 1)

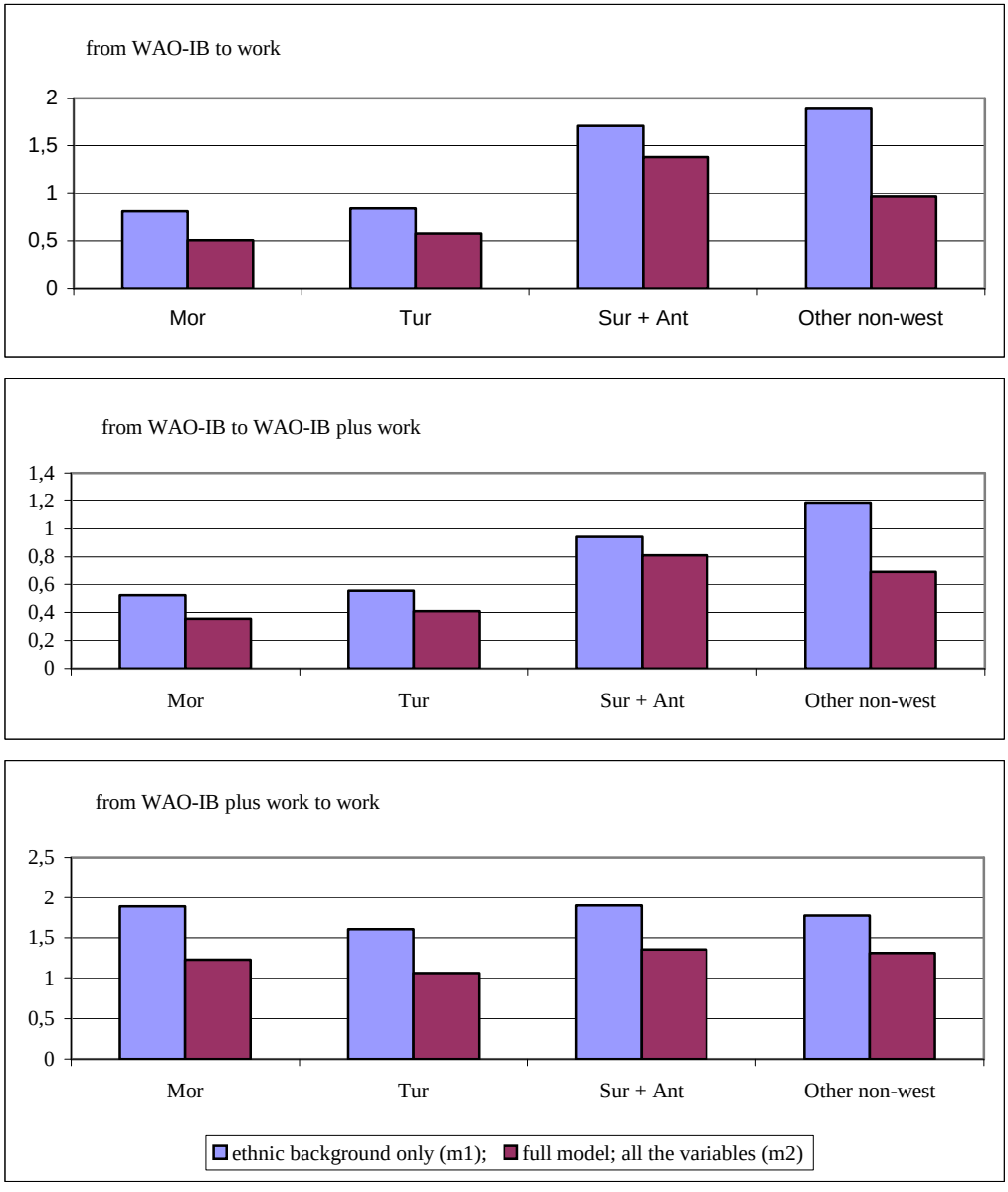


Figure 1 again distinguishes three different types of work resumption: the transition from only incapacity benefit to either only work or incapacity plus work and the transition from incapacity plus work to only work. In each figure, the left-hand bar shows the initial differences in resumption of work between the various migrant groups and the native Dutch reference category (= 1). The right-hand bar shows the difference in resumption of work between the migrant groups and native Dutch benefit recipients when all variables are included in the analysis (the 'full model'). The question is to what extent the background variables explain the initial differences in resumption of work between the migrant groups and the native Dutch. If they fully explain the differences, the value of model 2 (the right-hand bar) approaches 1.

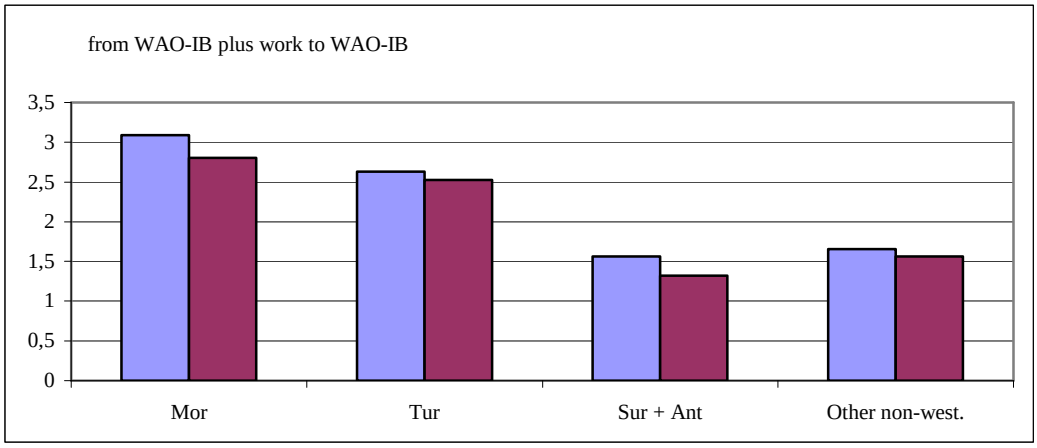
The most striking finding of figure 1 is that the included background variables do not explain the relatively low incidence of work resumption for Turkish and Moroccan incapacity benefit recipients. On the contrary, after including the background variables the differences in resumption of work between Turkish and Moroccan benefit recipients and the native Dutch do not become smaller, as expected, but larger! This is true for at least for two of the three kinds of resumption of work (from only incapacity to work or to incapacity plus work). This means that the fact that Turkish and Moroccan incapacity benefit recipients show relatively little resumption of work cannot be explained by the unfavourable characteristics of these migrant groups. On the contrary, given the rather favourable characteristics of these categories of migrant workers (relatively more men, young and rather recent benefit recipients) it may be expected that they resume work more often, not less often but than the native Dutch. Their generally lower educational levels explain part of the low incidence of resumption of work, but as we have already seen, education has only a limited effect on resumption of work.

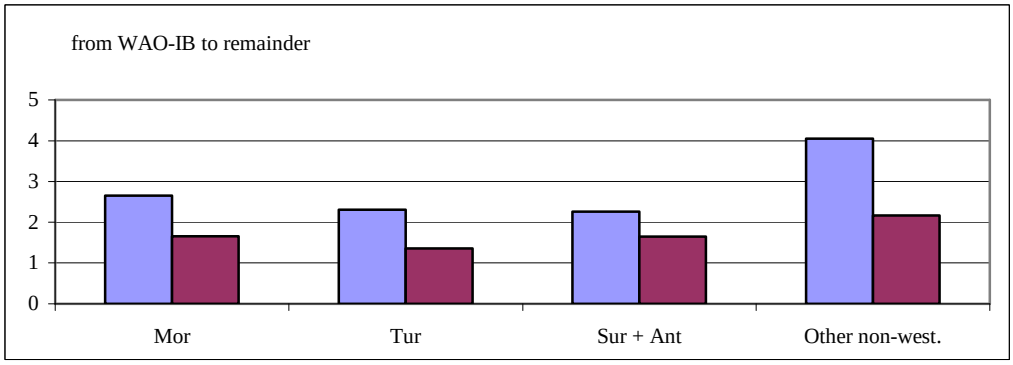
For the other non-western immigrant groups (Surinamese, Antilleans, other non-western immigrant groups), the top chart in figure 1 shows that the initially observed higher incidence of work resumption for these groups can be attributed largely (or completely as far as other non-Western immigrant groups are concerned) to their favourable background variables. The same is true for the last type of resumption of work, the transition from benefit to only work. Above we have seen that this transition occurs more often for all non-western immigrant groups than for the native Dutch. Figure 1 now shows that this difference can be attributed completely to the favourable background variables of the incapacity benefit recipients with an immigrant background.

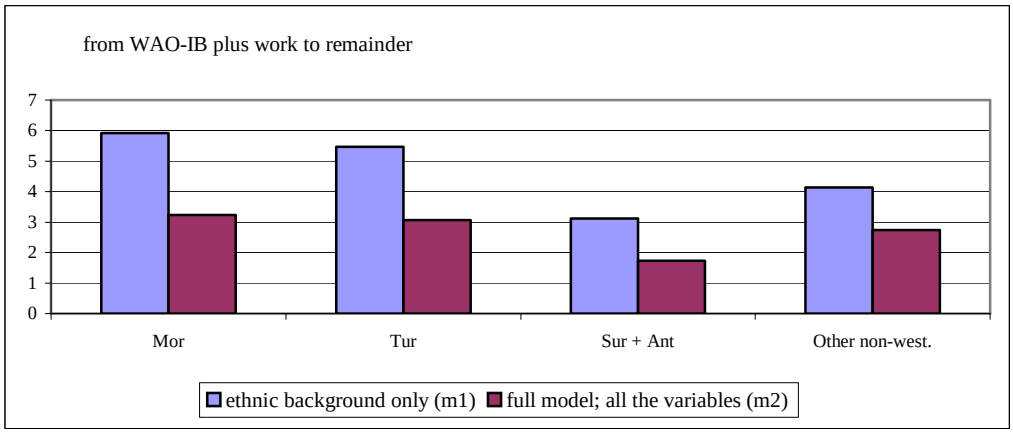
Figure 2 analyses the other types outflow from incapacity benefits in a similar way. It starts with the relapse from benefit plus work to only benefit. This transition is more common for Turkish and Moroccan benefit recipients than for the native Dutch. The same is true, but to a lesser extent, for the other non-western immigrant groups. Figure 2 shows that the higher incidence of relapse to only

incapacity benefit for the Turkish and Moroccan groups can hardly be explained by the background variables. After inclusion of these variables, there are still large differences with the native Dutch reference group. For the other non-western immigrant groups, the included background variables explain the higher incidence of relapse to only incapacity benefit to some extent, but not completely.

Figure 2: Other transitions from WAO-IB or WAO-IB plus work (1999-2002) for people of non-western origin (reference category: no transitions) (odds ratios; native Dutch = 1)







Lastly, figure 2 also describes the other outflow from incapacity benefit. We have already seen that this transition (discontinuation of incapacity benefit without new employment) occurs more often for all non-western immigrant groups than for the native Dutch. Figure 2 now shows that this difference can in part, but not completely be explained by the background characteristics of the benefit recipients

with an immigrant background and of the benefits they receive. Even when all background variables are taken in account, these kinds of outflow from incapacity benefits affect non-Western immigrants 1.5 to 3 times more often than the native Dutch reference category (=1)

6 Conclusions

A proactive social security system complying with the normative ideals of TLM is not so much directed at providing income compensation for social risks connected with unemployment or illness, but at getting the claimants of social benefits back to work. The Dutch system of incapacity benefits, however, is far removed from this normative ideal. Resumption of work after receiving an incapacity benefit is the exception rather than the rule. Only 8 percent of people claiming incapacity benefit in 1999 had resumed work to some extent in 2002 (including people who had labour income alongside the incapacity benefit). This article describes and tries to explain possible ethnic differences in work resumption following WAO-incapacity benefit. Although resumption of work is generally rather exceptional, we observed significant differences between native Dutch benefit recipients and those with an immigrant (first and second generation) background. The incidence of resumption of work is lowest for Turkish and Moroccan benefit recipients. Whereas 8.4 percent of native Dutch claimants of incapacity benefit in 1999 resumed work to some extent in the subsequent three years, this was true for less than 6 percent of claimants with a Turkish or Moroccan background. For the other non-western immigrant categories (Surinamese, Antillean/Aruban, and other non-western) the work resumption rates were significantly higher (11.0 – 11.6 percent).

Apart from resumption of work, we also described other kinds of outflow from incapacity benefits. Demographic outflow because of retirement, death or emigration is most common. The incidence of demographic outflow is highest for native Dutch benefit recipients (14.9 percent) and significantly lower for all non-western immigrant categories (8.5 – 11.0 percent). Another transition is relapse to only an incapacity benefit from a situation of having additional labour income alongside an incapacity benefit. This was least common for Turkish and Moroccan benefit recipients in 1999, mainly because very few of them had additional labour income. Lastly, we distinguished ‘other outflow’: the incapacity benefit is discontinued without demographic reasons or resumption of work. For instance, when the person involved is unable to resume work or find new employment. Some of these people are eligible for an unemployment or income support benefit (the latter only if there is no other earner in the household). ‘Other outflow’ affects Turkish, Moroccan and other non-western benefit recipients considerably more often than native Dutch and Surinamese recipients.

We then tried to explain the observed ethnic differences in outflow. In the scarce literature that is available, we found both general explanations (differences in general characteristics of benefit recipients and the incapacity benefits, e.g. age, gender, educational level, nature and degree of

incapacity and duration of the benefit) and ethnic-specific explanations (possible ethnic differences in perception of and coping with illness, the alleged tendency of (some) ethnic groups to somatise mental health problems, etc.). Given the available empirical data, we were only able to examine the effect of the general factors. Although the alleged ethnic-specific or cultural factors could not be included in the analysis, indirectly our analysis also says something about the possible effects of these factors. If the observed differences in resumption of work between ethnic groups can be explained completely by the general factors in the analysis, no room is left for the alleged ethnic-specific or cultural factors.

We found that the lower rates of work resumption (from incapacity to work or to incapacity plus work) for Turkish and Moroccan benefit recipients cannot be explained by the general factors included in the analysis. On the contrary, when we take all general factors into account, the differences between the Turkish and Moroccan groups on the one hand and the native Dutch on the other increase. Given the apparently favourable personal and benefit characteristics of Turkish and Moroccan benefit recipients, one would expect that these groups resume work more and not less often than the native Dutch. Turkish and Moroccan incapacity benefit recipients are more often male, are generally younger and have received a benefit for a shorter period than native Dutch recipients. Turkish and Moroccan benefit recipients on the other hand are often less skilled than native Dutch benefit recipients, but social status (educational level) appears to be of little influence on the odds of resumption of work. We conclude that the lower work resumption rates for Turkish and Moroccan incapacity benefit recipients cannot be explained by the general factors included in the statistical analysis. This may (but not necessarily does) imply that the ethnic-specific or cultural aspects mentioned above are of influence on the odds of resuming work following incapacity benefit.

With respect to all other kinds of outflow from incapacity benefits, we observed higher incidences for all immigrant groups compared with the native Dutch. In general we can say that these higher outflow rates for non-western immigrant groups can partly, but not completely, be explained by the general factors included in the analysis. However, there are some exceptions. The observed higher incidence of the last kind of resumption of work (from incapacity plus work to only work) for the Turkish and Moroccan groups can be fully explained by the general factors in the analysis. Conversely, the higher incidence of relapse from an incapacity benefit plus additional labour income in 1999 to only an incapacity benefit three years later, as we observed for the Turkish and Moroccan groups, cannot be explained by the general factors in the analysis. For all other kinds of outflow, the general factors included in the analysis explain the observed differences between benefit recipients with a native Dutch and an immigrant background to some extent, but not completely. Again, this may (but not necessarily does) imply that the ethnic-specific or cultural aspects mentioned above are also of influence on the observed ethnic differences of resumption of work following an incapacity benefit.

Appendix 1

Table A.1. WAO-Incapacity benefit recipients in 1999 and their socio-economic position in 2002 by ethnic origin (in absolute numbers and in %)

	WAO-Incapacity benefit recipients In 1999	Socio-economic position in 2002 in %:					
		Demographic outflow		Situation unchanged + net outflow			
	All (x 1,000)	retirement (age 65+)	death/ migration	WAO-IB	WAO-IB plus work	Only work	Other outflow
All groups							
Overall	687.8	10.9	3.9	58.6	20.0	5.3	1.4
Only WAO-IB	483.5	14.7	4.4	73.2	4.2	2.2	1.3
WAO-IB plus work	204.2	1.8	2.7	24.0	57.3	12.7	1.5
Native Dutch							
Overall	562.0	11.1	3.8	57.0	21.4	5.4	1.2
Only WAO-IB	385.2	15.4	4.3	72.6	4.4	2.2	1.1
WAO-IB plus work	176.8	1.9	2.6	23.2	58.5	12.5	1.4
Moroccans							
Overall	12.9	7.9	3.1	75.2	6.8	3.5	3.5
Only WAO-IB	11.2	9.0	3.3	80.0	2.5	1.9	3.3
WAO-IB plus work	1.7	0.7	1.4	43.2	35.3	14.3	4.9
Turks							
Overall	23.1	5.7	3.1	78.2	6.6	3.3	3.2
Only WAO-IB	20.6	6.3	3.3	82.6	2.8	2.1	3.0
WAO-IB plus work	2.5	0.4	1.3	40.7	39.1	13.4	5.1
Surinamese, Antilleans/Arubans							
Overall	15.4	5.4	4.3	64.6	15.1	7.7	2.9
Only WAO-IB	11.4	7.0	4.8	77.2	4.4	3.9	2.7
WAO-IB plus work	4.0	0.8	2.8	28.4	45.9	18.7	3.4
Other non-Western immigrants							
Overall	5.2	4.0	4.5	63.5	15.8	7.6	4.7
Only WAO-IB	3.8	5.2	4.8	75.6	5.4	4.2	4.8
WAO-IB plus work	1.4	0.8	3.4	29.4	44.9	17.1	4.4

Source: Statistics Netherlands, Social Statistical Database (SSD)

Table A.2. Transition from WAO-IB in 1999 to a different situation in 2002, demographic outflow not included (Odds-ratios OR)

	Transition from WAO-IB to (ref: remains WAO-incapacitated):						
	Sign. main effect[1])	WAO-IB plus work		Work		Remainder	
		OR	sign.	OR	sign.	OR	sign.
Personal and household characteristics							
ethnic origin (ref. Native Dutch)	**						
Moroccan		0.355	**	0.506	**	1.656	**
Turkish		0.409	**	0.576	**	1.356	**
Surinamese, Antillean/Aruban		0.811		1.381	**	1.649	**
Other non-Western origin		0.689	**	0.966		2.163	**
Western origin		0.901		1.070		1.183	
gender (reference: female)	**						
Male		1.932	**	1.743	**	0.830	**

Table A.2. Transition from WAO-IB in 1999 to a different situation in 2002, demographic outflow not included (Odds-ratios OR)

	Transition from WAO-IB to (ref: remains WAO-incapacitated):						
	Sign. main effect[1])	WAO-IB plus work		Work		Remainder	
		OR	sign.	OR	sign.	OR	sign.
age (reference: 50-64)	**						
15-34		4.445	**	7.751	**	6.579	**
35-49		3.154	**	3.226	**	2.919	**
position in household (reference: couple without children)	**						
Single		1.273	**	0.872		1.339	**
Couple with children		1.447	**	1.061		1.237	**
Single parent		1.898	**	1.488	**	1.593	**
Other		1.665	**	0.968		1.237	
educational attainment (reference: primary level or less)	***						
Secondary level first stage (lbo,mavo,vmbo)		1.304	**	1.451	**	1.446	**
Secondary level second stage (mbo,havo,vwo)		1.475	**	1.697	**	1.181	*
Tertiary level (hbo,wo)		1.830	**	2.046	**	1.200	
Characteristics of WAO-incapacity benefit							
degree of incapacity (reference: fully incapacitated (80-100%)	**						
Partially incapacitated (15-80%)		4.915	**	2.829	**	1.946	**
nature of incapacity (reference: mental)	**						
Physical		1.078		1.120	*	0.992	
duration of incapacity benefit (reference: 5 years or longer)	**						
0-<1 years		3.310	**	8.288	**	10.114	**
1-<2 years		2.474	**	4.462	**	5.636	**
2-<5 years		1.754	**	2.083	**	2.815	**
Characteristics of former job							
economic sector of former job (reference: other service activities)	**						
Agriculture, forestry and fishing		1.127		1.232	*	1.514	**
Manufacturing, mining and quarrying		1.319	**	1.003		0.965	
Construction, electricity, gas and water supply		1.461	**	0.965		0.480	**
Trade and repair, hotels and restaurants		1.192	**	1.233	**	1.309	**
Transport, storage and communications		1.375	**	1.164		0.860	
Financial and business activities		1.329	**	1.288	***	1.323	**
Education		0.957		0.782		0.385	**
Care		1.262	**	1.090		0.766	*

n=145.514 (sample size).

** significant at 1% level / * significant at 5% level

age, position in household, educational attainment, degree and nature of incapacity as in September 1999; duration of benefit measured from start until September1999

1) significance of main effect simultaneously for all transitions based on Likelihood Ratio test

Source: Statistics Netherlands, Social Statistical Database

Table A.3. Transition from WAO-IB plus work in 1999 to a different situation in 2002, demographic outflow not included (Odds-ratios OR)

	Transition from WAO-IB plus work to (ref: remains in situation WAO plus work):						
	Sign. main effect[1])	Work OR	sign.	WAO OR	sign.	Remainder OR	sign.
Personal and household characteristics							
ethnic origin (ref. Native Dutch)	**						
Moroccan		1.225		2.803	**	3.238	**
Turkish		1.059		2.527	**	3.073	**
Surinamese, Antillean/Aruban		1.351	*	1.319	*	1.727	**
Other non-Western origin		1.310		1.560	*	2.745	**
Western origin		1.100		1.208	**	1.332	*
gender (reference: female)	**						
Male		0.950		0.658	**	0.637	**
age (reference: 50-64)	**						
15-34		3.186	**	0.625	**	1.950	**
35-49		1.651	**	0.519	**	0.911	**
position in household (reference: couple without children)	**						
Single		0.952		1.013		1.117	
Couple with children		0.987		0.779	**	0.835	
Single parent		1.262	**	0.871		1.210	
Other		0.808		0.840		1.093	
educational attainment (reference: primary level or less)	**						
Secondary level first stage (lbo,mavo,vmbo)		1.013		0.884	*	1.361	*
Secondary level second stage (mbo,havo,vwo)		1.064		0.793	**	1.226	
Tertiary level (hbo,wo)		1.189		0.743	**	1.141	
Characteristics of WAO-incapacity benefit							
degree of incapacity (reference: fully incapacitated (80-100%)	**						
Partially incapacitated (15-80%)		0.920		0.369	**	0.491	**
nature of incapacity (reference: mental)	**						
Physical		1.039		1.053		1.225	*
duration of incapacity benefit (reference: 5 years or longer)	**						
0-<1 years		4.885	**	3.227	**	14.585	**
1-<2 years		2.822	**	2.915	**	8.225	**
2-<5 years		1.445	**	1.478	**	3.065	**
Characteristics of job during incapacity in 1999							
economic sector of job during incapacity in 1999 (reference: other service activities)	**						
Agriculture, forestry and fishing		1.127		0.931		1.142	
Manufacturing, mining and quarrying		0.583	**	0.864		0.528	**
Construction, electricity, gas and water supply		0.843		1.092		0.519	**
Trade and repair, hotels and restaurants		1.065		1.233	**	1.364	
Transport, storage and communications		0.941		1.324	**	1.297	
Financial and business activities		1.223	*	1.382	**	1.882	**
Education		0.706	**	1.321	**	0.437	**
Care		0.926		1.083		0.603	**

Table A.3. Transition from WAO-IB plus work in 1999 to a different situation in 2002, demographic outflow not included (Odds-ratios OR)

n=85.706 (sample size).

** significant at 1% level / * significant at 5% level

age, position in household, educational attainment, degree and nature of incapacity, economic sector as in September 1999; duration of benefit measured from start until September 1999

1) significance of main effect simultaneously for all transitions based on Likelihood Ratio test

Source: Statistics Netherlands, Social Statistical Database

References

Aarts, L., P. de Jong en R. van der Veen (2002), *Met de beste bedoelingen: WAO 1975-1999, Trends, onderzoek en beleid*. Doetinchem: Elsevier Bedrijfsinformatie.

Arts, C.H. and E.M.J. Hoogteijling, 2002. 'The Social Statistical Database of 1998 and 1999'. *Monthly Bulletin of Socio-economic Statistics*. Vol. 2002/12 (December 2002), pp. 13-21. *[in Dutch]*.

Bakker, B.F.M., 2005. 'Some information on the Social Statistical Database'. Information leaflet 2005. *[in Dutch]*.

Buitendam, A. (2001), *Een open architectuur voor arbeid en organisatie*. Assen: Van Gorcum.

Cebrian, I., M. Lallement en J. O'Reilly (2000), Introduction, in: O'Reilly, J., I. Cebrián en M. Lallement (red.), *Working-time changes, Social integration through transitional labour markets.* Cheltenham, UK: Edward Elgar, p. 1-21.

Copinga, M. en R. Selten (2003). Wie komen er in de WAO? *Sociaal-Economische Maandstatistiek*, januari 2003, p. 35-52.

De Koning, et al. (2003), *Arbeidsmarkttransities en aanboddiscrepanties*, Rotterdam: SEOR.

Engbersen, G. (1995, The Road to Anomia? Poverty Regimes and Life Chances. In: B. Unger en F. van Waarden (ed.). /Convergence or Diversity? /Aldershot: Avebury, 1995, pp. 200-225.

Giddens, A. (1994), *Beyond left and right, The future of radical politics*. Cambridge (UK): Polity Press.

Gorter, C. (2002), The Dutch Miracle? In: G. Esping-Andersen & M. Regini (eds.), *Why Deregulate Labour Markets?* Oxford: University Press, pp.181-210.

Hijmans van den Bergh, A. (2002), *Sociaal-medische begeleiding van allochtonen, Een verkennend onderzoek*. Utrecht: Forum.

Hoff, Stella, Gerda Jehoel-Gijsbers en J.M. Wildeboer Schut (2003), *De Uitkering van de Baan: Reïntegratie van uitkeringsontvangers, ontwikkelingen in de periode 1999-2002*. Den Haag: SCP.

Kamphuis, P., J. van Poppel, A. en Hijmans van den Bergh (2003), *Arbozorg voor allochtone werknemers. Onderzoek naar de toerusting van de Nederlandse arbo-infrastructuur voor de multiculturele samenleving*. Tilburg: IVA.

Linder, F., 2005. 'Dynamics in WAO (Disablement Insurance Act), WAZ (Disablement Insurance Act for Self-employed) and Wajong (Disablement Provision Act for Disabled from an Early Age): a longitudinal study of persons with an incapacity benefit'. *Monthly Bulletin of Socio-economic Statistics*. Vol. 2005/11 (January 2005), pp. 62-77. *[in Dutch]*.

Meershoek, A., A. Krumeich en L. Desain (2005), *Arbeidsongeschiktheid, reïntegratie en etniciteit*. Amsterdam: Het Spinhuis.

Meershoek, A., A. Krumeich & E. Snel (2006), Ziekteverzuim en werkhervatting. In: J. Veenman (ed.), *Nieuwe ongelijkheden op de transitionele arbeidsmarkt*. Amsterdam: Aksant, pp. 126-157.

Muffels, R., T. Wilthagen en N. van den Heuvel (2002), *Labour market transitions and employment regimes, Evidence on the flexibility-security nexus in transitional labour markets*. Berlijn: Wissenschaftszentrum Berlin (Discussion paper FS I 02-204).

Nagelkerke, A. en T. Wilthagen (2002), Towards a transitional concept of social security, in: Berghman, J. e.a. (red.), *Social security in transition*. Den Haag: Kluwer Law International, p. 157-170.

Schmid, G. (1998a), *Transitional labour markets, A new European employment strategy*. (Discussion paper FS I 98-206). Berlijn: Wissenschaftszentrum Berlin.

Schmid, G. (1998b), *Enhancing gender equality by transitional labour markets : changing labour market and gender equality*. Parijs : OECD working papers ; jrg. 6, no. 80.

Schmid, G. (2000), Foreword. in: O'Reilly, J., I. Cebrián en M. Lallement (red.), *Working-time changes: social integration through transitional labour markets.* Cheltenham, UK: Edward Elgar, p. xix-xxi.

Schmid, G. (2002a), Employment systems in transition: explaining performance differentials of post-industrial economies, in: Schmid, G. en B. Glazier (red.), *The Dynamics of full employment, Social integration through transitional labour markets.* Cheltenham, UK: Edward Elgar, p. 23-48.

Schmid, G. (2002b), Towards a Theory of Transitional Labour Markets, in: Schmid, G. en B. Glazier (red.), *The Dynamics of Full Employment: social integration through transitional labour markets.* Cheltenham, UK: Edward Elgar, p. 151-195.

Snel, E. et al. (2002), *In de fuik. Turken en Marokkanen in de WAO*. Utrecht: Verwey-Jonker Instituut.Teulings ea (1997)

Snel, Erik, Frank Linder en Radjesh Manna (2006), Allochtonen en werkhervatting vanuit de WAO, In: J. Veenman (ed.), *Nieuwe ongelijkheden op de transitionele arbeidsmarkt*. Amsterdam: Aksant, pp. 89-126.

Therborn, G. (1986), *Why some people are more unemployed than others. The strange paradox of growth and unemployment*. London: Verso.

Veen, R.J. van der (2005), De WAO: Nederlandse chronische ziekte?, in: Arentsen, M. en W. Trommel (red.), *Moderniteit en overheidsbeleid. Hardnekkige beleidsproblemen en hun oorzaken*, Bussum: Uitgeverij Coutinho, p. 35-60.

Visser, J. & A. Hemerijck (1996), *A Dutch Miracle: Job growth, welfare reform and corporatism in the Netherlands*. Amsterdam: Amsterdam University Press

Wilthagen, T. (2002), Managing social risks with transitional labour markets, in: Mosley, H., J. O'Reilly en K. Schönmann (red.), *Labour Markets, Gender and Institutional Changes, Essays in honour of Günther Schmid*. Cheltenham (UK): Edward Elgar, p. 264-289.

Endnotes

[1] Recent modifications in legislation and regulations in the Dutch system of incapacity benefits are: 1) 'Wet Verbetering Poortwachter' (WVP) in 2002: more proactive policy on guidance of absentees because of illness and incapacity and on reintegration of the incapacitated on the labour market; 2) 'Aanpassing Schattingsbesluit' in 2004: stricter medical examination of the incapacitated intended to declare more incapacitated people fit for work; 3) 'Wet Werk en Inkomen naar Arbeidsvermogen' (WIA) in 2006, the new Disablement Insurance Act, replacing the WAO: the emphasis has been shifted from the incapacity to work to the capacity to work.
All these measures are aimed at reducing inflow into the incapacity benefit scheme, as well at increasing resumption of work.

[2] This means that from the mid 1970s until the early 1980s the incapacity benefit also contained a 'hidden unemployment' component. For the benefit recipient an attractive aspect of this 'improper' use of the incapacity benefit for unemployment reasons was that (until 1985) the incapacity benefit sum was higher (80% of last earned wage) than that of the unemployment benefit WW (70% of last earned wage).

[3] Aarts et al. (2002) point out a 'new incapacity benefit recipient' in the Netherlands: incapacity benefit recipients of the 1980s and 1990s were often men with physical health problems after a life of heavy work in traditional industries, the harbour, etc. Current incapacity benefit recipients are increasingly men and women that work in service occupations and have mental health problems ('burn out', etc.).

[4] See note 1

[5] Apart from the WAO, incapacity benefits in this case also include WAZ for the self-employed and Wajong for disabled from an early age.

[6] In our paper we restrict ourselves to incapacity benefits intended for employees and provided by the WAO-disablement act, which covers the majority of incapacity cases in the Netherlands.

[7] Incapacity benefits are only registered in the SSD if real payments are made. Someone may be entitled to a benefit without receiving payments. This is, for instance, the case when a person is employed for a trial period after a period of incapacity to see if he can become independent of the benefit. He will receive a wage instead of a benefit and for that period will not be registered in the SSD as a person with an incapacity benefit. If the trial does not succeed because of disability he can return to the benefit without complicated application procedures, because he still has his entitlement.

[8] It should be noted that a combination of an incapacity benefit and work may also mean that the claimant receives an employer's supplement to his benefit, without working for it. Unfortunately in these situations of benefit in combination with labour income it is impossible to deduce from the administration whether the person works for his money or not.
In various collective labour agreements it is regulated that for the first (and sometimes even the second) year of incapacity, the incapacity benefit recipient receives an employer's supplement to his benefit without the necessity to work. If someone in our analysis had an incapacity benefit in 1999 which he still had in 2002 but then combined with labour income, it is very likely that this labour income is from actual work. This is because the person in question is already in at least his third year of incapacity.

[9] Emigration does not always lead to termination of an incapacity benefit. Persons with an incapacity benefit emigrating to countries that have a treaty with the Netherlands, among which Turkey and Morocco, are allowed to export their benefit. These persons have to be available for medical examination to test their incapacity for work. Our analysis, however, is restricted to incapacity benefit recipients living in the Netherlands, which means that as soon as a benefit recipient leaves the country his benefit is considered to be terminated.

[10] Note that outflow because of early retirement before the age of 65 is not categorised as retirement but as Other outflow.

[11] For part of the group of benefit recipients in 1999, the additional labour income is an employer's supplement to the benefit, for the remainder it is payment for actual work done.

[12] If an incapacity benefit is terminated because a claimant is considered fit for work after medical examination, there is no guarantee that he can resume his former job. In that case he may be eligible for an unemployment benefit (WW). One necessary condition for this is that the person is actively searching for a new job and is available to start work immediately. If the person fails to find a job his unemployment benefit will be terminated after a period. The person may then be eligible for income support (ABW). However, income support is a 'means-tested' scheme, which means it may only be applied for if no other member of the household has sufficient income. If there is another household income, for instance a working partner, no social benefits will be paid.

[13] In our explanation, the odds ratio (OR) is interpreted as though it is a relative risk (RR). In fact the interpretation of the OR is a bit more complex. An OR is to be considered as the ratio of the odds in the group concerned to that of the reference group. The odds in our example for Turks are the probability of a transition from an incapacity benefit only in 1999 to an incapacity benefit plus an additional labour income in 2002, divided by the probability of an unchanged situation.

The OR compares these odds for Turks with those of the reference group (the native Dutch):

$$OR = [\, P_{(\text{WAO-IB} \rightarrow \text{WAO-IB +work})} / P_{(\text{situation unchanged})}]_{\text{Turks}} / [\, P_{(\text{WAO-IB} \rightarrow \text{WAO-IB +work})} / P_{(\text{situation unchanged})}]_{\text{Natives}}$$

From the fact that in our analysis the value of the numerator in the odds is much smaller than that of the denominator (for natives and all ethnic minority groups) the OR is by approximation equal to the relative risk:

$$RR = [P_{(\text{WAO-IB} \rightarrow \text{WAO-IB +work})}]_{\text{Turks}} / [P_{(\text{WAO-IB} \rightarrow \text{WAO-IB +work})}]_{\text{Natives}}$$

[14] The results of tables 1, 2, 3 and A.1 are based on observations of the complete SSD population of incapacity benefit recipients (WAO) in September 1999. The results of tables A.2 and A.3, as well as the bars in figures 1 and 2 related to model m2 are based on a large 40 percent weighted sample. This is because observations on educational attainment are not yet available for the complete population. The 40 percent weighted sample is in fact a mixed design of observations from the register of educational attainment ('sample' weight 1), which is not complete, and sample observations from the Labour Force Survey (with reweighted sample weights in order to make the total sample representative for the total population).