Disabled well-being

Research on impairments, social exclusion and well-being across distinct socio-economic and institutional contexts

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I am content.

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Introduction

Social inequalities in health and well-being are well established; they are longstanding, large, persistent, and well documented (Phelan, Link, & Tehranifar, 2010). People with lower education, lower income and lower status have a higher rate of morbidity and generally die earlier than others. They are more likely to have longstanding physical illnesses and impairments, and mental health problems (House, 2002; Mackenbach et al., 2008; Marmot, 2005; Marmot et al., 1991; McNamara et al., 2017; Nordahl, 2014). This may be due to a higher exposure and vulnerability to health risks compared to groups in higher socio-economic positions (Diderichsen, Evans, & Whitehead, 2001). Moreover, the consequences of poor health and lower subjective well-being are also unequal. Those who have more protective resources are likely to receive the correct treatment more often, to heal more quickly, or to be able to limit possible detrimental effects (Link & Phelan, 1995; Phelan et al., 2010). As such, people in lower socio-economic positions are in a double jeopardy situation: because of a lack of protective resources, they are more likely to have a poorer health and lower well-being, and they are less able to minimize the consequences of disease once it occurs. Material resources - such as sufficient income, good quality housing - and immaterial resources - such as knowledge, social support and networks - play a role in this process, as they can be used flexibly in different ways and in different situations (Phelan et al., 2010). Those with fewer resources are likely to experience the physical, mental and social consequences of health problems to the fullest, as they might not know about certain risks or have the money to pay for special treatments, and may feel lonely and stressed by their situation.

The distribution of risk and resources is connected with people's position in society, as people in lower socio-economic positions and people with a migrant background tend to have fewer resources (Diderichsen et al., 2001; Phelan et al., 2010). An equitable distribution is not random given, but is tied to major axes of social exclusion in our societies. Prior research reveals that social class relations, gender and ethnicity have power and play a central role in the allocation of those protective resources according to different social positions. In this dissertation, however, I consider disability to be an additional form of social exclusion that may contribute to social inequalities in health and well-being. As such, I consider the role of social exclusion triggered by the presence of a longstanding illness or impairment, and how it is related to subjective health and well-being.

Disability and social exclusion

Recently, a Belgian newspaper reported that "in ten years time, the number of long-term sick persons increased by almost 70 percent, by which the cost of their benefits has risen to over 5 billion euros" (D'hoore, 2017). While this statement refers to Belgium, similar observations have been made about other European countries (Eurofound, 2010; OECD, 2010). Both in popular media and academia, the associated costs for individuals, companies and society have been problematized (Hvinden, 2009; Sjoberg, 2017).

Two research lines are dominant within the social-scientific research on long-term illnesses and impairments. First, studies document the social inequality in chronic illnesses and impairments. Research has consistently reported that people from lower socio-economic positions, women and people with a migrant background tend be more susceptible to chronic illnesses and to have a higher risks of having an impairment than people of higher socio-economic positions, men or natives (e.g. European Commission, 2013; Mackenbach et al., 2008; Marmot, 2005; McNamara et al., 2017). Indeed, some people are, as mentioned before, more likely than others to have a longstanding illness.

Second, studies also look into the consequences of long-term conditions in terms of well-being and quality of life. Impairments or chronic illnesses are also easily associated with poor subjective health and low well-being. Indeed, an impairment can be experienced as a stressful life event (because of the onset period, symptoms, or diagnosis) and as a chronic stressor, due to its long-term character; both are known to be risk factors to decreased well-being (Bury, 1982; Charmaz, 1983; Menne, 2006). The onset of an impairment is frequently experienced as a traumatic event, shattering life-long dreams and personal expectations of the future (Bury, 1982; Charmaz, 1983; Thomas, 2007). Having an impairment is associated with ill health, suffering and sadness by people without impairments (Albrecht & Devlieger, 1999; Bruno et al., 2011; Ubel, Loewenstein, Schwarz, & Smith, 2005). People assume that impairment will dominate one's life; this reduces a complex person to a single sad attribute (Garland-Thomson, 1997; Goering, 2008; Söderfeldt & Verstraete, 2013).

Nevertheless, the seemingly "natural" negative relationship between an impairment and well-being has been challenged. Although an impairment may have a serious impact on life, some studies have concluded that not all people with impairments see themselves as unhealthy, nor do people with impairments necessarily report a lower subjective well-being than people without impairments (Albrecht & Devlieger, 1999; Bowling, Seetai, Morris, & Ebrahim, 2007; Bruno et al., 2011; Casier et al., 2013; Dijkers, 1997; Drum, Horner-Johnson, & Krahn, 2008; Fellinghauer, Reinhardt, Stucki, & Bickenbach, 2012; Moller, 2011). Studies have documented the possibility of adaptation to having an impairments and have examined the different role of distinct types of impairment – such as congenital and acquired impairment – can play. Psychological resources and traits (self-esteem, perceived control and acceptance) and social support also appear to suggest a more nuanced approach to the relation.

What those studies still disregard, however, is that impairments and chronic illnesses might also function to triggers to activate social exclusionary processes. They neglect to consider the existence of "disabling" social exclusionary relations, processes and structures that might expose people with impairments to stressful situations, and risk factors that are detrimental to people's health and well-being. Furthermore, they do not consider that the subjective well-being of people with impairments might also be dependent on the accessibility and availability of protective resources. As such, they do not consider the impact of an impairment or chronic illness on subjective health or well-being might be dependent on a person's social position in society. This neglect might be due to the dominance of an individual and bio-medical conceptualization of disability, in which diseases and impairments are seen as anatomical, physiological, mental or emotional abnormalities that cause functional limitations, participation restrictions and a lower well-being (Rioux, 1997). However, this ignores an alternative understanding of disability, in which it might act as a process of social exclusion, that contributes to the social stratification in society and social inequalities in health.

Several reports and statistics of intergovernmental and human rights organisations demonstrate, nonetheless, that people with impairments face social exclusion and disadvantage. The publication of the World report on disability (WHO & WorldBank, 2011) and the establishment of the Convention on Rights of Persons with Disabilities (United Nations, 2006) acknowledge and emphasize what non-governmental organizations, researchers and activists have been problematizing for decades: people with impairments lack the opportunities of the mainstream population.

As an example, figures 1 and 2 provide a look at the labour market participation and financial poverty in Europe in 2011, two crucial areas in our contemporary societies. Based on a special module of the European Labour Force survey on disability (Eurostat, 2014, 2015a), both figures show that people with activity limitations have lower employment rates and higher risks of financial poverty compared to people without activity limitations. Although this pattern is found in every European country, there is considerable cross-national variation in both the level of employment and poverty, and in the difference between people with and without activity limitations. While the gap in labour market participation in countries, such as Sweden, Luxembourg and France, is relatively small, it is significant in countries like Hungary, the Netherlands and Poland. Although people with and without activity limitations have about the same poverty risk in Romania and Denmark, the rate is much higher for people with impairments in Belgium, Germany, Estonia, Croatia, Greece, Austria, France, Portugal and Bulgaria. As such, these figures are examples of the social exclusion that people with an impairments experience. They also indicate that more social exclusion is present in certain countries and not as present in others. In other words, they show that the social exclusion and disadvantages faced by people with impairments are not necessarily inevitable consequences of their condition, but are powerfully shaped by (macro-level) socio-political structures and processes, and socio-cultural practices.

In sum, the relation between impairments and well-being needs to be examined from a more sociological perspective that goes beyond a personal tragedy perspective and considers that impairments and chronic illnesses may trigger processes of social exclusion that are detrimental for their health and well-being. Moreover, it is necessary to address these relations not only at the individual level; because the extent to which people experience social exclusion differs cross-nationally. Identifying the context in which disabling social exclusionary processes occur to a lesser or greater degree, and investigating which policies might moderate its role may improve the understanding of the study of social stratification in general and provide more insight into disabling processes.

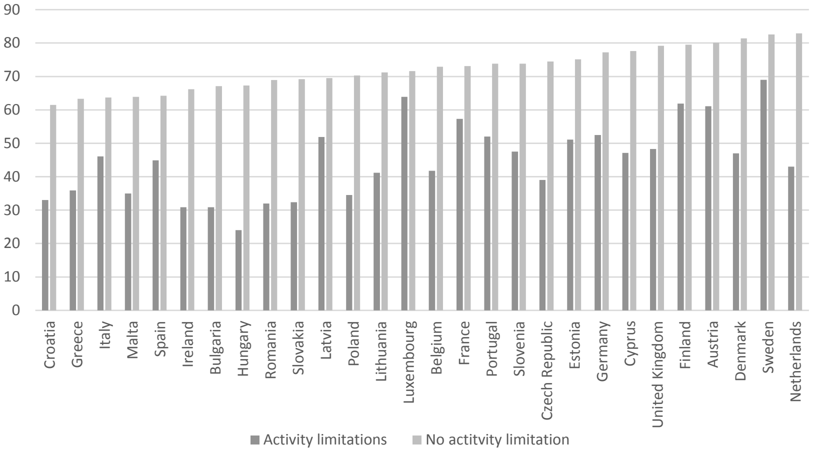
Objectives

In the study of disability as a form of social exclusion, two types of research literature emerge as most relevant to this dissertation: medical sociology and disability studies. Medical sociologists have given the most consideration to defining impairment or chronic illness in terms of personal experience. They have also focussed on the consequences of impairment or chronic illness on daily life, social roles and social position (Goffman, 1963; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Lively & Smith, 2011; Thomas, 2012). Increasingly, however, medical sociologists have begun to approach the study of health and illness from a macro-structural perspective, which includes a focus on the fundamental social causes of health, such as social exclusion (Cockerham, 2013; Link & Phelan, 1995). However, this approach has only been applied to the study of disability to a limited extent (Thomas, 2007; Witvliet, Kunst, Stronks, & Arah, 2012). The work of scholars in disability studies centres on social exclusionary processes and situations people with impairments are prone to (Barnes & Mercer, 2010; Oliver, 1996). The social model of disability emerged from their writings, identifying social barriers and structures, such as the welfare state and labour markets, as creating or enabling disability. This focus was, however, at the expense of considering bodily experiences and personal well-being.

This dissertation combines the strengths of both perspectives and gives insight into the role of social exclusion in the subjective health and well-being of people with impairments. In addition to other well-known drivers that cause exclusion, such as social class, gender and ethnicity, I look at disability as a form of social exclusion with possible consequences for health and subjective well-being. Figure 3 presents the analytical model that guides this dissertation. It graphically represents the hypothesis that the extent to which people with impairments are restricted in their activities is dependent on the social context within which disabling social exclusionary processes and structures are active to a greater or lesser degree. The extent to which people with impairments have worse subjective health or lower subjective well-being is shown as well. The model also shows that the subjective well-being of people who are restricted in their activities (both by impairment and by social processes) is also dependent on that social context. In this dissertation, I focus on the factors and relationships depicted in black.

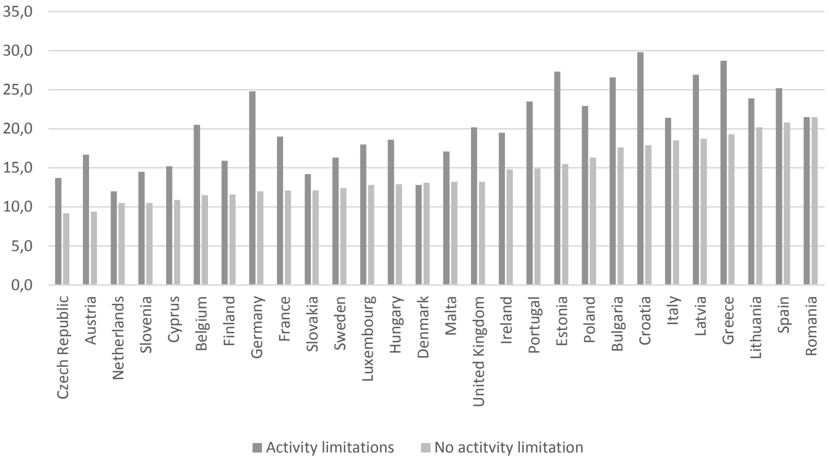
Specifically, I consider the social exclusion of people with impairments in two ways. First, I will focus on the role of exclusionary processes in the labour market because the labour market is one of the most central and influential structures in contemporary Western societies. Many people with

Figure 1: Employment rates (%) of people with and without activity limitations in Europe in 2011



Source: Eurostat (2015)

Figure 2: Financial poverty risks (%) of people with and without of activity limitations in Europe in 2011



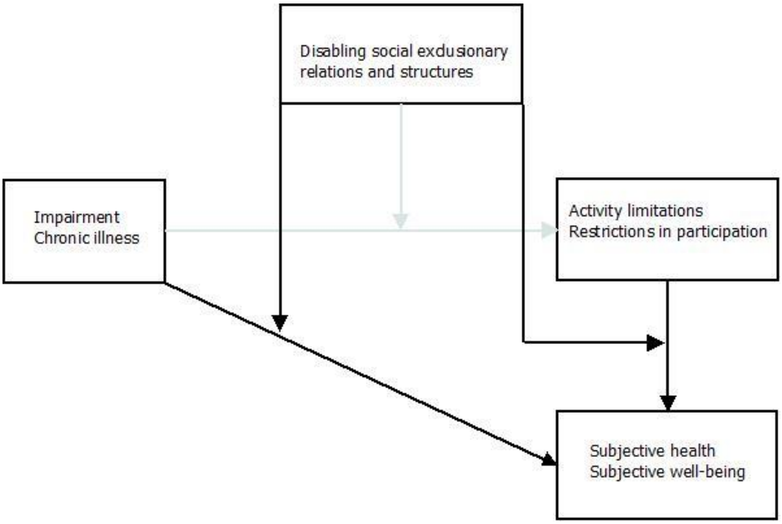
Source: Eurostat (2015)

impairments either permanently withdraw from the labour market or never enter it. Those who are economically active are typically also marginalised, as they tend to occupy positions that are often poorly paid, and their employment situation, which is often at the bottom of the occupational ladder, is characterised by its precarious position (Roulstone, 2012). Being unemployed or being in a precarious job situation, however, is known to be detrimental to health and subjective well-being. Both pecuniary and non-pecuniary factors such as psychological stress and self-esteem are part of the explanation (Batinic, Selenko, Stiglbauer, & Paul, 2010; Jahoda, 1982; Paul & Batinic, 2010). However, as Figure 1 shows, some contexts offer a better chance for finding employment than others. Therefore, it is important to consider how national labour market exclusion levels might play a role in contextualizing the understanding of personal unemployment and employment opportunities (Buffel, Missinne, & Bracke, 2016; Clark, 2003). My contribution to understanding this consists of quantitatively combining different levels of social reality into the analysis, by which I evaluate the role of labour market exclusion in a more nuanced way.

Second, I also pay particular attention to the welfare state. While social inequalities in health and well-being are well established, the degree of these inequalities also varies across countries (Phelan et al., 2010). Within medical sociology, there literature that examines how between-country differences in health inequalities are potentially related to variation in welfare provisions is growing (Beckfield et al., 2015; Wulfgramm, 2014). Welfare states are viewed as institutions that set the parameters in which the social inequalities occur. They redistribute financial resources, provide services that are beneficial to health and well-being, and regulate the behaviour of different actors, like firms and organizations, within society. Moreover, researchers in disability studies have highlighted the role of the welfare state in creating opportunities for people with impairments to participate in society (Hvinden, 2003). However, this research also emphasizes that welfare states have contributed to categorizing people with impairments as a particular group with special needs, which might have unintended but negative consequences for well-being (Tremain, 2015). However, to date, few studies have examined empirically to extent to which the integration of the welfare state might provide insight into the research of the relationship of impairments and well-being.

In the empirical studies presented in this dissertation, I first link the welfare state to the relation between impairments and subjective health. Then, I progress with a study that focuses on the role of welfare state policy on the job satisfaction of people with and without impairments. In both studies, I build on literature that describes the role of the welfare state in those two ways: as a "positive enabler", or as a "potential disabler". Moreover, in the following two studies I focus on how European welfare states try to tackle the social exclusion of people with impairments in a more detailed way. I use both a theoretical and an empirical approach, and present a comparative analysis of the national disability policies. This is based on the finding that the studies on comparative disability policy are quite limited, despite its central role for social inclusion.

Figure 3: Analytical model



In sum, in this dissertation I aim to answer the research questions presented below.

1) "Is the relationship between impairment and well-being dependent on labour market exclusion? If so, how is it dependent and to what extent?"

To address the questions above, I pay particular attention to the role of paid work and unemployment.

2) "Is the relationship between impairment and subjective health or well-being dependent on the macro-context of society? If so, to what extent is it context dependent?"

To address the second pair of questions, I pay particular attention to macro-level labour market social exclusion and welfare state institutions.

3) "How do European countries try to combat the social exclusion of people with impairments?"

To address this third question, I review general comparative welfare state policies, reflect on a theoretical concept to compare disability policy and compare contemporary disability policy of European countries.

Outlining

The remainder of this dissertation consists of three sections. The first specifies the theoretical and methodological framework, while the second consists of four empirical and one theoretical sub-studies. A summary of the main findings and conclusion can be found in the third and last section.

The first section presents the theoretical framework and highlights studies that form the body of this work. Initially, I define the main concepts: subjective health, subjective well-being (including job satisfaction) and social exclusion in Chapter 1. I also describe the main relationship between well-being and social exclusion by referring to the main findings of studies on social inequalities in health and well-being. I conclude Chapter 1 with the observation that social stratification literature—in particular, the literature on health inequalities—has neglected the topic of disability as a form of social exclusion.

The second chapter focuses on medical sociology and disability studies. I present a literature overview of their approach to impairment and disability. While both have their own tradition and research fields, both have been evolving towards similar ideas and conceptions. I end Chapter 2 by presenting the theoretical framework of this dissertation. This theoretical framework integrates the strengths of both the medical sociological focus on disability and the specific focus of disability studies. From the medical sociologists, I adopt both the earlier attention paid to personal well-being and their current focus on macro-structural institutions and processes. I also draw from disability studies' emphasis on social exclusion and social barriers.

After presenting my overall approach, I make it more concrete for empirical research in Chapter 3. In this chapter, I provide an overview of the main theories that guide my studies on the role of labour market exclusion and welfare states. Since the economic production process is still one of the central structuring forces of contemporary societies, the welfare state and the labour market are key focuses of my studies and are discussed in detail. I start by discussing the relation between impairment, employment and well-being, which I link to the role of the broader country context. Subsequently, I consider the role the welfare state plays in contextualizing the relation between impairment and subjective health or subjective well-being.

In Chapter 4, I briefly highlight the specific research aims of the studies and indicate how they are carried out in the empirical studies. Each study is presented by a short summary that includes a reference to the relevant theory from Chapter 3 and a conceptual model. The papers form this dissertation's second section, which includes Chapter 6 through Chapter 10. First, however, I provide information on the research methodology in Chapter 5 that includes the datasets used, a description of the most important measurements, and analytical techniques used to test my hypotheses.

In Part 3, I conclude the dissertation with a discussion of the general results of the research papers and the research's limitations, and offer suggestions for future research. I reflect on the implications of this research for future research, and suggest possible improvements for policy makers.

Part 1: Theoretical framework and methodology

Chapter 1

Capturing impairments, social exclusion, well-being and their interrelationship

This dissertation examines the relationship between having impairments, or activity limitations, and a selected set of other health-related outcomes. More specifically, I consider subjective health, mental well-being and job satisfaction concepts and focus on how social exclusionary processes and situations affect their interrelationship with impairment. Academic research uses the above mentioned concepts in a variety of ways, which makes it particularly important to be clear about my approach. In this dissertation, both impairment and the different outcomes are embedded in a larger and commonly accepted definition of health provided by the World Health Organization (WHO). In 1946, the WHO defined health as “a state of complete physical, mental and social well-being and not merely (as) the absence of disease or infirmity” (WHO, 1946, 2006). While impairment can be related to diseases and illnesses, mental well-being is understood as an umbrella term for the evaluation of people’s lives, with a specific focus on positive feelings and functioning in life, and satisfaction that includes both affective and cognitive states (for reviews of the large body of relevant literature see Diener, Scollon, & Lucas, 2009; Noll, 2004; Ryan & Deci, 2001; Veenhoven, 2000, 2007, 2008). Job satisfaction, in particular, is seen as a work-related indicator of well-being (Warr, 1990).

1.1 Impairments and activity limitations

Researchers generally concur with the WHO’s definitional approach to impairment set out in the International Classification of Functioning (ICF) (WHO, 2001). The ICF makes a distinction between the body’s functions, the body systems’ physiological functions (including psychological functions) and the body’s structures (the anatomical parts of the body such as organs and limbs) that together describe the actual anatomy, physiology and psychology of the human body. Impairments are understood as variations in the structure, functions and workings of the body that are medically defined as significant abnormalities or pathologies. They may be physical or mental, congenital or acquired. When interacting with a person’s environment, impairment may create difficulties in executing tasks or actions, i.e. activity limitations. Visual impairment or blindness, hearing impairment or deafness and oral or speech impediments are among the most frequently experienced impairments (WHO, 2017). This definition also includes diseases referred to as chronic illnesses. These long-term and often incurable medical conditions may be relatively stable or degenerative, and are sometimes marked by episodes in which an impairment may be exacerbated. Currently, chronic diseases such as cardiovascular disease, cancer, mental health problems, chronic respiratory disease, diabetes mellitus and musculoskeletal conditions are the leading causes of death in the world (Commission, 2017). Like Thomas (2007), I also consider chronic illnesses or chronic diseases as a category of impairment. It is important to keep in mind that social context may define the degree to which impairment constrains a person. New impairments may also be "discovered", depending on one's social context. It would not be correct to consider impairments as purely "pre-social" and consign them to the medical world, since our understanding and definition of impairment changes with time and place. This is demonstrated by the apparent rise of dyslexia, which became prevalent only after literacy became widespread (Riddick, 2000).

1.2 Subjective health

Subjective health (or self-rated, self-perceived or self-assessed health) is the outcome of study 1. Subjective health has been one of the most frequently used indicators of health in sociological health research since the 1950's (Jylha, 2009; Knauper & Turner, 2003). It represents a person's summary statement, in which the various aspects of health are combined (Jylha, 2009; Maddox, 1962; Tissue, 1972). It is an inclusive concept, not linked to a specific medical condition and is identified as an important predictor of mortality (Idler, 1999; Idler & Benyamini, 1997; Idler, Hudson, & Leventhal, 1999; Jylha, 2009) and various other health dimensions, such as morbidity (Latham & Peek, 2013) and health-care use (Doiron, Fiebig, Johar, & Suziedelyte, 2015; Miilunpalo, Vuori, Oja, Pasanen, & Urponen, 1997).

Despite the abundance of studies that provide empirical information on correlates of subjective health, an understanding of the concept's nature and of how individuals estimate their health is incomplete rather fragmentary (Jylha, 2009; Knauper & Turner, 2003; Layes, Asada, & Kepart, 2012). In an attempt to gain better understanding of subjective health, Jylhä (2009) proposes a model in which subjective health is the outcome of phased cognitive processes. While the degree of rationality has been debated (Huisman & Deeg, 2010; Jylha, 2010), initially, an individual has to recognize the meaning of health and identify the components that should be taken into account. At this stage, it is apparent that the aspects an individual's evaluation incorporates are not pre-determined or straightforward, as conceptions of health can vary historically and culturally. The choice of components is thus guided by what culturally belongs to the realm of "health". Knauper and Turner (2003) indicate that ane individual's judgement is based on a mental representation of personal health that consists of semantic and episodic knowledge and of information about changes. Frequently considered concrete factors include information from medical diagnoses, observations about functional status, individual bodily sensations, and symptoms and formal signs of illness, such as taking sick leave or utilizing care services (Jylhä, 2009).

Next, the individual considers the specific relevant components and determines how to summarize them as "my health status" (Jylhä, 2009). People may not think about available information in abstract terms but rather in terms of their health history, health expectations and others' situations. Indeed, an obvious yardstick for health evaluations is a comparison with a chosen reference group. Positive or negative dispositions and depression also seem to affect the evaluations. When individuals are asked to summarize their situation using a scale, the next and final step in the process is to consider what level of the pre-set scale reflects their situation best.

Given the potential influence of personal and contextual aspects, some could argue the subjective is irrelevant for sociological comparative research. Indeed, reporting heterogeneity may result in differences of the stated health across population subgroups, even when the underlying 'true' health status is the same (Pfarr, Schmid, & Schneider, 2012). The results of studies that examined this issue across different social positions document both under- and over-reporting among socially disadvantaged groups, or no reporting bias at all (Elstad, 1996; Macintyre, Der, & Norrie, 2005; Subramanian, Huijts, & Avendano, 2002). Despite these distinct conclusions, a meta-analysis shows studies have consistently found that individuals in higher socio-economic positions and with higher education report better health (Furnée, Groot, & van Den Brink, 2008). Based on the World Health Survey, which will be used in this dissertation too, Subramanian et al. (2002) found little evidence for reporting heterogeneity, related to the disadvantaged underreporting poor health, within each of the 69 countries in their sample. They conclude that while self-reports of health may not always accurately capture variations in absolute health across countries, their use to study health disparities within countries is justified.

The results about cross-cultural differences warrant additional research that looks into possible differences in response styles, as studies again report contradicting results (Jurges, 2007; Jylha, Guralnik, Ferrucci, Jokela, & Heikkinen, 1998; Nielsen & Krasnik, 2010; Pfarr et al., 2012). For example, although using the same dataset (Survey of Health, Ageing and Retirement in Europe 2004), Jurges (2007) found cultural differences in reporting styles on subjective health, while Verropoulou (2009) concluded that the main health-related components of subjective health, such as chronic conditions, somatic symptoms and level of physical activity, are the same across Europe. The latter points to the assumption that despite living in different contexts, individuals still share a common idea of what health means. While international comparisons should thus be carried out with caution, they are not ruled out (Quesnel-Vallée, 2007), especially if research focuses on the relationship between health and its determinants, rather than capturing absolute levels of health. In my cross-national study on the relation between impairments and subjective health, I provide greater insight into how the concepts are connected in different contexts.

1.3 Well-being and job satisfaction

In Study 2, I investigate mental well-being, which is sometimes also approached as psychological or subjective well-being. The underlying models of mental well-being used in available sociological studies are influenced by two main approaches, despite on-going scholarly debate about their differing aspects (Bartram, 2012; Cieslik, 2015; Veenhoven, 2008): the hedonic and eudemonic approaches. Studies based on a hedonic perspective associate a high well-being with judging life positively and frequently feeling good and experiencing joy, and with only infrequently experiencing negative emotions like sadness or anger (Diener & Suh, 1997; Sirgy et al., 2006; Veenhoven, 2000, 2007). Subjective well-being is easily connected to and often used synonymously with happiness and life satisfaction (Kahneman, Diener, & Schwarz, 1999; Keyes, Shmotkin, & Ryff, 2002; McGregor & Little, 1998; Ryan & Deci, 2001). Diener et al.'s (1997, 2009) studies identify four specific components of well-being: positive affects and negative affects, life satisfaction and domain satisfaction.

Although these components are moderately correlated, they each provide unique insights information about a person's subjective quality of life. Positive and negative affects reflect people's on-going evaluations of their lives. Affective evaluations that take the form of moods and emotions. Emotions are generally thought of as short-lived reactions tied to specific events; moods are understood as more diffuse affective feelings that are not connected to particular events. Some studies have raised questions about whether positive and negative affects are separable and independent dimensions or whether they are two extremes of the same continuum; consideration of these questions dovetails with discussions about the differences between mental health, distress and disorder (Bradburn, 1969; Diener et al., 2009; Mirowsky & Ross, 2003; Payton, 2009; Ryan & Deci, 2001).

Judgements about the quality of one's life or about specific domains in life that are more reflective can complement affective evaluations. Life and domain satisfaction are seen as cognitive judgments; to make cognitive judgments, individuals examine the conditions of their lives, weigh the importance of these discussions and then evaluate their lives on a scale ranging from dissatisfied to satisfied. Being satisfied implies a convergence of aspirations and achievements that reflects accomplishment and resignation acceptance (Mirowsky & Ross, 2003). To arrive at this conclusion, people might compare their situation to their (current, previous or future) expectations and to others' situations (Diener et al., 2009). Dissatisfaction may therefore result from a sense of deprivation relative to one's own expectations or others' situations.

In contrast, the hedonic tradition includes the development of a eudemonic tradition that focuses on human potential and self-realization (Jahoda, 1958; McDowell, 2010; Ryan & Deci, 2001; Ryff, 1989). Studies based on this approach consider positive (psychological) functioning. Rather than equatinge subjective well-being with happiness, these researchers suggest that well-being consists of realizing and fulfilling one's true nature. They are interested in whether people live according to their true self or potential, and view being virtuous—living up to the standard of highest human behaviour, such as being honest or courageous—as a part of well-being. They tend to speak of psychological well-being and take a multi-dimensional approach towards measuring it. Ryff's (1989) work describes six distinct aspects of human actualization: autonomy, personal growth, self-acceptance, life purpose, mastery and positive relatedness. Inclusion of the last aspect—positive relationships with others—indicates that positive functioning has a social dimension.

Consequently, I conclude that it is necessary to be aware of the diverse use of the term mental or subjective well-being. Some use it to denote happiness, others as a synonym for mental health or for positive functioning.

Furthermore, this short review connects the subjects discussed in Study 2 and Study 3 to provide a broader perspective. In Study 2, I take a hedonic approach to mental well-being, paying particular attention to its affective component. This study focuses on positive affect, or the extent to which people enjoy positive and pleasant emotions and moods. The survey data that is used in this dissertation, focuses on cognitive and affective components rather than on issues about self-realization and human virtue, influenced this choice of focus. However, I also believe that using an outcome based on the eudemonic approach would result in findings on human virtue, rather than on whether people felt positive or negative about themselves. Ideas about the nature of the "true self" might also be more susceptible to the cultural values of a society.

In study 3, I tap into a specific domain satisfaction: job satisfaction. While the outcome of study 2 is more connected to an affective appraisal of life, job satisfaction is seen as a more cognitive way of evaluating someone's subjective well-being. Job satisfaction has been described as an individual's evaluation of her or his job and work context (Spector, 1997). It has a history of being used to operationalize work-related well-being (Soh, Zarola, Palaiou, & Furnham, 2016; Van Aerden, Moors, Levecque, & Vanroelen, 2014; Warr, 1990). As a construct, it is operationalized both globally and multi-dimensionally (Soh et al., 2016). Common dimensions are satisfaction with co-workers, promotion and pay.

1.4 Social determinants of subjective health and well-being

The studies in this dissertation investigate the social roots of well-being and subjective health. This approach views individuals' personal troubles, emotions and perceptions as "social problems" rooted in the socio-economic organization, structure and culture of society. While personality factors such as optimism, self-esteem and genetic make-up are powerful predictors of well-being (Diener et al., 2009; Goodwin & Engstrom, 2002; Helliwell & Putnam, 2004; Jerant, Chapman, & Franks, 2008; Kahneman et al., 1999; Olsen & Dahl, 2007; Ryan & Deci, 2001), they are not the focus of this work. Here, well-being and health are seen as the result of factors situated at the individual's physical and psychological levels, as well as at communal and social levels. They are understood as both an outcome of social systems and a factor in social systems' functioning (Veenhoven, 2008).

Today the development of large-scale and international surveys on well-being and health (such as the European Social Survey and the World Values Survey) enables scholars to link individuals' subjective well-being and health to societal features and wider social structures (Cieslik, 2015). However, although many empirical correlates have been revealed, it remains unclear how these associations relate to larger theoretical narratives and mechanisms. The study of subjective well-being is often depicted as an a-theoretical research topic (Bartram, 2012; George, 2010) that may have been over-researched and under-theorised (Griffiths & Reeves, 2009; Kroll, 2011). Sociological theories could play a role in clarifying possible connections between social determinants and well-being and subjective health.

Studies that seek to explain variations in well-being and subjective health have approached it using a variety of sociological paradigms—such as symbolic interactionism or structural-functionalism—and have been guided by different middle-range theories. Two examples of informative middle-range theories about health inequalities are the social ties and social capital perspectives (Berkman, Glass, Brissette, & Seeman, 2000; Helliwell & Putnam, 2004; Thoits, 2011), social comparison (Festinger, 1954; Hudson, 2013) and social stratification (George, 2010; Kawachi, Daniels, & Robinson, 2005; Olafsdottir, 2007; Reynolds & Ross, 1998). This dissertation can be situated within a conflict sociological paradigm and aligned with the study of social stratification. Studies within this framework examine the social structures and social processes that result in allocation of risks, resources and assets to individuals who occupy different positions in society. Well-being and subjective health are assumed to be highest and greatest among individuals who have access to the most beneficial resources and have the least exposure to health risks and stressors (Diderichsen et al., 2001; George, 2010; Link & Phelan, 1995). This type of research acknowledges that inequities in health and well-being are rooted in individuals' different social structural locations in society, which are not only associated with differential exposure to risks and resources, but also with social roles and opportunities (Coburn, 2004; Diderichsen et al., 2001; Kawachi, Subramanian, & Almeida-Filho, 2002; Marmot, 2005; Olafsdottir & Beckfield, 2011; Whitehead, Burstrom, & Diderichsen, 2000).

1.4.1 Social exclusion

More specifically, this dissertation looks at social reality through the lens of social exclusion. The concept of social exclusion in European public debate and research on social stratification emerged in the 1990s (Béland, 2007; Room, 1995; Silver, 1994). Social exclusion has a multi-dimensional face, that operates at several levels. It can describe a person's exclusion from several domains of life, such as the labour market, professional education, the housing market, cultural life or voting; alternatively, the term sometimes describes a specific phenomenon, such as exclusion from social networks. Therefore, although the term social exclusion is widely used, how it is defined is not always clear.

Table 1: A typology of social differences in terms of hierarchy and fault lines

	Hierarchy	
Fault lines	No	Yes
No	Social Differentiation	Social Inequality
Yes	Social fragmentation	Social Exclusion

Source: Vranken (2001)

I base my understanding on Vranken's framework (2001), in which social exclusion is clearly distinguished from other processes and situations that define social reality. Vranken's framework sees social relations as the basis of social reality and notes two main characteristics that typify social relations: the presence or absence of a hierarchy, and the presence or absence of fault lines. Fault lines manifest themselves as gaps, walls or barriers and refer to both processes and situations. This leads to a typology of social differences, as presented in Table 1, that juxtaposes social exclusion with three other types of social differences: social differentiation, social fragmentation and social inequality.

According to Vranken, social exclusion implies the presence of two conditions: a hierarchical relationship between individuals, positions or groups, and a separation by clearly discernible fault lines (Vranken, 2001; Vranken, De Decker, & Van Nieuwenhuyze, 2003). Based on his framework, social exclusion can still be considered a multi-dimensional concept that refers to exclusion from different areas of life. People can be excluded from economic life, from an appropriate residential context, from the health system, from education and from social and cultural life. Nonetheless, in this framework, social exclusion is more clearly delineated as a specific social situation or process. To create a social exclusion situation, a society would need to be organized according to a centre-periphery relationship within which economic, social and cultural capital were unequally distributed. In contrast to social inequality, social exclusion is about more than gradual differences in capital or common ruptures in the fabric of society; it consists of real gaps that result in the division between "in" and "out" (Vranken et al., 2001). Social exclusion implies a process that results in a situation in which people lack crucial resources, and structural gaps that make it almost impossible to change their situation. The main forms that social exclusion takes are polarisation, discrimination, institutional isolation, poverty and physical inaccessibility.

Fault lines are therefore necessary for the construction of social exclusion situations. They are social gaps or barriers between insiders and outsiders, between those who do not possess the necessary means (social commodities, or different forms of economic, social and cultural capital such as income, employment, housing, status or political power) to bridge the gap between themselves and others in society. The consideration of fault lines prompts a crucial questions: namely, social exclusion from what? Analytically, Vranken (2001) distinguishes between relational, spatial and societal fault lines, all of which can occur at different society levels: at the micro-level (individuals and their networks), the meso-level (groups and neighbourhoods) and the macro-level (society). In this dissertation, I focus primarily on processes of social exclusion that are initiated and situated at the macro-level. In particular, I pay particular attention to differences in the well-being of people on different "sides" of larger societal fault lines.

In Western societies, the economic production process still stands out as one of the defining organizational relationships in society (Vranken, 2001). It reveals at least two main gaps or distinctions between groups of people. The first distinction resides in the well-known relation between those who "own" the means of production and those who do not; this points to the differences between the possessing and the working classes, as put forward by Marx (Engels & Marx, 2004; Marx, Moore, Aveling, & Engels, 2012). Vranken (2001) points out another distinction, the differences between those who can survive because they have a production factor (e.g. capital, control of capital, labour or land) and those who cannot because they do not, and therefore must depend on the redistribution system of the welfare state. While the first group can survive because their "possession" is marketable and produces revenue, the other group is composed of people who are unemployed or inactive or who cannot implement a production factor successfully (such as unskilled workers or migrant workers whose certificates have not been approved). This latter group is likely to experience social exclusion if their access to means central to the organization and functioning of society and welfare state resources is not sufficient. Given the centrality of the economic production process and of the welfare state in Western societies, this dissertation's studies on social exclusion are necessarily tied to processes and situations that can be traced back to those two structuring institutions. While one study considers macro-level labour market exclusion of people with impairments, others focus on the role and organization of welfare policy in constituting the situation of these people.

However, this does not mean other forms of social exclusion based on relational or spatial fault lines are not part of this theoretical framework. For instance, a country's labour market policy and social security system can make it either easier or more difficult for people with impairments to be active in the labour market (Holland et al., 2011; K. A. van der Wel, Dahl, & Thielen, 2011); they might thus affect a person's chances of employment and subsequent inclusion in the labour market. Moreover, one could say they affect the chance of socially excluded people to access to certain social commodities, like employment. Having a job, however, can also give these people access to a variety of other social commodities via participation in social networks. The previous touches upon decomposing a relational fault line that pushes (groups of) individuals out of important social networks. When people with impairments are, however, directed mainly towards sheltered employment, in a sense, they are also spatially excluded, as they have minimal contact with people in the primary labour market. Indeed, while it is possible to differentiate between different sorts of fault lines analytically, in reality, the different processes and situations are likely to intersect with each other in the production of social exclusion.

1.4.2 Social exclusion, subjective health and well-being

The evidence of an association between social exclusion and self-perceived health and different forms of subjective well-being is extensive (Bambra, 2011; Clark, Knabe, & Ratzel, 2010; Evans, Kantrowitz, & Eshelman, 2002; Levecque & Van Rossem, 2015; Levecque, Van Rossem, De Boyser, Van de Velde, & Bracke, 2011; Lorant et al., 2003; Marmot, 2005). Most people in disadvantaged positions—such as lower socio-economic positions, women and migrants—consistently report lower levels of health and lower well-being than people in higher socio-economic positions, —such as men and natives.

Social exclusion is both cause and consequence of poor health and subjective well-being (Marmot, Ryff, Bumpass, Shipley, & Marks, 1997). The social selection perspective argues that health and well-being influence social mobility, and hence, people's position in society. It suggests people with poor health and lower well-being are more likely to become socially excluded. This may happen directly, by manifestly limiting their chances for social inclusion. Regarding labour market exclusion, for example, it has been shown that people with poorer subjective health and poorer well-being are more likely to be without a job and to remain unemployed for longer periods (Heggebo & Dahl, 2015; Elstad, 1995; Stewart, 2001). Once a person becomes unemployed long-term, their probability of finding a new job will also decline as employers may wonder if there is a problem with motivation, health or competence. Indirect health selection, where movement between social positions is primarily affected by factors other than health is also likely. Furthermore, people with poorer health may also have a lower educational degree, which makes it more difficult to gain full-time employment. Thus, education functions as a mediator between health status and employment. This shows how poor health might also be indirectly associated with downward social mobility. Therefore, an accumulation of disadvantages over time might increase the chances of being socially excluded (Blane, Smith, & Bartley, 1993).

In contrast, the social causation hypothesis posits that social exclusion leads to health problems and lower well-being. Social exclusion from social commodities and protective resources, roles and opportunities is considered harmful for the health and well-being of people in at least two ways. First, occupying less privileged socio-economic positions increases people's exposure to hardship, risk factors for health and well-being, and stress (Diderichsen et al., 2001; Whitehead et al., 2000). It also limits their access to resources—such as money, knowledge, social support—that prevent and cure diseases (Link & Phelan, 1995). Moreover, social exclusion might affect these groups' health and subjective well-being more indirectly through psychosocial stress processes and social roles (Aneshensel, 1992; Artazcoz, Benach, Borrell, & Cortes, 2004; Tausig, 2013). Being excluded from paid work might not only be detrimental only to health in terms of financial resources but also in terms of effect on social contact, social status and identity (Jahoda, 1981; Paul & Batinic, 2010; Ross & Mirowsky, 1995).

In sociological research on social stratification and research on social inequalities in health and well-being, most studies focus on three forms of social exclusion: those associated with social class relations, with gender and with ethnicity. While these forms of social exclusion function as central organizing and stratifying axes within contemporary Western societies, this dissertation intends to draw attention to a rarely considered form of social exclusion that may also cause poorer subjective health and well-being: disability.

1.4.3 Disability and social exclusion

Chronic diseases and impairments are usually understood as outcomes of social exclusionary processes, and are considered along with other health indicators such as life expectancy and mortality. Research consistently reports social inequality in chronic conditions and well-being: people in lower socio-economic positions and women tend be more susceptible to chronic illnesses and to have a higher risk of impairment than people from higher socio-economic positions and men (e.g. European Commission, 2013; Mackenbach et al., 2008; Marmot, 2005; McNamara et al., 2017).

In addition, impairment is often understood as the main cause of disability, or restriction of activities and limitation in participation. This perception is based on an individual conceptualization of disability in which diseases and impairments are seen as anatomical, physiological, mental or emotional abnormalities that cause functional limitations and restricted participation (Rioux, 1997). Furthermore, impairments or chronic illnesses are also easily associated with poor subjective health and lower well-being. Indeed, impairment can be experienced as a stressful life event (because of the onset period, diagnosis, or symptoms) and as a chronic stressor (due to its long-term character and its consequences for how life is organized), both of which are known to be risk factors for decreased well-being (Bury, 1982; Charmaz, 1983; Menne, 2006). The onset of impairment is frequently experienced as a traumatic "event" or as a biographical disruption, and life with impairment is frequently viewed as a personal tragedy leading to a diminished self (Bury, 1982; Charmaz, 1983; Thomas, 2007). Impairment is often associated with ill health, suffering and sadness by people without impairments (Albrecht & Devlieger, 1999; Bruno et al., 2011; Ubel, Loewenstein, Schwarz, et al., 2005). Impairment is assumed to dominate one's life, thereby reducing a complex person to a single sad attribute (Garland-Thomson, 1997; Goering, 2008; Söderfeldt & Verstraete, 2013). Accordingly, studies suggest that people with impairments have a lower subjective well-being than those without impairment (Emerson, Llewellyn, Honey, & Kariuki, 2012; Lucas, 2007).

Nevertheless, this seemingly "natural" negative relationship between having an impairment and well-being has been challenged. Although impairment may have a serious impact on life, some studies have concluded that not all people with impairments see themselves as unhealthy, nor do they necessarily report lower subjective well-being than people without impairments (Albrecht & Devlieger, 1999; Bowling et al., 2007; Bruno et al., 2011; Casier et al., 2013; Dijkers, 1997; Drum et al., 2008; Fellinghauer et al., 2012; Moller, 2011). Much of the existing literature has sought to understand how individuals adapt to impairments psychosocially, especially as this form of adaptation is assumed to affect subjective well-being positively (Gignac, Cott, & Badley, 2000; Livneh & Antonak, 2005; Livneh & Parker, 2005; Martz, Livneh, Priebe, Wuermser, & Ottomanelli, 2005; Ubel, Loewenstein, & Jepson, 2005; Ubel, Loewenstein, Schwarz, et al., 2005).

An informative example is related to the distinction between congenital and acquired impairments. While some people are born with an impairment, others might suddenly acquire it during a car accident or an incident at work. Other impairments develop more slowly and are caused by progressive diseases. The literature indicates that people who become impaired might grieve over a loss of functioning, especially following the onset of impairment, and have to adapt to their situation or new identity. People with congenital impairments have not experienced such a loss, so it is implicitly assumed they have a higher subjective well-being (Bogart, 2014). As one of the first, Bogart (2014) empirically tested the foregoing assumption and concludes that people with congenital impairments where more likely than those who had an acquired onset to have a higher satisfaction with life. Their higher life satisfaction was explained by their high likelihood to have a positive disability identity. According to her study, it was especially the time of onset, but not the duration of the impairment that was crucial for this positive identity.

In addition, the role of psychological resources and traits (self-esteem, perceived control, acceptance and the balance between body, mind and spirit) and social support and other ways of coping also contribute to a more nuanced finding (Fellinghauer et al., 2012; Felton & Revenson, 1984;

Gignac et al., 2000; Pearlin, Schieman, Fazio, & Meersman, 2005). What these last studies have in common is that they question the equatingon of impairment with unhappiness and misery. They seek to understand the extent to which lower subjective well-being is the direct consequence of having an impairment or, rather, is the indirect result of the interaction between the impairment and psychological attributes and social relations. They demonstrate that individual agency and social relationships can counteract the potentially negative effects of impairments and chronic illnesses.

What they overlook, however, is how impairment might function as a trigger to activate social exclusionary processes. Disability is only rarely considered an unequal social relationship that manifests itself through exclusionary and oppressive practices, and a factor contributing to social stratification and social inequalities in health and well-being by itself (Jenkins, 1991; Thomas, 2012). Nevertheless, several reports and statistics from intergovernmental and human rights organizations have provided evidence of this social exclusion. The publication of the World report on disability (WHO & WorldBank, 2011) and the establishment of the Convention on Rights of Persons with Disabilities (United Nations, 2006) validate and emphasize what non-governmental organizations, researchers and activists have been problematizing for decades: people with impairments lack the opportunities of the mainstream population. Impairments may prevent them from receiving education, from getting jobs (even if they are well qualified), from getting around, and from fitting in and being accepted. Over the years, perspectives that emphasize the disabling effects of social barriers and physical environments have gradually become accepted (Thomas, 2004; WHO, 2001; Williams, 1999b; Bury, 2000; Oliver, 1986). In other words, it is now more generally acknowledged that a myriad of physical and social structures and barriers prevent people with impairments from doing what they want to do, from being what they want to be.

To obtain a better understanding of disability as a form of social exclusion, in the following chapter I examine and discuss two branches of sociology that focus on disability as one of their main subjects. In this way, I hope to enrich the study of social stratification in general and to provide greater insight into disabling processes.

Chapter 2

Different approaches to disability and well-being in medical sociology and disability studies

A multitude of theoretical perspectives on disability—with smaller or larger, implicit or explicit disagreements—coexist: some are in opposition to each other, some not. In this chapter, I call attention to the main evolutions and considerations of these perspectives, but limit the discussion to literature from medical sociology and disability studies. For an overview of the perspectives from the social sciences and a more extensive discussion, I refer to Barnes and Mercer (2010b), Desnerck (2007), Priestley (1998) and Thomas (2007). These different conceptualizations of disability all focus on different elements and their explanations about the relationship between impairment, well-being and social exclusion shape research. In the following sections, I a discussion of disability and its application in sociological studies that concern issues of subjective health, social exclusion and well-being. In conclusion, I elaborate on the theoretical framework about disability that has guided this dissertation.

2.1 Disability in sociological studies

The causes and consequences of disability have been the concern of two separate branches of research aligned with sociology: medical sociology and disability studies. While scholars in both fields use sociological perspectives to explore disability, impairment and chronic illness, they are informed by the distinct, sometimes competing concepts and motives of their research. Because of their chosen frameworks, they are guided by different understandings of disability, which sometimes results in the pursuit of different research interests about and approaches to well-being and impairment. Most of the time, the two branches of study tend to co-exist passively. Because of recent developments, however, their research aims are beginning to converge as they pursue mutual interests.

2.1.1 Medical sociology

Medical sociologists' interest in chronic illness and disability has been influenced by many different general sociological perspectives throughout time (Desnerck, 2007; Larsen, 2009). Parson's concept of the sick role laid the fundaments for the sociological study of health and illness (Parsons, 1975; Williams, Annandale, & Tritter, 1998). In his structural-functionalist framework, illness is approached as a social problem, and is viewed as a form of deviance that threatens the social order of society. In this understanding the ill are people who are failing to fulfil their social responsibilities—such as maintaining employment and caring for their families—which negatively affects the social order and functioning of society. Their deviance is, however, tolerated because of the introduction of the "sick role" for those who are ill and need to "opt out of their social duties;" this has become a mechanism for social control and regulation (Varul, 2010). Periodically, the individual's everyday obligations are replaced by a set of sick-role specific rights and obligations. The most fundamental right is obviously the exemption from the normal role. Others include the assumption of innocence and the obligation to get well and seek professional help.

Although criticized for not questioning the power of medicine and other professions to label (Oliver, 1996), and not taking into account longstanding conditions (Varul, 2010), the sick role does demonstrate that illness not only involves physical or mental dysfunction, but also has social consequences and may lead to the construction of a specific social role and social position. It has evolved to include the "handicapped role" (Fine & Asch, 1988), "impaired role" (Gordon, 1966; Siegler & Osmond, 1973) and "rehabilitation role"(Safilios-Rothschild, 1970), concepts that stress that impairments and chronic illnesses are more permanent than ordinary colds. Similar to the sick role, the impaired role indicates that societies might exempt people with impairments from the obligation to recover, but those people are then generally treated as dependents and awarded a low social status. They are no longer considered "full humans" (Siegler & Osmond, 1973), and are shunted into a particular social role that limits their opportunities and their role in society.

Next to structural-functionalist research, interactionist and interpretative perspectives have affected many medical sociological studies on disability. Goffman, Lemert and Becker's works, for instance, can be considered landmarks in showing how disability is a socially constructed category. Strauss and Glaser's work on the negotiation process during patient-doctor interactions (Strauss, 1976; Strauss & Glaser, 1975), and Garfinkel's ethnomethodological work on the construction of illness and disability as "a trouble or disruptors of the social order" (Garfinkel, 1967), are also valuable contributions. While these authors share Parson's perspective that illness represents a form of social deviance, they place greater emphasis on the micro-level social construction processes of this deviant status. They open the door for questions about social action and social order. Some pay particular attention to the construction of meaning through interactions, through symbols, gestures and informal rules (Thomas, 2007). Becker's (1963) labelling perspective shows that chronically ill people are carriers of unfortunate labels that carry stigmatizing meanings. Goffman's (1963) study on stigma considers how people are negatively classified based on the presence of "discrediting" features (like an impairment) that distinguish them from others. Furthermore, he shows how stigmatized persons have developed strategies to manage social interactions in a way that serves the interests of those who are deemed "normal" that range from avoiding social contact to controlling information; these observations provide insight into possible discriminatory situations in society.

In accordance with these earlier perspectives, medical sociology has focused on the experience and meaning of chronic illness and impairment in two ways: first, by considering meaning as a "consequence", looking into the impact of a chronic illness on practical aspects of life and relationships (social roles), and second, by looking at meaning as a source of "significance", focusing on the cultural connotations and implications associated with a particular illness and its impact on self-assessment and identity (Lively & Smith, 2011; Thomas, 2007). A majority of studies have approached identity and sense of self as a function of illness, with the predominant view that illness is an identity disruption or discontinuity (Larsen, 2009; Secrest & Zeller, 2007), which leads to ideas such as "loss of self" (Charmaz, 1983), "biographical disruption" (Bury, 1982, 2000), "devalued self" (Anderson, 1991), and has resulted in many studies on the relation between illness, stigma and identity (Lively & Smith, 2011). These perspectives studies underscore the potentially disruptive impact (of the onset) of chronic illnesses on the self-perception and identity of people, and challenge assumptions and behaviour that are normally taken for granted (Galvin, 2005; Pierret, 2003). These may have a major impact on self-image and well-being because of the restrictions they create, the social isolation they sometimes entail and the stigmatizing reactions of others (Charmaz, 1983; Galvin, 2005; Bury, 1991).

Because of the attention paid to personal experience and the consequences of impairment, some authors might claim that medical sociologists lean towards individual models of disability, of which biomedical models of disability are some of the most well-known (Desnerck, 2007; Priestley, 1998). Medical sociologists generally share the focus on individual pathology and locate the problem of disability within the individual (Barnes & Mercer, 2010b; Priestley, 1998; Rioux, 1997). Disability is seen as a restriction or the inability to perform activities that results from impairment normally (Oliver, 1996). Disability is viewed as a mental or physical condition that can be prevented or ameliorated through medical, biological or genetic intervention. Rehabilitation services—made available to enable the individual to become as socially functional as possible, to develop their potential and fulfil valued social roles—is seen as another option (Flynn &

Lemay, 1999; Wolfensberger, 1972). With the rise of institutional facilities and welfare benefits and services, the medical sciences and health-related professions become gatekeepers, and thus their determination of who is disabled is legitimatized. Normal, healthy persons are taken as a reference point; people with impairments are thus viewed as deviating from the norm. The needs of disabled people are seen as special and different from the normal population. In these models, individual differences are emphasised and more attention is paid to specific disorders and deficiencies and individual experiences; commonalities are downplayed (Desnerck, 2007).

One criticism of the individual models is that they individualize and medicalize disability and couple it with a discourse about personal tragedy and individual difficulties (Barnes & Mercer, 2010b; Gleeson, 1997; Rioux, 1997). By focusing on a causal relation between impairment and disability, individual models can lose sight of environmental and situational factors that may limit individuals in their doing and being. The environment is presented as neutral; this downplays the potential that social policy and legislation have to guarantee citizenship rights to people with impairments. In this way, disability is depoliticized (Barnes & Mercer, 2010a).

From the medical sociologists' point of view, equating their studies with individual models is short sighted. Indeed, the examination of the role of stigma and attitude can be seen instead as a challenge to medical models, and may direct attention to the social environment (Desnerck, 2007). Moreover, the studies inspired by Parson's sick role do consider the limited role ascribed to people with impairments as a social construction, not necessarily as inherent to impairment. Nonetheless, their representation of illness and disability does not consider the influence of medicine and other professions on labelling people as such. Furthermore, Thomas (2007) indicates that these medical sociological studies share a social deviance lens, in which implies there is a social norm, without challenging the social order or actually considering the power relations by which disability is being constituted. These studies fail to explicitly consider is the social exclusion experienced by people with impairments that is clearly demonstrated by empirical evidence and advocated by the social model of disability (see infra).

Since the 1970s, the number of medical sociologists who have adopted a perspective that emphasises a society characterised by conflict and social inequality has grown. There is increased awareness of the need to understand the social roots of health and illness that has resulted in a paradigm shift away from the methodological individualism towards theories with a structural orientation (Cockerham, 2013). For instance, interest in researching the social control exercised by powerful socio-political institutions like the capitalist state and medicine has grown and has led to studies on medicalization and power over life (Conrad, 2013; Conrad & Barker, 2010; Foucault, 1998, 2010; Foucault & Sheridan, 1977; Illich, Zola, McKnight, Caplan, & Shaiken, 1977; Nye, 2003; Roberts, 2005; Stone, 1984). Moreover, the domination of the biomedical perspective has received considerable criticism from, among others, those in research fields that focus on social inequality in health and illness and look at the socio-economic inequality in chronic diseases and mental distress (Black, Townsend, & Davidson, 1992; McKeown, 2014).

Under the influence of a loosely associated combination of (neo-)Marxists, political economists, critical social-epidemiologists, feminists and others, medical sociology has gradually developed alternative middle-range theories pointing to possible mechanisms for understanding the unequal social outcomes in health and illness: social selection, social stress processes, fundamental social causes of health and illness (Aneshensel, 1992; Coburn, 2000; Link & Phelan, 1995; Pearlin, 1989; Poland, Coburn, Robertson, & Eakin, 1998), life course perspectives (Pearlin, Schieman, Fazio, & Meersman, 2005) and intersectionality (Annandale & Hunt, 2000; Annandale & Hunt, 2000; Weber & Parra-Medina, 2003). Currently, medical sociology also employs methodologies to more fully assess structural effects on individuals' health: the ready availability of quantitative datasets and advanced statistical techniques such as multilevel modelling allows researchers to determine the separate effects of multiple levels of social structures on the health of individuals (Cockerham, 2013). Despite the evolution towards a structural perspective, these methodologies have been incorporated by studies about the health and subjective well-being of people with impairments to only a small extent (Emerson, Llewellyn, Honey, & Kariuki, 2012; Emerson et al., 2011), as mentioned before.

2.1.2 Disability studies

From the start, research in the comparatively young field of disability studies adopted the processes and outcomes of social exclusion as its central point. It began in the 60s, mainly in the UK and US (Desnerck, 2007; Thomas, 2004). It is an interdisciplinary research field with psychological, political and pedagogical influences that widely uses sociological perspectives and methodologies. Moreover, it has a direct link with practice, as many of the researchers are (disabled) activists too. They share a conceptualization of disability based on a social oppression or social exclusion paradigm. The social model understanding of disability originated in this paradigm and is at the heart of their research. Most of the research is of qualitative nature.

Social model approaches explain the well-being of people with impairments in terms of the socio-political nature of disability (Desnerck, 2007; Rioux, 1997). These approaches developed as a critical reaction to individual conceptualizations that led mainly to medical actions and rehabilitation services. The social models assume that disability is not inherent to the individual, but is a consequence of having a particular position in the social structure (Rioux, 1997). It is not the impairment that is disabling, but the way in which societies are organized and structured. Thus, disability, or restrictions in activity, becomes a political and social problem, which clearly distinguishes it from impairment. Social modelists focus on collective reality and show that all people with (different kinds of) impairments share a collective experience of discrimination, oppression and exclusion (Desnerck, 2007; Priestley, 1998). Instead of setting up interventions aimed at the individual, approaches based on a social model target the social, environmental, cultural or economic system.

Priestley (1998) highlights two social model approaches: social structural models and social constructionist models. In the former, disability is the material product of socio-economic relations within a specific historic context. It focuses on social barriers in the environment, or material and physical structures and power relations (Finkelstein, 1991; Oliver, 1996; UPIAS, 1975). A person's restricted activity is the effect of a society that excludes people with impairments by preventing access and integration into society. The framework of most studies in the discipline has been heavily informed by macro-sociological material and (neo-Marxist) conflict perspectives (Thomas, 2007). Although significant social changes have been taking place over the last few decades in Western societies, materialist perspectives still indicate that the drive for capital continues to direct the economy and shape political and cultural ideas, institutions and practices. They focus on the role of structures and barriers both at the macro-level, such as the role of the capitalist nature of work (Abberley, 1999; Baumberg, 2014; O'Brien, 2013; Roulstone, 2012) and welfare state policies and legislation (Bambra & Smith, 2010; Finkelstein, 1991; Oliver, 1990; Waddington & Lawson, 2009). At the meso-level, attention is directed towards organizational policies and practices (Stone & Colella, 1996), corporate culture (Schur, Kruse, Blasi, & Blanck, 2009), housing (Imrie, 2004), transport and accessibility of environment (Allerton & Emerson, 2012; Gleeson, 1999), and independent living (Allerton & Emerson, 2012; Barnes & Mercer, 2010; Mansell, Knapp, Beadle-Brown, & Beecham, 2007).

However, because of the focus on macro- and meso-level social exclusionary processes and situations, the structuralist research tends to ignore at least three other aspects of disability. First, it ignores the fact that a strong advocacy of the social model considers the social barriers that hinder participation in society by people with a chronic illness or impairment at the expense of recognizing the cultural construction of disability (Thomas, 2007; Tremain, 2015). In recent years, the ideas of post-structuralist theorists like Derrida, Braudillard and Foucault have offered a contrasting ideas about the cultural creation of the exclusion of disabled people by deconstructing dominant social discourses and cultural representations (Hahn, 1996; Hughes, 2015; Shakespeare & Watson, 2001; Tremain, 2015; Waldschmidt, 2015). This approach accords with other social creationist models that draw attention towards the role of cultural values and representations. Disability is seen as a social construct, an idealist product of society within a specific cultural context (Priestley, 1998). Most studies in these branches of research study the role of discursive practices in the disablement process at the macro-level (such as the discourse of national policies) and at the meso-level (discourses within organizations and firms) (Goodley, 2014; Shakespeare & Watson, 2001).

Second, their research also ignores the invisible role of the body, of impairment in the materialist social model (Shakespeare & Watson, 2001). The dualism of the social model, which indicates a clear division between impairment and disability, has been challenged as well. The rigid classification of impairment as biological and disability as purely social has been called into question (Hughes, 2015; Hughes & Paterson, 2010; Shakespeare & Watson, 2001). Research increasingly acknowledges that people are disabled and limited by their bodies as well as by social barriers. Shakespeare and Watson (2001), for instance, indicate that disability has to be understood as the product of multiple biopsychosocial forces.

Third, for some time now, research within disability studies has (somehow intentionally) ignored the consequences of social exclusion for the subjective well-being, emotions and feelings of people with impairments in order to avoid being associated with the personal tragedy approach to disability (Oliver, 1996; Reeve, 2012; Reeve, 2014; Thomas, 2007). Consideration of the role of the flesh and blood individual, however, with its feelings and emotions, has been quite limited in these models. Due to the work of (predominantly feminist) scholars, there is now scope for research that looks into the private sphere, which was for a long time dismissed as being a-political (French, 1993; Morris, 1992; Thomas, 1999). Because of this work, it has become acceptable to examine the extent to which social barriers in society not only place limits on what people can do, but also on what they can be by shaping individuals' inner worlds, sense of self and social behaviour.

2.2 An integrative approach: linking disabling social exclusionary relations with health and well-being

The previous section considers the two branches of sociology that are occupied with the study of well-being, impairment and disability: X. While they have functioned more or less independently, both have received internal and external criticism about what their approach and theoretical reservoir lacks. This made me wonder whether combining the strengths of both approaches might advance our understanding of the relationship between well-being, impairment and the role of social exclusion across multiple social contexts.

Furthermore, there are observations made in the previous discussion that have influenced how I approach my studies. Therefore, I will first employ an integrative approach to studying disability that combines the strengths of the two branches because, while medical sociology evolved from more individual-oriented models of disability and paid attention to impairments, and while research within disability studies has emphasised the social imposition of restrictions and neglected impairments, both approaches have started to concede that even strong medical and social models are flawed. Actors from both sides acknowledge that impairments can restrict people's participation in society, and social barriers and social exclusionary processes definitely play a role in socially limiting people too. In this dissertation, I therefore adopt the approach proposed by Carol Thomas in an endeavour to leave behind the fierce contradictions between individual and social model ways of thinking about disability (Thomas, 2007; Thomas, 2012, 2014; UPIAS, 1975).

Specifically, Thomas suggests that what has been lost over the years is the idea that disability only comes into play when the restriction of activity or the undermining of well-being experienced by people with impairments is socially imposed. This implies that there is the possibility that chronic illnesses and impairments could directly cause restrictions in activities, but also suggests that disability only comes into play when these restrictions are socially reinforced. Thomas (1999) introduced an analytical distinction between "impairment effects" and disability based on this perspective. The former term refers to restrictions in activities—such as the presence of chronic pain or an inability to walk because of a missing limb—that directly stem from chronic illness or impairment. Disability, however, refers to restrictions in activities experienced by people with a chronic illness or impairment that are socially imposed. An example of a socially imposed restriction is the denial of admission to certain schools for impaired children because of their condition that results in a lack of opportunity for adequate education. Disability, or "disablism", therefore, is a process of social exclusion associated with relationships at the macro-, meso- and micro-levels between the impaired and the non-impaired. It is a process of systematic social exclusion on par with other processes of social exclusion based on gender, social class, ethnicity and sexuality.

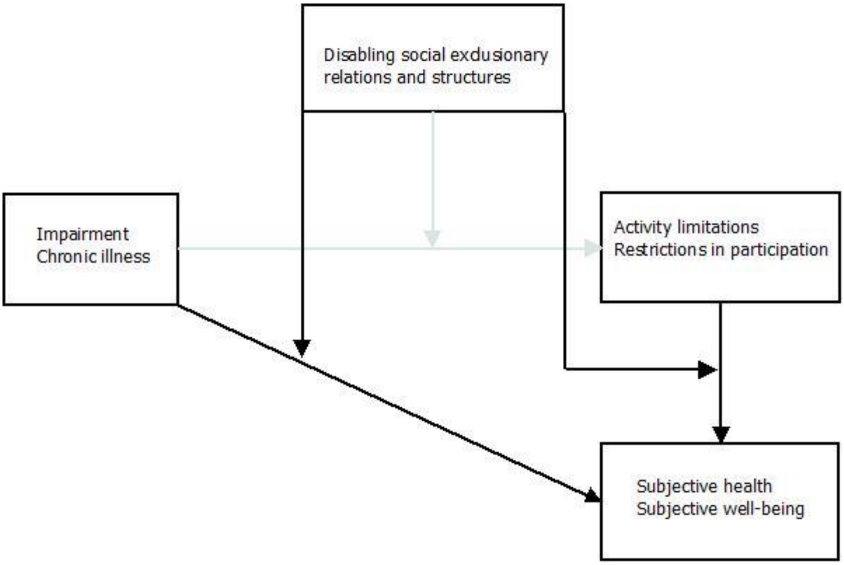
Thomas' approach is not the only one that presents a consensus perspective. The moderation of the two perspectives on disability has, for example, also led to the acceptance of biopsychosocial models of disability, in which disability is seen as the product of the interaction of different biopsychosocial forces (Bury, 2000; Shakespeare, 2005; Shakespeare & Watson, 2001, Williams, 1999).The WHO's International Classification of Functioning, Disability and Health (ICF) is one of the most well-known examples of this approach (WHO, 2001). While I value biopsychosocial contributions like those of the ICF model and see them as a significant step towards a broader international recognition of the interplay of biological, environmental and social factors in the constitution of the disability concept, they risk making it more difficult to distinguish between the different roles of social factors by grouping all three types of factors together. I deem it necessary to make, at least analytically, a distinction between impairment and disability. While one could state that making a distinction between impairment effects and disability ignores the socio-cultural construction of impairments, a social-relational understanding does offers fertile ground for theoretical, empirical and policy-related work by indicating those areas where social conditions and power relations reinforce the restrictions in social participation for people with impairments.

Second, in this dissertation I will combine medical sociology's attention to the subjective health and well-being of people with impairments with disability studies' focus on processes of social exclusion. I raise questions about what the role of social exclusion is in explaining the well-being of people with and without impairments across different social contexts. On one hand, medical sociologists consider the meaning of chronic illness or impairment in terms of identity, feelings about oneself and subjective well-being, but pay little attention to the role of social exclusion. I ponder to what extent the relation between impairment and subjective health or well-being is dependent on social exclusionary situations and processes. On the other hand, previous research in disability studies has been occupied with studying restrictions in activities, especially with what people are prevented from doing, thereby ignoring those restrictions that are situated in the realm of private life, those that involve subjectivity and relate to feelings and emotions (Thomas, 1999). Thomas, however, strives to enlarge the focus of disability studies to include restrictions in how people feel about themselves or that prevent them from being. Consequently, she broadens her definition of disability: "Disability is a form of social oppression involving the social imposition of restriction of activity on people with impairments and the socially engendered undermining of their psycho-emotional well-being" (1999:156). The socially engendered undermining of psycho-emotional well-being is what she refers to as the psycho-emotional dimension of disability. It indicates socially caused and thus avoidable consequences for the well-being of people with impairments. It does not ignore or overstress the social and individual aspects of disability. Using the concept of impairment effects, it acknowledges that impairment leads directly to lower well-being, but indicates such non-socially imposed restrictions and the undermining of well-being do not constitute disability.

In my opinion, this approach offers a guiding theoretical framework that could prove fruitful for future empirical research. It shows that, on the one hand, impairment can limit activities and participation and, on the other, can undermine subjective well-being; above all, it indicates that people become disabled when these limitations or lower well-being are socially reinforced by social exclusionary relations, processes and structures. The analytical model shown below in Figure 4 depicts the approach that guides this dissertation. This model also demonstrates that the subjective well-being of people who are restricted in their activities (both by impairments and social processes) is in turn also dependent on that social context. In this dissertation, I focus on the factors and relations represented in black.

Third, in my research on the role of social exclusionary processes in the relationship between impairment and well-being, I adopt a structural materialist perspective that points to the role of macro-level institutions and structures. Although materialist perspectives that consider the role of macro-level institutions and structures such as the welfare state and the nature of the labour market have long influenced scholars in disability studies, those scholars have only tested the effect of different contexts in constituting disability to a limited extent empirically. Medical sociologists have also started to examine these structural perspectives within the last decade, while making use of datasets that make it possible to empirically examine their influence. Based on the assumption that macro-level structures constitute the main context in which individual relationships are embedded and thereby affect and shape these relationships, I will look at the role of the welfare state organization and aspects of the labour market in structuring the relation between impairment, well-being and social exclusion. To achieve the aims of this dissertation, I will make use of multilevel modelling techniques, which have increasingly become part of medical sociologist research, to estimate the role of macro-level structures on health and well-being more correctly. My intention is to enhance the understanding of whether or how macro-level structures indirectly enable or psycho-emotionally disable people with impairments by affecting their experience of social exclusion.

Figure 4: Analytical model of dissertation



Chapter 3

Studying impairments, subjective health and well-being within a framework of social exclusion at the micro- and macro level

In this chapter, I present the integrative approach from the end of the previous section in a more concrete form to facilitate testing hypotheses and answering the research questions. I offer a theoretical framework on how social exclusionary processes may affect the relation between impairment and well-being.

I consider the social exclusion of people with impairments in two ways. First, I focus on the role of exclusionary processes surrounding the labour market because the labour market is one of the most central and influential structures in contemporary Western societies. Many people with impairments have either permanently withdrawn from the labour market or have never entered it all. In addition, those that are economically active are typically marginalised because they tend to occupy positions that are poorly paid and their employment situation can be precarious, as it is often at the bottom of the occupational ladder. Second, while the evidence of the social exclusion of people with impairments is overwhelming, the cross-national variation in the rates of social exclusion is remarkable. Therefore, I consider the macro-level context to identify in what context and under which conditions social exclusionary processes may or may not occur and pay attention to the role social policies may play in fostering or restricting the opportunities for people with impairments to be socially included, which can affect their well-being.

3.1 Labour market exclusion

The labour market functions as an important steering and organizing structure in contemporary societies. For the majority of the working-age population, it is the source of their principal income and where they accumulate social security rights (Atkinson & Hills, 1998; Bradshaw, Kemp, Baldwin, & Rowe, 2004). A secure, long-term and paying job is an important protection against financial difficulties. Moreover, a lack of paid work may lead to poorer mental health and lower psychological well-being (Artazcoz, Benach, Borrell, & Cortes, 2004; Bartley, 1994; Jahoda, 1981; Paul & Moser, 2006; Ross & Mirowsky, 1995). Studies indicate that the mental well-being of people who are economically inactive and not looking for work is as bad as that of people who are unemployed (Bambra & Popham, 2010; Brown et al., 2012; Honkonen et al., 2007; Milner, Spittal, Page, &

LaMontagne, 2014). The adverse health effects of unemployment can be explained by the financial pressure unemployment usually causes (Artazcoz et al., 2004; Bartley, 1994), but those effects might also be a result of not enjoying the non-pecuniary functions of employment (Artazcoz et al., 2004; Bartley, 1994; Jahoda, 1981; Janlert & Hammarström, 2009). A job not only provides people with structured time and mental and physical activity, it also leads to a particular social status and identity (Bartley, 1994; Jahoda, 1981). Additionally, participation in the labour market offers an opportunity to develop social networks and social support, which are thought to positively impact health (Berkman, Glass, Brissette, & Seeman, 2000), while unemployment can increase feelings of shame and insecurity and lead to negative coping behaviours such as smoking and alcohol consumption (Roelfs, Shor, Davidson, & Schwartz, 2011).

The right to work has since long been part of the political agenda of people with impairments (Hvinden, 2009; Priestley, Waddington, & Bessozi, 2010; Soldatic & Meekosha, 2012). However, compared to the general population, people with impairments have lower employment rates (Grammenos et al., 2007; OECD, 2010). People with impairment view access to the labour market as a means to social inclusion and equity and as a part of their collective and individual struggle for respect and recognition. Although their impairment might prevent them from taking some jobs, they encounter many barriers to (re-) entering even the broader labour market (Barnes & Mercer, 2010a; Jones, 2008; OECD, 2010; Roulstone, 2012), such as erratic vocational training, transportation and commuting problems, as well as architectural barriers.

In addition, research has concentrated on barriers to employment related to processes and practices within firms and organizations (Cavanagh et al., 2017; Gerber, Price, Mulligan, & Shessel, 2004; Shier, Graham, & Jones, 2009; Towalski, 2009). People with impairments frequently mention encountering discriminatory attitudes from employers regarding hiring people with impairments. They indicate they often feel labelled, and are approached as “the disabled”, as someone not capable of doing tasks alluded to during job interviews (Shier et al., 2009). For employers, one of the greatest impediments to hiring people with impairments is the risk of high payroll costs. The prevailing view is that employees with impairments are inherently less productive and will frequently be absent from work for health reasons (Towalski, 2009). At work, people with impairments may feel that fellow workers are discontented about having to work with an impaired person (Snyder, Carmichael, Blackwell, Cleveland, & Thornton, 2010). In addition, a shortage of workstations adapted to their condition and the lack of other reasonable accommodations can make it difficult to perform job tasks. Some studies report that the rejection of adding appropriate accommodations is sometimes based on the assumption that everyone should fit in the existing environment or on an unwillingness to change out of fear of losing control over work processes (Robert & Harlan, 2006). This accords with certain critical sociologists' arguments that contemporary employment environments and job designs are based on able-bodied norms, making it impossible to accommodate people with impairments (Foster & Wass, 2013). Employers construct job descriptions with certain expectations about workload and tasks, flexibility and behaviour that eliminate people with impairments as potential candidates.

Yet, paid work is consistently mentioned as a source of identity, and it contributes to feelings of normality, worth and self-esteem by people with various types of impairments (Saunders & Nedelec, 2014). Employment is generally described in terms of its contribution to social and personal identity and its role in integration into society (Dunn, Wewiorski, & Rogers, 2008; Galvin, 2005; Honey, 2004; Schedin Leiulfsrud, Reinhardt, Osterman, Ruoranen, & Post, 2014). People with impairments may view having a regular job as proof of being equal to other people, and consider it a primary factor in social recognition and a prerequisite for being considered a full citizen (Saunders & Nedelec, 2014; Honey, 2004). As such, these additional benefits of paid work are reasons to expect that the relationship between having an impairment and subjective well-being might be dependent on being excluded from it.

To summarize, and to hypothesize about the possible effect of micro-level labour market exclusion, I refer to the social stress model, which medical sociology often uses. In this model, social stress is understood as the negative feelings that result from a discrepancy between social conditions—or societal claims and goals—and individual characteristics (needs, values, norms and resources) (Aneshensel, 1992; Pearlin, 1989; Pearlin, Schieman, Fazio, & Meersman, 2005). As indicated in the previous chapters, impairment can be experienced as a stressful life event (due to the onset period, symptoms or diagnosis) and a chronic stressor (due to its long-term character and its consequences for how life is organized), both of which are known to be risk factors for poor well-being (Bury, 1982; Charmaz, 1983; Menne, 2006). However, the effect of having an impairment might be moderated by whether or not the person is excluded from paid work. A lack of paid work is detrimental to one's well-being (Artazcoz et al., 2004; Bartley, 1994; Brown et al., 2012). Unemployment exposes people to stress in several ways. In addition to its possible negative impact on financial resources, unemployment can be accompanied by feelings of shame and insecurity. A job provides structured time, status and prestige, as well as access to a broader social network and more social support resources.

Furthermore, people with a chronic condition consider employment an important source of self-validation, proof that they are equal to other people and a prerequisite for social inclusion (Dunn, Wewiorski, & Rogers 2008; Honey, 2004; Roulstone, 2012; Saunders & Nedelec, 2014; Schedin Leiulfsrud et al. 2014). They may view the lack of opportunities for paid work as a way of keeping individuals from feeling included. This lack can also be seen as a form of role stress that interacts with the stress associated with the chronic condition itself. Having a chronic condition might therefore be more strongly associated with lower subjective well-being for people who do not have a paid job, because they are confronted with the stress of the chronic condition as well as the lack of paid work and with not fulfilling a socially valued role. Additionally, employment can be seen as a gateway to other well-known protective factors within the stress process, such as social support, a sense of control and self-efficacy (Bartley, 1994; Borgonovi, 2008; Jahoda, 1981; Musick & Wilson, 2003; Paul & Batinic, 2010). This hypothesised moderating role of paid work is empirically tested in Study 2.

3.2 Integrating the macro-level: national labour market exclusion

The social exclusion of people with impairments differs greatly between countries, however. One of this dissertation's strengths is that it combines characteristics of the country context with individual-level data to examine the role of social exclusion for well-being. As such, it considers that the relationship between impairment and well-being might also differ according to national structures and processes. In the following sections, I theorize about the role of national labour market exclusion levels and the welfare state.

A striking example of the cross-national variation in the exclusion of people with impairments is seen in their employment rates. As mentioned in the Introduction, they vary greatly across Europe (Eurostat, 2014). Recently, research has demonstrated that macro-level labour market characteristics are also associated with well-being (Buffel, Missinne, & Bracke, 2016; Clark, Knabe, & Ratzel, 2010; Oesch & Lipps, 2013). For example, higher regional unemployment levels are assumed to negatively affect the well-being of unemployed people because they theoretically reduce the likelihood of an unemployed person finding work and indicate bleaker future labour market prospects (Clark et al., 2010). Indeed, labour market participation and unemployment rates are indicators of the economic climate of a country or region; which should be considered when studying the role of employment (Oesch & Lipps, 2013). Likewise, in a country with lower labour market participation rates for people with impairments, those people might have the bleakest prospects of getting a job and may feel more stressed about it.

The difficulties surrounding the employment of people with impairments should also prompt us to explore the tension between structuralist and behavioural approaches to unemployment and inactivity (Buffel et al., 2016). The line between acknowledging individual agency and blaming people or viewing them as responsible for their unemployment can be thin and blurry. In a structuralist view, unemployed people are seen as powerless victims. In a behaviourist interpretation, people in unemployment are seen as active agents, responsible for their condition.

Over the past few decades, in Western countries there has been a shift from structural determinism to a behaviourist interpretation. Profound transformations in the welfare state institutions governing social life have taken place based on a neoliberal rationality (Karanikolos et al., 2013; Rose & Miller, 1992). This neoliberal rationality cultivates the view that the welfare state has a morally damaging effect on its citizens because it creates a culture of dependency. Social security creates a passive solidarity among recipients because it de-emphasises active engagement and an individual striving for self-protection. This is reflected in the arguments of a number of scholars and spokespersons from disability organizations who have indicated that income transfers play a prominent role in many Western countries' disability protection systems at the expense of services, recognition and anti-discrimination (Barnes & Mercer, 2010; Barnes & Mercer, 2010a). Providing income benefits alone may exclude people with impairments from the mainstream labour market and in turn contribute to the de facto societal segregation they experience and may categorize them as dependants. Although the motivation for targeting the disability population by activating the social security system has partly been to expand citizenship rights and increase participation in society among this group, it has also been inspired by budgetary concerns raised by an ageing population and economic recessions in Europe (Hvinden, 2004; OECD, 2003, 2010). Most Western social security systems have taken an "activation turn" over the last few decades, where social protection is increasingly linked to labour market participation and labour market programmes (Bonoli, 2010; Daguerre & Etherington, 2009; Dingeldey, 2007; Halvorsen & Jensen, 2004). Although there is significant cross-national variation in approaches to the activation of social security systems, generally the emphasis is on the social functions of paid work and labour market participation (Barbier & Ludwig-Mayerhofer, 2004). Since the 1990s, the on-going growth of disability income-maintenance schemes has garnered attention, provoked by the renewed interest in paid employment as the best option to inclusion and by concerns about budgets (Hvinden, 2004; O'Brien, 2015; OECD, 2003, 2010).

The preceding paragraph suggests two reasons for reforming disability protection: one oriented towards social justice and equity; economic efficiency considerations dominate the other. Demands for the right to work from disability groups have been partly met by the ratification of anti-discrimination measures and by reasonable accommodation legislation in the labour market; the demands are also compatible with the state's neoliberal informed policy reforms that increasingly place emphasis on work as the best option for financial and broader social inclusion. This has led to an increased targeting of people with impairments in terms of the described benefits reforms, where a portion of them are forced to work in low-wage and unskilled labour markets. Women with impairments, in particular, who often have caring roles, tend to end up in low pay, part-time or short-term casual jobs (Soldatic & Meekosha, 2012).

This moral discourse of individual responsibility (Goodin, 2002) can have consequences for people with impairments in at least two ways. First, it may restrict the collective potentiality of people with impairments to demand changes in exclusionary and discriminatory structures (Soldatic & Meekosha, 2012). When the moral discourse makes the individual responsible, those who suffer from structural disadvantages are easy to blame. Because of this, structural and systematic exclusions remain hidden—discrimination in the workplace and in the housing market remains covert, and people with impairments are considered less "able" and less reliable. Focusing on individual responsibility runs the risk of depoliticising the shared social exclusion and discrimination disabled people experience (Goodley, 2014).

Second, the representation of the fit, competitive and employed individual as the ideal promotes a social norm from which people with impairments are seen to deviate, which in turn might affect how they evaluate and perceive their own situation (Schwarz, 2012; Thoits, 2011). Previously, the state was responsible for enacting social rights and entitlements; now the attainment of these ideals has become the responsibility of the individual. The newer policies tend to focus on individual competence and ability, concepts that disability studies strongly contest and problematize (Soldatic & Meekosha, 2012). These policies are connected to a discourse which Campbell (2009) describes as ableism. Ableism can be understood as a network of beliefs, processes and practices that produces a particular (corporeal) standard that is projected as the essential and fully human (Soldatic & Meekosha, 2012). This view of what and who is "fully human" betrays, however, an attitude that devalues those who are seen as functioning differently, that are seen as a "caste" of lesser human. These policies seem to promote a "species-typical individual citizen" (Campbell, 2009), a citizen that is ready and able to work and contribute (Goodley, 2014). This differentiation between the able and responsible citizen-employee and the irresponsible and lesser other can be understood as a technique of government (Schinkel, 2010). Schinkel (2010) observes a distinction between citizens based on perceived morality, in which citizenship is connected to what are seen as the moral aspects of good societal behaviour and being a good citizen. This moral discourse on the good citizen contributes to the constitution of a particular kind of society by drawing a line between those who are and those who are not "real" citizens. It establishes the boundary between those who are truly in and those who are only formally members. Schinkel (2010:166) describes the latter as the "Janus face of the social schizophrenic, who is and at the same time isn't a member of the community". People who are not active in the labour market could easily be placed in this category of second-class citizens.

The way people in general understand unemployment and inactivity—from a structural or a behaviourist perspective—can be addressed as a the social norm (Buffel et al., 2016), which can affect how unemployment is perceived and experienced by those who are unemployed and impaired. This is based on the idea that the psychosocial consequences of unemployment are not only related to its importance for financial means, but also for social identity and acceptance. The social norm theory indicates that the negative effects of unemployment become weaker as the deviation from the social norm becomes smaller because people are concerned about their relative standing and position in comparison to the reference group (Schwarz, 2012; Winkelmann, 2014). By using unemployment rates as proxies for the descriptive social norm of unemployment, studies have argued that the rates function as indicators of the degree of adherence to the norm of unemployment (Buffel et al., 2016; Clark et al., 2010). Implicitly, this perspective relies on the assumption that in regions or countries where the unemployment rate or labour market exclusion rate is higher, unemployment or inactivity are more likely to be seen as a structural problem. Living in such a context may diminish the feeling of personal responsibility about unemployment, as there are more structural barriers, which thus reduces the negative effect of unemployment on well-being.

I conclude that the moderating role of paid work on the relationship between a chronic condition and well-being might also be dependent on the labour market exclusion of people with chronic conditions at the country level. On the one hand, in countries with higher labour market exclusion, having a chronic condition and being unemployed or inactive might be associated with the lowest level of well-being. In those countries, people with a chronic condition have the bleakest prospects of getting a job, which could lead to the highest levels of social stress. On the other hand, with regard to labour market exclusion, social norm theory (e.g. Clark, 2003; Clark, Knabe, & Ratzel 2010) suggests that in countries with higher exclusion levels for people with chronic conditions, people with a chronic condition who are unemployed or economically inactive might actually benefit from a social norm effect: being economically inactive might be less stigmatizing if more people share the same experience. In those countries, people might feel less personal responsibility and perceive inactivity as the result of structural barriers. The role of national labour market exclusion is also tested in Study 2.

3.3 Integrating the macro-level: welfare states

With this dissertation, I also want to contribute to the existing literature by integrating welfare state and policy research and the domain of medical sociology and disability studies in three ways. On the one hand, welfare states can be seen as institutionalised forms of solidarity that provide social security and help protect their citizens' social rights. In other words, welfare state institutions and their accompanying benefits, services and regulations can function as a central means of combatting social exclusion, which in turn is detrimental to health and well-being. Hence, I hypothesize that welfare state arrangements can play a beneficial role in the well-being of the population in general and for those who experience social exclusion, especially, such as people with impairments, by providing the means to overcome systematic social exclusion and by empowering those people. As such, they are a means of preventing disabling processes that socially limit the ability of people with impairments to feel healthy or to feel well and satisfied. Another objective is to provide better understanding of the strategies of contemporary welfare states for combatting the social exclusion of people with impairments. Most comparative welfare studies do not actively consider disability; thus, insight into the different approaches of disability policies is still limited.

On the other hand, welfare states can also be seen as cultural agents that contribute to a certain understanding of how the world works and to the social construction of disability as a particular social position with a particular role. Consequently, I discuss literature on how the welfare state has created "disabled subjects" and placed them into a particular socio-economic role. Moreover, the policies and programmes of the welfare states may contribute to the construction of social norms that are based on the roles of citizen and good behaviour. The welfare state thus becomes associated with morality and norms from which people can deviate. Based on social norm theory, social comparison and labelling, my hypothesis is that the welfare state could potentially have a disabling effect on well-being of people with impairments. In short, I expect to find two different, yet complementary, roles played by the welfare state in moderating the relationship between impairment and subjective health or subjective well-being.

3.3.1 Approaches to the welfare state in medical sociology and disability studies

A long tradition of comparative welfare state research has shown that welfare states vary systematically in their design and the extent to which they alleviate social problems such as poverty and unemployment (Arts & Gelissen, 2002; Chung & Muntaner, 2008; Ferragina, 2015; Ferragina & Seeleib-Kaiser, 2011; Ferragina, Seeleib-Kaiser, & Spreckelsen, 2015). In comparative welfare state research, the central subjects have been the forces that drive the development of modern welfare states, the assessment of variation in and categorisation of the main principles that shape the welfare states, and the consequences of particular types of welfare state constructions for aggregated outcomes such as fertility, employment rates and poverty alleviation.

However, welfare policies also shape the life of individuals, even more so if they depend on state support, like people who receive out-of-work benefits, which is the case for people who are unemployed (Palme, Nelson, Sjöberg, & Minas, 2009; Wulfgramm, 2014), or people with impairments who also make use of cash benefits and services at additional cost (Holland et al., 2011; Hvinden, 2009; Witvliet, Kunst, Stronks, & Arah, 2012). In general, one could say the welfare state forms the environment in which social determinants of health and well-being occur and take a particular shape (Beckfield et al., 2015). By providing and redistributing benefits and services on the one hand, and imposing regulations that guide behaviour on the other, welfare states affect wider socio-economic conditions—the "causes of causes"—that lead to poor health and lower well-being. If it can be assumed that certain types of welfare states are expected to deliver a decent life to a greater part of the population, then it is easy to suppose that their actions will also lead to better health and subjective well-being and smaller social inequalities (Brennenstuhl, 2011). To better understand this, it is important to combine macro-level outcomes with individual health and well-being outcomes, within and across countries, as the differences may appear not only in aggregated outcomes but also in the relations between individual-level determinants and health (Olafsdottir, 2007; Olafsdottir & Beckfield, 2011). I believe that a cross-national comparison that explicitly considers and models the welfare state context could offer additional insight into what it means to have an impairment across different contexts. Such a comparison could also influence the relationship between having an impairment and well-being.

The best method for the inclusion of the welfare state context in cross-national comparative research is still being discussed. Studies with a socio-epidemiological or health sociological perspective have been cross-nationally comparing the effect of different welfare states across larger groups of countries. In these studies, collective resources such as social protection and services provided by the welfare states are indeed assumed to shape the lives and living conditions of people, especially of those who have fewer resources at their disposal. Although the body of research on welfare state characteristics and health produced over the last decade has grown, the results were ambiguous (Bergqvist, Yngwe, & Lundberg, 2013; Brennenstuhl, 2011; Lundberg, 2009; Lundberg, Fritzell, Yngwe, & Kolegard, 2010; Lundberg, Yngwe, Bergqvist, & Sjoberg, 2015). In a review article, Bergqvist et al. (2013) present a possible explanation for this ambiguity that is based on the different approaches of health-related studies to the welfare state. Generally, three main approaches to comparative welfare state research are currently being employed: the welfare regime approach, the institutional approach and the social expenditure approach (Dahl & van der Wel, 2013; Lundberg et al., 2015).

Many studies adhere to the regime approach, where countries are clustered in "welfare state regimes" based on similar principles of redistribution or political traditions. While some countries might, for example, support universal access to benefits and services, others might operate on the assumption that the individual will take responsibility for his or her own welfare and well-being. Three regime typologies seem to dominate studies on health inequalities: those of, Ferrera, Huber and Stephens, and Esping-Andersen. Esping-Andersen's typology (1990, 1999) incorporates the characteristics of sickness, unemployment and pension benefits. He classifies countries based on three characteristics of the benefit systems: the degree of decommodification (the extent to which individuals or households can uphold an acceptable standard of living independent of the market), the degree of social stratification and the nexus between public and private responsibilities. Compared to Esping-Andersen, Ferrera (1996) focuses less on cash benefits and more on how welfare is delivered in terms of benefits and services. This typology is based on coverage, replacement rates and poverty rates. Huber and Stephens (2001) group countries based on the number of years that a country has been governed by a particular political tradition. Compared to the others, this typology is less popular in health studies, as the mechanisms that lead towards smaller health inequalities are obviously less visible.

It should be noted that the regime approach gives broad but blunt insight into the characteristics of welfare states and might neglect to consider differences between countries. As these clusters of regimes tend to be quite static (because of their generality), this approach is also likely to miss changes in policy focus within a country over time. This approach makes it difficult for comparative studies on health and health inequalities to draw valid conclusions about the specific mechanisms that link macro-level welfare state characteristics to individual-level health and well-being outcomes (Lundberg et al., 2015). Many health studies tend to be based on a variety of regime-type theories and elements, which may lead to different classifications of countries; even among studies that use the same underlying welfare state theory, the classification of countries might differ. Therefore, the picture these studies paint of health is one of ambiguity: depending on what countries are included in an analyses and depending on the outcome that is of interest (e.g. morbidity, mortality), differing results may be found.

Moreover, while some theoretical hypotheses seem straightforward, the empirical results are sometimes unexpected; this is difficult to understand because of the regime approach. For example, while countries following a universal approach to benefits (i.e. Scandinavian countries) are assumed to have smaller social inequalities in health, this is not consistently found to be true in practice (Brennenstuhl, 2011). It is also noticeable that both health care and disability are absent from the regime approach. While health care has been studied on its own, it is a notably absent from broader welfare state literature in general, and, in particular, from the regime debate (Bambra, 2005, 2006). Disability too, Although it is one of the traditional pillars of social protection in welfare states, in comparison to other areas of welfare policy disability too has received little attention from comparative welfare researchers (Hvinden, 2004). Given this lack of attention, studies that aim to examine the effects of different socio-political contexts on the well-being of people who experience disabilities (e.g. Foubert, Levecque, Van Rossem, & Romagnoli, 2014; Witvliet et al., 2012) revert to describing and categorising welfare states in general terms. Therefore it is assumed that the general characteristics of welfare regimes can also be used as proxies for the handling of the social risk of disability in the countries. The question remains: to what extent are general welfare typologies helpful in understanding cross-country variations in more specifically focused policies, such as disability policies (Myles, 1998; Powell & Barrientos, 2011), especially when it is likely that countries cluster in different ways when different social risks are considered (Bambra, 2007; Ferragina et al., 2015).

In the social expenditure approach, differences in welfare states are operationalized in terms of public spending on different programs and services (Ferrarini, Nelson, & Sjoberg, 2014). The main advantage to this approach is that these data are publicly available from international organizations

(OECD, Eurostat) for a larger number of countries and span of years. Although a certain amount of economic resources in the form of public expenditures are necessary to reach a certain level and quality of benefits and services, the poorer validity of social expenditure data in accounting for welfare state structures and in differentiating between effort and need is also well known (Esping-Andersen, 1990; Ferrarini, et al., 2014; Gilbert, 2009). A larger expenditure on, for instance, unemployment benefits might simply reflect a larger number of unemployed people and not a greater desire to fund coverage (the proportion of the relevant population that is eligible for benefits) or replacement rates (the extent to which benefits replace the income of the unemployed person) (Lundberg et al., 2015). In addition, expenditures are also sensitive to changes in the gross domestic product (GDP), the most widely used denominator for reporting spending rates. Moreover, the same economic resources could be spent in different ways: on benefits and services for a limited group in society, or on broader population groups with increased availability and coverage of services and income maintenance schemes (Ferrarini, et al. 2014). In recent studies, expenditure databases such as Eurostat have been refined (in terms of specification, disaggregation and scaling) and have tried to deal with some of these problems by, for example, trying to adjust to the need for spending (Dahl & van der Wel, 2013; van der Wel & Halvorsen, 2015). Although this approach has been used less often than the regime approach, the studies that use this approach more consistently conclude that higher social and health spending are associated with better population health and smaller health inequalities (Bergqvist, et al. 2013). Compared to the regime approach, a social expenditure approach has the advantage of being able to focus on more disability-specific data (Grammenos et al., 2007), in part because some databases—for instance, Eurostat—recognize disability as a separate category.

The institutional approach focuses on the development of social rights via the welfare state. This perspective looks at the institutional organization and design of specific policies and programs and at how they translate into health (Ferrarini, Nelson, Korpi, & Palme, 2013; Korpi, 1989). Studies tend to examine the characteristics of, for example, pensions, sickness pay, unemployment benefits, family policies and work benefits. With regard to income maintenance programs, these organizational characteristics can be related to qualifying criteria, the coverage (or the proportion of the relevant population eligible for benefits), the duration and the generosity of the benefits (the replacement rate) (Palme, 2006). In comparison to the social expenditure approach, an institutional focus is more sensitive to the fact that programs are often organized along different principles, and provides greater understanding of what it means for an individual to live in a particular institutional and programmatic context. The drawback of the institutional approach is its reliance on databases that may apply a number of assumptions regarding the age and family situation of a "standard worker" to construct relative programme features (Bergqvist, et al 2013). This can be problematic as important groups may fall outside the living situations captured by the standard cases. Examples of such databases are the Social Citizenship Indicator Programme (SCIP), which is part of the Social Policy Indicators database (SPIN) (Ferrarini & Nelson, 2017), and the Comparative Welfare Entitlements Dataset (CWED) (Scruggs, Detlef, & Kati, 2014), which focus on old age pensions, sickness, unemployment and work accident insurances. Neither database collects information on disability, and lack insight into welfare services and regulations. The results of a meta-analysis, however, do show that policies and benefits that are more generous are positively associated with health for the whole population and not only for those who have been targeted.

The preference for one approach over another depends on the research objective. The regime approach relies on country clusters and average differences. As a result, it is necessary to be actively aware of the concepts and theories that underlie regime classification, to understand the variety of mechanisms that may lead to the results, and to remember that this approach can only provide early, explorative insights, not actual factors that determine a certain outcome. The institutional and expenditure approaches are more useful when it comes to examining specific welfare and health outcomes. Their focus can be included in analyses using a variable approach that makes it possible to see how countries' policies are different in different areas. Based on a consideration of these approaches, I point out the main arguments of the studies on welfare states in this dissertation.

3.3.2 Moderating the relationship between impairments and subjective health

In Study 1, I focus on the relationship between impairment and subjective health across very distinct socio-political contexts. Although impairment and activity limitations are risk factors for poorer self-rated health and well-being, many people with a disability report a good quality of life (Albrecht & Devlieger, 1999). Previous articles have focused on psychological resources and social support to explain these findings (Albrecht & Devlieger, 1999; Cott et al., 1999). The role welfare state arrangements play in this relationship is not yet clear. I argue that the relationship between impairment and subjective well-being is also a function of the "rules of the game" that organize a political economy such as the welfare state (Beckfield et al., 2015). The welfare state may matter to people with impairments as it functions as a complex system of citizenship rights that shapes the proximate causes and consequences of health conditions, impairments and well-being (Olafsdottir & Beckfield, 2011). Although most studies on the relation between impairment and subjective health focus on a particular national context, I will adopt a cross-national approach in which European welfare regimes are analysed together with others in Asia, Latin-America and Africa. By opening up the focus to include a range of countries, I not only gain insight into very distinct institutional contexts, but am also able to consider a large number of people with impairments who do not live in Europe (WHO & WorldBank, 2011).

To compare these different national contexts, my research utilizes Wood and Gough's (2006) typology. Because the state and markets in non-Western countries have proven inadequate for the realization of an acceptable standard of living, citizens have come to rely on informal, and most likely hierarchical and even clientelist relations. In response to this reliance on other relationships, Wood and Gough have complemented the decommodification axis advanced by the welfare state typology of Esping-Andersen (1990) by adding a declientalisation axis. While decommodification refers to the degree to which a person can maintain an acceptable standard of living without participation in the market, declientalisation refers to the extent to which informal relationships are characterised by a patron-clientelism that is unbalanced, and the need to establish more formal, universal rights to welfare and security. Wood and Gough have identified three main types of welfare regimes based on these definitions: welfare state, informal security and insecurity regimes. Based on their approach as well as other studies, I choose to use these more general welfare regimes as proxies for disability regimes within the countries. The main hypothesized characteristics are described below.

Despite between-regime and within-regime differences, welfare state regimes recognize that disability is a risk to one's well-being and to having an acceptable standard of living (Harris, Owen, & Gould, 2012). All welfare states are characterised by a state-led mediation of impairment's effect on daily life and health by supplying various amenities, which makes it possible for people with impairments to have an acceptable standard of life and to participate in society. Although welfare state regimes may support people with impairments to a greater or lesser extent, they do set a minimum parameters for the health of their citizens and may limit inequality in some of the factors that are established as robust social determinants of health (Beckfield et al., 2015). Because impairment is associated with poorer subjective health, I argue that welfare states may address the presence of impairment through prevention or the provision of health care, but may also moderate impairment's relationship with subjective health by providing decommodifying social benefits, services and regulation to account for additional costs related to impairment (such as personal assistance and care) and the consequences that are related to social exclusion (such as not being able to participate on the labour market). Although it does not give insight into concrete mechanisms, the advantage of a regime approach is that it encompasses a general approach towards tackling social exclusion processes and situations in society, and implicitly considers various programs and policies which may directly or indirectly affect the relationship between impairment and subjective health. This is related to the concept of institutional imbrication which is the overlapping and cross-cutting of two or more institutional arrangements in a particular domain, such as disability or health care (Beckfield et al., 2015).

In informal security regimes, people rely more heavily on informal, community and family relationships to satisfy their needs (Wood & Gough, 2006). These relationships are mostly hierarchical and asymmetrical, but result in some form of (informal) security. While progress has been made, detailed evaluations show that most countries started off from such a low baseline that the position of people with impairments in these countries still needs significant improvement (Dudzik, Elwan, & Metts, 2001; Price & Takamine, 2003). The final type of welfare regime identified by Wood and Gough is the insecurity regime. It can be characterised as the most fragile of the regimes, as powerful (external) players generate conflict and political instability. Because this unpredictable environment undermines stable patterns of informal relationships within communities, personal safety is an issue. To meet basic needs, citizens must depend heavily on external organizations, as the weak governments provide little assistance (Witvliet, Arah, Stronks, & Kunst, 2011; Wood & Gough, 2006). This results in a vicious cycle of suffering and insecurity for most of the population and in particular for people living with a disability. It is probable that the lack of welfare resources is especially harmful for groups that experience social exclusion, such as people with impairments, as they more often draw on collective resources to compensate for a lack of individual resources to meet their needs (Lundberg, 2009).

Based on the foregoing characteristics, my argument is that the strength of the often-negative association between impairment and subjective health will vary across welfare regimes. When considering perspectives that focus on the role of welfare policies in helping people with impairments to attain an acceptable standard of living, I expect to find that impairment has the weakest association with self-rated health in welfare state regimes because their provision and services for people with impairments are more comprehensive.

3.3.3 Moderating the role between impairment and job satisfaction

In the third study, I focus on European countries and current welfare state changes. Again, I refer to the fact that in recent decades many governments have installed policies to strengthen the labour market attachment of "vulnerable" groups such as people impairments (Etherington & Ingold, 2012; OECD, 2010). I point out two national policy factors connected to the activation policies pursued by EU governments: investments in Active Labour Market policies (ALMPS) and spending on out-of-work benefits (sickness, unemployment and invalidity). On the one hand, easily accessible and generous out-of-work benefits have been criticized as threatening the sustainability of the welfare state, and are often viewed as disincentives to work and creators of dependency cultures (Heinemann, 2008). This has led to the introduction of additional employment stimulating policies in the last twenty years in which ALMPS have played a crucial part (Coutts, Stuckler, & Cann, 2014; Daguerre & Etherington, 2009).

While activation and longer working-life policies may increase employment levels, few studies have focused on their effect on job satisfaction. The small number of available studies on impairment and job satisfaction do not present a uniform conclusion. These studies' perspective is similar to perspectives that examine psychological well-being or subjective health. For example, because there is an assumption that activity limitations equal poor health (Ahn & Garcia, 2004; Baumgartner, Dwertmann, Boehm, & Bruch, 2015), activity limitations are often assumed to negatively affect job satisfaction (Pagan & Malo, 2009). However, Pagan and Malo (2009) tested this hypothesis using Spanish household data, and concluded that activity limitations cannot be treated as equivalent to health and that they have an independent influence on job satisfaction. Moreover, the studies are conducted in different countries that represent distinct welfare and labour market regimes. Previous research on job satisfaction in the general working population suggests that these structural and institutional factors influence job satisfaction and its relationship to job characteristics (Gallie, 2007; Hipp & Kolins Givan, 2015; Pichler & Wallace, 2009). I intend to contribute to the literature by examining how two particular and actual social policy characteristics affect job satisfaction and its relationship to impairments.

My main hypothesis is shaped by the same reasoning as in the previous section: comprehensive welfare services and social protection arrangements represent important collective resources that enable individuals to control their own lives and manage their participation in society, which includes finding a good job, i.e. a good job match. This is especially true for people with activity limitations, for whom social protection plays an important role in securing their rights (Lundberg, 2009), for those who may face the greatest difficulties in finding a job that is compatible with their skills and abilities. In this third study, I employ an expenditure approach in which each country has its own value, while controlling for possible need-related differences across countries.

3.3.4 Comparative disability policy

In Study 4 and Study 5, I acknowledge that disability has largely been absent from comparative welfare state literature and cross-national comparative health sociological studies. It is also notably absent in regime and institutional approaches. Often, approaches that are more general are used as proxies for disability regimes.

While disability welfare policy is now acknowledged as one of the main ways to ensure the social inclusion and rights of people with impairments in society (Barnes & Mercer, 2010a; Witvliet et al., 2012) few studies have attempted to cross-nationally compare the disability policies of a large number of countries (Dixon & Hyde, 2000; Maschke, 2008; OECD, 2003, 2010; Waldschmidt, 2009). The available studies tend to be biased towards income transfer arrangements and labour market participation at the expense of broader social services and social regulation (Burkhauser & Hirvonen, 1989; Halvorsen & Hvinden, 2009; Hvinden, 2004; OECD, 2003, 2010; Phillips, 2012; van Santvoort, 2009). The lack of comparable policy-related data on disability definitely contributes to this bias (Grammenos et al., 2007). As such, insight into the different strategies for the social inclusion of people with impairments in contemporary welfare states is limited.

There are also theoretical and conceptual obstacles hindering contemporary comparative disability policies. It is easy to propose social inclusion as the solution or as a central policy goal. As with social exclusion, however, what social inclusion actually entails is often ambiguous. However, when social inclusion is defined as the opposite of social exclusion, analyses and strategies do have to involve the myriad of heterogeneous processes that are connected to social exclusion. According to Vranken's framework, social inclusion should mean more than simply social equality; it should also incorporate overcoming fault lines and the closing of structural gaps (Vranken, 2003). Additionally, his framework emphasises that social inclusion is not always a spontaneous process: it has to be organized, so that individuals have the chance to overcome structural fault lines on their own. Therefore, it can reasonably be assumed that welfare state policy is a valuable way to accomplish social inclusion.

For a long time, no comparative study on disability policy had departed from a theoretical construct that specifically related to disability. The multidimensional character of disability policy complicates the search for a sound theoretical basis for comparison. In a general sense, one could say that contemporary disability policy refers to the totality of policy measures that have consequences for the welfare, autonomy and participation of people with impairments (Halvorsen & Hvinden, 2009; Hvinden & Halvorsen, 2003). Previous studies often seem to lack an explicit theoretical concept that enables them to test qualitative differences in countries' approach to disability. Mainstream comparative welfare state research has made great progress by focusing on how and to what extent welfare states develop social rights or social citizenship, with an emphasis on social security systems (Arts & Gelissen, 2002; Ferragina, 2015; Ferrarini, Nelson, Korpi, & Palme, 2013; Korpi, 1989; Marshall, 1950; Powell & Barrientos, 2011). Researchers have questioned whether existing theories on citizenship and theoretical background concepts employed in general welfare typologies are helpful starting points for comparative research on disability policy (Beckett, 2006; Waldschmidt & Lingnau, 2008).

Furthermore, Vranken's framework could be helpful because it indicates social inclusion for the individual might also mean being able to take up different sets of roles in society: that of the producer (at the labour market), consumer (access to goods and services), "signifier" (lifestyle), citizen (political rights) and social networks' member (private and public networks). The individual gains access to different crucial forms of capital and resources for participation in society, and could thus potentially bridge structural gaps. Indeed, the role of the producer is one of the most fundamental roles in Western societies. It is commonly accepted that overall social integration is fundamentally rooted in labour market integration (or economic integration, in a larger sense). To be a consumer, individuals need access to private and public goods and services, which may contribute to the development of a certain lifestyle. Recognition that one is a citizen with political rights connects the individual and the state.

To better understand different approaches to the social inclusion of people with impairments in contemporary European welfare states, I propose to develop a typology of disability policy in Europe based on the concept of Active Citizenship (AC) for people with disabilities. This concept was developed with the social situation of people with impairment in mind (Halvorsen & Hvinden, 2013a, 2013b; Halvorsen & Hvinden, 2013; Waldschmidt, 2013), and enables me to examine varying social inclusion strategies in Europe. With the aid of two studies—one theoretical, one empirical—I assess the extent to which welfare states support and combine different dimensions of Active Citizenship for people with disabilities—security, autonomy and influence; combined, these dimensions could create circumstances that allow people with impairments to overcome their social exclusion and to participate as acknowledged citizens. The different dimensions of AC relate to different social roles for an individual, which a disability policy of a particular country may or may not support.

3.3.5 Alternative role: welfare states as disabling institutions?

In the last part of this chapter, I aim to reveal the possibility of an alternative role for the welfare state in the constitution of disability. Although welfare states provide an organized way to overcome social exclusion, welfare state arrangements can potentially act in other ways. One could say it is the paradox of the welfare state in general and disability policies in particular that if people want to make use of welfare arrangements they first have to be identified as qualified claimants (Marin, 2004). In other words, people with impairments have to be labelled as "disabled" or "having a problem" before the government and social organizations can take steps to help them to function in a manner consistent with the societal standard. Thus, welfare states categorise and create certain social positions and roles. Additionally, welfare states can act as cultural agents that contribute to our cultural understanding of individual responsibilities and social roles (Kremer, 2007; Olafsdottir & Beckfield, 2011). By establishing a certain type of social policy, welfare states not only establish a specific form of social stratification and socio-economic order in society, but also define what is a "legitimate" reason to opt out of work and who morally deserves benefits or care. They may constitute ideal types of citizenship and that may have a moral impact on individuals' life.

Although the relationship between the welfare state and the culture system is not (yet) adequately theorized and developed as a field of study, or is often rather implicitly included (Kremer, 2007; Pfau-Effinger, 2005; Van Oorschot, Opielka, & Pfau-Effinger, 2008), the interdependence of the two systems is broadly acknowledged in several studies. The cultural system is seen as a space or construction of values and ideas that orients people in their behaviour and helps them make sense of and interpret what is happening around them (Pfau-Effinger, 2005). On the one hand, the development and design of the welfare state with its own specific constellation of social rights is affected by cultural factors, such as religious cultures and the struggle between different ideologies (Bonoli, George, & Taylor-Gooby, 2000; Esping-Andersen, 1990; Fitzpatrick, 2001; Korpi, 1989; Van Kersbergen, 1995; Van Oorschot et al., 2008). On the other hand, the inverse relationship—which means that social policy influences culture—has also been observed and studied (Van Oorschot et al., 2008).

Researchers have, for instance, looked into the role of the welfare state in shaping attitudes towards public provisions and redistributions (Chung & Meuleman, 2017; Wulfgramm & Starke, 2016), and examined the link between welfare policies and work ethics (van der Wel & Halvorsen, 2015). Hence, welfare states socialize citizens and prepare them for what to expect about the relation between state, market and family in taking care of security and health (Kremer, 2007). Because of this, the welfare state context can also shape the cultural space in which meaning and understanding about impairment are developed (Kikuzawa, Olafsdottir, & Pescosolido, 2008; Olafsdottir & Beckfield, 2011). Its management of the "social risk of disability" in social policy might thus constitute the way people think of people with impairments (e.g. a victim or poor and unhealthy individual vs. an active citizen and participant), and how people with impairments come to think of themselves.

A more critical reading of the role of the welfare state as a shaping agent dovetails with Michel Foucault's work on different modes of power, including disciplinary and biopower, and social construction of subjects. Foucault's work has been used to show how, during the last two centuries, a vast apparatus of technologies and techniques erected to secure the well-being of the general population allowed the social existence of the "disabled subject" to emerge and caused it to enter the discourse (Tremain, 2015). If Foucault's reading of biopower and governmentality is applied to disability, it may help to uncover the less obvious processes of how disabled subjects are socially produced and what it means to live in a specific socio-historical context for the subjective well-being of people with impairments. Although mainstream studies of the welfare state and social policy consider the welfare state as an organizing principle that not only redistributes wealth but also constitutes a particular form of social stratification (Arts & Gelissen, 2002), they tend to overlook its productive functions in terms of the creation of social categories and connection with knowledge.

3.3.5.1 The emergence of power focused on life: bio-power

In his analyses of power and government, Foucault describes the evolution towards biopower (Foucault, 1978–1979, 2010; Foucault, 1998; Foucault, Bertani, Fontana, Ewald, & Macey, 2003). For long, sovereign power was the dominant form of power in Western societies. In this mode of power, the sovereign/ruler—or in a later age, the state—had the right to seize property, persons and time, and could ultimately decide whether subjects lived or died (Rabinow & Rose, 2006). Sovereign power governed and controlled subjects through the threat of death. During the late 17th century through the 18th century, a new power technology appeared that

Foucalt called biopower; it generally focused more on life and replaced the threat of death with securing the survival and life of the social body. Once biopower emerged, political power no longer resided solely with the threat of life and death (Rose, 2007). The emergence of biopower and its techniques could easily be seen as a more humane manner of exercising power (people were now punished less often with the overt threat of death). It should however be understood instead as an alternative, subtler way of exercising power, as it was still a way to regulate and control individuals.

In the name of the well-being of the population, biopower undertook the management of life (Rose, 2007). To accomplish this, political authorities took on new management tasks that developed around specific problems such as illness, sanitary conditions and population reproduction in the 18th and 19th centuries. To understand and intervene in these problems, political and other authorities needed to expand their responsibilities to include fundamental processes and to approach human beings as members of a species with biological characteristics. In the biopolitical era, biological life became part of political techniques which served to safeguard the survival of the population and to render it productive (Devisch & Vanheule, 2015; Schinkel, 2010). When taking this biological approach, it followed that biological characteristics could be studied scientifically and acted upon by various institutions, organizations and individuals. Furthermore, to manage life, authorities needed information about and understanding of individual and collective lives. Therefore, the establishment of biopower cannot be seen as independent of the development of those sciences whose main function is to study public hygiene and the "general population". Consequently, the body became subject to the attentions of various experts that scrutinized it characteristics. This development can be easily linked to the emergence of biomedical individual models of disability.

After biopower emerged in the 18th and 19th century, disabled people were considered to be "a textbook" docile population (Hughes, 2015). In a sense, one could say people with impairments were disciplined. Foucault describes the discipline as those forms of biopower that focus on the human body and seek to maximize its force to make it useful in a particular social system. The discipline can be seen as the microphysics of power that survey individuals' bodies, distinguish their singularity and point the individuals towards a preferred action (Foucault & Sheridan, 1977). The body was viewed as a machine in which abnormalities could be erradicated. To deal with illnesses, accidents and other deviations, different charitable, penal and corrective institutions like prisons, schools and asylums were established. They would survey and control individuals, and mould them into a particular role through punishment or reward according to norms and rules to which they must conform. Individuals became separated from others through the construction of categories, such as the sick and the healthy, the disabled and the able, the mad and the sane. Bodies that deviated from the norm were retrained or modified to return them to a more productive state. The objective of disciplinary power was to make individuals internalize certain social roles and practices that were useful in a certain presentation of reality.

Medical, administrative and legal practices interacted with and defined disability as an socio-political category over time (Soldatic & Meekosha, 2012). Thus, people with impairments became the subject of discussion for professional groups; concurrently, the discourse also defined and redefined that subject matter. Practices and procedure were created to classify, manage or control social abnormalities; this resulted in a division between certain individuals and the rest of the population, and objectified certain groups such as the impaired, insane, handicapped, retarded or mentally ill (Tremain, 2015). With the birth of institutions for the insane and impaired, people with impairments were being defined as a particular and separated kind of individuals and excluded from the abled society.

These institutions established two main tracks and focuses (Carlson, 2015; Sullivan, 2015). For some that were considered impervious to education or improvement, an institution existed mainly to provide shelter and supervision. Not only would the institutionalisation of these individuals (for example the “mentally retarded”) protect them from neglect or harm in an unsuitable (family) environment, their families would also be protected from economic and financial hardship. Moreover, the institutionalisation would protect the rest of society from them. Mentally retarded persons, for example, were better off in institutions because they might act immorally or criminally (Carlson, 2015). This perspective justified their social exclusion and spatial segregation.

On the other hand, the institutions claimed to transform those cases that were considered educable and potentially even curable. In that situation, the judgement and knowledge discourses of the medical community or of experts were translated into practices and techniques that should have fostered training and rehabilitation. Both the discourses and the practices justified the construction of appropriate facilities: the argument was that disabled bodies can only be educated or improved in the proper environment. Because of this, the institution was not viewed as a custodial or protective environment but as a reformative and productive one.

In both ways, however, the institutions’ disciplinary techniques engaged in constructing disability as a particular social position, which resulted in the systematic closure of opportunities for agency for people with impairments, and led to incarceration, with or without a future perspective of discharge (Hughes, 2015; Tremain, 2015).

3.3.5.2 Welfare states and the construction of disability

The diverse programs through which the social body was governed in the 18th and 19th century involved a complex alliance of private and professional agents, such as charitable and religious organizations, medicine and the state (Rose & Miller, 1992). During the first half of the 20th century, however, many Western societies became welfare states. In these societies, the "state" bundled the diverse mechanisms through which political forces try to ensure economic progress, social security, health and housing through tax systems and investments, interventions in the economy and the development of social policy. The development of an extensive bureaucratic social administration apparatus was vital to fulfilling these aims (Rose & Miller, 1992). Although welfare states differ in their organization, they do share the fact that they manage the politics of life to shape so that the social body accords with the state's tasks (Hewitt, 1983). As previously mentioned, disability was among the first social risks to become the welfare state's responsibility (Van Oorschot & Hvinden, 2000). As such, welfare state practices and social policies are related to biopolitical ways of governing disability, an aspect that is often neglected in mainstream research on welfare states and social policy.

Foucault's later analyses of biopower acknowledges the role of the welfare state (Foucault, 2007, 2010). More specifically, his analysis of liberal governmentality and the development of the apparatus of security reflects that role. Power techniques, which govern at a distance, are currently receiving more attention than exclusionary and subjective disciplinary techniques (Rose & Miller, 1992). Informed by a liberal philosophy, individuals are understood as active subjects are allowed to act in their own interests. However, this does not mean there is complete individual freedom. Freedom is restricted by the apparatuses of security that are installed to make sure personal autonomy is used in a particular way (Waldschmidt, 2015). Welfare states wish to encourage national growth and well-being, and therefore structure the range of possibilities for individual behaviour (Kristensen, 2013). They form institutional modes of solidarity by installing social security systems, but in turn demand that individuals be socially responsible and meet their obligations (Rose & Miller, 1992).

In a sense, the role of the welfare state resembles that of a pastor or shepherd who is responsible for a flock. Foucault suggests modern states have integrated this older Christian idea of the pastorate into the development of welfare state institutions (Devisch & Vanheule, 2015; Foucault, 2000, 2007). Although welfare states aim to augment the well-being of the "flock", a precondition for its "salvation" is the profound understanding of characteristics, behaviour and mind. To manage their growing need for information, welfare states need to bring structured order to their social reality and to introduce procedures such as (national) surveys, population registers or censuses. Statistics become part of the administrative apparatus, an essential medium for gathering knowledge, crucial to the welfare state and its exercise of power (Foucault, 2007). Moreover, statistics function as a screening technology that sorts the population and identifies residual categories such as "disabled" and "invalid" (Louckx & Vanderstraeten, 2014). Although the emergence of these categories in statistics is not independent from what happens in reality (Louckx & Vanderstraeten, 2014; Uprichard, 2012), statistics do tend to rationalize and standardize the social body into an administratively more convenient format, and assist the state with producing official representations (Louckx & Vanderstraeten, 2014).

Stone (1984) documents this categorising and constructing role of the welfare state and its connection to expert knowledge and scientific procedures with a particular attention to disability. In her empirical study on social welfare developments in US, Germany and the UK, she points out that disability is a socially constructed category with flexible borders and the result of the interplay of individual and institutional forces. She shows that the creation of the categories functions as a way to control exemption from work and the access to the early forms of poverty relief and to subsequent forms of the mechanisms of the redistribution of social security. Her book indicates that states struggle with the following problem: it is assumed that most people secure their income and wealth through participation in the labour market; however, not all people are willing or able to adopt the capitalist work regime. Policy makers are confronted with the problem of defining "access to redistribution policy". They therefore need to establish a system that identifies people who can claim state support legitimately and that does not undermine the primacy of the work-based approach to welfare. The development of the administrative category of disability in the welfare state, together with legitimizing the power of medicine, could be seen as the solution to this problem. This category functions as a boundary category, as a gatekeeper for the different social security systems. Disability has to be seen as a deeply stigmatizing but "privileged" status (Soldatic & Meekosha, 2012; Stone, 1984), because the individual is freed from the discipline of the capitalist market, but now has to bear the stigma of welfare dependent.

In the early versions of the UK poor relief, for example, the disabled individual had to endure the harsh conditions of the workhouse. In the analysis on the creation of the United States' social security disability insurance, the connection between power and medical expertise is very clear. Medical certification serves as a classification system that separates the deserving poor from the undeserving poor, the "genuine" from the "artificial" claims of sickness and impairment (Barnes & Mercer, 2010b; Finkelstein, 1991; Oliver, 1990; Soldatic & Meekosha, 2012). Stone (1984) also points to the crucial role a physician's diagnosis plays in the validation and objectification of the label, and ultimately in the state's endeavour to control labour supply and welfare expenditures. Disability becomes a clinical concept defined by medical examinations and expertise. The individuals who are labelled as disabled receive special treatment and benefits because they are blameless for their condition and suffer from it. Disability, therefore, can be seen as the product of a medical-welfare discourse, a category that comes into existence within a welfare program (Hewitt, 1983). Moreover, the individuals who are labelled as "disabled" are also defined by particular characteristics. They are presented as subjects with special needs, who are unproductive because they are not working, and need (financial) protection and additional services. Thus, understanding the creation and perception of disability as a specific position and role in society echoes Parson's concept of the sick role (Parsons, 1975).

In an analysis of the UK's Disability Living Allowance (DLA), Shildrick (1997) provides a more contemporary example of the ways in which people with impairments become the targets of supervision are produced as disabled subjects. Her analysis is situated at the intersection of health, care and the welfare state, as she shows how disabled subjects are constructed as corporeally flawed in order to receive a benefit of the state that can be used for help with mobility or care costs (Hughes, 2015). To attain the benefit, claimants need to be assessed and are subjected to a questionnaire to determine the level of help needed. The questionnaire includes questions on whether they need help with daily activities or need supervision to avoid putting themselves or others in danger, and whether they have been assessed as blind, deaf, or severely mentally impaired with severe behavioural problems. Shildrick (1997) remarks that during assessment, claimants are obliged to view their own body critically and compare its dysfunctions to the ideal body, which is often defined as male and normal. With this questionnaire, the government agencies try to determine deficits and gather knowledge about the needs of disabled people. Although the process might result in benefit, it also indicates the ways and to what extent the bodies of people with impairments deviate from the normal and functional body.

A Foucauldian analysis of impairment and disability sheds light on the practices that lead to the social construction of "impaired" and "disabled" people and offers greater insight into the practices that restrict their actions. If not confined or institutionalised, disabled people are directed to a life of welfare dependency. Since the emergence of biopower in the 18th and 19th centuries, they have been identified as a group who cannot organize or do things for themselves, who are a burden and social risk, a group in need of intensive systems of surveillance (Hughes, 2015). People with impairments have also been transformed into dependent, invalidated and incapacitated people by different forms of surveillance in different institutes and contexts. Medicine "pathologizes" and "imprisons" them through disciplinary technologies in "special" places. They are normalized using strategies of rehabilitation, trying to get them back on track, to curing them. In welfare state policies, this focus on invalidation translates into a definition of disabled people as passive, as not able to work; that perception is then often proved by medical examination. In different ways, the construction of the disabled category is used as a mechanism for social control, separating the deserving from the undeserving bodies via surveillance and supervision. Although individuals in the disabled category can enjoy social rights and other services, and as state support is often welcome because the capitalist system does not accommodate everyone, the analyses also show that people with impairments are actively labelled and invalidated by a certain socio-economic organization of society.

Moreover, because making a distinction between a normal and an invalidated person is both implicitly and explicitly normative, it contributes to the social stigma surrounding disability (Hughes, 2015; Stone, 1984). An unintended consequence of welfare policies may thus be that persons in the disabled category feel that they deviate from the societal norm and thus perceive themselves as being less healthy than other people are. They may experience a feeling of profound "otherness" (Link & Phelan, 2001) The labelling may induce processes of status loss and discrimination, which may lead to the experience of individual and structural discrimination and in turn, social exclusion (Goffman, 1963; Green, Davis, Karshmer, Marsh, & Straight, 2005; Link & Phelan, 2001; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001). Hence, being dependent on welfare provisions to function in society and social comparison with people without impairments might lead to worse subjective well-being and self-rated health, as people may internalise these conceptions of inferiority into their identity and come to think less of themselves (Blumer, 1969; Lemert, 1972; Mead, 1934). Indeed, if one finds oneself labelled, the ideas attached to that label become personally relevant. A person might become stigma conscious and apply or project the ideas onto oneself. People with impairments might therefore become less confident, and have lower self-esteem and poorer subjective well-being (Green et al., 2005).

3.3.5.3 Technologies of the self

While the previous section informs us about the social construction of disability during the emergence of the welfare state and in contemporary welfare assessments, it does not consider new welfare rationalities and reforms that have been established and implemented in the last several decades. More specifically, as of the mid-1970s, neoliberal outlooks began to shape political programmes and their perceptions of individuals (Rose & Miller, 1992). Neoliberalism sees the free market as the key organizing principle, and views the individual as a free, autonomous agent (Harvey, 2007; Rose & Miller, 1992). This political rationale is based on another conception of what it is to be human, one that views the individual as an active citizen, as a rational actor who constitutes his- or herself as a particular subject in relation to surrounding cultural ideas and social norms. The individual acts as a homo economicus who makes targeted choices and responds systematically to challenges and therefore thinks in economic terms about other areas of social life: education, health, marriage, and so forth. This perspective also warrants a different approach to governing individuals. Political power may therefore seem to be less a matter of imposing constraints upon individuals, as individuals are now perceived as citizens capable of handling a kind of regulated freedom (Rose & Miller, 1992). However, that freedom is not only regulated but also incomplete because certain forms of authority pressure individuals to develop themselves in accordance with certain truth discourses and the norms of society (Rabinow & Rose, 2006). Furthermore, this approach renders individuals inherently governable, as they compete according to certain rules and display behaviour that fits social circumstances. Personal autonomy becomes the key to the exercise of political power, as individuals become part of its operations. Individuals are viewed as active agents, as citizens who pursue their own advantage.

This governing from a distance is also visible in Foucault’s analysis on the formation of the individual subject (Lemke, 2002). He argues that an analysis of the formation of the subject in Western societies needs to consider more explicitly how individuals are encouraged to improve themselves. In his consideration of the concept of government, he not only explores techniques in which individuals are forced to act in certain ways by others, but also techniques by which “autonomous” individuals control and modify their own conduct. Hence, Foucault adds governmental practice to his range of studies: modes of subjectification through which individuals control and shape themselves by specific self-knowledge or conscience (Foucault, 2010; Lemke, 2001). Based on practice, Rose (2007) attempts to show more explicitly how individuals are encouraged to work on themselves based on “ethopolitics”. More specifically, he indicates that in contemporary politics, there is an attempt to shape individuals' behaviours through their sentiments, beliefs or values. The aims and goals of good government are to connect to the self-government of the autonomous individual by acting on an individual's ethics, or the sentiments, moral nature or guiding beliefs.

This shift in governing in relationship to work was discussed in the section on macro-level labour market exclusion. In relationship to health, Rose (2007) and Devisch and Vanheule (2015) note that empowerment and self-management are among the leading principles of today's health care. Whether the subjects are children, the elderly or people with impairments, patients must be empowered. Empowerment stems from the idea that (medical) professionals should no longer paternalize patients, an issue that has been part of the day-to-day reality of people with impairments (Barnes & Mercer, 2010a; Priestley et al., 2010). They are encouraged to manage their own condition (to progress from medication to diet and the use of devices) or trained to become "active and responsible agents". Empowerment is presented as an obvious moral choice, as a good thing and a goal in itself. Self-management is advanced as the optimal choice that results in better and more personalised health care.

Despite consensus on the merits of empowerment in health, the idea of empowerment is not as neutral or value-free as it may look (Devisch and Vanheule, 2015). Although the discourse is about empowerment and choice, the choices have been outlined in advance. Although the autonomous subject plays the central role, paternalism has not been abandoned completely, but integrated into a subtler form of governing. Although no single member of the government is requiring individuals to be healthy, it is nevertheless very hard to escape the moral imperatives present in contemporary society and culture. People are urged to live healthily and responsibly to achieve quality of life. That is, people are free to make the "right" choices (Rose, 2007), although the proposed norm is subjective (Nye, 2003). Because the importance of a healthy lifestyle and acting responsibly have been internalised, the norms created by health care professionals and policy makers still guide behaviour. Those who deviate from the norm, especially, are targets of empowering strategies, because they demonstrate "risky behaviour". The norms of health and the responsible individual can cause individuals to understand themselves as "somatic individuals" (Rose, 2007). Rose points out that individuals come to view and judge themselves according to biomedical language, and to understand that individuality is, at least partly, grounded within their fleshly, corporeal existence. The body and the vitality of the self have become the privileged site of experiments on the self.

The aforementioned arguments make clear that contemporary welfare politics are constituted by and may contribute to social norms about responsible behaviour and the actions of society's citizens. What, however, does this somatization of the self mean for individuals who do not necessarily reflect healthy individual norm, such as people with impairments? Will they perceive themselves as less healthy? And how will the perceived norm of the responsible employee-citizen affect their well-being? The role social norms (in both health and work) and technologies of the self play for the subjective well-being of the individual can theoretically be described by referring to social norm theory and a social comparison mechanism. The theory is based on the assumption that the norm is shared by other people and sustained, in part, by others' approval or disapproval, and that people are concerned with their relative standing in society (Festinger, 1954; Schwarz, 2012). Social comparison can be seen as a link between health and social integration in society (Thoits, 2011). Whether people conform or deviate from the social reference group norm will affect how they evaluate and perceive their situation (Winkelmann, 2014). In the current neoliberal discourse, people are expected to act like responsible citizens, and are encouraged to take care of themselves and consider their position in society. By appealing to ethical sensibilities, this discourse encourages people to internalize the norm and better themselves (Rose, 2007). Based on the perceived norm of the responsible, healthy and employee- citizen, people with impairments, especially, might feel that their situation deviates from both the norm and the social reference group (healthy, able and active employee-citizens). Therefore, people with impairments might come to see themselves as less healthy individuals and may have lower subjective well-being.

For people with impairments, welfare state institutions are potentially disabling institutions. They can restrict activities and participation in society, and can socially undermine subjective well-being or subjective health. Where the former relates to direct disciplinary practices of denying access and directing them towards formally organized care institutions, the latter refers to more indirect effects of governmental techniques of self-management. When people with impairments are socially constructed by policy into a group that cannot participate in mainstream society and are directed towards separately organized care institutions, it may affect their self-rated health and subjective well-being. They might feel socially excluded, think less of themselves or even think of themselves as abnormal, particularly if they are living separately from other people, in a care institution whose aim is to rehabilitate, re-educate or cure them. Moreover, even if they live independently in society, biopolitical techniques of self-government might indirectly undermine feelings and self-esteem. The fact that they have to make use of special services and benefits, a process for which they often have to be officially recognized as “disabled”, might have negative consequences. Via internalisation and socializing processes, deviating from the norm of the productive active citizen might also have harmful consequences for their subjective well-being and satisfaction with different life domains. It remains important to acknowledge that these different mechanisms of power are analytical concepts that in reality intersect and modify each other. Although the different forms of power have their own aims and practices, they may in reality overlap or act simultaneously—in spite of one or the other being dominant at different times. While the current theoretical focus might be primarily on the role of governmentality and self-management, many people with impairments still live in disciplinary care institutions. The theory in the studies in chapter 6, 7 and 8 reflect parts of this alternative role.

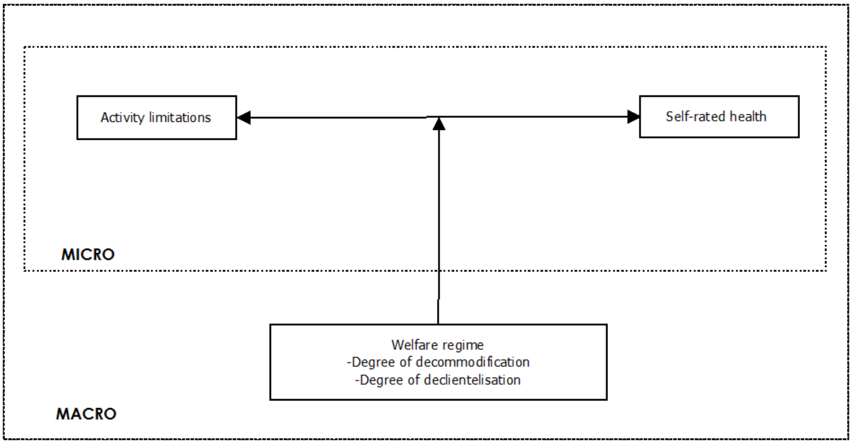
Chapter 4

Highlighting the empirical and theoretical studies

In this chapter, I provide a brief overview of the five studies included in this dissertation and review the questions they seek to answer. I highlight the main rationale that supports each study and present the theoretical models that define the analyses.

Study 1 considers the relationship between impairment and self-rated health across distinct socio-political contexts. It examines the impact a particular country's welfare regime can have on the association between having activity limitations and subjective health. Study 1 explores one of this dissertation's central ideas: the extent to which the socio-political organization of a country can affect an apparently straightforward relationship. It challenges common-sense assumptions that equate impairment and restrictions in participation with being unhealthy or a personal tragedy. It also links the relationship to a defining structural institution of society. The theoretical framework used in Study 1 highlights both of the hypothetical roles of a welfare state: the enabling and empowering role, and the disabling or dividing role. Because this was the first study undertaken, I compared contexts that are obviously distinct. The analyses compared European welfare regimes with regimes in Asia, Latin America and Africa. The different welfare regimes are classified using a welfare typology that characterises countries based on their degree of decommodification and declientelisation. Figure 5 presents the theoretical model that supports the paper.

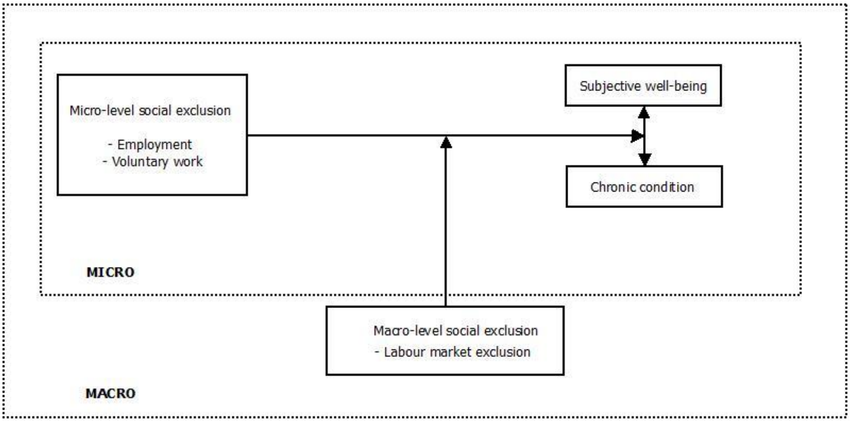
Figure 5: Theoretical model of Study 1



The remaining studies examine the European context more closely. To facilitate this deeper exploration, a more fine-grained approach to making a distinction between social contexts was preferable to the more general welfare typology applied in Study 1. Therefore, I considered a variety of specific aspects of country context. However, the primary focus remained challenging the more common association between impairment and subjective health or well-being. A structural-material perspective informs the research questions of all the studies, which tap into different aspects related to the social exclusion of people with impairment.

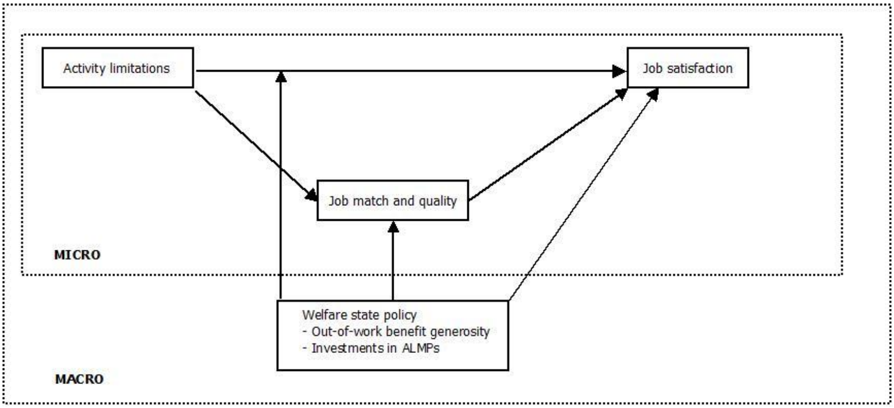
Study 2 examines the extent to which the relationship between impairment and well-being is dependent on labour market exclusion, both at the micro- and macro-level. Employment is a key factor for social inclusion, and lack of paid work is a major cause of social exclusion and may, in turn, lead to poorer mental health and lower psychological well-being. However, the labour market participation of people with impairments varies considerably across European countries. For people with impairments, formal volunteering is often promoted as both a stepping-stone and an alternative to employment. However, voluntary work does not automatically function as an equivalent to paid work or as a substitute for employment with regard to impact on integration and participation in society. The main research questions in Study 2 are, therefore, "Does paid work or voluntary work reduce the negative associations between having a chronic condition and psychological well-being?" and "Does the moderating role of either paid or voluntary work on the relation between having a chronic condition and subjective well-being differ according to the level of labour market exclusion of people with chronic conditions in a country?" Using the social stress model and social norm theory, the study considers and theoretically links the different factors. Figure 6 displays the main theoretical model of Study 2.

Figure 6: Theoretical model of Study 2



Study 3 focuses on labour market insiders, and assesses variation in job satisfaction. The main objective was to evaluate the role of a country's investment in Active Labour Market Policies (ALMPS) and out-of-work benefit generosity on the job satisfaction of workers with and without activity limitations. Figure 7 shows the theoretical model tested in Study 3. Across Europe, many governments have established policies aimed at strengthening the labour market attachment of the working-age population. This shift in policy is also targeting groups with weaker labour market attachment, such as less-educated younger people and people experiencing ill health and activity limitations. Investments in ALMPS and cuts in out-of-work benefit spending are considered two aspects of the shift. However, whether and how these policies affect workers' job satisfaction is less well known. In this paper, I tested whether higher investments in ALMPS and out-of-work benefits also affect job satisfaction across 21 European countries. Theoretically, higher investments are hypothesized to enable individuals to have more control over their life; this may include finding a job that matches their skills set and impairment and that satisfies them, or a higher quality job. I assume that welfare resources could be especially beneficial to people with activity limitations for securing a matching job.

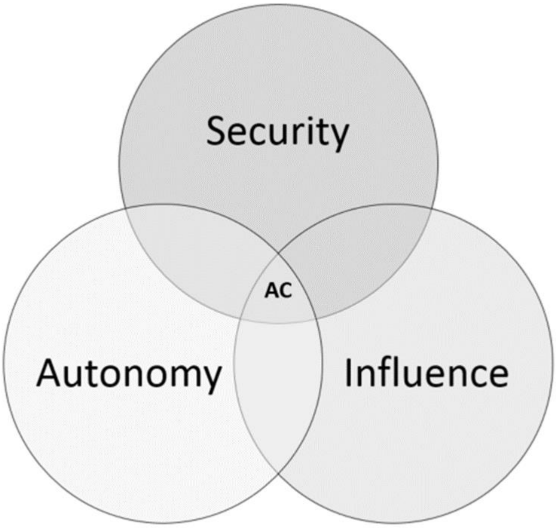
Figure 7: Theoretical model of Study 3



In the next two studies, I aim at gaining clearer insight into the disability policies of European countries. As mentioned before, welfare states have the potential to empower people with impairments and to foster social inclusion. Moreover, disability policies have the potential to reduce division and to eradicate the social exclusion experienced by people with impairments. Currently, only a few studies have compared the disability policies of different European welfare states. However, understanding how different countries try to foster social inclusion is a necessary first step towards comparing different outcomes. With Study 4 and 5, I aim to improve theoretical and empirical understanding of the different strategies

European countries employ to tackle the social exclusion from society of people with impairments. In Study 4, I reflect on the theoretical concept that can be used to compare national disability policies across countries. While the literature comparative welfare state studies have produced that compares welfare state policies has been substantial, the concepts that underlie those policies have not been developed with disabilities in mind. This has hindered the development of comparative disability policy research. The concept of Active Citizenship (AC) for people with disabilities is discussed as a way out of this impasse. Figure 8 shows the AC concept and its different dimensions. Study 5 complements Study 4, as it presents an empirical analysis of the variation in strategies among European countries towards AC for people with disabilities. Via a fuzzy-set ideal-type analysis, Study 5 distinguishes distinct ways of supporting people with disabilities as citizens by using different combinations of AC's dimensions.

Figure 8: Graphical presentation of the concept of Active Citizenship for people with disability and its dimensions



Chapter 5

Methodology

This chapter offers a more detailed discussion of the data, the most important operationalizations and the analysis techniques employed throughout this dissertation. Subsequent chapters will also discuss data and methods; therefore, a certain amount of repetition is inevitable. However, in this chapter, I elaborate on the rationale underlying the choice of datasets and the data collection methodology, as well as the measurement and analytical techniques. In addition, supplementary diagnostics will be included and discussed.

5.1 Data

Cross-national research on individual outcomes across social contexts and institutions demands comparative data gathered via standardized methods. In this dissertation, I conducted the analyses using data from several sources. In three of the studies, I examined individual-level outcomes across different national contexts. This required a combination of individual-level data and country-level information (e.g. the social organization of a welfare state, expenditures on policy or structural labour market indicators). Comparative individual-level datasets that include information on health while also offering substantial insight into the individual's socio-economic position are relatively scarce. However, a large sample size was preferable because I needed sufficiently large groups of individuals to investigate differences in the experience of social exclusion among people with and without impairments. Therefore, I opted to use different datasets from different times for my analyses. Some datasets provided limited insight into health and impairments, but offered a better understanding of other aspects of the model, and vice versa. In the fifth study I only used country-level data. Since comparable country-data on disability is scarce, finding and choosing data was a delicate mission. Below, I describe the various datasets used when comparing individual outcomes across countries. Subsequently, country-level data are presented.

5.1.1 Micro-level data

Table 2 provides an overview of the survey data, the time period and sample size used in the three empirical studies that used individual-level data. Depending on the research question being considered, I chose data from specific surveys and survey waves.

Table 2: Overview of individual-level datasets, periods and sample sizes per study

Study	Survey	Wave	Period	Final sample size
1	World Health Survey	1	2002-2004	213 764
2	European Quality of Life Survey	3	2011-2012	22 466
3	European Social Survey	6	2012	16 058

5.1.1.1 World Health Survey

The WHO developed the World Health Survey (WHS) to strengthen the monitoring of health outcomes through a valid, reliable and comparable survey instrument. This survey contains self-reported information on personal health (e.g. general health, daily functioning, mental health, pregnancy), health-care usage and costs, and household and personal socio-economic situation (Ustün, Chatterji, Villanueva, et al., 2003). The WHS is a cross-sectional survey conducted in 70 countries from 2002 through 2004. The survey covers African (18), Eastern Mediterranean (4), American (7), South-East Asian (5), Western Pacific (6), and European and Central Asian (30) countries. This approach makes the WHS unique: it is one of the only rich comparative individual-level health datasets on people living in high-, middle- and low-income countries. Compared to other surveys, research in the field of global health that uses this data source effectively is rare limited (Witvliet, 2014). Although this cross-sectional approach may not provide the most recent data and does not provide insight into individual health changes over time, it does enable researchers to study health determinants on a large comparable scale. At the time of completion of my research, no more current version of the WHS had been made available.

To enhance the utility of the survey, questions were bundled into several independent modules. The modules address different aspects of health and health systems and are organized into two sections: the household questionnaire and the individual questionnaire (Ustün, Chatterji, Mechbal, et al., 2003). The participating countries could choose which modules were used to assess in their population. Although this might have had the benefit of encouraging countries to participate, it also resulted in missing data problems for certain countries (Ustün, Chatterji, Villanueva, et al., 2003; Witvliet, 2014). To ensure the quality of the survey instrument, the development of the modules went through a cyclical process of development, testing and revision. The development of the WHS drew on the WHO's experience with developing the WHO Multi-country Survey Study on Health and Responsiveness 2000–2001 (Ustün, Chatterji, Mechbal, et al., 2003; Ustün, Chatterji, Villanueva, et al., 2003). An important aspect in the development of the WHS was the use of anchoring vignettes to enhance the comparability of self-responses on health. The purpose of the vignettes is to gain insight into how people from different socio-economic, demographic and cultural settings might understand and use response categories differently. In early 2002, an initial pilot study was launched in 12 countries across several continents. Based on the psychometric evaluation of the pilot study's different modules, a final survey instrument that was translated into different languages following a standardized protocol including back translation was presented in August 2002. The WHS process ensured that all modules could be fielded within 90 minutes, on average, though countries could also opt for a briefer 30-minute version.

A range of different sampling modes were available, though all participating countries needed to employ a probability sample design; practicality and cost-effectiveness determined each country's choice (Ustün, Chatterji, Mechbal, et al., 2003). The WHS Quality Assurance Standards & Guidelines identified critical operational criteria and best practices. All sampling modes had to involve random selection of respondents based on a nationally representative sampling frame. Although single-stage random sampling was preferred, in most countries a multi-stage cluster sample representing the general adult population (18+) was drawn instead. A household was the primary sampling unit (PSU), but only one individual per household was randomly selected to respond to the survey via Kish tables. The primary survey mode for collecting data was a face-to-face interview, though a small group of countries (Norway, Australia, Israel and Luxembourg) opted for computerized telephone surveys (CATI). This sampling design excludes extremely vulnerable members of society, such as those living in institutions or hospitals, refugees or others living in a non-traditional home setting during the data collection. Depending on the data needs of a country and the amount of detail required, the sample sizes ranged from 600 to 10,000 respondents. National household response rates ranged from 50% in Slovenia to 100% in several other countries. The Czech Republic stands out as an exception with a response rate of 24%.

Although the WHS provides different weighting factors, the final analyses are not weighted. Other studies have used the same approach (Witvliet, Kunst, Stronks, & Arah, 2012a, 2012b). While weighting is normally applied to ensure nationally representative samples, the information provided by the WHO is very limited and different weighting factors are not available for all countries. As such, if the analyses were weighted, it would not necessarily be clear which weighting factors had been considered. In the development process, the effect of weighting was tested. Because the weighting and the lack of clear information on the weighting variables in the dataset did not affect the results and conclusions, I decided to show only the unweighted results.

5.1.1.2 European Quality of Life Survey

The European Foundation for the Improvement of Living and Working conditions (Eurofound) established the first European Quality of Life Survey (EQLS) in 2003. In this dissertation, I use the third wave, which was collected in 2011–2012 from 27 European Member countries and 7 non-EU countries (Eurofound, 2012a). The survey's aim is to look into both the objective circumstances of European citizens' lives, and those citizens' perception of those circumstances and their lives. It looks at a range of issues, such as employment, income, education, housing, family, health and work-life balance. It also looks at subjective topics, such as people's level of happiness, level of psychological well-being and perception of their society's quality. The EQLS surveys are especially developed to complement the more economically centred indicators of quality of life and living standards, such as GDP and income (Wallace, Pichler, & Hayes, 2007). For my research, the scales on positive well-being were especially interesting.

The third version of the EQLS questionnaire is founded on the preceding waves; however, it has gone through several additional phases of development (Eurofound, 2011, 2013). After an evaluation of the 2007 EQLS questionnaire, the new questionnaire containing new elements was pre-tested in Belgium and the UK using a mixed-method approach with cognitive interviews and face-to-face interviews. Two independent local translators translated all the new elements. The versions of the two were compared and back translated. Experts in the field conducted an extra quality check on the translation of the new questions and trend questions. Extra validation of cognitive interviews was performed at this stage to ensure that the language had been properly understood and the translations were accurate and fluent. Next, a pilot phase was conducted in all countries to simulate the real study and to verify that all fieldwork materials worked appropriately. National implementation teams proposed adjustments and some final revisions were made based on these observations.

In 16 countries, random probability sampling was performed from a sampling frame that covered at least 95% of households/individuals in the country. In most of those countries, a multi-stage stratified sample was created based on strata defined by region and degree of urbanization, in each of which the PSUs were drawn randomly. Subsequently, a random sample of persons or addresses was drawn in each PSU. In a small number of countries, a one-stage stratified random sampling of registered individuals was carried out. In 18 other countries, enumerated address samples were pulled via random route sampling. If households were selected, only one person was interviewed and the eligible respondent was the person with the next upcoming birthday. The target sample sizes ranged from 1,000 respondents in smaller countries to 3,000 in bigger countries. Each country's survey is representative of all people aged 18.. People living in nursing homes, prisons or other institutions were not eligible to participate. The first interviews were carried out in September 2011. In 20 EU countries and 2 non-EU countries, Computed Aided Personal Interviewing (CAPI) was used; in the others, the survey was implemented using pen-and-paper questionnaires (PAPI). On average, the interviews lasted about 38 minutes in the EU countries. The response rates ranged from below 30% in Luxembourg and the UK to more than 60% in Bulgaria, Cyprus, Malta, Poland and Slovakia.

In my analyses, I use final weights (which acted as post-stratification weights) that were provided by the EQLS that correct for possible sampling or non-response errors and were pre-weighted by the design weights to correct for possible discrepancies in the selection probabilities (Eurofound, 2012b). The final weights have been constructed by comparing the EQLS data to the Eurostat data on age, gender, degree of urbanization and region, and by using the EU Survey on Income and Living Conditions (EU-SILC) data on households by household size.

5.1.1.3 European Social Survey

The European Social Survey (ESS) is a biennial cross-sectional survey covering attitudes, beliefs and behaviour patterns across Europe (ESS, 2014). ESS is an academically driven survey established in 2001. Currently, it is considered one of the most used cross-national surveys in the social sciences. The survey consists of a core section and a rotating section. The core section includes questions on socio-demographics, social trust, politics, human values and subjective well-being, and accounts for about half of the questions. The rotating section changes with every wave and is dedicated to specific themes of interest (e.g. welfare attitudes, immigration and ageism), which are sometimes repeated in later rounds of the ESS. In total, 36 countries have taken part in at least one survey wave. I use the sixth wave that focuses on personal and social well-being that was collected in 2012 from 27 countries.

While the ESS has the virtue of containing a large variety of variables across countries, its information on health and the impairment status of individuals is often limited. I chose the European Social Survey of 2012 because it asks about the job satisfaction of workers. Although the ESS had a rotating module in 2004 and 2010 on "family, work and well-being" that included more information on working conditions and employment relations, the questionnaire used in that rotating module did not ask about the respondents' job satisfaction (the variable I am interested in). I also considered using the EQLS, but in comparison, the 2012 ESS contains more information about work organizations and employment environments. The European Working Conditions Survey, which is often considered the best option for examining workers' job satisfaction and well-being, did not contain information on impairment or chronic conditions when it was written. Unfortunately, the 2015 wave that does include chronic conditions was only released at the end of 2016.

The development of the core questionnaire is subject to various evaluations and studies on reliability and validity (Beullens, Matsuo, Loosveldt, & Vandenplas, 2014; ESS, 2014). The consistency of the items and scale across time and space, the internal consistency, and the avoidance of biases and item non-response are also of central attention. The core team takes the lead with the assistance of several academic specialists. In 2001, the first English-language core questionnaire was translated into another language to facilitate the construction of two national pilot studies and experiments regarding question-wording alternatives. The quality of the questions and the distribution of answers in terms of deviant distributions or weak scales were tested, and weak questions were sent back to the development phase. Subsequently, the questionnaire was translated into additional national languages, with careful attention paid to avoiding ambiguities by providing definitions and clarification about the concept behind each question. The design process of the rotating module presented by the successful selected-question design team includes a pre-testing phase with both qualitative and quantitative strategies to achieve optimal comparability across countries. It incorporates expert reviews, tests of the coding item characteristics, cognitive interviews and, again, a two-nation pilot survey.

The samples are representative of all people aged 15 and over living in private households, irrespective of language, citizenship and nationality. Again, this excludes people with impairments and chronic conditions who are living in residential institutions or homes. It is necessary to keep this particular selection in mind, as it is likely to affect the strength of association between impairments or activity limitations in the analyses. The samples may exclude a considerate number of people with impairments who reside there. They might be the most needy of assistance because they have the most painful or weighty impairments in terms of physical or mental effects.

Strict random probability sampling was prescribed at each stage. In most countries, stratified multi-stage probability sampling was used to collect the data (ESS, 2014). The respondents were interviewed face-to-face (assisted by computer or paper), in their country's national language. The sample's lowest response rate in 2012 was found in Germany (33.8%), the highest in Portugal (77.1%). The overall response rate for 2012 was 62.7%. In the analyses, all data were weighted using the post-stratification weights provided by the ESS.

5.1.2 Macro-level data

In the first three empirical studies, multilevel analyses that model the effects of macro-variables were performed. Table 3 gives an overview of the sources of these macro-data that are included in each of the studies. Most information comes from Eurostat. For the first study, economic development data from non-European countries was also needed. The World Bank database was helpful for this, and where possible, the year the World Bank data was collected corresponds with the year the survey data was collected. The Eurostat data on benefit spending and public expenditures for care and other services is part of the European system of integrated social protection statistics (ESSPROS) (Eurostat, 2015). In the late 1970s, Eurostat and the EU Member States developed this framework to provide coherent comparisons of social protection between European countries based on administrative national data.

The fourth empirical study on the disability policies of European countries uses data from several sources, including Eurostat, but other databases and reports are consulted as well. It should be noted that comparative, representative and reliable data on the output and outcomes of disability protection is limited, and that data about the well-being and, more generally, the capabilities and agency of people with impairments, is even more scarce (Hvinden, 2009; Van Oorschot, Balvers, Schols, & Lodewijks, 2009). Most available country-level data is extracted from cross-national surveys such as the EU-SILC and ESS. Again, however, the drawback of this method is that it does not consider a substantial part of the potentially disabled population. Moreover, despite the availability of databases that collect data on many institutional features of the main social insurance programs (unemployment, sickness and old age) of European and OECD countries (e.g. Social Citizenship Indicator Program, Welfare Entitlements Dataset), some institutional features—for example, disability benefits—are not included by default. To the best of my knowledge, only one prior research report (Palme, Nelson, Sjöberg, & Minas, 2009) has published replacement rates for disability benefits. Other data for this fourth study was gathered from existing research reports and policy documents. The disadvantage of these data sources compared to other databases is that they usually focus only on a specific moment in time, though they contain detailed background information. For future research that aims to replicate research based on these types of information sources, however, continuing to use the same approach may be difficult.

To collect sufficient data, my analysis focused on 2010. Because an institutional approach offers more detail about the programmatic features of respective policies, I pursued this kind of data first before considering expenditure or data gathered from documents. I wanted to calculate the replacement rates of disability benefits; fortunately, I was able to draw on calculations made from an earlier report (Palme, Nelson, Sjöberg, & Minas, 2009) during a stay at the Swedish Institute for Social Research (SOFI) at Stockholm University in September 2015. Mainly, I drew on two information sources: the MISSOC and the SPIN databases. The MISSOC (Mutual Information System on Social Protection) was established by the European Commission and provides up-to-date information on social protection systems in 32 countries and covers 12 areas of social protection, including invalidity (European Commission, 2015). It provides information about the framework of the benefit systems, the calculations of the amount, and whether the benefits are taxed and social security contributions have to be paid. The data are updated every six months, but the user can select the main themes, countries and periods of interest. The SPIN (Social Policy Indicators) database provides the foundation for longitudinal and comparative research on welfare states based on T. H. Marshall's ideas of social citizenship (Swedish Institute for Social Research, 2015). SPIN makes data on the social rights and duties of citizens available and is oriented towards analyses of institutions as manifested in social policy legislation. Within the SPIN database, the Social Insurance Entitlements Dataset (SIED) stores data about three social insurance programs (sickness, unemployment and old age pensions) and information on wages and benefit recipients for all EU Member States for two data waves: 2005 and 2010. The SIED is a continuation of the SCIP (Social Citizenship Indicators Program) database, which covers 1930 through 2005.

5.2 Measurements of central variables

In this section, I provide a more elaborate discussion of central variables in the three multilevel studies. Depending on the specific dataset and research objectives, their construction varies somewhat between the studies. Table 4 provides an overview of the micro-level variables in those three studies. As the construction of the macro-level variables in the study on disability policy has been extensively described in this paper already, I will not repeat it here.

Table 3: Overview of data sources and years of macro-level data used in the four empirical studies

Study	**1**	**2**	**3**	**4**
Macro-data				
GDP per capita	World Bank 2002			Eurostat 2010
Non-employment rate people with impairments		Eurostat 2011		
Non-employment rate people with impairments		Eurostat 2011		
Unemployment rate			Eurostat 2011	Eurostat 2010
Employment rate			Eurostat 2011	
Investments in ALMP			Eurostat 2011	Eurostat 2010
Out-of-work benefit generosity			Eurostat 2011	
Public spending on disability cash benefits				Eurostat 2010
Public spending on benefits in kind				Eurostat 2010
Ratio public expenditure ion in-patient LTC to total public expenditure LTC				Lipszyc et al. 2012
Replacement rates disability benefits				SCIP 2010 MISSOC 2010
Reasonable accommodation				Chopin and Uyen Do 2012
Combination benefit receipt and work				MISSOC 2010
Availability personal assistance				DOTCOM 2010 ENIL 2013
Ratification of articles UN CRPD				FRA 2010

5.2.1 Well-being and subjective health

The three multilevel studies focus on three different dependent variables that consider different aspects of health and well-being. In Study 1, which makes use of the WHS, the self-perceived health of the respondents is the dependent variable. It was measured by stating, “The first questions are about your overall health, including both your physical and your mental health. In general, how would you rate your health today?” The respondents had to evaluate their health status on a 5-point scale. Response categories were “very good”, “good”, “moderate”, “bad”, and “very bad”. The introductory phrase indicates that one’s general health includes both physical and mental health. In the analyses, it is treated as a continuous variable, keeping the range of answer categories open.

In Study 2, I look into psychological well-being, using the 5-item World Health Organization Well-being Index (WHO-5) to measure the concept. This instrument captures positive psychological well-being over the two weeks preceding the interview (Bech, 2004; McDowell, 2010; WHO, 1998). In a review article, Topp, Østergaard, Søndergaard, and Bech (2015) conclude the scale was developed and functions as a generic well-being scale without any diagnostic specificity and can be used across many different settings, such as clinical trial studies and general population research. In another comprehensive review, the estimate of the clinical validity of the WHO-5 was very high, as it can be used irrespective of an underlying illness (or a lack of illness) (Hall, Krahn, Horner-Johnson, & Lamb, 2011). Respondents were asked to what extent they had felt the way indicated by the following five statements the two weeks before the interview. The statements were “I have felt cheerful and in good spirits”, “I have felt calm and relaxed”, “I have felt active and vigorous”, “I have woken up feeling fresh and rested”, and “my daily life has been filled with things that interest me”. Response categories ranged from “all of the time” (score 5) through “most of the time”, “more than half of the time”, “less than half of the time”, “some of the time”, and “at no time” (score 0). The final score was calculated by summing the scores of the items. The score was multiplied by four, resulting in a scale ranging from 0 (worst possible mental well-being) to 100 (best possible mental well-being). Scale reliability was good for all countries (the overall Cronbach’s alpha was 0.85; the lowest value was 0.78 for Finland). I opted for a continuous measure for examining the variation in psychological well-being rather than identifying a specific group that is at risk of having a very low or low psychological well-being with a cut-off point.

In addition, one could question the measurement equivalence of the instruments used to look into subjective health and well-being of people with and without impairments, who are also living across different countries. Indeed, when comparing the well-being of these groups, it is important to know if the measured construct has the same meaning across the groups, and whether the findings report true differences in well-being or are contaminated by group-specific attributes unrelated to the construct of interest, but affecting its measurement (Van de Velde, Levecque, & Bracke, 2009).

With regard of the usage of the scale, I tested the measurement invariance of the WHO-5 across people with and without an impairment in the Belgian population. Using the same data and measures as in study 2 (European Quality of Life Survey of 2011-2012), I conducted multi-group confirmatory factor analyses to test for different levels of measurement invariance (configural, metric and scalar). In the study, I found evidence for partial scalar invariance, suggesting that comparisons across people who are chronically ill and those who are healthy, are defensible. The study also confirmed the worse well-being of chronically ill people compared to those who are healthy. The short paper can be found in appendix 1. Additionally, it would be insightful to know whether people with physical and mental impairments also look at the items in the same way. For people with longstanding mental health problems, such as chronic or recurrent depression, the association could be stronger. However, one should keep in mind that studies increasingly indicate mental health problems and (positive) well-being are not just the extremes of a continuum, which accords with the finding that positive and negative do not correlate as strongly either (Diener et al., 2009; Payton, 2009; Ryan & Deci, 2001; Seligman & Csikszentmihalyi, 2014).

In Study 3, I was interested in workers' satisfaction with their job. In the ESS, job satisfaction is measured via a single-item question: "All things considered, how satisfied are you with your present job?" The respondents needed to indicate their satisfaction using an 11-point scale that runs from extremely dissatisfied (0) to extremely satisfied (10). The answers give insight into general job satisfaction without providing additional information about specific aspects of the job they are doing. However, overall job satisfaction combines the satisfaction with a range of aspects, such as satisfaction with physical working conditions, immediate supervisor and co-workers, wage, chances of promotion, opportunities to use skills and talent, job security, etcetera (Warr, Cook, & Wall, 1979). Previous research has indicated that important job aspects for people with impairments and activity limitations are the physicality of the job, the relationship with supervisors and training opportunities (Baumberg, 2014; Pagan, 2014). For future research it would be opportune to be able to look into the satisfaction with different job aspects.

5.2.2 Impairments

Despite the wider acceptance of a social models of disability, social surveys that aim to measure the proportion of a given population that is disabled and to examine what this means for their living situation tend to be oriented towards medical understandings of the concept (Hvinden, 2009). Typically, they inquire whether people have any longstanding (limiting) illness, physical or mental health problems, activity limitations, impairments or even "disabilities". These questions suggest that people who have an impairment or who are restricted in functioning are always disabled. Information about the individual's relationship with his or her physical, social and organizational environment must be ascertained from other questions not related to the impairment and the difficulties that may be experienced as a result.

The use of these medical model-oriented survey questions on disability might seem erroneous in a dissertation guided by a social-relational conceptualization of disability. In accordance with the Academic Network of European Disability Experts (ANED) (Van Oorschot et al., 2009), I consider those questions “disability identification questions,” because they ask about the respondent’s health and disability status, and could be used to distinguish self-reported disabilities from self-reported non-disabilities. As such, I regard those questions about whether impairments or experiences in restrictions in everyday life to be a screening device to identify people who may be prone to disabling processes.

Table 4: Overview of the dependent and independent variable at the individual level per study

	1	2	3
Dependent variable			
Subjective health	Self-rated health (metric - 1 item)		
Well-being		WHO-5 (metric)	Job satisfaction (metric - 1 item)
Impairment-related variable			
Impairment		Long-standing health problem	
Activity limitations	At least 1 severe activity limitations out of four options (categorical - Witvliet et al., 2012a)		GALI
Other independent variables			
Employment status	Categorical (11 groups)	Categorical (3 groups)	
Job classification			ISCO-job group dummies
Employment relation			Categorical (4 groups)
Employee involvement			Metric (1 item)
Job control			Metric (1 item)
Voluntary work		Categorical (3 groups)	
Education	Categorical (3 groups)	Categorical (4 groups)	Metric
Marital status	Categorical (4 groups)	Categorical (4 groups)	Categorical (4 groups)
Income	Household wealth index (metric – outcome of PCA)	Average household income (metric - imputed)	Financial difficulties (categorical – 2 groups)
Gender	Categorical (2 groups)	Categorical (2 groups)	Categorical (2 groups)
Age	Metric	Metric (+age^2)	Metric
Social support		Categorical (2 groups)	
Housing		Categorical (2 groups)	

The WHS survey used in Study 1 provides a considerable amount of information on a person’s health status. To enhance comparability of research findings, we based our work on Witvliet and colleagues (Witvliet, Kunst, Arah, & Stronks, 2013; Witvliet et al., 2012a, 2012b) to gain insight about people who are prone to disabling processes. Witvliet and colleagues were among the first to use the World Health Survey to examine the social inequality in disability from a global perspective, simultaneously looking at both higher and lower income countries. Their approach incorporated measurement of functional problems with vision (recognizing a person across the street), cognition (concentrating or remembering things), self-care (such as washing or dressing) and mobility (moving around) experienced within the 30 days before the survey. Possible response categories were "none" (1), "mild" (2), "moderate" (3), "severe" (4) and "extreme or cannot do" (5). If a person indicates at least one severe or extreme problem, she or he was labelled as "disabled". As a result, a dichotomous measure was constructed. Nonetheless, I am aware of other possibilities and the limitations of this particular operationalization measure. Indeed, the use of a continuous measure would permit me to examine the distribution or degree of activity limitations experienced. Although I did consider using a dimensional approach instead of a categorical approach, I finally opted not to do so, because such an approach also has its limitations. At the conceptual level, summing the item scores with a resulting variable ranging from 4 (no problems) to 20 (four extreme problems), would suggest measuring a condition ranging from "having no problems at all" to "having four extreme problems". Although the minimum and maximum values of this measure signify clearly delineated conditions, the values between these extremes do not. To give a concrete example: person A with one severe problem but no other problems will have a score of 7; person B with four mild problems will score 8 on this variable. However, can we assume that person B is more disabled than person A, who has only one but yet extreme problem? In my opinion, we cannot assume a gradual and linear increase in disablement in this variable. In other words, this measure does not fulfil the requirements of a continuous ratio scale variable. Moreover, the construction of this summed scale also assumes that the four items measure one latent construct. As the problems with scoring already indicate, I could not presume that the four items measure the underlying concept of disability. Additionally, the Cronbach's alpha of the four items, a test for internal consistency, was poor or unacceptable in most countries. Alternatively, I could presume that people who have at least one severe or extreme problem are more likely to be disabled than people who do not have a severe or extreme problem. The use of this variable gives us the possibility of making statements about a well-delineated group.

In the EQLS and ESS, the data on health and disability is more limited. Their questions are based on the Minimum European Health Module (MEHM) as proposed by the EU to ensure a minimum of disability-related statistics. The MEHM consists of three general questions that look into three different aspects of health: self-perceived health, chronic morbidity or longstanding health problems, and activity limitations or the presence of longstanding activity limitations due to health problems measured via the Global Activity Limitation Indicator (GALI). GALI is an instrument that identifies subjects, both in general and specific populations, who perceive themselves to have longstanding, health-related limitations in usual activities (van Oyen, Heyden, Perenboom, & Jagger, 2006). Depending on the dataset, the specific indicators identifying people with longstanding health problems or activity limitations differ in their articulation. In the EQLS, the following question is asked: "Do you have any chronic (longstanding) physical or mental health problem, illness or disability? By chronic (longstanding), we mean illnesses or health problems that have lasted, or are expected to last, for six months or more." Respondents could answer via a binary scale, indicating yes or no. In the ESS, the respondents are asked a question referring to activity limitations: "Are you hampered in your daily activities in any way by any longstanding illness, or disability, infirmity or mental health problem? If yes, is that a lot or to some extent?" To answer, they could choose "No", "Yes, to some extent" and "Yes, a lot". In the final analyses of Study 3, I opted to construct a binary variable that combined the two "yes" categories to avoid power issues in the last group.

As a consequence, these datasets do not allow me to distinguish between different types of chronic illnesses or impairments. Crucial distinctions might be related to the difference between congenital and acquired impairments, visible and invisible conditions or physical and psycho-social ones. The data only provides the information that people have already had their impairment or activity limitations for at least six months. As a consequence, the onset and duration effects will be masked in my analysis. The six month barrier could potentially indicate that the largest declines in subjective well-being and subjective health are already over, though this is only speculation. If I assume to have a mixed group of people with acquired and congenital impairments in the datasets, this indicates that the association of impairments and subjective well-being is probably weaker in my studies.

The difference in adaptation between congenital and acquired impairments in terms of well-being also made me ponder what the difference would mean with regard to social exclusion. On the one hand, based on the adaptation theory, one could say that people who are born with their condition have had more time to find their way around than people with an acquired condition. This assumption, however, would ignore that people who are born with impairments might accumulate disadvantage over time and are likely to go through various social exclusionary processes from an early stage (Priestley, 2003). This refers to living in a household with a lower income, as parents (and more specifically mothers) might opt out of work to take care of their impaired child (Hope, Pearce, Whitehead, & Law, 2017), interrupted schooling and education, disparate vocational training, being stigmatized, etcetera. On the other hand, however, we also know that people who acquire an impairment are also more likely to be disadvantaged before its onset (Jenkins & Rigg, 2004; Lindholm et al., 2002). Not having educational classifications and not being in paid work might select people into chronic conditions, as both are associated with a higher chance of acquiring an impairment. In addition, the onset of an impairment is also associated with marked declines in the likelihood of being in paid work and income (Jenkins, 1991; Jenkins & Rigg, 2004; Lindholm, Burstrom, & Diderichsen, 2001). On top, the longer the duration of the impairment, the harder it tends to be to get back into employment (Lindholm et al., 2002). So, while people who acquire an impairment at a later point in time might go through different processes than those who are born with it, both groups are likely to experience a myriad of social exclusionary processes that are detrimental for subjective health and well-being. I therefore conclude that while having more information about the onset would certainly lead to more fine-grained analyses, there is, however, enough common ground to take the groups together.

Furthermore, the measurements do not give insight into what kind of physical or psychosocial conditions are in the sample. So far, studies have shown that ,in early adulthood, answers to questions on chronic illnesses are strongly associated with specific and serious conditions like epilepsy, cancer, diabetes and heart conditions and, more weakly, with less serious conditions such as eczema and hay fever (Manor, Matthews, & Power, 2001). Among older people, Ayis, Gooberman-Hill, Ebrahim, et al., (2003) indicate longstanding illnesses are strongly associated with respiratory, cardiovascular diseases and musculoskeletal disorders. In both groups, indeed, physical conditions seem to be more strongly associated with a positive answer on a longstanding illness or impairment question than mental and psychosocial conditions (Cohen, Forbes, & Garraway, 1995). However, as mental and psychosocial conditions like depression and burnout are among the main contributors to morbidity and mortality today (WHO & WorldBank, 2011), they might also become visible in the samples of these studies.

5.3 Analysis methods

5.3.1 Multilevel regression analysis

In the three first empirical studies, the research questions relate to the influence of context. A quantitative approach was needed to grasp how micro-level relations are affected by institutional and societal contexts. Additionally, I needed an analytical technique that was able to consider the hierarchical structure of the datasets. Because the sampling of individuals took place within countries, the clustering of individuals within countries needed to be considered. Given my research interest and the data, I chose to perform multilevel regression techniques (Hox, 2010) with the statistical software package MLwiN.

Multilevel analyses expressly consider cases that are nested in higher-level units. In this dissertation, individuals are clustered within countries. This implies that they are not completely independent from each other. Individuals living in the same country may be more similar to each other (because of shared history or because of the organization of the welfare state, for example) than to individuals living in other countries. As a result, the average correlation between variables for individuals from the same country might be higher than for individuals from different countries. If this clustering is not accounted for, the assumption of independence of observations (or more specifically, the assumption of uncorrelated residuals) is violated. This may result in an underestimation of the standard errors in single-level regression techniques. In this kind of analyses, each case is treated as an independent piece of information. When outcomes are clustered, however, the effective sample size (cases that bring in new, independent information) is smaller. In multilevel analyses, standard errors are calculated differently to avoid spurious significant results.

In addition, multilevel techniques are specifically designed to simultaneously model the statistical effects of variables at different levels while properly including the various dependencies. In my studies, I variables at the individual level as well as at the country level. Moreover, I also wanted to understand the possible moderating impact of context variables on individual-level relationships. Multilevel modelling enables testing this via the addition of cross-level interaction terms in the analyses. Not only does the technique provide insight into the significance of a certain societal or institutional context, it also explicitly estimates how the variance in the outcome is distributed among different levels. In this dissertation, this means the variance is divided into two components: the between-group variance, showing the differences between countries, and the within-group between-individuals variance, showing the differences between individuals within a country. This division makes it possible to calculate what proportion of the total variance in the outcome is due to differences between countries. In the three multilevel papers, I performed multiple linear regression analyses since the variables were constructed in a metric way. The corresponding assumptions were tested in the analyses. For Study 1, in which self-perceived health is the dependent variable, logistic regressions for dichotomous outcomes were also executed; it did not affect the outcome or the conclusions of the study.

5.3.2 Fuzzy-set ideal type analysis

In the fifth study, I examine disability policy at the country-level in Europe. This led to a small sample size, which has repercussions for the use of standard statistical techniques. Comparative welfare state researchers employ a range of different techniques to compare social policy institutions across countries that include cluster analysis, multiple classification analysis and, increasingly, fuzzy-set ideal-type analysis. Each approach has advantages and disadvantages that one needs to consider before beginning the analysis. Based on a review of articles on the different techniques, the aim of my study and the data that was available at the time of the study, I opted for a fuzzy-set ideal-type analysis (FSITA).

FSITA is an approach that originated in qualitative comparative analysis (QCA) (Kvist, 2007; Ragin, 1987, 2000) in which cases—in this dissertation, countries—are seen as configurations of multiple dimensions. In fuzzy-set methods, the researcher first defines the key aspects (or "sets" in the QCA language) of the multidimensional concept under scrutiny. Then the degree to which a case adheres to a given set is expressed by calculating the set membership score. Membership values fall between 0 and 1, where 0 indicates that a case does not adhere to the aspect at all ("fully out of the set") and where 1 indicates that a case completely aligns with it ("fully in the set") (Kvist, 1999). A value of 0.5 is considered the crossover point (or point of maximum ambiguity) where the case begins to move from being more out of to being more in the set. The set membership score is primarily defined based on substantive and theoretical knowledge of the investigated aspect. Fuzzy-set methods let researchers consider how empirical data relates to the theoretical concepts and to define qualitative breakpoints in the sets. Nevertheless, fuzzy-set theory challenges the assumption that all variation is meaningful (Ragin, 2000), as values below or above a qualitative breakpoint may not indicate substantial differences. By logically combining the main dimensions (sets), the researcher constructs a multidimensional property space that includes all logically possible combinations. Where k is the number of aspects, 2k denotes the number of possible ideal-type locations in the property space, although not all need to be theoretically (Ciccia & Verloo, 2012). By combining the set membership scores, the researcher can determine each case's adherence to the overarching ideal types. Two key principles are employed to achieve this goal: the minimum principle and the principle of logical negation in fuzzy-set theory (Ragin, 2000). The latter principle indicates that a case is only a member of a set to the extent that it is not a member of the negated set. If a case scores 0.70 on "adequate' income support", its score on "no adequate income support" will be 0.30. The former principle denotes that the membership score is equal to the case's minimum score on the involved dimensions in the ideal type. The score is the lowest value on the dimension measuring for the ideal type. On the one hand, a FSITA leads to a classification of cases as qualitatively distinct types. It provides a view of differences in kind. Given the use of fuzzy sets that go from 0 to 1, however, FSITA also provides insight into differences in degree within a same ideal type.

I consider FSITA appropriate for analysing disability policies, as several dimensions can be considered simultaneously without neglecting their distinctness. It overcomes the compensation effects present in statistical analyses that rely on averages or indices. If a country is stronger in one area, this cannot compensate it weakness in another area (Hudson & Kuhner, 2012, 2013), as every aspect is evenly important to define a country's adherence to a certain strategy or ideal type. It can handle both quantitative and qualitative types of data, as it is the researcher's job to define to what extent the data reflects the theoretical concept under scrutiny. Given the limited availability of comparative data on disability policy, the need to combine different sources and kinds of data was necessary for practical reasons. As such, FSITA is an appropriate method for categorising cases that allow for a precise operationalization of concepts based on a variety of data. Nonetheless, the technique also has its drawbacks. The lack of statistical interference that indicates the best fitting models, and the sensitivity of the calibrations on the cut-off points can be debated. As with all kinds of analyses, it is important for a researcher to be open and clear about the possible different outcomes and how they affect the conclusion.

5.4 Descriptive analyses

Before going into part 2 of this dissertation, I shortly provide additional descriptive information on the datasets that is not included in the individual chapters. In table 5, the percentages of people with and without impairments or activity limitations are presented for each survey. Of the EQLS dataset, I used a question that gives insight into the presence of impairments, without enquiring whether the condition limits the person's activities. In the other datasets, the question was focused on conditions that limited the respondents' activities. Based on these datasets, the percentages of people with an impairment is higher than the percentage of people with activity limitations. The percentages of people with activity limitations in the WHS and ESS surveys are relatively equal.

Table 5: Percentages of people with and without impairment or activity limitation

		No impairment	**Impairment**
EQLS	2011-2012	74,2	25,8
		No activity limitation	**Activity limitation**
WHS	2002-2004	88,6	11,4
ESS	2012	84,6	15,4

Both study 2 and 3 contain the results of descriptive analyses within the paper. Therefore table 6 only presents additional descriptive and bivariate statistics of study 1.

Table 6: Descriptive and bivariate results of the sample by activity limitations, WHS 2002-2004

	No activity limitations	**Activity limitations**	**Significance**
Subjective health (mean - SD)	3,89 – 0,83	2,93 – 0,99	***
Gender (%)			***
Male	45,4	36,3	
Female	54,6	63,7	
Education (%)			***
Lower	50,9	71,4	
Middle	41,5	24,5	
High	7,7	4,1	
Labour market position (%)			***
Government employee	8,1	3,4	
Non-government employee	14,8	6,3	
Employer	1,3	0,8	
Self-employed	31,6	25,9	
Homeworker	24,3	24,6	
Volunteer	0,6	0,6	
Student	3,9	1,4	
Retired	7,4	22,6	
Unemployed due to sickness	1,0	7,7	
Unemployed due to not finding work	4,8	3,9	
Missing status	2,4	2,9	
Marital position (%)			***
Married or living together	67,7	61,6	
Never married	19,7	10,1	
Divorced	5,5	6,7	
Widowed	7,1	21,7	
Age (mean - SD)	39,59 – 15,76	52,59 – 19,01	***
Household wealth index (mean - SD)	0,03 – 1,00	-0,24 – 0,95	***
Total N	189310	24454	

*=p<0,050; **=p<0,010; ***=p<0,001 - Anova-test for metric variables, Chi-square test for categorical variables

In the WHS, people with activity limitations tend to estimate their health significantly lower than people without activity limitations. 64% of the people with activity limitations are women, and the group also consists of a high number of people who are unemployed or retired. The composition of the group of people with activity limitations compared to that of those without activity limitations also varies with regard to age, marital positions and income. They are on average lower educated, more likely to be living in a less wealthy household, more likely to be widowed and older. These descriptive observations are in line with the observations based on the other surveys (see chapter 7 and 8).

Part 2: Research papers

Chapter 6

Study 1. Do welfare regimes influence the association between activity limitations and self-perceived health? A multilevel analysis of 57 countries

Based on Foubert, J., Levecque, K., Van Rossem, R., & Romagnoli, A. (2014). Do welfare regimes influence the association between disability and self-perceived health? A multilevel analysis of 57 countries. Social Science & Medicine, 117, 10-17[1]*.*

Abstract

Disability is usually associated with poorer self-rated health. However, as many people who are disabled do not consider themselves unhealthy, the association may not be as straightforward as it appears. This study examines whether the relationship between activity limitations and self-rated health is dependent on a country's welfare regime. Welfare regimes can play a significant role in securing the needs of disabled people and lessening their social exclusion. However, welfare regimes also label disabled people accordingly, before they become entitled to specific provisions and services. Being given a low status label and being dependent on welfare provisions might trigger a negative self-evaluation of health. Using data from 57 countries of the World Health Survey of 2002-2004, the multilevel regression analyses show that people with activity limitations tend to rate their health worse than people without any activity limitations. Moreover, the strength of this negative association varies significantly across countries and is affected by a country's welfare regime. The association is the strongest in the various Welfare State regimes (mostly European countries) and the weakest in Informal-Security regimes (Latin-American and Asian countries) and in Insecurity regimes (African countries). People with activity limitations living in Welfare States regimes tend to rate their health worse than people in other regimes. These findings confirm that welfare regimes play a role in shaping the health perception of disabled people and that processes of labelling may result in unintended and negative consequences of welfare programs. Research on the nexus between disability and self-rated health that neglects this macro-social context of welfare regimes may lead to undifferentiated and even incorrect conclusions.

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[1] Compared to the rest of this dissertation, this study is based on the WHO framework in its understanding of disability. It was the first paper I wrote in the context of this PhD, while my understanding of disability still was evolving. As such, in this paper, disability equals activity limitations, that are the result of the interaction of bodily conditions and social, contextual factors. This does acknowledge the limitations might also results from social exclusionary processes within the environment people live. In this study, however, I look into whether also their subjective health can be socially 'disabled', which can be framed within the sociological understanding of 'being disabled' used in this dissertation.

Introduction

Although impairments and disability are risk factors for a poorer self-rated health and well-being, many people with a disability report a good quality of life (Albrecht & Devlieger, 1999). Previous articles have focused on psychological resources and social support to explain these findings (Albrecht & Devlieger, 1999; Cott et al., 1999). In this article, we examine the impact of a country's welfare regime on the association between disability and self-rated health based on data from the World Health Survey (2002-2004). We argue that welfare arrangements are not only determinants of population health (see e.g. Eikemo & Bambra, 2008), but also influence the relationship between disability and self-rated health. On the one hand, welfare regimes might have policies for people with disabilities to attain an acceptable and healthy standard of living. On the other hand, the implementation of such policies and an individual's entitlement to provisions and services depend on prior labeling as 'disabled'. A better understanding of the link between disability and self-rated health may lead to better informed health promotion strategies for people with disabilities and the population in general (Cott, Gignac, & Badley, 1999).

In the following sections we review existing literature on disability and self-rated health and elaborate on why welfare regimes might affect their interrelation. Two hypotheses are outlined. After the description of the analyses, the findings are discussed.

Background

Disability and self-rated health

Almost everybody will experience difficulties in functioning at some point in their life (World Health WHO & WorldBank, 2011; Zola, 1989). In 2011, the World Report on Disability estimated that about 15 percent of the world's population, approximately one billion people, have a moderate or severe disability (World Health WHO & WorldBank, 2011).

According to the International Classification of Functioning, Disability and Health (ICF) (WHO, 2001), disability refers to difficulties encountered in human functioning. It arises from the interaction of a person's health condition with contextual factors, such as the built environment, but also social relationships and policies (Fellinghauer et al., 2012; WHO, 2001) and refers to problems in body functions or structures, difficulties in performing activities such as walking or eating, or problems with involvement in any area of life, for example discrimination in the labor market.

A number of studies found that disability is associated with poorer self-rated health (Cott et al., 1999; Debpuur, Welaga, Wak, & Hodgson, 2010; Drum, 2008). The latter has been identified as an important predictor of mortality (Idler & Benyamini, 1997; Jylha, 2009), morbidity (Latham & Peek, 2013) and health care use (Miilunpalo et al., 1997). It is an inclusive concept, not linked to a specific medical condition, and covers physical, mental and social aspects of health (Idler et al., 1999). It can be seen as summary statement, in which various aspects of health are combined (Jylha, 2009; Tissue, 1972). Nevertheless, disabled people do not always tend to see themselves as unhealthy (Cott et al., 1999). The Australian National Health Survey of 2007-2008, for example, concluded that approximately 40 percent of people with a severe impairment perceived their health as being good, very good, or excellent (Australian Bureau of Statistics, 2009). This is in accordance with the disability paradox, or the finding that many people with profound disabilities report a high quality of life, while observers think they live an undesirable daily existence (Albrecht & Devlieger, 1999).

Previous research has explained this finding by means of balance theory framework, pointing to the importance of an equilibrium between body, mind, and spirit (Albrecht & Devlieger, 1999) and psychological factors such as self-esteem (Cott et al., 1999) for a good self-rated health. The strength of social support should also not be neglected in preventing poor self-rated health for impaired people (Albrecht & Devlieger, 1999; Fellinghauer et al., 2012).

Although we acknowledge the strengths of these explanations, in this paper we focus on the broader socio-political context of the welfare regime. Many studies show that country characteristics and welfare policies, in addition to personal characteristics and intrapersonal relationships, explain a substantial part of the variations in socio-economic inequality in health and disability across countries (Beckfield & Krieger, 2009; Bergqvist et al., 2013; Chung & Muntaner 2006; Coburn, 2004; Levecque et al., 2011; Witvliet et al., 2011; Witvliet et al., 2013; Witvliet et al., 2012a). With regard to welfare regimes, the underlying assumption is that these not only affect socio-economic positions, but also health, as they mediate the health effects of socio-economic positions by providing sufficient and affordable (health) services and cash benefits (Bergqvist et al., 2013; Levecque et al., 2011).

Welfare regimes may affect the association between disability and self-rated health through two competing mechanisms. The first concerns the role of welfare policies for people with disabilities in helping them attain an acceptable and healthy standard of living. The other concerns the consequences of labeling people as ‘disabled’ before they become entitled to various provisions and services.

Welfare provision and services

People with disabilities are more likely to experience worse educational and labor market outcomes and to be poorer than people without disabilities (WHO, 2011). Through a range of programs and services, countries can buffer the detrimental outcomes for people with disabilities and thereby improve their quality of life. Historically, disability was one of the first risks covered by social insurance (Van Oorschot & Hvinden, 2000) and by the mid-1990’s, 163 countries had statutory disability social security programs (Dixon & Hyde, 2000). The comparative assessment of design features of these programs published by Dixon and Hyde (2000) showed that Australia and Western European countries had the best designed social security program. Brazil and Nicaragua also performed well, while Ireland, the UK and Slovenia performed rather poorly. Although social insurance and supplementary cash transfers are important means to improve the standard of living of disabled people, other significant tools are found in healthcare services, as well as in labor market and anti-discrimination policies. Independent living programs and personal assistance with care are other examples through which welfare regimes can enhance disabled people’s participation in society. However, many variations exist in national disability policies (Dixon & Hyde, 2000; OECD, 2010). One way of taking this diversity into account is by looking at welfare regimes, as programs and services dealing with disability tend to map onto the broader socio-political context of the welfare regime (van Santvoort, 2009).

Although most existing welfare regime studies tend to be restricted to Western states, in this study we expand the focus to countries in other continents by applying the typology of Wood and Gough (2006). Because the state and markets in non-Western countries prove inadequate to realize an acceptable standard of living, citizens rely to a greater extent on informal, and most likely hierarchical and even clientelist relations. Therefore, Wood and Gough complemented the ‘de-commodification’ axis put forward in the welfare state typology of Esping-Andersen (1990) with the axis of ‘de-clientalization’. While de-commodification refers to the degree to which a person can maintain an acceptable standard of living without participation in the market, de-clientalization refers to the extent to which informal relationships are characterized by unequal patron-clientelism and the need to establish more formal and universal rights to welfare and security.

Wood & Gough specified three main types of welfare regimes. The first main one is the Welfare State regime. Based on Esping-Andersen (1990), Wood and Gough (2006) distinguish three subtypes: Social-Democratic, Conservative, and Liberal welfare states. In these countries a more secure climate prevails, as welfare arrangements are provided by the state. Social-Democratic countries are characterized by a relatively generous benefits and coverage, broad (labor market) integration policies and legislation based on citizenship (van Santvoort, 2009). Conservative welfare states have relatively accessible and generous benefits, and quite developed employment programs, but not at the level of the Social-Democratic states. In the Liberal countries, the labor market plays a key role in securing the needs of disabled people, as securing an acceptable standard of living is assumed to be accomplished through paid work (Harris et al., 2012).

In our study, we follow others (e.g. Ferrera 1996; Levecque et al., 2011) by distinguishing Bismarckian and Southern European welfare states within the subgroup of Conservative countries. The welfare policy of Southern European countries is characterized by an emphasis on (highly fragmented) income maintenance programs and a central role for the family in the provision of support (Ferrera, 1996; Pinto, 2011). With regard to disability in particular, there seems to be a heavy workload for family members, as the formal support services for people with a disability are limited (Pinto, 2011). In addition to subdividing the Conservative welfare state regime, we add a fifth welfare state regime type, namely the post-communist countries of Eastern Europe. Following the demise of the universalistic communist welfare state in the 1990s, these countries underwent intense economic and social reforms. The political and social changes did not bring positive changes to the quality of life of disabled people in general (Ursic, 1996). Although all these countries formulated policy lines that conform to the EU objectives of inclusion, they have only started to develop disability policy in recent years (van Santvoort, 2009).

Despite between-regime and within-regime differences, all welfare states grant disabled people equal rights to participation in society (Harris et al., 2012). All Welfare States are characterized by a state-led mediation of the effects of disability by the supply of various facilities, that makes it possible for people with a disability to live an acceptable standard of life and to participate in society.

The second main type of welfare regime is the Informal Security regime in which people rely heavily on informal, community and family relationships to satisfy their needs (Wood & Gough, 2006). These relationships are mostly hierarchical and asymmetrical, but result in some form of (informal) security. Wood and Gough identified three subtypes: 1) the

Liberal-Informal regime of Latin-America, where both public and private institutions substitute for the social welfare; 2) the Productivist regime of East Asia, in which there is also a combination of formal and informal ways to fulfill basic needs but historically less exclusion from social benefits; and 3) the South Asian regime that is characterized by the highest insecurity of the three types, as people are highly dependent on informal relationships and state-allocated benefits are limited. Subsequent to the United Nations Decade of Disabled Persons (1983-1992), the Asia- Pacific region was the first to launch its own decade (1993-2002). The aim of the program was to expand the opportunities for people with a disability to participate in society and to improve their quality of life (Price & Takamine, 2003). While progress has been made, detailed evaluations show that most countries started off from such a low baseline that the positions of disabled people in these countries still needs to be greatly improved. The same applies to the Latin-American countries. Although the Organization of American States launched the Inter-American Convention on the Elimination of All Forms of Discrimination Against Persons with Disabilities to foster the inclusion of disabled people throughout all aspects of society in 2000, researchers have concluded that policy implementation and law enforcement remain inadequate or even non-existent (Dudzik et al., 2001).

The final main type of welfare regime identified by Wood and Gough is the Insecurity regime. It can be characterized as the most fragile of the regimes, as powerful (external) players generate conflict and political instability. Because this unpredictable environment undermines stable patterns of informal relationships within communities, personal safety is constantly at issue. To fulfill basic needs, citizens depend heavily on external organizations, as the weak governments provide little assistance (M. I. Witvliet et al., 2011; Wood & Gough, 2006). This results in a vicious circle of suffering and insecurity for most of the population and in particular for people living with a disability. Although the African Decade of Disabled Persons (1999-2009) raised awareness about disability, people with a disability remain the poorest of the poor, least educated and least likely to be active in the formal labor market (African Union, 2008). Moreover, most disabled people have barely any access to health care, which results in severe health conditions and an overall deterioration in their quality of life.

Consequences of being labeled as disabled

Other researchers take a more critical stance regarding welfare policy (Finkelstein, 1991; Gleeson, 1999; Oliver, 1990; Priestley, 2010). On the one hand, they acknowledge the importance of welfare state provisions to satisfy the needs of people with a disability, but on the other hand, they also emphasize the structuring role of the welfare state in creating norms about how people should function in society and the production of social exclusion.

Olafsdottir and Beckfield (2011:110) argue that, “the social organization of welfare is a cultural institution that provides individuals with the overarching understanding of how the world works”, which, includes an overall national understanding of health and illness, and of how to function in society in general. Therefore, by providing various facilities to assist disabled peoples, Welfare States create social norms about good health and functioning in society. Welfare arrangements are offered in order to make it possible for disabled people to meet these standards. The paradox of equal opportunity and anti-discrimination disability policies is, however, that if disabled people want to make use of these facilities they first have to be identified as such (Marin, 2004). In other words, people who experience difficulties with functioning first have to be labeled as ‘disabled’ or ‘having a problem’ before the government and social organizations can take steps to help them to function in a manner consistent with the societal standard.

An unintended consequence may be that these persons get the feeling they deviate from the societal norm and perceive themselves as being not as healthy as other people. This labeling may impose (perceived) inferiority and trigger stigmatization (Goffman, 1963; Link & Phelan, 2001). Being dependent on welfare provisions to function in society and the social comparison with people without disability may thus lead to worse self-rated health, as people may integrate these inferior conceptions in their identity (Blumer, 1969; Lemert, 1972; Mead, 1934).

In many of the Informal Security and Insecurity regimes the state lacks power, authority, and legitimacy (Wood & Gough, 2006). People in general, including disabled people as well, search for other ways to fulfill their needs. Therefore, other sub-national structures such as households, community, markets, and also supra-national organizations (e.g. international non-governmental organizations) represent other loci of power and are recognized as legitimate institutions. This reduces the capacity of a state to act in open, democratic ways (Wood & Newton, 2005:16) and to design a universal disability welfare policy.

As there is to a lesser extent a government apparatus that tries to inform its citizens and make them sensitive to issues about health and disability in general, it could be that disabled people do not perceive themselves as having an inferior status, deviant from the societal norm. The lack of social organization of disability welfare schemes may lead to a weaker link between disability and self-rated health status.

Hypotheses

Based on the foregoing studies, we hypothesize that disabled people will rate their health worse than non-disabled people, and that the strength of this association will vary across welfare regimes. On the basis of the perspective focusing on the role of welfare policies in helping people with a disability to attain an acceptable standard of living, hypothesis 1 expects that disability has the weakest influence on self-rated health in the Welfare State regimes, because of the comprehensive provisions and facilities for disabled. Due to the fewer disability provisions, we expect a stronger negative association between disability and self-rated health in the Informal Security regimes, but because of the generally poor living conditions we expect to find the strongest negative link in the Insecurity regimes (hypothesis 1).

The labeling paradigm leads to a second hypothesis that contradicts the first one. More specifically, it suggests that the negative association between disability and self-rated health is strongest in the Welfare State regimes, as a consequence of the dependence on welfare provisions, the labeling as disabled, and the imposed inferiority this may induce. Hypothesis 2 thus expects that disabled people have the worst health perception in the Welfare States. The negative association will be weaker in Informal-Security regimes as the welfare provisions for disabled people are less developed and the weakest in the Insecurity regimes, due to the least developed or even completely lacking disability policy that may induce labeling.

Data and methods

Data

We analyze individual-level cross-sectional data from the World Health Survey (WHS), gathered between 2002 and 2004 in 70 countries selected to represent all the regions of the world. A detailed description of the sampling design, data gathering and response analysis can be found elsewhere (Ustün, Chatterji, Villanueva, et al., 2003; WHO, 2013a). In most countries, a multi-stage cluster sample was drawn, representative off the general adult population. Households were the primary sampling units, but only one individual per household was randomly selected to respond to the survey. National household response rates range from 50 percent in Slovenia to 100 percent in several other countries. The Czech Republic stands out as an exception with a response rate of 24 percent. Because some countries included in the WHS do not unambiguously fit the welfare regime typology outlined above, they are omitted from the analyses

(Kazakhstan, Georgia, Russia, Turkey, Israel, Morocco, Tunisia, and the United Arab Emirates). Because of their small sample sizes Mauritius and the Comoros are excluded as well. Three countries had more than 15 percent non-response on the self-rated health indicator and were excluded: Ireland, Slovakia and Swaziland. As a result, our study includes data for 57 countries (see Appendix 2 for a full list of the countries). Only respondents aged 18 or above and without missing values on the variables are included. This results in a sample size of 213.764 individuals.

Variables

Self-rated health was measured by asking "In general, how would you rate your health today?". Response categories range from "very bad"(0) to "very good" (5). An introductory phrase mentioned that one's general health includes both physical and mental health.

To operationalize disability we follow Witvliet et al. (2012a). Respondents were asked whether during the 30 days prior to the survey they had experienced any difficulties with mobility ("moving around"), self-care ("washing or dressing yourself"), cognition ("concentrating or remembering things") and vision ("seeing and recognizing a person you know from across the road"). Response categories are: "none" , "mild", "moderate", "severe" and "extreme or cannot do". Respondents whose answers included at least one "severe" or "extreme" problem are classified as 'disabled'. Although a dichotomous variable reduces the available information, we opted for such operationalization, as alternative approaches present other problems. For example, a continuous measure could be computed by summing the item scores. This would suggest we measure a condition ranging "having no problems at all" to "having four extreme problems". Although the minimum and maximum values of this measure signify clearly delineated conditions, the values between these extremes do not, as a same score can be obtained in several ways. For instance: person A with one severe problem, but no other problems, will have a score of 7, while person B with four mild problems will score 8 on this variable. However, can one assume that person B is more disabled than person A? Moreover, such a scale assumes that the four items measure one latent construct. As the problems with scoring already indicate, this cannot be assumed, which is further confirmed by a low internal consistency in most countries as indicated by a low Cronbach's alpha.

Individual-level controls are gender (0= female, 1= male), age (in years), educational level (lower, middle, high), labor market position (government employees, non-government employees, employers, self-employed, homeworkers, volunteers, students, retired people, unemployed people due to sickness, and unemployed people due to not finding work) and a household asset-index attribute. The WHS includes 19 indicators measuring household wealth, e.g. the number of rooms in the home, and the possession of durables such as a telephone or a refrigerator. The indicators are different for low and high income countries, and countries were able to add country-specific assets (for detailed information see (WHO, 2013b)). Questions about the number of assets in the home are dichotomized. The missing values for respondents with five or fewer missing values are set to zero (=‘do not possess’). The household asset-index was then computed for each country separately by means of a principal components analysis, as suggested by Filmer and Pritchett (2001).

We define three main types of welfare regimes and nine subtypes in total. We distinguish five Welfare States: Social Democratic, Bismarkcian, Liberal, Southern and Eastern European welfare states. In line with Wood and Gough, we distinguish three subtypes of Informal-Security regimes, namely Liberal-Informal, Productivist and South Asian welfare regimes and one Insecurity regime (see Appendix 2 for the distribution of the countries). As the economic prosperity of a country provides the necessary basis for the organization of living conditions (Fritzell & Lundberg, 2005) and is linked with population health (Beckfield, 2004; Olsen & Dahl, 2007), we also include the natural log of gross domestic product per capita (GDP/cap) (WorldBank, 2012). Because we did not find a valid measurement for the GDP/cap of Myanmar, this country is excluded in the estimations containing GDP/cap.

Statistical procedure

Due to the multi-country sampling design and the nature of the dependent variable, we use multilevel linear regression techniques. Metric variables are grand-mean centered. First, we estimate the fixed effects of the individual-level variables and the welfare regimes on self-rated health. Then, we estimate random-slope models to examine whether the effect of disability on perceived health shows significant cross-national variation. Subsequently, we add the interaction effect between disability and respectively welfare regimes and GDP/cap to estimate the impact of the welfare regime on the association between disability and self-perceived health. To assess the significance of the models, the deviances of the models are compared by means of a Chi-square test. A deviance indicates how well the model fits the data, and generally, the lower the deviance, the better the model fit (Hox, 2010). For the analyses, we use MLwiN (version 2.28) and IGLS-estimation.

Results

Multilevel analyses

Table 7 illustrates the main effects of the independent variables on self-rated health. Model 1 contains only the individual-level variables, Model 2 adds the welfare regimes. Model 1 shows that, other things being equal, people living with at least one severe activity limitation rate their general health on average 0.669 points worse than people without one. As for the other variables in the model, older people and women tend to have a poorer health perception. The same holds true for people who are lower educated, unemployed or living in a poorer household. We observe that 7.44 percent of the variance in self-rated health is attributable to country-level factors. With regard to the influence of the welfare regime on self-rated health, Model 2 shows that people in Southern European or Eastern European welfare states perceive their health worse than people living in Social-Democratic welfare states do. Inhabitants of other welfare regimes do not rate their health significantly different than people in Social-Democratic welfare states.

Table 7: Results of multilevel regression analyses of self-perceived general health (part one)

	Model 1		Model 2	
X	B	S.E.	B	S.E.
Fixed parts				
Intercept	4.080***	0.031	4.247***	0.091
Age	-0.010***	0.000	-0.010***	0.000
Gender (0=male)	-0.105***	0.004	-0.105***	0.004
Educational level (0=higher educated)				
Lower educated	0.143***	0.008	-0.143***	0.008
Middle educated	-0.098***	0.008	-0.098***	0.008
Labor market position (0= government employee)				
Non-government employee	-0.012	0.008	-0.013	0.008
Employer	-0.028	0.017	-0.028	0.017
Self-employed	-0.015	0.008	-0.015	0.008
Homeworker	-0.057***	0.008	-0.057***	0.008
Volunteer	-0.009	0.023	-0.009	0.023
Student	-0.022	0.012	-0.022	0.012
Retired	-0.159***	0.010	-0.159***	0.010
Unemployed due to sickness	-0.712***	0.015	-0.712***	0.015
Unemployed due to not finding work	-0.053***	0.011	-0.053***	0.011
Missing group	-0.107***	0.013	-0.108***	0.013
Marital status (0= married or living together)				
Never married	0.062***	0.005	0.062***	0.005
Divorced	-0.020*	0.008	-0.020*	0.008
Widowed	0.004	0.007	0.004	0.007
Household wealth index	0.043***	0.002	0.043***	0.002
Disability (0= no disability)	-0.669***	0.006	-0.669***	0.006
Welfare regime (0= Social-Democratic)				
Liberal			0.048	0.156
Bismarckian			-0.024	0.116
Southern European			-0.254*	0.128
Eastern European			-0.439***	0.110
Liberal-informal			-0.190	0.116
Productivist			-0.213	0.121
South Asian			-0.188	0.116
Insecurity			-0.102	0.101
Random parts				
Within countries variance	0.622***	0.002	0.622***	0.002
Between countries variance	0.050***	0.009	0.032***	0.006
VPC	7.44%		4.89%	
Deviance	505550.628		505525.337	
$N_{countries}$	57		57	
$N_{individuals}$	213764		213764	

Significance: *p<0.050; **p<0.010; ***p<0.001; For the fixed effects we used a t-test. for the random parts a Wald Z test.

Model 3 (Table 8) additionally estimates the cross-national variation in the effect of disability on self-rated health. The deviance of this model is significantly lower than that of Model 2 (^{2}=824.419; df= 2; p<0.001), and the significant random slope variance for disability indicates that the effect of disability on self-rated health varies significantly across countries. With regard to the welfare regimes, Model 3 shows us that only respondents from Eastern European Welfare States rate their health significantly worse than respondents from Social-Democratic welfare states. In fact, additional Wald tests (results not shown) indicate that respondents from Eastern European welfare states rate their health significantly worse than respondents from all the other welfare regimes except from those living in the Southern European welfare states. People living in the Southern European welfare states rate their health significantly worse than those from both the Insecurity regimes and Bismarckian welfare states. Other differences between the regimes are not observed.

In Model 4 (Table 8), the cross-level interaction between welfare regime and disability is added to the analysis, to test whether the welfare regime of a country moderates the effect of disability on self-rated health. This addition significantly improves the model fit (^{2}=27.695; df= 8; $p<0.001$) and decreases the residual random slope variance of disability by 42 percent (0.42= (0.036-0.021)/0.036) compared to Model 3. Disabled citizens of Social-Democratic welfare states tend to rate their health almost one point worse than people without a disability do. This also holds true for respondents from Liberal, Bismarckian, Southern European, and Eastern European welfare states. In other words, no significant differences in the effect of disability on self-rated health are observed between the various welfare states. However, the situation is different for other welfare regimes. We observe that for people in Liberal-Informal welfare regimes, the link between disability and perceived health is about half of that in the Social-Democratic regime (B= -0.957+0.421=-0.536). For people living in a Productivist (B=-0.957+0.309=-0.648), South Asian (B=-0.957+0.252=-0.705) or Insecurity regime (B=-0.957+0.251=-0.706) disability has a significantly lower negative effect on self-rated health than in the Social-Democratic countries. Having a disability entails a worse health perception in the Welfare States regimes than in other types of welfare regimes.

The final model (Model 5) adds the natural logarithm of GDP/cap and the interaction between this term and disability, to test whether the observed differences between the welfare regimes are not attributable to the economic development of the countries. The analysis shows that the association between disability and self-rated health is dependent on the country's GDP/cap. The significant interaction-term indicates that the higher a country's GDP/cap, the weaker the link between disability and self-rated health becomes. However, after controlling for the influence of GDP/cap, the differences in the strength of the effect of disability on self-rated health among the welfare regimes in Model 4 remain. We observe that people with disabilities living in Eastern European Welfare States will rate their health as better than people living in a Social-Democratic welfare state, but still worse than disabled people living in an Informal-Security or Insecurity regime.

Table 8: Results of multilevel regression analyses of self-perceived general health (part two)

	Model 3^a		Model 4^a		Model 5^a	
X	B	S.E.	B	S.E.	B	S.E.
Fixed parts						
Disability (0= no disability)	-0.749***	0.027	-0.957***	0.086	-1.162***	0.121
Welfare regime (0= Social-Democratic)						
Liberal	0.022	0.155	0.043	0.161	0.046	0.162
Bismarckcian	-0.007	0.116	-0.046	0.121	-0.045	0.121
Southern European	-0.248	0.127	-0.260	0.132	-0.249	0.135
Eastern European	-0.413***	0.110	-0.440***	0.115	-0.411**	0.138
Liberal-informal	-0.095	0.115	-0.237	0.120	-0.201	0.153
Productivist	-0.154	0.120	-0.250	0.125	-0.198	0.184
South Asian	-0.127	0.115	-0.222	0.120	-0.186	0.206
Insecurity	-0.053	0.100	-0.132	0.104	-0.070	0.191
Welfare regime x disability (0=Social-Democratic)						
Liberal x disability			-0.042	0.143	-0.018	0.137
Bismarckian x disability			0.125	0.114	0.135	0.109
Southern European x disability			0.059	0.119	0.112	0.115
Eastern European x disability			0.104	0.103	0.247*	0.115
Liberal-informal x disability			0.419***	0.106	0.589***	0.124
Productivist x disability			0.304**	0.111	0.551***	0.148
South Asian x disability			0.292**	0.105	0.544***	0.163
Insecurity x disability			0.249**	0.094	0.536***	0.153
Ln(GDP/cap)					0.015	0.038
Ln(GDP/cap) x disability					0.068*	0.030
Random parts						
Within countries variance	0.619***	0.002	0.619***	0.002	0.624***	0.002
Between countries variance	0.036***	0.007	0.034***	0.006	0.034***	0.007
Disability Random slope variance	0.036***	0.007	0.021***	0.005	0.018***	0.004
Deviance	504700.918		504673.223		492256.973	
$N_{countries}$	57		57		56	
$N_{individuals}$	213764		213764		207879	

*p<0.050; **p<0.010; ***p<0.001; For the fixed effects we used a t-test. for the random parts we used a Wald Z test. Notes a: These models also estimated the effects of gender. age. labor market position. educational level. marital status and household wealth. Because their coefficients generally stay equal. We do not report them for the clearness of the results.

Discussion

Consistent with other quantitative studies, we find that on average, people with one or more severe disability (i.e. activity limitation) rate their health worse than people with no disabilities (Drum et al., 2008; Krokavcova et al., 2008). However, our analyses also indicate that the strength of the association between disability and self-rated health is not equal across countries, but dependent on the country's welfare regime. We find that in the case of disablement, people living in a Social-Democratic, Liberal, Bismarckian or Southern European Welfare State are inclined to rate their health worse than people living in a Liberal-Informal, Productivist or South Asian Informal-Security regime, or in an Insecurity regime. Disability thus has the least impact on self-rated health in the Liberal-Informal regimes, the Productivist and South Asian welfare regimes. Insecurity regimes, in which disability provisions are the least developed or even completely lacking, are situated at the same level. Eastern European Welfare States are in an intermediate position: after controlling for the influence of the economic prosperity of the countries, people with disabilities living in Eastern European Welfare States will rate their health better than disabled people living in the other Welfare States, but worse than disabled people living in Informal-Security and Insecurity regimes. These findings show that there are elements of the socio-political context of a country, irrespective of its economic development, which are decisive factors in shaping the association between disability and self-rated health. Our observations hence suggest that in order to fully understand what having a disability means for self-rated health, research might benefit from taking into account the broader societal context in which a person needs to deal with their disability. A framework that combines both micro and macro perspectives seems necessary to enable us to take the interpretation of the relationship between disability and self-rated health a step further.

The results contradict hypothesis 1, which is founded on the beneficent role of welfare provisions for disabled people, and only partly support hypothesis 2, stating that disabled people will rate their health worst in Welfare States, better in Informal Security regimes and comparatively the best in Insecurity regimes. The main difference between the Welfare States and other welfare regimes may equally be explained by the rationale behind hypothesis 2. In order to become entitled to the manifold disability welfare benefits and services in Welfare States, disabled people first have to be labeled as such (Marin, 2004). Inspired by labeling theories and symbolic interactionism (Blumer, 1969; Lemert, 1972; Mead, 1934), we theorized that this labeling and the dependence on welfare may lead to the perception that disabled people have special needs and consequently lead to an inferior social status. As people who are given this label might internalize these conceptions, this could result in a stronger negative association between disability and self-rated health in the Welfare States.

Although the findings that the strongest negative impact of disability on self-rated health in the Welfare States could easily be interpreted negatively, it is important to keep in mind that the most comprehensive provisions and services for disabled people are present in Welfare State regimes. Linked to Sen's (1999) capabilities approach applied to disability (Mitra, 2006), one could argue that welfare states provide the conditions that increase the practical opportunities or achievement possibilities for people with a disability. As we have already pointed out, labor market regulations and personal support extend the job opportunities for disabled people and can result in a better standard of living. These facilities thus increase the things disabled people can do or be (Mitra, 2006). Future research should try to uncover why and through which specific mechanisms welfare arrangements enlarge the differences between people with and without disabilities in terms of self-rated health and well-being. Based on our findings, we suggest that future research should also focus on the unintended consequences of labeling as disabled, possible stigmatization, the social status of disabled people in their society and the broader societal or cultural ideas about disability.

Our results also indicate that the strength of the association between disability and self-rated health is as weak in the Insecurity regimes as in the Informal-Security regimes. These findings contradict our expectations – we hypothesized that the strength of the association between self-rated health and disability would be different for the three groups of welfare regimes – and are an indication that other factors are at play. Given the significant role of non-institutional and informal actors in Informal Security regimes and especially in Insecurity regimes (Wood & Gough, 2006), not taking these factors explicitly into account in our analyses might have hindered us in capturing the specific mechanisms that lead to similar associations between disability and self-rated health in both types of welfare regime. If state arrangements are absent, people seek other ways to secure their needs. Disabled people might seek help from NGOs, civil society organizations, ethnic and religious groups, and also family or community care. As Wood and Newton (2005:21) indicated, we might consider these non-state actors as "stepping stones towards more state-led de-commodification".

Implicitly, our study also investigates the impact of welfare regimes on differences in self-rated health. Previous articles, which focused on higher income countries (Beckfield & Krieger, 2009), have concluded that population health is the best in the Social-Democratic regimes and the worst in the Southern and Eastern European regimes (Chung & Muntaner 2008; Eikemo, Bambra, Judge, & Ringdal, 2008). Our results only partly support previous findings: whereas the self-rated health of individuals in Social-Democratic welfare states does not significantly differ from that of people in a Liberal, Bismarckian or Southern European welfare state, it is significantly better than that of people living in an Eastern European welfare state. People living in non-state welfare regimes do not rate their health significantly worse than people living in Social-Democratic welfare states. Future research could benefit from focusing on the differences in the evaluation of self-rated health between the welfare regimes.

When interpreting our results, some remarks are worth noting. First, differences in modes of data collection, translation and survey set-up could have affected the comparability of this multi-country study and biased the estimates in our analysis. However, the WHO emphasizes that the survey instrument was developed using cognitive interviews and cultural applicability tests to produce comparable estimates across different cultures and groups (Ustün, Chatterji, Villanueva, et al., 2003). Second, the sample size in our analyses is about seven percent smaller than the original sample size because of missing data. This reduction is almost entirely due to missing values for disability. Missing values analyses showed more missing information for lower educated, single and unemployed people, but no differences between people with either good or poor self-rated health. Accordingly, we assume these missing values biased our results only minimally. Moreover, it should be stressed not only self-rated health but also disability was measured subjectively. Therefore the same mechanisms of underreporting might apply there, resulting in an ignorable bias in the association between self-reported disability and self-rated health. Third, we acknowledge that the measurement of disability we employ is not widely used. However, the use of the WHS provided us the unique opportunity to perform cross-national analyses on disability and its relation with self-rated health in different contexts. By adopting the same operationalization of disability as Witvliet et al, (2011; 2012a), we tried to optimize the comparability of research results.

Finally, our research indicates that the association between disability and self-rated health is conditional on the socio-political context of a country, and, that welfare regimes have a significant impact on the strength of this association. Research on the disability-self-rated health nexus that neglects this context dependency may thus be limited in terms of generalization and may lead to false conclusions. However, the concept of the ‘welfare regime’ is a catchall term. It captures various differences between countries - such as welfare generosity and disability policy-, but it also captures variation that is not strictly part of the welfare system, such as bodily cultures, stigma and welfare attitudes. This opens up possibilities for future research on more specific policy dimensions and other country characteristics.

Chapter 7

Study 2. Feeling well while chronically ill or impaired: A multilevel study on the moderating role of employment and volunteering in Europe

Based on Foubert, J., Levecque, K., & Van Rossem, R. (2017). Feeling well while chronically ill or impaired: a multilevel study on the moderating role of employment and volunteering in Europe. Disability & Society, 32(1), 17-36.

Abstract

People with a chronic condition tend to report poorer subjective wellbeing than people without one. This paper examines the dependence of the relationship on doing paid and voluntary work, and macro-level labour market exclusion of people with and without chronic conditions. Data from the European Quality of Life Survey (2011–2012) of people between 25 and 65 are analysed using multilevel regression techniques. A chronic condition has a stronger negative effect on subjective wellbeing for persons who are economically inactive or who never engage in voluntary work. The importance of paid work, however, varies with national levels of labour exclusion.

Introduction

People with a chronic illness or impairment (hereafter referred to as a chronic condition) generally have a lower subjective wellbeing than people without a chronic condition (Brown, Ang, & Pebley, 2007; Cott et al., 1999; Drum et al., 2008; Emerson et al., 2011; Freedman, Stafford, Schwarz, Conrad, & Cornman, 2012; Lenze et al., 2001; Reinhardt, von Elm, Fekete, & Siegrist, 2012; Uppal, 2006). They report lower levels of overall life satisfaction and happiness, and rate both their general health and mental health as poor. This is in line with theoretical arguments such as that of 'biographical disruption' (Bury, 1982) and 'loss of self' (Charmaz, 1983). These theories highlight the disruptive impact (of the onset) of chronic conditions on the self-perception and identity of a person, as they challenge assumptions and behaviours that are normally taken for granted (Galvin, 2005; Pierret, 2003). A chronic condition may have a major impact on people's self-image and wellbeing because of the restricted lives they lead, the social isolation they experience and the stigmatizing reactions of others (Bury, 1991b; Charmaz, 1983; Galvin, 2005).

Other studies, conversely, conclude that people with a chronic condition do not necessarily report lower subjective wellbeing or quality of life

(Albrecht & Devlieger, 1999; Watson, 2002). They point to the importance of achieving equilibrium between body and mind (Albrecht & Devlieger, 1999), of mastery, of self-esteem (Cott, Gignac, and Badley 1999) and of social support (Albrecht & Devlieger, 1999; Fellinghauer et al., 2012). To date, few studies have examined how the difference in subjective wellbeing between people with and without a chronic condition can be explained by differences in how they experience social exclusion (Emerson et al., 2012). There is, however, ample evidence that people with a chronic condition experience more social disadvantage (Barnes & G. Mercer, 2010a; Emerson et al., 2009; Grammenos, Moons, et al., 2007; Jenkins, 1991; WHO & WorldBank, 2011), which is known to be detrimental to health and wellbeing (Levecque et al., 2011; Marmot et al., 1991; Olsen & Dahl, 2007). Available studies indicate that the impact on subjective wellbeing of a chronic condition can be explained by socioeconomic disadvantage, rather than by the chronic condition itself, and that this impact varies according to available socioeconomic resources (Emerson et al., 2012; Emerson et al., 2009).

This study focuses on the role of paid and voluntary work in the association between chronic condition and subjective wellbeing in European countries with different labour market integration levels of people with chronic conditions (Eurostat, 2014). Employment is a key factor for social inclusion and the lack of paid work is a major cause of social exclusion (Atkinson & Hills, 1998; Bradshaw et al., 2004), which, in turn, may lead to poorer mental health and lower psychological wellbeing (Levecque et al., 2011; WHO, 2010). Voluntary work is often also seen as an alternative to paid work for people with a chronic condition (Held & Granholm, 2007; Schedin Leiulfsrud et al., 2014; Trembath, Balandin, Stancliffe, & Togher, 2010). Therefore, the main research questions of this paper are ‘Does paid work or voluntary work reduce the negative associations between having a chronic condition and psychological wellbeing?’ and ‘Does the moderating role of paid or voluntary work on the relation between having a chronic condition and subjective wellbeing differ according to the labour market exclusion of people with chronic conditions in a country?’

Theoretical framework

Social-relational understanding of disablism

In the following paper, we adopt the social-relational approach of disablism developed by Thomas (2004, 2007, 2012). This framework reconciles the medical sociology approach, which focuses on the subjective experience of a chronic condition, with the disability studies approach, which focuses on social exclusion. Disablism is considered the ‘social imposition of avoidable restrictions on the life activities, aspirations and psycho-emotional wellbeing of people categorized as “impaired” by those deemed “normal”’ (Thomas, 2012, p. 211: 211), and has to be understood as a form of social exclusion, along with other dimensions of exclusion associated with gender, ethnicity and other axes of social diversity in society (Thomas 2014). Although the framework acknowledges that chronic conditions can directly cause restrictions in activities or undermine subjective wellbeing, it stresses that these restrictions can also be socially constructed or reinforced (Thomas 2007, 2012, 2014). Disability is then understood in terms of socially imposed restrictions on activities as well as the social undermining of subjective wellbeing. Accordingly, the framework it acknowledges the direct impact of chronic conditions, but also opens up the possibilities of examining how the experience of a chronic condition and its link with subjective wellbeing might depend on being able to fulfil social roles and comply with social norms, such as taking on a working role and being economically active.

The moderating role of employment and voluntary work

Unemployment is often associated with poorer mental health and wellbeing (Artazcoz et al., 2004; Bartley, 1994; Jahoda, 1981; Paul & Moser, 2006; Ross & Mirowsky, 1995). Studies also indicate that the mental wellbeing of people who are economically inactive and not looking for work is as bad as that of people who are unemployed (Bambra & Popham, 2010; Brown et al., 2012; Honkonen et al., 2007; Milner, Spittal, et al., 2014). The adverse health effects of unemployment can be explained by the financial pressure it usually entails (Artazcoz et al., 2004; Bartley, 1994), but those effects might also be a result of not enjoying the non-pecuniary functions of employment (Artazcoz et al., 2004; Bartley, 1994; Jahoda, 1981). A job not only provides people with structured time and mental and physical activity, but also leads to social contact and to a particular social status and identity (Bartley, 1994; Jahoda, 1981).

People with chronic conditions have lower employment rates when compared with the general population (Grammenos, Moons, et al., 2007; OECD, 2010). Although their chronic condition might prevent them from taking some jobs, they encounter many barriers to (re-)entering the labour market in general (Barnes & G. Mercer, 2010a; Jones, 2008; OECD, 2010; Roulstone, 2012). Erratic vocational training, unsuitable work accommodations and transportation, and discriminatory attitudes from employers regarding hiring people with chronic conditions are frequently mentioned issues. Nevertheless, this does not preclude the benefits of employment regarding wellbeing extending to people with a chronic condition (Milner, LaMontagne, Aitken, Bentley, & Kavanagh, 2014). In a review article, Saunders and Nedelec (2013) conclude that for most people with chronic conditions, work is not only an important source of financial security, but also functions as a source of identity and contributes to feelings of normality, worth and self-esteem. A number of qualitative studies underscores the importance of the non-pecuniary value of work for people with chronic conditions (Dunn et al., 2008; Galvin, 2005; Honey, 2004; Schedin Leiulfsrud et al., 2014). In these studies, employment is generally described in terms of its contribution to a social and personal identity and to integration into society. Having a regular job is seen as proof being equal to other people, and is considered a primary factor for social recognition and a prerequisite for being considered a full citizen. This description is common among people with different types of chronic conditions (Saunders and Nedelec 2014; Honey 2004). Sometimes participants also mention drawbacks from employment (Dunn et al., 2008; Honey, 2004), although these do not seem to outweigh the benefits (Dunn et al., 2008). The negatives are often related to work experiences that were boring or pointless and felt like a waste of time. These results correspond with the finding that people with a chronic condition who are in employment often have jobs with poor financial rewards and prospects at the lower end of the occupational hierarchy (Roulstone, 2012).

Involvement in voluntary work is also associated with better mental wellbeing (Borgonovi, 2008; Musick & Wilson, 2003; Piliavin & Siegl, 2007; Post, 2005; Thoits & Hewitt, 2001). Explanations for this positive association focus mainly on the psychological (e.g. self-esteem) and social (e.g. social support) resources provided by volunteering. Through volunteering, people gain confidence, become more self-assured and have higher self-esteem (Musick and Wilson 2003). Moreover, volunteers may feel they are engaged in useful activity and therefore might report a better health status and a higher level of happiness (Borgonovi, 2008; Musick & Wilson, 2003). Volunteering also fosters social contact, which increases the chances of finding social support and useful information, when necessary, and counters social isolation that can lead to depression (Musick and Wilson 2003). For people with a chronic condition, formal volunteering is promoted as both a stepping-stone and an alternative to employment (Held & Granholm, 2007; Trembath et al., 2010). However, research indicates that people with a chronic condition feel that voluntary work is not socially accepted as an equivalent to paid work, nor can it be a substitution for employment with regard to its impact on participation and integration in society (Schedin Leiulfsrud et al., 2014).

Macro-level labour market exclusion

Recent studies show that wellbeing is also associated with other people's employment and macro-level labour market characteristics (see e.g. Buffel et al., 2016; Clark et al., 2010; Clark, 2003; Oesch & Lipps, 2013; Shields, Price, & Wooden, 2009). For example, higher regional unemployment levels are assumed to negatively affect the wellbeing of unemployed people because they theoretically reduce the likelihood of an unemployed person finding work and indicate bleaker future labour market prospects (Clark, Knabe et al. 2010). However, Clark (2003) found that unemployed people report higher levels of wellbeing in regions with higher levels of unemployment. This result has been explained by the idea that the unemployment level of a region or country can be considered as an indirect indicator of the social norm of unemployment (Buffel et al., 2016). The logic of the social norm theory is that people are concerned about their relative standing in a group (Schwarz, 2012), and that their evaluation of their situation depends on how they conform to or deviate from the de facto social norm (Winkelmann, 2014). The psychological impact of unemployment will therefore be less when unemployment is high, as people feel less personally responsible for their own situation and attribute their unemployment to structural causes rather than personal failure. Given that the labour market integration of people with chronic conditions varies considerably across European countries (Eurostat 2015), this should be considered when investigating the micro-level role of paid and voluntary work. The moderating roles on the relationship between having a chronic condition and subjective wellbeing might depend on the extent of the country's exclusion of people with chronic conditions from the labour market.

Integration of micro- and macro-relationships

The social stress model (Aneshensel, 1992; Menne, 2006; Pearlin, 1989; Turner, Wheaton, & Lloyd, 1995) provides a schematic background to combine the previously outlined micro- and macro- aspects. In this model, social stress is understood as the negative feelings that result from a discrepancy between social conditions or societal claims and goals, and the characteristics of an individual (needs, values, norms and resources) (Aneshensel 1992). A chronic condition can be experienced as a stressful life event (due to the onset period, diagnosis or symptoms) and a chronic stressor (due to its long-term character and the consequences for the organization of life), both of which are known to be risk factors for poor wellbeing (Bury, 1982; Charmaz, 1983; Menne, 2006). Furthermore, people with a chronic condition – compared to those without one – have a higher risk of experiencing other stressors that are harmful to one's wellbeing

(Emerson et al., 2012; Reeve, 2012; Roulstone, 2012; Thomas, 2007; Thomas, 2012). Having a chronic condition may induce social processes of structural and psycho-emotional disablism that impede social inclusion, and this makes it, among other things, difficult to enter and remain in the labour market (Emerson et al., 2012; Reeve, 2012; Roulstone, 2012; Thomas, 2007; Thomas, 2012). A lack of paid work is detrimental to one's wellbeing (Artazcoz et al. 2004; Bartley 1994; Brown et al. 2012). Furthermore, people with a chronic condition consider employment an important source of self-validation, proof of being equal to other people, and a prerequisite for social inclusion (Dunn et al., 2008; Honey, 2004; Roulstone, 2012; Saunders & Nedelec, 2014; Schedin Leiulfsrud et al., 2014). Therefore, the lack of paid work can also be seen as a form of role stress that interacts with the stress associated with the chronic condition itself. Having a chronic condition might therefore be more strongly associated with lower subjective wellbeing for people who do not have a paid job, as they are confronted with the stress of the chronic condition and the lack of paid work and with not fulfilling a socially valued role. Because voluntary work is sometimes seen as an alternative to paid work for people with a chronic condition (Trembath et al., 2010), and because it is also a source of self-esteem and social integration (Musick & Wilson, 2003), carrying out voluntary work might also diminish the generally negative association between impairments and subjective wellbeing. Additionally, employment and volunteering can be seen as gateways to other well-known protective factors within the stress process, such as social support, a sense of control and self-efficacy (Bartley, 1994; Borgonovi, 2008; Jahoda, 1981; Musick & Wilson, 2003; Paul & Batinic, 2010). This illustrates another pathway through which the lack of paid or voluntary work could strengthen the negative effect of chronic conditions on wellbeing. Furthermore, the moderating role of paid or voluntary work on the relationship between a chronic condition and wellbeing might also be dependent on the labour market exclusion of people with chronic conditions at the country level. On the one hand, in countries with higher labour market exclusion, having a chronic condition and being unemployed or inactive might be associated with the lowest level of wellbeing. In those countries, people with a chronic condition have the bleakest prospects of getting a job, which could lead to the highest level of social stress. On the other hand, with regard to labour market exclusion, social norm theory (e.g. Clark 2003; Clark, Knabe et al. 2010) suggests that in countries with higher exclusion levels for people with chronic condition, people who have a chronic condition and are unemployed or economically inactive might actually benefit from a social norm effect: being economically inactive might be less stigmatizing if more people share the same experience. In those countries, people might feel less personal responsibility and explain their inactivity as due to structural barriers.

Data and Methods

Data

This paper used cross-sectional data from the 2011–2012 European Quality of Life Survey (EQLS), a population-based survey with information on both objective and subjective life circumstances (Eurofound, 2012a). The analyses are based on data from the 28 EU Member States. Full details about the sampling design and field work can be found elsewhere (Eurofound, 2012a); however, for most countries, a multistage stratified random sampling design was used and data were collected via face-to-face interviews. National response rates ranged from 31.7% in France to 80.7% in Cyprus, with Luxembourg as an exception at a response rate of only 15.5%. The data is representative of the adult population living in private households. Our analyses were restricted to the population between 25 and 65 years old, without student status, resulting in a total sample of 22,466. Cases with missing values were not included in the analyses (Nmissing = 1279, 5.39%). Analyses were weighted using the final trimmed weights provided by the EQLS.

Variables

Subjective wellbeing is an umbrella term for the diverse concepts that concern people's evaluations of their life (for an overview see Ed Diener et al., 2009). As stated above, we focused on psychological wellbeing using the World Health Organization-Five Well-being Index (WHO-5) to measure the concept. This measure captured positive psychological wellbeing over the two weeks prior to the interview (P. Bech, Olsen, Kjoller, & Rasmussen, 2003; McDowell, 2010; WHO, 1998). Response categories ranged from all of the time (5) to at no time (0). Respondents could select from five items: 1) I have felt cheerful and in good spirits, 2) I have felt calm and relaxed, 3) I have felt active and vigorous, 4) I have woken up feeling fresh and rested and 5) my daily life has been filled with things that interest me. The final score was calculated by summing the scores of the items. We multiplied the score by four, resulting in a scale ranging from 0 (worst possible mental wellbeing) to 100 (best possible mental wellbeing). Scale reliability was good for all countries (the overall Cronbach's alpha was 0.85; the lowest value was 0.78 for Finland); the total response rate was 99.2%.

People with a chronic condition were identified by means of the following question: 'Do you have any chronic (long-standing) physical or mental health problem, illness or disability? By chronic (longstanding), we mean illnesses or health problems that have lasted, or are expected to last, for six months or more.' Respondents could answer with 'no' (0) or 'yes' (1). The overall response rate is 99.3%.

We distinguished between three labour market positions: 'employed or self-employed', 'unemployed' and 'economically inactive in the labour market' at the time of the interview. Those who were economically inactive could have been out of the labour market for various reasons, including ill health, early retirement or home making. In the EQLS, respondents could indicate how often they carried out unpaid voluntary work and what type of work that was. They could choose from community services, educational, cultural, sports or professional organizations, social movements, political parties or trade unions, or other voluntary organizations. We constructed a variable that measures the frequency of volunteering and which has three categories: doing voluntary work on a weekly or monthly basis, doing voluntary work less than once per month and not doing any voluntary work at all.

We also controlled for age (in years) and its squared value to account for a possible non-linear association between age and psychological wellbeing, gender ('men' and 'women'), marital status ('married or living together', 'divorced', 'widowed' or 'single') and social support when needing advice on a serious personal or family matter ('no support' and 'support'). Educational level was measured using four categories: 'no education or only primary education completed', 'lower secondary education', 'upper secondary education' and 'tertiary education'. Deprived housing conditions was included as a binary variable ('no deprivation' and 'deprivation'). Respondents with at least two of the following problems were classified as 'living in deprived housing conditions': 'shortage of space', 'rot in windows, doors or floor', 'damp or leaks in walls or roof', 'lack of indoor flushing toilet' and 'lack of bath or shower'. To obtain an indication of the income, we used information on the monthly net household income. Respondents who could not give an estimate of their monthly income could show a card indicating different levels of income. We randomly distributed people who used this card within the limits of the category they selected. To adjust for differences in household size and composition, we employed the modified OECD equivalence scale. This attributes a weight of 1 to the first adult, 0.5 to each additional adult and 0.3 to each person younger than 14 years old (T. B. Atkinson, Cantillon, Marlier, & Nolan, 2002). As 22.5% of the sample did not answer the question on income, we used regression imputation to prevent losing these cases from the analyses (Durrant, 2005). In this method, the values of the income variable are predicted by estimating a regression of the income variable based on the other variables in the final model (without interaction terms), an indicator of household financial difficulties ('able to make ends meet'), the number of children and adults in the household and whether someone in the household had received social benefits in the 12 months before the interview. The missing values on the income variable were then substituted by the score predicted by the regression of the income variable. To control for differences between the people with a missing value on income and the rest of the sample, we included a missing value indicator in the analysis.

Country-level data for the labour market exclusion of people with chronic conditions was taken from Eurostat (2015a). The ad hoc module in the European Labour Force Survey of 2011 offers a unique opportunity to obtain an insight into the labour market's integration of 'people having a basic activity difficulty (such as sight, hearing, walking or communicating)'. We used non-employment rates, calculated by subtracting the employment rate from 100. Compared with unemployment rates, non-employment rates also included discouraged workers who have given up looking for work and therefore provide a figure for all working-age people who are not in employment. We used the rates for people between 20 and 64 years in 2011, with and without chronic conditions.

Statistical procedure

First, we presented descriptive and bivariate information for the variables in the analyses. We then studied whether the differences in wellbeing between people with and without a chronic illness are related to differences in employment status and voluntary work, and performed multilevel linear regression analyses in MLwiN 2.30 with IGLS estimation. This way, we controlled for the clustering of cases within countries (Hox, 2010). Furthermore, cross-level interaction effects were added to see whether macro-level labour market exclusion affects the micro-level models. Metric variables were grand-mean centred in the multilevel analysis.

Results

Descriptive and bivariate results

Table 9 shows the non-employment rates of people with and without chronic conditions in the countries in the sample. The highest non-employment rates for people with chronic conditions are found in Bulgaria, Ireland, Hungary and Romania. The lowest are found in Sweden, Luxembourg, Finland and Austria. Table 10 provides an overview of the characteristics of the total sample and indicates significant differences between people with and without a chronic condition. Of the sample, 25.9% report a chronic condition. People with a chronic condition on average score 11 points less on the subjective wellbeing scale than people without a chronic condition and are less likely to have a job. About 40% of those with a chronic condition are economically inactive, which is about 25 percentage points higher than people without a chronic condition. Both groups contain about 10% unemployed. Compared to people without a chronic condition, those with a chronic condition are more likely to be engaged in voluntary work every week or month, although the difference is minimal. Furthermore, people with a chronic condition are more likely to have only primary or lower secondary education, to live in a household with a lower income and to live in deprived housing. The mean age of people with a chronic condition is higher than that of people without; they are also more likely to be divorced, separated or widowed.

Multilevel results

Table 11 shows the results of multilevel analyses on the WHO-5 wellbeing index. In Model 1, the main effects of the controls and having a chronic condition are estimated. In Model 2, employment, voluntary work and country-level labour market exclusion are added to the analysis. People with a chronic condition on average score about 11 points less on the WHO-5 wellbeing scale. This score is about half a standard deviation lower on the scale than people without a chronic condition (SDwellbeing = 20.47). That is, people with a chronic condition tend to report worse subjective wellbeing than people without a chronic condition. People who are unemployed or economically inactive generally report worse subjective wellbeing than people who are employed. People who are volunteering on a weekly or monthly basis in general also score significantly higher than people who only occasionally or never carry out voluntary work. Higher or lower non-employment rates are not significantly associated with subjective wellbeing.

Table 9: Non-employment rates (%) of people with and without chronic condition between 20-64 years old across 28 European countries in 2011

Country	With chronic condition	Without chronic condition
Austria	38.9	19.9
Belgium	58.2	27.1
Bulgaria	69.1	32.9
Cyprus	52.9	22.4
Czech Republic	61.0	25.5
Germany	47.5	22.8
Denmark	53.0	18.6
Estonia	48.9	24.9
Greece	64.1	36.7
Spain	55.1	35.8
Finland	38.1	20.5
France	42.7	26.9
Hungary	76.0	32.7
Ireland	69.1	33.8
Italy	53.9	36.3
Lithuania	58.8	28.8
Luxemburg	36.1	28.4
Latvia	48.1	30.5
Malta	65.0	36.1
Netherlands	57.0	17.1
Poland	65.5	29.7
Portugal	48.0	26.2
Romania	68.0	31.1
Sweden	31.0	17.4
Slovenia	52.5	26.2
Slovakia	67.6	30.8
UK	51.7	20.8
Croatia	67.0	38.5

Table 10: Descriptive and bivariate results of the sample by chronic condition, EQLS, 2012

	No chronic condition *(observations=16669)*	Chronic condition *(observations=5797)*	Significance
	%	%	
Employment status			***
Employed/self-employed	74.4	49.3	
Unemployed	9.9	11.4	
Economically inactive	15.7	39.3	
Voluntary work			***
Every week or month	16.7	19.6	
Occasionally	16.9	13.9	
Never	66.4	66.6	
Educational level			***
No or primary	5.0	9.7	
Lower secondary	17.4	21.8	
Upper secondary	48.4	44.8	
Tertiary	29.2	23.7	
Gender			***
Male	50.6	46.3	
Female	49.4	53.7	
Housing condition			***
No deprivation	89.6	84.9	
Deprivation	10.4	15.1	
Social support			***
No support	2.6	4.3	
Support	97.4	95.7	
Marital status			***
Married/living together	65.0	57.6	
Divorced/separated	12.6	17.8	
Widowed	3.8	7.1	
Single	18.0	17.0	
	mean (SD)	*mean (SD)*	
Subjective well-being	64.72 (19.10)	53.11 (21.95)	***
Household income	1276.04 (1522.84)	1179.77(2113.29)	***
Age	44.09 (10.28)	50.10 (10.28)	***

The association between two categorical variables was tested by chi square test. the association between a categorical and continuous variable is tested by means of an unpaired t-test. *=p<0.050; **=p<0.010; ***=p<0.001

In Table 12, we add the micro-level moderating roles of employment status and volunteering. The significant interaction effects in Models 3 and 4 indicate that the effect of having a chronic condition varies depending on employment status or on the frequency of carrying out voluntary work. When active in the labour market, people with a chronic condition on average score 8.6 points lower on the WHO-5 wellbeing scale than people without a chronic condition. However, economically inactive people with a chronic condition, compared with employed people without one, score 14 points lower on the wellbeing scale, with all other things being equal [(-8.6) + (-5.3) = -13]. Being economically inactive is therefore, on average, associated with a 5-point (= 1/4th of SDwellbeing) stronger statistical effect of having a chronic condition on subjective wellbeing. Having a chronic condition is also associated with worse wellbeing when unemployed compared with being (self-)employed, although the difference is small (2.7 points). Also, when people do not engage in voluntary work, compared to engaging in voluntary work on a weekly or monthly basis, a chronic condition is more strongly associated with subjective wellbeing in a negative way. Looking at Model 5 in Table 12, we note that in the analysis the inclusion of the interaction of employment status and volunteering with having a chronic condition does not alter the interpretation of the findings. Although the moderation effects are a bit smaller than before, the association between having a chronic condition and subjective wellbeing is still dependent on employment status or volunteering frequency. Having a chronic condition still has a stronger negative effect on subjective wellbeing when people are economically inactive compared to when they are (self-)employed. A chronic condition is also significantly associated with worse subjective wellbeing if people never do any voluntary work compared to doing voluntary work on a weekly or monthly basis. Having a chronic condition is associated with the worst subjective wellbeing when economically inactive.

In the final step, we test for the dependency of both the moderating effects of employment status and voluntary work on macro-level labour market exclusion. Table 13 shows results that are significant. Only the moderating role of employment status – not that of voluntary work – depends significantly on the country's labour market integration of people with and without chronic conditions. In Model 6, we observe that the higher the non-employment rate of people with a chronic condition in a country, the stronger the negative association between having a chronic condition and subjective wellbeing for people who are unemployed. In countries with an average non-employment rate for people with chronic conditions, having a chronic condition has a negative effect of 8.703 points on wellbeing for employed people, and a negative effect of 11.071 points for unemployed people [(-8.703) + (-2.369)]. In countries where this non-employment rate for people with chronic conditions is 1 percentage point higher, the interaction of a chronic condition and being unemployed is already 0.271 points more negative [(-2.369) + (-0.271)], and therefore results in poorer subjective wellbeing for those people. The situation of people who have a chronic condition and are economically inactive does not seem to vary with the non-employment rate for people with chronic conditions, but does with that of people without chronic conditions. More specifically, in Model 7 we can see that in countries with higher non-employment rates for people without chronic conditions, the interaction term between chronic conditions and being economically inactive is smaller [(-5.055) + 0.307)]. In those countries having a chronic condition and being economically inactive is less strongly associated with subjective wellbeing in a negative way.

Discussion

Many studies have concluded that people with a chronic condition generally report lower subjective wellbeing than people without a chronic condition (Brown et al., 2007; Cott et al., 1999; Drum et al., 2008; Emerson et al., 2011; Freedman et al., 2012; Lenze et al., 2001; Reinhardt et al., 2012). Although this study confirms this, it also notes that people with a chronic condition tend to report better subjective wellbeing if they are still active in the labour market compared with being either economically inactive or unemployed. Volunteering is also beneficial for subjective wellbeing when one has a chronic condition. However, it is not an alternative to employment, as having a chronic condition remains strongly associated with a lower subjective wellbeing when economically inactive or unemployed, even after volunteering is considered. In addition, the moderating role of employment status varies across a country's macro-level labour market exclusion levels of both people with and without chronic conditions.

There are several explanations for the lower subjective wellbeing of people with a chronic condition who are unemployed or economically inactive. Indeed, their wellbeing might be explained by the presence of a serious health condition or impairment that has led to their labour market exit (Milner et al. 2014). The existence of health selection out of the labour market is backed by empirical evidence (Heggebo, 2015; Heggebo & Dahl, 2015). However, a recent study suggests that this health selection is dependent upon a country's employment protection legislation (Heggebö and Dahl 2015). Moreover, cross-national comparisons show that the employment rate for people with (severe) chronic conditions varies greatly across Europe (Eurostat, 2014) and is linked to the size and design of welfare and labour market programs (van der Wel et al., 2011). This confirms that having a chronic condition does not necessarily lead to non-participation in the labour market; this leaves room for alternative explanations that are independent of health status.

When it comes to the social-relational framework of disablism and the social stress model, the poor mental wellbeing of those who are economically inactive and have a chronic condition might also be the result of interaction among several sources of social stress. First, people in this position have to deal with the potentially stressful experience of the chronic condition (Bury 1982; Charmaz 1983; Menne 2006; Thomas 2007). The onset and/or longer-term symptoms may well directly undermine their subjective well-being; it also requires a major (re)organization of their life. As people in a disadvantaged socioeconomic position are more likely to have a chronic condition (European Commission, 2013), they may experience strain in their material and psychological resources, causing additional stress.

Table 11: Results of linear multilevel regression of WHO-5 well-being index on controls. chronic condition. employment. volunteering. macro-level labour market exclusion, EQLS, 2012

	Model 1: Controls and chronic condition		Model 2: main effects employment. volunteering and macro-level	
X	B	s.e.	B	s.e.
Fixed Part				
Intercept	58.393***	1.134	66.982***	3.275
Controls				
Age	-0.979***	0.103	-1.144***	0.106
Age square	0.011***	0.001	0.013***	0.001
Gender (ref=male)	-2.345***	0.263	-2.108***	0.266
Marital status (ref=married/living together)	***		***	
separated/divorced	-2.585***	0.393	-2.480***	0.392
widowed	-4.860***	0.639	-4.822***	0.637
single	-1.265**	0.407	-1.069**	0.407
Social support (ref=no support)	5.822***	0.778	5.610***	0.775
Education (ref=no or primary education)	***		***	
lower secondary	2.077***	0.610	1.762**	0.608
upper secondary	3.335***	0.573	2.581***	0.574
higher	4.725***	0.600	3.351***	0.609
Household income	0.599***	0.082	0.504***	0.082
Missing value income	0.535	0.321	0.623	0.320
Housing (ref= no deprivation)	-6.111***	0.420	-5.821***	0.420
Main variables				
Chronic condition (ref= no)	-10.925***	0.309	-10.661***	0.312
Employment status (ref= employed)			***	
Unemployed			-2.909***	0.458
Economically inactive			-1.910***	0.365
Volunteering (ref= weekly or monthly)			***	
Occasionally			-1.953**	0.445
Never			-3.436***	0.359
Non-employment rate chronic			-0.010	0.067
Non-employment rate not chronic			-0.143	0.122
Random Part				
Between countries variance	10.869***	3.043	9.006***	2.543
Within countries variance	368.382***	3.478	365.893***	3.454
-2*loglikelihood:	196598.078		196440.933	
Nindivual	22466		22466	

*=p<0.050; **=p<0.010; ***=p<0.001

Table 12: Results of multilevel linear regression on WHO-5 well-being scale. focus on interaction between chronic condition. employment status and volunteering. EQLS. 2012

	Model 3: interaction employment[a]		Model 4: interaction volunteering[a]		Model 5: both interactions[a]	
X	B	s.e.	B	s.e.	B	s.e.
Fixed Part						
Intercept	66.662***	3.287	66.289***	3.274	66.085***	3.286
Main variables						
Chronic condition	-8.586***	0.413	-8.060***	0.683	-6.491***	0.715
Employment status (ref= employed)			***			
Unemployed	-2.393***	0.529	-2.892***	0.458	-2.449***	0.529
Economically inactive	0.083	0.433	-1.860***	0.365	-0.133	0.433
Volunteering(ref=weekly or monthly)	***		***		***	
Occasionally	-1.865**	0.445	-1.449**	0.513	-1.415**	0.512
Never	-3.353***	0.359	-2.447***	0.417	-2.520***	0.416
Non-employment rate chronic	-0.007	0.067	-0.010	0.067	-0.007	0.067
Non-employment rate not chronic	-0.148	0.122	-0.145	0.121	-0.149	0.122
Chronic condition X employment status	***				***	
chronic X unemployed	-2.691**	1.006			-2.382**	1.008
chronic X economically inactive	-5.264***	0.659			-4.987***	0.662
Chronic condition X volunteering			***		***	
Chronic X occasionally			-1.559	1.021	-1.449	1.021
Chronic X never			-3.595***	0.767	-3.044***	0.770
Random Part						
Between countries variance	9.085***	2.543	9.746***	2.741	9.054***	2.533
Within countries variance	364.842***	3.454	365.993***	3.488	364.570***	3.451
-2*loglikelihood:	196376.636		196416.693		196359.805	
Nindividuals	22466		22466		22466	

a: All models include control variables. *=p<0.050; **=p<0.010; ***=p<0.001

Table 13: Results of multilevel linear regression on WHO-5 well-being scale. focus on interaction between chronic condition. employment status and volunteering. and macro-level labour market exclusion, EQLS, 2012

	Model 6: interaction with non-employment rate chronic[a]		Model 7: interaction with non-employment rate not chronic[a]	
X	B	s.e.	B	s.e.
Fixed Part				
Intercept	62.173***	1.153	62.202***	1.157
Main variables				
Chronic condition	-8.703***	0.420	-8.947***	0.429
Employment status (ref= employed)	***		***	
Unemployed	-2.760***	0.538	-2.711***	0.544
Economically inactive	0.096	0.436	0.039***	0.411
Volunteering(ref=weekly or monthly)	***		***	
Occasionally	-1.824***	0.444	-1.829***	0.445
Never	-3.322***	0.358	-3.330***	0.358
Non-employment rate chronic	0.041	0.067	-0.007	0.067
Non-employment rate not chronic	-0.153	0.121	-0.105	0.123
Chronic condition X employment status	***		***	
chronic X unemployed	-2.369**	1.015	-2.081**	1.022
chronic X economically inactive	-5.310***	0.666	-5.055***	0.675
Chronic condition X non-employment rate chronic	-0.082*	0.037		
Employment status X non-employment rate chronic				
Unemployed X non-employment rate chronic	0.139**	0.054		
Economically inactive X non-employment rate chronic	-0.173***	0.038		
Chronic condition X employment status X non-employment rate chronic				
Chronic X unemployed X non-employment rate chronic	-0.271**	0.100		
Chronic X economically inactive X non-employment rate chronic	0.095	0.062		
Chronic condition X non-employment rate not chronic			-0.231***	0.071
Employment status X non-employment rate not chronic				
Unemployed X non-employment rate not chronic			0.161	0.090
Economically inactive X non-employment rate not chronic			-0.132*	0.065
Chronic condition X employment stats X non-employment rate not chronic				
Chronic X unemployed X non-employment rate not chronic			-0.109	0.175
Chronic X economically inactive X non-employment rate not chronic			0.307**	0.114
Random Part				
Between countries variance	8.891***	2.512	8.921***	2.520
Within countries variance	364.049***	3.437	364.527***	3.442
-2*loglikelihood:	196327.217		196356.793	
Nindividuals	22466		22466	

a: All models include control variables. *=p<0.050; **=p<0.010; ***=p<0.001

Second, because of the processes of structural and psycho-emotional disablism, people with a chronic condition might encounter stressful situations that are not experienced by people without such a condition. With regard to employment, many barriers prevent them from entering or remaining in the labour market (OECD, 2010; Roulstone, 2012; Schuring, Burdorf, Kunst, & Mackenbach, 2007). Poor work accommodation and transportation, and employers' discriminatory attitudes are well documented. Moreover, because of these labour market processes, a proportion of people with a chronic condition might be 'frustrated jobseekers' who have given up looking for work (Milner, LaMontagne, et al., 2014). As a result, they have a greater chance of being unemployed or economically inactive. Both labour market positions are known to negatively affect one's wellbeing (Artazcoz et al., 2004; Bartley, 1994; J. Brown et al., 2012; Jahoda, 1981; Paul & Batinic, 2010). Through being economically inactive or unemployed they might experience financial strain and a loss of social contact and social support – important factors for quality of life – and thus feel socially excluded. At the same time, being economically inactive might be a major source of role stress, as they feel they are not fulfilling an important social duty. This role stress might not be experienced solely towards society in general, but also towards their family or partner. Because of their economic inactivity, they might feel unable to take responsibility for caring for their household. Moreover, the combination of a chronic condition with an inactive labour market position might put additional pressure on family relationships, which can add to the stress.

The importance of paid work as a moderator of the relation between chronic condition and subjective wellbeing, however, varies with the level to which countries exclude people with and without a chronic condition from active labour market participation. Unemployed people with a chronic condition experience lower wellbeing in countries with higher non-employment rates for people with chronic conditions. This might be explained by the negative impact of higher labour market exclusion (Oesch and Lipps 2013). In countries with higher non-employment rates for people with a chronic condition, the future labour market prospects for these people may seem especially bleak; the duration of unemployment might be longer and the prospects of finding a job low. This might be the case particularly for unemployed people, who are supposed to be actively looking for a job. They might experience feeling powerless and discouraged in such a context. People who have a chronic condition and are economically inactive – termed 'out of the labour market' – have a better experience in countries with higher non-employment rates for people without chronic conditions. This finding might be explained by referring to the social norm theory of labour market exclusion (Clark 2003; Winkelmann 2014). Being out of the labour market can be attributed to structural labour market characteristics for those with chronic conditions when it is just as hard for those without chronic conditions to get a job, which can be signalled by a higher non-employment rate. It might feel less like a personal failure and be less stressful.

A number of limitations need to be considered when reading this study. One major limitation is its cross-sectional design, which does not allow causal interferences. A longitudinal design would enable the mapping of labour market histories, offer more insight into the interplay of the existing social selection and causation processes at play and provide causal information on psycho-emotional disablist practices. The lack of detailed health and impairment information is another limitation. We cannot ignore the fact that people with, for example, mental health problems or learning difficulties are more likely to be economically inactive (Marin, 2004; Roulstone, 2012), and will be treated in a different way. The issue of cross-cultural comparability of measurement instruments also complicates the interpretation of the results (Diener & Suh, 2000; Jylha et al., 1998; O'Brien, 2015), and applies to both indicators of chronic conditions and subjective wellbeing. Both measures might also represent how judgements are based on norms and values within a particular context. O'Brien (2015), for instance, indicates that residents of more generous northern welfare states are more likely to report a limiting longstanding illness, net of self-rated general health and sociodemographic characteristics. To explain this, he suggests that people in more generous welfare states might be more likely to report limiting longstanding conditions just because in these contexts the available benefits and services do not translate the longstanding conditions into 'disabling' conditions. In our data, as well, we observe the highest frequency rates of chronic conditions in northern social-democratic welfare states. This may mean that the group of people reporting chronic conditions might be more heterogeneous than in other countries and that the 'less serious' conditions present in these countries' sample lead to an underestimation of the relation between chronic conditions, employment and subjective wellbeing compared to other countries. Our data does not contain the information to test these hypotheses.

Conclusion

This study concludes that the difference in subjective wellbeing between people with and without a chronic condition is not only affected by the presence of a chronic condition in one group, but also by the non-fulfilment of important societal roles, such as employment and, to a lesser extent, voluntary work. Because many people with a chronic condition cannot fulfil these roles as a result of the interplay between several structural barriers, their wellbeing might be psycho-emotionally undermined or disabled by the impossibility of fulfilling these roles. The importance of paid work as a moderator varies, however, across national levels of labour market exclusion. This indicates that the wellbeing of people with a chronic condition who are not working is also affected by labour market prospects and social norms about work in society. The findings underline the beneficial role of employment for people with a chronic condition and may encourage policy makers to structurally improve employment opportunities and prevent job loss for people with chronic conditions and ill health. Nevertheless, they also point to the centrality of employment in contemporary Europe (Abberley, 1999). As it will remain difficult for some people with a chronic condition to enter the labour market, it is important to value alternative ways, like voluntary work, of being a member of society.

Chapter 8

Study 3. Job satisfaction among workers with and without activity limitations: role of investments in active labour market policies and welfare generosity in Europe

Based on Foubert, J., van der Wel, K.A., Levecque, K. & Van Rossem, R. Job satisfaction among workers with and without activity limitations: role of investments in active labour market policies and welfare generosity in Europe. To be resubmitted.

Abstract

Activation and longer working life policies are important features of recent welfare reforms to increase employment. Against this background, we examine 1) whether investments in active labour market policy (ALMP) and welfare generosity also affect workers' job satisfaction across Europe, and 2) whether they affect the job satisfaction of workers with and without activity limitations differently. We use data of the 2012 European Social Survey focusing on the working population between 25 and 65 in 21 countries. Multilevel regression analyses, stratified for gender, show that in all 21 countries workers with activity limitations generally report a lower job satisfaction. Higher investments in ALMPS were associated with higher job satisfaction for all workers. For all male workers and for female workers without activity limitations this effect is related to the quality of jobs. For female workers with activity limitations this was only partly true, indicating a possible role of societal norms about work and responsibility. In addition, in countries with a higher spending on out-of-work benefits, the job satisfaction of female workers with activity limitations was also better. Differences between men and women might be related to the gendered division of labour and family models in the particular countries.

Introduction

Many governments have installed policies to strengthen the labour market attachment of 'vulnerable' groups, such as people with ill-health and activity limitations in the past decades (Etherington & Ingold 2012; Hvinden 2004; OECD 2003, 2010). These policies were not only motivated by an ambition to increase citizenship and participation in society among those groups, but also by a wish to increase employment to solve budgetary concerns (Hvinden 2004). While activation and longer working lives policies may increase employment levels, little research has focused on their effect on job satisfaction. Nevertheless, low job satisfaction among workers may be at odds with the aim of increasing their employment. The existing literature does not provide an answer regarding the influence of welfare arrangements, such as Active Labour Market policies (ALMPS) investments and welfare generosity, which both vary across Europe (OECD 2010), on job satisfaction of people with and without activity limitations. In addition, the limited number of previous studies on job satisfaction of workers with activity limitations do not present a uniform conclusion about whether people with activity limitations report lower job satisfaction than people without activity limitations (Ahn & Garcia, 2004; Baumgartner et al., 2015; Pagan, 2007, 2011, 2013; Pagan & Malo, 2009; Uppal, 2005).

In this paper, we examine differences in job satisfaction between people with and without activity limitations across 21 different countries in Europe. We test the role of investments in ALMPS and levels of welfare generosity, two policy aspects of the welfare policy debate. Our main hypothesis is that comprehensive welfare services and social protection arrangements represent important collective resources that enable individuals to control their own lives and their participation in society, including finding a 'good' job, i.e. a good job match. This should be particularly true in the case of people with activity limitations, for whom social protection plays an important role in securing their rights (Lundberg 2009), and who may face the largest difficulties in finding a job that is compatible with their skills and abilities.

Previous research on job satisfaction and activity limitations

Job satisfaction is an individual's global appreciation of his or her current work situation (Locke, 1969; Pichler & Wallace, 2009; Seashore, 1974; Sirgy, Efraty, Siegel, & Lee, 2001; Spector, 1997). It is an important determinant of employment commitment (Snir, 2014), turnover and turnover intentions (Clark, 2005).

The number of studies of the relation between job satisfaction and activity limitations is scarce. Moreover, the available studies do not present a uniform conclusion and employ different arguments. For example, based on the assumption that activity limitations equals poor health (Ahn and Garcia 2004; Baumgartner et al. 2015), activity limitations are often hypothesized to negatively affect job satisfaction (Pagan and Malo 2009). However, Pagan and Malo (2009) tested this pathway based on Spanish household data and concluded that activity limitations cannot be treated as equivalent to health and have an independent influence on job satisfaction. They conclude that Spanish workers with activity limitations are more likely to be satisfied with their jobs and suggest this might be explained by different job expectations. Analogous to the situation of other disadvantaged groups in the labour market (see e.g. Clark, 1997 for gender differences), it is theorised that people with activity limitations have low job expectations and greater returns in terms of job satisfaction from their job characteristics (Pagan 2011; Pagan and Malo 2009). Because of the many barriers towards employment, workers with activity limitations may have adapted their hopes and aims and assumed to be happy to have a job at all, whatever its characteristics. In Canada, however, Uppal (2005) found that workers with impairments generally reported lower levels of job satisfaction, but after controlling for work characteristics, such as high job demands, poor interpersonal relations, threat of layoff and discrimination, the deficit for workers with impairments decreased, while it even disappeared for workers with mobility impairments. Job satisfaction has indeed been found to be determined by 'work-role inputs (such as education, working time, effort) and 'work-role outputs' (such as wages, fringe benefits, status, working conditions, intrinsic aspects) (Sousa-Poza & Sousa-Poza, 2000:519). The combination of high psychological demands and low control or decision-making power might be especially detrimental of one's job satisfaction (Karasek et al. 1998; Vanroelen et al. 2009). For people with activity limitations the following job aspects seem especially detrimental for their job satisfaction (Baumberg 2014; Pagan 2014): the physicality of the job and working in an hazardous, unhealthy environment, a bad relationship with supervisors, and no training opportunities. Keeping this in mind, studies have repeatedly concluded that workers with impairments and activity limitations face work-place related discrimination, generally have jobs at the lower end of the occupational hierarchy, and are more likely to have temporary contracts (Heggebo 2015; Kaye 2009; Pagan and Malo 2009; Roulstone 2012). These are often characterised by precarious work and employment conditions recurrently found to be detrimental for one's job satisfaction, what explains Uppal (2005) findings.

We note that these studies are conducted in different countries that represent distinct welfare and labour market regimes. Previous research on job satisfaction in the general working population suggests that these structural and institutional factors influence job satisfaction and its relationship with job characteristics (Ahn & Garcia, 2004; Gallie, 2007; Hipp & Kolins Givan, 2015; Pichler & Wallace, 2009). Integrating this context-dependency in our research might shed light on the incongruent results found in the previously discussed studies.

Theoretical hypotheses: job quality and matching, welfare policy and activity limitations

The focus here is on two national policy-factors that are connected to the activation policies pursued by EU governments: investments in Active Labour Market policies (ALMPS) and spending on out-of-work benefits (sickness, unemployment and invalidity). On the one hand, easily accessible and generous out-of-work benefits are criticized because they threaten the sustainability of the welfare state and are often presented as disincentives to work and creators of dependency cultures (Heinemann, 2008). This has led to the introduction of more employment stimulating policies in which ALMPS have played a crucial part in the last twenty years (Coutts et al., 2014; Daguerre & Etherington, 2009). On the other hand, comprehensive welfare provision is also seen as a productive force in society that stimulates employment commitment and labour market participation, particularly in disadvantaged groups (van der Wel et al., 2011; van der Wel & Halvorsen, 2015).

van der Wel et al. (2011) concluded that higher investments in ALMPS and more generous benefits are associated with higher labour market participation of people with longstanding limiting illnesses. This is explained using a social investment perspective argument in which ALMPS and generous benefits encapsulate a number of interventions and policies that furnish individuals with resources – broadly divided into cash, care and education - and control over their own lives. Based on this perspective combined with Sen's capability approach (1997, 1999), we argue that these policies not only positively affect the labour market participation of socially disadvantaged groups, such as people with activity limitations, but also their level of job satisfaction. In Sen's terms, welfare states may increase the 'capabilities' (or the freedom to achieve desired goals, such as being satisfied with one's job) of people through providing (in obtaining) the resources (such as education, training, time to look for a job without financial stress and better working conditions) necessary to achieve it (Lundberg, 2009; van der Wel & Halvorsen, 2015).

We suggest two possible pathways through which investments in ALMPS might affect the job satisfaction of people with activity limitations: one pathway via better job matches and enabling collective resources, and one pathway via work norms and obligations. Concerning the former, job satisfaction can be thought of as a condition dependent on the balance between job characteristics and individual motivations and abilities. When the match between an worker's ambitions and desires, skills and abilities on the one hand, and the demands, rewards and opportunities of the job on the other, approaches the optimal, the worker's job satisfaction will be high.

A mismatch between e.g. ambitions and opportunities, skills and tasks, or between demands and abilities, may reduce satisfaction. Hence, job satisfaction is not only dependent on overall extrinsic and intrinsic factors in the labour market (Sousa-Poza and Sousa-Poza 2000), but also on the extent to which individuals and jobs are matched effectively. Like any market, the labour market is dependent on several facilitating mechanisms in order for workers and jobs to be matched optimally. The obvious basic factors are channels of job information and recruitment, a recognised system of credentials, and the predictability provided by norms and expectations towards workers and employers embodied by national and international labour law and regulation. For instance, some of the simpler activation strategies, such as crude economic incentives like restriction in availability and the tightening of eligibility criteria, may shift welfare recipients into work but do not necessarily create durable results (Tatsiramos, 2009). If a job provides a poor match with your skills, ambitions and motivations, you may be less likely to enjoy it and ultimately keep it, even if you need the money. An activation strategy that emphasises upskilling or reskilling, job search training, employer support and sufficient time to job search, on the other hand, may support good matches between workers and jobs.

ALMPS are assumed to increase employability and develop human capital (Daguerre and Etherington 2009). ALMPS include job search assistance, training, employment subsidies and rehabilitation services (Bothfeld & Betzelt, 2011; Eichhorst & Konle-Seidl, 2008). The training and education provided by ALMPS might lead to a higher skill acquisition, which makes people who were unqualified before, now qualified for positions with better job and employment characteristics, or jobs in higher occupational classes. Further, the services provided through ALMPS might lead to better bargaining and communication skills, and help job applicants put more effort in finding the right job that matches with available skills. As mentioned before, workers with activity limitations often have jobs characterised by precarious work and employment conditions recurrently found to be detrimental for one's job satisfaction (Kaye, 2009; Pagan & Malo, 2009; Roulstone, 2012). For people with activity limitations, ALMPS thus might be especially beneficial, if this leads to jobs more compatible with their (health) limitations, as well as with motivations and preferences more generally. In the second pathway, we argue that people with activity limitations might be more satisfied with their job in countries with high ALMP investments, irrespective of their work and employment conditions, but because they also feel more obliged to work or have a higher employment commitment in those countries. A recent study on welfare states effects on motivation to work finds that higher investments in ALMPS are associated with higher employment commitment, understood as the non-financial and non-job specific motivation to work (Van der Wel and

Halvorsen 2015). Higher investment in ALMPs might thus signify a strong social and national commitment to full employment and the centrality of work in society.

Generous out-of-work benefits are considered a means to increase people's control over one's (working) life (Lundberg 2009; van der Wel et al. 2015). One mechanism suggests that higher benefit generosity and accessibility, and thus higher de-commodification levels, make people less dependent on taking on every job available just because of financial reasons. Generous and accessible benefits create the opportunity to opt out of work and invest in a decent job search. As such, they give people a certain freedom to choose a job they want and thus enhance people's capability to be satisfied with the job they take on. More generous benefits are thus likely to result in people findings jobs that match their skills and preferences, and better job satisfaction in the end. They weaken the link between income and work and thus disconnect work from the tyranny of necessity (van der Wel and Halvorsen 2015). This might be true for all workers in general, but especially for people with activity limitations as they are more likely to live in economic hardship and have more difficulties to find a job higher up the occupational ladder (WHO and World Bank 2011). Generous benefits may also strengthen the autonomy of potential workers with activity limitations as a group by increasing their bargaining power (van der Wel et al. 2015), because they are less dependent on work for income provision, and are therefore better able to negotiate good working conditions in the labour market. In addition, more generous benefits may function as a source of control for people with activity limitations as they enable turnover without facing financial penalties. This may result in more satisfied workers as it enables to take a break when facing health problems. Generous benefits thus create the freedom to adjust their work effort according to one's subjective physical and mental energy (van der Wel et al. 2015).

Data and methods

Data

The analyses are based on the European Social Survey (ESS), a biennial survey covering attitudes, beliefs and behaviour patterns across Europe. The 2012 wave focusses on the personal and social well-being and is collected in 27 countries. In most countries stratified multi-stage probability sampling is used to collect the data (ESS 2014). The samples are representative of all people aged 15 and over living in private households, irrespective of language, citizenship and nationality. The respondents were face-to-face interviewed (computer or paper assisted) in the national languages. The lowest response rate in our sample is found in Germany (33.8 per cent) and the highest in Portugal (77,1 per cent). The overall response rate for 2012 was 62.7 per cent. We limit our analyses to the population who has a job, between 25 and 65 years old, living in 21 countries for which we have macro-level data (see Table 14 for the countries and samples).

Variables

Respondents were asked: “All things considered, how satisfied are you with your present job?”. They could rate their job satisfaction on a scale from 0 ‘extremely dissatisfied’ to 10 ‘extremely satisfied’ (response rate: 99.0%). Respondents were also asked to indicate whether they were hampered in their daily activities in any way by any longstanding illness, or disability, infirmity or mental health problem. We make a distinction between people without activity limitations (coded ‘0’) and people with activity limitations (coded ‘1’)(response rate: 99.3%).

Occupation is given a three-digit ISCO (International Standard Classification of Occupations) code based on the ISCO information provided by the ESS. The job groups based on this coding are added as dummy variables in the analyses. This approach has been applied by Mastekaasa (2014) and provides considerable details with more than 100 separate categories in most countries. This way we work around the limited job related information available in the 2012 wave of the ESS. Although there might still be systematic differences between people with and without activity limitations within the categories, related to wage, working conditions and job rank, we found no systematic evidence for this. In addition, information is provided on the employment quality and work conditions. Based on the information on the work contract and the employment relation, we constructed a variable with four categories, making a distinction between people with an ‘employment contract of unlimited duration’, ‘a contract of limited duration’, ‘those without a contract’ and ‘people who are self-employed’. This variable can be seen as a proxy for employment stability (Van Aerden et al. 2014). In addition, respondents were asked to what extent they were allowed to decide how their daily work is organised (termed perceived job control) and whether they were allowed to influence policy decisions about the activities of the organisation (termed perceived worker involvement). Response categories ranged from 0 ‘no influence’ to 10 ‘complete control’. The former question is more related to job control one perceives, while the latter has a broader focus on the firm or organisation and the balance of interpersonal power relations at the work space.

We control for marital status (‘living with partner’, ‘divorced’ , ‘widowed’ and ‘single’), age (in years, grand-mean centred), the respondent’s subjective feeling about the current household income (‘people who are coping or living comfortably’ and ‘people who find it (very) difficult on present income’), and education (in number of years, grand-mean centred in the multivariate analyses). Education was measured in the total number of years of full-time education. If respondents reported a number of years that was three standard deviations or more from the country mean, they were considered outliers and excluded from the sample.

At the macro-level we include spending on ALMPS (including training, employment incentives, supported employment and rehabilitation, direct job creation and start-up incentives, categories 2-7 in the database). Eurostat provides the expenditures as a percentage of the GDP. However, differences in the size of the GDP and the need for spending on active labour market policy influence the outcomes of the measure. Countries with similar spending levels but different GDPS would misleadingly be ordered differently (Gilbert, 2009). To account for both problems, ALMP spending was measured in purchasing power parities by taking the relevant percentage of the GDP expressed in the Purchasing Power Standard (PPS), also provided by Eurostat. PPS is an artificial currency unit adjusted to the price level of goods and services within a country. This measure was then divided by the non-employment rate of a country (the inverse of the Eurostat employment rate in the age group 25-64), to adjust the spending on ALMPS more to the need on activation and training (van der Wel and Halvorsen 2015). This way we try to take the cross-country variation in the number of people receiving services into account as far as possible. Benefit generosity is measured by summing the spending rates on social protection benefits of the sickness, disability and unemployment functions of Eurostat expressed in purchasing power parities per capita and divided by the mean non-employment rate of the three years. Otherwise, a less generous welfare state with a very large unemployment problem could even be ranked higher than a generous welfare state with a very small unemployment problem. In addition, we control for the employment rate (average of two years before wave and the year of the wave) as a proxy for the structural labour market conditions (availability of work)in a country. All measures refer to the year 2011.

Statistical procedure

We perform gender stratified multilevel models to disentangle cross-sectional country differences. The analyses are performed in MLwiN (version 2.35) using IGLS-estimation. Both random intercept and random slope models are tested. Given the scale of the dependent variable (0-10), linear regressions are performed. Metric variables are grand-mean centred for easier interpretation. The actual analyses are performed in a step-wise manner. First, we test whether activity limitations are associated with lower levels of job satisfaction after controlling for individual level characteristics. Subsequently, we test whether national welfare policy investments are associated with bigger or smaller differences between the groups. To test whether investments in almps and benefit generosity are associated with job satisfaction levels via their link with job characteristics, those variables are added in a third step.

Results

Table 15 shows the characteristics of both the male and female samples and provides bivariate statistical differences between workers with and without activity limitations regarding the main variables of the analyses. Table 16, 17 and 18 give the results of the multilevel linear regression analyses stratified by gender. Only a small part of the variation in job satisfaction is attributed to the country-level (around 3% in the null-model). After including the control variables, both female and male workers with activity limitations still tend to report a lower job satisfaction in all models.

Both almp investments and out-of-work benefit generosity are related to employment, either through group-specific effects only or through main effects. In model 2 of Table 16 for both men and women, we note that in countries with higher almp spending, workers tend to report a higher job satisfaction. The analysis shows that investments in almps do not accentuate or diminish the difference in job satisfaction levels between male workers with and without activity limitations (see model 4, table 17). Moreover, after including the job related variables in the analysis, the main effect of almp investments is halved and its significance disappears (see model 5, table 17). For male workers, the effect of almp investments mainly runs through job characteristics, or in other words better jobs or job matching processes. Both one’s employment relation, perceived job control and worker involvement are significantly related to the job satisfaction of male workers. Job satisfaction is better when perceived job control and worker involvement are higher and having no contract or being self-employed seem to be associated with a lower job satisfaction. For female workers the effect of almp investments is, however, different for workers with and without activity limitations. After including the job related characteristics in the analysis, the significant main effect of almp investments disappears, while the interaction term between activity limitations and almp investments becomes significant. This indicates that while both female workers with and without activity limitations report better job satisfaction in countries with higher ALMP investments, work and employment conditions explain most differences among the female workers without activity limitations, and only partly so for those with limitations. Consequently, some of the effect of ALMP on job satisfaction among female workers with limitations does not run through the quality of work, and may be attributed to other factors, such as the norm compliance effect.

Table 14: Country-level variables and sample sizes by gender, 2011

	Sample size men	Sample size women	ALMP * 100 (2-7)	Out-of-work benefits	Employment rate (25-64)
Country					
Belgium	426	358	2,38	122,72	67,30
Bulgaria	385	437	0,16	20,81	62,90
Cyprus	232	213	1,13	61,30	73,40
Germany	685	533	2,32	173,93	76,50
Denmark	373	342	7,97	154,07	75,70
Estonia	448	533	0,32	40,24	70,60
Spain	362	314	1,77	76,32	62,00
Finland	514	454	3,83	141,21	73,80
France	407	423	2,36	117,96	69,20
United Kingdom	386	428	0,12	113,10	73,50
Hungary	355	388	0,58	36,08	60,40
Ireland	456	416	2,71	142,85	63,80
Italy	165	124	0,82	62,70	61,00
Lithuania	361	458	0,36	34,94	66,90
The Netherlands	427	374	4,15	200,15	76,40
Norway	493	379	4,02	265,91	79,60
Poland	436	347	0,60	30,59	64,50
Portugal	309	381	1,15	58,34	68,80
Sweden	461	410	5,91	187,37	79,40
Slovenia	230	198	0,67	67,85	68,40
Slovakia	320	387	0,47	43,90	65,00

Source: Eurostat and own calculations.
ALMPs: % of GDP in PPS, divided by national non-employment rate
Benefit generosity: in PPS per capita, divided by national non-employment rate
Employment rate: harmonised national percentages.

Table 15: Bivariate statistics of samples

X	No activity limitations	Activity limitations	Significance	No activity limitations	Activity limitations	Significance
Job satisfaction (X - SD)	7,49 – 1,95	7,28 – 2,09	F=11,559**	7,53 – 1,85	7,21 – 2,05	F=32,296***
Age (X, SD)	43,32 – 10,38	47,97– 10,08	F=155,372 ***	42,95 – 10,48	46,24 – 10,20	F=103,865***
Marital status (%)			χ^2= 11,372 *			χ^2= 10,240**
Married	59,5	57,3		62,2	63,4	
Divorced	12,4	15,0		7,4	9,5	
Widowed	3,1	4,2		0,7	0,4	
Single	25,1	23,5		29,7	26,7	
Education (X, SD)	14,29– 3,64	13,01– 3,68	F=6,643*	13,87 – 3,75	13,53 – 3,72	F=8,695**
Subjective income			χ^2= 16,607***			χ^2= 12,312***
Living OK	79,4	74,1		81,6	77,3	
Difficulties	20,6	25,9		18,4	22,7	
Employment relation (%)			χ^2= 1,082			χ^2=0,045
Permanent contract	75,8	74,9		69,4	69,2	
Limited contract	11,1	12,1		9,4	9,4	
No contract	4,4	4,2		4,1	4,2	
Self-employed	8,7	8,9		17,1	17,2	
Perceived employee involvement (X, SD)	4,64 – 3,43	4,51 – 3,47	F=1,282	5,08 – 3,60	5,00 – 3,54	F=0,486
Perceived job control (X, SD)	6,80 – 3,12	6,98 – 2,98	F=3,340	6,99 – 3,07	7,18 – 2,95	F=3,948*
Total N	6596	1279		7015	1195	
%	83,8	16,2		85,4	14,6	

Weighted analyses; Significance is tested by using anova-test with the metric variables and Chi-square tests for categorical variables
*p<0.05; **p<0.010; ***p<0.001.

Figure 9 shows the predicted job satisfaction levels for female workers with and without activity limitations based on the minimum and maximum values of the ALMP investments and the coefficients of model 4 and 5. It makes clear that the job satisfaction of female workers with activity limitations in countries with the highest investments on ALMP, like Denmark, the Netherlands and Sweden, is equal or higher than the job satisfaction of female workers without activity limitations in countries with the lowest investments in ALMPS, like Bulgaria, Slovakia or even the UK. After the inclusion of the job related variables in model 5, we see that it is mainly the job satisfaction of female workers with activity limitations that is related to investments in ALMP. After controlling for the job related characteristics, we see that in countries with higher ALMP investments female works with activity limitations even have higher job satisfaction than female workers without activity limitations.

In Model 6 of table 18 the interaction between activity limitations and spending on out-of-work benefits is tested. In model 7 we also control for job characteristics. We observe that for men, with and without activity limitations, the spending on out-of-work benefits neither affects job satisfaction nor is associated with smaller differences between workers with and without activity limitations. Nevertheless, we observe a positive effect of benefit spending for female workers with activity limitations. Note that this is only visible after including job characteristics. Again, better perceived job control and worker involvement are associated with better job satisfaction. Thus whilst taking into account differences in job characteristics, female workers with activity limitations generally report a higher job satisfaction in countries with higher spending on out-of-work benefits.

Table 16: Multilevel results, job satisfaction regressed on individual and country level controls, activity limitations and welfare policy, stratified by gender, ESS, 2012

	Model 1		Model 2		Model3		Model 1		Model 2		Model 3	
X	b	S.E.	b	S.E.	b	S.E.	b	S.E.	b	S.E.	b	S.E.
Intercept	7,727***	0,064	7,727***	0,057	7,732***	0,063	7,804***	0,060	7,816***	0,051	7,818***	0,055
Individual variables												
Age	0,012***	0,003	0,012***	0,003	0,012***	0,003	0,006	0,004	0,006	0,004	0,006	0,004
Marital status (ref: married)												
Divorced	-0,078	0,071	-0,081	0,071	-0,080	0,071	-0,148	0,083	-0,148	0,083	-0,149	0,083
Widowed	0,051	0,163	0,056	0,162	0,053	0,163	0,452*	0,209	0,459*	0,208	0,455*	0,208
Single	-0,087	0,056	-0,096	0,056	-0,092	0,056	-0,170***	0,040	-0,172***	0,039	-0,171***	0,040
Difficulties with income	-0,899***	0,104	-0,878***	0,103	-0,886***	0,103	-1,002***	0,082	-0,986***	0,082	-0,990***	0,083
Education (in years)	0,011	0,014	0,011	0,014	0,011	0,014	0,003	0,009	0,003	0,008	0,003	0,009
Activity limitations	-0,221***	0,060	-0,227***	0,060	-0,226***	0,059	-0,330***	0,051	-0,336***	0,052	-0,335***	0,052
Country variables												
Employment rate			0,003	0,009	0,013	0,015	0,006	0,012	0,008	0,010	0,015	0,014
ALMP investment			8,138***	2,452					6,156**	2,329		
Benefit generosity					0,931	1,323					0,745	1,211
Variance												
Country	0,068**	0,023	0,012	0,014	0,051**	0,017	0,057	0,020	0,030	0,012	0,039**	0,013
Individual	3,544***	0,161	3,690***	0,030	3,544***	0,162	3,479***	0,217	3,479***	0,217	3,479***	0,217
-2LL	33405,403		33394,433		33400,303		33821,164		33810,688		33814,722	
N individual	7875		7875		7875		8210		8210		8210	
N country	21		21		21		21		21		21	

*p<0,050; **p<0,010; ***p<0,001; Significance tests: fixed effects: t-tests, random variances: Wald-tests. Weighted analyses.

Table 17: Multilevel results, job satisfaction regressed on individual and country level controls, activity limitations and ALMP investments, interaction effects and job characteristics, stratified by gender, ESS, 2012

	Women				Men			
	Model 4		Model 5[a]		Model 4		Model 5[a]	
X	b	S.E.	b	S.E.	b	S.E.	b	S.E.
Intercept	7,727***	0,056	7,433***	0,156	7,816***	0,051	7,331***	0,240
Individual variables								
Age	0,012***	0,003	0,007***	0,003	0,005	0,004	0,001	0,003
Marital status (ref: married)								
Divorced	-0,083	0,071	-0,141	0,153	-0,147	0,084	-0,129	0,081
Widowed	0,055	0,162	0,056	0,162	0,461*	0,208	0,486*	0,216
Single	-0,096	0,056	-0,065	0,058	-0,172***	0,039	-0,106***	0,042
Difficulties with income	-0,876***	0,103	-0,654***	0,089	-0,988***	0,082	-0,750***	0,075
Education (in years)	0,011	0,014	-0,045***	0,010	0,003	0,009	0,042***	0,008
Activity limitations	-0,238***	0,064	-0,231***	0,060	-0,331***	0,047	-0,316***	0,048
Country variables								
Employment rate	0,003	0,009	0,005	0,012	0,008	0,010	0,003	0,010
ALMP investment	7,426***	2,406	3,382	2,754	6,553**	2,298	3,027	2,427
Interaction effect								
Activity limitations X ALMP investment	4,106	2,720	5,150*	2,528	-2,570	2,430	-1,781	2,409
Job characteristics								
Employment relation (ref: permanent)							**	
No permanent contract			-0,028	0,094			-0,099	0,101
No contract			-0,117	0,112			-0,385***	0,111
Self-employed			0,000	0,084			-0,233*	0,111
Perceived job control			0,109***	0,013			0,099***	0,013
Perceived employee involvement			0,071***	0,011			0,060***	0,013
Variance								
Country	0,034	0,018	0,057*	0,022	0,030*	0,012	0,027*	0,012
Individual	3,544***	0,162	3,167***	0,157	3,478***	0,218	3,156***	0,207
-2LL	33392,313		32519,424		33809,857		33011,943	
N individual	7875		7875		8210		8210	
N country	21		21		21		21	

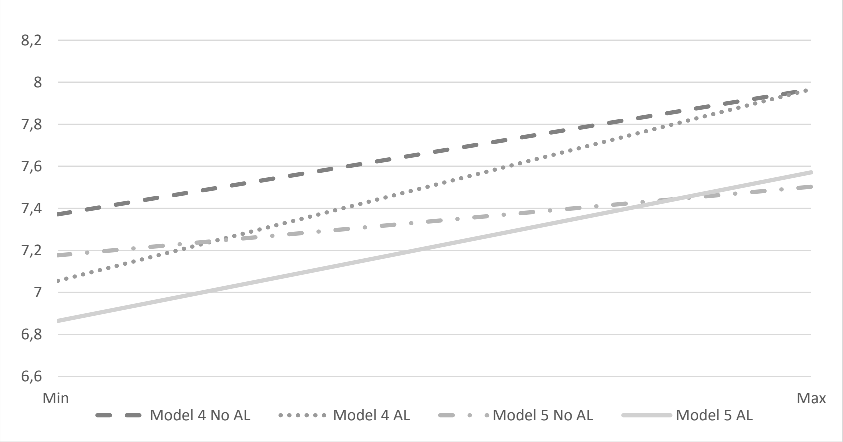
*p<0,050; **p<0,010; ***p<0,001; Significance tests: fixed effects: t-tests, random variances: Wald-tests. a: These models also include the occupational class information, due to the many categories these coefficients are not displayed. Weighted analyses.

Table 18: Multilevel results, job satisfaction regressed on individual and country level controls, activity limitations and out-of-work benefits, interaction effects and job characteristics, stratified by gender, ESS, 2012

	Women				Men			
	Model 6		Model 7[a]		Model 6		Model 7[a]	
X	b	S.E.	b	S.E.	b	S.E.	b	S.E.
Intercept	7,732***	0,063	7,441***	0,148	7,818***	0,055	7,344***	0,231
Individual variables								
Age	0,012***	0,003	0,007***	0,003	0,006	0,004	0,001	0,003
Marital status (ref: married)								
Divorced	-0,083	0,071	-0,033	0,063	-0,148	0,084	-0,129	0,081
Widowed	0,053	0,163	0,140	0,153	0,456*	0,207	0,483*	0,215
Single	-0,094	0,056	-0,064	0,058	-0,171***	0,040	-0,105***	0,042
Difficulties with income	-0,884***	0,104	-0,657***	0,088	-0,991***	0,082	-0,753***	0,075
Education (in years)	0,011	0,014	-0,045***	0,010	0,003	0,009	0,042***	0,008
Activity limitations	-0,237***	0,065	-0,231***	0,062	-0,331***	0,049	-0,318***	0,049
Country variables								
Employment rate	0,013	0,015	0,005	0,019	0,015	0,014	0,013	0,013
Benefit generosity	0,755	1,345	-0,315	1,599	0,805	1,225	-0,436	1,155
Interaction effect								
Activity limitations X Benefit generosity	1,098	0,646	1,320*	0,642	-0,465	0,802	-0,087	0,897
Job characteristics								
Employment relation (ref: permanent)							**	
No permanent contract			-0,027	0,094			-0,099	0,101
No contract			-0,119	0,114			-0,391***	0,109
Self-employed			-0,004	0,084			-0,236*	0,113
Perceived job control			0,109***	0,013			0,100***	0,013
Perceived employee involvement			0,072***	0,011			0,061***	0,013
Variance								
Country	0,050**	0,017	0,063**	0,019	0,039*	0,013	0,029**	0,009
Individual	3,543***	0,162	3,168***	0,157	3,479***	0,217	3,156***	0,207
-2LL	33398,700		32519,424		33814,441		33013,222	
N individual	7875		7875		8210		8210	
N country	21		21		21		21	

*p<0,050; **p<0,010; ***p<0,001; Significance tests: fixed effects: t-tests, random variances: Wald-tests. a: These models also include the occupational class information, due to the many categories these coefficients are not displayed. Weighted analyses.

Figure 9: Predicted job satisfaction of female employees displayed by minimum and maximum values among the countries



Own calculations, prediction based on all coefficients (significant and not significant), based on person with grand mean age, grand mean number of years education and grand mean difficulties with income, who is married and has permanent contract, grand mean perceived job control and employee involvement and grand-mean centered value of country-level variables.

Discussion

This multilevel study of 21 European countries shows that workers with activity limitations generally experience lower levels of job satisfaction compared to workers without activity limitations. In accordance with the handful of cross-national studies considering job satisfaction in the general work population (Ahn and Garcia 2004; Gallie 2007; Hipp and Kolins Givan 2015; Pichler and Wallace 2009), we conclude that job satisfaction is mainly explained by differences between individuals within a country. The experience of activity limitations is one source of inequality. Although this finding is consistent across Europe, this should not rule out that welfare policies can minimize the deficit or even revert the relationship between activity limitations and job satisfaction by affecting micro-level antecedents of job satisfaction or by creating a specific cultural and socio-economic context. For male workers with and without activity limitations, we conclude that whilst spending on out-of-work benefits does not affect job satisfaction, investments in ALMPS are generally associated with better job satisfaction for both groups. The analysis pointed out this relation could be explained by job characteristics. These findings are in line with the cross-national European study of Pichler and Wallace (2009) who conclude that most country differences in job satisfaction are explained by the composition of labour markets, rather than welfare policy directly. Higher investments in ALMPS can lead to better work and employment conditions which influence job satisfaction. ALMPS can increase the opportunity for people to be satisfied with one's job by providing the necessary resources and skills. In particular, the services provided through ALMPS might lead to better bargaining and communication skills, and help job applicants put more effort in finding the right job that matches with available skills.

Both aspects of the welfare policy play a role in the job satisfaction of female workers. We observed that higher benefit spending is associated with higher job satisfaction among female workers with activity limitations after controlling for job characteristics. Earlier we hypothesized that more generous out-of-work benefits could be associated with a better job satisfaction either because they create the opportunity to invest in a decent job search and enhance bargaining power, and/or, because they might act as a source of control for people with activity limitations who are able to take a break when facing (health) problems. We can now confirm that these welfare resources are important for people with activity limitations, as they are more likely to draw upon collective resources to compensate for less individual resources and needs (Lundberg 2009). As suggested by previous research however (van der Wel et al. 2015), it looks like more generous benefits create the freedom to adjust one's work effort according to one's subjective physical and mental energy. Since the effect of benefit generosity is visible after controlling for job characteristics, it seems that the effect is indeed more due to its link with being able to control one's life and work scheme rather than to the explanation that says higher benefits related to better jobs. In addition, this result also contradicts the believe that more generous benefits are disincentives to work (e.g. Heinemann, 2008).

Regarding ALMPS, we see that female worker's job satisfaction is higher in countries with more investments in ALMPS. However, for female workers without activity limitations this significant association between ALMP investments and job satisfaction disappears after controlling for work and employment conditions. Again, this association between ALMP and job satisfaction is thus explained by its link with job quality and possibly also job matching processes. In addition, in countries with higher investments, the job satisfaction of female workers with activity limitations, will be higher, irrespective the kind of jobs they are doing and approaches the level of job satisfaction of workers without activity limitations in countries with the lowest investments. For this group, other pathways are at play. ALMPS are much used elements of the active welfare state, pointing to the centrality of paid work and employment in the social organisation of life. Therefore, female workers with activity limitations might just be satisfied with their jobs, irrespective of its characteristics just because they are working in an environment which values work and self-reliance. Previous research has indicated the lower job expectations of people with activity limitations (Pagan 2011, 2013), indicating that they are happy just to be at work.

This might be signalled by a higher job satisfaction, given that research points out that paid work is an important way for them to feel a valuable member in society and the difficulties they experience to get a job (Honey 2004; Roulstone 2012; Saunders and Nedelec 2014). This might be especially true in environments with a focus on full employment as signified by higher ALMP investments. This mechanisms is supported by the findings of van der Wel and Halvorsen (2015) that indicate that employment commitment is higher across all different population groups, including those with limiting longstanding illnesses, in countries with higher ALMP spending. In contrast to a welfare scepticism perspective, the authors conclude that higher spending is associated with higher non-financial and non-job specific motivation. People might therefore be satisfied with their jobs irrespective of its characteristics, as they may want to avoid social sanctions that arise from violating the work norm, or feel more obliged to work (van der Wel and Halvorsen 2015)[2].

The more outspoken influence of the welfare policies for women compared to men might be linked to the division of labour and family models in the countries. The countries with higher out-of-work benefit and ALMP spending of the sample, like Denmark, Sweden, the Netherlands and Ireland, are generally classified as universal breadwinning or universal caregiver models (Ciccia and Verloo 2012). Though these models differ in the extent to which care work is valued and outsourced to the state or market, both assume that men and women are (fully) engaged in the labour market. Again, in those countries being at work might be a societal norm, which points to an extra explanation for why female workers with activity limitations in those countries especially seem to be more satisfied with their jobs, irrespective of its characteristics.

Finally, some limitations should be taken into account. First, we are unable to consider different types of activity limitations and impairments due to limitations of the dataset. It is likely that people with long-standing mental health problems might experiences the lowest levels of job satisfaction and respond differently to active labour market programs than people with

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[2] Additional analyses were performed to get a better insight in this last mechanism. With data of the European Values Survey of 2010, a country-level social norm to work variable was created based on the previous research of Stam et al. (2016). The variable was the aggregated individual work ethic, which was the average of at least three valid scores of five items ('To fully develop your talents, you need to have a job'; 'It is humiliating to receive money without having to work for it'; 'People who don't work turn lazy'; 'Work is a duty towards society'; and 'Work should always come first, even if it means less spare time.'). The items all centre around whether work is a moral duty. Contrary to what we expected, this social norm to work variable correlated negatively with investments in ALMPs; higher investments in ALMPs are generally associated with lower social norms to work. Additional multilevel analysis, with and without ALMP investments, the social norm to work did not seem to be related to job satisfaction of any group, nor did it explain the effect of ALMP investments. This does, however not rule out that in countries with higher ALMP investments, individuals have a stronger employment commitment, feel more obliged to work and are therefore more satisfied with their current job. The current data, however, does not let us take that individual level mechanism into account.

muscular-skeletal or lower back problems. Second, the analyses are limited to an overall single indicator of job satisfaction. We are not able to make statements about specific aspects of job satisfaction. Higher investments in ALMPs might, for instance, lead to increase in income satisfaction but not necessarily with an increased satisfaction about career opportunities. A more refined approach is needed to disentangle the processes influencing the general job satisfaction indicator. Third, the organizational structure is not explicitly taken into account in the analysis. Nevertheless, organizations and firms are the main context in which the job satisfaction of workers is constituted. D. L. Stone and Colella (1996) aim for the inclusion of organizational policies and practices in research around job satisfaction, with particular attention for people with impairments and activity limitations. Specific policies relevant for people with activity limitations could be the degree of reasonable accommodation provided by the firm, coaching, or the presence of diversity management policies with attention for disability.

Chapter 9

Study 4. Old social risk, alternative theoretical approach - A reflection on the analytic concepts for comparative disability policy research

Based on Foubert, J., Halvorsen, R. & Van Rossem, R. Old social risk, alternative theoretical approach - A reflection on the analytic concepts for comparative disability policy research. To be resubmitted.

Abstract

Although disability protection is one of the traditional areas of social policy, it has received relatively little attention of comparative welfare research. Although a lack of data contributes to this, theoretical issues also impede the research. We reflect on concepts guiding comparative welfare state research and discuss whether or not they are suited for the cross-national comparison of contemporary disability policy. More specifically, we elaborate on the link between disability and decommodification, defamilisation and dedomestication respectively and conclude they are not tailor-made to describe the aim and goals of disability policy. In the last decades, full and effective participation of people who experience disability became an explicit goal of disability policy. We argue that theoretical concepts underlying most comparative welfare state do not capture this policy focus. Conversely, we point to the potential of recent developments around active citizenship that could provide a way out of the status quo.

Introduction

Disability policy is one of the main and traditional pillars of social protection in welfare states. In comparison to other areas of welfare policy, it has, however, received little attention from comparative welfare researchers (Hvinden, 2004). At the same time, there is ample evidence that people with impairments and chronic illnesses experience varying levels of social exclusion across (Western) countries (Barnes & G. Mercer, 2010a; Emerson et al., 2011; Mitra, Posarac, & Vick, 2011; van der Wel et al., 2011; WHO & WorldBank, 2011). Disability welfare policy is acknowledged as one of the main roads to ensure the social inclusion and rights of people impairments in society (Barnes & Mercer, 2010a; Witvliet et al., 2012a). Better insight in countries' organisation of social protection for person who experience disability, is a first step towards uncovering best practices in policy.

Historically, disability was one of the first social risks covered by social insurance systems. By now most countries have developed income maintenance schemes with special provisions for people who experience disability (Dixon & Hyde, 2000; Van Oorschot & Hvinden, 2000). The scope of disability policy is, however, not restricted to income security. Labour market participation, health and social care are also part of the package nowadays. In a broad sense, one could say that contemporary disability policy refers to the totality of policy measures that have consequences for the welfare, autonomy and participation of people with impairments (Halvorsen & Hvinden, 2009; Hvinden, 2004). It cuts across different fields of social policy systems, which together, intended or unintended, influence the well-being and social participation of people with impairments (Halvorsen & Hvinden, 2009).

Few studies have attempted to cross-nationally compare the disability policy of a greater number of countries (Dixon & Hyde, 2000; Maschke, 2008; OECD, 2003, 2010; Waldschmidt, 2009). The lack of comparable policy-related data gathered about disability definitely contributes to this (Grammenos, Moons, et al., 2007). Because of this, most studies tend to be biased towards income transfer arrangements and activation measures, at the expense of broader social services and social regulation. However, there are also theoretical and conceptual obstacles hindering contemporary comparative disability policy. So far, no comparative study on disability policy departed from a theoretical construct that functions as the basis of comparison of the social organisation of social rights related to disability. The multidimensional character of disability policy complicates the search a sound theoretical basis for comparison. Previous studies thus seem to lack an explicit theoretical concept that enables them to test qualitative differences in countries' approach towards disability.

In this paper, we reflect on recent developments related to citizenship and disability that could provide a way out of the theoretical status quo. More specifically, a recent approach centred around Active Citizenship for people with disabilities promises to be an insightful way of looking into disability policy (Halvorsen & Hvinden, 2013c). Throughout the discussion, we also elaborate on the theoretical approaches of mainstream comparative welfare studies and indicate theoretical reasons whether or not they are feasible for comparing disability policy across countries. We conclude studies on disability policy should employ their own theoretical basis for comparison that captures the reality of people who experience disability and is able to pinpoint crucial differences in countries' social organisation towards disability.

Evolution of disability policy and research

Throughout the 20th and the early 21st centuries the understanding of disability changed considerably. The traditional medically-oriented and person-centred definitions, in which impairments limit participation and well-being, have gradually been replaced by perspectives that emphasize the social exclusion and disabling effects of social barriers and the physical environment (Bury, 2000; Oliver, 1986; Thomas, 2004; WHO, 2001). The questioning of the accessibility of public places, buildings and transport, but also that of the potentially discriminating set-up of job tests in assessment centres exemplifies this shift. Gradually, disability policy itself also evolved away from segregation and containment in grand residential institutions towards a focus on integration, inclusion and welfare policy from the 1940s onwards (Drake, 1999; Marin, 2004). Pressured by independent and community living organizations, governments increasingly started to invest in deinstitutionalization and support to include people with impairments as equal citizens in society, especially since the 1960s (Mansell et al., 2007). Since the 1990s, equal rights and anti-discrimination policies also came to the front (Drake, 1999; Hvinden, 2004; Waldschmidt, 2009). Accordingly, full participation in society of people who experience disability has thus become an explicit goal (Hästbacka, Nygard, & Nyqvist, 2016).

So far, no study provides insight in how and to what extent different countries seek to effectuate this participation. Most studies of disability policy primarily focus on a single or on a limited number countries (B. Hvinden, 2003, 2004; Maschke, 2008) or on supra-national disability policy (e.g. EU) (Waldschmidt, 2009). In addition, the available studies tend to be biased towards income transfer arrangements and labour market participation, at the expense of broader social services and social regulation (Burkhauser & Hirvonen, 1989; Halvorsen & Hvinden, 2009; Hvinden, 2004; OECD, 2003, 2010; Phillips, 2012; van Santvoort, 2009). Given this lack, studies that aim to examine the effects of different socio-political contexts on the well-being of people who experience disabilities (e.g. Foubert et al., 2014; Witvliet et al., 2012a) revert therefore to more general descriptions and categorisations of welfare states. The mainstream of comparative welfare state research has been highly advanced by a focus on how and to what extent welfare states develop social rights or social citizenship with a focus on social security systems (Arts & Gelissen, 2002; Ferragina, 2015; Ferrarini et al., 2013; Korpi, 1989; Marshall, 1950; Powell & Barrientos, 2011). This was done not in the least by the publication of Esping-Andersen's (1990) 'The three worlds of welfare capitalism'. It is, however, an open question to what extent general welfare typologies are helpful in understanding cross-country variations in more specific policies (Myles, 1998; Powell & Barrientos, 2011), especially because it is likely that countries cluster in different ways when other social risks are considered (Bambra, 2007; Ferragina et al., 2015). Researchers have indeed questioned to what extent existing theories on citizenship and theoretical background concepts employed in general welfare typologies are helpful starting points for comparative research on disability policy (Beckett, 2006; Waldschmidt & Lingnau, 2008). These general descriptions and categorisations of welfare states do not give insight in countries' social organization of disability policy, nor do they explicitly take into account to what extent disability policy ensure full and effective participation of people with disabilities in society. In the following, we elaborate on perspectives on disability and citizenship and how central concepts of comparative welfare state research relate to disability policy.

Disability and comparative welfare state research

In the past decades, the concept of decommodification, as introduced by Esping-Andersen's (1990), has been the main reference point of comparative welfare state research (Bothfeld, 2009). It is understood as the extent to which an individual can uphold an acceptable standard of living independent from the labour market. Decommodifying social policies thus decrease workers' market dependency and therefore create more space for individuals to control their lives. Underlying this idea was the notion of social citizenship as defined by Marshall (1950) which pointed to social rights as economic welfare and security. Esping-Andersen tested the decommodifying qualities of three central social insurance schemes of states, being old age, sickness and unemployment monetary support. Invalidity or disability benefits were not taken into account. While still being very influential, his publication received both theoretical as well as methodological critiques (for an overview see e.g. Arts and Gelissen, 2002; Powell and Barrientos, 2011; Ferragina, 2015; Ferragina and Seeleib-Kaiser, 2011).

As already mentioned, the scope of disability policy is broader than income replacement schemes. As indicated by Waldschmidt and Lingnau (2008), however, disability income replacement schemes can indeed be studied in terms of the degree to which they lead to income security independent of the persons position of the labour market. Nevertheless, many people with disabilities are excluded from the labour market because of the nature of the labour market, the combination with care arrangements, social exclusionary processes or institutionalization (WHO & WorldBank, 2011). In 2011, the employment rates of people with a longstanding health condition or activity limitation were considerably lower than those of people without such a condition in all European countries (Eurostat, 2014). As such, for most people with disabilities having the opportunity to take part in the labour market would serve as a source of independency from the family or the institution, and welfare state support. Therefore, countries increasingly try to foster the labour market participation of people who experience disabilities (OECD, 2010). This starts with the provision of special and/or inclusive education of children with disabilities and evolves into vocational training and social support in the form of work-promotion services, rehabilitation and (re-)integration in the labour market of adults who were once employees but acquired impairments. Moreover, other policies stimulate what Waldschmidt and Lingnau (2008) termed quasi-commodification, by providing sheltered employment and work programs for people with learning difficulties or mental health problems. In that account, we could say that for a long time (and still) people with disabilities have struggled to solidify their right to participate in the labour market, rather than being concerned with freedom from the labour market. However, although people with disability have always been considered as part of the people who 'deserve' welfare benefits (de Swaan, 1988; Van Oorschot, 2000), ongoing 'activation turn' tendencies in many social security systems (Bonoli, 2010; Dingeldey, 2007; Marchal & Van Mechelen, 2014), create a (new) tension field in which also people with disabilities are stimulated or forced to be active on the labour market (Etherington & Ingold, 2012).

For many people, disability policy is thus centred around establishing a link with the labour market, or, in other words, the establishment of (re-)commodification of the person with a disability (A. Waldschmidt & Lingnau, 2008). These remarks make it doubtful whether decommodification would be an appropriate starting point for comparative studies of disability policy, as it only points to social security provided by income insurance. This resonates with the critique that decommodification was not suited to describe the dependency situation of many women. On the basis of gender as a stratification mechanism, critics (Bambra, 2007; Bambra, 2004; Sainsbury, 1994; Orloff, 1993; Lewis, 1992) made it clear that the focus on the state-market nexus on welfare provision that for women it was often the reliance on the family that was the primary source of dependency. Patriarchal family structures caused women to be economically dependent on their male counterparts and women's access to paid work had to be seen as a main source of emancipation (Powell and Barrientos, 2011; Ferragina and Seeleib-Kaiser, 2011; for more information see Bothfeld, 2009; O'Connor and Olsen, 1998; Kröger, 2011). To make the welfare state analysis more gender-sensitive, new concepts soon developed (for a discussion see Kröger, 2011; Bambra, 2007). The concept of defamilisation developed by Lister (1997) has received the widest use and is generally seen as the degree to which adults can uphold an acceptable standard of living independent from family relations. Although it is gender-neutral an sich, it foremost used to test how welfare states facilitate female autonomy and economic independence from the family (Bambra, 2007). The concept acknowledges that a major part of welfare provision and thus care are indeed nested in the private sphere of the family and pre-dominantly was the responsibility of women. Paid work and welfare benefits are seen as the main routes towards independence.

At first sight, defamilisation could function as a theoretical starting point for disability policy as well. Indeed, it could give insight in the extent towards states foster the economic independence of people who experience disability from their family. As discussed in Kroger (2011), at the heart, both Esping-Andersen and Lister share a focus on the financial autonomy of citizens. In their theory, decommodification and defamilisation concentrate on economic independence, from the market and the family respectively, and income benefits are seen as a way to ensure this when labour market participation is not possible. Defamilisation would, again, only tend to highlight only one of the necessary elements for the full participation of people with disabilities in society and neglects other aspects related to social participation. Another conceptual problem with defamilisation is, however, related to the fact that it mainly neglects that people who experience disabilities are mainly receivers of care, as opposed to women who are predominantly care-takers in the family and therefore hindered to be active on the labour market. Different to the situation of most women, social services and care are also necessary for people with impairments to build up their own livelihoods and live independent in society, and not just a mean to and end (Halvorsen & Hvinden, 2009; Waldschmidt 2009; Nussbaum, 2006).

Comparative studies on social care developed as a reaction on the dominance of economic independence and social insurance of both perspectives. Social care researchers asked for a switch of attention to the right to have time to care as opposed to engagement in paid work, the social and emotional dimensions of care work, and the perspective of care receivers (for a discussion see Kröger, 2011; Alber, 1995; Kautto, 2002; Bettio and Plantenga, 2004; Leitner and Lessenich, 2007; Mclaughlin and Glendinning, 1994). In response, other definitions of defamilisation have been developed that focus more on giving care than on economic independence (Mclaughlin and Glendinning, 1994; Leitner and Lessenich, 2007; Esping-Andersen, 1999). This however, does not really promote conceptual clarity (Bambra, 2007; Kröger, 2011). To meet a number of those critiques and avoid conceptual ambiguity, Kröger (2011) proposed the concept of ‘dedomestication’, which has to be understood as the degree to which social care policies make it possible for people to take part in society, by taking over their caring responsibilites. If defamilisation is primarily understood as economic independence from family relations as defined by Lister (1994), Kröger (2011) reasons, dedomestication describes independence from familial care relations for care givers through bringing freedom from forced altruism. Although he applies the concept to a comparative study of childcare service provision, he underscores the concept is suited for the study of care provisions for people with disabilities as well. Moreover, he indicates that the concept could also be employed to study the situations of care receivers. In that account, dedomestication has to be seen as the degree to which a country's (disability) policy offers alternatives to enforced dependency on family members. With regard to disability policy, we would add it is possible to extent this manner of thinking towards deinstitutionalization, or the extent countries focus on community living, outside care taking institutions.

Disability and citizenship as a matter of social practices

The previous discussion of the main concepts employed in most comparative welfare studies points out that no concept in traditional comparative welfare policy grabs the daily reality of people with disabilities in society in a holistic way, nor do they focus on the participation in society which is central in their struggle. Decommodification and defamilisation, on the one hand, tend to focus on the provision of social security to compensate for insufficient or lack of income from paid work in the ordinary labour market and extra costs associated with disability. Dedomestication, on the other hand, refers more to autonomy or independence in care relationships. In the following we discuss other approaches that (un)consciously depart from the same critique on the mainstream welfare state concepts.

Nussbaum's (2006) describes an approach that sees people with impairments as holders of fully equal rights, whilst being ensured that they get a chance to exercise their rights. By means of including disability into the capabilities approach to social justice (Nussbaum, 2006; Sen, 1999), she indicates we need to pose the following question: what are people with impairments actually able to do and to be? Guided by this, we need to consider to what extent the public arrangements provide the social basis to give people with impairments the possibility to fully live as equal citizens who are members of the community, with the ability to lead a good human life. By equal rights she does not only mean the right to economic autonomy, and even actively discusses the adverse consequences of focusing on income and wealth only when researching disability. Nussbaum elaborates that a focus on income and wealth alone would ignore that in the case of disability, the social environment can be disabling and needs to be changed to be inclusive. No matter how much money you give to a person in a wheelchair, he or she will still not be able to access public space unless the space itself is redesigned. This is in line with the focus on full participation of disability policy in recent years and the centrality of it in for example the UNCRPD. Although not applied to disability, other perspectives on citizenship support this vision on autonomy and indicate that next to the satisfaction of material or physical needs, it is also about having the opportunity to develop independent ideas about life plans, respect for diversity and the acknowledgement of a person's ability to make decisions, and opportunities for participation in society (Bothfeld, 2009; Bothfeld & Betzelt, 2011).

This plea for a focus on social practices is being reflected in the concept of Active Citizenship (AC) developed specifically for study of the situation of people with disabilities in light of the DISCIT project. According to Halvorsen & Hvinden (2013b), citizenship for people with disability is mainly related to being acknowledged as full members of society and who can actively participate on an equal basis with others. AC can thus be understood as matter of practices: "living a decent life according to the prevailing standards of societies, being able to participate in social and political life in the broadest sense, and having 'civic' orientations to the political community and one's fellow citizens" (Andersen & Halvorsen, 2002: 12-13) They stress AC does not refer to (neoliberal) activation strategies that promote individualism and responsibilities (Waldschmidt, 2013), but has to be understood as an instance of 'thick citizenship' that incorporates not only obligations to participate in the ordinary labour market, but opportunities to exercise choice and responsibilities, engage actively in the public sphere and influence decision making processes of importance to themselves and the society they live in (Bickenbach, 2014).

Within the concept of AC for people who experience disability three dimensions are distinguished: security, autonomy and influence (R. Halvorsen & B. Hvinden, 2013a). The first dimension, security, refers to the right to enjoy social protection against life risks and to avoid constant worrying about (financial) matters in the future, whilst also pointing to (the duty of) participation in efforts to improve security.

Indeed, the security dimension of AC is easily linked to the concept of decommodification and defamilization, as both refer to the right not the be active on the labour market whilst still being financially independent. Nevertheless, the security dimension of AC seems to hold a broader scope. It directs us to the question of whether a policy enables people with impairments to attain or maintain a sense of security. Contrary to Esping-Andersen's focus on social insurance systems, it is stressed only a mixture of social benefits, services and regulations can provide proper social protection for people with impairments. Security can thus be attained in different ways and this leads us back to the demands or need for (re-)commodification and the access to the labour market of people with impairments.

The security concept as takes into account the greater emphasis that is placed on work's role as an important and more active way of generating security. This also serves to draw increasing attention to the employability of people with impairments (Etherington & Ingold, 2012; Lindsay & Houston, 2013). Generally, the activation of labour market policy involves a mixture of two approaches (Marchal and Van Mechelen 2014; Eichhorst and Konle-Seidl 2008; see e.g. Bonoli 2010; Bothfeld and Betzelt 2011; Dingeldey 2007). In the first approach, governments may condition social rights to limit benefit receipt and demand more individual job search activities. Examples of this kind of approach for people with impairments are lower benefit levels, stricter eligibility rules, time limits and more regular assessments of incapacity. A second approach focuses on increasing employability and human capital formation (Marchal and Van Mechelen 2014; Eichhorst and Konle-Seidl 2008). This may include 'enabling' policies, which refer to services with a more or less direct labour finality, such as education, vocational training and job search assistance, but can also point to a broader set of services that may make achievement and retaining of paid employment more likely. Research points out that for PWD the importance of the possibility to accumulate benefits with earnings from work, subsidies for employers when hiring workers with disabilities and the duty to provide reasonable accommodation at the workplace are central (Etherington and Ingold 2012; Grammenos et al. 2007; Greve 2009).

Second, autonomy covers the right to enjoy opportunities to live independently and to exercise freedom to choose the life one has, without dependence on or interference from others. It centres around getting insight how and to what extent a country's disability policy allows for people with impairments to make their own life choices and define their needs. Kröger's conceptualization of dedomestication in relation to care receivers resonates with the autonomy dimension of AC. However, though we acknowledge that dedomestication opens possibilities for comparative studies of disability services, again only one part of disability policy is taken into account. We recall that disability policy cuts across different fields of social policy systems, which together, intended or unintended, influence the well-being and social participation of people with impairments (Halvorsen & Hvinden, 2009). From mainstream comparative welfare state research, we know that some countries tend to be more service-intensive and other tend to rely on income benefits to secure people's welfare levels. This implies that if we are interested in knowing where people with impairments fare best, different aspects, and not only income-benefits or services, need to be taken into account simultaneously. Over the last two decades the concept of independent living has gained momentum as an important way to gain autonomy and independence (ANED 2009; Townsley et al. 2009). The objective is to allow people with impairments to decide for themselves how and where to live, with access to services such as personal assistance, to support their life in the community (Townsley et al. 2009). Social services provide benefits in kind to compensate for impairments, and offers medical and social services aimed at assistance and rehabilitation, education and vocational training and other services to improve the independence of people with impairments (Bickenbach, 2014).

Influence, lastly, refers to participating in discussion and decision-making aimed at one's own life and the promotion of the common good and regulating social behaviour. It questions whether or not a country's policy ensures people with impairment's participation in participation in the political decision-making process and affecting the direction of policy. No other concept discussed in the other sections touches this one.

Together the three dimensions ensure the full and effective participation of people with disabilities in society. Compared to the other approaches, a comparative analysis based on the concept of AC for people who experience disability might be more fine-grained and better suited to describe the struggle of people with impairments to participate in society. Rather than asking whether or not the a country's income benefit-scheme is decommodifying or not, although definitely one part of the story, studies on disability policy might progress more taking an alternative perspective that centres around what they are able to do and to be in different societies (Nussbaum, 2006). Empirical studies could for example examine the variation in welfare state approaches towards supporting the full and effective participation of people with impairments, and ask to what extent welfare states support the different dimensions of AC for people with impairments.

Conclusion

This article has argued that while disability policy is one of the main and traditional pillars of social protection in welfare states, it has received less attention from comparative welfare researchers than other welfare policy areas (Hvinden, 2004). Class and gender continue to be the dominating social relationships taken into account by comparative welfare state researchers. Disability, however, is a 'risk' that every individual in society faces in some point of our lives (Beckett, 2006). The relative inattention to disability has resulted in a lack of relevant theoretical models for cross-national studies about citizenship and disability.

Comparative welfare state studies have been highly advanced by a focus on social citizenship and institutional characteristics of states. To see to what extent and how welfare state organize the fulfilment of people's social rights, one of the most useful concepts that has been developed is decommodification (Esping-Andersen, 1990). Nevertheless, critics have rightly disputed the neglect of women and care within the family. As a response other concepts and categorizations of welfare state have been pushed forward. Defamilisation (Lister, 1997), or the extent to which (female) adults can uphold an acceptable standard of living independent from family relations. To ensure more attention to care providers and care receivers Kröger (2011) proposed the concept of dedomestication, i.e. the degree to which a country's policy offers alternatives to enforced dependence on family members. None of these concepts has been developed to better understand the lived experiences of people with disabilities and their struggle for full and effective participation in society. This reflects the relative neglect of disability in discussions about social citizenship and the fulfilment of social rights. Progressively, however, this neglect has been recognized by researchers from equal rights, citizenship and comparative welfare state researchers (Nussbaum, 2006; Halvorsen & Hvinden, 2013b). These actual perspectives share their turn away from widely employed concepts in mainstream welfare state research. Rather they start from the recognition that people with disabilities still are denied full membership and participation in society. Instead of urging for the right of economic independence from the market or the family, they indicate citizenship for people with disabilities is a matter of practices and participation: living a decent life according to the prevailing standards, being able to act autonomously and participate in social and political life. They suggest it is necessary to get insight in the extent to which states make it possible for people with disability to effectively and fully participate in society. We believe these conceptualizations are a better starting point for comparative disability policy than other, more widely known and employed concepts that do not take into account the specific social processes surrounding disability.

Chapter 10

Study 5. Disability policy in Europe: a fuzzy-set ideal-type analysis of approaches to Active Citizenship

Based on Foubert, J., Halvorsen, R., Van Rossem, R. Disability policy in Europe: a fuzzy-set ideal-type analysis of approaches to Active Citizenship. Social Policy & Administration, revise & resubmit.

Abstract

People with disabilities experience varying levels of social exclusion across European countries. Few studies have, however, cross-nationally compared how and to what extent contemporary European welfare states approach this social exclusion and aim for social inclusion and participation in society. Based on the multidimensional concept of Active Citizenship (AC) for people with disabilities, we assess the variation of approaches in contemporary European countries to the participation of people with disabilities. First, we discuss the three core dimensions of Active Citizenship for people with disabilities (security, autonomy and influence), and outline possible ideal-typical approaches to AC. Next, we perform a fuzzy-set ideal-type analysis based on institutional and outcome country-level data from 2010 to empirically map different approaches in Europe. The results demonstrate that the clusters of different approaches in European countries only partly coincides with countries' geographical proximity. In most countries, attention is paid to at least one dimensions of AC and thus one type or another of participation in society. We find that four groups of countries follow a pure ideal-typical approach, and four other groups employ a hybrid strategy or a combination of ideal-types. Our data suggests that only Denmark and Sweden pay explicit attention to all three dimensions of AC. Adequate income support and labour market participation are part of most countries' strategies. However, a large group of countries, predominantly Eastern European, focuses largely on formal rights for political participation, rather than providing security or autonomy.

Introduction

Disability welfare policy is one of the main ways to ensure the social inclusion and rights of people with disabilities (PWD) in society (Barnes and Mercer 2010; Witvliet et al. 2012). Compared to other areas of welfare policy, disability policy has, however, received little attention from comparative welfare researchers (Hvinden 2004). Disability is historically one of the first risks covered by social insurance systems (Dixon & Hyde, 2000; Van Oorschot & Hvinden, 2000). The scope of disability policy is not restricted to income security, however. Countries have increasingly invested in deinstitutionalization and in personal support services to ensure that PWD participate in society – especially since the 1960s (Mansell et al., 2007). Since the 1990s, equal rights and anti-discrimination policies have also come to the forefront (Drake 1999; Hvinden 2004; Waldschmidt 2009).

In this paper, we empirically assess the variation in welfare state approaches to the 'full and effective participation' (UN 2006: 1) of PWD from 27 European Union countries. To this end, we employ the multidimensional concept of Active Citizenship (AC) for PWD, as developed by Halvorsen and Hvinden (2013b). AC for PWD consists of three pillars – security, autonomy and influence – and is an innovative analytical construct to assess a country's approach to the social inclusion of PWD (R. Halvorsen, Hvinden, Bickenbach, Ferri, & Guillén, 2017). We also further elaborate on the main dimensions of AC and identify ideal-typical welfare state approaches to AC for PWD. Next, we perform a fuzzy-set ideal-type analysis to assess the empirical variation of AC in Europe. In this way, we shed light on a country's organization of social protection for PWD, a first step towards uncovering best practices in policy, and thus contribute to the literature on the nature and diversity of disability policy in contemporary European welfare states.

Theoretical framework

Active Citizenship for PWD

Few studies have cross-nationally compared the disability policies of a large number of countries (OECD 2003, 2010; Maschke 2008; Dixon and Hyde 2000; Waldschmidt 2009). In addition to the limited availability of country-level data related to disability, this lack of cross-national comparative studies relates to the overall exclusion of disability from theoretical discussions about citizenship (Beckett 2006; Halvorsen and Hvinden 2013b; Nussbaum 2006).

The multidimensional concept of AC for PWD, as developed by Halvorsen and Hvinden (2013b), is developed around the social situation and struggle for recognition and rights of PWD . AC refers to the opportunity of living 'a decent life according to the prevailing standards of societies, being able to participate in social and political life in the broadest sense, and having "civic" orientations to the political community and one's fellow citizens'

(Andersen and Halvorsen 2002: 12–13). AC does not refer to neoliberal activation strategies that promote individualism and self-responsibility (Waldschmidt 2013). Instead, AC involves 'thick citizenship' that incorporates both rights and obligations, both 'passive' entitlements as well as expectations to exercise more choice and responsibilities and engage actively in the public sphere (Bickenbach 2014).

The main dimensions of AC are security, autonomy and influence, which present different aspects of the full and effective participation of PWD (R. Halvorsen & B. Hvinden, 2013a). Security refers to the right to enjoy social protection against major life risks and to avoid constant worrying about (financial) matters, but also includes a duty to participate in activities that improve one's own security. To ensure security, welfare states provide adequate income maintenance for PWD. Such programmes include social benefits for people unable to participate in the labour market and compensation for higher expenses related to disability (e.g. transportation, medical expenses and housing). However, over the last few decades, a greater emphasis has been placed on work's role as an important and more active ways of generating security. This also serves to draw increasing attention to the employability of PWD (Lindsay and Houston 2013; Etherington and Ingold 2012). Generally, the activation of labour market policy involves a mixture of two approaches (see e.g. Bonoli, 2010; Bothfeld & Betzelt, 2011; Dingeldey, 2007; Eichhorst & Konle-Seidl, 2008; Marchal & Van Mechelen, 2014). In the first approach, governments may condition social rights to limit benefit receipt and demand more individual job search activities. Examples of this kind of approach for PWD are lower benefit levels, stricter eligibility rules, time limits and more regular assessments of incapacity. A second approach focuses on increasing employability and human capital formation. This may include 'enabling' policies, which refer to services with a more or less direct labour finality, such as education, vocational training and job search assistance, but can also point to a broader set of services that may make achievement and retaining of paid employment more likely, such as childcare services or supported employment (Marchal and Van Mechelen 2014). Research points out that for PWD the importance of the possibility to accumulate benefits with earnings from work, subsidies for employers when hiring workers with disabilities and the duty to provide reasonable accommodation at the workplace are central (Etherington & Ingold, 2012; Grammenos, Atta, et al., 2007; Greve, 2009).

The autonomy dimension of AC goes beyond labour market participation. It covers the right to enjoy the opportunity to live independently and to choose the life one desires for oneself without unwanted dependence on or interference from others. In the post-war period there has been a trend away from institutionalizing PWD to integrating them with mainstream society

(Halvorsen and Hvinden 2009; Drake 1999). Over the last two decades the concept of independent living has gained momentum as an important way to gain autonomy and independence (ANED, 2009; Townsley, Ward, Abbott, & Williams, 2009). The objective is to allow PWD to decide for themselves how and where to live, with access to services such as personal assistance, to support their life in the community (Townsley et al., 2009). Social services provide benefits in kind to compensate for impairments, and offers medical and social services aimed at assistance and rehabilitation, education and vocational training and other services to improve the independence and social participation of PWD (Bickenbach, 2014; Halvorsen and Hvinden 2009).

Finally, influence refers to participating in decision-making aimed at one's own and regulating social behaviour of individuals, organizations and governments (Halvorsen and Hvinden, 2013). Influence can be attained by participation in discussions with service providers and relevant authorities, and by campaigns and conventional politics, both at the individual and collective level. Equal rights and anti-discrimination policies came to the forefront in disability policy as of the 1990s (Drake, 1999; Waddington & Lawson, 2009). By 2000, the EU had adopted a number of recommendations, directives and regulations designed to enhance accessibility of the physical environment for PWD, of transportation and of new technologies (European Commission, 2010). The duty to provide reasonable accommodation, especially at the workplace, for persons with disabilities to make use of their political rights is one of the main examples (FRA 2014; Grammenos 2013; Priestley et al. 2016).

Ideal-typical approaches to Active Citizenship for PWD

Based on the dimensions of AC, we have identified four main elements to a country's approach to attaining AC for PWD: adequate income maintenance, labour market participation, independent living opportunities and political participation. How the countries approach the social inclusion and participation of PWD can, however, differ significantly. We identify seven ideal-typical approaches based on different combinations of the elements (see Table 19). See appendix 3 for a presentation of all logically possible approaches.

Table 19: Theoretical ideal-types of country strategies towards the full and effective participation in society of pwd based on the dimensions of active citizenship

	SECURITY	AUTONOMY		INFLUENCE
	Adequate income maintenance	*Enabling labor market participation*	*Services for independent living*	*Political participation*
THEORETICAL IDEAL-TYPES				
Active citizenship	+	+	+	+
Passive security	+	-	-	-
Activation	-	+	-	-
Active security	+	+	-	-
Autonomy	-	+	+	-
Influence	-	-	-	+
No focus on AC	-	-	-	-

First, a country that combines all four elements adheres to a full Active Citizenship approach to the social inclusion of PWD. Countries following this approach employ a multidimensional understanding of participation in line with the AC concept as defined for PWD. In these countries, the state provides structural opportunities to access security, autonomy and influence. Second, a country that has a single-minded focus on income support is seen as having ‘passive security’, a strategy that builds solely on providing financial security or poverty alleviation to persons with disabilities. This is an approach that might be constructed on a more limited conception of social exclusion and participation confined to the experience of restricted economic resources (Dewilde, 2008; Piškur et al., 2014). Arguably, such focus on income maintenance reflects an assumption that PWD almost by definition are not able to fully participate in the ordinary labour market or contribute to society. A third strategy is ‘activation’ and focuses exclusively on enabling labour market participation. This approach relies on acceptance that participation in employment is the key to social inclusion, improved social status and a meaningful role in society (Van Oorschot and Hvinden 2000). A fourth strategy entails the combination of both income maintenance and labour market participation. We refer to this as ‘active security’. It is interesting to pay attention to this strategy as it entails efforts to combine active and passive approaches to security. This strategy can be understood in terms of the paradigmatic shift from passive social protection to activation and social investment (Machal and Van Mechelen 2016; OECD 2010). A fifth ideal-typical strategy stresses AC’s autonomy dimension. Such a regime stimulates both labour market participation and independent living opportunities. Services are well developed but without further guarantee of security or influence. A sixth alternative ideal-type focuses on political participation and thus AC’s influence dimension. The countries involved focus on granting political rights and providing anti-discrimination. This is seen as an approach that centres on giving equal chances on paper only, without guaranteeing anything else. Of the former approaches, types two through four mainly correspond to the security dimension, although labour market participation also affects the opportunity to achieve autonomy and live the life one wants for oneself. The last two corresponds to the autonomy and influence dimension, respectively. Finally, we also need to consider a seventh strategy: countries may have no strategy to AC as we have defined it above. In such cases, countries typically do not see the welfare state as a means towards the participation of PWD in society, and they are expected to rely on other producers of welfare, like themselves, families or markets.

Fuzzy-set ideal-type analysis

Method

We used fuzzy-set ideal-type analysis (FSITA) to compare the approaches to AC among European countries. FSITA is an approach that originated in qualitative comparative analysis (QCA) (Kvist, 2007; Ragin, 1987, 2000) in which cases are seen as configurations of multiple dimensions. In fuzzy-set methods, the researcher first defines the key aspects (or 'sets' in the QCA language) of the multidimensional concept under scrutiny. Then the degree to which a case adheres to a given set is expressed by calculating the set membership score. Membership values fall between 0 and 1, where 0 indicates that a case does not adhere to the aspect at all ('fully out of the set') and where 1 indicates that a case completely aligns with it ('fully in the set') (Kvist 1999). A value of 0.5 is considered to be the crossover point (or point of maximum ambiguity), where the case begins to move from being more out to being more in the set. The set membership score is primarily defined on the basis of substantive and theoretical knowledge on the investigated aspect. By logically combining the main dimensions (sets), the researcher constructs a multidimensional property space that includes all logically possible combinations. Where k is the number of aspects, 2k denotes the number of possible ideal-typical locations in the property space, although not all need to be theoretically relevant (Ciccia & Verloo, 2012). By combining the set membership scores, the researcher can determine each case's adherence to the overarching ideal-types. Two key principles are employed for this goal: the minimum principle and the principle of logical negation of fuzzy-set theory (Ragin, 2000). The latter principle indicates that a case is only a member of a set to the extent that it is not a member of the negated set. If a case scores 0.70 on 'adequate income support', its score on 'no adequate income support' will be 0.30. The former principle denotes that the membership score is equal to the case's minimum score on the involved dimensions in the ideal-type. The score is the lowest value on the dimension measuring for the ideal-type.

Operationalization and calibration of the fuzzy-sets

Table 20 shows the indicators used to assess the countries' adherence to the different aspects of AC. All data relates to 2010, unless stated otherwise. For an overview of the specific translation of all empirical indicators into fuzzy-set scores, see Table 21.

1) Adequate income support

To gain insight into the degree of income support, we used expenditure data on cash benefits for persons with disability from Eurostat social protection expenditure database (Eurostat 2016b). The rationale behind this is that a certain amount of money has to be spent in order for the cash benefits to work in redistributing and providing income security. The cash benefits include disability pensions and early retirement benefits due to reduced capacity of work, care allowances and other cash benefits to compensate for higher expenses. Eurostat provides these expenditures as measured by the percentage of GDP. However, since we did not consider the population size or the size of the GDP, this may result in misleading information (Gilbert, 2009). Eurostat provides information on the GDP per capita in the Power Purchasing Standard (PPS). The percentage of GDP spent on disability cash benefits is multiplied by the index score to get a more nuanced view of the size of spending. For the calibration of the fuzzy-set scores, we followed Hudson and Kuhner (2013) who propose an additional calibration method when substantial knowledge is not available, as is the case with the spending data we are using. Although this might not be in line with the QCA framework, it provided the opportunity to use the restricted but available data. We first identified outliers and extreme cases, and calculated adjusted means and maximum and minimum cut-off points based on one standard deviation from the adjusted mean. Determining the crossover point was a more difficult task. However, based on Kvist's research, Vis (2007) showed that in continuous fuzzy-sets, the crossover point is less important than it is in fuzzy-sets with more limited values. In continuous sets the upper and lower limits should be justifiable as the points of maximum ambiguity, rather than the crossover point (Ragin 2006). As such, we did not explicitly specify a crossover point, but made a linear transformation to calculate the fuzzy-set scores.

Table 20: Operationalization of dimensions

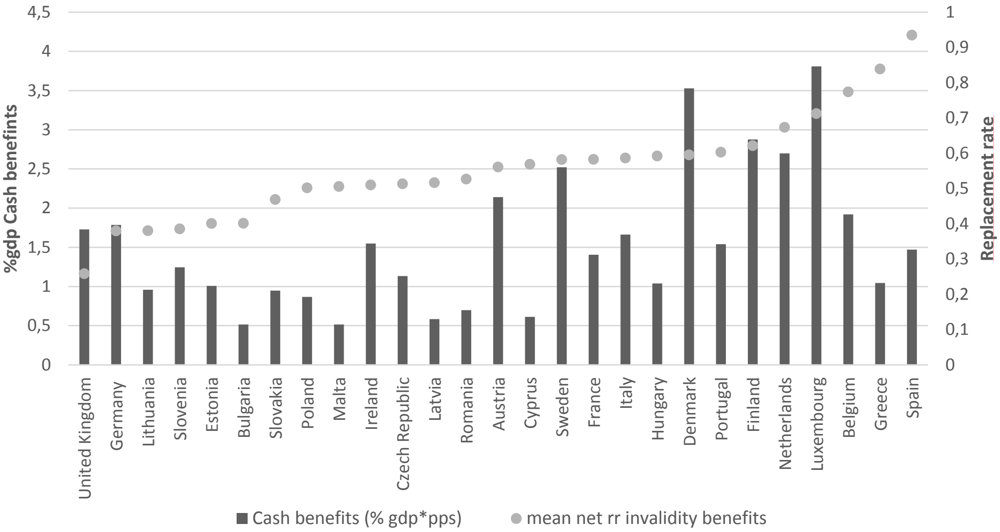
Dimension	*Indicator*
Adequate income support	-Public spending on disability cash benefits, expressed in PPS -Replacement rate of disability benefits
Enabling labor market participation	-Spending on active labor market policies, expressed in percentage of GDP and divided by the unemployment rate -Possibility for reasonable accommodation -Combination of benefit receipt and work
Possibility for Independent living	-Public expenditure on benefits in kind, percentage of GDP in PPS -Ratio of public expenditure on in-patient long-term care to the total public expenditures in LTC (~institutionalization, inverse for independence) -Availability of personal assistance
Influence	-Ratification of Articles 9,12 & 29 of UN CRPD

Because expenditure data do not necessarily give insight into the adequacy or decommodifying potential of the cash benefits, we additionally considered the mean net replacement rates of invalidity benefits of two model families in the social insurance system (single-person household and single-earner family, with a wage at the level of the average production worker). The calculation of the rate is based on the data and on the method used by the Social Citizenship Indicator Programme (SCIP), with additional information supplied by Mutual Information System on Social Protection (MISSOC) of the European Commission (see appendix 4 and 5 for a general report of the calculations and country-specific decisions). In line with common practice (see Kvist 2007), we considered a replacement rate of 90 per cent or more as generous and thus fully in the set; a replacement rate of 20 per cent or lower is seen as ungenerous and thus fully out of the set.

Luxembourg was the top spender, with 6.7 per cent of the GDP in PPS attributed to disability cash benefits (see Figure 10). Moreover, all Nordic countries, together with the Netherlands and Austria, were amongst the highest spenders, and achieved a level above 2.5 per cent GDP in PPS. The lowest spending was found in Eastern European (Bulgaria, Latvia and

Romania) and Southern European (Malta and Cyprus) countries. The data on the replacement rates shows a more mixed outcome. Spain was the only country that could be considered generous. Other countries that come close were Greece and Belgium followed by Luxembourg, the Netherlands and Finland. Lowest replacement rates were found in the UK, Germany and most Eastern European countries.

Figure 10: Spending on disability cash benefits and mean net replacement rate of invalidity benefits, EU, 2010



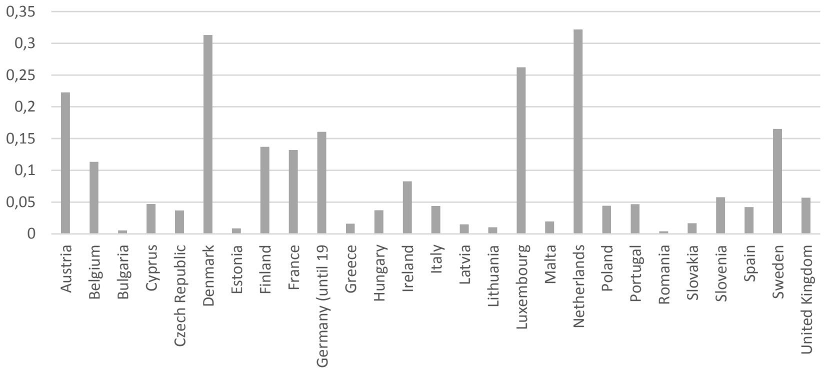
2) Enabling labour market participation

A flexible way in and out of the benefit system reduces disincentives for PWD to take up work (Greve, 2009). Searching for a job or starting work is sometimes perceived as a risk to (the level of) the benefit, and might therefore be a reason to remain inactive. The ability to combine work with benefit is important, especially when it comes to accepting low wages; one should have the option for partial work, while still feeling economically safe. Therefore, we considered accumulating benefit receipt along with income from work as a precondition for enabling labour market participation. Countries that do not provide this option are considered fully out of the set of enabling labour market participation. Information on the benefit accumulation is gathered from the MISSOC comparative tables that focus on invalidity. Invalidity pension beneficiaries were excluded from work only in Ireland and Malta (see Table 22).

In addition, one of the most innovative measures that gained momentum in the last few years was the duty of reasonable accommodation. As described in the EU Employment Equality Directive (EC/78/2000), it obliges employers to take appropriate measures to enable a person with an impairment to be employed, to advance in employment or to undergo training, unless it would place an inappropriate burden on the employer. Analyses show that the duty of reasonable accommodation is implemented unevenly across the EU Member States (Chopin & Uyen Do, 2012; Waddington & Lawson, 2009). In 2010, Italy was the only country in which the concept of reasonable accommodation was not included in national legislation (Chopin & Uyen Do 2012), therefore it received a zero score on this indicator. The Commission initiated an infringement procedure against Italy for its failure to transpose its duty. Some other countries have also breached the duty of reasonable accommodation as described in the Directive and are considered to be not in or out of the set of reasonable accommodation. In Malta, for instance, reasonable accommodation is restricted to employees and excludes job seekers. Gaps have also been found in the French legislation, as the legislation does not cover certain magistrates, PWD who are not registered as disabled or the self-employed. In Hungary as well, reasonable accommodation has not been completely implemented; juridical interpretation is still needed.

Finally, previous research on investment in active labour market policies (ALMPS) showed that higher spending on ALMPS is associated with a higher employment rate of PWD (van der Wel et al., 2011). In order for the policy to have a positive effect, a minimum amount of resources seemed to need to be invested (Grammenos, 2003). The data were collected from Eurostat's labour market policies database. ALMP spending was measured as the total expenses on labour market services and active measures (categories 1–7) as GDP percentage in 2010. Although Eurostat also provides separate spending rates for the categories, including supported employment and rehabilitation, we decided to focus on the total spending of the active measures, since expenses for training, employment incentives and job creation might also benefit the participation of PWD. Income maintenance expenses were excluded from the variable. Because the spending on labour market programs usually increases with the level of unemployment, it is, however, recommended to divide the percentage of the GDP (expressed in PPS) spent on ALMPS by the standardized unemployment rate of a country (Vis 2007). Figure 11 shows the spending rates on ALMPS across the European countries. Together with the Netherlands, the Nordic countries are again among the highest spenders. The UK and most Eastern European countries are the lowest spenders. For the calibration of the fuzzy-set scores the alternative method of Hudson & Kühner was also used.

Figure 11: Spending rates on active labor market policies (categories 1-7 in Eurostat) in % of GDP (expressed in PPS) per 1% of standardized unemployment, EU, 2010



3) Opportunities for independent living

We looked at public expenditures on benefits in kind of the disability function from the Eurostat social protection expenditure database (see Figure 12). Although expenditure data do not capture the efficiency or the quality of the services delivered, we reasoned that the higher the share of public expenditures on benefits in kind, the greater the likelihood that states provide formal care. This makes the person in need of services less dependent on market provision or informal care. Again, Eurostat provides these expenditures as measured by the percentage of GDP. Considering the size of the GDP, we multiplied the percentage of GDP spent on benefits in kind by the PPS score to get a more nuanced view in the size of the spending. For the calibration of the fuzzy-set scores, we followed Hudson and Kühner (2013) who propose additional calibration methods if theoretical considerations are lacking.

Table 21: Calibration of the fuzzy-set scores

	Fully out	Almost fully out	Fairly out	More or less in	Nor more in or out	More or less in	Fairly in	Almost fully in	Fully in
	0	0.01-0.16	0.17-0.32	0.33-0.49	0.50	0.51-0.66	0.67-0.82	0.83-0.99	1
ADEQUATE INCOME SUPPORT									
Public expenditure on cash benefits	<=0,67 % GDP in PPS	]0.67 - 0.93[	[0.93 – 1,19[	[1,19 – 1,45[	[1.45-1.50[	[1.50-1.76[	[1.76 – 2,02[	[2,02 – 2,24[	>=2,24 % GDP in PPS
Replacement rate	<20%	[20.0-31.5[	[31.5-43[	[43-54.5[	[54,5-55,5[	[55.5-67.0[	[67-78.5[	[78.5-90[	>=90%
ENABLING LABOR MARKET PARTICIPATION									
Investment in ALMPs	<=0,00	]0,00-0,033]	]0,033-0,067]	]0,067-0,099]	]0,099 - 0,100]	]0,100-0,133]	]0,133-0,166]	]0,166-0,199]	>=0,20
Reasonable accommodation	No				Yes, with restrictions				Yes, without restrictions
Combination benefit receipt and work possible	No								Yes
POSSIBILITIES FOR INDEPENDENT LIVING									
Public expenditure benefits in kind	<=0,009 %GDP in PPS	]0,009 – 0.125[	[0.125 – 0.241[	[0.241 – 0.357[	[0.357-0.358[	[0.358 – 0.474[	[0.474 – 0.590[	[0.590 – 0.707]	>=0,708 %GDP in PPS
No institutional LTC	>=0,789	]0,789 – 0.718[	[0.718 – 0.647[	[0.647 – 0,577[	[0.577 – 0.576[	[0.576 – 0.505[	[0.505 – 0.435[	[0.435 – 0.365[	<= 0,365
Personal assistance	No PA legislation	-	0,33: PA is only available for certain types of impairments, limited in practice	-		-	0.67: PA is available, less extensive as in Sweden	-	PA is personal right, no types excluded,
INFLUENCE									
Ratification of Articles 9, 12 & 29 of UN CPRD	Not ratified								Ratified

Additional information: Nine value fuzzy-set labels are used as proposed by Kvist (2007) for translating fuzzy-set scores into verbal labels. In line with common practice (Van Mechelen & Marchal, 2016; Vis, 2007; Ciccia & Verloo, 2012), linear transformations are applied when no transformation of the underlying data was theoretically preferable.

Table 22: Provision of reasonable accommodation and possibility of accumulation of benefit receipt and employment, EU, situation in 2010

	Reasonable accommodation	*Accumulation benefit and employment*
Austria	Yes	Possible within certain limits
Belgium	Yes	Possible within certain limits
Bulgaria	Yes	Full accumulation possible
Cyprus	Yes	Possible within certain limits
Czech Republic	Yes	Full accumulation possible
Denmark	Yes	Possible within certain limits
Estonia	Yes	Full accumulation possible
Finland	Yes	Possible within certain limits
France	Gaps in law	Possible within certain limits
Germany	Yes	Possible within certain limits
Greece	Yes	Possible within certain limits
Hungary	Gaps in law	Possible within certain limits
Ireland	Yes	No
Italy	No	Possible within certain limits
Latvia	Yes	Possible within certain limits
Lithuania	Yes	Full accumulation possible
Luxemburg	Yes	Possible within certain limits
Malta	Gaps in law	No
Netherlands	Yes	Possible within certain limits
Poland	Yes	Possible within certain limits
Portugal	Yes	Possible within certain limits
Romania	Yes	Possible within certain limits
Slovakia	Yes	Possible within certain limits
Slovenia	Yes	Possible within certain limits
Spain	Yes	Possible within certain limits
Sweden	Yes	Possible within certain limits
United Kingdom	Yes	Possible within certain limits

Additionally, we considered the ratio of the public expenditure on inpatient long-term care (LTC) to the total public expenditures on long-term care (also shown in figure 12). We see the ratio as a proxy for reliance on institutional care in contrast to independent living and Active Citizenship. In general, LTC consists of health care and social care. LTC expenditures give insight into how states take up responsibility for the organization and delivery of a broad range of services and assistance to PWD (and older people) on a daily basis. Typically these services include help with (instrumental) activities of daily living (e.g. eating, but also shopping and housework), personal care and basic medical services (Lipszyc, Sail, & Xavier, 2012). Increasingly, countries provide cash benefits that can be used to purchase formal services at home or at institutions or that can be used to pay informal caregivers (Lipszyc et al., 2012; Lundsgaard, 2005). The data we use comes from a publication of the European Commission reporting on LTC expenditures of EU members in 2010 (Lipszyc et al., 2012). In this report, data of the OECD/Eurostat System of Health Accounts (SHA) and the ESSPROS dataset are the primary sources of data, supplemented by data from the Member states if data was not available from SHA/ESSPROS.

Fuzzy scores are calibrated based on the method proposed by Hudson and Kühner (2013). We take the inverse of the fuzzy scores to make sure membership depicts independent living. The higher the LTC spending on institutions is, relative to the total LTC spending, the lower the fuzzy-set score for this component will be.

***Figure 12**: Spending rates on benefits in kind (disability function) in % GDP*PPS and ratio expenditures on institutional long-term care relative to total long-term care spending, EU, 2010.*

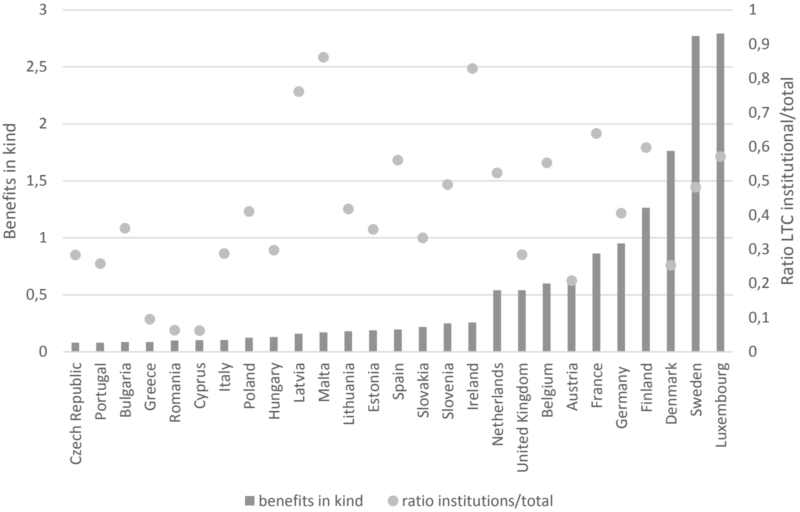


Figure 12 displays the spending rates on benefits in kind from the European countries. All Eastern and Southern European countries, together with Ireland, have a spending level lower than 0.5 per cent of their GDP in PPS. The UK and many Western European countries from the continent form the middle group. Denmark, Sweden and Luxembourg have the highest spending rates (between 1.7% and 2.8% of GDP in PPS). The reliance on institutional LTC is not parallel to spending on benefits in kind. Although some countries score low on both indicators (e.g. Romania, Greece and Cyprus), the countries have a more mixed result when it comes to LTC expenditures. Malta, Latvia and Ireland rely most heavily on institutional care, as 80 per cent of their LTC expenditures are attributed to institutions. Other countries in which institutional LTC accounts for more than half of their resources are France, Finland, Luxembourg, Spain, Belgium and the Netherlands. Denmark is the only country that combines high spending on benefits in kind with low spending on institutional LTC.

Finally, we examined whether personal assistance is available in a country. The availability of personal assistance schemes can be seen as an important means to increase the independence of PWD. This information was gathered from DOTCOM and the personal assistance tables of ENIL, or the European Network on Independent Living (ENIL, 2013). In the ENIL survey, Sweden is indicated as a pioneering country in which personal assistance (PA) is part of a national legislation and seen as a personal right, available 24 hours a day, 7 days a week, without the exemption of certain types of impairments. Based on these criteria, the fuzzy-set score for Sweden is a 1 for this indicator.

4) Political participation

Available data on this dimension are limited for EU Member States; therefore we focused on two main approaches that contribute to the influence dimension: whether the country has wide or narrow restrictions in terms of legal capacity for persons with disabilities and whether it ensures participation in political decision making.

A country's commitment to the political participation of PWD is assessed through its acceptance of Article 29, 12 and 9 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD). The CRPD provides a global reference frame and consists of obligations related to civil, political, social and cultural rights for those countries that have ratified it (Priestley et al. 2016). Article 29 obliges states to ensure equal rights to participate in public and political life and to enjoy them on an equal basis with other people. It includes the freedom to join political parties, free and accessible voting procedures, engagement in non-governmental organizations and standing for elections. Article 12 addresses the legal capacity of a person with a disability, that is, whether or not the law recognizes the decisions that person makes. Article 9 highlights the states' obligation to ensure that PWD have access to the physical environment, to information and to communication. It has clear implications for the political participation of PWD, including accessibility of voting stations, media and Internet communication and public meetings. Information is gathered from the European Union Agency for Fundamental Rights, which developed indicators to assess the political participation of PWD (FRA 2016). Countries that ratify these articles without reservation or declaration receive a fuzzy-set score of 1; those that did not (yet) receive a 0; those that entered a legal declaration against the article receive a score of 0.5. In the analysis, the mean fuzzy-set score of the three indicators is used.

Table 23 lists information on the three UN CRPD articles in 2010. In 2010 only the Netherlands, Ireland and Finland had not yet ratified the CRPD , which explains their low score.

Table 23: Ratification of article 9, 12 & 29 of UNCRPD in 2010

	Article 29	Article 12	Article 9
Austria	1	1	1
Belgium	1	1	1
Bulgaria	1	1	1
Cyprus	1	1	1
Czech Republic	1	1	1
Denmark	1	1	1
Estonia	1	0,5	1
Finland	0	0	0
France	1	0,5	1
Germany	1	1	1
Greece	1	1	1
Hungary	1	1	1
Ireland	0	0	0
Italy	1	1	1
Latvia	1	1	1
Lithuania	1	1	1
Luxembourg	1	1	1
Malta	0,5	1	1
Netherlands	0	0	0
Poland	1	0,5	1
Portugal	1	1	1
Romania	1	1	1
Slovakia	1	1	1
Slovenia	1	1	1
Spain	1	1	1
Sweden	1	1	1
United Kingdom	1	1	1

Strategies for Active Citizenship among European countries in 2010

Table 24 presents the membership scores of the countries on the four AC elements. Figure 13 presents the countries' principal strategy on how to engage PWD. The fuzzy-set membership scores to all logically possible ideal-types are provided in Table 25 and 26. See appendix 6 for a visual presentation of each country's membership per strategy.

Table 24: Set membership scores

	ADEQUATE INCOME SUPPORT	ENABLING LABOR MARKET PARTICIPATION	INDEPENDENT LIVING	POLITICAL PARTICIPATION
Austria	**0,52**	**1,00**	0,33	**1,00**
Belgium	**0,79**	**0,57**	0,19	**1,00**
Bulgaria	0,00	0,03	0,00	**1,00**
Cyprus	0,00	0,24	0,00	**1,00**
Czech Republic	0,29	0,18	0,10	**1,00**
Denmark	**0,57**	**1,00**	**0,67**	**1,00**
Estonia	0,21	0,04	0,26	**0,83**
Finland	**0,60**	**0,69**	0,09	0,00
France	0,46	**0,50**	0,00	**0,83**
Germany	0,26	**0,81**	**0,54**	**1,00**
Greece	0,23	0,08	0,00	**1,00**
Hungary	0,23	0,19	0,17	**1,00**
Ireland	0,44	0,00	0,00	0,00
Italy	**0,55**	0,00	0,14	**1,00**
Latvia	0,00	0,08	0,00	**1,00**
Lithuania	0,18	0,05	0,00	**1,00**
Luxembourg	**0,73**	**1,00**	0,15	**1,00**
Malta	0,00	0,00	0,01	**0,83**
The Netherlands	**0,68**	**1,00**	0,26	0,00
Poland	0,12	0,22	0,16	**0,83**
Portugal	**0,55**	0,23	0,10	**1,00**
Romania	0,01	0,02	0,13	**1,00**
Slovakia	0,17	0,08	0,30	**1,00**
Slovenia	0,27	0,29	0,00	**1,00**
Spain	**0,51**	0,21	0,18	**1,00**
Sweden	**0,55**	**0,83**	0,36	**1,00**
United Kingdom	0,08	0,29	**0,67**	**1,00**

Adequate income support: minimum principle is used to combine the fuzzy-scores of the indicators; *Enabling labor market participation:* Minimum principle is used to combine fuzzy-scores of first two indicators, accumulation benefits and work as a pre-condition; *Independent living:* Minimum principle, we use the inverse (1-X) of the fuzzy-scores for the institutional LTC indicator; *Influence:* mean fuzzy-set score of the three Articles in used in the analysis

Table 25: Ideal-type membership scores for all logically possible approaches towards AC (part 1)

	Theoretical ideal-types							Other logically possible ideal-types								
	Active citizenship (IN LA IL PO)	Passive security (IN la il po)	Activation (in LA il po)	Active security (IN LA il po)	Autonomy (in LA IL po)	Influence (in la il PO)	No AC (in la il po)	IN LA IL po	IN LA il PO	IN la IL PO	In LA IL PO	Independence (in la IL po)	influential security (IN la il PO)	independent influence (in la IL PO)	active influence (in LA il PO)	secure independence (IN la IL po)
Austria	0,3300	0	0	0	0	0	0	0	**0,5163**	0	0,33	0	0	0	0	0
Belgium	0,1935	0	0	0	0	0,2067	0	0	**0,5694**	0,1935	0,1935	0	0,4306	0,1935	0	0
Bulgaria	0	0	0	0	0	**0,9724**	0	0	0	0	0	0	0	0	0	0
Cyprus	0	0	0	0	0	**0,7644**	0	0	0	0	0	0	0	0	0	0
Czech Republic	0,1026	0	0	0	0	**0,7095**	0	0	0,1848	0,1026	0,1026	0	0,2905	0,1026	0	0
Denmark	**0,5660**	0	0	0	0	0	0	0	0,3300	0	0,4340	0	0	0	0	0
Estonia	0,0437	0,1667	0,0437	0,0437	0,0437	**0,7429**	0,1667	0,0437	0,0437	0,2099	0,0437	0,1667	0,2099	0,2571	0,0437	0,1667
Finland	0	0,3118	0,3974	**0,6026**	0,0888	0	0,3118	0,0888	0	0	0	0,0888	0	0	0	0,0888
France	0	0,1667	0,1667	0,1667	0	**0,5**	0,1667	0	0,4632	0	0	0	0,4632	0	0,1667	0
Germany	0,2577	0	0	0	0	0,1932	0	0	0,2577	0,1932	**0,5417**	0	0,1932	0,1932	0	0
Greece	0	0	0	0	0	**0,7671**	0	0	0,0808	0	0	0	0,2329	0	0	0
Hungary	0,1727	0	0	0	0	**0,7697**	0	0	0,1872	0,1727	0,1727	0	0,2303	0,1727	0	0
Ireland	0	0,4441	0	0	0	0	**0,5559**	0	0	0	0	0	0	0	0	0
Italy	0	0	0	0	0	0,4472	0	0	0	0,1355	0	0	**0,5528**	0,1355	0	0
Latvia	0	0	0	0	0	**0,9248**	0	0	0	0	0	0	0	0	0	0
Lithuania	0	0	0	0	0	**0,8209**	0	0	0,0519	0	0	0	0,1791	0	0	0
Luxembourg	0,1505	0	0	0	0	0	0	0	**0,7326**	0	0,1505	0	0	0	0	0
Malta	0	0	0	0	0	**0,8333**	0,1667	0	0	0	0	0,0128	0	0,0128	0	0

IN= adequate income support, in= no adequate income support; LA= enabling labor market participation, la= not enabling labor market participation; IL= no opportunities for independent living; PO= political participation, po= no political participation

Table 26: Ideal-type membership scores for all logically possible approaches towards AC (part 2)

	Active citizenship (IN LA IL PO)	Passive security (IN la il po)	Activation (in LA il po)	Active security (IN LA il po)	Autonomy (in LA IL po)	Influence (in la il PO)	No ac (in la il po)	IN LA IL po	IN LA il PO	IN la IL PO	In LA IL PO	Independence (in la IL po)	influential security (IN la il PO)	independent influence (in la IL PO)	active influence (in LA il PO)	secure independence (IN la IL po)
The Netherlands	0	0	0,3226	**0,6773**	0,2634	0	0	0,2634	0	0	0	0	0	0	0	0
Poland	0,1203	0,1203	0,1667	0,1203	0,1641	**0,7774**	0,1667	0,1203	0,1203	0,1203	0,1641	0,1641	0,1203	0,1641	0,1667	0,1203
Portugal	0,1026	0	0	0	0	0,4504	0	0	0,2347	0,1026	0,1026	0	**0,5496**	0,10260	0	0
Romania	0,0128	0	0	0	0	**0,8702**	0	0	0,0128	0,0128	0,0201	0	0,0128	0,1298	0	0
Slovakia	0,0839	0	0	0	0	**0,7000**	0	0	0,0839	0,1721	0,0839	0	0,1721	0,3000	0	0
Slovenia	0	0	0	0	0	**0,7097**	0	0	0,2659	0	0	0	0,2659	0	0	0
Spain	0,1752	0	0	0	0	0,4946	0	0	0,2117	0,1752	0,1752	0	**0,5054**	0,1752	0	0
Sweden	0,3616	0	0	0	0	0,1716	0	0	**0,5462**	0,1716	0,3616	0	0,1716	0,1716	0	0
United Kingdom	0,0844	0	0	0	0	0,33	0	0	0,0844	0,0844	0,2855	0	0,0844	**0,67**	0	0

IN= adequate income support, in= no adequate income support; LA= enabling labor market participation, la= not enabling labor market participation; IL= opportunities for independent living, il= no opportunities for independent living; PO= political participation, po= no political participation

Based on our data, the only country that adheres to a full AC strategy is Denmark. Denmark provides a foundation for political participation and anti-discrimination joined with a strong emphasis on labour market participation, income maintenance is also sufficient. The latter was already visible in the OECD (2010) analysis based on data from 2007, in which Denmark was among the countries that scored high on labour market inclusion of people with long-term health conditions and disabilities. Sweden is another country that comes closes to this full AC approach. Overall, the countries we covered scored low on the income support dimension. This is due primarily to the low replacement rates in most countries.

The Netherlands is another country with a strong focus on labour market participation. However, this is combined with a substantial degree of income support, leading to membership in the active security strategy cluster of countries. The strategy of the Netherlands corresponds with its former high disability benefits receipt – often referred to as 'the Dutch disease' – and the comprehensive policy reforms to counter this. Since the 1990s, greater responsibility for rehabilitation has been given to employers and employees, and new benefit schemes with tighter eligibility conditions for people of working age have been installed (OECD 2010). Finland also has membership in this ideal-typical approach to AC. It does so to a lesser extent than the Netherlands because it has less adequate income support and lower labour market focus.

The ideal-typical approach to AC with the largest membership is the influence approach. In this cluster, we find mainly Eastern European countries, together with France, Greece, Cyprus and Malta. Typically, this strategy gives PWD the opportunity to take part in the political decision-making process, guaranteeing political rights and respecting their legal capacity, without a strong focus on AC's security and autonomy dimensions. This does not mean there are no differences in the degree to which the countries of this group predominantly focus on political participation as such. Countries that have paid explicit attention to political participation are Bulgaria, Latvia and Romania. In contrast, France can be seen as a borderline country. France has in place invalidity benefits with a reasonably high replacement rates (around 60%), but its general spending on cash benefits is rather low, which explains why it is almost but not quite member of the adequate income support cluster of countries. Moreover, although the country invests reasonably well in active labour market policies, there are gaps in the reasonable accommodation legislation, since it excludes several groups of employees such as magistrates, non-registered PWD and the self-employed (Chopin and Uyen Do 2012).

Ireland is the only country in which the welfare state policy is not explicitly focused on any of the AC dimensions. Although it is almost in the set of adequate income maintenance because of reasonably high benefit replacement rates, it scores 0 on the other dimensions. Many other countries also score rather low on these dimensions; however, Ireland had not yet ratified the UN CRPD in 2010. Moreover, combining income benefit receipt with employment is rather difficult and long-term care services are predominantly based in institutions. In Ireland there is no national system for PAs available, which means that those services are mainly provided through the health care system, which seems to be underfunded as well (ENIL, 2013).

No country falls in the three other theoretical ideal-types we presented: passive security, activation or autonomy. The nine remaining countries apply a hybrid strategy to the participation of PWD. We can, for example, characterize Austria, Belgium and Luxembourg and in a similar way in this calibration. Although the three countries tend to have an almost full AC approach, they fall short on the opportunity for independent living dimension, mainly due to their rather high provision of institutional long-term care. Belgium and Luxembourg are strong in the adequate income support dimension; Austria focusses more on labour market participation. All have ratified the UN CPRD. While Germany has also ratified the convention articles without reservations, it combines fairly high scores on the labour market dimension with more attention to independent living than the previous four countries. Germany's income support, however, is lower. Thus, Germany takes a hybrid approach to AC, fulfilling three of the four approaches we examine. The three remaining Southern European countries, Portugal, Spain and Italy, adhere to an approach that mainly focuses on income support and political participation. This generally matches the other Southern European countries, which have high pensions (i.e. before the economic and financial crisis) but less labour market participation focus (Ferrera 1996). Finally, the UK's strategy to socially include PWD is centred on providing opportunities for independent living and political participation. It scores low on the income support dimension because of the low income benefit replacement rates, and has lower investments in active labour market policies.

Figure 13: Classification of countries into different strategies towards Active Citizenship for PWD

<table>
<tr><th colspan="12">Theoretical ideal-types</th></tr>
<tr><td colspan="3"><i>Active citizenship</i>
(IN LA IL PO)
Denmark</td><td colspan="3"><i>Passive security</i>
(IN la il po)
None</td><td colspan="3"><i>Activation</i>
(in LA il po)
None</td><td colspan="3"><i>Active security</i>
(IN LA il po)
the Netherlands, Finland</td></tr>
<tr><td colspan="4"><i>Autonomy</i>
(in LA IL po)
None</td><td colspan="4"><i>Influence</i>
(in la il PO)
Bulgaria, Cyprus, Czech Republic, Estonia, France, Greece, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia, Slovenia</td><td colspan="4"><i>No active citizenship</i>
(in la il po)
Ireland</td></tr>
<tr><th colspan="12">Other hybrid empirical combinations</th></tr>
<tr><td colspan="3"><i>Active citizenship –</i>
(IN LA il PO)
Austria, Belgium, Luxemburg, Sweden</td><td colspan="3"><i>Active Citizenship –</i>
(in LA IL PO)
Germany</td><td colspan="3"><i>Influential security</i>
(IN la il PO)
Portugal, Spain, Italy</td><td colspan="3"><i>Independent influence</i>
(in la IL PO)
UK</td></tr>
</table>

Discussion

This article used fuzzy-set ideal-type analysis to assess the conformity of European countries' disability policies to ideal-typical approaches to the participation of PWD in society. With this analysis we are among the first to provide a more systematic understanding of the study of cross-national variations in disability policy in Europe. Theoretically, we moved away from the classic concepts of welfare state analysis that are not specifically developed to capture the situation of PWD by employing the concept of Active Citizenship. Empirically, we provided more insight about the priorities in European welfare states.

The analysis showed that European countries cluster in different groups that only partly coincide with geographical proximity. Four of the seven ideal-types are present among the 27 EU countries. Denmark's approach to the participation of PWD was the only approach that leans towards a welfare state approach that lays the foundations for the full and effective participation of PWD in society. As it combines adequate income maintenance with enabling labour market participation, opportunities for independent living and political participation, the Danish welfare state aims to provide opportunities for PWD to experience security, autonomy and influence, i.e. the three dimensions of AC. Sweden's approach come close as well. Although Sweden seems to pay less attention to independent living because of its rather high rate of institutional long-term care in the data of the analysis (Lipszyc et al. 2012), we do note its advanced personal assistance scheme (ENIL 2013) and the high spending on disability services in general. Moreover, Sweden can be considered as a lead country when it comes to normalisation and deinstitutionalisation (Mansell et al., 2007; Tøssebro et al., 2012) Based on this additional evidence, Sweden may be seen as another country following a full AC approach. Belgium, Austria, Germany and Luxembourg cluster together in their approach to the social inclusion of people with disability. Instead of focusing on all three conceptual dimensions of AC, they fulfil two, and only partially focus on a third. Therefore, they present a hybrid approach to AC. Finland and the Netherlands follow the approach called active security, which focuses on income security and views autonomy as centred on labour market participation. No country follows a purely passive security, activation or autonomy approach.

The remaining strategies are centred on the influence dimension combined with one other dimension. Spain, Italy and Portugal combine it with income security; the UK is the only country that predominantly focusses on opportunities for independent living. The most common approach is, however, defined by a predominant focus on the influence dimension. The countries that adhere to this type are Eastern European countries (Bulgaria, Hungary, Latvia, Lithuania, Poland, Romania and Slovakia), Malta and France. In these countries, the welfare states mainly provides the institutional grounds for the political participation of PWD without trying to guarantee (income) security or autonomy by enabling labour market participation and/or opportunities for independent living to a theoretically sufficient extent.

Some caveats apply. Given the limited availability of institutional data on disability policy, we were confined to using (more problematic) social expenditure data for a considerable part of the analysis. To achieve more refined insights, future research should consider the cross-national collection of institutional data. The use of expenditure data forced us to make assumptions that cannot be tested and to rely on alternative calibration methods that are not always in line with the QCA framework. Therefore, the validity of the threshold choices for these data can be called into question and alternative calibrations did affect the categorization of some countries (see appendix 7).

Bearing the previous limitations in mind, two things stand out in this analysis. First, many countries show goodwill on paper to PWD. This was certainly visible in the high ratification rate of the UN CRPD and the low rate of legal objections to Articles 29, 12 and 9. In most Eastern European countries, governments have provided the institutional foundations for political participation, but have fallen short of offering adequate income support, stimulating labour market participation or providing opportunities for independent living. Most of these countries have also presented national disability action plans and strategies around 2010 (ANED 2012). Nevertheless, to achieve security and autonomy in these countries, PWD have had to rely more on the nongovernmental welfare providers in society, namely, family and significant others or the market. The welfare state policy for this dimension could be considered – unintentionally or intentionally – as a liberal, hands-off approach. The question is whether the commitment to the UN CRPD will lead to a more complex understanding of inclusion in the future.

Second, we discovered an East/West division in approaches to the disabled's social inclusion in Europe. Eastern European countries, along with France, Malta and Ireland, are separated from the rest by a somewhat constrained approach to AC. The other countries tend to combine the influence dimension with at least one other dimension of AC or to focus on the two other dimensions. Southern European countries add income security to political participation; the Netherlands and Finland stimulate labour market participation while providing adequate income support. The remaining countries adhere to a more complete idea of participation in society, as they have policies that exceed the minimum threshold on all three ACE dimensions.

The findings demonstrate the need for future research within this field. First, triangulation of the results presented in this article with other data sources is necessary. Only in this way will we reach a thicker understanding of the various ways of combatting the social exclusion of PWD. The analyses were only based on data of 2010, which was due to data availability on the moment of writing. Despite the existence of comprehensive institutional databases on welfare states and social rights, national data on disability is still limited. The need for comparable data provided on a structural basis is high (B. Hvinden, 2015). To complement the existing data and indicators which is mainly based on survey data or governmental expenditures, it would be set-up a regular assessment of a range of policy areas where country policies are benchmarked to the highest, newest international standards. Within the DISCIT-project, which examined the disability policy of nine countries in light of the UN CRPD, this has been done by expert interviews (Hvinden, 2015). Though related to another field, a good example of such an extended approach is the Migrant Integration Policy Index (MIPEX, 2010).

Although the results are connected into a specific point in time, as a first endeavour, they already give us more detailed insight in disability policy of European countries and go beyond the one-sided attention for income and labour market participation. Expanding the time range will provide insight in the dynamics of disability policy and the changes in policy changes over time. Moreover, it should be noted that the outcome of this study is a descriptive categorisation of different strategies within welfare state policy around disability. Now, one of the next steps is to explain the variation within these strategies, and to link the different approaches to different outcomes. Related to the latter, I picture two possibilities. In a first step, it can be insightful to link it to country-level rates related to social exclusion of PWD. Is their less social exclusion in countries where the welfare state encounter the subject with a multi-dimensional approach? Or do different strategies lead to the same outcomes? The latter could be the case if other actors, like markets, families or civil society, take on these responsibilities. In a second step, it could insightful to link the strategies to individual-level outcomes such as well-being and mental health problems. Related to the former, it would be insightful to know whether the approaches align with cultural norms and values related to the different roles of actors in providing opportunities for social inclusion. This analysis might give the impression, the state-led way is the only option towards inclusion. However, some countries, like Southern European ones, have other cultural traditions that put family first. Therefore, explaining why countries opt for one approach and not for the other will also benefit future research. This is the best way to understand what it actually means for PWD to live in one country or another. Moreover, this will also yield a better understanding of the nexus between welfare state, family and market responsibilities, and how they interact and affect the social exclusion of PWD.

Acknowledgements

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Part 3: Discussion and conclusion

General results and suggestions for future research

This dissertation departed from the observation that within the sociological study of social stratification, disability has been neglected and ignored as a form of social exclusion (Jenkins, 1991; Thomas, Chilvers, & Stanbury, 2012). This, along with other factors, contributes to a biased and limited examination of social inequalities in health and well-being and, in particular; of the health and well-being of people with impairments. While the multi-dimensional social exclusion of people with impairments and chronic illnesses is hard to deny and widely acknowledged by multiple intergovernmental and human rights organisations (United Nations, 2006; WHO & WorldBank, 2011), this is not taken into account sufficiently in the research field of social inequality in health and well-being.

Studies consistently show social gradients in chronic diseases and impairments: society's less privileged members and those who occupy lower socio-economic positions have poorer general health and are more likely to develop chronic diseases or to have impairments (Mackenbach et al., 2008; Marmot, 2005; Marmot et al., 1991; McNamara et al., 2017; Nordahl, 2014). This unequal outcome might be explained by a differential exposure to health risks and stressors (Diderichsen et al., 2001) and a differential possession of protective and flexibly employable resources (Link & Phelan, 1995; Phelan et al., 2010). Those resources will not only shape people's health behaviour, but also define the access and exposure to contexts that vary dramatically in risk profile and protective factors. They will also affect the way diseases develop, are handled once they occur and how they in turn affect people's lives.

In this dissertation, I wanted to direct attention to a part of this process that remains in the background, which is related to the role of disabling social exclusionary processes once chronic diseases and impairments are present. I wanted to consider the extent to which the subjective health and well-being of people with impairments or activity limitations is dependent on social exclusion of protective resources and beneficial contexts, which are decisive factors for health and well-being. As such, the main goal of this work was to look into the social roots of their subjective health and well-being.

In this last part, I first provide a general overview of the research aims and results of the studies. Based on this suggestions for future research are also made. Subsequently, the main limitations of the approach and empirical works are discussed. Last, I discuss potential implications for policy makers.

The relation between impairments and subjective health or well-being

Impairments and chronic illnesses are assumed to dominate one's life and are associated with poor health, suffering and sadness by people without impairments. Notwithstanding the potential serious impact on life, the seemingly obvious relationship has been challenged. Not all people with impairments see themselves as unhealthy nor do they always report a lower well-being than people without impairments. To obtain a proper understanding on the relationship between impairments and subjective health or well-being, I integrated literature of medical sociology and disability studies in the theoretical framework. Although both approaches increasingly accept that strong individual and social models of disability are flawed, they pay attention to different aspects of the process. Medical sociological studies have predominantly examined the meaning of impairments and chronic illnesses in terms of personal experience and well-being, and consequences for social roles. Research within disability studies has emphasised the social exclusion and social imposition of restrictions of activities. Based on Carol Thomas' endeavour to leave behind the contradictions between more individual and social model approaches to disability (Thomas, 2007; Thomas, 2012, 2014; UPIAS, 1975), my work understood disability as the social imposition of restrictions of activity on people with impairments and the socially engendered undermining of their psycho-emotional well-being. While this definition points to the socially caused and thus avoidable consequences for the well-being of people with impairments or activity limitations, it does not rule out the role of impairments themselves.

A first step towards the study of the potential social undermining of well-being is, of course, to account for the effects of impairments or activity limitations. Without this control, the integrative approach of this dissertation would be biased. Throughout my empirical multilevel work, the negative association between impairments or activity limitations and subjective health and aspects of psychological well-being has been confirmed, as described in chapter 6 and 7. These analyses were carried out on the basis of the World Health Survey (WHS, 2002-2004) for the relationship between activity limitations and subjective health, and on the basis of the third European Quality of Life Survey (EQLS, 2011-2012) for the relationship between impairments and well-being. After taking into account important confounders, such as gender, income, household wealth or perceived financial problems, employment, educational level, age, marital status, and social support, the findings remain significant.

In other subfields, however, the role of impairments or activity limitations has only received limited attention. This is true for the study of job satisfaction. While there is a whole field of research within the sociology of work that also looks into the determinants of work-related well-being and worker satisfaction, the number of studies that looks into the job satisfaction of people with impairments or the difference between people with and without impairments is limited. Based on European data of 21 countries in 2012 (ESS), the study in chapter 8 concludes workers with activity limitations are generally less satisfied with their jobs. While it contradicts the conclusion of Pagan and Malo (2009) who found that Spanish workers with activity limitations are generally more likely to be satisfied with their jobs, it is in accordance with the results of other studies (Pagan, 2013, 2014; Rodriguez, Sanchez, de Haro, & Maldonado, 2014; Uppal, 2005).

While this might seem a straightforward conclusion, all the associations, seem to be robust and irrespective of whether a more affective or cognitive aspect of well-being was measured. The results underscore the existence of 'impairment effects' (Thomas, 1999). Thomas uses the term to refer to the restrictions in activities or diminishments of well-being that are directly associated with, or caused by, having a physical, sensory or mental impairment. Examples of impairment effects are chronic pain, physical and mental fatigue, feeling low in energy because of sleep disturbances, or simply, not being able to pick up a mug because you miss a thumb. Within disability studies, the social model of disability has for a long time been very strong. This implied the ignorance of seeing individuals as flesh and blood, partly to prevent the re-entrance of a medical model of disability in the arena. With the concept of impairment effects, however, these bodily experiences regain their place and are acknowledged, without equating disability with restrictions in activities or a diminished well-being caused by impairments. The results here show indeed that, regardless of different social positions, people with activity limitations generally consider themselves less healthy, and people with impairments generally feel less active, cheerful and vigorous than those without.

The role of labour market exclusion

After the establishment of the basic relationship, the next step was to see whether the difference in subjective health and well-being among people with and without impairments was related to the experience of social exclusion in distinct country-contexts. I chose to focus on processes in and around the labour market because of its central structuring role in our contemporary societies and the difficulties it entails for people with impairments and chronic illnesses (Jones, 2008; Vassilev et al., 2014).

On the micro-level, the role of labour market exclusion was examined in chapter 7. This study also took the potential effect of volunteering into account, because it is often mentioned as an alternative to labour market participation for people with impairments. The results based on European data support the hypothesized beneficial role of employment for well-being. The negative association between impairments and well-being is less strong if people are still in paid work, compared to being unemployed or economically inactive. Compared to those who had a paid job, it was especially the people who were out of the labour market, or economically inactive, who had the lowest well-being. While volunteering was also beneficial, it did not change the moderating effect of having paid work. People who have an impairment and were unemployed or economically inactive are thus in a double jeopardy situation for a good well-being. This is in line with the longitudinal study of Milner, LaMontagne, et al. (2014) in Australia where the mental health of people with impairments is higher among those who are employed.

Theoretically, the study elaborated on the idea that their situation combines different forms of social exclusion and therefore different sources of stress that cluster and interact, and are detrimental for well-being. In addition to hassles and stress that comes with an impairment in terms of symptoms and activity limitations (Krokavcova et al., 2008; Pearlin, 1989; Pearlin et al., 2005; Van Houdenhove et al., 2002), they also face the drawbacks of being unemployed or economically inactive. Within the language of social exclusion, one could say the lack of paid work potentially excludes them from real financial security (since benefits are likely to be lower than wages), a broader social network and social contacts and a certain social status in society. The previous factors are known to be beneficial to health and well-being in general, but could also be especially helpful when you are living with an impairment. Having an impairment might therefore be especially negative for well-being if one is also excluded from the securities and commodities associated with paid work.

In addition, the study in chapter 7 juxtaposed the role of paid work to the one of voluntary work. Next to the previously mentioned functions of paid work, qualitative studies also indicate it as a critical factor for personal identity and social recognition. Voluntary work is often mentioned as a stepping-stone towards paid work, or as an alternative for people with impairments. Across six European countries, Leiulfsrud et al. (2016) found that, irrespective of the current employment status, people with spinal cord injuries emphasised voluntary and domestic work could not replace all social functions of employment. This was also visible in the results of chapter 7, which showed that those people with impairments who are also volunteer generally have a better well-being than those who do not actively volunteer. This is in line with studies that showed that through volunteering people can gain confidence, higher self-esteem, social contact, and increase the feeling of engaging in a meaningful activity (Borgonovi, 2008; Musick & Wilson, 2003). While this result does not downplay the beneficial role of voluntary work, I also noted that accounting for this moderating role of voluntary work did not have an influence on the role of employment. Based on the analyses, the moderating role of voluntary work was also weaker than that of paid work. Again, this is in line with the conclusion of Leiulfsrud et al. (2016) where the participants of their study indicated voluntary work could not replace the social and symbolic functions of employment, despite the fact that it is often mentioned as an alternative to employment for people with impairments. Voluntary work and employment have in common that they offer a time structure, function as a social arena, increase self-esteem and confidence, and are associated with better mental health. Nonetheless, voluntary work often does not lead to financial security, nor does it seem to reach the same level when it becomes a more symbolic form of social inclusion related to membership of society.

The important role of employment makes sense within the contemporary discourse on paid work as the number one option and the emphasis on the able and responsible citizen-employee who works and takes care of him/herself (de Graaf & Maier, 2017; Soldatic & Meekosha, 2012). As discussed in chapter 3, connecting citizenship with moral aspects on good social behaviour and duties demarcates a symbolic line between those who are truly members of society and those who are only formally so (Schinkel, 2010). In chapter 7, however, a potential drawback of this symbolic distinction is uncovered: worse mental well-being for those who deviate from the moral goal. In this study, it was especially the combination of having an impairment and being economically inactive that seemed to be associated with the worst well-being. The people in this situation deviate from the previously mentioned ideal in two ways: they are neither ‘able’, nor are they responsible ‘citizen-employees’. Compared to the study of unemployment and well-being, the study of the specific mechanisms linking economic inactivity with mental health is more limited (Brown et al., 2012; Norstrom, Virtanen, Hammarstrom, Gustafsson, & Janlert, 2014). Based on chapter 7, I suggest more attention is needed for this subgroup, as they especially seem to be in the worst situation. A potential explanation might be found in the fact that being economically inactive signals an unbridgeable symbolic distance from the labour market, or from the social ideal.

The role of the macro-context

The models developed in this dissertation did not only address the relationships at an individual level, but also tried to understand whether, how and why the relationship of impairments and subjective health or well-being is dependent on macro-level labour market exclusion and welfare state arrangements. By linking it with aspects of the macro-structural context, the studies challenged the association of impairments and chronic illnesses with a personal tragedy. They take into account that in some contexts people with impairments might have a greater chance to be socially included, to be less or more exposed to social stress processes, and to obtain easier or more difficult access to protective resources. The social undermining of subjective health and well-being became visible throughout my multilevel studies that quantitatively explored how the strength of the relationship between impairments and subjective health or aspects of subjective well-being varies across contexts.

Labour markets

In the theoretical framework I discussed the barriers that prevent people with impairments from employment. Frequently mentioned ones are problems with transportation, inaccessible buildings, interrupted vocational training, discriminatory attitudes and behaviour of employers and co-workers and unwillingness to provide reasonable accommodation. Moreover, I also mentioned that the chances for participation in the labour market of people with impairments vary significantly across European countries (Eurostat, 2014). As hypothesized, this also affected the moderating role of employment on the relation between impairments and well-being. I observed that in countries with higher levels labour market exclusion of people with impairments, having an impairment and being unemployed was more strongly associated with lower well-being. This corresponded with the hypothesis based on labour market perspectives, which draws on the assumption that the national labour market exclusion rates are also important parameters of the economic climate and the prevailing labour market conditions (Oesch & Lipps, 2013). In countries with the highest rates, people might have the bleakest prospects of finding a job, which might result in higher social stress. The duration of unemployment might also be longer. This effect makes sense for the unemployed as they are supposed to still be actively looking for a job. In those countries, they might feel especially powerless and discouraged.

The well-being of people with an impairment who are economically inactive did not vary with the level labour market exclusion of people with impairments. It is, however, dependent on the labour market exclusion level of people without impairments. In countries with higher labour market exclusion of people without impairments, the well-being of people with impairments who were also economically inactive was closer to that of those who were employed. Indirectly, these results might point in the direction of the social norm hypothesis. Social norm theory suggests that if unemployment and inactivity are considered as a structural problem, the stigmatization and negative attitudes around unemployment (like people who are unemployed are lazy and just do not want to work) will be lower, and the well-being of people who are unemployed or inactive will be less negatively affected (Buffel et al., 2016; Clark et al., 2010; Clark, 2003). In those situations, being out of the labour market can be more easily attributed to structural labour market conditions. If it is even difficult for people without an impairment to find a job, being economically inactive might feel less of a personal failure. As such, people with an impairment that are unemployed or inactive might benefit from a social norm effect on their well-being.

Related to the study of social norm effects of labour market exclusion, I should highlight and question to what extent these national rates are good proxies for the adherence to the norm of unemployment or being economically inactive. This topic has also been discussed in recent studies (Buffel et al., 2016; Stam, Sieben, Verbakel, & Graaf, 2016). To explain the results of chapter 7, two alternative and more fine-grained measures can be used. A first alternative refers to the use of regional labour market indicators. Compared to national measures, they show a considerable regional variation in labour market conditions within a country, and are more tied to a person's reality. When people look for a job, their job search generally starts within the boundaries of the region in which they live. For Europe, regional labour market exclusion rates at different NUTS-levels (Nomenclature des Unités Territoriales Statistiques) can be downloaded from Eurostat. While this would be a step forward for my research, studies that used regional indicators do not present unidimensional conclusions (Clark et al., 2010; Clark, 2003). Despite the smaller distance to a person's reality, the structural indictor does not give direct insight in the person's experience. This approach would assume that in regions with higher unemployment, unemployment is more likely to be seen as a structural problem. It does not give insight in the extent to which unemployed people share their experience with friends and family, and the extent to which they are confronted with stigmatizing attitudes.

Because of these uncertainties, as a second alternative I point to the research that recently highlighted the importance of a more direct and subjective measurement of the social norm, such as societal tolerance of unemployment. An example can be found in the study of Stam et al. (2016). They used individual information on items such as 'Work is a duty toward society', 'the unemployed are lazy', or 'the fate of the unemployed is the responsibility of the government'. By aggregating this information on the country- or regional level, researchers have constructed a measurement of the social norm of work or unemployment. Based on this measure, the researchers did not find an effect of the social norm. However, research that measures the work norm at the community (Stutzer & Lalive, 2004) or individual level (Winkelmann, 2014) did confirm its role. The ambiguity in the previous results asks for a differentiated approach in future studies.

Furthermore, I propose to look into other regional or meso-level characteristics in future research. It could be valuable to look at the sector or sort of companies that are available in the region of the person. For people with impairments especially, the presence or absence of a certain sector might make it more or less difficult to find a job. If information on the kind of impairment is available, it might, for instance, be insightful to look into the nature of the main job sources in the region. If people experience musculoskeletal problems, if might be hard to find a job if one lives in a region where most jobs are in engineering, industry or manufacturing.

In sum, based on the study in chapter 7, I can conclude the relationship between having an impairment and well-being is affected by a person's social position in a particular society. The relationship is stronger if people are unemployment or excluded from the labour market. The interaction of impairments with labour market exclusion has to be seen as a situation in which people are exposed to a clustering of several forms of stress, and are excluded from means that can be beneficial for their well-being. Moreover, in countries with bleaker labour market perspectives for people with impairments, unemployment seems to have a more detrimental effect. On the other hand, social norms on labour market exclusion could level out the negative consequences of being out of the labour market. The seemingly straightforward relationship between impairments and well-being is thus also affected and shaped by social processes and structures that make it more or less difficult to enter the labour market. Since several structural barriers hinder the way to employment for people with impairments and affect their well-being, I can conclude their well-being is being socially undermined or, in other words, psycho-emotionally disabled Reeve, 2012).

Welfare regimes

Next to the labour market, welfare state institutions played a central role in this dissertation. In chapter 6, the dependency of the relation between activity limitations and subjective health on a country's general welfare regimes was examined within a sample of 57 countries. Based on the idea that welfare state policies can play a significant role in securing the needs of people with impairments or activity limitations by providing resources and services to overcome social exclusion, I hypothesized the association between activity limitations and subjective health would be less strong in countries with more developed, extensive and secure welfare regimes. Nonetheless, I also paid attention to more critical perspectives on the welfare state and its relation with disability (Finkelstein, 1991; Stone, 1984).

The results pointed into the direction of more critical perspectives: in different European welfare states (Social-Democratic, Liberal, Bismarckian and Southern European) people with activity limitations tended to rate their health worse than people with activity limitations living in informal-security regimes (Liberal-Informal, Productivist or South Asian), or those who are living in insecurity regimes. People with activity limitations in Eastern European welfare states were in an intermediate position: while they rated their health better than those living in other welfare states, their health perception was still worse compared to those living in informal-security or insecurity regimes. These observations were independent from the economic development within the countries.

According to the common approaches in medical sociology that highlight the role of welfare states in providing social protection and fulfilling citizen's social rights, my results are hard to explain and contradictory. Interpretations of the results within this framework could even lead to the conclusion that investments in welfare states should be diminished since they lead to absurd and adverse situations. In my opinion, making such a conclusion would be a step too far. While I do not want to rule out further research that looks in that direction, I will elaborate on a less known but possible function of welfare states.

Next to their redistributing role and influence on the shape and degree of social stratification in society, in the third chapter I outlined a perspective on welfare states that sheds light on their role as designer of social categories and positions (Stone, 1984). This is accompanied by a role of a cultural agent that shapes our understanding of individual responsibilities and social roles (Kremer, 2007; Olafsdottir & Beckfield, 2011). Guided by Foucault's writings on Bio-power and discipline, I showed how 'disability' has been constructed as a social risk category over time. Within the book of Tremain (2015), it is underlined that since the evolution towards Bio-power in the West, people with impairments have been treated as a particular group with special needs. Disability was created as a specific social position, the incumbents of which were labelled 'disabled', unproductive and welfare dependent. A side-effect of this labelling may be that the individuals experience a feeling of profound 'otherness' (Link & Phelan, 2001). They might feel they deviate from the social norm and, in addition, the labelling might induce processes of status loss and discrimination (Goffman, 1963; Green et al., 2005; Link et al., 2001). In addition, the more contemporary discourse on ‘autonomous’, healthy and responsible individuals that take care of themselves (de Graaf & Maier, 2017; Devisch & Vanheule, 2015; Rose, 2007), might increase the likelihood they internalise their received label. By processes of social comparison (Thoits, 2011), they might consider themselves as less healthy in these contexts.

More empirical research is needed to document this structuring, and potentially disabling, role of welfare state institutions. One way to get more insight would be to compare the subjective health or well-being of different categories of people with impairments and activity limitations. My study was based on self-reported measures only. However, datasets like SHARE (2017) and EU-SILC (Eurostat, 2017) also contain information on whether individuals receive disability benefits. This would create the possibility to compare the subjective health of people who have been officially labelled as disabled with the subjective health of those who have not been through an official labelling process. In addition, it would be insightful to switch to another approach to the inclusion of welfare state institutions. As discussed, the welfare regime approach is a good way to explore general relations, but does not provide insight into the specific mechanisms at stake. The institutional and expenditure approaches are more appropriate for this endeavour. The integration of institutional characteristics of health care or disability benefits could enlarge the insight.

In sum, the results of chapter 6 challenge the ‘natural’ association between activity limitations and subjective health again. The study shows the relation is dependent on the socio-political country-context in which people live. As such, I could say the lower subjective health of people with activity limitations is also a social product. Extrapolating research findings on the relationship between activity limitations and health found in one social context to another could thus lead to biased conclusions. Moreover, the study also uncovered a possible unintended disabling role of welfare state institutions, via the construction of specific benefits and services tied to a specific group; labelled as the ‘disabled’.

Welfare policies

In chapter 8, I examined whether two aspects of contemporary European welfare state policy also affect work-related well-being of both workers with and without activity limitations. More specifically, I asked whether workers’ job satisfaction was affected by the amount of investments in ALMPS and the expenditures on out-of-work benefits. This time, gender differentiated analyses were performed to account for the different position within the labour market and different effects of work and employment conditions on health and well-being between women and men (Artazcoz, Borrell, & Benach, 2001; Benavides, Amick, Benach, & Martínez, 2004; Menéndez, Benach, Muntaner, Amable, & O'Campo, 2007). Compared to the previous study on welfare regimes, this paper followed an expenditure approach. As such, country-differences were more fully taken into account.

As one of the first of its kind, the study showed that, across Europe, workers with activity limitations generally have a lower job satisfaction than workers without them. This finding was irrespective of gender. However, the average job satisfaction and the difference between people with and without activity limitations did vary according the amount of investment in the two policies. Of the two welfare policies I considered, ALMP was associated with higher job satisfaction among both male and female workers. For male workers, the results pointed out this association could be explained by their job characteristics. This is in line with the hypothesis that ALMP investments, which are supposed to increase employability and human capital (Daguerre & Etherington, 2009), can enhance job matching between the job applicant and the job. Through employment services and enhanced bargaining and communications skills, workers might feel strengthened and more able to communicate their needs and demands. It should be noted, however, that they did not seem to diminish the differences between male workers with and without activity limitations.

For female workers, the results showed again that higher investments in ALMPS seemed to be associated with higher job satisfaction. While this effect disappeared after accounting for job characteristics for female workers without activity limitations, the effect of ALMP investments for female workers with activity limitations only partly diminished. After accounting for job characteristics, it was observed that in countries with higher ALMP investments female workers with activity limitations reached higher levels of job satisfaction than female workers without activity limitations in countries with lower ALMP investments. As such, ALMP investments could potentially diminish the gap in job satisfaction between female workers with and without activity limitations.

However, the finding that job characteristics could not explain this effect of ALMP completely pointed in the direction of other explanations. One option is related to the alternative role of welfare states in creating norms about good societal behaviour, described at the end of chapter 3. Previous research indicated people with activity limitations are sometimes just happy to be working and satisfied with their jobs, irrespective of the kind of job they are doing (Pagán-Rodríguez, 2012; Pagan, 2011, 2013). This might especially be true in an environment that, via investments in ALMPS, stimulates people by training and job services to find employment. This might signal a stronger societal commitment to work. In countries with higher investments in ALMPs people generally have higher employment commitment, including among less educated people and people with limiting longstanding illnesses (van der Wel & Halvorsen, 2015). While the effect of a macro-level norm to work did not help explaining our outcome, I would advise that individual-level employment commitment could be considered in future research.

To really test the link between ALMPs and job matches, research should start to look into the experiences of individuals who followed training and see how this affected their job search process. The analyses would profit from a more extensive examination of people's employment and working conditions. Studies have described the changing nature of employment in recent decades and documented the increased emphasis on flexibility and competitiveness in European labour markets (Benach et al., 2014a; Van Aerden et al., 2014; Van Aerden, Puig-Barrachina, Bosmans, & Vanroelen, 2016). They showed that precarious, de-standardised and flexible employment situations are associated with lowest job satisfaction and also cause more general health inequalities. Since people with impairments are more likely to end up in these more precarious positions (Kaye, 2009; Pagan & Malo, 2009; Roulstone, 2012), this could explain their deficit. It would also allow us to look into which kind of jobs match their conditions better. Second, future research could also investigate more refined policy measures. Because of data availability, the ALMP measures that were used in this study were not focused on investments for people with impairments only. Although more detailed data is available on Eurostat, not all countries report at that level. A way around this problem would be to narrow the comparison down to four or even only two countries. As such, the difference between the policies can be described in a more extensive and informative way. In addition, it can be insightful to look at the impact of specific policy measures and legislation. Regarding the latter, Bambra and Pope (2007) present an example in which they examine the impact of the British Disability Discrimination Act on the employment rates of people with impairments based on longitudinal data. This could also be incorporated in studies on work-related well-being.

Expenditures on out-of-work benefits were only relevant for the job satisfaction of female workers. More specifically, I observed that higher benefit spending was especially associated with higher job satisfaction levels among female workers with activity limitations only. Since the effect stays after controlling for job characteristics, it looks like more generous benefits seem to create the freedom to adjust one's work effort according to one's subjective physical and mental energy, and might give the impression that opting out of work is possible when necessary.

In sum, the results of the study showed that, in addition to being excluded from the labour market, within the labour market people with activity limitations have a lower well-being. However, this relationship is dependent on the broader country-context, that this time was taken into account by a focus on two specific but actual aspects of welfare policy. As such, I conclude again that the relation is not as straightforward as it seems at first sight. It should be placed within a framework that accounts for the particular job situation people are in, and the broader country-context. People with activity limitations should not necessarily be considered as deficient.

Comparative disability policy

The previous studies showed that the well-being and subjective health of people with impairments varied across national contexts. Depending on whether they could participate in the labour market, the general organisation of the welfare regime, or more specific welfare policies, the strength of the association between impairments or activity limitations and the well-being outcome differed. This led me to conclude that the approach to people with impairments within social policy may have a decisive effect on the way people with impairments feel.

Therefore, the studies in chapter 9 and 10 were devoted to the study of disability policy across Europe. In my search for more information on policy towards people with impairments, I did, however, make the observation that insight into the contemporary approaches of European countries is limited. This forced researchers, including myself, who are interested in connecting individual-level outcomes with welfare state approaches to disability, to use more general welfare regimes and measures as proxies for a country's disability policy. To contribute to a more nuanced perspective, I first reflected on a theoretical concept to use in the comparison of disability policies of different countries. Consequently, I carried out an empirical analysis on disability policy across European countries.

In the theoretical reflection of chapter 9, it was pointed out that most of the studies that compared disability policy before were limited to income benefits or labour market participation. Theoretically, they gave us insight into the extent disability benefits, for instance, lead to an acceptable standard of living based on the concept decommodification, but did not consider people with impairments are likely to be socially excluded or disabled, in many different ways and manners. Financial poverty might only be one example, but the social exclusion of people with impairments has also been characterised by institutionalisation, being dependent on family members and charity for care and mobility, and a denial of political rights.

Their specific situation was not taken into account by common concepts in mainstream comparative welfare state policy.

On the basis of the concept of Active Citizenship for people who are disabled (Halvorsen & Hvinden, 2013c; Waldschmidt, 2013), the study in chapter 10 explored the different manners by which countries try to foster the social inclusion of people who are disabled. More specifically, it examined the extent to which European welfare states support the possibilities for people who are disabled to experience security, autonomy and influence.

According to the analyses, that uses 2010 data, different cluster of approaches towards the social inclusion of people could be found in Europe, that only to a certain extent mirrored the more general welfare typologies. More specifically, seven different strategies were observed, of which some were aligned with the theoretical ideal-types I proposed. Denmark and Sweden came out as countries that support AC for people who are disabled in the most complete way. In other words, they fostered security by providing adequate income support and enabling labour market participation, and provided the possibility to live autonomous and participate politically. The largest number of countries could, however, be found, employing a strategy tied to giving rights to political participation, without more extensive attention for one of the other dimensions of AC. While this does not say income support or care services are not available in these countries, it does say the countries only provide it in a residual way. Most Eastern European and some Southern countries could be found in this type.

Compared to previous studies, the results of chapter 10 show in a more nuanced way that there is considerable variation in the European approaches towards people with impairments. Although most countries acknowledged their right to political participation, other dimensions of citizenship are less likely to be included in the welfare state policy. The cross-national variation also adds to the discussion on the concept of disability. Given the variety in approaches, it seems more likely that disability should not be treated as an absolute given based on the presence of an impairment, but rather as a social process or a situation that is socially constructed. A country's policy can affect the capabilities of people with impairments to act as 'active citizens' and to overcome social exclusion.

To conclude

Based on my empirical studies, I can conclude that the research on the health and well-being of people with impairments or activity limitations benefits from a structural perspective that approaches their well-being as the result of micro-, meso- and macro-level characteristics and processes. Each in their own way, the quantitative multilevel studies make clear that people's subjective health or well-being is not just dependent on their conditions. They rather show that the well-being is contingent on the experience of social exclusion, or that the association between impairments and well-being differs depending on the country-context. As such, I underline the need for a social understanding of disability that treats their activity limitations or lower well-being more as social constructions, than absolute. Impairments seem to trigger social exclusion processes that disable their participation options and undermine their well-being. The studies on disability policy underline the distinct approaches toward disability across European countries, and contribute to the understanding that the position and role of people with impairments in society is also socially created.

Limitations

Unavoidably, there are several limitations in the empirical studies which I could not deal with in this dissertation. In the following section, I discuss the most prominent ones that apply to most of my studies and make some suggestions on how they can be tackled by future research.

Measurements

A first general limitation refers to the kind of information used within the multi-level studies. Survey-data is a good way to identify the subjective health and well-being of a representative population, in addition to a series of socio-economic and demographic indicators. However, it does entail some limitations. As already mentioned, persons living with more severe health problems and impairments, living in institutional or group home settings, are not included in the datasets. This can lead to a general underestimation of the impact of impairments or activity limitations on subjective health and well-being.

Self-reported information as such, should not need to be considered as a limitation of this dissertation. I was especially interested in how people perceive their health and well-being under different circumstances, instead of an expert's opinion. However, register data could have been useful for other topics, such as employment and disability status, as they are sensitive topics, and could be underreported. Combining information from governmental labour, health-care and social security departments could improve the measurement accuracy of the concepts and provide more detailed information. Nonetheless, register data has its disadvantages too. Although the information could be very useful for single-country studies, each country has its own system of classification, its own way of data collection and different privacy rules may apply. This would complicate the analyses considerably. Moreover, related to impairments, it would only give insight into the population that is officially classified as 'disabled', a definition that differs across countries and leaves out those excluded by the system.

The indicators on longstanding illnesses and impairments employed here are widely used in epidemiological literature and seem to be a sound alternative to more detailed measures. Another argument in favor of the general measures is that selecting specific conditions would potentially hamper the analyses because of low prevalence rates (van der Wel, 2011). Over- or underreporting of longstanding illnesses or impairments is, however, a possible flaw. It has been variously suggested that the answers to such (limiting) long-standing conditions may be affected by social factors (Macintyre et al., 2005). As a result, people of lower socio-economic positions would ‘over-report’, which would lead to an overestimation of socioeconomic differences in impairments (Heliövaara et al., 1993; Lindholm, Burstrom, & Diderichsen, 2002). In contrast, other authors have suggested that socially disadvantaged groups would ‘underreport’ ill health and impairments because of low health expectations and higher thresholds perceiving ill health (Cornwell, 1984; Elstad, 1996; Macintyre et al., 2005). However, the empirical research on this topic is rather limited. In the UK, Macintyre et al. (2005) do not find support for significant differences in reporting chronic conditions between people of different socio-economic positions, even after detailed further prompting of health issues such as mental health problems, which are assumed not to be considered as ‘real illnesses’ by poorer groups. While their conclusion is positive for the studies in this dissertation, further research is necessary to provide firmer evidence and better insight across different contexts.

As already discussed in the methodology chapter, the datasets also provide limited information about different types of impairments. Crucial distinctions in terms of social processes might lie in congenital or acquired conditions (Bogaert, 2014), visible and non-visible (Goffman, 1963; Link & Phelan, 2001), and physical and mental impairments and chronic illnesses (Mithen, Aitken, Ziersch, & Kavanagh, 2015; Pagán-Rodríguez, 2012; Roulstone, 2012). Especially regarding possible policy implications, the need for a more detailed study on different types of impairments is high. The social exclusionary processes may vary depending on the type of impairment. For instance, people with mental and psychological problems might suffer the most negative stigmatizing attitudes and have the lowest probability of employment (Roulstone, 2012). As such, adaptation to their condition might be more difficult and social exclusion might be harder to overcome.

Selection, causation and temporal ordering

A second and important limitation of my work is related to the design of the datasets. The empirical chapters of this dissertation are based on cross-sectional surveys. This cross-sectional nature does not allow me to make firm conclusions regarding the causal direction of the relationships under study. For instance, although my framework predominantly pointed to the impact of unemployment on mental health and meta-analyses document the evidence for this interpretation (McKee-Ryan, Song, Wanberg, & Kinicki, 2005; Paul & Moser, 2009), health selection effects are not ruled out (Schuring et al., 2007). The latter hypothesis points to the possibility that people with poor mental well-being are selected out of the labour market (Heggebo & Dahl, 2015; Marmot, 2005). Or, while I indicated people with impairments and ill-health are more vulnerable to job loss and experience barriers towards paid work, unemployment might also contribute to the development of chronic illnesses and impairments. It was not my aim to deny or to contest effects in another direction than those highlighted. The main aim was rather to contextualize the relationship between impairments or activity limitations and subjective health and well-being, and direct attention to the social exclusion that is associated with being impaired. This theoretical focus does not have to rule out that, especially over the course of a life, the relation between disadvantage or social exclusion and health is complex and dynamic (Ben-Shlomo & Kuh, 2002; Dewilde, 2003; Graham, 2002).

Nevertheless, I should emphasise that this cross-sectional approach also overlooks the dynamics of being disabled; it tends to present an oversimplified reality. The analyses in my studies divide the population into those "being disabled" and those "not being disabled". However, one should keep in mind, that while impairments and chronic illnesses are longstanding conditions, they are not necessarily permanent and can evolve negatively or positively. Cross-sectional surveys provide a snapshot of "those who are being disabled", which will include some who are temporarily impaired (through an injury), some who have been impairment since birth or childhood, and some who have recently developed a condition which is likely to be long-term (Burchardt, 2000). Moreover, it is the premise of this dissertation that disability entails a process of being socially restricted in activity, participation or well-being, that is constituted within a certain context. As such, it is not an absolute given: people can enter a situation of disability, but also come out of it.

The use of panel data, preferably with sufficient sequential interviews with short time intervals between them, is essential to get this more granular insight. Based on the British Household Panel survey, Burchardt (2000) followed 'disability trajectories' over seven years. Her results show, indeed, that only a small proportion of the working-age people who experience impairments and activity limitations experience this for a long time. However, her results do indicate that at any point in time, the long-term impaired people do make up a high proportion of all people with impairments and activity limitations. While over half of those who become limited in their activities experience difficulties for over two years, few remain in the same situation after four years and recover. For people having mental health problems, intermittent patterns of experiencing activity limitations were common. This displays that it is very unlikely that the saying "once disabled, always disabled" is true.

Cross-sectional studies also cannot precisely examine the impact of an impairment or activity limitation on disadvantage. Jenkins and Rigg's study (2004) with longitudinal analyses, again based on British panel data, pointed to the fact that the economic disadvantage among currently impaired people reflects three different processes: pre-existing disadvantage, effects associated with the onset of the impairment and effects associated with the remaining impairment, post-onset. Although the results indicated employment rates fell with the onset of an impairment and they kept on declining the longer people had an impairment, those who became impaired were typically also more likely to be more socio-economically disadvantaged before. This is in line with the general causation perspective on social inequalities in health (Marmot et al., 1997; Mossakowski, 2014).

In this dissertation, causality is only presumed on the basis of theoretical insights and the analogy of our results with earlier research findings based on longitudinal data. With regard to the theoretical focus on the role of social exclusion, the hypothesis is supported by a limited number of longitudinal studies within the UK and Australia that show that the disadvantaged circumstances in which they live are major contributors to the poorer health status and lower well-being of people with impairments (Emerson et al., 2012; Emerson et al., 2011). Future research with an international and longitudinal scope is essential to disentangle the direction of the relationships described within this work.

Meso-level mechanisms and indicators

I examined the dependence of the relations between impairments, employment and well-being on the societal level. For this I took national labour market exclusion rates and welfare state arrangements into account. However, to get a more refined insight into the mechanisms at play, I referred to the use of regional or other meso-level characteristics.

The need for integration of region indicators is related to a more general observation on the research of contemporary medical sociology, and my own research in particular. While I support the attention given to structural perspectives on social inequalities in health (Cockerham, 2013), I do think the meso-level has been neglected in medical sociological research. Research has been focusing on integrating country-characteristics such as welfare states, health care systems and macro-economic situations in multi-level analyses that combine micro- and macro-level data. While these studies have been evolving (e.g. increasingly institutional and expenditure measures are used instead of welfare regimes) and bringing compelling insights, additional and new insights could be gained from taking a step further inwards. We should not forget that the meso-level connects the two main focus points of today's health sociological studies: macro-level structures on the one hand, and individual actions, behaviour and well-being on the other. Taking the meso-level into account could involve looking into the availability of (health) care facilities in the community, regional job opportunities, more granular information on firms and organization, and the role of civil society organizations. For people with impairments, the disabled people's organizations for instance have played an important role as policy influencers and as a form of organized support.

However, I do have the impression that research wanting to look into these different factors is hindered by the lack of data available on the meso-level. While structural data is easily found on Eurostat, more substantial measures are rare. One example of an alternative data source is the 'Database on Institutional Characteristics of Trade Unions, Wage Setting, State Intervention and Social Pacts in 51 countries between 1960 and 2014' of Visser (2015). While it is still tied to the national level, it does include information on the number of employees in different sectors, union densities in different types of firms, sectoral agreements and collective bargaining arrangements. Another alternative database could be the Civicus Civil Society Indicator database (Civicus, 2009) which consists of information on the structure of civil society in a country, the values practiced and promoted and the impact of the activities pursued by civil society actors. In addition, the conclusion of qualitative research that is already investigating what happens at the meso-level should be considered. Studies like those of Baldridge and Kulkarni (2017) and Jammaers, Zanoni, and Hardonk (2016), for instance, provide more insight into what happens on the work floor and approach the subject from both employees' and employers' perspectives. They point to symbolic and attitudinal barriers and behaviours and offer the most practical leads for policy design. In comparison to my studies, these studies give more insight into individual actions and capabilities, or the efforts of persons with impairments to combat social exclusion.

Intersectionality

The studies in this dissertation were framed within a perspective that highlights disabling social exclusionary processes triggered by the presence of impairments. These processes are rooted and being constituted within the social relations of production (labour markets) and reproduction (families), and socio-cultural formations in society (Thomas, 1999). However, both in labour markets, families and other parts of reality, social exclusion occurs on a multidimensional basis, in which different axes of social exclusion intersect (Collins, 2015). These forms of exclusion do not act independently from each other but form a clustered system of multiple forms of exclusion and discrimination. In chapter 8 on job satisfaction, this intersectionality was accounted for by stratifying the analyses based on gender. This was based on the idea that the form and impact of disabling relations are refracted by gender relations (Thomas, 1999). Due to the feminisation of the labour market, the presence of women in the workforce cannot be trivialised. However, gaining a deeper understanding of how disabilism is shaped by gender and other social relations would be a fruitful way forward. Next to gender, social class relations, and class positions can moderate and form the impact of disabling processes. Social class relations, that have at their core the relationship between capital and labour, are defining for social inequalities in health (Scambler & Higgs, 1999). Lindholm et al. (2002) found, for instance, that the social consequences of an impairment and chronic illness are dependent on one's social class. While I emphasized the general labour market exclusion of people with impairments, their study showed the risk of economic inactivity is significantly higher for manual workers compared to non-manual workers. In addition, migrants and members of an ethnic minority also have subordinate locations in social relations. Research on labour markets in particular shows the discrimination they suffer (Kingston, McGinnity, & O'Connell, 2015). Within the European context, the research on ethnicity and health is still limited, though studies have shown how people's social exclusion is connected with their mental health status (Levecque & Van Rossem, 2015). Researching the interaction between ethnicity relations with disability in the labour market, such as the study of Heggebø (2017), provides an interesting field for future research.

Policy implications

The prime aim of this dissertation was to contribute to the study of social inequalities in health and well-being from a sociological point of view that approached disability as a form of social exclusion. To conclude, I present some cautious reflections with regard to policy implications.

Prevention of impairments, social inclusion and alternative roles

Given the social exclusion of people with impairments and their lower subjective health and well-being compared to those without, I believe a first broader implication of this work relates to the prevention of chronic illnesses and impairments. Reality shows, however, that most industrialised countries are confronted with a rising number of people with long-standing illnesses who are absent from work. According to the latest numbers of the Belgian governmental institute for sickness and invalidity insurance (RIZIV), psychosocial conditions, such as depression and burn-out, are rising particularly quickly and are among the main causes for sickness absence (D'hoore, 2017; RIZIV, 2017). They cause about 35% of the long-term sickness absences. Musculoskeletal disorders take the second place with 30%. Within Belgium, the strongest increase in sickness absence is observed by women. Although this increase is, of course, related to their inflow since the 1960's, the end of their work career also seems to weigh on their health. The results of this dissertation, however, indicate it is likely that the combination of having an impairment and being unemployed or inactive may result in an even worse well-being.

As such, we are confronted with two problems. On the one hand, the rising number of people that opt out of work because of illness and, on the other hand, the potential interaction between impairments and (labour market) exclusion that may result in worse well-being. To mediate these problems, I will briefly discuss three important affairs.

First, the rising number of people that opt out of work because of an illness calls attention towards sustainable jobs and a sustainable organisation of work in general. This is also particularly relevant given current focus on longer working lives and the increase of the retirement age. To prevent mental health problems among workers, studies nowadays point to the importance of employment quality (Benach et al., 2014b; De Moortel, Vandenheede, & Vanroelen, 2014; Puig-Barrachina et al., 2014; Van Aerden et al., 2016; Vives et al., 2013). At the end of the

20th century, the psychosocial work environment became the primary source of work-related health risks (De Moortel et al., 2014; Vanroelen, Levecque, & Louckx, 2009). Studies relying on frameworks such as the Job Demand-Control-Support model (Karasek & Theorell, 1990) or the Effort-Reward Imbalance model (Siegrist, 1996), put psychosocial job characteristics and well-being on the research agenda next to physical working conditions (De Jonge, Bosma, Peter, & Siegrist, 2000; van der Wel, Bambra, Dragano, Eikemo, & Lunau, 2015). In contemporary labour markets, however, the market risks for the work force seem to be related to flexible employment arrangements (e.g. atypical contracts, flexible working hours, small jobs without permanent contracts, etcetera) (De Moortel, Vandenheede, Muntaner, & Vanroelen, 2014; De Moortel et al., 2014). Studies that look into the effect of these arrangements indicate they are not neutral towards employee well-being and question their long-term sustainability (De Moortel et al., 2014; Van Aerden et al., 2016). Based on the European Working Conditions Survey, Van Aerden et al. (2016) found that well-being was especially low among workers in 'precarious intensive jobs', characterized by highly unpredictable schedules, long working hours and uncompensated exceptional working times, and among workers with overall beneficial employment conditions and relations, but with a high probability of long working hours and uncompensated exceptional working times. In the latter type of job, highly educated employees and white collar workers are overrepresented (Van Aerden et al., 2014), while the first groups mainly consists of young employees, blue collar workers, low educated workers and agricultural sector workers. As such, the prevention of impairments and chronic illnesses would benefit from taking the nature of employment conditions into account. Safeguarding high-quality employment arrangements for all employees seems one of the policy options.

Second, in order to cut the rising costs of sickness, invalidity or disability benefits (depending on the country), and stimulate labour market participation of people with impairments and chronic illness, governments have used a range of techniques (OECD, 2010). Based on the belief that overly generous benefits without proper control would increase the number of recipients, one option seemed to cut benefits, make eligibility criteria stricter, and sanction individuals with lower benefits to increase compliance with administrative rules (Etherington & Ingold, 2012; Hvinden, 2009; Sjoberg, 2017). However, longitudinal research over the period of 1992-2011 across 21 European countries now shows that in the long run more generous sickness benefits are more likely to reduce sickness absence (Sjoberg, 2017). As such, in the longer run, these reforms may actually increase sickness absence rates. This is in accordance with previous studies which concluded that more generous sickness benefit provision may strengthen employee’s resilience against mental health risks at work (van der Wel et al., 2015).

Based on the foregoing, I would conclude that spending cuts are not likely to have the presumed effects. Although people with long-term illnesses and impairments generally also want to be included in the labour market (Hvinden, 2009), targeting individuals financially does not seem a valuable option. By contrast, my research indicates the job satisfaction of employees with activity limitations is also higher in countries with higher spending on out-of-work benefits and in countries that invest more in ALMPS (such as training and education and employment services). Other solutions that have been proposed are employment quotas and reserved job systems. However, research has also stressed quotas need to be backed up with sanctions (Waddington, 1996). Therefore, given the evidence for discriminations and discriminatory attitudes of employers, initiatives that point in the direction of financial incentives for employers such as wage subsidies (Samoy & Waterplas, 2012), anti-discrimination legislation (Waddington, 1996), or increasing employer liability for a period of the sick or invalidity pay (OECD, 2010), seem more promising. In addition, installing internships that give both employers and potential employees with impairments a better view on the demands, costs and rewards could also be a manner to eradicate prejudices and misunderstanding (VDAB, 2017).

Third, the possible negative impact of unemployment also implies we need to think of re-evaluating roles outside the labour market. For a lot of people with impairments, labour market participation is currently still not part of their reality for a mixture of reasons. The results of this dissertation indicate that the well-being of this group is likely to be the worst, especially in countries with the bleakest labour market perspectives. Although voluntary work is sometimes mentioned as an alternative form of time use, it does not function as an alternative for their well-being (Leiulfsrud et al., 2016; Schedin Leiulfsrud et al., 2014). This is in line with the strong (moral) connection between work, social recognition and citizenship (Abberley, 1999; Bothfeld & Betzelt, 2011; de Graaf & Maier, 2017). Recognizing and sensitizing about the structural barriers towards employment might be one step in that direction.

Acknowledging other roles is also related to the well-known fact that people with impairments are socially excluded in many ways. In addition to a more difficult labour market participation, they are often also denied opportunities for independent living, or autonomy in general. My analyses of the variation in disability policies across European countries underscore the idea that many welfare states approach people with impairment in a specific way. In a lot of countries, the ways in which they could act as full citizens is only supported to a limited extent. However, the other studies in this dissertation indicate it is this approach towards ‘disability’ that can also affect their well-being and health. A more comprehensive policy that acknowledges the different dimensions of active citizenship is likely to contribute to better well-being;

The organisation of welfare state policy

A more striking finding of one of the studies was the potential negative consequences of welfare state organization for subjective health. This was linked with the creation of ‘disability’ as a social category with a specific social role, and the labeling of people as such. This is acknowledged as a broader paradox of disability policy (Marin, 2004). Waddington and Diller (2002) for instance describe that social welfare creates separate parallel tracks that provide income and services, but put people with impairments in a category that can be treated apart from the mainstream of society.

A restructuring and reorganization of welfare policy towards more universal approaches could be a way around the labeling of people as disabled. Danermark and Gellerstedt (2004) address the tension between recognition for disability and achieving equal opportunities based on Fraser’s (2001) theory on social justice. In her theory, Fraser suggests we should avoid a model of recognition based on various group-specific practices, traits and identities, which are not and cannot be universally shared. She indicates that the root of social injustice maybe lies within institutionalized patterns of cultural values that categorise some social actors as less than full members of society. This makes me ponder whether labeling and categorizing by welfare states might contribute or even constitute the basis of social exclusion. This could be avoided if we provide benefits and services on a more universal basis. Danermark and Gellerstedt (2004: 341) support this view by stating that the labeling can be avoided if we address “the reshaping of social and physical environment in general redistributive terms without conceptualizing it as measures for disabled people, but as measures to meet a variety of needs in the society.” An easy example is related to the accessibility of buildings, to public transportation and streets, which requires the same architectural and technical solutions for people with wheelchairs, people with children’s carriers, children, people with walking sticks and so on. Universal design initiatives follow this idea (Ostroff, 2011). However, this could also be expanded to work environments. While reasonable accommodations provide assistance to people with impairments to get a job, they are ‘special’ and individual arrangements that need to be demanded. Instead, we could also think of more structural reorganizations of the work floor. These suggestions are in line with Zola's (1989) early plea for the universalizing of disability policy; away from a special needs approach and towards the recognition that the entire population is "at risk" of chronic illnesses and impairments and the disabling processes they might trigger.

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Summaries

Disabled well-being

Research on impairments, social exclusion and well-being across distinct socio-economic and institutional contexts

In most industrialised countries the number of people with long-standing illnesses and impairments who are absent from work is rising. Impairments and chronic illnesses are, however, linked with poor subjective health and low well-being. They are assumed to dominate one's life and associated with being unhealthy, suffering and sadness by people without impairments. Notwithstanding the potential serious impact on life, studies also indicate not all people with impairments see themselves as unhealthy nor do they always report a lower well-being than people without impairments. Depending on the type of impairment or activity limitation, people can adapt to their situation, while psychological resources and social support are also associated with a more positive outcome.

While the previous findings challenge the seemingly obvious negative relationship between an impairment and well-being, they neglect that impairments and chronic illnesses also trigger social exclusionary processes. Several reports and statistics of intergovernmental and human rights organisations exemplify, nonetheless, the multi-dimensional social exclusion and disadvantage faced by people with impairments. They also show this social exclusion is shaped by macro-level socio-political structures and socio-cultural practices, as it varies considerably across countries. Giving the recurrent finding that social exclusion is known to expose people to stressful situations and risk factors that are detrimental for health and well-being, it was the focus of the studies in this dissertation. As such, I examined whether and to what extent the subjective health and well-being of people with impairments or activity limitations is socially undermined by the experience of social exclusion across distinct contexts.

Based on a theoretical framework that draws on insights from medical sociology and disability studies, and by using a quantitative cross-national multilevel approach, the studies in this dissertation took the social exclusion into account in three ways. First, given its central structural role in our contemporary society, the role of exclusion from the labour market was examined. The results showed the well-being of people with impairments is worst if they are also excluded from paid work. In addition to hassles and stress that comes with an impairment in terms of symptoms, they also face the drawbacks of being unemployed or economically inactive. Within the language of social exclusion, one could say the lack of paid work potentially excludes them from real financial security, a broader social network and social contacts and a certain social status in society. Moreover, I also observed the combination of an impairment with unemployment was especially negative for well-being in countries with the higher levels of labour market exclusion. In those countries they might have the bleakest prospects of finding a job, feel powerless and discouraged, which might result in a higher level of social stress.

Second, the moderating role of the welfare state was examined. On the one hand, researchers in disability studies have been highlighting the role of the welfare state in creating opportunities for people with impairments to participate in society and increase their capabilities. In line with this, there is a growing literature that examines how between-country differences in health inequalities are potentially related to variation in welfare provisions. The results of one of my studies support this view and showed the work-related well-being of people with activity limitations is better in countries with higher investment in active labour market policies that foster training, human capital and employability. More generous out-of-work benefits also seemed to contribute to higher well-being of female workers. This might be related to the freedom they create to adjust one's work effort according to one's subjective physical and mental energy, and to opt out of work is possible when necessary. On the other hand, however, the results of this work, also point to a potential 'disabling' role of welfare states. More specifically, I found that people with activity limitations in mature welfare state regimes rate their health worse than people in developing, more insecure welfare regimes. This is linked to the creation of separate 'special needs' tracks for disability, and the labelling of people 'as such'. A side-effect of this labelling may be that the individuals experience a feeling of profound 'otherness', and think they deviate from the social norm. In addition, the labelling might induce processes of status loss and discrimination.

In a third step, the approaches of contemporary European welfare states towards the social inclusion of people with impairments were scrutinized. Based on a framework developed with their situation at the centre, I examined whether and how to which a country's policy support the possibilities for people with impairments to be socially included and to act as active citizens. The analysis showed that European countries cluster in different seven groups that only partly coincide with geographical proximity. However, while most countries provided the institutional foundations for political participation, a lot fall short of offering adequate income support, stimulating labour market participation or providing opportunities for independent living.

All taken together, the studies in this dissertation constitute a counterweight to the common-sense approach that equal impairments and activity limitations with a personal tragedy. In different ways, each of the studies show the relation is shaped by social exclusion within a particular socio-economic or institutional context. As such, I contributed to a socially rooted understanding of the well-being of people with impairments and the knowledge of disability as a form of social stratification.

Gehandicapt welzijn

Onderzoek naar beperkingen, sociale uitsluiting en welzijn over verschillende socio-economische en institutionele contexten

In de meeste geïndustrialiseerde landen stijgt het aantal personen met een langdurige ziekte of handicap. Deze laatsten worden echter gelinkt aan een slechte subjectieve gezondheid en een laag welzijn. Ze zouden iemands leven domineren en worden snel geassocieerd met zich ongezond voelen, lijden en verdriet door personen zonder een handicap. Ondanks de mogelijke ernstige gevolgen, geven studies toch aan dat niet alle mensen met een handicap of langdurige ziekte zichzelf als ongezond zouden omschrijven. Ook rapporteren ze niet steeds een lager welzijn dan mensen zonder handicap. Afhankelijk van de aard van de handicap of de activiteitsbeperking, kunnen mensen zich aanpassen aan hun situatie. Daarnaast worden ook psychologische hulpmiddelen en sociale ondersteuning aan een meer positieve uitkomst gelinkt.

Terwijl de bovenstaande bevindingen de schijnbare evidente negatieve relatie tussen het hebben van een langdurige ziekte of handicap en welzijn uitdagen, verzuimen ze dat handicaps en langdurige ziektes ook sociale uitsluitingsprocessen veroorzaken. Niettemin illustreren verscheidene rapporten en statistieken van intergouvernementele en mensenrechtenorganisaties deze multidimensionale sociale uitsluiting en benadeling van mensen met een handicap. Bovendien tonen ze ook aan dat deze sociale uitsluiting gevormd wordt door sociaal-politieke en -culturele structuren en praktijken, aangezien ze aanzienlijk verschilt over landen heen. Omdat onderzoek veelvuldig heeft aangetoond dat sociale uitsluiting mensen blootstelt aan stressvolle situaties en risicofactoren die schadelijk zijn voor gezondheid en welzijn, vormde ze de focus van dit doctoraatsonderzoek. Als zodanig ben ik nagegaan of en in hoeverre de subjectieve gezondheid en het welzijn van personen met een handicap of activiteitsbeperking sociaal ondermijnd wordt door de ervaring van sociale uitsluiting in verschillende contexten.

De studies in dit doctoraat zijn gebaseerd op een theoretisch kader dat inzichten uit de medische sociologie en ‘disability studies’ samenbrengt en volgen een kwantitatieve cross-nationaal vergelijkende aanpak. De sociale uitsluiting wordt op drie manieren in rekening gebracht. Ten eerste, gezien de centrale structurele rol in onze hedendaagse samenleving, werd de rol van uitsluiting op de arbeidsmarkt onderzocht. De resultaten toonden dat het welzijn van personen met een handicap het laagst was indien ze ook geen betaald werk hadden. Bovenop de dagelijkse stress die vasthangt aan een handicap in termen van symptomen en beperkingen, worden zij ook geconfronteerd met de nadelen van werkloos zijn. Geherformuleerd naar de taal van sociale uitsluiting zou men kunnen stellen dat het gebrek aan betaald werk hen uitsluit van echte financiële zekerheid, een breder sociaal netwerk en sociale contacten, en een bepaalde maatschappelijke positie. Bovendien observeerde ik ook dat de combinatie van een handicap en werkloosheid vooral een negatieve associatie met welzijn had in landen met een hogere uitsluiting van mensen met een handicap op de arbeidsmarkt. In die landen hebben zij waarschijnlijk de minst goede vooruitzichten op het vinden van een job, wat kan leiden tot een gevoel van machteloosheid en een hoger niveau van sociale stress.

Ten tweede werd de modererende rol van de welvaartsstaat onderzocht. Enerzijds hebben onderzoekers binnen 'disability studies' de rol van de welvaartsstaat in het creëren van kansen om deel te nemen aan het maatschappelijk leven benadrukt. In lijn hiermee toont een groeiend aantal studies aan dat cross-nationale verschillen in sociale ongelijkheid in gezondheid samenhangen met verschillen in de welvaartsvoorzieningen van landen. De resultaten van een van mijn studies ondersteunen deze opvatting en laten zien dat het werkgerelateerde welzijn van personen met activiteitsbeperkingen beter is in landen met hogere investeringen in actief arbeidsmarktbeleid dat inzet op opleidingen en menselijk kapitaal. Meer genereuze werkloosheids-, ziekte-en invaliditeitsuitkeringen lijken ook bij te dragen tot een hoger welzijn van vrouwelijke werknemers met activiteitsbeperkingen. Dit kan verband houden met de vrijheid die de uitkeringen creëren om de werkinspanning aan te passen volgends de fysieke of mentale energie die men heeft, en om te stoppen met werken wanneer nodig. Anderzijds wijzen de resultaten van een andere studie echter ook op een mogelijke 'invaliderende' rol van welvaartsstaten. Meer specifiek stelde ik vast dat personen met activiteitsbeperkingen die leven volwassen en uitgebouwde welvaartsstaatregimes hun gezondheid slechter beoordelen dan personen met activiteitsbeperkingen in meer onzekere en minder uitgebouwde welvaartsregimes. Dit zou te maken kunnen hebben met het creëren van aparte 'speciale behoeften' –sporen voor personen met een handicap en de etikettering van personen als zodanig in de welvaartsstaatregimes. Een bijwerking van deze etikettering kan zijn dat het de personen in kwestie een gevoel van diepgaande 'andersheid' geeft en het voor hen aanvoelt dat ze afwijken van de sociale norm. Bovendien kan de etikettering processen van statusverlies en discriminatie veroorzaken.

In een derde stap nam ik de benadering van de sociale inclusie van personen met een handicap binnen de verschillende hedendaagse Europese welvaartsstaten onder de loep. Gebaseerd op een theoretisch kader dat is ontwikkeld met hun situatie in het achterhoofd, onderzocht ik of en hoe een beleid de mogelijkheden biedt aan personen met een handicap om zich sociaal te integreren en te handelen als actieve burgers. Uit de analyse bleek dat de aanpak van de Europese landen erg verschilt: zeven verschillende benaderingen werden geobserveerd en beschreven. Hoewel de meeste landen de institutionele grondslagen voor politieke participatie vertrekken, is er veel variatie in verband met inkomenssteun, stimulering van arbeidsmarktparticipatie en het bieden van kans voor zelfstandig leven.

Een voor een, vormen de studies in dit proefschrift een tegengewicht tegen de eenvoudige gelijkstelling van handicaps en activiteitsbeperkingen met een persoonlijke tragedie. Op verschillende manieren tonen de studies aan dat de relatie tussen handicap en welzijn gevormd wordt door sociale uitsluiting binnen een bepaalde sociaal-economische of institutionele context. Op deze manier heb ik bijgedragen aan een sociaal geworteld begrip van het welzijn van personen met een handicap en de kennis van handicap als een vorm van sociale stratificatie.

Statement about co-authored chapters

The body of this dissertation consists of four empirical and one theoretical chapter. They are based on co-authored articles of which I am the first author. My supervisor, Prof. dr. Ronan Van Rossem, is a co-author of all the studies, and my co-supervisor, Prof. dr. Katia Levecque, is a co-author of the first three studies. In study 3, Prof. dr. Kjetil van der Wel is the second author, and studies 4 and 5 are co-authored by Prof. dr. Rune Halvorsen. While all of the chapters are characterized by a more or less similar division of labour, a more specific description is provided below.

As a first author, I developed the initial theoretical ideas for the different studies and performed preliminary analyses. They were based on the literature review and the research proposal I wrote to obtain my personal doctoral scholarship. In study 1 and 2, I discussed the potential tracks with my supervisors. Katia Levecque gave theoretical suggestions for the theoretical frameworks and discussion. The ideas and analytical approach of study 3 were closely discussed with Kjetil van der Wel and afterwards with my supervisors. Rune Halvorsen gave me the first feedback for studies 4 and 5. The foundations of these three last studies were developed during my research stay in Oslo during the spring of 2015.

Next, I conducted the analyses on the basis of secondary data. For study 1, Alessia Romagnoli contributed significantly to the construction of the dataset and the earlier written versions of study 1 by giving detailed feedback. For study 5, I first had to gather data from a variety of sources. Based on these analyses, I wrote drafts of the different articles, which changed considerably during a process of continuous discussion with the co-authors.

Study 1 and 2 are based on published research articles. My supervisors were available to the discus the revision of these articles and were closely involved in the revision of study 1. Kjetil van der Wel has contributed significantly to the final version of study 3 in terms of theoretical input and structure, and together we discussed the reviewers' comments. At the moment, the article still needs to be submitted for the second time. Rune Halvorsen was the main co-author of studies 4 and 5, while I always critically discussed the main ideas and changes with my supervisor. Both studies are also to be resubmitted. The co-authors thus contributed to the theoretical framework and interpretation of the analyses, mainly by providing feedback and being available for discussion, while the final decisions and formulations were left to me.

Appendices

Appendix 1: Does the WHO Well-Being scale (5 items) allow for meaningful comparisons among healthy and chronically ill people? Testing its measurement invariance in the general Belgian population

Abstract

In quantitative studies people who are chronically ill or impaired generally report a worse subjective well-being than people who are not chronically ill or impaired. When comparing the subjective well-being of these groups, it is, however, important to know if the measured construct (of for example subjective well-being) has the same meaning across the groups, and, whether the findings report true differences in well-being or are contaminated by group-specific attributes unrelated to the construct of interest, but affecting its measurement. In this paper we test the measurement invariance of the World Health Organization Fove Well-Being scale (WHO-5) across people with and without a chronic illness or impairment in the Belgian population. Using data from the European Quality of Life Survey of 2011-2012, multi-group confirmatory factor analyses were performed to the test for different levels of measurement invariance (configural, metric and scalar). In our study, evidence was found for partial scalar invariance, suggesting that comparisons across people who are chronically ill and those who are healthy, are defensible. Our study also confirms the worse well-being of chronically ill people compared to those who are healthy.

Introduction

In quantitative studies, people with a chronic illness or impairment are found to have a worse self-rated health and subjective well-being than people without one (Cott, Gignac, & Badley, 1999; Freedman, Stafford, Schwarz, Conrad, & Cornman, 2012; Reinhardt, von Elm, Fekete, & Siegrist, 2012; Stewart et al., 1989). However, qualitative research concludes that many impaired people do not see themselves as unhealthy and often continue to report a high quality of life (Albrecht & Devlieger, 1999). In the literature this finding is explained by means of a balance framework pointing to the importance of achieving a balance between body, mind and spirit to experience of well-being and life satisfaction (Albrecht & Devlieger, 1999). Psychological resources, especially a high mastery and self-esteem, are also associated with a better self-rated health when chronically ill (Cott et al., 1999). These recurrent findings of both sorts of studies indicate the existence of a true, but conditional, negative influence of being chronically ill or impairment on the subjective well-being.

Nevertheless, the observed differences may also be partly due to the measurement variance of the measured construct, or in other words, due to the fact that the instrument does not measure the same construct across groups. Maybe the observed differences are contaminated by group-specific attributes that are unrelated to the construct of interest, but still affect its measurement (Van de Velde, Levecque, & Bracke, 2009). In this study we aim to evaluate the measurement invariance, and thus the comparability, of a well-being scale across people who are chronically ill and those who are not in the general Belgian population. More specifically, we assess the World Health Organization Five Well-Being scale (WHO Well-Being scale) making use of the Belgian sample of the European Quality of Life Survey (2011-2012).

Testing measurement invariance

Mostly subjective well-being is measured using a multi-item self-report instrument, such as the WHO Five Well-Being scale (WHO-5). Although each item alone is considered to be an imperfect measure of the underlying construct, together they should provide a valid, but indirect, assessment of a latent construct like subjective well-being (Gregorich, 2006; Nunally, 1978). The responses to the items are usually summed to constitute a composite measure score, which is assumed to be more reliable than the scores of the single item scores.

An important issue that is assumed when comparing different population groups is that the scale used to asses a personal attribute or feeling measures the same construct across groups. When this condition is attained, we can speak of measurement invariance or measurement equivalence (see the following studies for more detailed information: Gregorich, 2006; Meredith & Teresi, 2006). Confirmatory factor analysis (CFA) is currently one of the most conventional techniques to test measurement invariance. More particularly, it tests the factorial invariance of a scale. In other words, CFA tests whether a common latent construct or factor underlies a scale (Gregorich, 2006). Moreover, Multigroup CFA (MCFA) can also test whether evidence for the construct validity of a scale is available across two or more groups (Van de Velde, et al., 2009). A such, MCFA is an excellent way of testing the factorial invariance of the WHO-5 across people with and without a chronic illness impairment in the General Belgian Population.

When estimating the measurement invariance of a scale across groups, it is necessary to perform a number of nested test that define the level of factorial invariance that is achieved (Gregorich, 2006). At each level a more restrictive requirement is introduced, providing increasing evidence for factorial invariance, and the comparability of the scale across groups. In the following paragraphs we shortly describe the levels:

1) Configural invariance: assumes the same factor structure across the groups. It thus requires that an instrument represents the same number of factors, or later variables, across the groups and that each underlying factor, is associated with identical items across the groups. If a specific model fits good in all the groups, we can assume configural invariance. However, establishing configural invariance is not enough to defend groups comparisons (Van de Velde et al., 2009).

2) Weak invariance: is also called metric or pattern invariance. It assumes the that the factor loadings of the items on the factor are equal across groups and therefore tests whether the factor has the same meaning across the groups. When weak invariance is not supported this might indicate that the meaning of a factor, or a subset or items, differs between groups, or an extreme response style by one of the groups (Van de Velde et al., 2009).

3) Strong invariance: is also called scalar invariance and requires that both factor loadings and intercepts are equal across groups. It tests whether there is differential additive response bias leading to systematically higher or lower valued items across the groups. When strong invariance is supported this means that the group differences in estimated factor means are unbiased and that the group differences in the observed means are related to true group differences and not contaminated by a response bias (Gregorich, 2006).

In practice, it is hard to establish complete strong measurement invariance. Therefore, researchers should try to examine whether there is at least partial measurement invariance (Byrne, Shavelson, & Muthen, 1989). This assumes that the factor is configurally invariant across the groups and that a substantial part of the parameters is also invariant in the additional hypotheses of weak and strong invariance. In this case, group comparisons are still defensible.

Data & Methods

Data

We use the Belgian data of the European Quality of Life Survey (EQLS) of 2011-2012. The EQLS is a pan-European survey on the objective circumstances of individuals' lives, but also on how they feel about these circumstances and their lives in general (Eurofound, 2012). It covers a range of issues, but important for this paper are the fields of health and well-being, and socio-economic status. It covers 34 countries and is representative for the adult population (aged 18 or older) living in private households. Details about the sampling design and field work can be found elsewhere (Eurofound, 2012), but in most countries a multi-stage stratified random sampling design was applied. The data was gathered via face-to-face interviews. The Belgian response rate is 49,9%. The effective Belgian sample size contains 1013 cases (=N). The data were weighted by the final trimmed weights provided by the EQLS. These weights are the product of the design weights and post-stratification weights. The dataset is freely available to the public for non-commercial purposes after registering at the UK Data Service. During this registration process researchers need to describe their position, affiliation and the project for which the data will be used.

Variables

The World Health Organization Five Well-Being Scale (WHO-5) is developed to measure positive psychological well-being over the past two weeks (P. Bech, 2004; P. Bech, Olsen, Kjoller, & Rasmussen, 2003; WHO, 1998). It is conceptualized as a one-dimensional measure, based on five items. Respondents are asked to indicate how often in the two weeks prior to the survey they felt in a certain way, ranging from 'all of the time' to 'at no time' (see table 1 for the items in the WHO-5). Response values are 6-point Likert scales, with a range from 0 to 5. The score on the scale is calculated by using non-weighted summated rating. For a more easily interpretation we multiplied the score by four, resulting in a scale from 0 (worst possible mental well-being) to 100 (best possible mental well-being). Previous research finds strong evidence for the scalability and reliability of the WHO-5 (f.e. Bech, et al. 2003; Saipanish, Lotrakul, & Sumrithe, 2009). In this paper we test the measurement invariance of the WHO-5 in the general Belgian population. The total response rate in the EQLS of 2012 is 99,2%.

People with a chronic illness or impairment were identified by means of the following question: "Do you have any chronic (long-standing) physical or mental health problem, illness or disability? By chronic (longstanding) I mean illnesses or health problems which have lasted, or are expected to last, for 6 months or more." Respondents could answer with 'yes' (1) or 'no' (2). The overall response rate was 99.3%. There is the possibility that within the group of chronically ill people, there are also people with a long-term depression. In the well-being literature there is debate about the extent to which negative affect (such as a depression) is correlated with positive affect (such as happiness) (f.e. Diener, Larsen, Levine, & Emmons, 1985; Larsen, McGraw, & Cacioppo, 2001). To avoid overestimating the association between chronic illness and subjective well-being, we opted to exclude those cases who indicated they felt all or most of the time downhearted and depressed the last two weeks prior to the survey from the analyses. This reduced the sample size with cases to 964.

Table 1: Description of the items of the World Health Organization Five Well-Being scale.

Please indicate for each of the five statements, which is closest to how you have been feeling over the last two weeks.

Over the past two weeks…

Answer categories range are:
5 (all of the time) , 4 (most of the time), 3 (more than half of the time), 2 (less than half of the time), 1(some of the time) and 0 (at no time)

… I have felt cheerful and in good spirits

… I have felt calm and relaxed

… I have felt active and vigorous

… I woke up feeling fresh and rested

… My daily life has been filled with things that interest me

Methods

To test the measurement invariance of the WHO-5 scale across people with and without a chronic illness or impairment in the general Belgian population, we perform a multiple group confirmatory factor analyses (MCFA). For this purpose we use the lavaan.survey package (Oberski, 2014), a package from the lavaan ecosystem in R. Lavaan is an open source R package to perform structural equation modeling (SEM) analyses (Rosseel, 2012). As lavaan.survey allows us to perform SEM analyses of weighted data, it is a good way to perform our MCFA. To account for possible non-normality of the observations we use a robust sort of maximum likelihood estimation (estimator= MLR) in our analyses.

Several model fit indicators are used to assess the goodness of fit our models. First, we use Chi-square test that tests the magnitude of the discrepancy between the sample and estimated covariance matrices. In our MLR-estimation this Chi-square test statistics as an equivalent of the Yuan-Bentler test statistic. When this test is significant, the model is usually rejected. However, as the outcome of this test is sensitive for the sample size, some additional model fit indices are used: the Tucker-Lewis Index (TLI) (Tucker & Lewis, 1973), the Comparative Fit Index (CFI) (Bentler, 1990) and the Root Mean Squared Error of Approximation (RMSEA) (Steiger, 1990). The fit can be perceived as reasonable when the TLI and CFI are higher than 0.9 and the RMSEA is less than 0.08 (Browne & Cudeck, 1992). A good fit is found when the TLI and CFI have a value of 0.95 or above and the RMSEA is smaller than 0.05. The absence of large modification indices (MI) and expected parameter changes (EPC) further informed us about the model fit.

Results

Table 2 shows an overview of the goodness of fit measures of all the estimated models. We start the analysis with a CFA with a determination of the best fitting model in the pooled data (thus without a distinction between people with and without an impairment or chronic illness). As described in the literature, a one-dimensional model we also find in the general Belgian population. Although the model has a significant chi-square, the other goodness of fit indices show a reasonable or good fit (TLI=0.931; CFI=0.965; RMSEA=0.076). Therefore this one-dimensional model will be the baseline model for the factorial invariance analysis.

Table 2: Overview of the goodness of fit indices of the estimated models

	Robust χ^2	Df	TLI	CFI	RMSEA
Pooled data	33.152***	5	0.931	0.965	0.076
Configural	42.600***	10	0.920	0.960	0.082
Weak	51.579***	14	0.934	0.954	0.075
Strong	71.491***	18	0.927	0.935	0.079
Partial strong	55.904***	17	0.944	0.952	0.069

Although the chi-square test statistics of the models in table 2 are corrected for non-normality, we observe that all of them have significant p-values, which would lead to a rejection of the models. However, the other goodness of fit measures report acceptable values. For example, for the model in which configural invariance is assumed, the TLI and CFI are both above 0.090 and the RMSEA measure is around 0.08. This allows us to conclude that the baseline model fits well both in the sample with and without a chronic illness. However, to assess the level of measurement invariance of the WHO-5 across people with and without a chronic illness or impairment it is necessary to compare the goodness of fit measures of the models. The results of these analyses are reported in table 3.

Table 3: Results of the Chi-square tests among the estimated models to test for the level of factorial invariance

Compared models	Difference in χ^2	Df	p-value
Configural – Weak	6.802	4	0.147
Weak – Strong	22.364	4	0.000
Weak – Partial strong	1.503	3	0.682
Configural – Partial strong	8.654	7	0.279

In a first step we compared the goodness of fit of the model assuming configural invariance with the model assuming weak invariance. In this last model the factor loadings are constrained to be equal in all groups. Although the model fit of the model assuming weak invariance is worse (higher chi-square), the chi-square test for the difference does not gives a significant p-value (^{2}= 6.802, df=4, p>0.05), indicating that the model assuming weak invariance is not significantly worse. Therefore we can report a weak measurement invariance of the WHO-5 across the two groups. In the following step we test for a strong or scalar invariance. This assumes that both the factor loadings and the intercepts are the same across the groups. As shown in table 3, the chi-square of this last model is significantly worse than the chi-square of the model assuming only weak measurement invariance (^{2}=22.364, df=4, p<0.001). Therefore, we cannot report strong measurement invariance. For this reason we opted to test for partial strong invariance. On the basis of an inspection of the values of the previous models and the modification indices, we decided to relax the intercept of the item ‘active and vigorous’. Table 4 reports the factor loadings and intercepts of the estimated model. The intercept of the group without a chronic illness or impairment on this item was significantly higher than the intercept for the group with a chronic illness (3.004 compared to 2.617). A comparison of the model fits of the model assuming weak invariance and partial strong invariance showed that the model fit of the model assuming strong invariance while relaxing the intercept constrained for one item is not significantly worse than the weak invariance model. Therefore we can assume partial strong invariance, an indication that comparisons of the observed means of the WHO-5 scale across the two groups are defensible.

Table 4: Overview of factor loadings and intercepts of the model assuming partial scalar variance

	Factor loading	Intercept
Cheerful and in good spirits	1.000***	3.349***
Calm and relaxed	1.079***	2.983***
Active and vigorous	1.114***	Group 1 (ill): 2.617*** Group 2 (not ill): 3.004***
Fresh and rested	1.251***	2.690***
Interested things	1.085***	3.109***
WHO-5	-	Group 1 (ill): 0.000 Group 2 (not ill): 0.421***

In a last step, we estimate a model in which the means on the latent construct are constrained to be equal as well. The summary gives the following goodness of fit statistics: Robust chi-square= 116.930 (df=18, p<0.001), TLI=0.866, CFI=0.879 and RMSEA=0.107. These indicate that a model that assumes that the means on the WHO-5 are equal across people with and without an illness or impairment in the general Belgian population has a bad fit to the data. Therefore, we reject this model. Additionally, we also tried to compare the chi-square of this model with the model assuming partial strong invariance. However, we received the following warning message 'some scaling factors are negative: [-0.04]; rerun with SB.classic= FALSE' which might be an indication for the bad fit of the last model.

Conclusion

In this paper we assesses the measurement invariance of the WHO-5 scale among people with and without a chronic illness or impairment in the general Belgian population. Using multiple group confirmatory factor analysis, we established partial measurement invariance. This indicates that the WHO-5 has the same meaning across the groups in the general Belgian population and can be used to make comparisons of their psychological well-being. Taking account of these model specification we then assessed the true difference in well-being across people with and without a chronic illness or impairment. Future research may focus on explaining these differences by including socio-economic variables in the analysis.

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Appendix 2: Division of countries by welfare regime of study 1

Welfare state regimes					**Informal-Security Regimes**			**Insecurity Regimes**
Socio-Democratic	Bismarckian	Liberal	Southern European	Eastern European	Liberal-Informal	Productivist	South Asian	Sub-Saharan Africa
Denmark	Austria	Australia	Greece	Bosnia Herzegovina	Brazil	China	Bangladesh	Burkina Faso
Finland	Belgium	United Kingdom	Italy	Croatia	Dominican Republic	Laos	India	Congo
Norway	France		Portugal	Czech Republic	Ecuador	Malaysia	Myanmar	Côte d’Ivoire
Sweden	Germany		Spain	Estonia	Guatemala	Philippines	Nepal	Chad
	Luxembourg			Hungary	Mexico	Vietnam	Pakistan	Ethiopia
	The Netherlands			Latvia	Paraguay		Sri Lanka	Ghana
				Slovenia	Uruguay			Kenya
				Ukraine				Malawi
								Mali
								Mauretania
								Namibia
								Senegal
								South Africa
								Zambia Zimbabwe

Appendix 3: All logically possible ideal-types of country strategies towards the full and effective participation in society of PWD based on the dimensions of Active Citizenship of study 5

	Security	**Autonomy**		**Influence**
	Adequate income maintenance	*Enabling labor market participation*	*Services for independent living*	*Political participation*
Theoretical ideal-types				
Active citizenship	+	+	+	+
Passive security	+	-	-	-
Activation	-	+	-	-
Active security	+	+	-	-
Autonomy	-	+	+	-
Influence	-	-	-	+
No focus on AC	-	-	-	-
Other logically possible types				
Active citizenship -	+	+	+	-
	+	+	-	+
	+	-	+	+
	-	+	+	+
Influential security	+	-	-	+
Independent influence	-	-	+	+
Active influence	-	+	-	+
Secure independence	+	-	+	-

Appendix 4: Technical report: replacement rates invalidity benefits 2010 of study 5. General documentation

Abstract

The purpose of this technical report is to provide more information on the data sources and calculations of the replacement rates of disability benefits as used in Foubert, Halvorsen, and Van Rossem (2015).

Introduction

One of the main challenges of comparative research on disability policy concerns the collection of comparative data related to the countries' social protection systems. One option is the use of social expenditure data. In this approach, differences in welfare states are operationalized in terms of public spending on different programs and services (Ferrarini, Nelson, & Sjoberg, 2014). The main advantage of this approach is that these data are publicly available from international organizations (OECD, Eurostat) for a larger number of countries and years. Although a certain amount of economic resources is necessary to provide quality services and benefits, the poor validity of social expenditure data to account for welfare state structures is also well known (Esping-Andersen, 1990; Ferrarini, et al., 2014; Gilbert, 2009). Social expenditures are not only heavily influenced by welfare needs, but they are also sensitive to changes in the gross domestic product (GDP) which is the most widely used denominator to report the spending rates. Moreover, the same amount of economic resources can be spent in different ways: on benefits and services for a limited group in society or on broader populations groups with increased availability and coverage of services and income maintenance schemes (Ferrarini, et al. 2014).

As a response to these problems, comparative welfare state research has established a focus on the development of social rights via the welfare state and looks into the institutional organization of specific policies and programs (Ferrarini, Nelson, Korpi, & Palme, 2013; Korpi, 1989). With regard to income maintenance programs, these organizational features can be summarized in two main dimensions: coverage (or the proportion of the relevant population eligible for benefits) and the generosity of the benefits (the replacement rate) (Palme, 2006). In comparison with the social expenditure approach, an institutional focus is sensitive to the fact that programs are often organized along different principles and gives to a greater extent insight in what it means for an individual to live in a certain institutional and programmatic context.

Although there are datasets available that gather data on the institutional features of the main social insurance programs (unemployment, sickness and old age) of European and OECD countries (e.g. Social Citizenship Indicator Program, Welfare entitlements Dataset), disability benefits are not included therein by default. To the best of my knowledge, only one research report (Palme, Nelson, Sjöberg, & Minas, 2009), published replacement rates of disability benefits before. For that report, the focus was on the year 2005. In my paper on disability policy types across Europe (Foubert, et al., 2015), the focus lies on 2010. As an institutional approach gives a more detailed insight in the programmatic features of the income maintenance policy, I wanted to calculate the replacement rates of disability benefits. Fortunately, I could draw on the calculations made earlier for the report published in 2009. In the following paragraphs data sources and calculation methods are described more systematically.

Mainly, I drew on two information sources: the MISSOC and the SPIN databases. The MISSOC (Mutual Information System on Social Protection) was established by the European Commission and provides up to date information on social protection systems on 32 countries and 12 areas of social protection, including invalidity (European Commission, 2015). It provides information on the main outline of the benefit systems, the calculations of the height of the benefits, whether the benefits are taxed and social security contributions have to be paid. Every half year the data are updated, but the user can select the main themes, countries and periods of interest. The SPIN (Social Policy Indicators) database provides the foundation for longitudinal and comparative research on welfare states, based on T.H. Marshall's ideas of social citizenship (Swedish Institute for Social Research, 2015). The SPIN makes data on social rights and duties of citizen's available and is oriented towards analyses of institutions as manifested in the social policy legislation. Within the SPIN database, the SIED (Social Insurance Entitlements Dataset) stores data on three social insurance programs (sickness, unemployment and old age pensions) and information on wages and benefit recipients for all EU Member States for two data waves: 2005 and 2010. The SIED is a continuation of the SCIP (Social Citizenship Indicators Program) database, which covers the years 1930 till 2005.

Following the example of previous research making used of the SPIN databases (e.g. Ferrarini, et al., 2013; Palme, et al., 2009), I made use of a type-case approach to get insight in the generosity of the invalidity benefits. This means the calculation of the benefits is based on the social rights provided to model family constellations in each respective country. The benefits are thus calculated based on the rules governing the social insurance systems of the countries. In the case of the invalidity benefits, the calculation is based on the case of a 55-year old man who receives invalidity benefits due to a 100 percent incapacity to work. In countries were the benefits entitlement is related to the insurance record, 25 years of contributions are assumed. Calculations were made for both a single earner household and a single-earner with a non-working spouse. No other benefits (such as those related to rehabilitation or long-term care) were taken into account.

The replacement rates are calculated in two steps. In a first step, the gross replacement rates, without taking into account the fiscal system of a country are established. The gross replacement rates are calculated by relating the amount of the benefit to the wage level of an average production worker. An average production worker (APW) works in manufacturing or the metal industry and has received earnings equal to the Average Production Worker's Wage (APWW). When different protection systems cover different types of workers, the program with the largest coverage among workers in manufacturing has been coded. In countries where different occupational categories (such as salaried employees, self-employed and farmers), programs covering salaried employees are used to calculate the replacement rates. The sum of the invalidity benefits the type-case receives in one year is the numerator. For the denominator, the yearly earnings of an APW are used. In a second step, the fiscal system of a country is taken into account. Both the benefits and the wages are calculated net of taxes and social security contribution. Consequently, the net replacement rate is the ratio of the net yearly benefit amount to the net yearly wage of the average production worker. In the paper, we use the average of the replacement rates for the two model households described previously. By calculating both gross and net replacement rates, it is possible to see the effects of the tax system and transfers.

Formally, the rates are calculated as follows:

$$
\begin{aligned}
&{}^{nr}dis^{si} = disnet_{si}/netapw_{si}\\
&{}^{nr}dis_{fa} = disnet_{fa}/netapw_{fa}\\
&{}^{nr}dis = ({}^{nr}dis_{si} + {}^{nr}dis_{fa})/2
\end{aligned}
$$

Where

si = single person
fa = family with single-earner and non-working spouse
dis = disability benefit (52w)
nr = net replacement rate
apw= average production worker.

The data concerning the gross and net APWW's are gathered from the SIED-database. Information on the calculation of the benefits is predominantly taken from MISSOC (update of 01/07/2010). For more information on country-specific calculations that were made, I refer you to the document listing the decisions for each country.

Acknowledgments

The research leading to these results has received support under the European Commission's 7th Framework Programme (FP7/2013-2017) under grant agreement n°312691, InGRID – Inclusive Growth Research Infrastructure Diffusion. I am grateful to the SOFI institute for hosting me for two weeks in Stockholm and providing me access to the SPIN-database and previous calculations on disability benefits. I would like to thank Laure Doctrinal, Maria Forslund and Daniel Fredriksson for their enthusiasm while answering my many questions on the calculations and for digging in the past, Katharina Wesolowski and Ola Sjöberg for their previous work on replacement rates of disability benefits in 2009, and Kenneth Nelson for discussing my research approach in general.

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Appendix 5: Technical report: country-specific decisions during calculation replacement rates of study 5

Abstract

The purpose of this technical report is to provide more information on the country-specific decisions made during the calculation of the replacement rates of disability benefits as used in Foubert, Halvorsen, and Van Rossem (2015). When I refer to the calculations rules in MISSOC, the update of 01/07/2010 is used. When I refer to the old age pension in the calculations, this is usually the gross old age pension amount as found in the SIED database (Swedish Institute for Social Research Research, 2015). In the following, RR is the acronym for replacement rate.

1) Austria

Different rules depending on age. If not reached 50 in 2005: different system, general pension rules seem to apply. Pension amount is determined by the sum of insurance months and reckonable months. Amount is reduced by percentage dependent on the number of years the pension is claimed before the regular pension age. We work with person of 55 years old. For those over 50 in 2005: pension is paid 14 times a year. Calculations rules see MISSOC.

No supplement for partner, so single and household calculations are the same.

We take a fictive person with 25 years contribution and 2 years reckonable period, so person between 55 and 57 years old. Best 17 years are used, but APWW is recalculated by means of an ‘aufwertungsfaktor’, provided by the country.

60% of Bemessungsgrundlage is the height of the maximum benefit. The sum of the best 17 years is divided by 238 months (17 years, 14 benefits a year) to get the monthly Bemessungsgrundlage (tax base). 60% of this monthly amount for full contribution period. Our model has no full contribution period, multiply by 0,0192 to get benefit amount.

General tax rules, 10% social security contribution. Rules shifted a bit in comparison with 2005.

2) Belgium

Invalidity starts after one year of sickness insurance. Gross rr calculated on the basis of APWW 2009. Pension deduction of 3.55% for the Sickness and Invalidity Insurance on the condition that the pension is not reduced below € 1,517.60 or - without dependents - € 1,280.53 per month. Tax credit for pensions: 1861.42 euro for single and double for spouses.

3) Denmark

Benefits are not dependent on previous earnings. Law changed in 2003. If income does not exceed a certain level, than pension is granted. General tax system, no social security contributions. Some changes in comparison with 2005 calculations.

4) Finland

Flat rate and earnings related, pension is mixture of both. When earnings related pension exceeds a certain limit, than no flat rate pension. Earnings related part has two categories, we will go for disability pension of earnings related part (Työkyvyttömyyseläke) (no more than 2/5 of work capacity left).

The pension starts after 300 days of sickness benefits first. Until old age retirement (63 years for earnings related and 65 for national pension scheme). The disability pension seems to be calculated in the same way as the old age pension. Decision: old age pension * 25/35 + fictive earnings between 55-63 years.

5) France

Income related social insurance, dependent on average annual salary in the best 10 insurance years and category of incapacity. We will focus on group 2, they get 50% of the average annual earnings prior to interruption of work.

Previous calculations take into account adjustments of consumption price indexes, to really see what the best years are.

Taxes and social security contributions. Tax basis is income net of social security contributions, less a 10% reduction. Difference between social taxes and social security contributions. Deductible allowance for invalids.

6) Germany

Social insurance, from beginning of month in which condition is fulfilled, temporary incapacity paid from 7th calendar month, in principle they are max three years. Amount dependent on income throughout insured life. And periods of child raising.

Old and new lander of Germany, we will focus on the old lander, West Germany.

Pensions granted in 2010: For all single pension recipients, approx. € 16,236 per year is not subject to taxation if there is no other income. The amount is double for married couples.

The sickness insurance contribution for compulsorily insured pensioners amounts to standardized 7.0% of the pension since 1 July 2009 (half of the general contribution rate of the statutory sickness insurance), plus an additional contribution of 0.9%. The remaining contribution of 7.0% is paid by the pension insurer. The pensioner’s contribution to long-term care insurance is 1.95% of the pension and is to be paid by the pensioner. Childless pensioners born in 1940 or later and aged 23 or more years pay an additional contribution of 0.25%.

7) Ireland

Flat rate depending on age, under or over 65 years, independent or previous earnings, supplement for dependent spouse. Starts after sickness, mostly one year after.

Tax, no social security contributions.

8) Italy

Earnings related and number of insurance rates, different systems. Invalidity allowance and incapacity pension. We go for incapacity pension, 100%. Pension is calculated by multiplying contribution amounts by an actuarial coefficient that varies according to age. Same as old age pension. No supplements for dependents.

Reference earnings: For those who on 31/12/1992 had worked < 15 years: average earnings over a variable period of between the last 5 and 10 years, with ceiling.

General Tax and social contributions (social security contributions are skippable, 0.01 euro per month – 0.13euro per year).

In comparison with 2005, personal allowances are tax credits in 2010.

9) The Netherlands

New scheme since 2006. WIA (before it was WAO) and WaJong. The systems start after being on sickness benefit for two years. Different systems for those who are still able to work are not, we will focus on IVA-system, the system of people who are fully disabled.

Wage reference year is thus 2007, but for the calculation of the of the replacement rate 2010 apww has to be taken as base.

Dependent on degree of disability, the employee´s last wage and the wage earned when being partially disabled. IVA people get 75% of the last wage

No credits or supplements.

General Tax rules and WIA/WAO/Wajong: Social insurance contributions for the General Surviving Relatives Act (Algemene Nabestaandenwet, Anw), the General Exceptional Medical Expenses Act (Algemene wet bijzondere ziektekosten, AWBZ), the General Old-Age Pensions Act (Algemene Ouderdomswet, AOW) and the Health Insurance Act (Zorgverzekeringswet, Zvw) are deducted from the benefits. The contributions deducted for the Health Insurance Act have to be refunded by the body that administers the payment of the pension. Furthermore from the WAO-benefit contributions for the Unemployment Benefit Act (Werkloosheidswet, WW) are deducted and from the Wajong-benefit a contribution is deducted that equals the WW-contribution.

Old age: Social insurance contributions for the General Surviving Relatives Act (Algemene nabestaandenwet, Anw), the General Exceptional Medical Expenses Act (Algemene wet bijzondere ziektekosten, AWBZ) and the Health Insurance Act (Zorgverzekeringswet, Zvw) are deducted from the pension. The contributions deducted for the Health Insurance Act have to be refunded by the body that administers the payment of the pension.

Old age pension tax calculations of 2010 are followed, without work credit.

10) Sweden

Earnings related benefits, sickness and invalidity systems. Two parts: income related compensation financed by contributions: And tax financed compensation for all residents with low income or no income. Sickness compensation: 30-64 years, our focus. Benefit amount is independent from insurance length, dependent on average of three highest gross annual incomes during framework period, depending on degree of incapacity. Full incapacity: 64% of assumed future earnings. For person 55 years old, the framework period is 5 yearsmpreceding the year disability occurred. No supplements. Use consumption price index to control for inflation over the five years.

General Tax, no social contributions.

11) UK

Compulsory social insurance, long-term incapacity benefit not available for claimants after 2008. ESA, employment and support allowance works from October 2008. ESA is based on the effects of a person’s condition. Test reflect capability and additional assessment for return to work. Flat rate benefit, 96,85 pounds per week. No supplements for dependents.

General Tax, no social contributions.

12) Bulgaria

Social insurance scheme. Earnings related. Different categories in reduced working capacity. Group 1: degree of disability over 90%. Benefit depending on years of insurance, difference age person and retirement age, degree of working incapacity, individual coefficient based on ratio between income of the person and the monthly net national average salary for the same period.

General sickness invalidity pension is determined by multiplying the income on the basis of which the pension is calculated by the total sum of 1,1% for each year of contributory service and the relevant proportionate part of the percentage for the months of contributory service.

The time counting as contributory service and the relevant proportionate part of the percentage for the months shall be multiplied by the following coefficient, depending on category, group 1 is 0,9. See for more information about the calculation basis on MISSOC.

No supplements.

National average wages, found in spin 2010.

Benefits are not taxed and no social security contributions.

13) Cyprus

Social insurance scheme, different categories, we focus on total invalidity. Benefit amount is dependent on amount of earnings, number of years insured and degree of invalidity.

Amount of total invalidity category is dependent on two systems:

- Basic pension: 60% of average lower part of the insurable earnings, increased by 1/3 for the first dependant.
- Supplementary pension: 1,5% of total amount of paid and credited insurable earnings in the upper part of insurable earnings over whole career plus credited insurable earnings.
- Credited insurable earnings: if incapacity before 63, the time between age and 63 is is seen as period of insurance, credited based on average insurable earnings in the upper band of the last five years preceding the incapacity.

Basic part of pension is increased to reflect the number of dependents, thus also the spouse.

Basic and supplementary system are the same as general pension system. Only credited is additional.

Old age calculations are the same and then multiplied by 33/35 as the years up to 63 are credited as well.

No social security contributions, general tax system.

No tax because amount is within first scheme.

14) Czech Republic

Social insurance, earnings related. Three categories of invalidity, third degree is 70% or more loss of working capacity. Benefit amount dependent on average earnings and insurance period. Two elements:

- Basis amount: flat rate 2170 CZK

- Percentage amount: third degree of invalidity: 1,5% of personal assessment base per year of insurance, no maximum.

Personal assessment base: average gross earnings since 1985. All earnings are indexed in relation to the average wage. But, not all earnings are incorporated: Up to 10500 CZK 100% incorporation, between 10500 CZK till 27000 CZK 30% incorporation and over 27000 CZK 10% incorporation.

No supplements. No other benefits.

The formula is the same for our category as for old age pensions. Also for invalidity take count up 30 years even though the person did not work 30 years, just as with old age pension. So we take the stw pension amount of 2010.

General tax, no social security contributions.

15) Estonia

State pension insurance act, social insurance system. Based on period of activity and contributions. Permanent work incapacity has two degrees, partial and total loss. Last category. Benefit is dependent on years of pensionable service before 31-12-1998, social tax payment after 1-1-1999 and percentage of loss of working capacity.

Calculation is the highest of two amounts:

- Old age pension, on the basis of years of pensionable service and pension insurance coefficient of applicant

- Old age pension for 30 years of pensionable service.

In our case: the latter because person is 55 years old with 25 years of work experience. So it would be the latter option, old age pension for 30 years of pensionable service. Pension is percentage of amount in relation with degree of loss.

No supplements.

So same formula as pension, adjusted for the number of years, 25 in our case.

Tax exemptions, no social contributions.

16) Greece

Social insurance scheme. Different categories, full incapacity. Benefit dependent on wage, number of insured years and degree of invalidity. Severe invalidity full pension. In total invalidity also a pension supplement is paid for third party care. Pension is calculated on the basis of the best five years during the last ten years before retirement. Supplement for partner every month 49,56 euro per month.

Percentage of the fictive wage taken as a reference (see below) varies between 70% and 30% in inverse relationship to earnings. No information on how this is further calculated.

So we follow general rule, to also take into account the number of years worked: old age pension *25/35.

General Tax rules, no social contributions.

17) Hungary

Social insurance, benefits dependent on age of onset insured period, degree of invalidity. If insured 25 years or more, than calculation is same as old age. Different classes get 5 or 10& more but not more than the average income of the individual. We focus on class two, thus 5% extra. But also period of higher education is taken into account. No supplements for dependents.

Tax is pension is accumulated with earnings, but that’s not the case, no social security contributions.

18) Latvia

Social insurance, benefit dependent on insurance record and the gross average earnings upon which insurance contributions have been calculated. Different categories again. Different calculations methods, see missoc. Mainly gross annual earnings of any consecutive period of 36 months during 5 years before pension. No supplements for dependents. Opted for category II.

No social security contributions, taxes apply but tax exemption:

Categories I & II: LVL 1,296 (€ 1,827),

19) Lithuania

Social insurance providing flat rate basic, with additional earnings related part. Benefit dependent on social insurance period, period of time between incidence of disability and retirement age, earnings on which contributions were based. Basic part: between 75-100% of work capacity loss: 150% of basic social insurance pension. Supplementary part: paid to those who have fulfilled the state social insurance period. This period is calculate until disability occurs and is added to the number of years remaining before the claimant reaches pensionable age. If this state social insurance period is not reached than the number of remaining years till pension is proportionately reduced.

No supplements for dependents.

No tax, no social contributions.

20) Luxemburg

Social insurance, benefit dependent on number of years insured, both flat rate pension part and earnings related. Flat rate is dependent on number of years insured, max 40 years, amount dependent on proportion of 1/40, so 25/40 in our situation. Flat rate is 405,35 for 40 years. Earnings related is 1,85% of total wage taken into account. No supplements for dependents. Based on pension calculations of 2010, disability pension was also calculated.

General tax rules, contributions for health care (2.7%) and long term care insurance (1.4%)

21) Malta

Social insurance, benefit dependent on contributions since 18, whether claimant is in receipt of service pension. Not in accordance with degree of invalidity, if receiving a service pension than amount of basic pension is reduced. A service pension is payable by or on behalf of persons employer in respect of past services in Malta or abroad.

Flat rate benefits not related to earnings, but dependent on receipt of the service pension. Pension rate dependent on spouse or not. Higher when married.

Not specified how the contributions are calculated, not related to old age pension. There is a difference between minimum and maximum but on the other hand it is also stated that benefits are flat rate. Based on the fact that the employee fulfilled the requirement of 250 paid weeks, I will go for maximum amount.

General Tax rules, no social contributions

22) Poland

Social insurance, benefit dependent on reference wage, number of insured years, degree of incapacity and basic amount. Full invalidity pension determined by formula see missoc.

Reference earning is equal to or the average wage over 10 years in the last 20 years or the best 20 years of insurance. No supplements for dependents.

Used old age pension calculations of 2010 as the same formula is employed, but multiplied by 25/35 factor.

General Tax rules and 9.0% health care contribution. Tax scheme of old age pensions is used.

23) Portugal

Social insurance, benefit dependent on the number of years covered, average monthly earnings, factor of financial sustainability. Different systems depending on date insured, our person before 2002 and pension before 2016: Monthly amount is set according to the proportional implementation of the calculations rules applying to the contribution period until 31-12-2006 and the rules in force since 2007. But no real calculation rules are then displayed. 14 benefits paid a year.

Supplement for spouse 36,80 euro per month, this is not the case in the old age pension system.

Tax, but different from earnings from work. no social security contributions.

24) Romania

Social insurance, benefit dependent on contribution period, level or earnings, invalidity category. Calculation method is comparable with old age pension. The difference is the contribution period taken into account, dependent on the invalidity category. No supplements for dependents.

Tax and social contributions, but pension under limit.

25) Slovakia

Social insurance, benefit dependent on incapacity level and amount of employee income. Different categories, we go for more than 70% incapacity, this leads to full pension. Formula is the same as the first pillar old age pension.

No supplements for dependents.

No tax, no social contributions

26) Slovenia

Social insurance, benefit dependent on cause of invalidity, previous earnings, gender of claimant, age at which invalidity occurred. Same manner as old age pension, but depending on when invalidity occurred and the gender (pension age is younger for women). Earnings are taken into account based on Pension rating basis (monthly average income of 18 consecutive years after 1970), then PRB is multiplied by percentage, depending on the gender and age invalidity occurred.

We take into account: actual period + fictive period – 2/3 of period between 55-58 and ½ of period between 58 and 63

No supplements for dependents.

Tax and social contributions

27) Spain

Social insurance, benefit dependent on degree of incapacity. Total incapacity for usual work, 55% as calculation basis, increased by 20% percent as over 55 years and out of work. Absolute permanent incapacity, 100% of calculation basis, our focus. 14 payments, no supplement.

Calculation basis is result of dividing the sum of the contribution basis of 96 month prior to the month preceding the one in which the event occurred by 112. The first 24 months are face value, the other 12 month adjusted to cpi. The old age percentage rate is applicable.

General tax rules, no social contributions.

Acknowledgments

The research leading to these results has received support under the European Commission's 7th Framework Programme (FP7/2013-2017) under grant agreement n°312691, InGRID – Inclusive Growth Research Infrastructure Diffusion. I am grateful to the SOFI institute for hosting me for two weeks in Stockholm and providing me access to the SPIN-database and previous calculations on disability benefits. I would like to thank Laure Doctrinal, Maria Forslund and Daniel Fredriksson for their enthusiasm while answering my many questions on the calculations and for digging in the past, Katharina Wesolowski and Ola Sjöberg for their previous work on replacement rates of disability benefits in 2009, and Kenneth Nelson for discussing my research approach in general.

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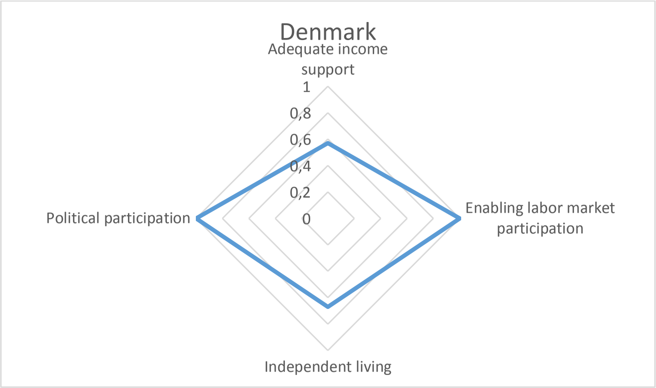
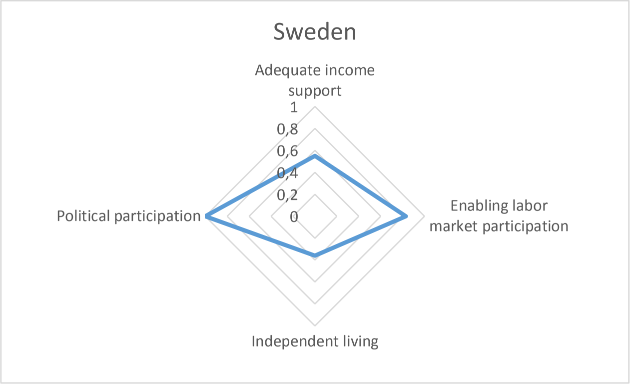
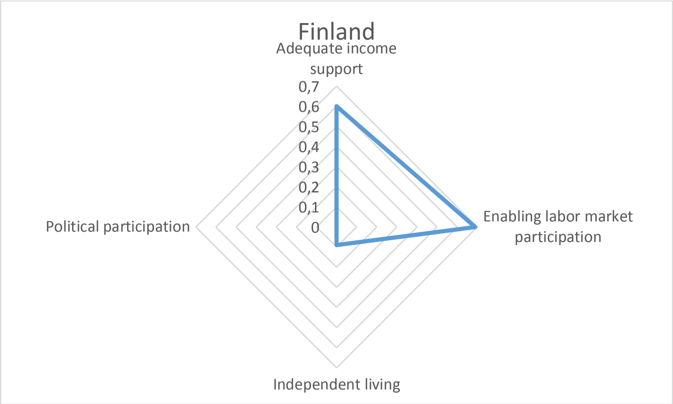
Appendix 6: Grouping countries based on FSITA of study 5

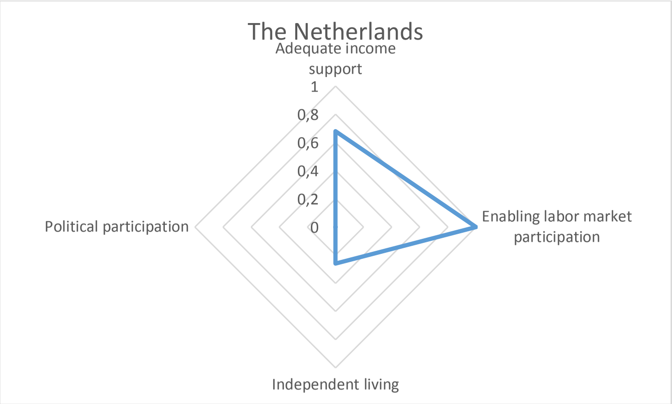
IDEAL TYPE/ ACTIVE CITIZENSHIP GROUP



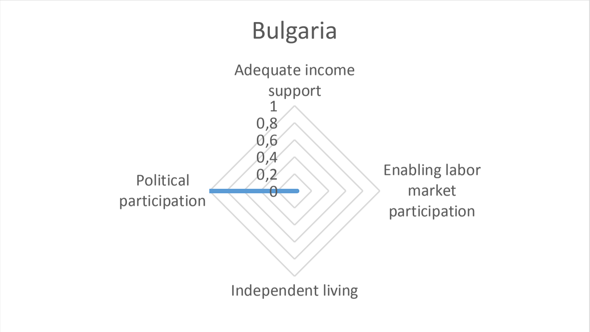


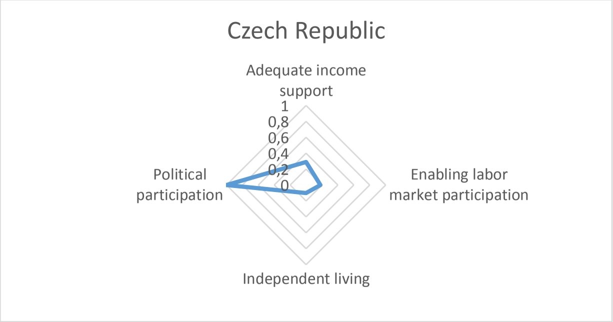
IDEAL TYPE/ ACTIVE SECURITY GROUP

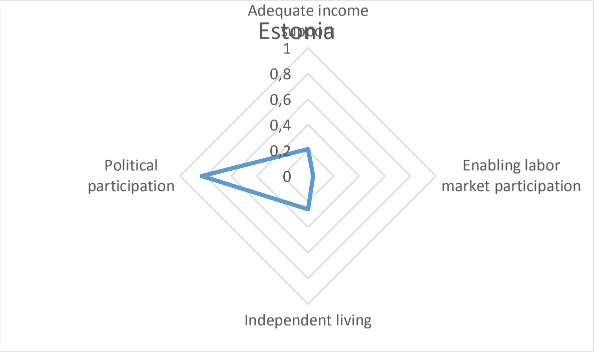


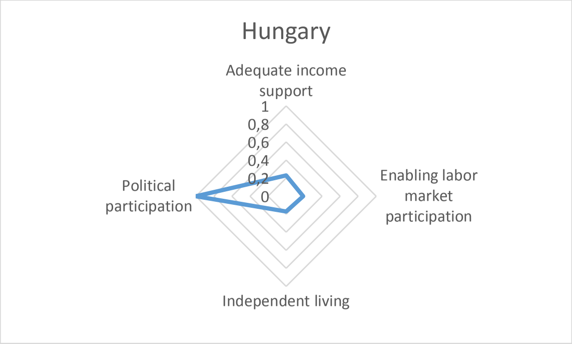


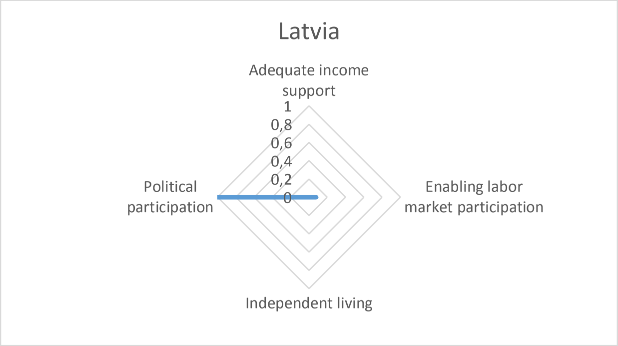
IDEAL TYPE/ INFLUENCE GROUP







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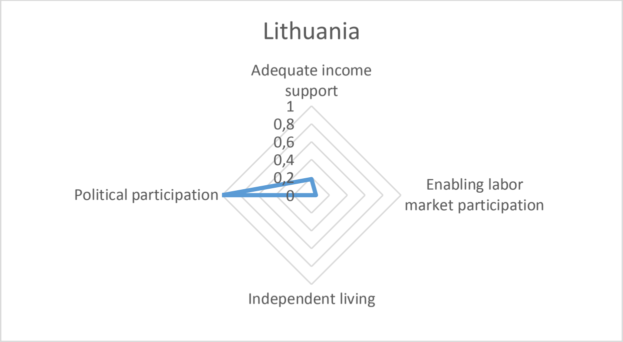
Adequate income support
1
0,8
0,6
0,4
0,2
0
Enabling labor market participation
Independent living
Political participation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Adequate income support
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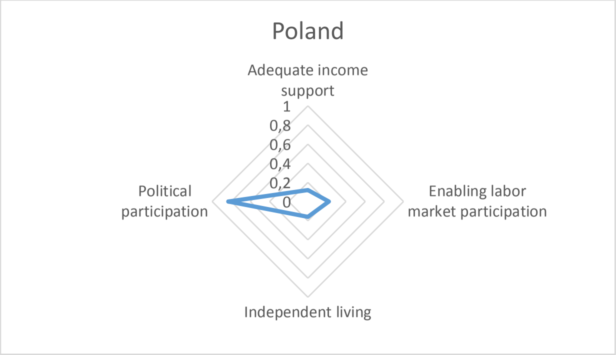
Enabling labor market participation
Independent living
Political participation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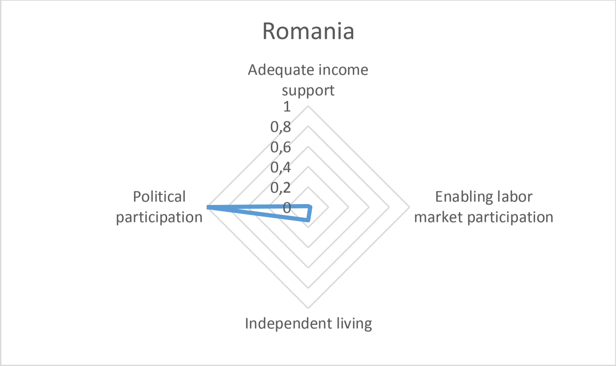
Enabling labor market participation
Independent living
Political participation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Adequate income support
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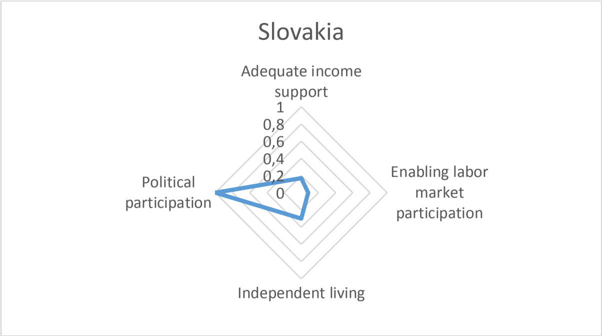
0
Enabling labor market participation
Independent living
Political participation


Slovakia
Adequate income support
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Enabling labor market participation
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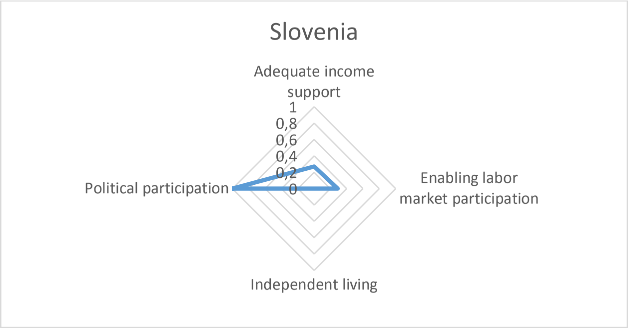
Political participation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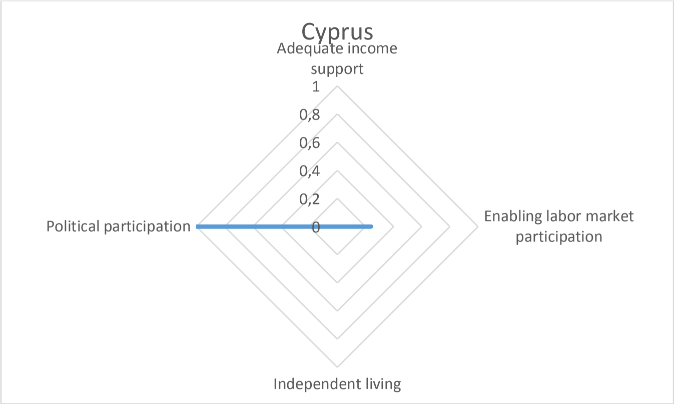
Enabling labor market participation
Independent living
Political participation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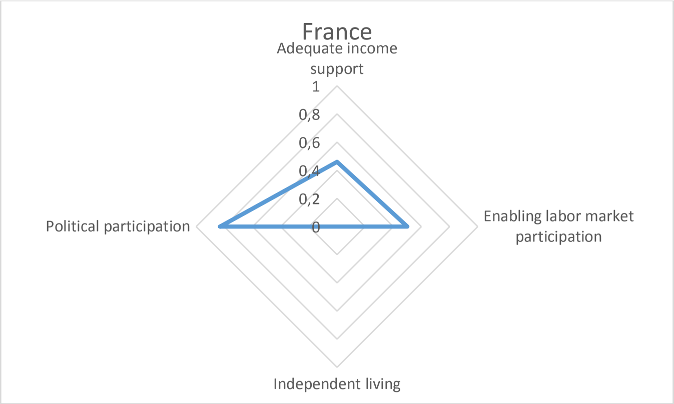
0
Enabling labor market participation
Independent living
Political participation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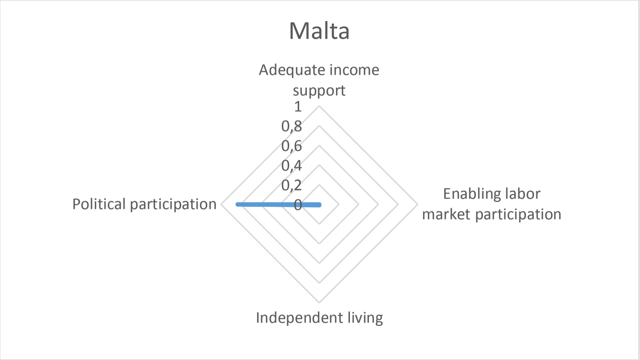
Independent living
Political participation


Malta
Adequate income support
1
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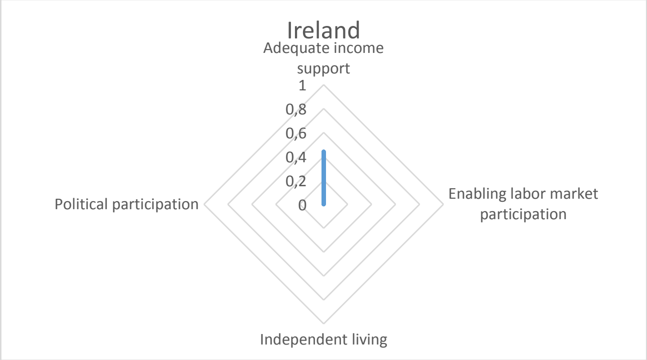
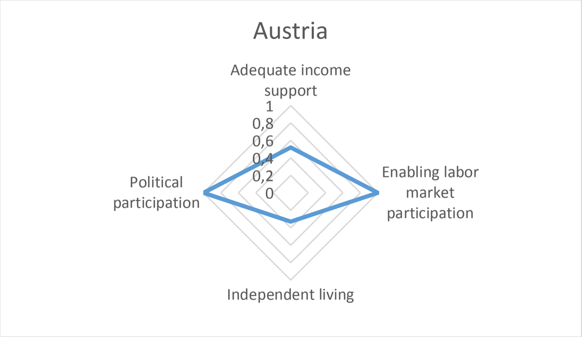
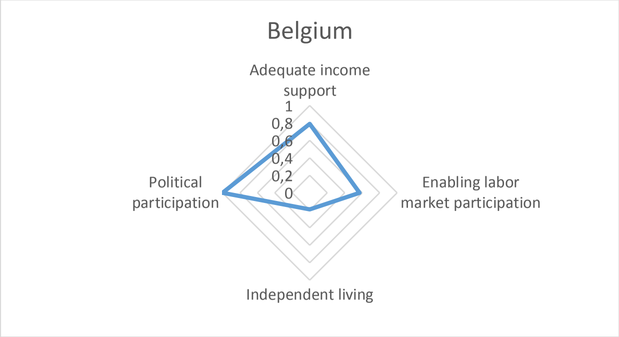
0,6
0,4
0,2
0
Enabling labor market participation
Independent living
Political participation

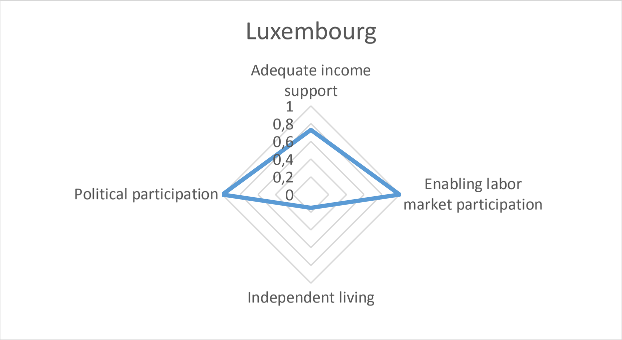
IDEAL TYPE/ NO ACTIVE CITIZENSHIP GROUP

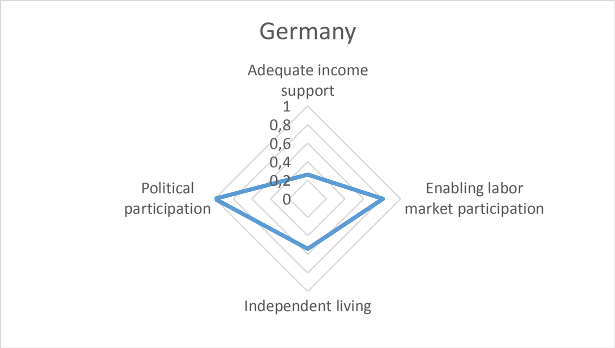


HYBRIDS/ ACTIVE CITIZENSHIP MINUS

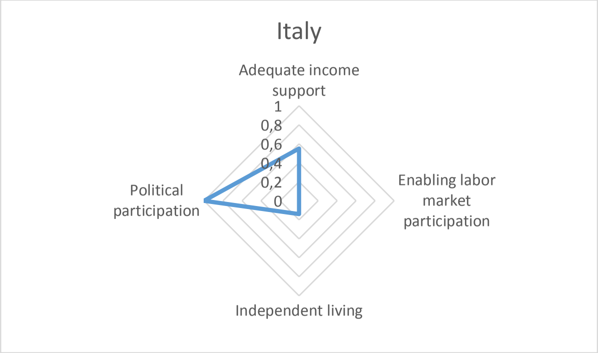


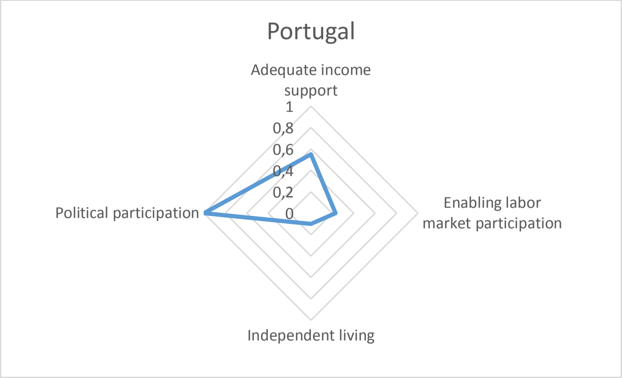


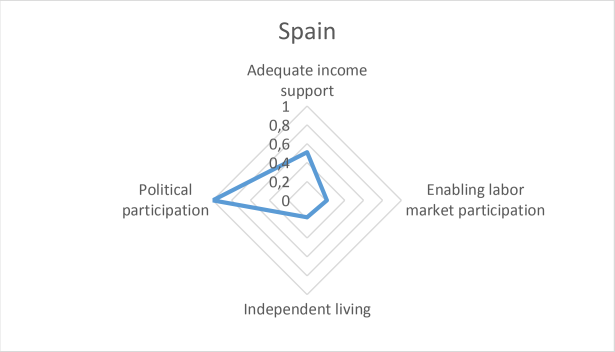




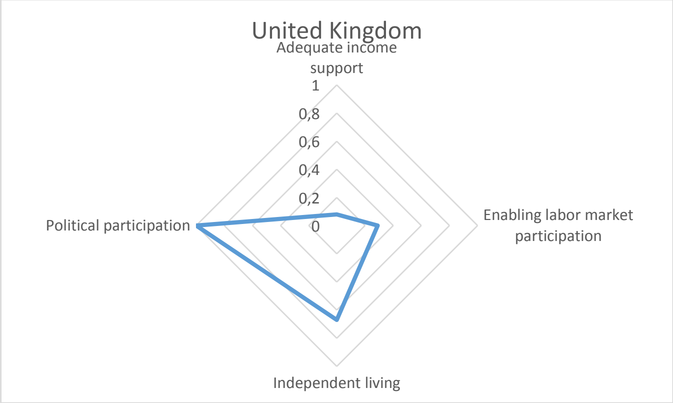
HYBRIDS/ INFLUENTIAL SECURITY







HYBRIDS/ INDEPENDENT INFLUENCE



Appendix 7: Alternative calibrations of study 5

AC Dimension	**Original calibration (in paper)**	**Variation on calibration**	**Countries that cross 0,5 threshold**	**New AC ideal-type membership**
1. Adequate income support	Spending on cash benefits Hudson & Kühner (2013) 1 sd	Hudson & Kühner (2013) 1,5 sd	None.	None.
2. Enabling labor market participation	Measuring investments in ALMPS in PPS – still linear transformations (1sd)	Investment in ALMPs calibrated as proposed by Vis(2007) (more information below table)	↓: Belgium, Finland, Germany, Luxemburg, Sweden	Belgium: AC- (IN LA il PO) → Influential security Finland: Active security → Passive security Germany: AC- (in LA IL PO) → Independent influence Luxemburg: AC- (IN LA il PO) → Influential security Sweden: AC- (IN LA il PO) → Influential security
3.		Using Hudson & Kühner (2013) calibration 1,5 sd, almp not expressed in pss	None.	None.
4.		Using Hudson & Kühner (2013) calibration 1 sd, almp not expressed in pss	None.	None.
5.	Accumulation benefit work	Using it as third value in the minimum rule (instead of a precondition for set membership)	None.	None.
6. Independent living	Ratio Institutional ltc/total ltc Hudson & Kuhner (1sd)	1,5sd	None.	None.
7.	Benefits in kind Hudson & Kuhner (1sd)	1,5sd	None.	None.
8.	Personal assistance	Two indicators, no use of personal assistance	↑: Austria	Austria: AC- (in LA IL I)

Related to alternative calibration 2: Vis (2007) determines that a spending rate lower or equal to 0,05% per 1% of standardized unemployment signifies a really low intention to activate and can be considered fully out of the set of activation. A spending rate of 0.25% per 1% of standardized unemployment, by contrast, would signify a high dedication to activate. However, it is not clear what she takes into account in her data (also spending on employment services?). Very conservative results. In general, the scores of the more hybrid countries seems to be affects: Belgium, Austria, Germany, Luxemburg. Finland and Sweden too.

Vis, B. (2007). States of welfare or states of workfare? Welfare state restructuring in 16 capitalist democracies, 1985-2002. Policy and Politics, 35(1), 105-122.

Disabled well-being
Research on impairments, social exclusion and well-being
across distinct socio-economic and institutional contexts

Josephine Foubert

Design
Afef Bouchrika

Ghent (2017)

Type
Times

UNIVERSITEIT
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