

**Discussion of “Disability Insurance and Health in Europe
and the US” (Croda and Skinner, 2009)**

Gerard J. van den Berg

(VU Univ Amsterdam, Netspar)

(Alexander von Humboldt Professor, Mannheim Univ)

A SUMMARY OF THE PAPER:

- Stylized fact: Across 12 countries: no association between % in DI and the average self-reported health status of those in DI.
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- Stylized fact: Across 12 countries: no association between % in DI and the average self-reported health status of those in DI.
- This can be explained if DI enrollment is (also) driven by the individual labor market prospects.
- Evidence from HRS and SHARE: by looking at associations between health, being in DI, level of education.
- Speculative alternative hypothesis: eligibility criteria focus more on health and less on labor market prospects \Rightarrow more illness among those who want to enter DI.

This paper explores some exciting lines of reasoning, about a *very* relevant topic!

In addition to the motivation given in the paper: notice that a large inflow into DI \Rightarrow

- Big increase in wedge between gross and net salary of working individuals. Reduces job-to-job transitions and upward mobility.
- If motivated by “individual labor market prospects”: increase in the unfairness of the social welfare system. Reduces solidarity in society.

About the empirical approach in the paper:

- Essentially cross-sectional, across countries with different institutions.
- However, institutional features do not directly enter the analyses.
- Instead: for each country separate micro analysis:
examine: explanatory power of health and labor market prospects for being in DI.
- “Health” = self-reported health,
“labor market prospects” = level of education.

Some obvious questions about this empirical approach:

- Does level of education capture “individual labor market prospects” within and across countries?
- Does self-reported health capture health within and across countries?
- Do we know enough about the institutional features of the DI systems in order to interpret the results?

Some deeper problems:

- Recently, Europe has been flooded by cross-sectional studies based on the 1st wave of the SHARE data....
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- May have different health outcomes than the inflow into DI.
- Those who were not ill may become ill (pain, depressed) while in DI.
- Age 50-65 in 2004 can be driven by cohort effects, e.g. Germany WW-2 cohort.
- Many health problems may start before age 50.

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 - Many health problems may start before age 50.
- Using the non-recipients as control? Problem:

$$E(x|x > a) - E(x|x < a)$$

is not necessarily monotone in a . Especially if x has long tails: it may increase in a (e.g. exponential, lognormal).

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- What is relevant is the health status just before entry into DI.
This is not the same as health while in DI.
- Follow individuals from before they enter DI and from before age 50:
health and job → entry into DI or not → health changes etc.
- Exploit time variation in institutions, like the minimum wage, which in downswings causes low-skilled ill individuals to be “unsuitable for any work”. (Also: early retirement.)
- Consider policy measures at the gate and shortly thereafter, to address adverse selection and moral hazard: monitoring (e.g. Lindeboom, Van der Klaauw et al. with Dutch register data).
- E.g. in NL: restrict inflow of back pain ⇒ increase inflow of mental illness.