THE EARLY RETIREMENT ON ILL HEALTH BASES: ACTUAL PROBLEMS IN E. U. MEMBER COUNTRIES

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Abstract: *Objectives: the aim of this study was to analyse the actual situation regarding the payed employment in the European Union, in connection with early retirement on ill health grounds. Methods: the studies of occupational health, sociology and psychology performed in most of the west- european countries and also within a transnational mega-study (SHARE), were used in order to create a general image regarding the labour force, mainly regarding the financially assisted population groups (unemployed, disable pension, early retired, challenged persons, age -based retired, pupils/students, etc), of the financial support problem of those groups from countries with different social policies, of the necessity of measures imposed by the maintaining/recuperating into payed employment of the disabled persons. Conclusions: despite social,medical and financial different policies in the EU- member countries, the proportion between the dependents and the employed is between 60-80 to 100 and can get to a 1 to 1 proportion by 2025: observations and suggestions are made in order to prolonge the duration of the labour period.*

Cuvinte cheie:
Medicina Muncii, retragere profesională prematură, pensionare de boală

Rezumat: *Obiective: scopul acestui studiu este de a analiza situaţia actuală privind activitatea profesională a salariaţilor din Uniunea Europeană, în legătură cu retragerea profesională prematură din cauze medicale. Metode: studiile de medicina muncii, sociologie şi psihologie ocupaţională efectuate în majoritatea ţărilor vest-europene, dar şi în cadrul unui mega-studiu (SHARE) transnaţional, au fost folosite pentru a creea o imagine de ansamblu a situaţiei forţei de muncă, mai ales din punctul de vedere al grupelor populaţionale nesalarizate (şomeri, pensionaţi din motive de boală, pensionaţi anticipat, persoane cu handicap, pensionaţi la limită de vârstă, copii/studenţi etc.), a problemelor legate de susţinerea lor financiară de către state cu diverse politici sociale, de necesitatea şi măsurile ce se impun pentru menţinerea/reintegrarea profesională a lucrătorilor cu capacitate de muncă limitată. Concluzii: în toate ţările membre EU, în pofida politicilor sociale, medicale şi financiare diferite, raportul susţinuţi/susţinători financiar, variază între 60/100 şi 80/100, cu perspectiva de a depăşi un raport unitar pînă în anul 2025; sunt prezentate observaţii şi sunt făcute sugestii pentru măsuri de prelungire a duratei de viaţa activă profesională.*

SCIENTIFICAL ARTICLE OF THEORETICAL PREDOMINANCE

Durring the last decade, all European countries face the problem of early retirement, an unexpected situation considering the modern medical care capabilities, the much better life conditions, the significantly better working facilities and a different approach on health and safety at work; all these factors would plead for the prolongeing of the professional life – instead it seems to be much shorter, the retirement age being much younger than the legal one (2-4).

The consequences on theEuropean national financies has two main downfalls: the deficit of the working force and the increased presure on the national finances. Regarding the deficit of the working force, yhe late entrance of the young in labour, second to the prolonging of the school/ learning time, has its toe. The impact of these factors on the cuantum of the working population emphasyses the fact that the early retirement is the cause of the high percentage of financialy susteined persons.

According to the financial ressources of every country, the attitude regarding the early retirement of the workers due to ill health, produces two main strategies of intervention (1):

- Reenternig work/ professional reconversion/ adjustement of the working environement to the dissabilities (phisical or mental) of the worker
- The externalization of the financing of the retired woker to the different social security sistems

The overwelming amount of the second cathegory, in all european countries, is more then obvious. In fact, it is statistically prouved that there is a much larger amount of early retired workers than of unemployed workers- a difference reflected in the state expences on these two cathegories of financially susteined people (1,6,7).

The dissability and the social assitence programes: Different countries have different terms for ill health retirement and for the financial benefits accorede on that base: ill health retirement pension, invalidity pension, dissability pension, etc, are terms used to deefine the situation in witch a person benefits of a form of social financial assistence, whose necesity is imposed by the innability of self - financeing by work (1,5-7). The general admited evolution is of staying in this supported situation until it is reached the age for normal retirement. We should not ignore the fact that the „generosity", and the lack of objectivity in the admission of a worker into the dissabled cathegory, this including the unimployement, as a reason for ill health retirement pension benefit, have lead to the large number of people profesionaly inactive.

The different social assistence programes cover, regularlly, three cathegories of income lose due to ill health (1):

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- Short-term medical leave
- Work related illnesses/accidents
- Ill health retirement pension, without professional –linked determination

The national differences reflect in:

- Presence/ absence of private health insurance
- Cathegories of beneficiaries: some countries include all national resident citizens, like Holland, while other include only those that are contribuitors to the national health sistem.

These extremes lead to either huge national financial efforts, or to the exclusion of the persons with congenital dissabilities, that have never been able to work and were never contributors to the health sistem (6-9).

The evolution into dissabilty pension is identical in all EU member countries (1):

- Paid ill health absence- usully prologed up to 52 weeks
- Ill health temporary retirement- periodicaly submissed to medical evaluation (every year in Romania, at 2-3 years in other EU member countries)

More or less, in all the europeean coutries, the second mentioned period is used for the application of the early intervention of occupational health, in order to obtain the professional rehablilitation by: professional qualification / reorientation / work environement accomodation according to the actual existeing dissabilities of the worker. The intensity and the consistence of the interventional measures aplication, is of different intensity, in different countries, from weak and occasional, to compulsory, especially regarding the professioanl up-gradeing (like in Germany and in Sweden). The inflow from the illhealth benefits back to workis, still, very low: an example is the highest inflow rate, belonging to UK and Holland (3-5%), while in the scandinavian countries, where the rehabilitation and trainig programes are very well studied, implemented and financed, the inflow rate is of only 1% of the temporarely ill health retired workers. It is more then obvious that occupational early intervention can't significantely compensatethe workers decision to retire from work, once this decision is taken (1,6-10).

The prevalence of ill health retirement in Europe

OECD apreciates that an average of 6% of the population of profesional active age, benefits of ill health retirement, in Europe. This situation is reflected, in %, as shown in the table:

Table no. 1. The representation of the population of active age in some european countries (%)

Country	Disability beneficiries	Women	Persons >45 years
Austria	4,6	24	92
Belgum	5.9	38	72
Denmark	7,7	57	87
Germany	4,2	39	89
Italy	5,5	40	97
Netherlands	9,0	40	75
Norway	9,2	58	78
France	4,7		
Poland	12,4	43	78
Portugal	6,5	55	92
Sweden	8,2	56	71
Spain	4,7	25	91
Switzerland	5,3	42	67
United Kingdom	6,6	33	75

It's obvious that Poland, followed by the Scandinavian countries, have the highest ill health retirement rate (12% and 8-9% of working population), compared to the rest of the countries, that have a percentage of 4-6%. The high proportion of women receiving ill health benefits in the North-European countries is due both to the national financial assistance programs and to the high amount of women employed. It is equally important to mention that 9 out of 10 retired workers on ill health causes (IHRW) are over 45 years old, the causes being:

- Higher incidence of pathology
- Better income, including retirement benefits, due to longer time in paid employment
- Lower requirements regarding professional relocation
- Low job offer for older workers, thus leading to their turning to the social assistance funds

Causes for disability benefit recipiency

At this moment, it is considered that, except the situations when the severity of the pathology reduces dramatically the worker's abilities/ and the self – care possibilities, the early retirement is more an personal option of the worker, with less connection with medical factors and more linked to social and personal factors. These last factors were divided in 2 categories (1,6-8,11,12,18):

1. "Pull factors"- at an individual level

- having tempting benefits from the social assistance, on salary discontent, the workers could appreciate IHR at least as satisfactory as an income as the salary (as o proof, the IHR rate in % is higher in the countries with better salaries)
- the option for low intensity work, more leisure time or the preference for hobby or volunteer activities are factors that don't motivate paid employment
- easy access, generous criteria of admission in IHR (like the admission of unemployment as reason for IHR in Sweden during the "80 , that lead to a 10% IHR workers out of all IHR workers).

2. "Push factors"- at the social and professional environment

- work environment: exposure to a poor psycho-social professional environment (negative/indifferent attitudes coming from the employers to the disabled employee, low educational and qualification level, restrains due to ethnic or religiouse belonging, low position inside the professional scale , frequent unemployment episodes)
- labor market situation: incompatibilities between the level of abilities, the learning and adapting of the elder / disabled worker and the needs of fullfilling the necessities of adaptation to the technological evolution, the increased level of professional competitivity and the organizational trends.

These "push factors" reflect mainly on the workers with a low qualification level: North-European statistics from 1998, regarding the proportion of IHR in the white-collars and of the blue-collars, shows that the employees from the second category retires early twice then the workers from the first category (1,3,12-16).

Although the 'push" and "pull" factors act simultaneously, the IHR workers blame the "push" factors as main reason for retirement from paid activity (8 out of 10 Danish IHR workers investigated within a study, have confirmed that they were forced to retire (1,5,15,17)).

In most European countries, the legislation regarding retirement has different versions and possible option for the workers, according to the time spent in paid activity, the salary level, the professional risk, the type of insurances and contributions to the state funds. After the age of the 50, regardless of the state funds level of contribution, workers reach a high enough level of pension that makes unappealing the idea of continuing the paid activity. The small difference between pension and salary, after 55-57 years of age, makes the extra

amount of money coming from salary a poor motivation for work.

This way, other factors, not the financial ones, are those that decide on the continuation of the professional activity: work related personal satisfaction, the investment in long years and complex studies that lead to a high qualification, an appealing cost/benefits balance, the awareness of the social importance of the work. On the other hand, there are those non-financial negative factors that determine the early retirement decision, even if it is obvious that the worker still has a certain ability to work, even if not in the same job/ place; often the worker accepts income loses and even unemployment. It is obvious that, in most of the early retirement cases it is all about a workers personal option, based on more or less objective criteria (19).

As shown by the SHARE study (Survey on Health and Ageing in Europe), the evaluation of the determining factors for early retirement, showed that 5 of them are dominant: low education, obesity, poor job control, unbalanced cost/benefit proportion and a self- perceived poor health. SHARE study was made between 2004-2006, in 11 European countries, on 12965 employees, aged between 50-63, over a 3 years long period, with an final evaluation at the end of this interval using the same methodology as at the beginning (only 8729 subjects from the initial lot responded to the final evaluation). The study was performed by a team of occupational health specialists from Rotterdam- Holland and Boston - Massachusetts, USA and the data acquired was related to: self-perceived health, chronic diseases, motor deficiency, obesity, smoking, alcohol abuse, physical training and work-related particularities.

At the end of the study a number of 175 employees have retired from paid work, most of them in ILR. If balancing the professional and personal factors for IHR, the self-estimated "less than good "or "poor" health factor being the most closely associated with IHR (Ors from 1,32 to 4,24). Later in the study, after adjusting with the work-environment conditions and with the life style, the association between self-perceived health and IHR significantly reduced. The proportion, expressed in %, of the medical determination for the IHR was 67% for those in disability pension, 27% for those in unemployment and 9% for the workers whose option was early retirement on incomplete payment (19).

The Occupational Health (OH) researches about the early intervention in the primary prevention have shown that: poor working conditions, lack of physical activity in the leasure time, smoking, alcohol abuse, and obesity are the confirmed negative factors and they represent the main targets for the OH intervention.

The health assessment in SHARE used the European version of Self-Perceived Health, where (20,21):

- Health is evaluated on a 5-point scale: very good, good, fair, bad, very bad
- There had to be at least one of the following chronic diseases, confirmed by a doctor: heart disease, stroke, diabetes, lung disease, arthritis / rheumatism, osteoporosis.
- Functional limitations, reflecting the ability of a person to normally perform in society:
  a) mobility problems- limitations of mobility, arm or fine motor functions
  b) instrumental limitations- one or more positive answers to 10 mobility problems, like the ability of walking 100m, reaching or extending arms above shoulder level
  c) limitations in one or more of 13 instrumental activities, such as preparing meals and making phone calls (22)

Out of all assessed workers, 17% reported "less than good health": 55% of them having chronic illneses, 57% mobility problems and 9% instrumental limitations.

The women represented 45% of the workers in the SHARE study: 88% were aged 50-59, 12% aged 60-63, education level (basic, high-school, university) being equally represented,27% smokers, 14% were having alcohol abuse problems, 56% were lacking physical activity, 25% with chronic pathologies, 28% had mobility problems, only 4% had instrumental limitations in every day activity, only 44% had a normal BMI, 15% 's BMI being over 30 kg/m2 (19).

Although working conditions, lifestyle and health issues have a cumulative effect, leading to retirement, it was proved that self-perceived poor health was most predictive for IHR: of the workers from the SHARE, 27%became unemployed, 9% retired early and 61% got IHR (23).

The stratified analyse on groups of European countries: Scandinavian (S weden, Denmark), Bismarckian (Austria, Belgium, France, Germany, the Netherlands, Switzerland0 and Southern European region (Greece, Italy, Spain), have confirmed a general validity of the results, despite the very different systems (medical, social, professional etc), that have a large range of variety. In all countries, the measure most predictive for exit from paid employment, was the self-perceived health and the employees option for IHR, as a solution for exiting the workforce, was equally, the main one.

This strong relation between self-perceived ill health and retirement can be explained by the existence of a discrepancy appeared between the workers abilities and the job demands: that explains why the number or nature of the chronic diseases have no real predictive value. The high incidence of the depressive neurosis, also the significant association between IHR and alcohol abuse (with a negative influence to the timetable, efficiency, concentration, personal relations at work and to the work-safety), also plead for the complex, yet very subjective nature of the self-perceived health as a measure of self-estimating status of the worker.

Early retirement of the elder worker is not the only way the pull-push factors influence in a negative manner the workforce stability: the young workers these factors have bad influence on the professional performance, and on the general well-being at work, leading to frequent changing of jobs, low performance and high level of absence from work (19).

CONCLUSIONS

Proving the fact that factors that determine early retirement, poor self-perceived health, poor job-control, physical and mental stress and effort-reward imbalance are generally available for all European countries, regardless of the profession, the education level and gender, allows us to reevaluate the targets for the OH intervention.

The emphasis on the medical issues: diagnosis and accordance of the chronic diseases to the working environment, that is almost overwhelming in our OH specialist activity, are not enough in order to insure the well-being of the workers. The actual trend, represented by retirement before the age of 57, in balance with the socio-economical need for a professional paid activity until, at least, 65, both in men and women, must change the OH intervention to another level:

- the cooperation of the OH specialist with the employer: leads to a better feed-back regarding the lack of satisfaction at work level of the employee, the poor quality of the relationship between the co-workers, the need for time-table changes if personal problems require it, the need to have facilities for health care to insure cheap-easy access to medical care (confirming to the employee that he is

protected and his health is important to the employer), the early evaluation of the medical problems that might have a dramatic impact in years (giving the employer the possibility of multiple qualification of the worker, in order to have options for the moment disabilities impair on the work performance).

- Cooperation with other occupational specialists, as:
  1. The ergonomy specialist- the expanding of his intervention on the work environment, to better and faster adjustments made to suit the work to the permanent/ temporary disabilities of the worker, estimated as necessary by the OH physician (that can appreciate the nature and intensity of the disabilities and to the remaining capabilities).
  2. The occupational psychology specialist- this cooperation would allow a complex and complete evaluation of the worker as a person, his personality, deffining his abilities, talents, areas of interest, the degree of implication in the job issues, the compatibility with the coworkers; a complexe objective evaluation of the work collectivity, with the purpose of decreasing the group incompatibilities at work, in order to reduce the stress at work.
- More involvement of the OH physician in finding solutions for maintaining and returning disabled or elder workers to paid employment, by allowing: part-time jobs, accessible schedule, limited activity according the remaining abilities of the workers.
- Intensifying the educational activity of the medical staff, in order to obtain a healthier life-style for the workers (the 57% of overweight workers and the 56% of workers with poor physical activity in leasure time), gives the OH physician targets within his competence.

Although, at this moment, the perspective of prolonging the retirement age over 65, on long time term, seems a faraway problem, the lack of a complex and coherent protocol, can put the OH specialist in front of the situation of being unable to efficiently professional assist the health and safety problems of the workers.

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