

Comparative systems of assessment of illness or
disability for the purposes of adult social welfare
payments

First Report (Final)
(Incapacity for Work)

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1. Introduction

Purpose of the report

This is the first report of the study of comparative systems of assessment of illness or disability for the purposes of adult 'incapacity' social welfare payments. The purpose of the research, as set out in the RFT is to examine systems for medical/disability assessment and review used in other comparable jurisdictions for assessing entitlement to social welfare illness and disability payments, and to draw key learning for the Irish system.

A second report will consider assessment systems for carer payments in relation to disability status of an adult cared-for person.

Context

The Irish Department of Social Protection (DSP) is currently looking at the structure of illness/disability support payments in the context of

- (a) Shifting the focus from 'incapacity' so that capacity, where it exists, is acknowledged and supported through closer engagement with people in receipt of such payments - the introduction in 2012 of partial capacity benefit is an example, and
- (b) Preventing a drift into long term welfare dependency.

To this end, the Department is already in the process of broadening the existing Intreo service so that people with disabilities can engage with the service on a 'walk in' basis across the country. Such an approach is also relevant in the context of the recently-launched Comprehensive Employment Strategy for people with disabilities.

Methodology

The research looks at assessment systems for adult illness and disability payments in a number of OECD countries, using

- a review of relevant literature (including review of various online academic databases)
- access to on-line information from social security authorities and others
- review of detailed evaluations of assessment systems (where these are available)
- contacts with key informants in the chosen countries.

The researchers first carried out a rapid review of assessment systems in a range of OECD countries (see Interim Review). On the basis of this study it was agreed to focus the research on Australia, Finland, France, Netherlands, Sweden and the United Kingdom (UK).²

Given the interest in ‘capacity’ and return to work (RTW), we have taken a broad interpretation of our remit and have examined the range of recent reforms of sickness and disability systems in the six countries insofar as they are relevant rather than focussing solely on their assessment systems. The NDA is currently carrying out a similar study of vocational rehabilitation and these issues are not addressed in this report.

Structure of the report

In chapter 2, we provide a short overview of issues concerning sickness absence and work-related disability including a look at the available data and a summary of the relevant literature. Chapter 3 provides an overview of the sickness and disability assessment systems in the six countries. Finally chapter 4 discusses the relevance of the findings to the Irish system. The detailed country reports are set out in the Annexes.

² Strictly speaking we focus here on the system in Great Britain as the Northern Irish system is legally separate and is not covered in most GB studies.

2. Sickness and disability absence – an overview.

Introduction

The importance of sickness and disability payments as policy issues has increasingly been recognised in recent decades (OECD, 2010). The OCED (2010) has emphasised the extent to which the barriers to people with health problems and/or disability participating fully in the labour market represents a ‘social and economic tragedy’. At the same time, the economic costs of such non-participation and the rising financial costs of sickness and disability benefits has led to an increasing focus on the role of such payments and on policies for improving work retention and return to work across a wide range of countries.

Data

Despite the recognition of the importance of the issues, the available data is surprisingly limited. Although there are a number of comparative studies of sickness absence in Europe (e.g. Gimeno et al., 2004; Chaupain-Guillot and Guillot, 2009; Niedhammer et al., 2012), these are generally based on the limited questions set out in Europe-wide employment studies such as the European Labour Force Survey and the European Working Conditions Survey. As set out in table 1.1, Chaupain-Guillot and Guillot, 2009 (on the basis of the then European Community Household Panel (ECHP)) found that, on average, one in 12 employees had taken at least one days absence during the last four weeks.³ Women were more likely to take leave than men and, of the countries considered in this study which we covered, absence was highest in Finland and the Netherlands and lowest in France. Ireland had average levels of absence.

Table 1.1: Employees having at least one day of absence during the last four weeks (%), 2001

| | Men | Women | Total |
|-------------|------|-------|-------|
| Finland | 19.2 | 24.3 | 21.3 |
| France | 8.6 | 11.3 | 9.7 |
| Ireland | 10.7 | 15.0 | 12.6 |
| Netherlands | 16.6 | 22.4 | 18.8 |
| Total | 10.4 | 13.7 | 11.7 |

Source: Chaupain-Guillot and Guillot, 2009.

³ Note that this was not confined to sick leave.

Using data from a different source (the European Working Conditions Survey) for 2000, Gimeno et al. (2004) found a somewhat higher rate of absence over a longer period but found that men were generally more likely to be sick absent (except in Nordic countries). This study again found the highest rates of sick absence in Finland and the Netherlands but France was at average levels and Ireland was the lowest.

Table 1.2: Age adjusted sickness absence (at least 1 day in the last 12 months) (%), 2000

| | Men | Women | Total |
|-------------|------|-------|-------|
| Finland | 24.0 | 22.0 | 25.7 |
| France | 14.3 | 15.4 | 12.9 |
| Ireland | 8.3 | 9.2 | 7.3 |
| Netherlands | 20.3 | 21.8 | 18.9 |
| Sweden | 17.0 | 14.9 | 18.8 |
| UK | 11.7 | 13.3 | 10.0 |
| EU | 14.5 | 15.5 | 13.3 |

Source: Gimeno et al. (2004)

The European Working Conditions Survey, 2010 asked a question about absence from work for health reasons for more than five days over the past year (thus excluding more short-term absence). The survey found that almost one-third of workers had been so absent. Absence was highest in the Finland and lowest in Ireland.

Table 1.3: Absence from work due to health reasons for more than five days over the past 12 months (%), 2010

| | Total |
|-------------|-------|
| Finland | 40.8 |
| France | 29.2 |
| Ireland | 17.1 |
| Netherlands | 25.2 |
| Sweden | 34.3 |
| UK | 24.2 |
| EU | 31.8 |

Source: European Working Conditions Survey, 2010

These surveys do not give a comprehensive picture of the level of sickness absence, e.g. the number of days of sickness absence in each country. Studies in the Nordic countries have found that these limited questions can be misleading and that

countries which score highest on one indicator may score lower on a different indicator (Thorsen et al., 2015).

The growing number of studies on the incidence of 'disability' are of limited use in the current context as disability in this context is usually meant in the sense of the Irish Disability Act, i.e. a substantial restriction in the capacity of the person to carry on a profession, business or occupation in the State or to participate in social or cultural life in by reason of an enduring physical, sensory, mental health or intellectual impairment. In this study, we focus on impairments which affect capacity to work only and again comparative data on the extent of disability in this sense is lacking.

There have been a number of studies which have attempted to use more detailed national administrative data for comparative purposes but there are significant differences between the coverage of national sources which again limit the extent to which valid comparisons can be made (e.g. OECD, 2010; Edwards and Greasley, 2010; Gimeno et al., 2014; Thorsen et al., 2015).

Literature review

As can be seen from this report (and the detailed bibliography) there is a vast literature on sickness and disability related issues. The more general literature emphasises the extent to which sickness and disability cannot be seen simply as a function of health-status and how it is affected by wider socio-economic factors. For example, studies generally find that sickness absence is higher for women and that not all of the difference can be explained by medical factors (e.g. Marbot and Pollak, 2014). There are also variations in sickness absence and disability by age, socio-economic status, work environment, type of employment, levels of human capital, firm size and in accordance with the business cycle (see, for example, Thorsen et al., 2015).⁴ Benitez-Silva et al. (2010) found that 'levels of claims for disability benefits are not simply related to changes in the incidence of health disability in the population and are strongly influenced by prevailing economic conditions'. These studies emphasise the extent to which sickness and disability is a social construct. For example, the evidence suggests that the incidence of disability is likely to be higher when the economy is booming and unemployment is lower.

Most of these studies do not look specifically at systems of assessment of illness or disability. Here the literature is much more limited. We have identified a number of different strands to this literature which are discussed in more detail in Chapters 3 and 4.

⁴ Detailed studies are set out in the Annexes.

Studies of sickness certification

There are many studies of sickness certification by doctors (e.g. Letrilliart and Barrau, 2012). These studies show that certification forms an important part of the work of doctors especially GPs but that, generally speaking, doctors often have limited knowledge or training in relation to the role and/or do not attach a high degree of importance to the task. The studies also look at the views of doctors in relation to certification and there are a number of common themes including a lack of clarity about certain aspects of the role, difficulties in certification in the absence of clear medical symptoms, difficulties in predicting the likely duration of absence, etc. It is clear that in all countries, there is a certain degree of 'negotiation' between the doctor and patient (Monneuse, 2015; Nilsen et al., 2015; Wainwright et al., 2015) and that certificates are sometimes given even though the doctor may have doubts about whether a person is incapable. In the countries considered here, these types of studies are most common in Sweden and the UK although they are also to be found in Australia, Finland and France. These studies are discussed in more detail in the Annexes. As discussed in Chapter 3, the Netherlands adopts a different approach to certification: separating treatment from control (i.e. certification).

Comparative studies of disability assessment

There are a number of, mainly descriptive, studies of disability assessment which focus mostly on European countries (Council of Europe, 2002; de Boer et al., 2004; ISF, 2013:7).⁵ De Boer et al. (2004, 2007) provided a comparison of the organisation of work disability evaluation in 15 countries (mainly European but also including the USA). These studies are now over a decade old and, although there is considerable continuity in assessment systems, they do not reflect the recent reforms in a number of countries such as the Netherlands. De Boer et al. (2007) identified a number of different approaches to disability assessment. The different approaches are explained as follows:

- **medical** is characterised by an emphasis on symptoms, diagnoses and impairments. These findings, in themselves, call for decisions regarding disability;
- **functional** is characterised by an emphasis on activity (or activity restrictions). These findings lead, either in themselves or through job matching, to decisions regarding disability;
- **rehabilitation** is characterised by an emphasis on the options for rehabilitation. These findings also lead to decisions on disability.

⁵ The de Boer study has appeared in a number of different guises: in most detail in de Boer et al. (2004), as a separate article (de Boer et al., 2007) and as part of his thesis (de Boer, 2010).

On the basis of this schema, de Boer et al. (2007) categorised assessment systems as

- purely medical (e.g. USA);
- medical combined with functional (IE, GB);
- medical combined with rehabilitation (FR);
- medical combined with functional and rehabilitation (NL).

Role and function of disability assessment

As Meershoek (2012) points out there is an ‘implicit assumption that illness certification is a process in which physicians objectively determine whether clients suffer from a certain (official) medical condition by diagnosing complaints and that functional limitations can be derived objectively from diagnoses’. However, this assumption has been criticised by many researchers who have argued that that a person’s incapacity to work cannot be deduced solely from that person’s *medical* condition. Instead ‘sickness, disability and incapacity are intricate and complex human experiences, rather than well-defined clinical conditions’ and incapacity for work ‘is the result of the complex mutual interaction between social, physical and psychological aspects and not a consequence of a medical condition only’ Meershoek (2012, 545). Studies indicate that doctors often find sickness certification to be problematic and find it difficult to assess ability to work for patients with symptoms that are difficult to diagnose.

Methods to improve assessment methodology

There are a number of studies, particularly in the Netherlands, of methods to improve the quality of disability assessment by, for example, the use of protocols for assessment, greater use of evidence based medicine (EBM) or improving the communications skills of doctors. These are discussed in more detail in the Annexes. However, considerable caution is required in considering these as they are often carried out under ‘experimental’ conditions (rather than in actual working conditions) and the assessment is based on the views of participants rather than on an actual assessment of the outcome on real-life decision-making.

Evaluations of assessment reforms

Finally, there are a number of Government-sponsored evaluations of assessments reforms (e.g. for UK Adams et al., 2012) or, in the French case, the need for reform (Roquel et al., 2012). Relevant findings are discussed in the individual country chapters.

3. Incapacity assessment in 6 countries.

This section addresses the key questions identified by NDA in the RFT (see Annex 1) in relation to the six countries, i.e. Australia, Finland, France, Netherlands, Sweden, and the UK. We focus on the main payments for incapacity for work (sickness and disability) in each of the countries. Where there are separate schemes for different groups (e.g. for the public sector) we have focused on the main scheme for private sector employees.⁶

Overview of supports during sickness absence/disability

There is a clear distinction between the four continental European countries and the two Anglophone countries.

In the case of the continental European countries, there is a much clearer link to employment. Persons who become incapable of work due to health issues qualify initially for sick pay or sickness benefits (often with supplementary employer payments). These are insurance-based (contributory) payments. In most cases, the employment relationship subsists for some or all of the sick leave. Only after the expiry of sick leave, in most cases, do people transition to a long-term disability payment. OECD (2010) data shows that in these countries between three-quarters (Finland and Sweden) and 100% of inflows to disability pensions come either from work (including sick pay) or from sickness benefits.⁷ These payments are generally income related with benefit levels (including employer top-ups) of up to 90% of previous earnings at least for an initial period.

Within this there is quite a range of approaches with Dutch employers now being responsible for sick pay for the first two years while in the other three countries sickness benefit is still payable from early on in the sickness absence period (although in many cases employers are required to provide supplementary payments).

In contrast, in Australia, a person is entitled to up to 10 days paid sick leave per year. After that s/he may be entitled to continued paid or unpaid sick leave and a small number of persons claim the restrictive sickness allowance which is means-tested.

⁶ Most of the countries have a separate scheme for occupational injuries but this is not included here. Again, some countries have specific schemes for persons who are disabled before adulthood (Borghouts-van de Pas and Pennings, 2008; Kaltenbrunner et al., 2013) while in several countries persons who do not qualify for the main insurance-based payments may qualify for a general social assistance payments. Again these are not included in this study.

⁷ France was not included in this study but French data indicates that the average persons coming onto invalidity pension has been on sick leave for about 2 years.

But less than half (45%) of inflows to the disability support pension are from employment (including sick pay) or sickness allowance. In the UK, in the past, the system was closer in structure to the European model with an initial period of short-term sickness benefit followed by a transition to a longer-term invalidity pension.⁸ There have been a range of reforms of the UK system beginning with the transfer of responsibility for the initial period to employers (statutory sick pay). In 2008, the existing incapacity benefit was replaced by an employment and support allowance (ESA). ESA has both a contributory and a non-contributory (income-based) element. The OECD study found that in 2002 only 57% of inflows to the longer-term payment came from employment or statutory sick pay. However, a more recent (post-ESA) study found that only half (51%) have been in paid employment before their claim (22% had been on paid or unpaid sick leave) while the other half (49%) were from a non-work background (Sissons et al., 2012).⁹ The Australian and UK schemes are flat-rate benefits with increases for specific purposes.

Thus the European schemes are much more closely related to employment and seek to provide a replacement income for those unable to work while the Anglophone schemes are more poverty-focussed with less close links to the labour market.

A summary of the main points of initial sickness absence is set out below and more detail is contained in the country reports.¹⁰ Long-term disability benefits are normally not limited in time (up to pension age).

| Country | Australia | Finland | France | Netherlands | Sweden | UK |
|------------------------------------|-----------------|----------|--------------------|-------------|---|----------|
| Duration of uncertified sick leave | - | 9 days | - | - | 7 days | 7 days |
| Waiting days | - | - | 3 days | - | 1 day | 3 days |
| Duration of sickness pay | 10 days minimum | 300 days | 360 days – 3 years | 2 years | - | 28 weeks |
| Duration of sickness benefit | No limit | - | - | | 28 days (normal) 550 days (extended) | |

⁸ In the UK this transition came very quickly at 28 weeks which is one of the reasons for the surge in the numbers on invalidity pension (Banks et al., 2015).

⁹ See also Adams et al., 2015. This study, which looked only at persons who had worked in the last 12 months before claiming ESA, found that 19% came straight from work, 45% had a period of sick leave and 36% were unemployed immediately before claiming ESA.

¹⁰ Note that in several countries, employers may pay additional benefits, for example, during waiting periods.

| Country | Australia | Finland | France | Netherlands | Sweden | UK |
|---------|---|---|---|---|--|--|
| Detail | All full-time employees are entitled to up to 10 days paid sick leave. After that, sick pay depends on employment contract. Means-tested sickness allowance may be payable. No limit to the length of time on Sickness Allowance but medical condition must be considered temporary (likely < 2 years). | Sickness benefit is payable for up to 300 days within a two year period | Sickness benefit is payable as a rule, for 12 months (360 days) per period of 3 consecutive years; up to 36 months in case of long-term sickness. | Employer is responsible for paying sick pay for up to 2 years | Sickness benefit may be paid for up to 364 days during a 450-day period. If the incapacity continues, the person can apply for extended sickness benefit which can be paid for up to 550 days. | Statutory sick pay is payable for up to 28 weeks |

Nature of incapacity criteria or fitness to work criteria

In the case of sick pay or short-term sickness benefit, the criterion is generally that the person is unable to work. In several countries, there is a period where this incapacity initially relates to the person’s own job but over time this is broadened. For example, in Sweden for the first 90 days, working capacity is assessed against the persons existing job, or other temporary suitable work provided by the employer. Up to 180 days, the worker is assessed against an alternative job with the same employer. Subsequently, working capacity is evaluated against all jobs on the regular labour market.

The Scandinavian countries generally have part-time capacity benefits whereby people who have a partial capacity to work can work part-time and receive a partial benefit. This is a long-standing system in Sweden and has recently been introduced in Finland. Studies indicate that these part-time benefits have some positive impact on return to work and reducing sickness absence at least for some claimants and in some periods (Andrén and Svensson 2012; Andrén, 2014; Kausto, 2013).

In the case of the disability pensions, there are a range of different approaches (see table). As can be seen, there is again a distinction between the Continental European models and the Anglophone approaches. In general, the European definitions require a long-term loss of labour capacity of a certain percentage while Australia and the UK use impairment tables (Australia) or Descriptors (UK) to assess incapacity for work. These are described in more detail below.

| Country | Australia | Finland | France | Netherlands | Sweden | UK |
|------------------------------------|---|---|--|--|--|---|
| Short-term support | Paid sick leave/sickness allowance | Sickness allowance | Sickness benefit | Paid sick leave | Sickness benefit | Statutory Sick Pay |
| Name of long-term payment | Disability Support Pension | Disability Pension | Invalidity pension | WIA benefit | Disability Pensions | Employment and Support Allowance |
| Definition of long-term incapacity | Recipients have to be: either permanently blind, or have been assessed as having a physical, intellectual or psychiatric impairment and unable to work for 15 hours or more per week within the next 2 years because of the impairment. | To receive a disability pension under the earnings-related system, a person must have lost at least three-fifths of their working capacity (which is lowered to two-fifths for eligibility for a partial disability pension). Under the residence based national Disability Pension scheme the eligibility criteria is loss of at least three-fifths of working capacity. | In order to qualify for IP, a person must have lost at least 66% of their work capacity due to a (non-occupational) accident or illness. This means that the person must only be able to earn less than one third of the normal wage of a person in the same work category and region. | A person must be more than 35 per cent work-disabled. If an employer can earn more than 65% of his/her former salary with generally accepted work (this includes work duties other than his/her former work duties), he/she is then considered to be less than 35% occupationally incapacitated and is not entitled to receive WIA benefits. | Sickness compensation (<i>sjukersättning</i>): Permanently full or partial incapacity for work (by at least 25%), on grounds of illness, or other impairments to the physical or mental capacity for work. Activity compensation (<i>aktivitetsersättning</i>): Long-term (at least one year) full or partial incapacity for work (by at least 25%), on grounds of illness, or other impairments to the physical or mental capacity for work. | Incapacity for work based on functional criteria known as Work Capability Assessment. |

| Country | Australia | Finland | France | Netherlands | Sweden | UK |
|---|--|---|--|--|---|--|
| Incapacity threshold as % of previous work capacity | - | To receive a disability pension under the earnings-related system, a person must have lost at least three-fifths of their working capacity (which is lowered to two-fifths for eligibility for a partial disability pension). Under the residence based national Disability Pension scheme the eligibility criteria is loss of at least three-fifths of working capacity. | 33% or less | 65% or less | 75% or less | - |
| How assessed | Impairment Tables are used to assess the functional impact of medical conditions on work capacity. | Assessment by social insurance officer of work capacity?? | Earning capacity as % of normal wage for same work category and region | Earning capacity as % of previous wage | Assessment by social insurance officer of work capacity | The WCA assessment is points-based and is based on 'descriptors' which describe a restriction in activity. |

| Country | Australia | Finland | France | Netherlands | Sweden | UK |
|-------------------------------------|---|--|---|--|--------------------|--|
| Who certifies – short term payments | Mainly own GP. Could be pharmacist, acupuncturist etc. | Mainly own GP but may also include dentists. Must be cert from occupational physician if over 90 days on short term payment | GP, other doctor, midwife. GPs give 75% of certs, specialists 25% | Doctors from Arbodienst (occupational health and safety organisations) | GP or other doctor | Own doctor, mainly GP (Statutory Sick Pay) |

| Country | Australia | Finland | France | Netherlands | Sweden | UK |
|-----------------------------------|-----------|---------|--------|--|--------|-----|
| Guidelines on duration of absence | No | No | Yes | No. However, after 6 weeks, Return to Work plan must be prepared | Yes | No. |

| Country | Australia | Finland | France | Netherlands | Sweden | UK |
|------------------------------------|--|--|--|------------------|---|---|
| Who certifies – long-term payments | <p>Disability medical Assessments – government-contracted doctor reviews supporting medical evidence</p> <p>Job Capacity Assessments Health/allied health professionals from agency of Dept of Human Services do desk or face to face assessment</p> | Typically own GP or treating doctor. Desk review of eligibility by social insurance doctor | Social insurance doctors employed in local medical service | Insurance doctor | Own doctor’s report reviewed by social insurance officer. May be referred to doctor of social insurance agency for a second opinion | Fit note – GP Work Capability Assessment – health care professional from contracted agency |

| Country | Australia | Finland | France | Netherlands | Sweden | UK |
|--|--|---|--|---|--|---|
| Summary of test of long-term disability | Physical, intellectual, mental health impairment scoring > 20 points and unable to work more than 15 hours a week in next 2 years at or above minimum wage | To receive a disability pension under the earnings-related system, a person must have lost at least three-fifths of their working capacity (which is lowered to two-fifths for eligibility for a partial disability pension). Under the residence based national Disability Pension scheme the eligibility criteria is loss of at least three-fifths of working capacity. | Lost 66% of work capacity, i.e. can earn under 1/3 of normal wage of equivalent worker | Lost over 35% of work capacity, as measured by earning capacity relative to former work | Full or partial (at least 25%) incapacity due to illness or impairment | Incapacity for work |
| Capacity to Work formula | Impairment Tables assess extent to which medical condition has functional impact on capacity to work. | No | No | Scores on Functional Ability List (70 items) matched against computerised list of requirements in 7,000 occupations | Activity Capacity Assessment model used after 6 months of absence | Points-based Work Capacity Assessment on restrictions in activity under various descriptors |
| Desk assessment by social security office? | Interview by Disability Support officers for Disability Support Pension | Yes | Yes | Desk assessment of medical and employer reports, plus face to face check | Yes | Yes. May be called for face-to-face assessment |

System of assessment of incapacity

Assessment of incapacity can be divided between short-term (sick pay and sickness benefit) and long-term (disability pension) systems.

In the case of short-term sickness absence, the key player in the original award of benefit is generally the certifying doctor (normally the claimant's GP) even if the actual decision is made by the social security authorities. In contrast, decision-makers employed by the social security authorities generally play a more active role in the award of long-term disability benefits.

Short-term assessment

In most OECD countries and all the countries here, except the Netherlands, short-term absence is assessed by the person's doctor (normally the GP). In some countries a wider range of persons are allowed to certify. For example, in Australia certificates can be issued by 10 types of 'registered health practitioner', including pharmacists, acupuncturists, chiropractors and traditional Chinese medicine practitioners.

As noted in chapter 2, there have been extensive studies of sickness certification, especially in Sweden and the UK (see, for example, Campbell and Ogden, 2006; Löfgren et al. 2007; Wynne-Jones et al., 2010; Letrilliart and Barrau 2012; Kiessling and Arrelöv 2012; Nilsing, 2013; Ljungquist, T. et al. 2015; Mazza et al., 2015). These are discussed in more detail in the country reports. Studies indicate the extent to which certification involves negotiations between the claimant and the certifier and the fact that doctors sometimes provide certificates even where they feel that this may not be warranted on medical grounds. Although there are, of course, differences between studies in different countries, there is a surprising level of common findings. Certifying doctors are often not trained on occupational capacity issues and, often, are not well-informed about detailed benefit rules. Certification makes up a considerable proportion of GPs' work but is often not seen as a high priority. Doctors in a number of countries highlight issues such as their lack of training on certification issues, the difficulties in dealing with requests for certification in the absence of clear symptoms, difficulty in predicting duration of illness and problems in communications with other stakeholders.

A number of reforms have been introduced in the sickness certification process in a number of countries. In particular, disease-specific guidelines have been introduced which advise doctors on whether certificates should be granted for common illnesses and as to the recommended duration (e.g. France and Sweden). Only limited evaluations of the impact of these guidelines have been carried out but the indications are that they have had an impact in limiting sickness absence.

In the UK, arising from the Review into the Health of Britain's Working Age Population in 2008, the sickness certificate was revised into a Statement

of Fitness for Work (or Fit Note). The purpose is to move the emphasis from certification of incapacity to a focus on capacity. Studies indicate that workers and doctors have a generally positive view of the reform although the impact on certification is less clear (Hann and Sibbald, 2012; DWP, 2013; Shiels et al., 2013; Coole et al., 2015; Gabbay et al, 2015). However, it is quite possible that such changes will take a number of years to have a full impact.

The Netherlands distinguishes between *treatment* and *control* and here assessment is by doctors that work for an *arbodienst* who are licensed to assess employees' sick leave claims. *Arbodiensten* are private organizations that are responsible for advising employers in matters relating to the health and safety of their employees. The main task of the doctors is to inform employers about the legitimacy of their employees' sick leave and to provide socio-medical coaching to employees who have reported ill. They are not involved in treating employees' health complaints. Depending on the agreements made between the employer and the *arbodienst*, doctors have an initial consultation with sick employees between two days and four weeks after they report ill. Subsequent visits are dependent on the specific nature of the complaints and, again, on the agreements made between the employer and the *arbodienst*. Most *arbodiensten* are specialized and work for certain sectors, such as industry, health care and transport.

Long-term assessments

In the continental European countries, decisions are made by social security officials following a process of information gathering by the social security authorities. This will not only start with the medical history of short-term certification¹¹ but may also include reports from specialists treating the claimant and other relevant evidence.

In some countries, e.g. France, the process appears to be quite unstructured without clear guidelines for the decision-makers. In contrast, in the Netherlands the first step in the process is an assessment of the claimant's work limitations by an insurance doctor. This is quite a structured process with a number of assessment protocols (see country report). These work limitations are recorded in a standardized list – the Functional Ability List (FAL). In this list the insurance doctor registers what work limitations the patient has and their extent. In the next step, a labour expert examines which jobs the employee is still able to perform despite the work limitations as assessed by the insurance doctor. The labour expert is supported by a computer which matches the work limitations as listed in the FAL with a database of 7,000 occupations that describes the job demands in detail. The occupations selected by the computer are assessed by the labour expert as to their suitability for

¹¹ As we have seen in these countries from c.75-100% of claimants of disability pension come from sick pay and/or sickness benefit.

the individual employee. Decision are then made on the basis of these reports by the social security authorities.

Australia and the UK have adopted quite a different approach with the establishment of a points-based system with specific indicators. For example, in Australia a person's eligibility for Disability Support Pension (DSP) requires a Job Capacity Assessment (JCA) to be conducted using Impairment Tables. In addition, claimants may have been required to undergo a Disability Medical Assessment (DMA). These assessments are conducted to review the medical evidence used to support a DSP claim. They are conducted by a government-contracted doctor, and cannot be carried out by the applicant's own doctor or specialist. The DMA does not involve any diagnosis of conditions, medical advice or treatment; rather it is a review of the supporting medical evidence for a claim for DSP. Eligibility for DSP is then determined by a social security decision-maker (or delegate) under the Social Security Act (SSA).

A broadly similar process – the Work Capacity Assessment (WCA) - has been established in the UK for the new Employment and Support Allowance (ESA).¹² The WCA is based on 'descriptors'. Descriptors are defined in the legislation and 'describe' a restriction in an activity – for example 'Cannot single-handedly use a suitable keyboard or mouse'. The descriptors attract various points. The descriptor representing the most severe level of disability will attract 15 points meaning the person will be considered as having limited capability for work. In many of the situations, this will also mean the restriction is so severe that the person would also be considered as having limited capability for work-related activity. Within the WCA, there are a number of assessments:

- Limited Capability for Work-Related Activity (LCWRA) Assessment – This aims to identify the most severely disabled where interaction with work-related activity is not required.
- Limited Capability for Work (LCW) Assessment - This aims to identify those people who currently have a limited capability for work but who would benefit from assistance and support with work and health related activity to maximise their full potential. (Department for Work and Pensions 2015: 21).

Certain well-defined groups are exempt from the test on the grounds that their level of functional impairment is such that they would clearly be found incapable of work. The exempt groups consist of those with specified severe and progressive conditions or severe disabilities. In addition, those who are terminally ill and claimants in receipt of the highest rate care component of Disability Living Allowance are exempt.

¹² New Zealand has also adopted a similar approach in recent years but there do not appear to be any evaluations as of yet.

The WCA has been rather controversial (see country report) and there have been a number of critical reports about the operation of this approach and a number of reforms as to how it operates in practice. However, the UK Government remains committed to this new approach.

It is difficult to compare the highly structured approach in the UK and Australia with the less-structured approach used in the other countries (and in Ireland). The new WCA criteria in the UK were intended to tighten up the criteria to qualify for a long-term sickness payment and a reassessment of claimants of the existing incapacity benefit was carried out. Data in 2012 indicated that about two-thirds of existing claimants (64%) were found to be entitled to ESA while over one-third (36%) were found fit for work and not entitled to ESA.¹³ There was a high rate of appeal from the decisions concerning ESA and a Parliamentary Committee found that 40% of appeals concerning 'fit-for work' decisions had been overturned in favour of the appellant (House of Commons, 2011, 45).

In terms of system to establish uniformity of decisions, de Boer (2004) did not find a strong emphasis on quality control systems and it is not clear that there has been a significant change in most countries since that study. The focus tends to be on the inputs to the process (e.g. qualifications of certifiers and decision-makers, training, guidelines, etc.) and on the systems of reviews discussed below rather than on specific mechanisms of quality control.

The UK appears to be one of the countries which puts more emphasis on quality control although it is not clear that this has assured good quality. For example, in the case of assessment reports for ESA (which are carried out by a contracted private-sector provider) the reports are audited by both the provider and DWP and there is a quality target of achieving a minimum of 95% of assessment of an acceptable standards.¹⁴ The DWP also introduced a Quality Assurance Framework in summer 2011 as a continuous improvement tool intended to act as a rigorous and robust measurement of decision making quality (Litchfield, 2013). The QAF requires that Decision Makers make justifiable decisions, but the Independent Reviewer found that there were limited incentives to make 'accurate' decisions. The Reviewer found that the Quality Assurance Framework focuses principally on whether processes have been followed correctly and there is less emphasis on outcomes than on the manner in which decisions have been reached so, for example, individual Decision Maker overturn rates are not monitored. The Reviewer noted examples of the Quality Assurance Framework being applied inconsistently between Benefit Centres.

¹³ These were not final figures as they did not take into account the outcome of appeals.

¹⁴ Although there were major issues about the quality of these reports in practice.

Life-long disabilities

Sweden is the only country which has a specific benefit for young adults which forms part of the overall disability pension. However, the system of assessment is generally the same as for older claimants. Issues in relation to (incapacity related) life-long disabilities are likely to arise in Australia and the UK where a significant number of claimants do not come from previous employment. In both countries, there are specific systems to avoid the need for claimants with certain specific disabilities (which might include some persons with life-long disabilities) to go through the full assessment process.¹⁵ In Australia, persons considered to be 'manifestly eligible' (e.g. terminal illness, permanent blindness) may be granted DSP without referral for an assessment although the categories which qualify would appear to be quite limited. In the UK, certain claimants are treated as having limited capacity to work and do not have to undergo an assessment. These include persons with terminal illness or undergoing cancer treatment. Again the categories covered are quite limited and there would appear to be many persons with like-long disabilities who would not be affected by these procedures and would, therefore, go through the normal assessment process. In the other countries studied, persons with lifelong disabilities are likely to qualify for other benefits (see Kaltenbrunner et al., 2013).

Desk review

In all countries desk reviews (i.e. review on papers only) form a part of the assessment system although this varies from country to country and depending on the assessment issue. Unfortunately detailed statistics are not available for many countries. In the case of claims for sickness benefit, the person will generally have met with a doctor (normally the person's GP). However, in the case of applications for disability pension, desk review is more common. It would appear that desk review (based on existing medical evidence) is the norm in Sweden and Finland although a medical assessment can be directed if this is left to be necessary (ISF, 2013:7). In contrast, personal interview is the norm in the Netherlands. In Australia, about 90% of claimants of disability support pension are seen face-to-face. In the UK, in the majority of cases (72% in 2013) the claim proceeds to a face-to-face assessment. (Litchfield, 2014, p. 9). In the case of reviews of existing payments, it would seem that desk review is common although again it is difficult to get detailed data.

We have not identified any legal challenges to desk review in itself although in some cases, courts and/or external assessors have expressed some concerns about the

¹⁵ Further details are set out in the country reports.

appropriateness of desk reviews in certain cases. In the Australian case of *Gilbert v Secretary, Department of Families, Housing, Community Services and Indigenous Affairs*¹⁶ (a case where a claim for DSP was rejected after a desk assessment), the Administrative Appeals Tribunal quashed the decision on the basis that the medical assessors did not have 'adequate medical information upon which to base their assessments'. The Tribunal recommended that a further medical examination be carried out. It expressed concerns about the practice of carrying out desk assessment where the available information was sparse and suggested that Centrelink should have in place written advice to guide job capacity assessors and decision makers in situations where doubts arise as to the adequacy of medical reports. In the UK, the Independent Reviewer recommended that where a person is found Fit for Work on paper without a face-to-face assessment and subsequently disagrees with the decision, a second Decision Maker should then reconsider the need for a face to face assessment as part of the new mandatory reconsideration process. This recommendation has been accepted in principle by DWP.

Reviews and return to work

Traditionally in all the systems examined there have been time-limited reviews. These were often carried out on a paper basis by the same people involved in the decision-making process. It appears from available studies that these often had a limited impact on entitlements (see the country reports for France and Sweden).

However, one clear trend in continental European countries has been to tighten up on controls of short-term sickness and, in some countries, to require that an assessment of capacity to return to work be carried out. The Netherlands (under the Gatekeeper protocol) sets out a guideline and time-table for employers in case of sickness. After a maximum of 6 weeks of sickness an occupational physician has to make a Problem Analysis, i.e. an assessment of medical cause, functional limitations and prognosis regarding work resumption. On the basis of this assessment the employer and sick employee together draft a return-to-work (RTW) plan in which they specify an aim (resumption of current/other job under current/accommodated conditions) and the steps needed to reach that aim. They appoint a case-manager, and fix dates at which the plan should be evaluated, and modified if necessary. The RTW plan should be ready in the eighth week of sickness. It is binding on both parties. Disability pension claims are only admissible if they are accompanied by a report containing an assessment as to why the plan has not resulted in work resumption.

Assessments of the return to work approach (the Gatekeeper Protocol) indicate that it has been successful in increasing return to work. At the introduction of the

¹⁶ [2012] AATA 198.

Gatekeeper approach, stricter screening was piloted in certain areas and evaluation showed that it reduced sickness benefit and disability applications (de Jong et al., 2006). One study found that the frequency of contact with the occupational doctor increased return to work (Dutch language studies quoted in van Sonsbeek and Gradus, 2013 and Everhardt et al., 2011). A second found that the full and timely implementation of the Protocol doubled the probability of having returned to work 9 months later. A third found that the Protocol had contributed to about half of the 43% reduction to inflows to disability pension between 2001-4. Everhardt et al., 2011 also found that employer-based vocational interventions (e.g. graduated work resumption) under the Gatekeeper Protocol had a strong impact on RTW.

Sweden introduced the Rehabilitation Chain in 2008 (although despite the name this has little to do with rehabilitation). For the first 90 days, working capacity is assessed against the person's existing job, or other temporary suitable work provided by the employer. From the 91st to the 180th days, the worker is assessed against an alternative job with the same employer. Alternatively the worker may be given leave of absence to try to find another job with an alternative employer. From the 181st day, working capacity is evaluated against all jobs on the regular labour market. An evaluation by the ISF of the 'rehabilitation chain' found that introducing time-restricted assessments had strengthened the downward trend in sickness absence (Hägglund, 2010). Large and positive effects on the exit rate from sickness benefit were found around the 181st day and smaller but positive impacts around the 91st day. The reform reduced the number of compensated days by 0.27 days.¹⁷ France and Finland have also introduced earlier reviews of sickness absence which appear have some positive impact on sickness impact.

The UK independent review of sickness absence (Black and Frost, 2011) recommended that the UK should establish a new Independent Assessment Service which would assess a person's capacity and provide advice on return to work. This would be accessed after about four weeks sick absence. The UK government accepted this recommendation (DWP, 2013) and this new service (Fit for Work) is now being rolled-out.¹⁸ However, the assessment, which will not be mandatory, has only just been put in place and it is not possible to assess its impact.

Role of medical assessors

As discussed in more detail in the country reports, medical assessors (i.e. medical personnel employed or contracted by the social security authorities) are involved in

¹⁷ While this may seem small, relatively few claimants reach either the 91st or 181st day.

¹⁸ <http://fitforwork.org/>

reviewing initial sickness claims and, in most countries, in assessing claims for long-term disability benefits. The role of the medical assessors is summarised below.

| Country | Australia | Finland | France | Netherlands | Sweden | UK |
|-----------------------------------|---|---|---|--|---|--|
| Assessment for sick/pay benefit | - | Involved in reviews of sickness benefit | - | Entitlement to sick pay is assessed by doctors employed by <i>arbodienst</i> | Involved in reviews of sickness benefit | - |
| Assessment for disability pension | Assessment carried out by doctor appointed by social security authorities | May be involved in assessment and/or review | Assessments are carried out by doctors employed by social security authorities who also make the decision | Assessments are carried out by doctors employed by social security authorities (and by labour experts) | May be involved in assessment and/or review | Assessment carried out by medical personnel appointed by social security authorities |

Appeals

In all the countries, there is a right of appeal to an independent court or tribunal following an internal review of the decision. In general, these courts and tribunals form part of the overall court system: for example, the First Tier Tribunal in the UK, the district court in the Netherlands and the Administrative Appeals Tribunal in Australia. Generally the judges are legally qualified persons (or persons with other relevant qualifications). In the UK, for appeals involving assessments for ability to work, such as in Employment and Support Allowance cases, the tribunal will comprise a Judge and a medical practitioner. In France, incapacity appeals are heard by a special Disability Appeals Tribunal (which includes medical members). In the Netherlands, a medical doctor can be appointed by the court to give an expert opinion on the case.

The impact of these courts and tribunals on assessment appears to vary from country to country. In the UK, decisions as to the interpretation of the law by the

specialist Upper Tribunal (formerly the Social Security Commissioners) are included in the DWP Guidelines for Decision Makers (DMGs).¹⁹ The DMGs are a detailed summary of the law in relation to specific benefits (legislation and case law) to assist in decision making. In contrast in France, a recent study (Roquel et al., 2012) found that the appeals system did not establish any general principles or guidance as to the interpretation of incapacity.

Overall assessment

It is very difficult to compare the different national systems in terms of outcomes. Even in terms of numbers on payments and the costs of payments, there are major issues in terms of comparable data. Some countries rely more heavily on private sector payments (sick pay) for which data is often lacking. Countries are also coming from different historical situations. For example, the Dutch system has to be seen in the context of very high reliance on the disability pension system in the past (Koning and Lindeboom, 2015)

There have been a range of reforms in all the countries studies including a reduction in the level of public benefits in many countries. The reforms have ranged from paradigmatic in the Netherlands to rather minor in Finland and France.

In terms of the structure of the current system and the rationale for reforms, the Netherlands system is clearly the most coherent. In a recent evaluation, Koning and Lindeboom (2015) identified the three main areas of reform in the Dutch system as (i) enhancing employer incentives to avoid sickness (e.g. experience rating), (ii) increased gatekeeping; and (iii) tightening eligibility criteria. They identified positive impacts in all three areas in reducing disability inflows with the introduction of the Gatekeeper Protocol consider to the most effective policy measure. The authors found that the tightening of eligibility criteria had led to a sharp increase in claims refused since 2006 (introduction of WIA). They concluded (2015, 164) that

The key to the success of disability insurance reform in the Netherlands has been the intensified role of employers in preventing long-term sickness, absence, and subsequent disability, with a strong emphasis on early interventions. The employer incentives increased the economic urgency among employers to exert sickness and accident prevention and workforce reintegration activities, while the Gatekeeper protocol has facilitated employer awareness and guided employers in their new role.

¹⁹ The DMGs are a detailed summary of the law in relation to specific benefits (both legislation and case law) to assist in decision making. They are publically available on the DWP website: <https://www.gov.uk/government/collections/decision-makers-guide-staff-guide>

Sweden has also introduced a number of successful reforms, including guidelines for GPs, strengthening reassessment of sickness claims (Rehabilitation Claim) and tightening conditions for access to benefits. In France and Finland, reforms have been more limited but have included strengthening reassessment of sickness claims, guidelines for certifiers (in France) and the introduction of part-time benefits (in Finland).

Australia and the UK have adopted quite a different approach. Reforms here have focused on making it more difficult to qualify for long-term benefits (DSP and ESA respectively) and encouraging claimants to 'return' to work. However, in both countries only about half of those going onto long-term benefits have come from employment and so they have limited links to work. Although the UK was an early reformer in terms of privatisation of sick pay, the focus on the role of the private sector appears to have stopped there and, until recently, there appears to have been little emphasis on the importance of keeping people in work and ensuring early return to work. This has begun to change with the introduction of the Fit Note and the reforms proposed by the Independent review of Sickness Absence (Black and Frost, 2011). However, this has as yet had a limited impact and it is difficult to predict whether it will have a long-term impact on sickness absence in the UK.

4. Relevance of the findings to Ireland

There is now widespread agreement on the need to promote employment for people with illness and disability issues. As the recent Department of Social Protection (2015) certification guidelines point out:

There is a wealth of evidence to show that employment is good for one's mental and physical health and wellbeing and conversely, that unemployment is damaging to one's mental and physical health and wellbeing.

There are two key lessons from this study for Ireland from a policy perspective. First, as highlighted by the OECD (2010) and as shown in the Dutch case, there is a need for cultural change supported by financial and other incentives for all actors (employers, individuals, medical professionals and social security authorities) to promote work-retention and return to work. As part of this reforms need to take into account the overall labour market and social welfare systems to ensure that particular approaches will have a positive impact and not simply lead to a transfer of costs from one sector to another or a transfer of claimants from one welfare scheme to another.

Second, early intervention to reduce sickness absence and promote return to work is most effective. The countries which have been most successful in achieving return to work (such as the Netherlands) have put the focus on assessing work capacity and developing return to work plans at an early stage. In contrast, by the time people are approaching long-term incapacity they have (almost by definition) reduced work capacity and they are further from the labour force. Rates of return to work from long-term disability are low in most countries.²⁰

Reducing sickness absence

The country studies show a number of measures which could be relevant to Ireland. These include:

Reforming the role of certifiers – The limited Irish studies indicate that the same issues identified in other studies of certification also apply in Ireland (Foley et al., 2012; 2013). This would indicate a need for improved training and information for certifiers so that they are clearer about their role and function. As we have seen a number of countries (including Ireland) have recently introduced guidelines on certification (e.g. where and for how long certificates should be issued). The implementation of these guidelines could draw on lessons from the implementation

²⁰ Some of the early reforms of the Dutch disability schemes led to significant levels of return to the workforce but this is probably more reflective of the level of capacity of those who had been allowed onto the Dutch rolls at the time.

in other countries. The reform of the sickness certificate in the UK to place an increased emphasis on return to work (Fit Note) could also be examined to see how far it could inform Irish practice.

Improved reassessment - As we have seen most countries have strengthened early reassessment and some have included mandatory development of return to work plans. DSP could usefully learn from this experience by looking at whether its current system of reviews could be better targeted both in terms of the timing and in focusing on illnesses likely to be of long duration. A number of studies have emphasised that it is possible to identify people at risk of long-term dependency on sickness and disability payments based on personal and medical characteristics (e.g. Flach et al., 2012 Lidwall, 2013). DSP have developed a system of profiling for unemployed claimants which aims to identify those at risk of long-term unemployment and, therefore, in need of intervention. Similarly, it should be possible to profile sickness claimants so as to identify those at risk of longer-term sickness and disability and, therefore, in need of intervention. Studies (e.g. Halonen et al., 2015) also suggest that the appropriate time for intervention may vary depending on the certified illness and again this could be built-in to the profiling system. Of course, this would require a significant improvement in the recording of the medical cause of certification.

Engaging employers – the Dutch experience shows the importance of involving employers centrally in the process. It might, perhaps, be unrealistic to expect that it will be possible to make Irish employers responsible for the costs of payments to the extent that this has happened in the Netherlands or even to impose a mandatory Gatekeeper Protocol. However, it would be possible to adapt this approach to an Irish context with, for example, a mandatory reassessment of persons at risk of long-term absence at an early stage followed by referral to assessment and occupational health services which support employers and employees in developing a return to work plan (as in the Fit for Work service in the UK).²¹

Part-time benefits

As noted above, the Scandinavian countries have part-time capacity benefits and studies seem to indicate at least some success in achieving earlier return to work and reducing sickness absence. However, these studies do not appear to have looked at the overall impact of part-time benefits, e.g. would claimants of such benefits have remained in work or claimed full-time benefits, and there is a lack of an overall cost-

²¹ See also the NDA and HSA guides which provide employers with information about how to help employees who have acquired a disability to stay in work or return to work after a period of recovery. See <http://nda.ie/Publications/Employment/Employment-Publications/Retaining-employees-who-acquire-a-disability-A-guide-for-employers1.html>

benefit analysis. In addition, the Scandinavian benefits are different to the Irish model and operate in a different labour market context so it is difficult to draw any conclusions for Ireland from these studies.

Incapacity assessment

In all the countries studied – as in Ireland – the focus is on capacity to work, i.e. the effect of an impairment on capacity to work. In the continental countries, it is noteworthy that although all have, to some extent, introduced reforms of their sickness and disability systems (major reforms in some cases) none have made major changes in the decision-making systems.

There would appear to be no major public dissatisfaction with the existing system of incapacity assessment in Ireland and recent trends in the numbers on illness benefit and invalidity pension are downwards (reflecting, in part, a number of recent policy changes re: eligibility). In that context, it is not obvious that there would be advantages in considering a major reform of the evaluation system along the lines adopted in Australia or the UK.

Disability allowance

Although it is not clear that there would be any advantage in moving to the Australian/UK approach to disability assessment, there are elements of their approach which might be relevant to DSP in relation to disability allowance (DA). There has been a dramatic growth in the numbers on DA over the last two decades from 37,000 in 1996 to 112,000 in 2014. In this context, there is a case for consideration of whether the approaches adopted in Australia (e.g. participation interviews and the program of support)²² and the UK (e.g. the Work Focussed Interviews and Work Programme)²³ could be relevant in an Irish context.

Legal robustness

Despite the varying systems adopted, there is nothing to suggest that the different systems which we have studied have faced any major legal issues. Obviously (except for Australia) the rules in relation to a fair hearing of appeals under the European Convention on Human Rights apply and this has led to a number of cases concerning access to medical reports and the right to a public hearing.

²² Although, as in Australia, one would expect that many claimants will have limited labour force capacity (see Brodway et al., 2014).

²³ Again the most recent UK statistics indicate a modest impact on employment: Department of Work and Pensions, Quarterly Work Programme national statistics to June 2015.

It might be suggested that the very high number of appeals concerning the UK ESA and the high rate of successful claimant appeals suggests that this system is not legally robust. However, it would probably be more accurate to see the high levels of appeal as the result of this major change in approach and also the practical difficulties experienced in its implementation.

As noted above, we have not found that the concept of desk reviews (as opposed to face-to-face assessments) has been subject to legal challenge although in particular cases there has been criticism of the appropriateness of desk reviews or the manner in which they have been carried out.

There is considerable UK case law on the role of the medical assessor (or equivalent) and how their findings should be taken into account. The UK courts²⁴ have accepted that the examining medical practitioner acting on behalf of the DWP is 'independent'.²⁵ However, the courts have also held that

there is no general rule that where there is a difference between the evidence of a medical professional producing reports for the use of the Department of Work and Pensions in making decisions as to social security benefits and the evidence of a claimant, the evidence of the medical professional should be preferred. It may be a legitimate conclusion in a particular case that a medical professional's view is to be preferred because it is more objective and independent, but that is a conclusion only to be reached after a consideration of the particular evidence ...²⁶

In terms of balancing the evidence of the person's doctor and an examining practitioner, the courts have stated that both the examining medical practitioner and the general practitioner should be assumed to be giving professional and independent evidence.²⁷ The medical evidence provided by both (and any other relevant evidence including the claimant's own evidence) should be evaluated and weighed on the issues in the case.

The courts have accepted that where the examining practitioner does not have medical expertise in relation to the person's disability (e.g. mental health) any medical opinion in relation to the disability is 'of little or no value'. However, the examining practitioner may still be able to prove relevant evidence as to the impact of the disability on capacity to work.²⁸ In the case of *PF v Secretary of State for Work*

²⁴ The specialist Upper Tribunal is equivalent to the High Court in its status in the judicial hierarchy.

²⁵ See, for example, CIB 2308 2001.

²⁶ *CW v Secretary of State for Work and Pensions* [2011] UKUT 386 at [24] citing CIB/16401/1996.

²⁷ CIB 2308 2001.

²⁸ See [2010] UKUT 340 and [2013] UKUT 469.

and Pensions,²⁹ the First Tier Tribunal had preferred the evidence of the medical assessor (who was a physiotherapist) to that of the claimant's psychiatrist without explanation. The Upper Tribunal held that 'Where evidence of opinion is put forward, key to the evidential value of that opinion is the source of it. The level and extent of the expertise must be of central relevance in relation to the evaluation of opinion evidence.'³⁰

In Ireland, an issue has been raised in relation to the role of the deciding officers who make decisions on entitlement to sickness and disability payments 'rubber-stamping' the opinion of a Departmental medical assessor.³¹ In *B. v Minister for Social Protection*,³² a case involving domiciliary care allowance (DCA), the deciding officer, in rejecting B's application, had relied on the negative opinion of the medical assessor. It emerged that in over 3,800 applications for DCA the same deciding officer had – in every case – relied on the medical assessor's decisions and the Department conceded that it would be 'highly unusual' for a deciding officer to decide against a medical assessor's opinion.

The High Court ruled that

The policy whereby deciding officers generally defer to the opinions of department medical assessors ... has yielded a situation in the instant case in which there has been an abdication of statutory duty by the deciding officer Indeed the manner of implementation of such policy ... is such that the court finds it has vitiated the decision-making process employed in relation to that application; this is because the deference manifested by this particular deciding officer to the opinion of medical assessors has been proven to be so great that the court concludes that the medical assessor's opinion ... was in fact determinative of that application, thus resulting in a contravention of s.300 of the Social Welfare Consolidation Act, 2005, thereby tainting the decision-making process.

This case involved DCA rather than an incapacity payment but it seems likely that similar issues could arise in relation to incapacity payments.³³ Without further amendment to the law, it is clear that deciding officers must make the decisions and

²⁹ [2013] UKUT 0634.

³⁰ At [13].

³¹ In *McLoughlin v. Minister for Social Welfare* [1958] IR 1 the Supreme Court ruled, at p.27, that 'deciding officers, are, and are required to be, free and unrestricted in discharging their functions under the Act.'

³² [2014] 2 ILRM 290.

³³ The Social Welfare (Miscellaneous Provisions) Act 2015 inserts a new section 300A re the opinion of the medical assessor which provides, inter alia, that 'a deciding officer shall have regard to [the medical assessor's] opinion in deciding the question in respect of which the opinion was sought.'

must have regard to all relevant evidence. This would still be likely to lead to decisions consistent with the medical assessor's opinion in most (but not all) cases. This is the approach which is taken, for example, in the UK where (in ESA cases) the decision maker (DM) has regard to the opinion of the medical assessor (then Atos) but does not in all cases follow that opinion (Adams et al., 2012). Research commissioned by the DWP found that in about one case in 40 the DM sought further guidance from the Atos or acted against its advice. These cases included those where there were difficulties in interpretation of the 'descriptors', where there were internal discrepancies in the assessment report or where the claimant had provided further medical evidence.

The alternative would be to change the law to make the medical assessor the deciding officer in 'disability' cases. Of course, if this was to be done, the medical assessor would have to have regard to all the evidence in coming to a decision and to comply with general rules of fair procedures which apply to decision-makers.

Annex 1: Research questions

- Who conducts capacity assessments for
 - Short-term illness
 - Longer term illness
 - Disability/invalidity
 - ‘fitness to work’ tests where these are in place

Detail where it is the person’s own doctor, one from the public health service or the social security body; if a generalist(GP) or specialist medical opinion is required; whether other health professionals are involved and which e.g. occupational therapists; whether non-health professionals are involved, and which e.g. vocational guidance specialists

- Is there desk review or actual medical examination at application stage
- Does the medical or other specialist assessor make a decision or give an opinion
- Is a medical etc opinion binding or is it advisory on the decision taker
- If the medical or other specialist assessor makes a decision what if any is the appeals process.
- What is the nature of the medical criteria or fitness to work criteria
- What system is in place for review of medical or fitness for work assessments
- What is the composition of the review panel (doctors, OTs etc)
- What system is in place to ensure uniformity of decisions
- Strengths or weaknesses of the systems
- Robustness of the systems from a legal perspective
- If possible, an assessment of the potential robustness of such systems in the Irish legal context.

Acronyms

AAT – Administrative Appeals Tribunal
AFU – Active Capacity Assessment
CBT – Cognitive Behaviour Therapy
CCG – Current Care Guidelines
CES – Commonwealth Employment Service
CITW – Continuing Inability to Work
CMO – Commonwealth Medical Officer
CNAM – Caisse Nationale de l'Assurance Maladie
CPAM – Caisse Primaire d'Assurance Maladie
CRS – Commonwealth Rehabilitation Service
DA – Disability Allowance
DASI - Disability Assessment Structured Interview
DCA – Domiciliary Care Allowance
DEEWR – Department of Education, Employment and Workplace Relations
DLA – Disability Living Allowance
DM – Decision Maker
DMA – Disability Medical Assessment
DMGs – Decision Maker Guidelines
DSO – Disability Support Officers
DSP – Department of Social Protection
DSP – Disability Support Pension
DSS – Department of Social Services
DWP – Department of Work and Pensions
EBM – Evidence Based Medicine
ECHP – European Community Household Panel
ECtHR – European Court of Human Rights
EEA – European Economic Area
ELSM - Employed in the Local Medical Service
ESA – Employment and Support Allowance
FAL – Functional Ability List
GP – General Practitioner
HCP – Health Care Professional
ICF - International Classification of Functioning Disability and Health
IGAS - Inspection general des affaires sociales
IMA – Interview of Methodical Assessment
ISF - Swedish Social Insurance Inspectorate/Inspektionen för socialförsäkringen
IVA - Dutch Income Provision Scheme for People Fully Occupationally Disabled/Regeling inkomensvoorziening volledig en duurzaam arbeidsongeschikten
JCA – Job Capacity Allowance
LCW - Limited Capability for Work

LCWRA - Limited Capability for Work-Related Activity
MCA – Mutli Casual Analysis
MMR - Moderate Mental and Behavioural Disorders and Rehabilitation
NDA – National Disability Authority
NWRN – National Welfare Rights Network
OECD – Organisation of Economic Co-operation and Development
PA – Personal Adviser
PTSL – Part Time Sick Leave
QAF – Quality Assurance Framework
RFT – Request for Tender
RTW - Return to Work
SIP – Social Insurance Physician
SSA – Social Security Act
SSIA – Swedish Social Insurance Agency
SSP – Statutory Sick Pay
UK – United Kingdom
UVA – Dutch Social Insurance Agency
WOA - Previous Dutch Disability Pension Scheme/Wet op de
arbeidsongeschiktheidsverzekering
WCA – Work Capacity Assessment
WFIs – Work Focused Interviews
WGA - Return to Work Scheme for the Partially Disabled/Regeling Werkhervatting
Gedeeltelijk Arbeidsgehandicapten
WIA – Current Dutch Disability Pension Scheme/Wet Werk en Inkomen naar
Arbeidsvermogen
WRAG – Work-Related Activity Group

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Annexes of country reports

Australia

1. Overview

In Australia, private sector employees are (subject to certain conditions) entitled under employment law to up to 10 days paid sick leave per year.³⁴ If this is used up, an employee may (depending on the employment contract) be entitled to some further sick leave or make take unpaid sick leave.³⁵ Alternatively, s/he may claim the means-tested sickness allowance if s/he can show that all illness is 'temporary' and that s/he has a job to go back to. A person who is long-term incapable of work can claim the means-tested disability support pension (DSP). The policy intention is that income support payments should be adequate enough to allow disabled people to live with dignity, whilst also encouraging disabled people to seek employment.

2. Description of main payments

Sickness Allowance is a means-tested payment for persons with 'temporary' illness. Sickness allowance and Disability Support pension (DSP) are aimed at different segments of the population suffering incapacity and ill-health, although Sickness Allowance may be a route to and/or off DSP for some people. Sickness Allowance has different medical eligibility criteria from DSP. It is intended to provide income support for those of working age who are temporarily unable to work or study due to a medical condition. There is a link with the DSP criteria in that a temporary medical condition is taken to mean two years or less - if the condition was expected to last for longer, then the person should consider a DSP application. Critically the Sickness Allowance applicant must have a job or a course to return to at the end of their period of incapacity. If not then they are required to claim unemployment benefit. Claims for Sickness Allowance have to be supported by a medical certificate from their doctor, which must state that the person is unable to work or study. Usually the medical certificate has to be reviewed at least every 13 weeks. The income and asset tests and the residency requirements that apply to DSP also apply to Sickness Allowance. The number of Sickness Allowance recipients is significantly smaller than for DSP; 7,937 in June 2015 compared to over 800,000 on DSP.³⁶

³⁴ Fair Work Act 2009.

³⁵ For up to three months, a person cannot be dismissed

³⁶ In terms of Ireland's population size, this would be the equivalent of about 1,500 people on Sickness Allowance, and about 160,000 on Disability Support Pension

Disability Support Pension (DSP) was announced in the 1990 Budget and introduced by Part 2.3 of the Social Security Act 1991 (SSA) as part of a wider policy initiative, the Disability Reform Package, which also increased spending on training and rehabilitation services. DSP replaced the Invalid Pension in November 1991.³⁷ The reform was designed to reduce the number of recipients and to promote disabled people's engagement in the labour market through combining income support with training and rehabilitation services (Yeend, 2002a). As Yeend (2002a:4) observes:

'For the first time the Department of Social Security (DSS) employed specialist Disability Support Officers (DSOs) who conducted interviews of all DSP applicants jointly with Commonwealth Employment Service (CES) and Commonwealth Rehabilitation Service (CRS) officers, providing holistic assessments and management.'

As part of the reform, the assessment of impairment was changed. There were concerns that under the Invalid Pension scheme, Commonwealth Medical Officers were too often taking into account the applicant's socio-economic circumstances (such as ethnicity, basic skills, and local labour market conditions) rather than concentrating on their impairment and its effect on work capacity (Yeend, 2002a). However, numbers in receipt of DSP still increased over time; from under 200,000 in the 1970s to over 800,000 by 2015. This has led to a number of further reforms to tighten eligibility for DSP. These reforms include:

- A reduction in the number of hours per week a claimant is unable work from 30 to 15 for those claiming after 2006. The change did not affect people qualifying for the DSP prior to May 2005, and only affected those qualifying between May 2005 and June 2006 after their first review. The change meant that people who were partially incapacitated (those who could work for 15 to 29 hours per week) now claimed Newstart, an unemployment benefit with payments that are lower than those for DSP. These changes were introduced as part of the then Howard Government's Welfare to Work reforms.
- The introduction of a Program of Support in 2011 - a Program of Support is designed to help disabled people find paid work and has to be wholly or partially funded by the Commonwealth Government.
- The Impairment Tables, used to assess capacity for work, were revised in 2012.
- Since July 2012 new and existing DSP recipients aged under 35 years who have an assessed work capacity of eight to 15 hours a week are required to attend periodic participation interviews with Centrelink staff to develop participation plans.

³⁷ A more detailed history of DSP up to 2010 is given in Daniels (2011).

- A targeted review of past cases commenced in July 2014, covering DSP recipients who were under the age of 35 and were granted the payment between 1 January 2008 and 31 December 2011; they are known as 'reviewed 2008-2011 DSP starters'.³⁸

Transitional protection arrangements have been put in place as these reforms have been implemented. This protection adds to the complexity of the system, because different eligibility rules apply to the stock of DSP recipients, with the criteria applied depending on when recipients made their claims and in some instances reviewed.

DSP is means-tested and for those under pension age non-taxable. Payment rates and methods for calculating the payments are set out in legislation - Part 2.3, Division 5 and Parts 3.1 to 3.4B of the *Social Security Act 1991*. The maximum amount paid also depends upon the recipients' age, presence of children and family structure; and for those aged under 21 their living arrangements. Younger DSP recipients receive a lower rate of payment. In addition, a DSP recipient whilst participating in the Program of Support obtains a payment of \$20.80 per fortnight (known as the approved program of work supplement) (Section 118, SSA 1991). The amount of DSP paid is reduced if the claimant has an income and assets above set thresholds.

DSP claimants have a long-term impairment that can make returning to work difficult. Nonetheless, successive Australian governments have sought to make DSP a more active benefit, encouraging more claimants to return to employment. DSP is administered by Centrelink, which is part of the Department for Human Services. In June 2015 there were 814,391 DSP recipients. It represents the largest income support payment to people of working age – a half of all such payments in 2008/9 (Productivity Commission, 2011).

The work capacity of DSP recipients varies from those unable to work to those able to undertake a few hours each week. However, notwithstanding a series of measures as outlined below to encourage recipients to move into employment relatively few do so. Fewer than one in ten recipients declare earnings from employment: 9.8 per cent in June 2008, 9.2 per cent in June 2009, 8.7 per cent in June 2010 (Productivity Commission, 2011:K3), and 8 per cent in June 2015 (see Table AUS2). Their employment durations can be relatively brief; of the 100,000 or so disability pensioners who reported earnings over the two years to the end of June 2008, only 36,000 were employed for the whole two years (Australian Government, 2009a). Of those that exit DSP for employment many return to the benefit (Productivity Commission, 2011:K3).

³⁸ Recipients may also become a reviewed 2008-2011 DSP starter due to other reviews of DSP claims that take place, such as random sample surveys or medical qualification updates. NB the reviewee is assessed against all of the eligibility criteria for DSP (these are discussed below).

In recent years the Commonwealth Government has been increasingly expecting DSP recipients to search for, and enter, employment (Lam, 2014; Hammer, 2009; Australian Government, 2009a and 2009b). Accordingly, new and reviewed DSP claimants, unless they are 'manifestly eligible' (due to a congenital disability, catastrophic injury or illness), are required to undertake a Job Capacity Assessment.³⁹ This is used to assess the individual's medical eligibility for DSP and whether they are capable of work. The assessment is conducted by an Assessor, namely, an allied health or health professional. Prior to July 2011 these Assessors were from a mix of government and private providers but concerns about the accuracy of the assessment led Centrelink (with the assistance of the Commonwealth Rehabilitation Service Australia) to take over all assessments. The Assessor uses Impairment Tables to assess the extent to which the applicant's medical condition has a functional impact on their capacity to work. The Impairment Tables and the separate work capacity assessment, known as the Continuing Inability to Work (CITW) test, are discussed in more detail below. The assessments are typically conducted at a Centrelink Service Centre. There is no user charge levied for the assessment. At the same time an assessment is made as to whether the applicant should be required to participate in a Program of Support, and a referral may be made to employment services. That is, policy makers see the Job Capacity Assessment as not simply a means to determine eligibility for DSP but also as a referral tool.

Many DSP recipients aged less than 35 years must have a participation plan and attend regular interviews at Centrelink (SSA, section 94 and 94A). In addition, it was announced in the 2014 Federal Budget that some DSP claimants aged less than 35 years who were able to work more than eight hours per week will be mandated to participate in work-related activities (NWRN, 2014; SSA, section 96). These activities include job search, work experience, education or training, Work for the Dole, rehabilitation or engaging with an agency that can help people find work, such as a Disability Employment Service or a Job Services Australia provider. There are some exclusions, for example, if the recipient has a dependent child under six years, or they employed in supported employment (that is, under the Supported Wage System or work in an Australian Disability Enterprise).

Although exemptions apply (see below), DSP applicants must have completed, or actively participate in, a Program of Support for at least 18 months over the last three years (Australian Government, 2015: Section 1.1.A.30). A Program of Support is meant to be a tailored programme to help people 'prepare for, find or maintain work' (SSA Section 94(5)). Those taking part in the Program of Support are those

³⁹ The JCA was introduced in July 2006. Non-DSP applicants who are disabled may be referred to an Employment Services Assessment.

making new claims for DSP on or after the 3rd September 2011 and who do not have a severe impairment; and the reviewed 2008-2011 DSP starters (SSA, Section 94).⁴⁰

A Program of Support must be delivered by a 'designated provider', include vocational, rehabilitation or employment services and at least one of the following elements (Australian Government, 2015: Section 1.1.A.30): job search, job preparation, education and training, work experience, employment, return to work, vocational or occupational rehabilitation, injury management, an activity designed to assist the person to prepare for, find or maintain work.

Programs of Support include:

- Disability Employment Services – run by the Department of Social Services which comprise a mix of for-profit and non-for-profit organisations that support both disabled job-seekers looking for employment and employers to support disabled workers.
- Jobactive – a Department for Employment job brokerage service.
- the Remote Jobs and Communities Program – a Department of the Prime Minister and Cabinet programme to develop skills and support local communities.
- Australian Disability Enterprises – which are not-for-profit supported (sheltered) employment providers funded by the Department of Social Services.

DSP recipients can for up to two years combine paid work and benefit payments provide they do not exceed the working hour limit (30 hours since July 2012) or the income test.

In terms of exits from DSP, which amount to 7 per cent of the stock, there are few returns to employment. Many recipients die or flow on to the Age Pension, some because they no longer fulfil the income and asset tests (Productivity Commission, 2011:K2-3). For the year June 2012 to June 2013 there were 56,836 exits from DSP of which 62 per cent were transfers to Age Pension (Department of Social Services, 2014).

⁴⁰ A 'severe impairment' arises when an applicant has an impairment rating of 20 or more and a score of at least 20 on one or more of the Impairment Tables. Thus someone who is not classed as having a severe impairment will have an overall score of 20 or over, but not a score or 20 or more across any one of the 15 Impairment Tables. These applicants must take part in a Program of Support.

3. Incapacity criteria

Short-term incapacity

A person is entitled to paid sick leave if ‘the employee is not fit for work because of a personal illness, or personal injury, affecting the employee’.⁴¹

A person is qualified for sickness allowance if (a) the person is incapacitated for work or study because of sickness or an accident; and (b) the incapacity is caused wholly or virtually wholly by a medical condition arising from the sickness or accident; and (c) the incapacity is, or is likely to be, of a temporary nature.⁴²

Long-term incapacity

There are a number of criteria used to determine eligibility for DSP. Assessment for DSP includes the use of Impairment Tables; and new tables were introduced as part of replacing Invalid Pension with DSP. The current three key work capacity tests are that claimants (Department of Human Service, nd; SSA, Section 94):

- are either permanently blind or have a permanent physical, intellectual or psychiatric impairment of 20 points or more against the Impairment Tables. To achieve this minimum percentage requires that the applicant has a ‘significant impairment’ (Yeend, 2002a:4); and
- have an inability to work at or above minimum wage, or to be retrained for work, for at least 15 hours a week within the next two years because of the impairment (that is, the Continuing Inability to Work (CITW) test). The CITW test is essentially a time-based work capacity assessment (Morris *et al.*, 2015); and
- have taken part in or completed a Program of Support if required (see above). This requirement was added to the eligibility criteria in September 2012 – it forms part of the CITW test. It is used to demonstrate that an applicant cannot obtain employment without assistance.

Following publication of the final report of the Reference Group on Welfare Reform (2000), *Participation Support for a More Equitable Society* (the McClure Report), there were three attempts to tighten the CITW test in 2002 (see Yeend, 2002a and 2002b). The 2002 attempts at reform sought to reduce the then 30 hours per week threshold to 15 hours. When DSP was introduced the 30 hour test was not seen as problematic because it was believed that most recipients would receive payments for a relatively short period of time and aided by training and rehabilitation

⁴¹ Fair Work Act 2009, s. 97.

⁴² Social Security Act 1991, s. 666.

measures the 30 hour rule would assist people's transition from DSP into full-time employment (Yeend, 2002a). However, reducing the threshold from 30 to 15 hours for new applicants had to wait until the *Employment and Workplace Relations Legislation Amendment (Welfare to Work and Other Measures) Act 2005*, with the change taking effect in the July of the following year (Mendes, 2009). The change, which occurred at a time of a wider neo-liberal critique of the Australian welfare state (see Mendes, 2001 and 2009), was designed to encourage many DSP recipients with a partial work capacity onto unemployment benefits. Those affected by the reduction in hours risked losing up to AU\$120 a week⁴³ (Mendes, 2009) if they received Newstart instead of DSP.

The CITW test is conducted because policy makers recognise that an applicant may have a significant impairment but still have a substantive capacity for paid work or training, in which case they would be ineligible for DSP. The CITW test takes into account the medical assessment using the Impairment Tables, as well as the applicants previous work history and access to employment services. It does not take into account the state of (local) labour markets.

Accessing DSP was further restricted with the introduction of revised Impairment Tables on 1st January 2012 (see Advisory Committee, 2011). A comparison of the new and old tables based on a representative but small sample of DSP cases (n=207) revealed that 41 per cent of people eligible under the old tables would no longer be eligible under the revised tables (Department of Families, Housing, Community Services and Indigenous Affairs, 2011:16). This analysis implies that between a third (36 per cent) and nearly a half (45 per cent) the DSP population would be affected by the introduction of the revised tables.⁴⁴

The tables, which as mentioned above are used in a Job Capacity Assessment, are specified in secondary legislation, the *Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011*.⁴⁵ The Determination was made by the then Minister for Families, Housing, Community Services and Indigenous Affairs using powers under the SSA (subsection 26(1)). However, the revised Tables only apply to those required to take part in an assessment on or after 1st January 2012. Recipients with older claims continue to be assessed against the pre-2012 Impairment Tables when their cases are reviewed.

The Determination defines impairment as '... a loss of functional capacity affecting a person's ability to work that results from the person's [medical] condition.' The Tables are function based (rather than diagnosis based) and cover the activities,

⁴³ About €80 a week at January 2016 exchange rates

⁴⁴ This estimate is based on using a 90 per cent confidence interval.

⁴⁵ Available at: <https://www.comlaw.gov.au/Details/F2011L02716/Download>.

abilities, symptoms and limitations of a claimant. They exclude possible non-medical/socio-economic barriers to obtaining employment.

There are 15 Impairment Tables (see Box 1), and each Table comprises five functional *descriptors*, which describe possible levels of impact of a medical condition. The five levels of functional impact specify what ‘no’, ‘mild’, ‘moderate’, ‘severe’ and ‘extreme’ impacts would look like. Each descriptor has an assigned *impairment rating* (or points); and the points awarded are summed to give the claimant’s overall impairment score. The number of points for each level of functional impact is:

| <i>Impact level</i> | <i>Points</i> |
|---------------------|---------------|
| No | 0 |
| Mild | 5 |
| Moderate | 10 |
| Severe | 20 |
| Extreme | 30 |

Box AUS 1: The Tables

Table 1 - Functions requiring Physical Exertion and Stamina

Table 2 – Upper Limb Function

Table 3 – Lower Limb Function

Table 4 – Spinal Function.

Table 5 – Mental Health Function

Table 6 – Functioning related to Alcohol, Drug and Other Substance Use

Table 7 – Brain Function

Table 8 – Communication Function

Table 9 – Intellectual Function

Table 10 – Digestive and Reproductive Function.

Table 11 – Hearing and other Functions of the Ear

Table 12 – Visual Function

Table 13 – Continence Function

Table 14 – Functions of the Skin

Table 15 – Functions of Consciousness

Source: *Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011.*

An example of a descriptor and its impairment rating (or points) is as follows:

Table 8 Communication Function

| Points | Descriptor |
|--------|--|
| 5 | <p>(1) <i>There is a mild functional impact on communication in the person's main language. At least one of the following applies:</i></p> <p>(a) the person has some difficulty understanding complex words and long sentences (e.g. a complex newspaper article); or</p> <p>(b) the person has mild difficulty in producing speech and has minor difficulty with being understood due to speech production or content.</p> |

Source: *Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011*, p.37.

For impairment ratings to be assigned, two conditions must be met (Sections 6(3)):

- The claimants' medical condition must be permanent, that is, it has been diagnosed by a qualified medical practitioner, the condition has been fully treated and is stabilised
- The impairment (due to the condition) is likely to last for two years.

When assessing the impairment, claimants must wear/use any aids, equipment or assistive technologies that they usually use (Section 9). For episodic and fluctuating conditions (which are stabilised (see above)) the rating must reflect '... the overall functional impact of those impairments, taking into account the severity, duration and frequency of the episodes or fluctuations as appropriate.' (Section 11(4)).

The *Determination* highlights that assessment of impairment is evidence-based, and the medical practitioner must have received corroborating evidence (such as worker compensation reports, or hospital or outpatient reports). Since the 1st July 2015, medical reports from the treating doctor are no longer required to be submitted as medical evidence. Instead, the applicant must provide their medical records.

Those not meeting the income and asset test may be eligible for the Newstart Allowance.

4. Assessment of incapacity

Short-term

Australian employees (except casual staff) have an entitlement to sick and carer's leave of up to 10 days per year for full-time workers; and unused leave can be rolled

forward to the next year. Sick leave is paid at the employee's base pay rate for each hour of sick leave. Following the implementation of the controversial WorkChoices legislation in 2006, employers were given more scope to demand medical evidence to justify sickness absences.⁴⁶ Prior to the reform employees could take up to four days sick leave without medical evidence, post-reform employers can demand a certificate from the first day of sickness absence. The form of the medical evidence must take is not specified in law (the *Fair Work Act 2009*), but a medical certificate from a registered medical practitioner is usually taken as proof of illness (although it can be challenged by an employer). However, the legislation also deregulated who could write a medical certificate. Medical certificates can be issued by 10 types of 'registered health practitioner', including pharmacists, acupuncturists, chiropractors and traditional Chinese medicine practitioners. In 2013 there were 95,013 registered medical practitioners in Australia.⁴⁷ Nonetheless, GPs continue to have a key role in the return to work process (Mazza et al., 2015).

For short-term illness the main route into the incapacity system is the GP and obtaining a medical certificate. Most people's initial contact with the health care system is with a general practitioner (GP). GPs see approximately 96 per cent of injured workers (Mazza et al., 2015). There have been relatively few studies of sickness certification in Australia (e.g. Dunstan, 2009; Mazza et al., 2015). As in some other countries, there have been concerns expressed about GPs acting as patients' advocates, prioritising their relationship with patients over other factors and lacking sufficient information about patients' job roles (Mazza et al., 2015). These concerns lead to sickness certificates being issued unnecessarily and endangered the return to work process. Also, there are allegations of 'doctor-shopping' whereby patients will contact health practitioners until they obtain the certificate outcome desired.

The various bodies that regulate the medical practitioners who can issue medical certificates have responsibility for quality assuring professional practice. In addition, medical practitioners are registered with the Australian Health Practitioner Regulation Agency.

Most employees claiming replacement income from a worker's compensation scheme return to work. A 2013/14 survey of returns to work shows that 87 per cent of injured workers who had been off work for 10 or more days had returned to work (The Social Research Centre, 2014). This is a rate of return that has been fairly stable over time.

⁴⁶ WorkChoices was introduced by the *Workplace Relations Amendment (Work Choices) Act 2005*, which amended the *Workplace Relations Act 1996*.

⁴⁷ Source: Australian Institute of Health and Welfare, <http://www.aihw.gov.au/workforce/medical/how-many-medical-practitioners/>

Long-term

As mentioned above, a person's medical eligibility for DSP requires a Job Capacity Assessment to be conducted using Impairment Tables. In addition, claimants may have been required to undergo a Disability Medical Assessment (DMA). Indeed, all claims for DSP submitted on or after 1st July 2015 must have a DMA. These assessments are conducted to review the medical evidence used to support a DSP claim. They are conducted by a government-contracted doctor, and cannot be carried out by the applicant's own doctor or specialist. The DMA does not involve any diagnosis of conditions, medical advice or treatment; rather it is a review of the supporting medical evidence for a claim for DSP.

Eligibility for DSP is determined by a social security decision-maker (or delegate) under the Social Security Act, and not by Commonwealth Medical Officers (CMO) or doctors (Yeend, 2002). Many Australians incorrectly believe that it is the CMOs or doctors that determine eligibility for DSP.

Desk based assessments

Desk based Job Capacity Assessments (JCAs), known as file assessments, are under certain circumstances allowed, but they are the exception. Job Capacity Assessments can be conducted face-to-face, by telephone/video-conference or paper-based. The preferred method is face-to-face interviews – 90 per cent were conducted this way in 2008/09 (Jackson, 2009:21).⁴⁸ Telephone/video-conference assessments are permitted where a claimant is geographically disadvantaged or their medical condition prevents them from attending an interview in person (Anon., 2006; Parliamentary Ombudsman, 2008:7). Official guidance has recognised that telephone/video-conference assessments may be necessary where:

- 'the client has severe mobility restrictions due to a disability, illness or injury; or
- the client is confined to hospital, home or an institution due to a medical condition or legal requirement; or
- the client would be required to travel for more than 60 minutes to attend an assessment AND there are no suitable facilities for the assessor to conduct an assessment in the client's local area; or

⁴⁸ Note not all of these will have been DSP claimants as claimants of other benefits may also have a JCA.

- travel for both the client and assessor is impossible or unreasonable for other reasons such as flood or storm.⁴⁹

The decision about whether a telephone/video-conference assessment is permitted is taken by the JCA assessor on a case by case basis. Guidance to assessors makes it clear that telephone/video-conference assessments are not to be used simply because a face-to-face appointment would be inconvenient. The Parliamentary Ombudsman (2008:7-8) has been critical of the use of telephone JCA assessments because it can ‘...lead to poor outcomes.’

File (or paper) assessments may be allowed were:

- a client’s medical condition(s) prevents them from attending a face-to-face assessment or participating in a telephone or other assessment;
- a DSP or foreign pension client is overseas;
- a client has a history of aggressive behaviour and/or difficulty dealing with Centrelink;
- a client’s geographic isolation prevents them from attending a face-to-face assessment and also prevents the assessor from arranging an assessment in the client’s local area, and telephone or other media are unavailable; or
- a client’s medical condition or geographic isolation prevents them from attending a face-to-face assessment, and medical, cultural or linguistic factors preclude a telephone or video-conference assessment.’

A difference with telephone/video-conference assessments is that Centrelink (not the JCA assessor) decides whether a file assessment is required.

In addition, JCAs are conducted by an Allied Health Professional, and their primary qualification should align with the Impairment Table being used in a claimant’s assessment. When this does not occur a Contributing Assessor is used to review the evidence in order to quality assure the assessment. The Contributing Assessor does not need to attend the interview, as they have electronic access to the primary assessor’s report. If required the Contributing Assessor can advise the primary Assessor over the phone or in writing.

‘Manifestly eligible’

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http://www.aph.gov.au/~media/estimates/live/fapa_ctte/estimates/bud_0607/human_services/hs2_5.ashx

There is a procedure, 'manifestly eligible', whereby DSP can be granted without a referral to the incapacity/medical assessments conducted as part of the Job Capacity Assessment (Social Security Act, Section 94). 'Manifest grants' of DSP are limited to the following circumstances:

- The prognosis for the claimant's current medical condition is terminal, the average life expectancy of patients with the condition is two years or less and there is a significantly reduced work capacity during this period.
- Permanent blindness (that is, no vision).
- The claimant has an intellectual disability and an IQ of less than 70 using the WAIS IV or equivalent assessment.
- Evidence indicating that a claimant is receipt of, or requires nursing home level of care for the foreseeable future due to illness or infirmity.
- Claimant has category 4 HIV/AIDS.
- Claimant is in receipt of a Department of Veterans' Affairs disability pension at special rate due to being 'totally and permanently incapacitated'.

To aid decision makers determine whether DSP should be manifestly granted on the grounds of terminal illness, nursing home level care requirements, and/or intellectual disability there are lists of medical conditions where DSP should be granted (list 1) or further investigations conducted (list 2).⁵⁰

5. Review and appeals

The review of 2008-2011 DSP starters (mentioned above) will cover 28,000 recipients aged under 35 years (NWRN, 2015a). The reviews include the use of the revised Impairment Tables. Between 1st July 2014 and 15th May 2015, about a quarter (7,249 cases) had been reviewed and 10.3 per cent (or 746) had their DSP payment cancelled because they were assessed as no longer eligible. Of these former recipients, 308 launched an appeal between 1st July 2014 and 14th March 2015.

In addition, Centrelink undertakes reviews of cases (known as 'service updates', which were introduced in September 2003) (Australian Government, 2015: Sections 6.2.5.05 and 6.2.5.15). The objective is to ensure that recipients have an ongoing eligibility for DSP. The selection of cases for review is risked-based ('statistical profiling') and considers the recipients' circumstances (such as medical condition,

⁵⁰ Further details are provided in the *Guide to Social Security Law* (section 3.6.2.20): <http://guides.dss.gov.au/guide-social-security-law/3/6/2/20>

and their income and assets). Whilst selection is focused on those whose circumstances are most likely to have changes, some categories of DSP recipient are exempt from review, for example, those that are permanently blind or if they are manifestly eligible for DSP. The service update reviews cover all details about a claim. The medical aspect to the review is used to check that the recipients continue to fulfil the relevant impairment and CITW criteria for DSP. The process includes the recipients having to get a medical report from their treating doctor.

Eligibility for DSP can be rescinded without conducting another Job Capacity Assessment if it is 'clear and evident' that the claimant's impairment would score less than 20 points using the Impairment Tables or if it is clear that they could work for more than 15 hours per week. Where there are doubts about the individual's work capacity then they should be referred for a Job Capacity Assessment.

Centrelink customers dissatisfied with the service they received are encouraged to initially raise issues with a member of staff before using one of the 'feedback options' (online, telephone or post) to make any complaints. Customers unhappy about a decision on their entitlement to a benefit, including DSP, have a number of review rights. The National Welfare Rights Network (2009b) reports that the proportion of claims rejected has been increasing. In 2011/12 50 per cent of DSP claims were rejected, but this increased to 63 per cent in 2014/5. The reasons why claims for DSP are rejected are given in Table AUS1. The top two reasons, accounting for seven out ten rejections in total, is that the applicant's medical condition has not been fully diagnosed, treated and stabilised or they were awarded less than 20 points on the impairment Tables.

Table AUS 1: Reasons for rejecting DSP applications

| Rejection Reason | Number | Percentage |
|---|---------------|--------------|
| Medical condition not fully diagnosed, treated & stabilised | 30,001 | 35.8 |
| Less than 20 points on the Impairment Tables | 28,504 | 34.0 |
| Failed to supply information | 12,275 | 14.6 |
| Did not meet the Program of Support requirements | 3,309 | 3.9 |
| Disability is short-term | 1,391 | 1.7 |
| Other | 8,439 | 11.3 |
| Total | 83,829 | 100.0 |

Source: National Welfare Rights Network (2015b)

If an individual is unhappy with a decision they may request a review. The legislation covering internal reviews and appeals is contained in Part 4 of the *Social Security (Administration) Act 1999*, which also applies and modifies the *Administrative Appeals Tribunal Act 1975*. They may request:

- A full explanation of the decision.

- Request an internal review of the decision, which is conducted by an independent review officer.
- If the person disputes the internal review decision, then they may appeal to the Administrative Appeals Tribunal (AAT). An appeal from Centrelink is heard by the Social Services & Child Support Division of the Administrative Appeals Tribunal. The tribunal conducts two levels of appeal. The initial review is known as an 'AAT first review', an application for a further review (an 'AAT second review') is also possible.
- An appeal through the courts. The *Administrative Appeals Tribunal Act* allows an individual to appeal to the Federal Court from a decision of the AAT on AAT second review. Decisions of this court can be appealed to the High Court.

6. Overall assessment

The Australian welfare system is very complex both as a whole and as it relates to the disability and incapacity sub-system and to Disability Support Pension in particular. The complexity is in part due to the governance and institutional framework of the welfare system – notably the mix of federal and state/territory legislation and of public and private sector provision. For DSP the complexity is also because of incremental reforms to the eligibility criteria, which have sought to reduce the numbers on, and hence the cost of, DSP. Changes to the eligibility criteria have led to different cohorts of recipients with varying eligibility criteria. This emphasises the importance of getting the eligibility criteria for a reformed system as correct as possible at the outset.

There is an on-going review of the national welfare system. The Government commissioned an independent review and its final report, *A New System for Better Employment and Social Outcomes*, was published on 25th February 2015 (Reference Group on Welfare Reform, 2015). The Reference Group argues for a simpler and more integrated welfare system with a greater focus on employment. For disabled people its proposals would appear to lead to some significant changes. The Reference Group proposes the introduction of a three Tiered Working Age Payment, where claimants of the Upper Tier and the Middle Tier would include disabled people with some capacity to work – eight to 14 hours per week for the Upper Tier, and 15 to 29 hours per week for the Middle Tier. There would also be a Supported Living Pension for those aged over 22 years with a *permanent* incapacity (not disability) to work for less than eight hours per week. The incapacity has to be expected to last for at least five years. Some commentators believe that the proposals will mean a loss of benefit income as many on DSP are unlikely to qualify for the Supported Living Pension (Morris *et al.*, 2015).

The deregulation of sickness certification and removing self-certification by employees has led to a rapid increase in the number of medical certificates issued. For instance, over a 10 year period the rate of issue of sickness certificates by GPs has increased from 0.6 per 100 encounters with patients in 1999/00 to 1.9 per 100 encounters in 2008/9; an estimated increase of 1.5m sickness certificates over the period (Britt, et al., 2009:75). Accompanying this have been concerns about certificates being written where the medical evidence would not always justify their use (Dunstan, 2009). The factors influencing the issue of sickness certificates are complex, and non-clinical factors are known to influence their issue; for example, a general practice is busy or patients having low job satisfaction, domestic arrangements and so on. As Dunstan (2009:62) notes:

When multiple factors are influencing the patient's request for a sickness certificate, GPs can feel torn between the desire to 'advocate' for their patient, and their legal responsibility to objectively 'judge' the patient's level of work disability. ... The priority for most GPs is to maintain a good relationship with their patient, so that even if the GP disagrees with a patient's request for extended time off work, many will acquiesce in order to avoid confrontation or damage to rapport.

Mazza et al. (2015) call for greater clarity about the GPs role in the return to work process.

A major change to the DSP eligibility criteria was the reduction from 30 hours per week to 15 hours per week in the Continuing Inability to Work (CITW) test in 2006/7 as part of the Government's wider Welfare to Work reforms. The official evaluation used a before and after design and whilst it acknowledged that its findings were not conclusive and other factors may have affected outcomes it found that (DEEWR, 2008:57):

people with disability who were directly affected by Welfare to Work during 2006-07 were those with a capacity to work of 15 to 29 hours per week. For these people, increases in workforce participation and decreases in income support reliance emerged. Those assessed with a capacity to work of 15 to 29 hours per week under Welfare to Work left income support at rates twice as high as in previous years, and mainly for employment. Also, they had a higher likelihood of being in employment, while remaining on income support.

The evidence presented provides evidence to indicate that Welfare to Work, with its changed payment eligibility conditions for DSP and the introduction of part-time participation requirements, was a key driver of the observed outcomes for this group.

More specifically, there was a reduction of four per cent in the number of claimants to DSP in 2006/7 compared to 2005/6 (DEEWR, 2008:25-6). Yet at the time the new criterion was seen as a significant tightening of the eligibility criteria.

Allowing partial DSP payments with up to 30 hours of paid work per week (subject to the means-tests) over a two year period may mean recipients cycle between hours worked/jobs towards the end on the period. Someone working between 15 and 30 hours and wishing to retain their benefit entitlement after the two years will wish to reduce their hours below 15 hours per week because this is the threshold in the CITW test. Indeed, the interaction between the rules may mean that a recipient is reluctant to take up offers of employment of more than 15 hours per week.

The Australian Government have undertaken some pilots to encourage DSP recipients to move into employment (see Productivity Commission, 2011). These include the \$6.8m Disability Support Pension Employment Incentive Pilot which commenced in March 2010 and lasted for two years. The pilot was part of the National Mental Health and Disability Employment Strategy. It covered 1,000 DSP recipients, and was a subsidy scheme with employers receiving up to \$3,000 after the DSP recipient remained in employment for at least eight hours a week for 26-weeks. The subsidy was paid as a lump sum at the end of the period. The normal income tapers applied to DSP participants. A 2010 DEEWR Survey of Employers and qualitative data from an online discussion forum conducted in 2011 (DEEWR, 2011) revealed that employers were divided on whether it encouraged recruitment of disabled people. However, employers believed that the scheme was not sustainable in the long-term; there were concerns about the cost to firms after the 26 week period. Employers claimed they may have to 'let go' of disabled employees because of higher costs due to lower productivity. Employers also thought the rules around when a payment was made were too restrictive – they could feel 'locked in' to the arrangements. When an employee left before the end of the 26-weeks they wanted a partial payment. They were critical of the payment being a lump-sum (they would prefer a phased payment).

DSP recipients are relatively dissatisfied with their benefit and everyday life. The Hammer review of pensions (2009:39) found that in comparison with recipients of Age Pension and Carer Payment, DSP recipients were:

- the least satisfied with the rate of payment;
- the least satisfied with their standard of living; and
- more likely to see their standard of living as worse than the community as a whole.

Those undergoing a Job Capacity Assessment can be critical of the process, seeing it as the state assuming they are dishonest and that its introduction represented a return to a medicalised model of provision (Marston and Lantz, 2012).

DSP recipients can have relatively long benefit durations. DSP has been regarded by some as a route into early retirement (Productivity Commission, 2011) and as a mechanism for militating against what would otherwise be higher unemployment (in effect an unemployment programme) (Morris *et al.*, 2015). The Productivity

Commission's Inquiry into disability (2011:K4) concluded that with respect to DSP '... policy measures have (so far) faced great difficulties in achieving permanent exits to more positive economic outcomes for people with disabilities.'

7. Data

Overall, the number of DSP recipients has grown steadily since it was introduced from less than 200,000 in the 1970s to over 800,000 by 2015. However, the rate of increase has in recent years slowed, especially since 2010. Indeed, the total number of recipients fell from 830,454 in June 2014 to 814,391 in June 2015. The increase in DSP numbers is due to an increase in the number of women claiming the benefit (Productivity Commission, 2011:K5; Department of Social Services, 2014:6). The main reasons for the increase in the numbers are (Productivity Commission, 2011):

- An increase in the size of the general population.
- An ageing population, which increases the rate or prevalence of disability and hence claims for DSP.
- Increases in the age-specific prevalence of DSP usage. This helps to account for the increase in female recipients, which largely reflects changes made elsewhere in the welfare system, for instance, the increase in the qualifying age for the Age Pension has led some women to claim DSP when they would have been eligible for the Age Pension.
- Structural changes in the economy which have seen a loss of low skilled manual work mean that it has become difficult for people with a disability and relatively low skills to find employment.

The last of these reasons appears to be the most important factor behind the growth in numbers.

The estimated cost of the DSP was \$11.6 billion in 2009-10 (Productivity Commission, 2011:K1). The cost in 2015 is about \$15bn and represents 21 per cent of the welfare budget (Morris *et al.*, 2015:43).⁵¹

Selected socio-economic characteristics of the DSP recipients as at June 2015 are shown in Table AUS2. A majority of the DSP population is male (53 per cent), single (74 per cent), and is not in paid work (92 per cent). The probability of a disabled person being a DSP recipient increases with age (Productivity Commission, 2011:K12-3). Thus two-thirds (68 per cent) of recipients are aged 45 years or over.

As indicated in Table AUS2 recipients tend to stay on DSP for relatively long periods of time. Seven out of ten (71 per cent) claimants have been in receipt of DSP

⁵¹ This is equivalent to just under €10bn at the 2016 exchange rate – adjusted for the different size of population between Ireland and Australia, it would be equivalent to spending of about €200m in Ireland

payments for five or more years. The average DSP duration is 11 years (570 weeks) (Australian Government, 2015b).

Table AUS 2: DSP population characteristics, June 2015

| Characteristic | Number | Percentage |
|--|---------|------------|
| Sex: | | |
| Male | 432,744 | 53 |
| Female | 381,647 | 47 |
| Marital status: | | |
| Partnered | 211,985 | 26 |
| Not partnered | 602,406 | 74 |
| Age | | |
| Under 16 | 0 | 0 |
| 16-20 | 23,837 | 3 |
| 21-24 | 29,913 | 4 |
| 25-34 | 83,619 | 10 |
| 35-44 | 124,581 | 15 |
| 45-54 | 203,872 | 25 |
| 55-64 | 307,396 | 38 |
| 65 and over | 41,173 | 5 |
| Payment duration: | | |
| Under 1 year | 38,985 | 5 |
| 1 < 2 years | 45,552 | 6 |
| 2 < 5 years | 156,788 | 19 |
| 5 < 10 years | 217,028 | 27 |
| 10 years + | 356,038 | 44 |
| Earnings from employment in last fortnight: | | |
| No earnings | 747,885 | 92 |
| Had earnings, of which | 66,506 | 8 |
| >\$0 - <\$100 | 10,022 | 1 |
| >\$100 - <\$143 | 6,150 | 1 |
| >\$143 - <\$250 | 12,820 | 2 |
| \$250+ | 37,514 | 5 |

Source: Australian Government (2015b); percentages are author's calculations

In 2013 the 'top 5' main medical conditions for DSP recipients were: psychological/psychiatric; musculo-skeletal and connective tissue; intellectual/learning; nervous system; and circulatory system (see Table AUS3). Since 2004 the proportion of DSP recipients with a musculo-skeletal and connective tissue condition has fallen, and the proportion with a psychological/psychiatric condition has increased (Department of Social Services, 2014:6).

Table AUS 3: Recipients by top five primary medical conditions, June 2001 and June 2013

| Year | Psychological/ psychiatric | | Musculo- skeletal and connective tissue | | Intellectual/ learning | | Nervous System | | Circulatory System | |
|------|-------------------------------|------|--|------|---------------------------|------|-------------------|-----|-----------------------|-----|
| | No. | % | No. | % | No. | % | No. | % | No. | % |
| 2001 | 140,965 | 22.6 | 202,732 | 32.5 | 63,168 | 10.1 | 19,270 | 3.1 | 33,742 | 5.4 |
| 2013 | 256,380 | 31.2 | 214,745 | 26.1 | 101,631 | 12.4 | 42,045 | 5.1 | 33,179 | 4.0 |

Source: Department of Social Services (2014:22)

Finland

1. Overview of supports during sickness absence

Finland has the characteristics of a Social-Democratic welfare regime, which include: a prominent role for the state, which provides access to benefits and services for all residents and aims for universal coverage, provides high replacement values of income, with dependence on the family minimised through extensive high quality services (these include day care, care for elderly, home help, etc.). The model is based on full employment and high female participation rates. Hantrais (2004) characterises Finland as a 'defamilialised' country which provides family policies that are explicit, coherent, legitimised, coordinated and supportive of working parents 'The state can be described as family and women friendly' (Hantrais, 2004).

Nevertheless, Finland was a late comer to the community of Scandinavian/Nordic welfare states. While an Industrial Accident scheme had been introduced in Finland to cover workmen's compensation in 1895 it was not until the 1950s and 60s that social insurance was expanded with a series of Acts that created the basis of today's national social security system (van Gerven, 2008). The first provisions for sickness and disability were introduced by the Sickness Insurance Act (Sairausvakuutuslaki 364/1963) in 1963. By the beginning of the 1980s the Finnish welfare state had caught up with the other Scandinavian/Nordic countries (Denmark, Norway and Sweden) in its comprehensiveness (van Gerven, 2008). However, at this stage, the Finnish programmes provided relatively low levels of benefits. Adequacy of benefit payments was improved during the expansion of provision in the 1980s. This expansion was reflected in the increased costs of welfare as social spending as a share of GDP rose from 19.3 per cent in 1980 to 25.1 per cent in 1990 (van Gerven, 2008).

2. Description of main payment(s)

The focus of this report is on the short term Sickness Allowance and the long term Disability Pension and the Rehabilitation Allowance. The Sickness Allowance and the Disability Pension have two components: an earnings-related benefit and a minimum benefit. The former is intended for employed and self-employed people who meet the contribution conditions while the latter is for people who have either a low income or no income at all (Toivonen, 2012). After being expanded in 1982 the earnings-related sickness benefit programme has remained relatively similar since then. However, the minimum sickness benefit has been revised and reformed. It was abolished and replaced with a new means-tested sickness benefit in 1995 which in turn was abolished in 2001 and replaced by a new minimum sickness benefit. The

long term Disability Pension has remained relatively unchanged since the beginning of the 1980s, but the temporary Disability Pension was replaced in 1995 by a Rehabilitation Subsidy and at the same time a programme of rehabilitation allowances was introduced for young people (van Gerven, 2008).

Today Finland provides statutory sickness schemes to compensate for loss of earnings during short and long term sickness and disability under the Sickness Insurance Act (*Sairausvakuutuslaki*) of 21 December 2004. The institutional framework for sickness and disability benefits is provided by the Ministry of Social Affairs and the Social Insurance Institution (Kela), which administers universal benefits and pensions through district offices and managed by a Parliamentary appointed governing body (Kela: <http://www.kela.fi>).

The financing of social protection expenditure is made up of contributions paid from central government and local authority taxes, insured persons' and employers' social insurance contributions, and income from property owned by the social security funds (Tanhua and Knape, 2015).

A timeline for recent reforms to sickness and disability benefits is shown below.

2004

- Vocational rehabilitation became a statutory earnings-related pension benefit.

2011

- Minimum sickness allowances were linked to the national pension index (1144/2010; 1145/2010; 1142/2010).

2014

- The act for promoting re-entry into employment for those on disability pension was continued for 2014–2016 (979/2013; 1051/2014).
- The maximum period of partial sickness allowance was lengthened to 120 weekdays (from the earlier 72 weekdays) (972/2013)

Grounds for granting occupational rehabilitation became less strict and the threat of disability was no longer a prerequisite (973/2013).

This section looks at the short term Sickness Allowance, the long term Disability Pension and Rehabilitation Allowance. As mentioned above, Sickness and Disability benefits in Finland have two components: an earnings-related insurance based

benefit and a minimum income benefit. The former is intended for employed and self-employed people (Toivonen, 2012).

To qualify for Sickness Allowance, a person must be aged between 16–67 years and reside in Finland and they must be unfit for their usual or closely related work on medical grounds. If a person has been employed for at least one month, their employer will continue to pay their full salary for the first nine days of their sickness absence. If, on the other hand, the employment relationship has lasted for less than one month, the employer will pay 50 per cent of their salary. Under collective agreements most employers pay full salary during the first one or two months of sickness absence (European Commission, 2013). Where an employer provides employees with paid sick leave the Sickness Allowance is paid directly to the employer. After the waiting period has elapsed, the Social Insurance Institution, Kela, takes over the payment. Sickness Allowance is income-related and the amount payable is calculated on the basis of annual earnings from a previous tax year (Toivonen, 2012; European Commission, 2013). The amount of Sickness Allowance payable has no ceiling (Toivonen, 2012).

Sickness Allowance is payable for the same illness for up to 300 days within a two year period. A person may be entitled to an additional 50 days of sickness allowance if, following receipt of Sickness Allowance for the full 300 days, they return to work for 30 days or longer. Of periods of Sickness Allowance that commenced in 2009, 5.7 per cent lasted between 241–300 days (Toivonen, 2012). A Partial Sickness Allowance, paid at 50 per cent of the full Sickness Allowance, may be payable for up to 120 days over a two year period for an employed or self-employed person who has been on sick leave for an uninterrupted period of at least 60 days. Partial Sickness Allowance is intended to facilitate a phased return to full time work for people who are sick or incapacitated. This allows full-time employees to return to work on a part-time basis with their employer. In response, to the low take up of the Partial Sickness Allowance the conditions of entitlement were eased at the beginning of 2010 and that year take up doubled to approximately 4,700 people (Toivonen, 2012).⁵²

After 300 days in receipt of Sickness Allowance, a person may become eligible for receipt of a long term Disability Pension (*Työkyyttömyyseläke*). As with the short term Sickness Allowance, there is a dual system for the long term Disability Pension in Finland:

- an insurance system – the statutory earnings-related pension (*Työeläke*) which is financed by contributions and covers all economically active persons

⁵² Equivalent to about 4,200 in Ireland on a pro-rata population basis

aged between 18 and 68 years, including employees, self-employed persons and farmers;

- a tax-financed universal system – the national disability pension (*Kansaneläke*) and the guarantee pension (*Takuueläke*) which provide a minimum pension to all residents aged 16 to 65.

The contributory and residence based pension schemes are coordinated and when statutory earnings-related pension exceeds a given limit, there is no entitlement to a national residence based pension or guarantee pension.

The residence conditions for the national pension or guarantee pension are that a person must have resided in Finland for at least three years of residence after reaching the age of 16. Residence periods completed in other European Union member states and Iceland, Liechtenstein, Norway (EEA) and Switzerland may be taken into account to satisfy the three year residence requirement, although one year of residence in Finland is always required (European Commission, 2013).

As long as the conditions of entitlement are met, the long term Disability Pension is payable indefinitely or until the claimant reaches old-age pension age (which is age 63 years for the contributory earnings-related pensions scheme and 65 years for the national residence based minimum income pension scheme). More lenient eligibility criteria are applied to receipt of Disability Pension from the age of 60 years onwards (European Commission, 2013). Different eligibility criteria apply to young people. A person under the age of 20 years is not eligible for a Disability Pension until their rehabilitation prospects have been assessed.

Within certain limits, a disability pensioner is permitted to work while receiving a pension. However, the full Disability Pension can be suspended for 3 to 24 months if the earnings are greater than 40 per cent of the pensionable salary. The Partial Disability Pension (*Osatyökyvyttömyyseläke*) can be suspended if earnings are more than 60 per cent of the pensionable salary. However, the pension is unaffected by earnings below a certain monthly threshold. In 2009, 7.5 per cent of Finnish people aged 16–64 years were receiving a Disability Pension (Toivonen, 2012).

To prevent 'disability', the pension institutions provide rehabilitation services. Before making the Disability Pension (*Työkyvyttömyyseläke*) determination, the pension provider has to make sure that the applicant's prospects of rehabilitation have been investigated (European Commission, 2013). Vocational rehabilitation became a statutory earnings-related pension benefit from the beginning of 2004. When a person has been absent from work on account of illness and has received sickness allowance for 150 working days, Kela will send information to their home address

about the process of applying for a Disability Pension and the availability of rehabilitation.⁵³

A Rehabilitation Allowance may be payable for a defined period when it seems likely that the worker's condition will be improved by participating in a rehabilitation programme. Rehabilitation Allowance is contingent on the beneficiary following a treatment and re-education programme. A claimant must draw up an individual treatment and rehabilitation plan, which can be provided as part of the statement from their doctor or as a separate document. A Rehabilitation Allowance is paid over the duration of the treatment period if the treatment is intended to allow patients to pursue or recommence their occupation or to enter the labour market. All eligibility criteria are the same as those that apply to a Disability Pension and, as a general rule, the amount of the Rehabilitation Allowance is determined in the same way as that of the Sickness Allowance.⁵⁴

In addition to statutory sickness insurance, most employed people in Finland are covered against the risk of sickness by a collective agreement. The coverage of collective agreements is around 90 percent of workers and they play an important role in supplementing the statutory schemes. The level of payment under schemes provided by collective agreements is usually higher than under the statutory scheme (Toivonen, 2012). However, this report focuses on the statutory scheme and does not include Finland's collective agreement schemes.

3. Nature of incapacity criteria or fitness to work criteria

To qualify for Sickness Allowance, a person must be unfit for their usual or closely related work on medical grounds.

To receive a disability pension under the earnings-related system, a person must have lost at least three-fifths of their working capacity (which is lowered to two-fifths for eligibility for a partial disability pension). Under the residence based national Disability Pension scheme the eligibility criteria is loss of at least three-fifths of working capacity. There is no partial pension under the residence based national Disability Pension scheme. From the age of 60, more lenient criteria are applied to disability pension. Persons under 20 years of age are not eligible for a Disability Pension until their prospects for 'rehabilitation' and entry into the labour market have been assessed.

⁵³ http://www.kela.fi/web/en/decreased-capacity-for-work_disability-pension

⁵⁴ http://www.kela.fi/web/en/decreased-capacity-for-work_rehabilitation-subsidy

Rehabilitation Allowance is paid when it seems likely that a person's condition will improve with care or re-education. This benefit is contingent on the beneficiary following a treatment and re-education programme.

4. Assessment of incapacity

Applications for sickness and disability benefits are addressed to the local Social Insurance Institution office or the occupational insurance fund. Applications for rehabilitation and Rehabilitation Allowance are also addressed to the local Social Insurance Institution office.

The employer pays the salary for the first 9 days after which the Social Insurance Institution (Kela) takes over the responsibility for covering the loss of salary. At this point a person who wishes to claim short term Sickness Allowance is required to provide a sickness certificate. If the employer pays the employee's salary while on sick leave, the Social Insurance Institution (Kela) pays the benefit entitlement as compensation from the tenth day onwards.

Incapacity for work is certified by a doctor – usually the claimant's GP - from the 9th day of illness. In Finland, the role of a doctor in the sickness certification process is one of 'medical expert'. In this respect the sickness certificate provides a recommendation and evidence for the basis of that recommendation. On receiving a sickness certificate, the Social Insurance Institution decides whether or not the claimant meets the criteria to qualify for sick leave and Sickness Allowance. Thus in Finland the doctor's sick certification is a recommendation and is not binding on the Social Security Institution which may reject the sickness certificate and make an adjudication decision that the claimant is not entitled to sick leave or payment of Sickness Allowance.

With respect to prescribing of sick leave in Finland, a more recent study by Kankaanpää (2014) found that there 'was considerable variation in the sick leave prescribing practices of Finnish health care professionals. This suggests that patients may not receive equal social benefits (Kankaanpää , 2014: 39). The difference between the lowest and the highest number of sick leave days prescribed for the 19 patient cases was almost four-fold in primary health care physicians and surgeons and eight-fold in occupational health care physicians. Some dentists did not prescribe sick leave to any of the 16 patient cases, and some prescribed nearly a hundred days altogether. The overall number of sick leave days occupational health care (OHC) physicians prescribed was smaller than in primary health care (PHC) physicians. More days of sick leave were prescribed by those working in smaller municipalities than larger population centres.' (Kankaanpää , 2014: 3).

Contextualising the study Kankaanpää (2014) describes the current system of prescribing sick leave in Finland:

In the Finnish health care system all doctors and dentists are equally entitled to prescribe sick leave and it is a part of every doctor's daily clinical practice. However, estimating the need for adequate length of sick leave is not included in the curriculum of medical students, and the guidelines for doctors on appropriate prescribing of sick leave are not well-known among doctors. In Finland, most health care professionals are familiar with Current Care Guidelines (CCG) and use these guidelines in their daily practice. CCGs are independent, evidence-based clinical practice guidelines that cover important issues related to Finnish health, medical treatment and prevention of diseases. Yet there is no guideline specifically about sick leave, and there is no recommendation on the reasonable amount of sick leave on each disease. Mostly, prescribing of sick leave is solely dependent on the experience, impressions and customs of each individual doctor. (Kankaanpää, 2014: 9).

Kankaanpää (2014) cites a Finnish 7-year follow-up study of the changes in the job characteristics of workers during the recession to predict their subsequent sick leave. The study found that 'Lowered job control increased the risk of sick leave. Decreased social support and increased job demands had similar effects. The highest risk of sick leave was associated with the combined effects of low job control, negative changes in job control, job demands and low social support.' (Kankaanpää , 2014: 16-17).

As described above, a full-time employee who has been on sick leave for an uninterrupted period of at least 60 days can agree with their employer to return to work on a part-time basis and receive a Partial Sickness Allowance, intended to facilitate return to full time work, which is paid at 50 per cent of the full Sickness Allowance, for up to 120 days over a two year period. To obtain Partial Sickness Allowance, an assessment is required from an occupational health care physician stating that the recovery from the illness or condition will not be compromised by working part-time. A number of studies of the part-time benefit indicate that persons on part-time benefit had more periods of sick leave during the study period than persons on full time benefit; they were less likely to go onto full time disability benefit but more likely to go to part-time disability benefit; and they experienced less sickness absence than those on full-time benefit. Kausto (2013) concluded that there were 'beneficial effects of partial sick leave on RTW and work participation'.

There is a move in Finland towards increased activation for the beneficiaries. In 2012, three changes were introduced to the sickness allowance in Finland. The first requires the employers to inform the occupational health service (OHS) provider whenever an employee has been ill for 30 or more calendar-days. The medical certificate for short-term SA was also modified with an addition of a specific section to include suggestions for work modifications or rehabilitation that could enhance RTW. Second, after 60 days on Sickness Allowance, recipients' rehabilitation needs and outlook are assessed. The third amendment was that although any physician can assess work disability and issue-related certificates, the Social Insurance Institution

will start to require an assessment by an occupational physician, if work disability persists for more than 90 compensated days. Halonen et al. (2015) examined the impact of the assessment of work capacity and found that the reforms had a modest positive impact and led to a sustainable return to work at an earlier point after the changes for employees with 60 days absence (but not at 30 and 90s days).

If rehabilitation is initiated, claimants are transferred under the Rehabilitation Allowance programme and the payment of the Sickness Allowance ends. This change is aimed at achieving faster re-entry to work. A Rehabilitation Allowance can be stopped if there is a change in working capacity or if rehabilitation treatment is refused without good reason. In the earnings-related scheme, the full disability pension and full re-education allowance can be converted into a partial disability pension and a partial re-education allowance if there is a change in working capacity and income.

The next assessment of work incapacity (with a stricter definition of suitable work) takes place after the 300 days when claimant is transferred to the Disability Pension programme. Assessment under the Sickness Allowance programme is reasonably relaxed as claimants are required for the first 300 days only to be unable to do their habitual activities (work/study). However, a wider concept of suitable work comes into play when considering entitlement to a Disability Pension. The assessment takes into account not only the medical reports but amongst other criteria such as level of education, professional experience, age and likelihood of finding work in the area (European Commission, 2013). Assessment is normally by desk review although an additional medical examination can be requested if this is felt to be necessary (ISF, 2013:7).

Persons receiving the Disability Pension must inform the Social Insurance Institution of any changes in circumstances that may affect entitlement. Social Insurance Institution doctors may assess the degree of incapacity at any time. Claimants apply for the Disability Pension using an application form, typically at their own or treating doctor's initiative. The form includes a medical certificate which includes history, status, findings, assessment of functional and working capacity, chances to recover working capacity through rehabilitation and final conclusion filled in by the treating doctor. Claims can be sent in by mail or submitted at the local Social Insurance Institute office. Sometimes the pension provider gets further information from the claimant, his or her employer or from the attending doctor(s). The applicant may also be subject to further medical examination. A social insurance doctor will provide a further opinion on eligibility but the final decision is made by a non-medical social insurance official.

The advantages of the system as identified by de Boer et al. (2004) are that:

- The occupational health services play an important role with regard to early reintegration.
- Specialised rehabilitation centres are responsible not only for the assessment, but also for rehabilitation.
- Local agencies/the Social Security Institute fulfil an important task with regard to coordination of the different schemes.
- The process requires two medical assessments in many cases (one by SSI and one by the earnings related insurance company). This implies a form of control for the assessing doctors.

Conversely the disadvantages are that

- The information about the labour market and occupational issues is not very well integrated in the process. The knowledge with regard to the possibilities of claimants to do other work is very poor.
- Local administrative staff and treating doctors lack information with regard to the standards and criteria of applications and the requirements of the assessment.
- Many decisions require more than one assessment, which causes inefficiency.
- There is no quality control in the process of decision making. The medical process is often controlled by the doctor providing the second opinion, but the final result is based on negotiation, not on objective criteria.
- 'Shopping' for certificates by the claimants (i.e. visiting several doctors in order to obtain a certificate).
- Efficiency and logistics could be better and, as there are many insurance bodies, the decisions take too much time so rehabilitation may be offered too late.

5. Review and appeals

The appeal procedure in social security matters varies according to the benefit in question and the authority which made the decision. Decisions by the Social Security Institution (Kela) may be appealed primarily by sending a letter of appeal to the office which made the decision. If Kela does not consider it possible to correct the decision in the manner requested, it forwards the appeal to the relevant Appeal

Board. It is further possible to appeal the decision of the Appeal Board to the Insurance Court, which is the highest and last level of appeal.

In the event of disputes arising out of any matter relating to invalidity benefits, the applicant can lodge an appeal with the pension provider, who will consider a possible correction. If this is not possible at this level, the complaint is referred to the Social Insurance Appeal Board or the Earnings-related Pension Appeal Board. The decisions of the appeal boards can further be appealed to the Social Insurance Court.

Anyone who believes that an authority, an official or other party performing a public task has violated fundamental or human rights, or in some other way acted unlawfully may file a complaint with the Parliamentary Ombudsman or the Chancellor of Justice. The Parliamentary Ombudsman and the Chancellor of Justice cannot investigate the matter, if it is subject of an appeal.

6. Overall assessment

In the 1990s Finland decided there was a need to 'activate' disabled people on benefits which led to the introduction of special rehabilitation programmes and Rehabilitation Allowance. From then on, the national Disability Pension was only available for claimants who are considered to be permanently disabled; while those who are assessed to have the potential to (re)join the labour market are directed to the Rehabilitation Allowance. As described above, young people aged 16–20 are automatically directed to rehabilitation rather than to a Disability Pension. A compulsory care and rehabilitation plan is required and even those people who are in receipt of a Disability Pension are encouraged to work, for instance by permitting their benefit to be suspended while they explore their potential to work. At the same time conditions of entitlement governing access to early retirement programmes have been tightened to promote the employment of older claimants (van Gerven, 2008).

Despite these policy aims, Kankaanpää (2014) found that

The sickness absence rate in Finland appears to have increased in the 21st century. According to Statistics Finland, in 2008, 67% of women and 62% of men were absent from work because of sickness at least once during the preceding year. In 2011, the average number of sick leave days in Finland was 9.4 per person per year. In 2012 in Finland, there was 336,647 new periods of sickness allowance. Every month sickness allowance was paid to an average of 56,430 people. (Kankaanpää, 2014: 10).

Miettinen et al. (2013) consider that the Finnish system of rehabilitation policies is 'an example of a complex welfare system with several problems' (Miettinen et. al,

2013: 1). The OECD has reported that the Finnish rehabilitation system is a complex one with several subsystems and lack of coordination. Miettinen et al. (2013) cite a recent report by Finland's National Institute of Health and Welfare which described the rehabilitation system as 'diffuse and fragmented' (Miettinen et. al, 2013: 1). Miettinen et al. (2013) identify 'lack of cooperation and clear allocation of responsibilities' as frequently cited concerns in Finnish national reports and studies and note that 'better cooperation between the subsystems has ... been one of the main goals in reforming the system in recent decades'. They suggest that the problems that have been identified 'at the upper level of the system may lead to important problems at the level of service delivery, such as citizens falling through 'the rehabilitation net' and ending up living without the rehabilitation services they need.' (Miettinen et. al., 2013: 1).

The Constitution of Finland prohibits any discrimination on the basis of a disability and Finland has signed The Convention on the Rights of Persons with Disabilities which entered into force in 2009. Nevertheless, Teittinen (2012) argues that Finnish labour policy is 'undeveloped' for the employment of disabled people and suggests that the 'ethos and practice of welfare is based on the idea that disabled people do not have to be at work and the welfare state disability pension attempts to compensate this matter.' (Teittinen, 2012).

Teittinen (2012) suggests that there needs to be better public support for the employment of disabled people in Finland and that sanctions should be considered if businesses fail to employ disabled people and notes that there is a need for further research on disabled people's employment in Finland pointing out that 'Only a few surveys or statistical analysis have been done, and these are not included in the strong Finnish tradition of the sociology of work' (Teittinen, 2012).

7. Data

In 2014, expenditure on sickness allowance was €866.6 million while expenditure on disability benefits was €744 million and rehabilitation benefit was €120 million.

As shown in the table FIN1 below the numbers on sickness allowance have declined in recent years from 345,000 in 2008 to 308,000 in 2014 although costs have continued to rise. As can be seen (table FIN 2), partial sickness allowance makes up a very small proportion of total allowances (13,000 out of over 300,000) and about 3% of total sickness allowance expenditure. The numbers on disability pension from Kela have also declined although the amount of pension has increased (table FIN3).

Table FIN 1: Sickness Allowance 2008-14

| Year | Benefit | Recipients | Benefit paid out in EUR |
|------|---------------------|------------|-------------------------|
| 2014 | Sickness allowances | 308,239 | 866,623,436 |
| 2013 | Sickness allowances | 311,677 | 856,482,443 |
| 2012 | Sickness allowances | 325,310 | 862,849,281 |
| 2011 | Sickness allowances | 323,468 | 850,787,934 |
| 2010 | Sickness allowances | 320,305 | 826,118,925 |
| 2009 | Sickness allowances | 329,036 | 808,460,083 |
| 2008 | Sickness allowances | 345,179 | 781,004,563 |

Table FIN 2: Sickness Allowance: Number of Recipients

| Time | Benefit | Recipients |
|------|----------------------------|------------|
| 2014 | Sickness Allowance | 304573 |
| 2014 | Partial Sickness Allowance | 13128 |

Table FIN 3: Recipients of Disability Pension in Kela

| Time | Recipients | Average Benefit EUR/month |
|------|------------|---------------------------|
| 2008 | 166 736 | 345,82 |
| 2009 | 167 902 | 361,07 |
| 2010 | 165 686 | 362,77 |
| 2011 | 162 181 | 367,22 |
| 2012 | 156 800 | 385,38 |
| 2013 | 152 163 | 403,16 |
| 2014 | 146 764 | 410,91 |

Source: Kelasto-reports | Kela / Statistics / tilastot@kela.fi / NIT100A

As in other countries, musculoskeletal diseases and psychological disorders are amongst the main causes of sickness absence. The breakdown of sickness allowance days paid in 2014 was musculoskeletal diseases (4.8 million days), psychological disorders (3.6 million), injuries, poisonings (2.3 million) and others (3.0 million).

France

1. Overview of supports during sickness absence

The French system involves a range of different sickness and invalidity benefits for different categories of workers (public sector, private sector, agriculture, self-employed). We focus here on the general scheme for private sector workers. In France there is a sickness benefit payable for up to a maximum of 3 years. In the case of long-term incapacity for work, there is an invalidity pension. Unlike most other countries there have been very limited reforms of the French system and, for example, the invalidity pension system has hardly changed since 1945 (Cour des Comptes, 2012).

2. Description of main payment(s)

In the case of short-term absence there is a sickness benefit (*Régime général d'assurance maladie des travailleurs salariés, RGAMTS*) paid by the relevant social security agency.⁵⁵ Benefits are payable after a waiting period of three days. The benefit pays 50% of the average earnings up to 1.8 times the minimum wage (SMIC). Employers are required to pay some or all of the difference between the salary and the amount of the sickness benefit in accordance with national inter-professional agreement on wages or collective agreement conditions (up to a maximum of 90% of net pay during the first 30 days). Sickness benefit is payable as a rule, for 12 months (360 days) per period of 3 consecutive years; up to 36 months in case of long-term sickness.

Although the general (private sector) population is covered by this scheme the Cour des Comptes⁵⁶ has estimated that 20-30% of employees are not covered by sickness insurance or are only covered by the basic scheme with no supplementary cover (Cour des Comptes, 2012, 7). It also estimated that somewhere between 55-80% of private sector employees were covered by diverse supplementary sickness insurance. These supplementary schemes varied greatly both in terms of their source (collective or individual) and their detail.

⁵⁵ Social Security Code (*Code de la sécurité sociale*), Articles L 323-1, et seq. The administration of the sickness benefit scheme is the responsibility of the local *caisse primaire d'assurance maladie* (CPAM) of which there are over 100. There is also a *Caisse nationale de l'assurance maladie* (CNAM) which is responsible for the organisation of the national system.

⁵⁶ Court of Auditors which plays a similar role to the Comptroller and Auditor General.

In the case of long-term incapacity, there is an invalidity pension (*pension d'invalidité*).⁵⁷

3. Nature of incapacity criteria

In the case of short-term incapacity, sickness absence is prescribed where the person is unable to continue (or resume) work due to a bodily incapacity (*l'incapacité physique*).⁵⁸

In the case of long-term incapacity, a worker who, as a result of a non-occupational accident or sickness, cannot earn more than one third of the normal earnings of a worker in the same category with the same training and in the same region will qualify for a pension. There are three different levels of payment of IP:

| Group | Description | Rate of pension | Average amount of pension (p.m.) | % of claimants |
|-------|------------------------------------|-----------------------------|----------------------------------|----------------|
| I | Medically still able to work | 30% of average earnings | €378 | 23 |
| II | Medically unable to work | 50% of average earnings | €621 | 74 |
| III | Requiring care from another person | As group II plus supplement | €1,466 | 3 |

4. Assessment of incapacity

In the case of sickness benefit, a medical certificate must be provided by a GP or other doctor (or midwife). About 8-10% of GP consultations give rise to a sickness absence certification. GPs provide 75% of certificates with specialists providing the remainder. This must be provided to the CPAM within 2 days of certification. The certificate must specify the cause and likely duration of incapacity. Decisions are made by the CPAM on the basis of this certification. Unlike other countries, there

⁵⁷ Social Security Code (*Code de la sécurité sociale*).

341-1. A recent study by IGAS (Inspection general des affaires sociales) (Roquel et al., 2012) states that in addition to the general invalidity pension regime, there are supplementary pension schemes for more than 200 occupational groups, a dozen schemes for public sector workers, about 20 schemes for non-salaried workers, and numerous individual insurance schemes.

⁵⁸ Article L-321-1 of the Social Security Code.

have been limited studies of the certification process and we have not located any studies of the actual decision-making.

Duflot (2012) carried out focus groups with certifying doctors to identify key factors in their decision making. She found that the issues taken into account included factors such as pathology, intensity of symptoms, pain, risk of contagion, type of illness, occupation and type of work, travel time, health and safety risks, family situation, social context, patient's personality, viewpoint and request for certification, and medical benefits to the person from work absence. Difficulties identified included prescribing for reasons other than medical, lack of expertise re occupational requirements, and identifying the length of absence.

One of the more interesting studies of certification is the sociological approach adopted by Monneuse (2015). He emphasised the extent to which, in practice, certification involves a negotiation between the doctor and the claimant (a factor also found in Duflot's study). Monneuse found that 90% of patients who approached a GP for a certificate were given one. He found that most GPs made some concessions to their patients (due to fear of losing a patient or damaging their relationship of trust) even if this led to unjustified or overestimated periods of sick leave. Interestingly, however, he also found that up to 15% of certificates issued at the initiative of the doctor were refused by the patient.

The CNAM issued guidelines in 2009 setting out indicative durations for sickness absence according to the pathology.⁵⁹ Before being issued these are reviewed by the Haute autorité de santé (National Health Authority). For example, in the case of minor anxiety-depression, the recommended period is 14 days. There does not appear to have been any evaluation to date of the impact of these guidelines.

A study found that five medical problems caused 86% of certification: musculoskeletal 27%, respiratory 25%, psychological 15%, general 12% and digestion 7%. For short-term absence fatigue, fever, and respiratory infections were more common while for longer-term illness (more than 15 days) psychological issues, lumbago and fractures were more prominent (Duflot, 2012). A more recent study found that the health problems most frequently reported in sick leave certificates concerned respiratory (27%), psychological (14%), or digestive (12%) systems; general problems (11%); pregnancy (3.5%); the neurological system (2.9%) (Leguevaquesa et al., 2014). This study found that while sick leave certificates almost always provided justifications for sick leave in nosological terms (i.e. by type of medical condition), less than one third of certificates provided information in functional or contextual terms. It recommended training practitioners to make functional and contextual assessments

⁵⁹ <http://www.ameli.fr/professionnels-de-sante/medecins/exercer-au-quotidien/aide-a-la-pratique-memos/les-memos-de-bonne-pratique/arrets-de-travail-des-referentiels-de-duree.php>

which would allow them better to assess the nature and the duration of sick leave, and facilitate communication around the patient.

It is clear that there are significant regional variations in awards of sickness benefit (Ben Halima, et al., 2011; Cour de Comptes, 2012). For example the Cour des Comptes found a variation from 2.7 days in Paris (average number of sick days per employee) to 12-13 days in a number of departments (i.e. the French administrative district) (2012, 34). These variations are explained, in part, by factors such as the extent of controls, the medical supply (density of GPs) and age when work started (a proxy indicator for human capital) (Ben Halima, et al., 2011).⁶⁰

In addition, there are also significant variations by sector of employment and by occupational type (for example, managers are much less likely to be sick absent than manual labourers) (Commission de affaires sociales, 2013, 13-14). Amongst the factors which increase the rate of sickness absence are age (especially for men), level of sick leave in the last year, full time work and size of enterprise⁶¹ (Ben Halima and Debrand, 2011). The factors which reduced absence were age of commencing work (a proxy for human capital) and level of salary. Absence also varied by sector of employment.

Ben Halima et al. (2015) found that women had sickness absence durations longer than men, age had a negative effect of the chances of exiting sick leave, part-time workers were more likely to exit sickness absence than full-time workers, employees of larger enterprises (10-49 employees) were more likely to have sickness absence than small enterprises, and that sickness absences were shorter where departmental unemployment was higher.

In general, women are more likely to be absent than men. Marbot and Pollak (2015) studied the differences between men and women in sickness absence. They found that pregnancy explained about 30% of the difference. However, they also found that low paid women were much more likely to take sick leave than better paid women or low paid men.

In the case of the invalidity pension, decisions are made by social insurance doctors employed in the local medical service (ELSM). A recent study by Roquel et al. (2012) has highlighted the lack of any oversight of how decision-making is carried out and the lack of any guideline for decision makers. The only procedures found by the

⁶⁰ Departments which have low GP density increases the possibility of sick leave (though one might speculate as to whether this relationship is causal or whether the low density of GPs is simply a proxy for other socio-economic factors).

⁶¹ It is speculated that individual control is lower in large enterprises and (perhaps more likely) large enterprises are more likely to have reinsurance.

report which would contribute to a standardisation of decision-making were the employment of medical professionals, initial training and collective case studies (2012, p. 40). The study found that there strong regional variations in the level of IP awards in different departments. Refusals of claims varied from 13% in one department up to 30% in another (with an even wider level of variation between offices from 9-54%). There is also a wide variation in terms of the number of pensions granted per 100,000 population from 167 in one department up to 341 in another (Roquel et al., 2012, 42).⁶² The study concluded that this variation could not be fully explained by variations in health status or the employment situation.

On average persons moving onto IP have been absent from work for 2 years and are aged about 50 years old (Cour des Comptes, 2010).⁶³ The main causes of invalidity are mental disorders (27%) and ostéo-articulaire (musculoskeletal) (25%).

In general, there appear to be very weak links to return to work for those on invalidity pension (Roquel et al., 2012).

5. Review and appeals

In the case of sickness absence, there is a complicated system of measures to control the claim although one might wonder how effective these are in practice. The rules have been tightened up somewhat in 2010, and in 2013 2.5 million administrative and medical controls were carried out. However, recent reports by the Cour des Comptes (2012) and by a Parliamentary committee concluded that the controls had limited impact (Commission de affaires sociales, 2013).⁶⁴

In principle, the claimant is supposed to remain at his or her home except during periods specified on the certificate by the doctor. The CPAM may make home visits and/or may call the claimant for examination by its medical service. The home visits are unannounced and the inspector is normally not a doctor. If the CPAM decides that the absence is not justified it can terminate the benefits. The Cour des Comptes found that the control by the CPAM of the person's presence at home varied greatly.

⁶² Indeed there are also important variations in the level of claim for IP between different departments (2012, 43).

⁶³ Again there are significant variation sin the prior duration of sick leave arising from variations in the system of control (Cour des Comptes, 2012).

⁶⁴ A recent Bill proposed by Opposition MPs which aimed to tighten up controls was rejected by Parliament.

Claimants who receive supplementary employer benefits are required to make themselves available for a control visit (usually by a doctor) organised by the employer. These visits are at the home of the claimant and may be unannounced. If the doctor is unable to find the claimant or decides that the sickness absence is unjustified, the employer may terminate any supplementary payments and should notify the CPAM which may decide to suspend the public benefit. However, in the majority of cases to date, the CPAM does not accept these notifications as justifying a termination of benefits (either because they are sent late or because the doctor was unable to see the claimant).

Since 2007, a systematic control of long-term claims has been put in place at 45 days (formerly 60 days from 2005 and 90 days before that) whereby the medical assessors of the CPAM call persons for review. These make up 90% of all controls carried out by the CPAMs. Unfortunately, there does not appear to have been an evaluation of the impact of this change. However, some impression of its effectiveness may be gained from the fact that in 2011 the aim for the medical services was to assess 95% of these claims within a period of 120 days (Cour des Comptes, 2012). And the intention was to review 70% of these claims on the papers only, with 30% being called for re-assessment.

The Cour des Comptes (2012, 87) found that, despite some improvements since 2004, the oversight of medical awards of sickness benefit. It found that one quarter of all sickness absences had been controlled by the medical services in 2008. These mainly focussed on long-term absence (45 days or more) and shorter-term absences received very little attention. However, as noted elsewhere, even the longer-term controls appear to be of rather limited effect. The Cour found that, for short-term absences, the percentage of negative reviews varied from 5% to 40% from one office to another (ELSM). One quarter of ELSMs had a level of negative decisions below 10% while one quarter rejected over 20%. Similar variations could be seen for longer-term reviews (2012, 90).

In the case of invalidity pension, the pension may be revised if the circumstances change. However, the Cour des Comptes (2010) found that revisions were very infrequent. In 2008, only 3% of total claims were revised and two-thirds of these were at the initiative of the claimant. The revisions led to an increase in pension in 50% of cases and a reduction or termination in only 4% (46% unchanged).

There is a rather complicated system of appeal depending on the issue involved. Some issues which involve the employer are considered part of employment law and would be subject to appeal to the employment tribunal (conseil des prudhommes). Others are subject to appeal to the general *tribunaux des affaires de sécurité sociale* (social security appeals tribunal). Finally, on disability assessment issues, a first appeal can be made to the regional CPAM office. This includes a further medical evaluation. Subsequently, there is a right of appeal to the *tribunal du contentieux de*

l'incapacité (Disability Appeals Tribunal) with possible further appeal to the general courts. However, the Roquel et al. (2012) report noted that the appeal system had not led to any common principles in relation to the definition of invalidity or to any detailed case law as to how the concept should be interpreted.

There have been a small number of recent cases in which the procedures concerning disability appeals have been considered by the ECtHR. In the case of *Augusto v. France*,⁶⁵ the Court of Human Rights followed its general approach and held that all medical reports which were relied on by the courts must be provided to the appellant.

6. Overall assessment

Although there have been a number of recent studies of both the sickness benefit (Cour des Comptes, 2012; Commission de affaires sociales, 2013; 2014) and invalidity pension system (Cour des Comptes, 2010; Roquel et al., 2012), there has been very limited reform of either. In the case of the sickness benefit scheme, the Cour (2010) found that there was a lack of proper analysis of the system which would allow for better regulation; that policies vis-a-vis different actors (employees, employers and medical) need to be strengthened; and that there was a need to modernise the service to improve the quality of service, improve productivity of the CPAMs and reduce costs. A subsequent more detailed study by the Cour des Comptes (2012) found that the system of sickness insurance was very complicated, identified a range of issues with the management of sickness benefit (including its assessment of the limited control discussed above), and again set out a range of proposals for reform.

There was a significant rise in sickness claims between 1997 and 2002 (34%). These fell back after 2003 and this was largely attributed to intensified control (Kusnik-Joinville et al., 2006; Lé and Raynaud, 2007; Behaghel et al., 2011).⁶⁶ However, although an enhanced review of long-term claims was put in place after 2005 (see above), there has again been a rise in claims in recent years. The number of sick days rose by 5% from 2008 to 2012 (from 195.3 million in 2008 to 204.7 million in 2012). This has been due largely to increased duration for longer-term claims (Commission de affaires sociales, 2014). The rise has been attributed to a number of factors including the ageing of the population and dis-improvements in conditions of work (Commission de affaires sociales, 2013, 15-16). However, it does call into question

⁶⁵ 71665/01, 11 January 2007.

⁶⁶ The number of controls on short-term claims rose from 34,000 in 2003 to 250,000 in 2005.

whether the dip after 2002 was due to increased controls or (if it was) why these controls have failed to have an impact on the recent rise.⁶⁷

Studies have looked at the effect of the level of sickness benefits on sickness absence. Ben Halima et al. (2015) found that the level of supplementary benefit had a very significant and negative effect on leaving sickness absence.⁶⁸ However, Grignon and Renaud (2007) found that the individual propensity to take sick leave was mainly influenced by strain in the workplace and by labour force composition. Perhaps surprisingly, Pollak (2015) found that employees who were entitled to supplementary sickness benefit during the three day waiting period were not more likely to have an absence during the year but did have significantly shorter absences.⁶⁹

The Court des Comptes (2012) found that the administrative and medical controls in relation to sickness insurance varied greatly depending on local practices, were insufficient and were of limited effectiveness (2012, 9).

In the case of invalidity pension, access to such pensions has played a less important role in early retirement in France than in other countries such as Netherlands and Sweden. However, this is not because of any particular factor related to the invalidity pension but because access to early retirement has been very easy in France due to the low age of retirement, ready access to early retirement schemes (at least in the past) and unemployment benefits (Behaghel et al., 2011). The detailed study of the evaluation of invalidity in France was rather critical of the lack of any standardised approach in this area and set out a range of recommendations to improve the situation. However, although the relevant Ministry has begun to study a response to these recommendations, there do not appear to have been any reforms to date.⁷⁰

7. Data

Due to the complexity of the system it is very difficult to get an overall estimate of the cost of sickness and invalidity claims in France. A recent Parliamentary

⁶⁷ Lé and Raynaud, 2007 suggested that such controls were likely to experience diminishing returns.

⁶⁸ However, Ménard and Pollak, 2014 did not find any impact of the extension of supplementary benefits to employees employed for one year (compared to three years before) has any effect on the number of volume of sickness claims.

⁶⁹ No convincing reason was advanced for this pattern.

⁷⁰ Parliamentary Question, 11 February 2014 <http://www2.assemblee-nationale.fr/questions/detail/14/QE/14441>

committee concluded that it was impossible to establish the total cost of supplementary pension schemes.

It has been estimated that the sickness benefit scheme for the private sector cost €6.3 billion in 2011.⁷¹ The Cour des Comptes (2010) estimated that in 2010 the invalidity pension system cost about €7.5 billion.⁷² In any year, about 20% of insured employees take sick leave.

The Cour des Comptes (2012) examined the rise in sickness benefit expenditure for private sector employees and in the sick days over the period from 2000 to 2011. It found that sickness expenditure has grown significantly over the period compared to changes in salary and compared to changes in the number of private sector employees.

It is interesting to note that, despite the lack of major reforms, there has been a significant variation in the level of sickness and invalidity claims in recent years. This emphasises the extent to which such claims are affected by factors such as changes in the composition of the labour force, the age of workers,⁷³ the economic cycle⁷⁴ and the relationship between disability payments and other welfare schemes. For example, in France it is estimated that there are significant numbers of persons (aged 55-59) who could qualify as incapable of work but who are in receipt of unemployment benefits which provide a higher replacement rate (Cour des Comptes, 2010).

⁷¹ This would rise to €9.3 billion including occupational injuries and sickness benefit for the self-employed. There appears to be no reliable estimate of the cost of supplementary schemes.

⁷² Pro rata to the Irish population, this would be the equivalent of about €520m.

⁷³ Studies found that the number of claims for sickness benefit fell with age but that the duration of claims increased (Kusnik-Joinville et al., 2006).

⁷⁴ For example, Lé and Raynaud, 2007 found that short-term sickness benefit claims increased when unemployment fell.

Netherlands

1. Overview of supports during sickness absence

The Dutch sickness and disability system has undergone extensive reform in the last two decades. Responsibility for payment during sick leave was transferred to employers initially for 1 year, later extended to 2 years.⁷⁵ In 2002 a Gatekeeper Protocol was introduced (see below) which sets out detailed structure as to the rights and obligations of employers and employees in cases of sickness absence. The previous disability pension scheme (Wet op de arbeidsongeschiktheidsverzekering, WAO) was replaced in 2006 by a new scheme (Wet Werk en Inkomen naar Arbeidsvermogen, WIA).⁷⁶ At the same time the existing stock of disability pensioners were reassessed using new criteria. Experience-rating of disability pension contributions for employers was also introduced in 1998.⁷⁷ There have been several evaluations of the impact of these reforms which are discussed below.

2. Description of main payment(s)

The employer is responsible for continued payment of 70% of wages for 104 weeks (subject to a maximum wage). This percentage can be increased by collective wage agreements.

The WIA covers all risks of inability to work for employees who are unable to work. The occupational disability level is set at 35%. The reforms split the previous all-encompassing disability benefits scheme into two separate programs. The Income Provision Scheme for People Fully Occupationally Disabled (Regeling inkomensvoorziening volledig en duurzaam arbeidsongeschikten, IVA) provides for income in case of full and permanent occupational disability, with no prospect or only a small chance of recovery. It provides benefits to those judged to have an

⁷⁵ Many small and medium employees reinsure against these costs but studies have not found any impact on the rate of sickness absence from an employer's choice of whether to insure or not (de Jong and Lindeboom, 2004). The Sickness Benefit Act (*Ziektewet, ZW*) continues to exist as a "safety net" for employees who do not or no longer have an employer, and in a few special circumstances. This is not discussed in this report but see Pennings (2013, 89-93).

⁷⁶ Work and Income according to Labour Capacity Act.

⁷⁷ Koning (2009) found that the introduction of experience-rating led to a significant fall in claims for disability pension. Van Sonsbeek and Gradus, 2013 found a similar impact and see the discussion in Koning and Lindeboom (2015).

unrecoverable loss of earnings capacity of at least 80 %. These individuals are eligible for full and permanent disability benefits replacing 75 % of gross earnings (subject to an upper limit).

The second provides benefits to those judged to have a loss of earnings capacity between 35 and 80 %, and those that are fully disabled when examined but with the prospect to recover part or all of their capacity. These individuals are eligible for partial benefits or temporary full benefits. Partial and temporary full beneficiaries can receive up to 70 % of gross earnings, but the percentage varies depending on actual work status and significant incentives have been built in to the program to encourage beneficiaries to work to their estimated earnings capacity. For the partly disabled, the emphasis is not on income protection but on the possibilities of rehabilitation; the Return to Work Scheme for the Partially Disabled (Regeling Werkhervatting Gedeeltelijk Arbeidsgehandicapten, WGA) encourages both the employee and the employer to endeavour to rehabilitate the employee.

3. Nature of incapacity criteria

An employee is entitled to sick pay, s 'if s/he has not done the agreed work on the grounds that s/he was unable to do so because of illness'.⁷⁸ Thus 'illness' (including infirmity) must be the cause of the inability to work and illness or infirmity must lead to an 'inability to work'. In the case of sickness absence (up to 2 years), the employer is obliged to reintegrate sick employees: first in his/her own previous work; secondly, if this is not possible, in other suitable work within the company; thirdly, if this is not possible, in work with another employer.

For the disability pensions, a person is considered completely or partially incapable of working when, as a result of sickness or infirmity, he/she cannot earn the same as healthy workers with similar training and equivalent skills normally earn at the location where he/she works or most previously worked, or in the vicinity. No distinction is made as to the cause of incapacity (invalidity or employment injury).⁷⁹

⁷⁸ See Pennings (2013, 82).

⁷⁹ See Pennings (2013, 96-102) for a legal discussion on the approach to defining incapacity to work.

4. Assessment of incapacity

Sickness absence

Sickness certification in the Netherlands is organized quite differently than in other countries and separates treatment from control (Meershoek, 2012; de Jong, 2015). In the Netherlands, only doctors that work for an arbodienst are licensed to assess employees' sick leave claims. Arbodiensten are private organizations that are responsible for advising employers in matters relating to the health and safety of their employees. The main task of the doctors is to inform employers about the legitimacy of their employees' sick leave and to provide socio-medical coaching to employees who have reported ill. They are not involved in treating employees' health complaints. Depending on the agreements made between the employer and the arbodienst, doctors have an initial consultation with sick employees between two days and four weeks after they report ill. Subsequent visits are dependent on the specific nature of the complaints and, again, on the agreements made between the employer and the arbodienst. Most arbodiensten are specialized and work for certain sectors, such as industry, health care and transport.

Meershoek (2012) found that doctors tended to deal with claimants so as to encourage them to 'internalise the implicit norms of active and responsible behaviour' rather than immediately imposing sanctions. In some cases, doctors preferred to grant claims which they did not feel were warranted so as to build up a relationship of trust so as to influence the claimant's long-term behaviour. Meershoek et al. (2007), from a sociological perspective, found that, in practice, assessing incapacity involved much more than formal rational decision-making. They argued that assessment were less a technical matter and more a normative one, i.e. that decisions were 'driven by often implicit, routinely and contextually determined views of what is appropriate in a given situation'. Thus the existence of guidelines and protocols, rather than generating transparency, made 'the complex deliberations on which such judgements are based invisible'.

Return to work

As noted above, employers are responsible for payment of sick pay for the first two years and during that period they are generally not allowed to dismiss a sick employee. Employers are subject to various financial and administrative incentives to recue long-term sickness absence and disability and have a strong interest in ensuring return to work (Everhardt et al., 2011).

In the first two years, employers may only dismiss employees who refuse to cooperate in a reasonable work-resumption plan. Employers have a set of prescribed rehabilitation and accommodation activities that they (via a contracted private

occupational health agency) must provide to try either to retain disabled employees or to find alternative employment for them in this period.

The reforms included the establishment of a 'Gatekeeper Protocol' which sets out a guideline and time-table for employers in case of sickness. The protocol indicate the following steps in the process:

- A sick employee has to contact his employer immediately (same day).
- In case of threatened disability, a problem analysis has to be made by a professional doctor from the health occupational service (within 6 weeks). This professional advises the employer and employee on sickness issues.
- The employer and employee have to make a plan on work rehabilitation and agree on this (within 8 weeks). They have to execute this plan and evaluate it regularly.
- In case of problems or disagreement, both the employer and the employee can ask for an expert-opinion from the Social Insurance Agency (UWV).
- Towards the end of the second year, the employer and employee have to make a reintegration file, in which they report on all rehabilitation activities undertaken. This file is checked by the UWV. When the file is approved, the employee is assessed for a disability benefit.

The system is mandatory and if an employer doesn't meet its obligations it must pay additional sickness benefit. A non-cooperating employee risks losing sick pay during the sickness period and can even be fired in severe cases.

Employers and employees are assisted by professionals (health occupational services, insurance companies) or Gatekeeper Centres (set up by employers). The implementation of the Gatekeeper Law was facilitated by a special Gatekeeper Task Force. All parties concerned are represented: the Ministry, social partners, the insurance companies, and the occupational health services. Its task is to implement the Gatekeeper Law and to solve problems that arise in practice.

As noted above, after a maximum of 6 weeks of sickness an occupational physician has to make a Problem Analysis, i.e. an assessment of medical cause, functional limitations and prognosis regarding work resumption. On the basis of this assessment the employer and sick employee together draft a return-to-work (RTW) plan in which they specify an aim (resumption of current/other job under current/accommodated conditions) and the steps needed to reach that aim. They appoint a case-manager, and fix dates at which the plan should be evaluated, and modified if necessary. The RTW-plan should be ready in the eighth week of sickness.

It is binding for both parties, and one party may summon the other when considered negligent.

Disability pension claims are only admissible if they are accompanied by a report containing an assessment as to why the plan has not resulted in work resumption. The claim is not processed by the UWV if the report is delayed or incomplete or if it is clear that the rehabilitation efforts were insufficient. Depending on the seriousness of the negligence, the UWV can return the reintegration report and give the employer the opportunity to complete it, or the UWV can start a sanction procedure against the employer. In 2007, nearly 11 % of disability insurance claims were returned to employers and the employer continued to be responsible for employing the worker until the employee had returned to work, or sufficient RTW activities were tried the benefit claim was considered admissible.

Assessments of the return to work approach (the Gatekeeper Protocol) indicate that it has been successful in increasing return to work. At the introduction of the Gatekeeper approach, stricter screening was piloted in certain areas, and evaluation showed that it reduced sickness benefit and disability applications (de Jong et al., 2006). One study found that the frequency of contact with the occupational doctor increased return to work (Dutch language studies quoted in van Sonsbeek and Gradus, 2013 and Everhardt et al., 2011). A second found that the full and timely implementation of the Protocol doubled the probability of having returned to work 9 months later. A third found that the Protocol had contributed to about half of the 43% reduction to inflows to disability pension between 2001-4. Everhardt et al., 2011 also found that employer-based vocational interventions (e.g. graduated work resumption) under the Gatekeeper Protocol had a strong impact on RTW. There have been a number of studies of issues concerning RTW for particular groups such as persons with mental disorders (Flach et al., 2012; Noordik, 2013; Witte, 2013; Dekkers-Sánchez, 2013).

Disability pensions

After two years, the employee can apply for a disability pension from the Social Security Office (see Spanjer, 2010). The pension is based on the loss of wage-earning capacity by the employee. This is the difference between what the employee's income was before the sick leave, and what he or she is theoretically still able to earn in suitable work. Assessment is normally by way of face-to-face interview. The first step in this work disability assessment is an assessment of the patient's work limitations by an insurance doctor. These work limitations are recorded in a standardised list – the Functional Ability List (FAL). In this list the insurance doctor registers what work limitations the patient has and their extent. In the next step, a labour expert examines which jobs the employee is still able to perform despite the work limitations as assessed by the insurance doctor. The labour expert is supported by a computer which matches the work limitations as listed in the FAL with a

database of 7,000 occupations that describes the job demands in detail. The occupations selected by the computer are assessed by the labour expert as to their suitability for the individual employee.

The FAL is an important instrument in communicating between insurance doctors and labour experts. The FAL consists of a list of 70 different mental, physical and social items entailed in functioning on the job that are, in turn, grouped into 6 functional domains (Box 1). Each item can be rated as a nominal or ordinal variable on a two-to-ten scale.

Box 1. Domains of the Functional Ability List (FAL)

- I. Personal functioning (9 items)
- II. Social functioning (12 items)
- III. Adjusting to physical environment (10 items)
- IV. Dynamic movement (24 items)
- V. Static movement (11 items)
- VI. Working hours (4 items)

One example is 'walking' which comes under the domain of 'dynamic movement', in which the insurance doctor has to choose among four gradations (Box 2).

Box 2. An example: the item "walking"

Walking

- 0 normal, can walk roughly one consecutive hour (a walk)
- 1 slightly limited, can walk for roughly 15-30 consecutive minutes (a stroll)
- 2 limited, can walk for roughly 5-15 consecutive minutes (to the mailbox)
- 3 very limited, can walk for less than 5 consecutive minutes (indoors)

Insurance doctors in the Netherlands base their assessments on the following data:

- a report from the employer in which the course of the first two years of work disability is summarized.
- medical information from the occupational physician who attended to the first two years of work disability.
- often, but not always, information from treating physicians (such as the primary care doctor or specialists). This is only available if the occupational physician has requested this information (in about half of the cases). The insurance doctor can always request medical information from the treating doctors if the patient agrees to this.
- every patient is seen by the insurance doctor for an interview, observation and, in case of somatic complaints, a physical examination.

It appears from studies that the decision of the insurance doctor concerning work limitations is based, for the most part, on the patient interview (Spanjer, 2010).

As part of the assessment interviews, doctors use standard medical history-taking, including inquiring about symptoms, therapeutic interventions and medication. In addition, they specifically focus their attention on activity limitations and participation restrictions. For instance, the patient is asked how a normal day is spent. Three defined interview protocols are described in the Netherlands (see Annex), but the insurance doctors often use various parts of the three different models in daily practice. The three protocols are:

- **Methodical Assessment Interview:** The interview is semi-structured and has 10 topics including work possibilities, motivation, personal ideas about the pathology, vitality, personal changes, life events, thoughts about the future, medical history, work history and a description of a normal day.
- **Multi-causal Analysis:** This is an interview with a limited structure that includes five broad fields which can be interchanged. These fields include medical history and complaints, functioning, personal characteristics, work factors and personal factors.
- **Disability Assessment Structured Interview (DASI):** This is a semi-structured interview protocol with fixed topics which are largely based on the International Classification of Functioning Disability and Health (ICF). The main topics are: introduction, work, impairments, the limitations to activity that are experienced, participation, the patient's opinion, and the doctor's opinion.

De Boer et al. (2009) carried out a study of the extent to which doctors used these models and found that all used some form of protocol, whether one of the above or their own combination of different approaches.⁸⁰ There was a general consensus amongst doctors about the approach to assessment.

There have been a number of studies of disability assessment by insurance doctors. Spanjer et al. (2009) found that consistency in assessment between insurance doctors was generally reasonable to good. However, they found low consistency in relation to the important issue of the number of hours claimants were able to work.⁸¹ A further study found that both insurance doctors and disability claimants were unable to predict improvements in work capacity with high levels of accuracy (Nieuwenhuijsen et al., 2014). One might speculate that Meershoek et al. (2007) findings as to the normative nature of decision-making may well also apply to disability decision making.

There have been a large number of studies in the Netherlands of approaches to improve adjudication by insurance doctors. However, considerable caution is required in considering these as they are often carried out under 'experimental' conditions (rather than in actual working conditions) and the assessment is based on the views of participants rather than on an actual assessment of the outcome on real-life decision-making. For example, there have been a number of studies of the use of evidence-based medicine (EBM) in disability assessment. Kok et al. (2008) found that a 1-day workshop on EBM led to a significant improvement in self-assessed skills. However, they did point out that in the implementation of any such program attention would need to be paid to organisational barriers which might limit the use of EBM, e.g. lack of time. The same team found that the use of EBM improved the use of evidence in disability evaluation but again without any 'real life' assessment of the implications for awards (Kok et al., 2013).⁸²

Spanjer et al. (2009) investigated the provision of detailed information on participation and activity limitations instead of or as well as medical information. They found that doctors who were provided with only the functional information gave higher disability assessments than those who had only medical information or both medical and functional data.

Other studies have advocated communication skills training for medical assessors (e.g. van Rijssen et al., 2010).

⁸⁰ See also Spanjer et al. (2010) for an assessment of the DASI protocol.

⁸¹ See also Schellart et al. (2011) who found small to moderate variations in the outcome of disability assessments.

⁸² See also Kok et al. (2011).

5. Review and appeals

The position in relation to reviews during sickness absence (Gatekeeper protocol) has been set out above. In the case of disability pensions, claimants are generally reassessed after 1 and 5 years of their initial claim. In the past, these reviews had a limited effect on entitlement but more focussed criteria for review have recently been introduced.

Persons who disagree with the decision taken by the UWV must first file a note of objection with the same body (see Pennings, 2013, 188-89) and, once the objection procedure has been completed, may lodge an appeal with the administrative law department of the district court.

Appeals in relation to decisions by the social security authorities go to the district court (see Pennings, 2013, 190-94 and 197). In cases involving disability appeals, a medical doctor can be appointed by the court to give an expert opinion on the case. This is done on paper. It appears that the view of this independent expert is often quite decisive. A further appeal on a point of law and good administration can be made to the Central Administrative Court (*Centrale Raad van Beroep*). There do not appear to be any recent cases before the European Court of Human Rights concerning disability appeals procedures in the Netherlands.

6. Overall assessment

As in other countries, studies in the Netherlands indicate that there is a relationship between the cash level of disability benefits and the level of inflow to benefits. Van Vuren and van Vuren (2007) estimated that a 5% rise in replacement rates led to a 6% increase in claims for disability pensions.⁸³

There have been a number of evaluations of the different reforms of the sickness and disability systems in the Netherlands. Van Sonsbeek and Gradus, 2013 found that the combined reforms had led to a fall in inflows to disability pension of over 60%, of which the introduction of experience rating led to a 13% fall and the Gatekeeper protocol to a 25% reduction. The study found that most reforms focussed on reducing inflows and that only the re-examination of the disability stock in the mid-2000s had led to a significant increase in disability outflows. Van der Burg

⁸³ See also the discussion by Koning and van Sonsbeek (2015) as to the effect of financial incentives on partially disabled workers.

and Prins (2010) studied the reassessment of disability pensioners in the mid-2000s and found that 20% had been disqualified and 12% had had their disability rating reduced (62% were unchanged and 6% increased). The study found that, of those with reduced or terminated benefit, after 18 months about one third were on unemployment benefits, one third still on Disability Pension and one third received no benefit. However, the percentage in employment increased to about two-thirds over time. They concluded that the reassessment had led to significant savings in public expenditure (although reduced by about 50% by the transfer of some claimants to unemployment benefits).

Koning and Lindeboom (2015) identified the three main areas of reform in disability insurance as (i) enhancing employer incentives to avoid sickness (e.g. experience rating), (ii) increased gatekeeping; and (iii) tightening eligibility criteria. As noted above, they found positive impacts in all three areas in reducing disability inflows with the introduction of the Gatekeeper Protocol consider to the most effective policy measure. They found that the tightening of eligibility criteria had led to a sharp increase in claims refused since 2006 (introduction of WIA). They found (2015, 164) that

The key to the success of disability insurance reform in the Netherlands has been the intensified role of employers in preventing long-term sickness, absence, and subsequent disability, with a strong emphasis on early interventions. The employer incentives increased the economic urgency among employers to exert sickness and accident prevention and workforce reintegration activities, while the Gatekeeper protocol has facilitated employer awareness and guided employers in their new role.

Koning and Lindeboom (2015) found that the percentage of Disability Pension claimants with musculoskeletal disorders had been almost halved as result of the reforms although there had been only small fall in the rate of reduction in awards due to mental disorders (which meant that this group increased as a percentage of new claims).

However, studies have also found some potentially negative impacts from the reforms. In particular, Koning and Lindeboom (2015) concluded that it is likely (although hard evidence seems to be lacking) that employers have responded to the new incentives by employing high-risk individuals on a temporary basis only. The Dutch government has, as a result, decided to extend sick pay and experience rating to such workers from 2016. The researchers also found that while effective in curbing inflows, the reforms had been less effective in using the residual work capacity of disability pensioners (perhaps unsurprisingly).

7. Data

There has been a long-term fall in both the numbers on disability pension and the cost of pensions (de Jong, 2015).

The Dutch statistics indicate that there were almost 210,000 persons in receipt of a disability pension (WIA) at the end of 2014.⁸⁴ Of these 49% were men and 51% women and 79% were fully disabled while 21% were partially disabled. This represented a significant increase from 186,000 in 2013 (12.4%). The number of new claims in 2013 and 2014 was about 37,000 per annum.

The longer term trends are analysed by Koning and Lindeboom (2015) who show that the level of awards of disability pension fell significantly after about 2002 with the percentage of the insured population on DP falling from about 11% to 7.2% in 2012 and the percentage of the insurance population being awarded a new claim for DP falling from 1.5% in 2001 to 0.5% in 2012. As in other countries the main diagnosis types for disability pensions are musculoskeletal disorders and mental disorders (Koning and Lindeboom, 2015).

In 2014, about 34,000 claims were terminated. The main reason for this was assessment as being no longer disabled (recovery) (35.6%), followed to retirement (33%), death (23.3%) and other reasons (8.1%).⁸⁵

⁸⁴ Data is taken from UWV, 2014. On a pro-rata population basis, this would be equivalent to about 58,000 claimant in Ireland

⁸⁵ 39% of claimants are in the age range 55-64 years.

Annex NET: Disability Interview Protocols. The description of three disability interview protocols, procedure and topics.

Interview of Methodical Assessment (IMA)

1 The IMA protocol describes ten topics that need to be addressed by at least one question and more if the Social Insurance Physician] (SIP) thinks the topic to be relevant to the case he is handling. The topics are clustered into topics that permit the claimant to state his claim and topics that permit the SIP to check on plausibility and consistency. The topics are best addressed in the sequence of the protocol and for the first three topics, this is mandatory. The description of the IMA contains many detailed instructions on how to ask specific questions and how to interpret answers. This enables the SIP to draft a complete picture of the claimant in his situation.

2 The IMA protocol requires a precise introduction, in which the aim and procedure of the assessment are explained and in which the SIP stresses that the claimant's opinion of his actual situation is of great importance and that the opinion of other people (for example, the treating doctor) and events of the past will be dealt with later on during the interview. The claimant is asked to agree with these rules. Thus, the SIP introduces rules for the interview that challenge the claimant to show his self-consciousness and autonomy. This enables the SIP to see if the claimant is able to follow these rules.

3 A physical examination, if necessary, is scheduled after the interview.

4 After each topic, a summary is given by the SIP and after the entire interview, a general summary is given. After each summary, the claimant is invited to comment on it. At the end, the SIP gives his provisional opinion and explains the further procedure.

1) Claim items:

- Work description: *Would you please describe the work you used to do?*
- Claimant's perception of his capacity for own work: *Do you think you could do that work now, fully or partly? If not, what do you experience in your health that prevents you from doing it?*
- Claimant's perception of his capacity for other work: *Do you think you could do other work? What would that need to look like?*

2) Items to check:

- Motivation: *How do/ did you like doing the work you used to do?*
- Claimant's perception of the cause of disease and handicap: *What do you think to be the cause of your being ill and disabled?*
- General Health: *Were you generally healthy and fit before you became disabled?*
- Changes (mental, personal): *Would you say you have changed as a person over the past period of sick leave?*
- Life – events: *Did you experience important events in the years before you reported sick? Which?*
- Claimant's perception of the future: *What do you expect about your future health/ work situation?*
- Activities of daily living: *Could you please describe an ordinary day, e.g. yesterday and indicate what you did, how you managed that and whom you met, in a chronological order?*
- Physical Examination is scheduled at the end of the assessment.

3) Conclusion of the Social Insurance Physician, for the moment, is relative to the claimant's opinion.

Disability Assessment Structured Interview (DASI)

1 The Social Insurance Physician is focused on the differences between the pre-morbid state and the actual state that indicates disease. Another key role is played by concrete and detailed examples that the claimant gives or is asked to give of every activity he performs and of the restriction of capacity that he claims to experience. This serves to reduce possible malingering or aggravation by the claimant. These examples are used to identify residual capacity to work. A semi-structured interview is conducted in which topics are fixed by the SIP but their sequence is free. All topics must be discussed, preferably in order of the protocol, but the SIP can decide to do otherwise. The description of DASI does not give examples of questions but considerations as to why and how the different topics are of importance. The purpose of this method is to reach a systematic assessment of what is to be assessed – the claimant's capacity for work.

DASI has a strong structure; in particular, in topics 3 and 4 the Social Insurance Physician (SIP) asks for concrete and detailed examples, which must be consistent and plausible.

2 In the interview, the SIP explains the purpose of the assessment and the procedure. The SIP summarises the claimant's record. Putting the client at ease, the SIP explains the aim of the assessment.

3 A physical examination is scheduled after the interview.

4 At the end, the SIP states clearly his opinion of the claimant's capacities.

- 1) Work description and perceived burden in the work (*motivation and consistency*).
- 2) Medical history and information on disease: complaints, cause, treatment (*impairments*).
- 3) Claimant's perception of (in-) capacity in examples, if needed, with help of LFC (*restrictions of activities*).
- 4) Actual functioning and problems of participation: current activities and relationships (*focus on capacities*).
- 5) Claimant's perception of his capacity to do his own or other work (*claimant's position in the assessment*).
- 6) Physical examination (*consistency and plausibility*).
- 7) Opinion of the SIP.

Multi Causal Analysis (MCA)

1 MCA is designed to help the Social Insurance Physician to determine the causes of restricted functioning and so to be able to give suggestions to promote a return to work. The approach is biopsychosocial and the disability is primarily conceived of as behaviour. The instruction describes general principles, fields of discussion and the relevance of these. The emphasis is put to the claimant's motivation and hindrances he experiences. The psychological and social aspects are determined as well as medical aspects. All subjects must be discussed but the order is free.

2 The SIP briefly explains the procedure and gives a short summary of the patient's records. A dialogue should be reached fast. A relationship of trust of the claimant in the SIP is necessary. Consequently, the SIP tries to explore the claimant's opinion on his situation. The SIP shows an attitude of empathy, respect and interest by

continually asking questions and by taking subjective perceptions of the claimant into account. There is much room for the claimant to follow his line of thought and for the SIP to decide how he wants to conduct the interview, provided he pays attention to all five fields of the discussion. This leads to a light structuring of the interview. Precise questioning reveals the plausibility and consistency of the image that the claimant puts forward and how serious his incapacity is. The purpose of this method is to reach an understanding evaluation.

3 A physical examination is scheduled after the interview.

4 The SIP's final conclusion is stated clearly to the claimant, who is invited to react to that. The SIP presents his conclusion about limitations in functioning, with room to discuss remarks from the claimant. Then, the SIP explains the further procedure.

- 1) Health and disease (*actual complaints, medical history, treatment and restrictions as experienced by claimant*).
- 2) Work description (*description and stressors*).
- 3) Private situation (*description and stressors*).
- 4) Actual functioning (*micro and meso, activities for the restoration of health and resumption of work*).
- 5) Person (*coping, locus of control etc.*).
- 6) Physical examination.
- 7) Conclusion of the Social insurance Physician, plan of action, if relevant, and plan of evaluation, if relevant.

Sweden

1. Overview of supports during sickness absence

In Sweden, the employer is responsible for payment of sickness pay for the first 14 days (with one waiting day).⁸⁶ After that, the social security authorities pay sickness benefit to persons unable to perform their regular job due to temporary sickness.⁸⁷ The replacement ratio is 80% up to a benefit cap during the first year. After that the benefit is reduced to 75% for up to a maximum of 2.5 further years. In addition to the public benefit, many Swedish employees (about 90% of employees) qualify for additional employment-related benefits negotiated between trade unions and employer bodies. The maximum limit for total compensation is normally 90% but this depends on the agreement.

Persons whose working capacity is permanently reduced are entitled to a disability pension which provides compensation at up to 64% of lost income. Again many individuals have supplementary disability cover which can increase the replacement rate to 79%.

Studies have indicated that there are strong associations between receipt of sickness benefit and the likelihood of going on to receive disability pension (Kivimäki, 2007⁸⁸; Karlsson et al., 2008).⁸⁹

There have been a range of reforms to the Swedish sickness and disability pension systems over the 1990s and 2000s. These include restrictions on the qualification conditions for benefits (e.g. excluding entitlement to disability pensions on labour market grounds), reductions in benefit levels and duration, more rigorous screening (e.g. the rehabilitation chain),⁹⁰ and the introduction of guidelines for sickness

⁸⁶ Sick Pay Act 1991. However, there is a public subvention of high sick pay costs that applies to all employers in Sweden. The policy means that employers can receive compensation for the annual sick pay cost that exceeds a certain level. The objective is that employers should be encouraged to hire people who may be a risk of sickness absence. However, this only amounted to 55 SEK million in 2013.

⁸⁷ Social Insurance Code 2010, section C, chapters 23-31.

⁸⁸ For example, an episode of certified sick leave was associated with an over 3 fold increased risk of receipt of disability pension.

⁸⁹ Karlsson et al. (2008) found that those with higher age, low income, previous sick leave, no employment and non-Swedish origin had a higher risk of disability pension and suggested that this type of study might be useful for identifying risk groups for receipt of DP.

⁹⁰ The rehabilitation chain involves a requirement for an additional work capacity assessment at about the 91st and 181st day of entitlement to sickness benefit. Despite the name, the chain has little to do with rehabilitation.

certification. The government also introduced a rehabilitation guarantee offering cognitive therapy and multidisciplinary treatment for people with mental health conditions. The reforms have been evaluated both by the Swedish Social Insurance Inspectorate (ISF) and by academic researchers and these evaluations are discussed in more detail below.

2. Description of main payment(s)

Sickness benefit (*sjukpenning*) is payable to persons unable to perform their regular job due to temporary sickness.⁹¹ The replacement ratio is 80% up to a benefit cap during the first year. After that the benefit is reduced to 75% for up to a maximum of 2.5 further years. Musculoskeletal and psychological disorders are the most common causes of sick leave in Sweden (see below). It has been argued that in some cases, employees with a diagnosis belonging to these two groups are better off if they do not leave the labour force but instead are supported to remain at work. Therefore, since the late 1990s there has been a focus on the use of part-time sick leave (PTSL) when possible. PTSL is a complex process that requires an initial joint decision made by the employee, employer, physician, and social insurance officer as well as actions and decisions (by the employee, colleagues, and employer) to adjust both the work time and work demands during the period of intervention and afterwards.

Persons whose working capacity is permanently reduced are entitled to a disability pension which provides compensation at up to 64% of lost income.⁹² The current disability pension consists of sickness compensation (*sjukersättning*) paid to persons aged 30-64 years or activity compensation (*aktivitetsersättning*) to persons aged 19-29 with fully or partially reduced work capacity. If the person has a partial disability, a reduced benefit is paid at 25, 50 or 75% of the full benefit according to the assessed degree of disability. Sickness compensation and activity compensation consist of two parts:

- The income-related sickness/activity compensation (*inkomstrelaterad sjukersättning/aktivitetsersättning*) financed by contributions paid by the working population (employees and self-employed);

The tax- financed sickness compensation and activity compensation, in the form of guaranteed compensation (*garantiersättning*) for all residents with low or no income related sickness/activity compensation. As noted, young adults (19-29 years) whose working capacity is reduced for at least one year may be entitled to activity

⁹¹ Social Insurance Code 2010, section C, chapters 23-31.

⁹² Social Insurance Code, Section C, Chapters 33-37.

compensation. The aim of the benefit is to provide special support for this age group and to encourage activity (including school attendance in some cases) while providing financial support (Kaltenbrunner et al., 2013; ISF, 2013:7).⁹³

3. Nature of incapacity criteria

In the case of sickness benefit, the insured person's work capacity must be reduced by at least 25% due to sickness in order to receive sickness cash benefit. Persons who have not lost more than 75% of their work capacity may qualify for part-time sick leave and partial sickness benefit.

In the case of disability pension, the definition of incapacity involves permanent full or partial incapacity for work (by at least 25%), on grounds of illness, or other impairments to the physical or mental capacity for work.

4. Assessment of incapacity

Initial certification

For the first week there does not have to be any certification. From the eighth day, the sickness absence must be certified by a doctor. The insured person's work capacity must be reduced by at least 25% due to sickness in order to receive sickness cash benefit. The sickness certificate should specify medical diagnosis, functional impairment and activity limitation. The doctor must also indicate his or her assessment of the person's ability to work and make recommendations about the degree and length of sick leave. The SSIA grants sickness benefit in about 98% of all applications for sickness benefit (i.e. where sickness certificates have been provided) (ISF, 2014). About 80% of those who terminated their sick leave did so on the day their medical certificate expired, i.e. less than one in five returned to work earlier than the prescribed duration of sick leave.

There have been many studies of the operation of sickness certification in Sweden. For example, Ljungquist et al. (2015) found that over half of GPs found it fairly or very problematic to assess a person's work capacity (58%), to make a long-term prognosis about work capacity (56%) and to handle long-term sickness certification (52%). Löfgren et al. (2007) found that about three quarters of doctors provided

⁹³ However, Kaltenbrunner et al., (2013) state that, contrary to objectives, the system appears to encourage long-term dependency on disability benefits as the majority of those who receive benefits for schooling continue onto regular disability benefits after they leave school.

sickness certification at least a few times a year (50% had at least 6 cases per week and 10% had 20 or more). The main issues identified as problematic from the doctors' perspective were conflicts with patients over certification, assessing work ability, estimated length and degree of absence, and handling cases originally certified by another doctor.⁹⁴ It has been noted that doctors often give into patient demand for sickness certification, even in cases when the doctor feels that sick-listing is not needed (Englund and Svärdsudd, 2000).

It appears that sickness certification and rehabilitation is not given a high priority by doctors who see this as somewhat peripheral to their main activities (Nilsing et al., 2013). A recent study assessing the quality of sickness certificates found that one-third (34%) of the certificates did not contain sufficient information requested, in particular, the descriptions of impairment of body function and activity limitation.⁹⁵ Full-time sick leave was more often prescribed for men than for women and there were significant differences between certificates issued for women and certificates issued for men in the group of musculoskeletal diseases. The study suggested a need for increased knowledge about the descriptions of functioning for sick-listed persons; more cooperation between health professionals and better gender awareness.

One study found that the identity of the certifying doctor had an important impact on rates of certification with GPs with GPs with a long experience of family medicine and doctors working part-time being more likely to issue certificates (Norrmén, 2010).

An examination of a national register of sickness certificates (ISF, 2014) found that the doctor's role was essential in deciding the length and degree of sick leave. It recommended that interventions to affect the duration and degree of sick leave need to include measures aimed at GPs' certification practices.

Diagnosis specific sickness certificates were introduced in Sweden in 2007-2008. The guidelines include suggestions for duration of sick leave spells due to different diagnoses. For example, the guidelines for 'social anxiety' are: sick leave should generally be avoided; work capacity may be temporarily impaired; sick leave duration should be short, 2-4 weeks, and combined with activating treatment and close follow up; Part Time Sick Leave should always be considered; for sick leave periods longer than 3 months cooperation with psychiatry should be established.

⁹⁴ Other studies to look at certification and the views of GPs in relation to sickness absence include Engblum, 2011; Nilsing et al., 2013; Nilsig, 2013; von Knorring et al., 2008; Lindholm et al., 2010. These studies again identified a range of areas considered problematic by GPs.

⁹⁵ See also Söderberg and Alexandersson (2005a) for an earlier study of the quality of sickness certificates which found that only about half (48%) of certificates contained a clear assessment of functional capacity and only a quarter (27%) were clear as to both functional capacity and medical disorder.

Evaluations have come to different conclusions about the impact of these guidelines. A study found that these were being widely used by GPs and that the GPs found them useful (Skånér et al., 2011). Nilsing (2013) found an improvement in the quality of sickness certificates issued between 2007 and 2009 with more relevant details being included (e.g. claimant's type of work). Skånér et al. (2013) also found an improvement in quality of certification. However, Brekke (2014) argues that this has not led to a significant change in the amount of sickness certification. Referring to previous studies, Brekke argues that the effect of guidelines tended to be short-term and has no effect on the amount of sickness certification (see also Englund et al. (2000) who found that an earlier reform of sick-listing practices led to forms being completed more fully but had no effect on duration of sick-listing). In contrast, Lidwall (2013) found that the guidelines had a considerable impact on the termination of sickness absence.

One study found that an experimental reduction in screening whereby the requirement for certification was extended from the eighth day to the 15th day led to an *increase* in sickness absence by 0.6 days (Hartman et al., 2013). Although there was some reduction in certification costs, overall the experiment led to increased public expenditure.

Decision making

Decisions in relation to entitlement to sickness benefit are made by social insurance officers (SIOs) employed by the social security agency. There have been a number of studies of the work of these officials (Söderberg and Alexanderson, 2005b; Ydreborg et al., 2007; Thorstensson et al., 2008). As noted above, in the vast majority of cases, the views of the certifying doctors are accepted by the social insurance officers (98%). Studies indicate that in many cases the certification provided does not provide sufficient information for the SIO to form an independent decision (Söderberg and Alexandersson, 2005a). Other studies suggest that this was also partly due to limited time available (Hensing et al., 1997). The studies of the work of SIOs indicated problems in communications with other health care professionals. SIOs frequently have to contact certifying doctors to obtain further information. In general, decisions are based on the documentation from the certifying doctor although studies indicate that, in some cases, SIOs are in direct contact with claimants either because the claimant contacts them to clarify the status of the claim or because the SIO contacts the claimant to try to clarify some information.

Return to work

One of the functions of sickness certification includes advice on return to work and rehabilitation. However, Söderberg and Alexanderson (2005a) found that information on rehabilitation measures was not included in a large proportion of certificates, particularly those for women (64% of women's certificates and 35% of

men's lacked such information). More recently, Nilsing (2013) found that RTW measures were proposed in only 13% of all certificates and that rehabilitation (i.e. physiotherapy, occupational therapy, counselling or a referral to an occupational health specialist or rehabilitation clinic) was proposed in only 35% of all certificates.

The ISF (ISF, 2012) evaluated the impact of the *rehabilitation guarantee* introduced in 2009. This provided cognitive behavioural therapy (CBT) to persons with light-moderate mental and behavioural disorders and rehabilitation (MMR) for persons with musculoskeletal-related pain in the back, neck and shoulders. CBT reduced sickness absence for persons not already on sick leave when treatment started but MMR *increased* sickness absence for all patients. Perhaps surprisingly, the ISF (ISF, 2011; Engström et al., 2012) found that early interventions to assess the possibilities for vocational rehabilitation were linked to *more* sickness absence and a *higher* probability of receiving disability pension. The study suggested that this negative impact was due to the difficulties of screening those who did need such an intervention from those who did not. It noted that the empirical literature did not provide strong support for reduced sickness absence from vocational rehabilitation.

A recent study of sick leave diagnosis and return to work was able to identify clear differences between rates of RTW for different diagnoses (Lidwall, 2013). High rates of RTW were seen for infectious respiratory diseases, viral infections and less severe cardiovascular diseases while the diseases with the lowest RTW included malign neoplasms, severe mental disorders and severe cardiovascular diseases. The study suggested that systematic use of such diagnostic information could, at a low cost, pinpoint cases at risk for prolonged sick leave. However, it also noted that there were large variations within some diagnostic categories such as mental disorders and musculoskeletal diseases which are the most common causes of sick leave.

There have been limited evaluations of the impact of part-time sick leave. However, recent evaluations indicate that this can lead to higher return to work for both persons certified with mental disorders (at least where it is assigned after 60 days of full-time sick leave) and musculoskeletal diseases (Andrén and Svensson, 2012; Andrén, 2014).

Reassessment (Rehabilitation Chain)

For the first 90 days, working capacity is assessed against the person's existing job, or other temporary suitable work provided by the employer. From the 91st to the 180th days, the worker is assessed against an alternative job with the same employer. Alternatively the worker may be given leave of absence to try to find another job with an alternative employer. From the 181st day, working capacity is evaluated against all jobs on the regular labour market. However, an exception can be made if the person is undergoing rehabilitation and is expected to be able to resume work within 12 months. Fewer than 20% of sickness spells reach 91 days and

fewer than 10% reach 181 days. This assessment is carried out by officials of the SSIA.

The Swedish system involves the use of Social Insurance Officers (or case-workers) employed by the Swedish Social Insurance Agency (SSIA).⁹⁶ They play an important role in deciding whether or not a person is entitled to sickness benefit and/or requires rehabilitation measures. The ISF (ISF, 2014) found that the more positive the case-worker was towards the rules of the SI system and to the operational goals specified at the workplace, the faster people return to regular employment.

The SSIA developed a new model for assessment of a person's capacity for work known as the AFU (activity capacity assessment). This is intended to be used mainly in relation to assessment for all work that normally occurs in the labour market (i.e. after 181 days). It is based on a standardised survey format. The SSIA in conjunction with the Swedish Employment Services had also developed a knowledge-base of requirements in relation to jobs normally occurring in the labour market for use by social insurance officers in the assessment of capacity for work. An evaluation of this new model by the ISF (2015:8) found that there was a lack of clarity about when the assessment should be applied and a lack of uniformity about how it was applied. It recommended process improvements to achieve proper functioning of the new system

However, an evaluation by the ISF of the 'rehabilitation chain' introduced in 2008 (i.e. the requirement that a person be reassessed for work capacity at about the 91st and 181st day of sickness) absence found that introducing time-restricted assessments had strengthened the downward trend in sickness absence (Hägglund, 2010). Large and positive effects on the exit rate from sickness benefit were found around the 181st day and smaller but positive impacts around the 91st day. The reform reduced the number of compensated days by 0.27 days.⁹⁷

Assessment of disability pensions

In the case of disability pensions, the definition of incapacity involves permanent full or partial incapacity for work (by at least 25%), on grounds of illness, or other impairments to the physical or mental capacity for work. The person may apply him/herself, or the social insurance office may propose that a person on a long-term sickness benefit should be granted a disability pension. A claimant may also be advised to apply for disability pension by a doctor, or by officers at the employment office or social services. Social insurance officers always deal with the applications. In one study the social insurance officers handled 100–175 cases at the same time

⁹⁶ *Försäkringskassan* in Swedish.

⁹⁷ While this may seem small, relatively few claimants reach either the 91st or 181st day.

(Ydreborg et al., 2007). The social insurance officer summarises all the information of a case to form the basis for a formal decision by the Social Insurance Board. The decision is based on assessment of the applicant's reduced work capacity due to medical reasons and is based on a medical certificate. The certifying doctor completes the medical certificate with details of diagnoses and treatment, functional limitations, rehabilitation measures, date of recovery, and, finally, whether or not work capacity is reduced. Studies indicate that the medical certificates sent to social insurance offices are of great importance. Findings from studies in relation to doctors' limited knowledge of various working conditions and of changing social insurance regulations also apply in this context. Assessment is normally by way of desk review but cases may be referred to doctors employed by the social insurance agency for a further opinion and for assessments of the need for additional examinations and rehabilitation. The social insurance doctor may refer the client for further assessment by insurance medical specialists such as physiotherapists, qualified social workers, behavioural scientists or physicians with specific competence to improve assessments of work capacity. The decisions of the social insurance board follow the recommendations of the officer reporting the cases in 90% of cases.

Focus groups with social insurance officers highlighted the heterogeneous nature of claims and the difficulty in dealing with some types of illness (e.g. ADHD); delays in obtaining medical certificates and incomplete certification; and differing understandings of the definition of disability amongst different stakeholders (Ydreborg et al., 2007). For example, it was said that certifying doctors may focus on medical issues without a clear understanding of incapacity for work while employment services may refer claimants who they consider lacking in capacity to work but who may not meet the legal criteria of incapacity.

The most common diagnosis groups for newly granted disability pension in 2009-11 were musculoskeletal diseases (32%) and psychological disorders (30%).

In relation to assessment of disability pension a study indicated that there were considerable geographic variations in the level of awards of DP by social insurance boards in different geographic areas for reasons other than 'medical' (Ydreborg and Ekborg, 2004).⁹⁸ The study suggested that the socio-economic situation was one of the factors which affected outcomes while Blomberg (2013) suggested that the variations could be due to local variations in norms and attitudes concerning sickness and disability pension.

⁹⁸ See also Blomberg, 2010.

5. Review and appeals

As we have noted, the Swedish system requires a reassessment of work capacity at the 91st and 181st day. In addition, Swedish law does provide that long-term recipients of sickness benefit or disability pensions should be reviewed at least every three years. The review is carried out by the SSIA and should involve a new assessment of work capacity and the need for rehabilitation. However, a study by the ISF (ISF, 2014) found that such reviews were only carried out to a limited extent and that few involved personal contact with the claimant with most being based on information already held by the SSIA. Few reviews led to a change in the level of sickness compensation. Between 2006-2008, the SSIA carried out a specific project (Pila) to provide more intense follow-up of the cases of persons on long-term sick leave to assess for any remaining work capacity (ISF, 2015:10). This project increased exits from sick leave by almost 30% after six months. However, part of this was due to increased exits to disability pension.

The ISF (ISF, 2013) carried out a survey of refused claims and found that the social security authorities did not fully describe the circumstances justifying denial or sickness benefits in 25% of decisions and that the information given to individuals was insufficient and did not allow them to fully exercise their legal rights.

Persons who disagree with a decision concerning entitlement to sickness or disability benefit can appeal to the general administrative courts. The social security agency must first review the decision. There are three levels of appeal: the county administrative court, the administrative court of appeal and the supreme administrative court. Generally, the administrative courts do not allow oral hearings in relation to disability appeals and there have been a number of cases before the European Court of Human Rights (ECtHR) as to whether this is compatible with Article 6 of the Convention which provides for a 'fair and public hearing'. There have been a number of cases in which the ECtHR has held that an oral hearing should have been held.⁹⁹ However, these cases generally involved an assessment of disability needs and costs. In contrast, in *Döry* the issue was the applicant's ability to work.¹⁰⁰ Here the courts' assessments were entirely based on the medical evidence presented in the form of written opinions. The ECtHR took the view that there was no dispute as to the medical evidence but only as to 'the correct interpretation of written medical evidence'. The Court considered that the appellate courts could adequately resolve this issue on the basis of the medical certificates in question and the appellant's written submissions. The Court noted that the appellant did not

⁹⁹ *Lundervall v. Sweden*, 38629/97, 12 November 2002; *Salomonsson v. Sweden*, 38978/97, 12 November 2002; *Miller v Sweden*, 55853/00, 8 February 2005; *Fexler v Sweden*, 36801/06, 13 October 2011.

¹⁰⁰ *Döry v. Sweden* 28394/95, 12 November 2002.

request the appeal court to call any witness, did not rely on any other oral evidence, and did not state any reasons for her request for an oral hearing.¹⁰¹ Accordingly the Court held that there were exceptional reasons justifying dispensing with an oral hearing in this case.¹⁰²

6. Overall assessment

The basic structure of the Swedish sickness and disability system is long standing and changes have been incremental and parametric rather than paradigmatic. The ISF (2015) concluded that despite decreases in the replacement rate of public benefits, sickness insurance as a whole (public and occupational schemes) provide replacement rates which largely corresponded to the income lost during illness. However, it found that there had been an 'institutional shift' in the provision of income protection from public to private with occupational insurance now playing a larger role. This has increased the complexity of the insurance system¹⁰³ and increased the differences in income protection between different groups in society. Thus the ISF identified a trend towards a more segmented approach with different risk groups divided along socio-economic lines. However, from an external perspective, one might suggest that this overstates the changes which have occurred and it is arguable that continuity is more apparent than change in the Swedish system.

Sweden was not included in the 15 country study carried out by de Boer et al (2004). However, there have been numerous evaluations of specific changes in the Swedish system.

A recent assessment of changes in the level of sickness absence (SSIA, 2014:17) found that it was *not* explained by changes in public health. Rather there were a range of factors including more restrictive regulations and an economic downturn in the 1990s which led to a fall in absence. However, the rise in absence after 1997 may have been influenced by the economic upturn which weakened the 'disciplinary' effect of high unemployment. The decline after 2003 was affected by grants of early retirement, and strengthening of review (such as the rehabilitation chain). In general

¹⁰¹ Although, before the Court, she had argued that the investigation had been inadequate and that an oral hearing was necessary for her to explain matters of importance to the Court's assessment, paras 15 and 34.

¹⁰² *Döry, supra*, paras. 42-44.

¹⁰³ Interestingly the study referred to prior investigations which had found that 25-30% of insured persons did not receive the benefit to which they were entitled from occupational insurance during sickness.

studies have shown that rises in levels of compensation have led to increased durations of sickness absence (Hesselius and Persson, 2007) while conversely, reductions in levels of compensation have led to reduced sickness absence (Johansson and Palme, 2004).

Tightening up conditions of entitlement to disability pensions in the 1990s led to a reduction in the inflows to this pension but, at least in the short-term, did not lead to any increase in the very low rates of return to employment (Karlström et al., 2008). Rather those who would have been on disability pension remained on sickness insurance or went onto unemployment insurance. However, Karlström et al., (2008) suggest that there may have been some more positive longer-term impact with a decreased rate of leaving employment in the relevant age groups. A study of the impact of stricter conditions and time limits for sickness benefits and stricter conditions for disability pensions found that these were modestly associated with an increase in termination of benefits and that transition to disability pensions decreased for men (Lidwall, 2013). Surprisingly, however, transitions to disability pension increased for women. Blomberg (2013) who looked at the effects of the 2008 reform on disability pensions found that the law did have a limited impact on the composition of those in receipt of benefit. Women remained overrepresented but less so than before 2008.¹⁰⁴

Some studies (quoted above) have indicated that guidelines in relation to the content of sickness certificates have led to improvements in the perceived quality of such certificates but without any marked impact of the level or duration of sickness certificates. However, guidelines as to the granting and duration of sick leave have led to a significant reduction in sickness absence. The introduction of time-limited reviews (the so-called rehabilitation chain) also had a significant impact on the level of sickness absence.

There is little to suggest that rehabilitation measures have had a clear positive impact on sickness absence and particularly for long-term disability pensioners there appears to have been limited RTW from any of the reform measures.

7. Data¹⁰⁵

Sickness benefit

The number of sickness benefit recipients rose rapidly from 1999 to 2002, including increasing long-term sickness absence. The number of recipients declined in 2002–

¹⁰⁴ This seems to be inconsistent with Lidwall's finding that women were *more* likely to transition to DB after 2008.

¹⁰⁵ Data is from SSIA, 2014.

2010 and then started rising again. Approximately 530,000 people, 63 per cent women and 37 per cent men, received sickness benefit at some point in 2013 (around 9 per cent of registered insured 16–64 year-olds).

Psychological and musculoskeletal conditions were among the most common diagnoses for both women and men who received sickness benefit in 2013. Psychological conditions accounted for 44 per cent of all cases among women and 32 per cent of all cases among men. Musculoskeletal conditions caused 24 per cent of cases among women and 28 per cent of cases among men.

Partial sickness benefit was encouraged by the Government and the proportion of partial sickness benefit days increased in the early 2000s but declined again after 2007. Approximately 30 per cent of sickness benefit days for women and 24 per cent for men were partial in 2013. This is most common among people with a psychological diagnosis.

Disability pension

There has been a significant fall in claims for disability pension in recent years. The number of people who were granted sickness compensation steadily declined in 2004–2011 but began rising again in 2012 and reached almost 12,000 in 2013. Activity compensation was granted to approximately 7,300 people younger than 30 in 2013. In contrast to sickness compensation, there has been a significant increase in these numbers.

The proportion of partial sickness compensation and activity compensation has varied over time but has consistently been more common among women than men. A total of 32 per cent of women and 21 per cent of men on disability pensions in December 2013 were receiving partial compensation.

Conditions of the musculoskeletal system, etc., represented the most common types of diagnoses for people who were granted sickness compensation until 2005. In 2006–2013, psychological conditions represented the most common types of diagnoses. Psychological conditions accounted for 43 per cent of sickness compensation among women and 39 per cent among men in 2013.

Overall costs

Sickness insurance expenditure amounted to 27,941 SEK million in 2013 and disability pension to 47,722 SEK million.¹⁰⁶ This represented 0.74 and 1.27% of GDP respectively. This does not include the full costs of sick pay paid by employers.

¹⁰⁶ Equivalent to approximately €1.5bn and €2.5bn respectively if adjusted pro-rata to Ireland's population

United Kingdom

1. Overview of supports during sickness absence

There are three broad categories of social security benefits in the United Kingdom: contributory, non-contributory categorical and non-contributory income-related. The contributory benefits include the contingencies of sickness and disability. Contributory benefits for sickness and disability are paid at a single prescribed flat rate, on the basis of the claimant's contributions record during the relevant income tax years. The cost of most of the contributory benefits and their administration is met from the National Insurance Fund, which is financed largely by employers' and employees' National Insurance contributions and the Fund's investment income. Income-related benefits are non-contributory and means-tested, designed to provide a minimum level of income for those out of work without means, or as a top up to other benefits or low wages or for workers with disabilities. Within this framework the UK provides a range of sickness and disability-related financial support which, in addition to benefits and tax credits, also includes direct payments, grants and concessions. This report focuses on Employment and Support Allowance (ESA), which has both a contributory and non-contributory income based element and is described in more detail in section 2 below.

2. Description of main payments

The benefits discussed in this section are Statutory Sick Pay (SSP) and the evolution of Sickness and Invalidation Benefit to Incapacity Benefit to Employment and Support Allowance.

Statutory Sick Pay

Statutory Sick Pay (SSP) is a legal minimum allowance paid and administered by the employer for up to 28 weeks to an employee who is incapable of work for four or more days in a row. To qualify the claimant must be working under a contract of service (ss 152-5 and Schs 11 and 12 SSCBA 1992).

Statutory Sick Pay was first introduced in April 1983. 'Its aims were, and still are, to provide a prescribed minimum amount of sick pay to employees unable to work because of short-term illness; to cut out duplication of cover between the state and industry by building on employers' occupational sick pay schemes; and to provide as simple a scheme as possible for employers to administer while at the same time

protecting the interests of employees –Statutory Sick Pay Bill.’ (*House of Lords, 1994*).

Sickness and Invalidity Benefit → Incapacity Benefit → Employment and Support Allowance

Incapacity Benefit replaced Sickness and Invalidity Benefit from 13 April, 1995. Incapacity Benefit was paid to a person whose work is interrupted by sickness, who was not entitled to Statutory Sick Pay and who satisfied the contribution conditions (unless the incapacity was the result of a prescribed disease or an industrial injury in which case the contribution conditions were deemed to be satisfied) (ss31 and Schedule 3, para 2 SSCBA 1992).

Incapacity Benefit was payable at three different rates. The short-term lower rate was payable for the first 28 weeks of incapacity; from weeks 29-52 the short-term higher rate was payable, and after one year, the higher rate. The long-term rate could be payable from week 29 to persons in receipt of the Disability Living Allowance (DLA) care component paid at the highest rate or to persons who were terminally ill.

On 24 January 2006, in the Green Paper 'A new deal for welfare: Empowering people to work', the then Labour government set out its intention to introduce a new 'Employment and Support Allowance' (comprising contributory and non-contributory components), to 'simplify the current system' (Department for Work and Pensions, 2006; House of Commons, 2006). The Government published its Welfare Reform Bill on 4 July 2006. The measures in the Bill, together with other welfare reform measures, were intended to enable the Government to realise its aspiration of an 80 per cent employment rate for people of working age and an inclusive society where there is opportunity for all. In addition to the new Employment and Support Allowance the Bill included:

- 'A focus on early intervention, with increased support to employers and employees in managing health in the workplace; improved absence and return to work management; and increased support to health professionals to enable them to provide holistic treatment plans which recognise the benefits of work with respect to rehabilitation and long-term health.
- More customer contact and more employment advice and support for individuals with health conditions to enable them to realise their ambition to return to work, building upon evidence from the ... Pathways to Work pilots.
- The ongoing development of disability rights to provide a level playing field for those with disabilities' (Department for Work and Pensions, 2006).

The Bill became law in 2007, and the Employment and Support Allowance Regulations were implemented in October 2008. Reforms to the system of assessment of incapacity accompanied the introduction of Employment and Support Allowance and are described in section 3 below.

Employment and Support Allowance is an integrated contributory and income-related allowance that from October 2008 replaced Incapacity Benefit and Income Support paid on the grounds of incapacity for all new claimants. It is paid at three different rates; the assessment rate (equivalent to Jobseeker's Allowance) is paid for the first 13 weeks while the claimant undergoes the Work Capability Assessment (described in sections 3 and 4 below) to assess their entitlement and the support they would need to get back into work. Provided the medical conditions are satisfied, most claimants will receive the Work Related Activity rate. However, there are sanctions attached for non-compliance with conditions of entitlement – receipt of the Work Related Activity rate is conditional on claimants undertaking work-related interviews, agreeing an action plan and participating in some form of work-related activity. If claimants do not fulfil these obligations, Employment and Support Allowance is reduced in a series of tranches, ultimately to the level of the baseline Assessment Rate. Claimants with the most severe health conditions or disabilities are paid the Support Rate set at a higher level than the Work Related Activity rate without the need to fulfil other conditions.

Eligibility criteria for Employment and Support Allowance are that an illness or disability affects ability to work and the person is:

- under State Pension age
- not getting Statutory Sick Pay or Statutory Maternity Pay or Jobseeker's Allowance
- and satisfies the income and savings rules.

A recipient of Employment and Support Allowance may carry out 'permitted work' and earn up to £20 a week; work for less than 16 hours a week and earn up to £104 a week, for 52 weeks or less (or for any length of time if in the Support Group); or carry out 'supported permitted work' and earn up to £104 a week. 'Supported permitted work' must be part of a treatment programme, or supervised by someone appropriate from a local council or voluntary organisation. Voluntary work does not usually affect entitlement to Employment and Support Allowance. (Gov.uk, <https://www.gov.uk/employment-support-allowance/eligibility>).

3. Nature of incapacity criteria

In the case of statutory sick pay, a person may be entitled to sick pay if their illness causes a period of four or more consecutive days of 'incapacity for work'.

There have been a number of reforms of the test for long-term benefits. Invalidity Benefit (established in 1972) was replaced by Incapacity Benefit in 1995. At the same time, the All Work Test was established as the medical test to determine eligibility (Houses of Parliament, 2012). Prior to 1995, entitlement to Invalidity Benefit had been decided by an Adjudication Officer, based partly on the opinion of the claimant's own GP. 'The government felt that medical assessment had to become more objective and rooted in occupational health to ensure that benefit was claimed only by those who genuinely needed it.' (Houses of Parliament, 2012: 1). In April 2000, the 'All Work Test' was renamed the 'Personal Capability Assessment' under the slogan '*a new test that will focus on ability rather than disability*'.

The Work Capability Assessment replaced the Personal Capability Assessment in 2008 alongside the introduction of Employment and Support Allowance. The Work Capability Assessment is a functional test that examines a range of activities relating to physical and/or mental, intellectual and cognitive performance, to determine if a person can reasonably be expected to work or undertake work-related activity (Department for Work and Pensions, 2015). The stated aims of the Work Capability Assessment are to:

Ensure that those who currently have limited capability for work or work-related activity are identified. Accurately identify those who, despite their condition, are fit to continue to work. Provide a fairer, more accurate and more robust assessment of the level of a person's functional ability in relation to capability for work in the modern workplace. Identify, for those who have limited capability for work, interventions that would help to support recovery such that return to work would again become an option. (Department for Work and Pensions, 2015: 22).

At the same time, the government introduced a 'Work Programme' to enable people to return to the workplace. The Work Programme is a single package of support providing personalised help for everyone who finds themselves out of work regardless of the benefit they are claiming. (Department for Work and Pensions, 2015: 22).

The Department for Work and Pensions' Training Manual for Health Care Professionals explains the Work Capability Assessment as follows. The WCA is based on 'descriptors'. Descriptors are defined in the legislation and 'describe' a restriction in an activity – for example 'Cannot single-handedly use a suitable keyboard or mouse'. The descriptors are presented in a hierarchical manner and attract various

points. The descriptor representing the most severe level of disability is at the top in each activity. This highest descriptor will attract 15 points meaning the person will be considered as having limited capability for work. In many of the situations, this will also mean the restriction is so severe that the person would also be considered as having limited capability for work-related activity. Within the WCA, there are a number of assessments:

- Limited Capability for Work-Related Activity (LCWRA) Assessment – This aims to identify the most severely disabled where interaction with work-related activity is not required.
- Limited Capability for Work (LCW) Assessment - This aims to identify those people who currently have a limited capability for work but who would benefit from assistance and support with work and health related activity to maximise their full potential. (Department for Work and Pensions 2015: 21).

Certain well-defined groups are exempt from the test on the grounds that their level of functional impairment is such that they would clearly be found incapable of work. The exempt groups consist of those with specified severe and progressive conditions or severe disabilities. In addition, those who are terminally ill and claimants in receipt of the highest rate care component of Disability Living Allowance are exempt.

The 2012 amendments to the Employment and Support Regulations 2008 impacted on several areas of the Work Capability Assessment process including the wording to some of the descriptors (Department for Work and Pensions 2015).

4. Assessment of incapacity

Sick pay

In the case of statutory sick pay, certification given is by the person's doctor (normally the GP). In the UK, arising from the Review into the Health of Britain's Working Age Population in 2008, the sickness certificate was revised into a Statement of Fitness for Work (or Fit Note). The purpose is to move the emphasis from certification of incapacity to a focus on capacity. Studies indicate that workers and doctors have a generally positive view of the reform although the impact on certification is less clear (Hann and Sibbald, 2012; DWP, 2013; Shiels et al., 2013; Coole et al., 2015). However, it is quite possible that such changes will take a number of years to have a full impact.

There have been a number of studies of sick certification in the UK including Campbell and Ogden (2005) who looked at the factors likely to influence the decision to issue a sick certificate. They found that doctors were more likely to issue

certificates to persons with psychological problems. Wynne-Jones et al. (2010) reviewed studies from the UK and Scandinavia and identified three main themes: conflict, role responsibility, and barriers to good practice. Conflict was predominantly centred on conflict between GP and patients regarding the need for a certificate, but conflict affects all stakeholders. Role responsibility focused on the multiple roles GPs had to fulfil, and barriers to good practice were identified both within and outside the healthcare system.¹⁰⁷

Work Capability Assessment

The procedure making a claim for Employment and Support Allowance is set out in detail in the Department for Work and Pensions' Training Manual for Health Care Professionals. The initial claim for ESA is made to Jobcentre Plus, by telephone in the majority of cases. All initial and re-referral claims are subject to a 'file work' process to determine whether a face-to-face assessment is required. The file work process aims to identify claimants where a certain level of disability can be confirmed without the need for a face-to-face assessment. If at the time of the claim, the claimant indicates they are terminally ill, the case is sent straight to the contracted Health Care Professional for advice (formerly Atos and now Maximus – See below). All other claimants will be asked to provide a Fit Note from their GP detailing their diagnosis. In most cases, the claimant is sent a form that they are expected to complete. This form gives the claimant the opportunity to provide details of their illnesses, treatment and functional abilities and restrictions. If a claimant has a mental function problem there is no compulsion for them to complete this form. In initial claims, the Decision Maker will refer the case to the Health Care Professional for advice on whether there is evidence that the claimant has limited capability for work/limited capability for work-related activity. At file work, a Health Care Professional reviews the Fit Note details as well as any information made available by the claimant, and may decide that further medical evidence is required. This may be requested from any healthcare professional involved in the claimant's care. All information is then reviewed, looking for any evidence that suggests the claimant does not require a face-to-face assessment to determine their level of disability. (Department for Work and Pensions, 2015: 22).

In initial claims, the Health Care Professional may be able to advise which category the claimant falls into, which means they do not need a face-to-face assessment. The examining Health Care Professional will complete an appropriate assessment which is submitted to the Decision Maker, who decides on all available evidence whether the claimant meets any one of the criteria for the Support Group, fulfils the prescribed degree of functional disability for limited capability for work, or does not fulfil the criteria for eligibility to ESA on grounds of disability. If the claimant fails to

¹⁰⁷ See also O'Brien et al., 2008; Wynne-Jones et al., 2009; Money et al, 2010 and many more.

reach the prescribed degree of disability where they would be considered to have limited capability for work, they will no longer be eligible for ESA. (Department for Work and Pensions, 2015: 23-24).

The criteria for determination of limited capability for work are set out in the Welfare Reform Act 2007. The claimant will be considered as having limited capability for work if he/she scores: 15 points in respect of the physical descriptors; or 15 points in respect of the mental function descriptors; or 15 points in respect of the descriptors in a combination of mental function and physical descriptors. In both the physical and mental function categories, the highest descriptors in any functional category attract 15 points. A claimant may reach the prescribed degree of disability to be considered as having limited capability for work if he/she is awarded the highest descriptor in any one physical or mental function category, or through a combination of lower scoring descriptors in a number of functional areas. If the Decision Maker accepts that a claimant does reach the threshold of having limited capability for work, they are placed in the Work-Related Activity Group (WRAG). In this case the claimant will be required to attend a series of Work Focused Interviews (WFIs) with the Personal Adviser (PA). The first Work-focussed Interview will take place after the decision on inclusion into the Work-Related Activity Group. The interviews will be conducted at intervals to suit the claimant's labour market likelihood of employment and needs. During these sessions, the claimant will draw up an agreed action plan of activity which is intended to help them with a potential return to work. This may include interventions such as retraining, education or condition management programmes. Their engagement in this process will result in entitlement to the 'work-related activity' component of ESA in addition to the 'basic ESA' allowance.' (Department for Work and Pensions, 2015: 24).

There has been considerable criticism of the Work Capability Assessment since its introduction. In December 2008, a White Paper 'Raising Expectations' announced a departmental review of the Work Capability Assessment. The review was led by officials within the Department of Work and Pensions and comprised medical experts in the fields of physical, mental and occupational health as well as representatives of employers and stakeholder groups. The group reviewed several thousand cases using descriptor analysis and expert case study to consider the effectiveness of the Work Capability Assessment (ESA Regulations 2008) to accurately establish an individual's capability for work. The cases comprised a wide range of mental health and/or physical problems covering a broad spectrum of levels of disability (Department for Work and Pensions, 2015: 17).

A House of Commons Post Note reported in 2012 that 'The Work Capability Assessment is controversial and has caused tension between the government and disability campaigners. Such groups question key aspects of the reassessment process, including:

- the extent to which the WCA can be used to assess problematic conditions such as mental health disorders or health conditions that fluctuate;
- the scope of the evidence taken into account in assessing eligibility for benefits more generally; versus the reliability of the decision making process;
- the impact of reassessment on disabled people;
- the impact on perceptions of the benefit system.’ (House of Commons, 2012: 2).

The House of Commons Post Note suggests that ‘The WCA is politically sensitive. Disability organisations cite cases of suicide where the coroner has mentioned denial of benefit as a contributory factor. A recently leaked memorandum published in the Guardian suggests the Department of Work and Pensions is aware of the potential impact on claimants.’ (Houses of Parliament, 2012: 2).

While the Post Note identifies ‘a consensus that some form of medical test is needed to determine who is entitled to disability-related benefits’ it reports that ‘a common criticism of the assessment process is that it places too much weight on the face-to-face assessment. Disability groups argue that other factors should be considered. This includes assessment of social factors as well as evidence from a claimant’s own doctor.’ (Houses of Parliament, 2012: 3).

A further ‘common complaint’ identified is that ‘the WCA is weighted in such a way that the mental health needs of claimants are underrepresented.’ The Post note states that a group of mental health experts suggested more descriptors so that a fuller picture of an individual’s capabilities could be drawn and would identify what support the individual needed to find work. They suggested 10 cognitive descriptors – the current WCA has 7. However, the government argues that this was too ambitious and required a substantial redesign of the entire system which could be impractical (Houses of Parliament, 2012: 2).

In the case of *R (MM and another) v Secretary of State for Work and Pensions*,¹⁰⁸ the English Court of Appeal considered the procedures of the WCA in relation to people with mental health difficulties (i.e. people with impaired mental, cognitive, or intellectual difficulties). The Court held that the process for assessing eligibility for employment and support allowance by way of a questionnaire and face-to-face interview placed mental health patients at a substantial disadvantage compared with other claimants. First, there was a greater risk in these cases that the decision maker would not reach the right decision because the information available from the

¹⁰⁸ [2013] EWCA Civ 1565.

claimant would often be insufficient to indicate the true nature and extent of the illness from which they were suffering. Second, the process itself was found to impose greater stress and anxiety on this group than others. The courts had to consider whether the Secretary of State was, therefore, under a duty under the UK Equality Act 2010 to make a reasonable adjustment to accommodate them such as requiring the decision-maker in every mental health case to obtain further medical evidence.¹⁰⁹

A recent review by the House of Commons Work and Pensions Committee (2014) called on the Government to undertake a fundamental redesign of the ESA end-to-end process to ensure that the main purpose of the benefit – helping claimants with health conditions and disabilities to move into employment where this is possible for them – is achieved. The redesign should aim to ensure that the process properly identifies claimants’ health barriers to employment and the particular support they need, so that the conditionality that they are subject to and the employment support they receive can be tailored more closely to their circumstances. The descriptors used in the WCA process should also be reviewed as part of the redesign, as concerns about their effectiveness, and the way they are applied, remain

The Government established an Independent Review of the WCA which has reported annually. The final report (Litchfield, 2014) stated that there remained an overwhelmingly negative perception of the WCA’s effectiveness amongst claimants and supporting organisations. It suggested that if the Government did undertake such a redesign it should take account of a number of key principles:

- Any assessment should not only be fair but be perceived as such
- There must be clarity of purpose - determining benefit eligibility and supporting employment outcomes may not be compatible objectives
- Residual elements of the medical model of disability should be eradicated in favour of a biopsychosocial model
- Departmental staff should be at the heart of the assessment and should drive information requirements
- Any revised assessment should make use of information already provided to the DWP, rather than duplicating effort and incurring unnecessary expense

¹⁰⁹ However, the Upper Tribunal subsequently dismissed this specific case on the basis that the individual applicants could not show that they had been disadvantaged ([2015] UKUT 107 AAC).

- Decision Makers and Health Care Professionals should see a representative range of cases and have appropriate training in the capability impact of common conditions

A briefing paper from the British Psychological Society (2015) also argued that the government should commission an 'end-to-end redesign' of the Work Capability Assessment (WCA) process. The paper cites a growing body of evidence that seriously ill people are being inappropriately subjected to the Work Capability Assessment. It also argues that the Work Capability Assessment 'does not effectively measure fitness for work and that its application is producing inappropriate outcomes for claimants.' To redesign the Work Capability Assessment system, the Society advocates a reliable, valid and fully researched method of assessment to replace the Limited Capacity for Work Questionnaire (ESA 50) and the face-to-face WCA; training in assessment, scoring and interpretation for the test administrators; specialist assessors to assess people with mental, cognitive and intellectual functioning difficulties; supervision of the assessors from qualified clinicians with expertise in rehabilitation, assessment and interpretation; referral routes to specialist assessment and support for those with psychological, cognitive and intellectual functioning difficulties; and appropriate periods of reassessment for people with long-term conditions, based on specialist advice to accurately reflect the prognosis. (British Psychological Society, 2015).

However, the Government is committed to continue with the existing WCA with more minor reforms. The Department for Work and Pensions, in its response to the House of Commons Work and Pensions Select Committee's Report on Employment and Support Allowance and Work Capability Assessment announced a package of measures 'to improve further the support we offer disabled people and people with health conditions.' These included pilots to help better understand what support ESA claimants need to help them move back into work, such as enhanced Work Coach support, for the first six months following completion of the Work Programme. In addition, the company contracted to carry out the Work Capability Assessment on behalf of the Department has been changed in Spring 2015. From October 2008 until March 2015, the assessment was carried out on behalf of the Department for Work and Pensions by a French multinational company, Atos Healthcare. On 1 March 2015 an American multinational company Maximus took over. The Department for Work and Pensions and Atos agreed to end its contract after 'significant quality failures'. Maximus has recruited Disability Rights UK to help with training and re-training its staff. However, Disability Rights UK said in a statement that it believed the work capability assessment system needed radical overhaul and was 'simply not fit for purpose....It is often experienced as punitive, it has no validity and the way it has been delivered is far too often inaccessible, disrespectful and distressing.'

Desk based and face-to-face assessments

Everyone who makes an application for Employment and Support Allowance is sent a capability for work questionnaire (Form ESA50). The completed questionnaire is returned to the Health Assessment Advisory Service where a 'fully trained Healthcare Professional' carries out an initial paper-based assessment. At this first check, the Healthcare Professional looks for information to decide whether a face-to-face assessment is necessary and advises the Department for Work and Pensions (DWP) accordingly. DWP can decide to award benefit to people with the most serious illnesses and disabilities on the basis of the evidence submitted during this first desk-based assessment phase alone. If a claimant is terminally ill, they do not need to take part in the assessment phase or have a medical assessment. Otherwise claimants must attend a face-to-face Work Capability Assessment conducted by a Healthcare Professional. The majority of people, after submitting an ESA50 form, will be required to undergo a medical assessment (Work Capability Assessment).

Claimants treated as having limited capacity to work

Certain claimants are treated as having limited capacity to work and do not have to undergo a WCA. These include hospital patients, persons who are terminally ill or undergoing cancer treatments and certain other treatments (e.g. for chronic renal failure), pregnant women where there is a serious risk of damage to her health or the health of the child, etc.¹¹⁰

5. Review and appeals

There are two stages to the appeal process. Before making an appeal a claimant who disagrees with a decision must within one month of the date of a decision request a 'mandatory reconsideration'. Mandatory reconsideration involves a Jobcentre Plus Decision Maker reviewing the Health Care Assessor's report and or any new evidence provided to support the reconsideration. To request a mandatory reconsideration a claimant must write to the Department for Work and Pensions stating the reasons they want the decision reconsidered including why they believe that the decision is wrong and including any supporting evidence. An appellant is legally entitled to access the Health Care Assessor's report under the Medical Records Act. Following reconsideration a 'mandatory reconsideration notice' is issued to the claimant.

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/439831/admu2.pdf

If a claimant does not agree with the outcome of the mandatory reconsideration they can appeal to the independent Social Security and Child Support Tribunal within a month of the date of the mandatory reconsideration decision. Late appeals up to 13 months after the date of the original decision, may be accepted if someone was ill or in hospital or coping with bereavement. The tribunal is comprised of a judge and an independent doctor. The relevant legislation governing tribunals is provided by the Tribunal Procedure (First-tier Tribunal) (Social Entitlement Chamber) Rules 2008 as amended (Ref: SI 2008 No 2685). These rules, from October 2014, include changes made to the original rules in 2008.

An appellant may choose to be present at the tribunal hearing or have the appeal decided on the basis of their application form and supporting documents. An appellant may have a representative, for example, a friend, lawyer or other advocate, at the hearing and request necessary arrangements for mobility or other health issues. Reasonable expenses are payable for loss of earnings, transport, subsistence etc. The tribunal's decision may either be reported at the hearing or by post.

A decision can be further appealed to the Upper Tribunal (Administrative Appeals Chamber) on the grounds of legal error. Decisions of the Upper Tribunal are appealable on points of law up through the hierarchy of courts to the Supreme Court.

A House of Parliament Post Note reported in 2012 that 'There is currently a backlog, with appeals taking, on average, 24.7 weeks in England, though this is falling. This is problematic for government and claimants. During the appeal process claimants will be on a lower rate of benefit. While in 2010/11, tribunals cost £42.2m. Since re-assessment of incapacity benefits claimants began in 2010, 41% fit-for-work decisions have been appealed and 38% of these have found in favour of the claimant. DWP notes that this does not necessarily mean that the claimant's WCA was flawed. Extra evidence – such as from the claimant's doctor – can be made available at appeal which may not initially be available to Jobcentre Plus. Further, it has been shown that claimants who have representation from rights organisations stand a much bigger chance of being awarded ESA after appeal than those who do not.' (Houses of Parliament, 2012: 2).

6. Overall assessment

As in other countries, disability pensions have been under reform in the UK since the mid 1990s. A recent review has identified a number of lessons from these reforms (Banks et al., 2015). These are:

- reforms concerning eligibility for disability benefits can reduce benefit levels from the levels they otherwise would have reached.
- when calculating potential cost savings from disability reforms, it is important not to consider a single programme in isolation, as some of the reduction in spending on disability benefits led to higher spending on other benefits
- receipt of disability has now become even more closely related to education level than in the past, and low-education 25–34 year-olds are now twice as likely to be on disability benefits as the highest-education 55–64 year-olds
- as a greater share of women enter the labour force, a greater share are also eligible for and receiving disability benefits.
- there is systematic growth over time in the proportion of claimants in any age and sex group with mental and behavioural disorders as their principal health condition,
- the evidence with regard to reforms that seek to expedite movements back to employment is mixed.

These reforms have focused on longer-term disability. However, the Government has also begun to focus on the role of employers and sickness absence. As we have seen the Government established an independent review of sickness absence (Black and Frost, 2011). This study highlighted that 140 million working days are lost every year due to sickness absence. In response to the recommendations of the independent review (DWP, 2013), the Government accepted many of the recommendations made and announced a range of measures to support people with health conditions both stay in and return to work. These include a health and work assessment and advisory service to make occupational health advice more readily available to employers and employees, so they can better manage sickness absence and improve sickness absence management (e.g. using the Employer's Charter to provide better guidance on what employers can do to manage sickness absence; and improving education on health and work for healthcare professionals). However, it is as yet too early to see whether these measures will have a major impact on sickness absence.

7. Data

Expenditure on disability payments has risen from the equivalent of £4.7 billion in 1972/73 to £14.0 billion in 2014. The number of claimants on invalidity and sickness benefits has risen from 1 million to 2.5 million over that period. The total numbers and cost of incapacity benefits rose rapidly to the mid-1990s. The numbers have declined somewhat from a high of 2.8 million in 1996-7.¹¹¹ In addition, it has estimated that sick pay and associated costs run to £9 billion per annum (Black and Frost, 2011).

¹¹¹ DWP, Benefit Expenditure and Caseload Data.