

Long-term disability arrangements

**A comparative study of assessment
and quality control**



the Netherlands Organisation for Applied Scientific
Research

W.E.L. de Boer, V. Brenninkmeijer, W. Zuidam

*Long-term disability arrangements
A comparative study of assessment and quality control*

TNO Work and Employment
P.O.Box 718
2130 AS Hoofddorp
The Netherlands

T:+31 23 554 93 93
F:+31 23 554 93 94
Website www.arbeid.tno.nl

This publication can be ordered at:

Fax +31 23 554 93 94
E-mail receptie@arbeid.tno.nl
Price EUR 25 excl. VAT

ISBN 90-5986-060-8
© 2004 TNO Work and Employment

Editors: W.E.L. de Boer, V. Brenninkmeijer, W. Zuidam

Print: PlantijnCasparie Heerhugowaard

No parts of this manuscript may be reproduced in any form, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, or otherwise, without prior written permission from the publisher

Acknowledgements

This research project was carried out by the Netherlands Organisation for Applied Scientific Research (TNO) in cooperation with the Department of Social Affairs and Employment (SZW) and the Dutch Workers Insurance Authority (UWV). Funding of the project was by SIG (Stichting Instituut GAK) and the participating organisations. The research and results are TNO's responsibility, yet the results could not have been achieved without the cooperation of very many people. We would like to thank the respondents for their friendly cooperation (see Appendix 4). Moreover, the EUMASS helped us in contacting our respondents. We would also like to thank the project members: J.P.A. Bakkum (SZW), R. Cremer (TNO Work and Employment), S. Desczka (SZW), M.C. de Groot (TNO Work and Employment), R. Jongkind (TNO Work and Employment), W. Otto (UWV), A.M. van de Ven (UWV), and W.S. Zwinkels (TNO Work and Employment). Finally, we would also like to thank the members of the committee that supervised this project: J.H.B.M. Willems (TNO Prevention and Health), L. van Rossum du Chattel (SZW), A.J. Mulder (UWV) and W. Otto (UWV).

Contents

- 1 Introduction — 9**
 - 1.1 Background and research questions — 9
 - 1.2 Method — 12
 - 1.2.1 Procedure — 13
 - 1.2.2 Interview/ questionnaire — 13
 - 1.2.3 Terms — 14
 - 1.3 Contents of the report — 14

- 2 Characteristics of disability arrangements — 17**
 - 2.1 Definition of disability — 17
 - 2.2 Operationalisation of disability — 19
 - 2.3 Other characteristics of the arrangement — 21
 - 2.3.1 Levels of disability — 21
 - 2.3.2 Lapse of time before application — 22
 - 2.3.3 Time schedule for reassessments — 22

- 3 Actors involved in the assessment process — 23**
 - 3.1 Organisation that contracts the assessors — 24
 - 3.2 Assessors — 24
 - 3.3 Backgrounds of assessors — 25
 - 3.4 Curative health care — 25
 - 3.5 Employer — 26
 - 3.6 External supervision and control — 27

- 4 Organisation of the evaluation process — 29**
 - 4.1 Basic characteristics of the assessment process — 29
 - 4.1.1 Primary goal of the assessment process — 29
 - 4.1.2 Time span — 29
 - 4.1.3 Method of first-time assessment — 30
 - 4.1.4 Differences between first-time assessments and reassessments — 31
 - 4.1.5 Appeal — 31
 - 4.2 Assessors — 31
 - 4.2.1 Number of medical assessors — 31
 - 4.2.2 Labour expert — 32
 - 4.2.3 Decision maker — 32
 - 4.3 Process steps — 33
 - 4.4 Advantages and disadvantages of the organisation of the assessment process — 33
 - 4.4.1 Advantages — 34
 - 4.4.2 Disadvantages — 34

- 5 The decision-making process — 35**
 - 5.1 Argumentation needed — 35
 - 5.2 Standard descriptions — 36
 - 5.3 Instrumentation — 36
 - 5.4 Other factors that may influence the decision-making — 38

- 6 Quality Control — 41**
 - 6.1 Controlling institutions — 41
 - 6.2 Official quality system — 42
 - 6.3 Evaluated aspects, criteria, and norms — 42
 - 6.4 Feedback — 43
 - 6.5 Other procedures to control quality — 44
 - 6.6 Advantages and disadvantages of quality control — 44

- 7 Discussion — 47**
 - 7.1 General conclusions — 47
 - 7.2 Major characteristics of the arrangement for long-term disability — 47
 - 7.2.1 Legal definition of disability — 47
 - 7.2.2 Operationalisation of disability — 47
 - 7.2.3 Other characteristics of the arrangement for long-term disability — 48
 - 7.3 Actors involved — 48
 - 7.4 Organisation of the assessment process — 49
 - 7.4.1 Primary goal of the assessment process — 49
 - 7.4.2 Time span — 49
 - 7.4.3 Method of assessment — 50
 - 7.4.4 Medical assessors — 50
 - 7.4.5 Labour experts — 50
 - 7.4.6 Decision maker — 51
 - 7.4.7 Process steps — 51
 - 7.4.8 Advantages and disadvantages of the organisation — 51
 - 7.5 Decision-making process — 52
 - 7.5.1 Argumentation — 52
 - 7.5.2 Instruments — 52
 - 7.5.3 Other factors influencing the decision-making — 52
 - 7.6 Quality control — 53
 - 7.6.1 Criteria and norms — 53
 - 7.6.2 Other procedures to control quality — 54
 - 7.6.3 Feedback — 54
 - 7.6.4 Advantages and disadvantages of quality control — 54
 - 7.6.5 Scientific foundation of disability evaluation — 54
 - 7.7 In sum — 55

8	References — 57
	Appendix 1 Tables — 63
	Appendix 2 Background information — 173
	Appendix 3 Questionnaire — 178
	Appendix 4 Respondents — 182

Long-term disability arrangements

1 Introduction

1.1 Background and research questions

Social insurance is an important focus of political activity in many countries. The topic of social organisation with regard to sickness and disability¹ is as old as society itself and it continues to present new challenges as societies develop in the course of post- industrialisation, individualisation, multiculturalism, and the like. The modern, but by no means new, thinking emphasises the promotion of individuals' participation in society and the reduction of individuals' dependence on allowances. In order to achieve these goals, governments have developed and implemented policies containing elements of income support and integration (OECD, 2003), as well as strategies for the prevention of disease and disability. Changes in policies take place against a background of Europeanisation of social policy and of a growing contribution from private insurers in social security provision. Benchmarking of practices is an important topic in these changes.

An important element with regard to policies on disability is the evaluation of disability in a percentage or a category. These evaluations are the crossroads for people in the journey from work through sickness to disability or reintegration (Aarts & De Jong, 2003) and open the way to social rights or not. The possible journeys of claimants from work to reintegration are depicted in Figure 1 (see below). These evaluations relate to short-term absenteeism, sick leave, and to long-term disability. In this project, we concentrated on the last. Part of these evaluations is the assessment of disability by medical doctors / advisors / professionals. This assessment takes many forms: single doctor, a number of doctors, multidisciplinary, single moment or extending over time, stand-alone or in close connection with health care or reintegration services (Council of Europe, 2001). The evaluations that exist in all countries studied are seen more and more as instruments that have to support policies to promote the creation of work for disabled people. This function is somewhat problematic (Grammenos, 2003; Waddell, Aylward & Sawney, 2003; Willems, 2000), as the method of evaluation of disability has not been designed to support reintegration, in spite of a long-standing ambition to look at possibilities rather than at incapacities.

¹ Throughout this report, the term 'disability' is used to mean long-term inability to work owing to a health problem. In different countries, various terms and provisions exist but all countries we investigated recognise and provide for this eventuality.

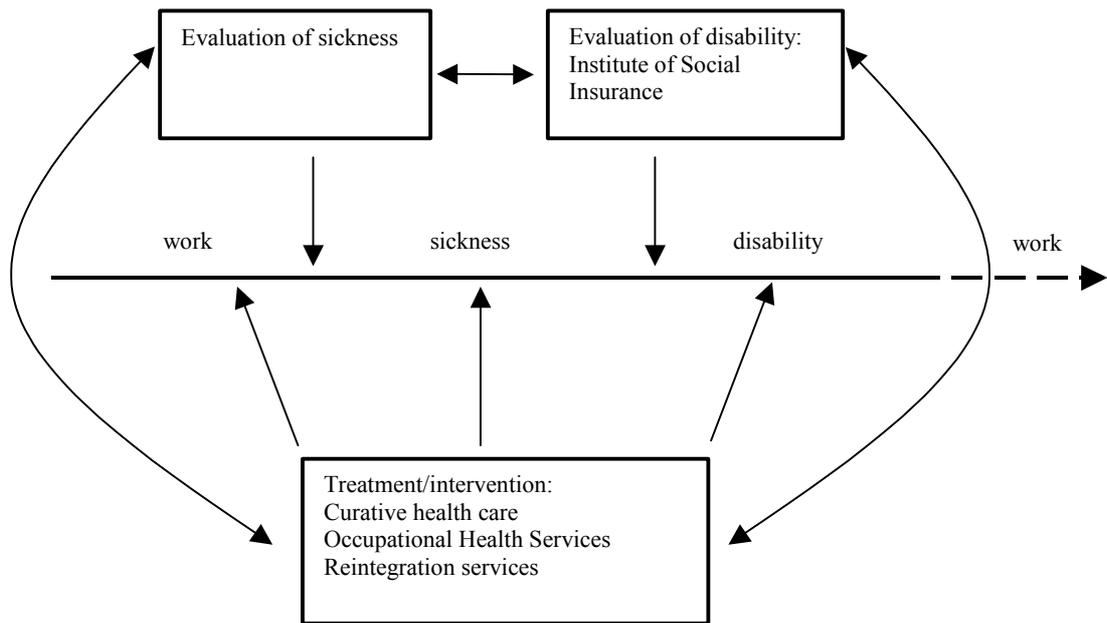


Figure 1: The journey of the claimant from work to disability.

In the Netherlands, an important change in disability policies is foreseen in the near future. Following the publication of the reports of several High Commissions (Donner Committee, 2001; SER, 2002), the present government aims at the creation of a new benefit scheme to activate people who still have capacities and to protect those who do not. This aim is not new to the Dutch government (Bovenberg, 2000), but up till now adaptations have been found unsatisfactory. What is new is the aim to redesign the daily practice of the evaluation in a more direct manner: so far, changes ordered by the government have been with regard to the criterion for disability and the organisation at a general level, rather than the practice of evaluation itself, and the impact of these changes has been at best indirect (Arrelöv, Borgquist, Ljungberg, & Svärdsudd, 2003; Boer, 2002; Veerman & Besseling, 2001).

The question arises as to what modalities of evaluation practice one can choose to implement. In the current study, we addressed this question by examining the practices of disability evaluation in different countries. So far, the scientific literature on the practice of evaluation has been scant. There is much economic and juridical-administrative literature and there is medical literature, but little has been written on the manner in which criteria are applied and decisions are taken (Jong, 2003). Against a background of international comparison with respect to social policies in Europe (Grammenos, 2003; OECD, 2003), this lack of literature seems undesirable.

In the process of disability evaluation, many problems concerning criteria, policy, and implementation become manifest (Jong, 2003; Marin, 2003; Stone, 1985). Although in the Netherlands much research has been done into the content of the assessments by medical doctors (Bont, Berendsen, Boonk & Brink, 2000; Croon & Langius, 1993; Eck, 1990; Goor, 1997; Kerstholt, Boer & Jansen, 2002; Meershoek, 1999; Razenberg, 1992; Willems, 2000), these assessments are sometimes regarded as a black box.² It is not surprising then that the assessments, or the processes of evaluation, are often subject to criticism (OECD, 2003; Prinz, 2003; Stone, 1985; Waddell et al., 2003). We believe it is important for policy makers, managers, and professionals involved in the assessment of disability to acquaint themselves with practices and problems in other countries. Difficulties are not exclusively Dutch. Knowledge of practices in other countries with regard to the execution of disability arrangements may help those concerned to gain insight into the evaluation process in one's own country and evaluate it.³ Moreover, it may offer suggestions to further improve the evaluation process. Work has been done in this field at the Council of Europe (2001) and at Brunel University (Bolderson, Mabbet & Hvinden 2002) and by Donceel and Prins (2001), which we have used to design our study.

A major goal of this study was to extend the knowledge in this important and sometimes neglected field. This knowledge may support the government in the Netherlands in the preparation of policies with respect to the Disability Benefits Act (WAO). It may also provide the Workers Insurance Authority, the UWV, with options to organise and steer the process of evaluation. In this study, the focus was on disability evaluation in those public schemes that cover the social risk of losing one's income from work because of disability. Private insurance policies and specific schemes for professional risk were excluded from the survey.

In this study, we made an international comparison of evaluation of disability for work. The main research question was:

What is the daily practice of disability evaluation in the various countries under investigation? In what way is the assessment organised?

² While the inputs and outputs to and from the box are clear, the mechanisms inside it are unknown and perhaps to some extent unknowable.

³ The collection of essays on practical problems and attempts to steer disability evaluation practice in various countries in Prinz (2003) is quite impressive

The second research question was:

How is the quality of disability evaluations controlled in the various countries under investigation?

To answer these questions in an internationally comparative way is a complex task. Consequently, we had to focus on the main aspects of these questions and had to leave out many interesting issues. For instance, we did not evaluate the practices we described with regard to their strictness (i.e., not too many claims accepted) or effectiveness (i.e., many people back to work). Examining the strictness and effectiveness of the practices would have required the inclusion of many other factors and data, variables that were not the subject of this study. Nor did we discuss why the practices are as they are. We realise that much could be explained by historical reasons but we did not look into that. Finally, we could have focused more on the differences between formal and informal practices. Many of our respondents recognised that these differences exist.

It should be noted that the focus of the study was on the organisation, practice, and management of disability evaluation in particular places and at a particular moment in time (late 2002 and early 2003). We are aware that practices may vary within countries. We also know that changes in this field regularly occur and that some findings may therefore be outdated at the moment of publication.

1.2 Method

Data were collected from the following 15 countries:

- Belgium
- Denmark
- Finland
- France
- Germany
- Hungary
- Ireland
- Italy
- The Netherlands
- Norway
- Russian Federation
- Slovenia
- Spain
- UK
- USA

Information was collected from various types of informants:

- medical officers
- non-medical officers
- managers
- central medical staff
- quality controllers
- other experts

1.2.1 Procedure

The research was carried out by 12 researchers: 2 from the Department of Social Affairs and Employment, 2 from UWV, and 8 from TNO. These researchers investigated countries in pairs. Through meeting and instruction, an effort was made to make the concepts and practices of this study as uniform as possible.

Respondents were obtained mainly through the EUMASS network and through members of the working group that made the report on criteria for disability (Council of Europe, 2001). EUMASS, the European Union of Medicine in Assurance and Social Security, is a European association for doctors, dentists, and other health-care professionals with involvement in Disability Assessment Medicine and Health-care Cost Control.

In most participating countries, respondents were interviewed face to face. The respondents were first sent a questionnaire, meant as a preparation for the interview, and were subsequently visited by one to three (generally two) researchers for an interview. The time allowed for interviews was generally two days per country. Countries in which respondents were interviewed face to face include Belgium, Denmark, Finland, France, Italy, Hungary, the Russian Federation, Slovenia, Spain, and the UK. After completion of the draft country descriptions, the researchers asked for approval and/or completion of the presented information. Formal approval of the presented information was obtained in Belgium, Denmark, Finland, France, Hungary, Italy, Slovenia, and the UK. Countries that had recently been visited for other research projects related to disability issues were sent only a questionnaire containing information that was collected during earlier visits. They were asked to complete or correct the information in the questionnaire.

Using these country descriptions, comparative tables were drawn up by the main researchers. We performed a further check by presenting these summaries to the researchers that had visited the countries. Apart from the interviews, we used the existing literature to complete the data. Finally, in several sessions, results and conclusions were worked out by cooperation between the three institutions (SZW, UWV, and TNO). The results remain the full responsibility of TNO.

1.2.2 Interview/questionnaire

In an iterative process of several rounds of examining the literature, policy, and practice, the questions were drafted and fine-tuned by the multidisciplinary group of researchers. The specific interview questions are displayed in Appendix 3. The interview or questionnaire contained questions on the following issues:

- The main characteristics of the long-term disability arrangements that were investigated
- The main actors involved in the assessment.
- The characteristics of the assessment and the process steps.
- Quality control.

To help respondents formulate their answers, we provided for each question an example of an answer: a description of the situation in the Netherlands.

1.2.3 *Terms*

In this report, the terms assessment and disability evaluation refer to different things. The term ‘assessment’ refers to the assessment by a professional, most often a medical assessor. The term ‘disability evaluation’ refers to the whole process of evaluation, from claim to decision, involving other people, such as case managers and administrative staff.

1.3 **Contents of the report**

In this report, we describe practices of disability evaluation in the 15 countries and the way in which the quality of disability evaluation is controlled. The contents of the chapters are as follows:

- Chapter 2: The main characteristics of the disability arrangements that were investigated. These characteristics include the definition of disability, its operationalisation, the levels of disability, the time that elapses from the onset of sickness to application for a disability benefit, and the time schedule for reassessments.
- Chapter 3: The main actors that are involved in the assessment process. These actors are the assessors, the organisation that contracts them, curative health care, and the bodies responsible for external supervision. The backgrounds of the assessors in terms of professional education are also described.
- Chapter 4: The characteristics of the assessment and the process steps. Characteristics of the assessment encompass the primary goal of the assessment process, the time span of the process, the estimated production time, the method of the first-time assessment, the differences between first-time assessments and reassessments, and the process of appeal. The process steps, that is, the organising of the whole assessment process, are described, as are the advantages and disadvantages of the organisation of the assessment process.

- Chapter 5: The characteristics of the decision-making process. These include the argumentation and information that is needed for the decision making, the availability of standard descriptions, the instrumentation, and other factors that may influence the decision making.
- Chapter 6: Quality control. Issues described are the controlling institutions / professionals, evaluated aspects, criteria and norms, other procedures to control quality, feedback, official quality systems, and advantages, disadvantages, and debatable points.
- Chapter 7: Discussion.
- In Appendix 1, the reader will find several tables, showing the aspects of the chapters in a systematic comparison of 15 countries.
- In Appendix 2, we provide more detailed background information for some countries. This information may pertain, for instance, to the way in which social security is organised, and to the number and level of disability benefits.
- In Appendix 3, the interview questions are displayed.
- In Appendix 4, a list of respondents is provided.

2 Characteristics of disability arrangements

In this chapter, we describe the main characteristics of the disability arrangements in the various countries investigated. We were particularly interested in differences between countries with respect to the legal definition of disability. To what extent do legal criteria in the various countries resemble each other? Other characteristics of the disability arrangement that we found of major interest were the operationalisation of disability, the levels of disability that can be distinguished, the time that elapses from the onset of sickness to application for a disability benefit, and the time schedule for reassessments. These characteristics are all described in this chapter.

Table 2 lists the legal definitions of disability, its operationalisation, the levels of disability that can be distinguished, the time that elapses from the onset of sickness to application for a disability benefit, and the time required for reassessments in the various countries.

2.1 Definition of disability

The core characteristic of the long-term disability arrangement is the definition of disability for work, that is, the legal criterion for disability for work. We investigated the definitions used in the evaluations. This may be more than is mentioned in the defining article in the law on disability for work. In the Netherlands, this definition is as follows:

As a direct and medically storable result of disease or impairment, a person is unable, fully or partially, to earn with customary labour the income of a comparable healthy person.

Customary labour refers to all possible jobs for a person. Disability refers to earning capacity.

Disability can be accepted after 52 weeks of sick leave and after employer and employee have shown sufficient evidence of trying to get the employee reintegrated.

How can this definition be compared with the definitions used in the other countries investigated (see Table 2)? In comparing definitions, it was necessary to decide which items to concentrate on and which to disregard.⁴ There is no internationally established tradition of research

⁴ We left out the criteria that are not disability related. Eligibility may depend, for instance, on the duration of work before becoming disabled. These criteria influence the result of the

into disability evaluation, but some authors have prepared the ground. Following Viaene (1975) and his legal conception of Human Damage, we distinguished in the definitions of disability the type of work that disability refers to (one's own work, any work, fitting work), the cause of disability (generally some health condition), the concept of disability (restriction of labour capacity, loss of earning capacity, anatomical damage, according to ICIDH (WHO 1980)),⁵ and the time perspective before and after recognition of disablement. These aspects correspond closely with the items that make up the sociological concept of the handicapped role, as defined by Gordon (1966), who followed the example of the sick role proposed by Parsons (1951). The handicapped role and sick role both point to another important aspect of disability evaluation: the obligation of the sick person and, progressively, his or her employer (OECD, 2003) to take all reasonable steps to promote recovery and reintegration. Considering the elements mentioned above, in what ways is the definition used in the Netherlands different from the definition in other countries? What variation may be found with respect to the different aspects? As outlined below, variation can be found in almost all elements:

- *Description of work*: The description of work may vary from the individual and the concrete to the general and the abstract (e.g., “any substantial gainful activity”, “regular or subsidized wage jobs”).
- *Cause of disability*: Most definitions of disability mention that incapacity should result from disease, impairment, injury, etcetera. The precise formulations vary but our impression is that these differences do not point to different intentions. However, requirements concerning medical objectivity with respect to the cause of disability do differ. In some countries (in the Netherlands, Spain, and the USA), it is stressed in the definition of disability that impairments or limitations should be medically and / or objectively determined.
- *The concept of disability*: Disability may be defined as a loss of labour capacity (i.e., the loss of capacity for work), as a loss of earning capacity (i.e., the loss of capacity to earn an income) and as anatomical damage (e.g., the loss of body parts). In 11 of the examined countries, the criterion for disability refers to a loss of

scheme but they are not the topic of the disability evaluation itself. Disability itself and the course of becoming disabled were excluded too. These topics are extensively described in the scientific literature. Interesting reviews are presented by Grammenos (2003), Prinz (2003), and Waddell et al. (2003).

⁵ Or, according to ICF (WHO 2002), health condition, body structure and function, activities, participation, environmental factors, and personal factors, such as coping efforts and personal situation. In the disability schemes we investigated, the personal factors are ruled out.

labour capacity. In the other countries, earning capacity (Belgium and the Netherlands) or a combination of labour and earning capacity (France and Norway) are used as the criterion. Anatomical damage is not used as a criterion for disability in any of the schemes we investigated.⁶

- *Time perspective*: In many countries, the required expected duration of the disability or impairment is explicitly stated in the definition of disability. Countries that mention a required expected duration include Denmark (permanent), Germany (indefinite period), Hungary (permanent, i.e., 7 years), Ireland (permanent or 1 year if the impairment has existed for 1 year), Italy (permanent), Norway (permanent), Spain (permanent), and the USA (1 year). In some countries (Finland, Ireland, the USA), the duration of the impairment before application is taken into account.
- *Requirements concerning reintegration or rehabilitation*: In some countries (Norway and Spain), respondents mentioned that medical treatment and medical / vocational rehabilitation or reintegration must have been tried. It should be noted that, in many definitions, it is not completely clear whether medical treatment and medical / vocational rehabilitation or reintegration must have been tried.

2.2 Operationalisation of disability

As the legal definition of disability is formulated in a general way, and hence is open to many interpretations, it was necessary for practical use to translate it into a more detailed concept for assessors. In this study, we used the term ‘operationalisation of disability’ to refer to this process of translation. This process can occur in various ways. OECD (2003) distinguished compensation-oriented policies, integration-oriented policies, and intermediate forms. Another way is to classify disability by the professionals involved in the assessment process, notably medical doctors and others. Yet another way is to take the disease as the starting point and to check the way in which disability is evaluated: at the level of impairment, disability, and/or handicap (e.g., Council of Europe, 2001). We took elements of all these but incorporated them into Stone’s (1985; Kohrman, 2003) approach, which introduced the concept of administrative categories to illustrate the decisions that are taken to make the general criteria practically applicable. These categories are to be seen as a lower form of regulation than the law itself but they constitute the *de facto* criterion for the actual evaluation. The decision to construct these categories accounts for operationalisations and for links between

⁶It is used in schemes for occupational risk, in common law suits, and in private insurance.

elements of the law. This is particularly the case with the requirements of rehabilitation. These are often not mentioned in the article on definition but they serve as such for the evaluators. In this study, we relied on the categories more than on the legal criterion.

One fundamental decision that is part of the operationalisation is whether to interpret the criterion as theoretical or not: does it evaluate what a person theoretically could do or what a person actually does? We found that with the possible exceptions of Denmark and Norway, all countries use theoretical operationalisations. In this type of operationalisation, participation in labour is deduced from the presence of disease and impairment (see below). According to Prinz (2003), these theoretical operationalisations constitute one of the key problems in social insurance, and they are the source of dissatisfaction and the focus of the civil rights approach (Grammenos, 2003). As far as we could see, they are almost inevitable: if a person does not work, an answer is necessary to the question of whether he/she is unable or unwilling.

Another decision, described by Stone (1985), is to choose the emphasis of the definition that has to be assessed. We distinguished three types of emphasis, which may be combined:

1. The operationalisation may be medical: in this kind of operationalisation, a relationship is assumed between specific diseases or impairments and participation in labour. Medical arguments refer to the diagnosis, impairments, severity of the symptoms, and the like. This is often a dichotomy: (fully) disabled or not.
2. The emphasis may be on functional capacities: in this kind of operationalisation, a relationship is assumed between a restriction in possible activities (sitting, standing, concentrating, etc.) and participation in labour. This relationship may be direct or involve a matching of jobs with activities.
3. The emphasis may be placed upon reintegration/rehabilitation: in this kind of operationalisation, disability for work is decided upon following consideration of the possibilities for and results of rehabilitation. When there are still possibilities for reintegration or rehabilitation, a person is not considered disabled. The period during which possibilities for reintegration or rehabilitation are taken into consideration is limited, however.

In the present study, the operationalisation was defined by the arguments needed to conclude that a person is disabled or not. These arguments can be found in instruction texts, in interviews with assessors, and in files.

The boundaries of these concepts are not clear, however, so the categorisation we made is subject to improvement in further research. This is particularly the case with the third category: treatment and vocational rehabilitation were taken together whereas it might be better to separate them.

In the Netherlands, a combination of medical (i.e., fully disabled is in most cases an entirely medical decision), functional (i.e., in all other cases, functional capacities are to be specified), and rehabilitation (i.e., employer and employee have to demonstrate adequate efforts to reintegrate the employee) operationalisations are used. In the other countries investigated, the following (combinations of) operationalisations were found (see Table 2):

- Uniquely medical operationalisations were found in Belgium, Italy, Russia, and the USA, and probably in Hungary.
- We found a combination of medical and functional operationalisations in Ireland, Slovenia, Spain, and the UK.
- A combination of medical and reintegration operationalisations was found in France, Norway, and Germany.
- We found a combination of all three operationalisations in Denmark and Slovenia and possibly in Spain.

It should be noted that the operationalisation does not seem to be determined by the definition. For instance, we could not find a relationship between the concept of disability (i.e., earning vs. labour capacity) and the way in which the definition is operationalised.

2.3 Other characteristics of the arrangement

Other important characteristics of the arrangement for disability encompass the levels of disability that can be distinguished, the time that elapses from the onset of sickness to application for a disability benefit, and the time schedule for reassessments. It should be noted, however, that in the Netherlands, changes are foreseen with respect to these characteristics (see Appendix 2).

2.3.1 Levels of disability

In the Netherlands, 7 levels of disability are distinguished, the largest number of levels found in this study. Table 2 shows that the levels of disability vary considerably: in 6 countries (Belgium, Denmark, Ireland, Italy, the UK, and the USA), it is “all or nothing”, whereas the other countries have more levels, with Norway (6 levels) and the Netherlands (7 levels) having the most. It should be mentioned that the system in

Denmark is rather different (see Appendix 2). Furthermore, it should be noted that, in some countries (France, Hungary, Spain), some levels of disability differ only with respect to the need for care (e.g., for basic daily activities), and not with respect to the percentage of disability. This is true in the Netherlands as well but it is seen as an augmentation of the benefit, not as a separate level.

2.3.2 *Lapse of time before application*

In the Netherlands, application for a disability benefit occurs after one year of absence owing to sickness. This is also the case in Ireland and Belgium (see Table 2). In the UK, a short-term invalidity benefit can be applied for after 28 weeks, whereas a long-term invalidity benefit at a higher rate can be applied for after 1 year. In most countries, a flexible time schedule is applied, in which a maximum is sometimes stated (e.g., “at latest after 18 months of sickness”).

2.3.3 *Time schedule for reassessments*

In the Netherlands, reassessments take place after fixed intervals: after 1 year, 4 years later, and then every 5 years. In Italy (invalidity allowance: every 3 years), Germany (every 3 years), and the USA (every 7 years), reassessments take also place at fixed intervals (see Table 2). In Finland, if recovery is still possible, individuals have to re-apply for a benefit after 9 months. In contrast, in many countries, the time schedule for reassessments is flexible: it is determined for each case when a reassessment should take place. Countries with a flexible time schedule for reassessments are Belgium, France, Hungary, the Russian Federation, Spain, and the UK. In Denmark, Ireland, Italy (disability pension), and Norway, no reassessments take place.

3 Actors involved in the assessment process

An important element with respect to the organisation of disability assessments pertains to the actors that are involved. It is believed by some that assessments take place only in the ‘black box’ of the medical doctor’s consulting room. Consequently, it is thought that these doctors are the only ones who control the assessments. We expect interplay between several parties, however. In accordance with, and in some extension of, Hofstee (1999), we take the view that formal assessments are played out by a consortium of parties (Boer, Hazelzet, & Gerven, 2002): the assessor, the disability agency, the external supervisor, the treating doctors, the employer, the courts of law. The assessor is formed by a professional group with all their values and techniques. The assessor is contracted by the organisation that has the legal assignment to apply the disability regulation, to which we refer as the Institute of Social Insurance. This organisation selects, instructs, and facilitates the work of the assessors. Moreover, this organisation has many other tasks that may influence the evaluations of disabilities. Next, there is some external supervisory organism that has to convince the lawgiver that the work is done as it should be done. This quality control influences the organisation of the process of evaluation. On top of that, the individual client is often backed up by his treating physician and employer. The professional education of the assessors is also described in this chapter. In this chapter, the main actors that are involved in the assessment of disability are described: the organisation that contracts the assessors, the assessors themselves (including their backgrounds), the role of curative health care, and the external organism that is responsible for supervision. It should be noted, however, that these actors are not the sole actors that are involved. In this research, we focused on the main actors, but the influence of other parties, such as the claimant, the professional organisations, and the courts of justice, should not be underestimated. The literature (Baldacci & De Santis, 2003; Prinz, 2003; Stone, 1985; Wörister, 2003) and several of our respondents named the courts of justice as an influential factor. A final actor who may influence the evaluation is the employer. The employer is increasingly recognised as of vital importance to sick leave and reintegration (OECD, 2003) so we looked at the influence of the employer on the assessment.

Table 3a lists the following actors that are involved in the assessment of disability: the organisation that contracts the assessors, the assessors, the role of curative health care, and the external organism that is responsible for supervision. Table 3b describes the backgrounds of the assessors. Table 3c displays the role of the employer.

3.1 Organisation that contracts the assessors

In the Netherlands, the execution of the disability benefit scheme is done by a public organisation, the Workers Insurance Authority (UWV). In virtually all countries, a public organisation (the Institute of Social Insurance) executes the disability benefit scheme. Almost everywhere, the same organisation also performs the evaluations. Exceptions are France, where the evaluation of disability is performed by a private institution, and the UK, where the medical part of the assessment is carried out by a private organisation. In the UK, the rest of the evaluation is carried out by the Department of Work and Pensions, DWP. Denmark is remarkable in the sense that the municipality is the executing organisation.

3.2 Assessors

In the Netherlands, a medical assessor, a labour expert, and a case manager are involved in the assessment process. The employment of medical assessors is common practice in all countries investigated, but the employment of labour experts appears to vary (see Table 3a). In three other countries (Germany, Slovenia, and Spain), a labour expert or another professional specialised in labour issues (e.g., a labour inspector) is involved in the assessment process, whereas in Denmark, a labour expert can be consulted. The use of a case manager, or a professional with a comparable function, was reported in some countries (Denmark, Slovenia, and the USA). It should be noted that the label and the content of this function shows considerable variation (see Chapter 4). Furthermore, it should be noted that in some countries there is a separate function for the decision maker: Finland, Ireland, Norway, and the UK. In none of the countries investigated a paramedical assessor was used to perform the assessment.

In Table 3b, the roles of the assessors are described. These roles vary tremendously. At one extreme is a single doctor model in which interventions during sick leave and decisions on the percentage of disability are combined (France) and at the other end of the scale are groups of doctors deciding only on disability (the Russian Federation) or multidisciplinary teams, led by a case manager that focuses on progress

in reintegration rather than on the evaluation of disability. See section 4.2 for further details.

3.3 Backgrounds of assessors

In the Netherlands, the medical assessor is an academically trained physician, with four years of (post-academic) specialisation in social medicine. This specialisation results in the legally recognised qualification of social insurance physician. The labour expert most often has received a Technical College Education or has a college degree in social studies, plus a special training course in disability evaluation. The case manager is generally a legal expert, who has had Higher Vocational Education or has received a college degree in law.

We were curious about the backgrounds of the involved professionals in other countries, in particular about that of the medical assessor, as there is generally no academic specialisation for the evaluation of disability. There is very limited comparative literature on this (Donceel & Prins, 2001).

In all countries, medical assessors are academically trained doctors (see Table 3b). In many countries (Belgium, France, Ireland, the Netherlands, the UK, and the USA), medical assessors should also have additional education or training in the field of disability evaluation. Where a special training course for doctors exists, this may vary in duration up to 4 years, but is most often in the region of 6 months. In other countries (Denmark, Germany, Hungary, Ireland, the Russian Federation, Slovenia, Spain), it is stressed that medical assessors should have at least some clinical experience in curative health care.

Labour experts are generally specialised in labour market conditions and job demands in relation to human capacity. Labour experts seem to be mainly trained on the job.

The backgrounds of the case managers and deciding officers appear to vary: they may have had an education in social work, or they may have an administrative, legal, paramedical, or economic background. Considering their varying tasks, this is not surprising. The case managers, too, seem to be mainly trained on the job.

3.4 Curative health care

In the Netherlands, a formal procedure of informed consent of the client is required in order to consult the treating physician. The curative health care provider is consulted only when this is considered necessary by the assessing doctor. This is also the case in Belgium and Spain (see Table

3a). In the majority of the countries investigated, consultation of curative health care is a standard procedure: Treating doctors are asked to provide medical information, often through forms or certificates. In Norway, the general practitioner is even the main medical assessor. In Germany, Finland, France, Spain, and the Russian Federation, curative health care is also involved in the application for a benefit. In Belgium, curative health care may assist claimants in appeals. It can be concluded that the role of curative health care appears to vary largely in the examined countries. Obtaining data as regards curative health does not seem to pose a problem in most countries, that is, information can be obtained without the client's consent. In addition to this influence at the individual level, it should be noted that curative health care has a structural influence in the professional education of doctors, and medical assessors in particular, both academic and post-graduate, and so in the setting of medical norms about the severity of symptoms and diseases and about what can reasonably be asked of clients with respect to efforts to recover and reintegrate.

3.5 Employer

In the Netherlands, the employer is involved in various ways in the assessment. The employer has an important role in the period of sickness benefit. The employer and the employee are jointly responsible for the reintegration of the employee in case of sickness. They have to provide a report about that in order for the social insurance agency to start evaluating disability.

In addition, if the employer has a clear interest in the decision about disability, he/she can make an appeal to the social insurance agency. If the employer is not satisfied with the ultimate decision of the social insurance agency, an appeal can be made to the administrative law department of the District Court. Decisions made by this court can be appealed to the Central Court of Appeals.

We found that, in the other countries, the employer was rarely formally involved in the assessment. Only in Slovenia and Finland did the employer have a formal role in the assessment. However, in many countries (Denmark, France, Hungary, Norway), the employer has a more informal influence, by offering adjustments or other work to claimants. In Ireland, employers have no formal role in the assessment, but they may appeal if they have a material interest in the case.

3.6 External supervision and control

In the Netherlands, external bodies control the quality of the assessment process: the Ministry of Social Affairs and Employment and the Inspection for Work and Income, supervised by the Ministry of Social Affairs and Employment.

In most countries, there are bodies that are responsible for the external supervision of the assessment processes (see Table 3a). External control is generally executed by the Ministry that is responsible (France, Hungary, the Netherlands, Spain, and the UK) or by a specific audit organisation (Belgium, Germany).

In some countries (Italy, Norway Slovenia, and the Russian Federation), there appear to be (virtually) no external authorities that control the quality of the assessment process. In these countries, the organisation that contracts the assessors is largely responsible for its own quality control. For more detailed information about quality control, the reader is referred to Chapter 7 (see also Table 6).

4 Organisation of the evaluation process

Having described the characteristics of the long-term disability arrangement (Chapter 2), and the actors involved (Chapter 3), we now turn to the characteristics of the actual process of evaluation. In this chapter, we describe the basic characteristics of the evaluation process (such as the goal, the time span, and methods for assessments), the assessors, and the process steps. Finally, we present the advantages and disadvantages of the processes mentioned by our respondents.

In Table 4a, various aspects of the process are listed: the primary goal of the assessment process, the time span of the total process, the estimated production time, the way in which the first-time assessment is executed (face to face or on paper), the differences between first-time assessments and reassessments, and possibilities for appeal. Table 4b describes the roles of the assessors in the process: the involvement of a labour expert, the medical assessor(s), and the final decision makers. Table 4c lists the various steps of the process and flow charts of the assessment. Finally, Table 4d describes the advantages and disadvantages of the design, as reported by the respondents.

4.1 Basic characteristics of the assessment process

4.1.1 *Primary goal of the assessment process*

In the Netherlands, the goal of the assessment is to check the entitlement to the benefit. In all other countries, too, checking the entitlement to the benefit is a major goal of the assessment process (see Table 4a). In many countries, the assessment process has an additional goal: to promote medical or vocational rehabilitation, in order to prevent disability. Countries in which the assessment of rehabilitation possibilities is an additional goal of the assessment include Denmark, France, Hungary, Slovenia, the Russian Federation, and the UK. In Germany, it is decided following assessment whether a benefit will be granted or if rehabilitation should take place first.

4.1.2 *Time span*

In the Netherlands, the claim must be decided on in 13 weeks. Approximately 60% of the assessments are indeed performed within this time limit. The production time for the assessment is set at approximately 2 hours for the medical assessor, but it was mentioned that, in reality, 3 to 3 1/2 hours are needed for the assessment. The time spent by the medical assessor on the report and form is approximately 75 minutes.

The time needed by the labour expert is set at approximately 3 hours. It was mentioned that the time spent by the labour expert in reality is 3-4 hours, of which 2-3 hours are spent on the report and consultation of the computer program. We estimate the production time in the Netherlands, that is, the amount of time spent on the actual assessing by all assessors concerned, at approximately 6 1/2 hours (405 minutes).

The duration of the whole process differs greatly between countries (see Table 4a). The period from claim to decision varies from approximately 5 days (the Russian Federation) to 3 or 4 months (several countries). These periods are difficult to compare, however, because in Russia an important part of the work is done by the health care institution in preparing the claim. And sometimes the start and end of the process are diffuse. Nevertheless, the differences illustrate the impact of different ways of organising.

We made estimations for the production time of assessments, which is the amount of time spent on the actual assessing by all assessors concerned. These production times appear to vary considerably, from 15 minutes (Ireland) to 125 minutes (France) and 405 minutes (the Netherlands). In most countries, production times are around 60 minutes. These periods are difficult to compare, however, because part of the work may be done by health care institutions (France, Norway, Russia), which we did not take into consideration. Furthermore, in the case of France and Belgium, we included the time that was spent by the medical advisor in an earlier phase of sick leave. It should be noted that these production times are estimated and that in some cases production times may be considerably longer, as is the case in Belgium when there are doubts. Nevertheless, it seems that the production time in the Netherlands is long in comparison with that in other countries. We have the impression that in the Netherlands, compared with other countries, much time is spent on writing the medical report.

4.1.3 Method of first-time assessment

In the Netherlands, the first-time assessment is a face-to-face examination. This appears to be the case in many other countries, too (see Table 4a). In Finland, Germany, Norway, the UK, and the USA, the initial assessment takes place on the basis of a paper file, if necessary completed by a face-to-face examination.

4.1.4 *Differences between first-time assessments and reassessments*

In the Netherlands, the requirements for first-time assessments are basically the same as for reassessments. The execution differs, however, because less information has to be gathered during reassessments. Face-to-face contact is, therefore, not always necessary and reassessments are generally shorter than first-time assessments.

In most other countries, reassessments do not seem to differ essentially from first-time assessments (see Table 4a). However, in Germany (after 9 years), reassessments are executed by means of questionnaires. Furthermore, the collection and processing of information about claimants for reassessments may be different because of the amount of information that has already been collected during former assessments.

4.1.5 *Appeal*

In the Netherlands, as in all other investigated countries, a claimant has the right to appeal against the decision made. During the first appeal, the deciding organ, the Workers Insurance Authority (UWV)), investigates the correctness of the decision. If the claimant still disagrees, the appeal is dealt with by the District court. A final possibility to appeal is provided by the Court of appeal.

Respondents from Denmark and Finland mentioned that the courts of appeal are also responsible for the quality control. In Slovenia, appeal cases are used to ensure the quality of the assessment. Assessors in Slovenia are given feedback about appeal cases to improve the quality of their assessments.

In Finland, it is not necessary for the claimant to appeal because a new claim can be started at any point in time. Logically, the number of appeals is low. In Italy a claimant can also request an assessment as often as he/she wants.

Sometimes, a new additional medical assessment (The Netherlands, Belgium, France, Hungary) or other additional information (the UK, the USA, Slovenia, Norway, France, the Russian Federation) is taken into account.

4.2 **Assessors**

4.2.1 *Number of medical assessors*

In the Netherlands, a medical assessor is routinely involved in the assessment process. Table 4b shows that this is common procedure: in all countries investigated, medical assessors (e.g., a social insurance

physician, medical advisor) are involved in the assessment process. Nevertheless, the number of medical assessors (apart from the general practitioner and medical specialists who can be consulted) varies among countries. In France, Germany, Ireland, Italy (local level), the Netherlands, and the UK generally one medical assessor is involved in the assessment process. Note that in Norway, the assessment is done primarily by the general practitioner. Several countries (Finland, Italy (specialist unit), Spain, Slovenia) employ 2 medical assessors for each assessment. The Russian Federation uses 3 assessors. In some countries, the number of assessors depends on the specific case:

1. In Hungary, if two assessors do not agree, a third may be consulted.
2. In Belgium, for the Invalidity Pension, the number may vary from 1 (in case of decline) to several.
3. In Denmark, Norway, and the USA a lay expert may consult other medical assessors if necessary.

In Belgium and Spain, the additional medical assessor(s) have the explicit function of controlling the advice of the first assessor. The number of medical assessors is independent of the operationalisation of the legal criterion. This would suggest that the number of medical assessors is primarily dictated by reasons of reliability.

More information on the role of the assessors is provided in Table 3b.

4.2.2 *Labour expert*

In the Netherlands, a labour expert is routinely involved in the assessment process, unless the medical examination has shown full medical disability. In three other countries (Germany, Slovenia, and Spain) also, a labour expert or another professional specialised in labour issues (e.g., a labour inspector) is involved in the assessment process (see Table 4b). It should be noted that in Denmark a labour expert can be consulted when necessary, whereas the disability examiner in the USA must have some expertise in labour market conditions. The use of a labour expert is related to the operationalisation of disability (see Chapter 2). Consultation of labour experts is less common in countries in which the operationalisation is more medical.

More information on the role of the assessors is provided in Table 3b.

4.2.3 *Decision maker*

In the Netherlands, formally, the final decision is not taken by the medical assessor (or the labour expert) but by a case manager. However, in the majority of cases, the medical assessor and labour expert reach a conclusion that is decisive for the decision maker. Hence, the case

manager generally follows the advice of the medical assessor or labour expert.

In many other countries (see Table 4b), formally, the final decision is not made by the medical assessor him/herself either but by another person, whose function is described as case manager (Slovenia), deciding officer (Hungary), decision maker (Finland, Norway, UK), or disability examiner (USA). It should be noted that there, too, the decision of the decision maker generally seems to follow directly from the advice of the medical and/or other assessors.

More information on the role of the assessors is provided in Table 3b.

4.3 Process steps

A good impression of the entire evaluation is obtained by following the different steps that are taken in the process, from claim to decision. In Table 4c, we describe these steps briefly, using terms from the earlier parts of this report.

4.4 Advantages and disadvantages of the organisation of the assessment process

In the Netherlands, several advantages and disadvantages/problems were mentioned by the respondents. The advantages mentioned pertained to the use of a multidisciplinary team: this was felt to result in a higher quality of the decision and better acceptance by the claimant of the final decision. The disadvantages/problems specified by the respondents outnumbered the advantages and pertained to (see also Table 4d):

- Communication between professionals from different disciplines (is time-consuming and entails risk of ‘translation errors’)
- Mutual dependence may aggravate problems: disruptions in one part of the organisation may have repercussions for the rest of the organisation.
- Non-optimal functioning of labour expert and social insurance physician.
- Poor understanding of the criteria for disability by claimants.

As the organisation of the assessment process and its context vary considerably between the countries investigated, there was a large diversity in the advantages and disadvantages put forward by interviewed professionals (see Table 4d). The advantages and disadvantages may even appear contradictory, as some elements have both advantages and disadvantages (e.g., the second assessor). Furthermore, it should be noted that the advantages and disadvantages reflect the opinions of the

respondents, and do not necessarily result from empirical studies investigating the effects of the process. They certainly do not qualify the functioning of particular procedures.

4.4.1 *Advantages*

Advantages that were mentioned in the countries investigated pertained to, among other things:

- Additional assessor(s) attending the assessment or reading the assessment report, which was thought to lead to a higher quality (Germany, Finland, Hungary, the Russian Federation, Slovenia, and Spain).
- Promoting reintegration / rehabilitation (Denmark, Finland). In Denmark, the funding system is organised in such a way that municipalities have an incentive to promote early reintegration. In Finland, the occupational health services play an important role with regard to early reintegration, whereas the specialised rehab centres are responsible for the assessment as well as rehabilitation.
- The use of a multidisciplinary team, which was thought to lead to a higher quality (Finland, the Netherlands, Slovenia).
- Speed (Ireland, Spain, the Russian Federation).

4.4.2 *Disadvantages*

Disadvantages or problems that were mentioned pertained to, among other things:

- Quality control (Finland, the Russian Federation). In Finland, it was mentioned that there is no quality control of the decision-making. In the Russian federation, a good system of quality control has not yet been established.
- Too few incentives for people to reintegrate (Belgium, Italy, and the USA).
- Low quality of information from/dependence on doctors in curative health care (Finland, Hungary, Norway, the UK, Slovenia, Spain).
- Efficiency problems (Finland). In Finland, a decision requires more than one assessment in many cases, which causes inefficiency.
- Vague criteria (the Russian Federation, Finland).
- Second assessor: the final opinion is not always based on argumentation, but on negotiation or authority (Finland, Hungary). Note that the use of a second assessor may have both advantages and disadvantages

5 The decision-making process

Apart from the organisation of the assessment, we were interested in the content of the decision-making process. What knowledge and what information is processed and in what manner? This crucial topic is particularly difficult to grasp, as it seems to rely on undefined professional knowledge applied in unique and individual cases. That seems to rebuff any attempt to formulate general principles. Yet, by focussing on the reasoning that is needed to support a certain conclusion, we hoped to get somewhat closer to answering this question. More insight into the decision-making process may be gained by focussing on the instruments that are used to make the decision and by examining the perceived influence of other factors (such as informal guidelines, targets that may influence the decision-making with respect to the number of people who are entitled to benefits, time pressure).

Technically, evaluations should be organised in a manner that complies at least with the requirements of validity and reliability. It is probable that many of the practices and instruments described below are intended to enhance this part of quality, but we have no information on how the relationship between, for instance, instruments and reliability is viewed.

Table 5a and 5b describe the various devices used in the decision-making process: the argumentation and information needed for the decision, the instrumentation, and possible standard descriptions that are needed to make the decision. Other factors that could influence the decision-making are also listed.

5.1 Argumentation needed

In the Netherlands, the argumentation that the assessors have to provide for the decision must be very detailed and extensive. To make a decision about disability, the social insurance physician has to determine (1) the functional capacities of the claimant, (2) the chance of recovery / prognosis, (3) the adequacy of the claimant's recovery behaviour. For all these decisions, several questions need to be answered (see Table 5a). Furthermore, unless the social insurance physician has concluded full disability on medical grounds, the labour expert has to compute the remaining earning capacity. The labour expert computes with the aid of a computer program the remaining earning capacity of the claimant on the basis of possible functions and the claimant's standard salary. The labour expert may register full disability if he/she cannot find at least 3 suitable

functions for the claimant, together with at least 30 existing jobs on the labour market.

Comparing the argumentation needed for the decision in the different countries, it seems difficult to grasp the exact reasoning for determining incapacity for work (see Table 5a). Although in most countries, it is specified on which aspects decisions have to be made, it remains hard to understand the dividing line between capacitated and incapacitated for work. For instance, what is the exact criterion for determining that a person is below or above a particular percentage (e.g., 67 %) of loss of labour or earning capacity? This seems to be particularly problematic when partially disabled individuals are not entitled to disability benefits. Even when there are a number of levels of disability, it is often not clear what exactly constitutes the dividing line between the different levels. In case of partial disability, the Netherlands seems to give somewhat more insight into the argumentation. In addition, as mentioned above, in the Netherlands, the argumentation must be very detailed and extensive (see also section 4.1.2).

Note that, in the present study, the argumentation was used to determine the operationalisation of the criterion for disability.

The information needed to make the decision is usually the health status of the claimant (medical history, diagnosis, medical statement) and sometimes the social status and work status. The main source of information for decision-making is in most countries the claimant. He/she is usually obliged to provide information (Germany, Finland, Spain, Slovenia, UK, Denmark, the Netherlands, Hungary). In Norway, it was mentioned that in the last years considerable informal pressure has been put on the claimant to participate in this process, although the claimant has no formal responsibility to gather information.

5.2 Standard descriptions

In the Netherlands, there are standard descriptions for the argumentation, although assessors should formulate these in their own words. Standard descriptions are also available in Ireland and the UK (see Table 5b).

5.3 Instrumentation

In the Netherlands, several instruments are used in the assessment of disability. The major legal standards for the social insurance physician are the standards of ‘medical disability criterion’ and ‘no lasting residual

earning capacity'. These, and the other standards, specify the rules of the evaluation: the gathering of the proof. They are published in a handbook, together with instructions about the work processes. The medical doctor has to describe his opinion of the client's (in)capacities in a number of functions (sitting, standing, concentrating etc). A computer program is used to help the labour expert in selecting functions that fit into the capacity pattern of the claimant. Many instruments to determine a client's capacity have been developed for the context of health care and vocational support. They have not been validated for the context of evaluation for social insurance. It is believed that this makes a difference.⁷

Similar to the Netherlands, many other countries use guidelines and handbooks as instruments that support the assessors in the assessment of disability. The Netherlands seems unique, however, with respect to the use of computer programs for selecting possible jobs. The instrumentation used for disability assessment can be broadly divided into the following categories (see Table 5b):

- Guidelines/ Handbooks (Germany, Hungary, Italy, the Netherlands, the Russian Federation, Slovenia, the UK).
- Classifications of diseases/impairments (Germany, Finland).
- Lists of impairments (Slovenia, the UK, the USA).
- Jurisprudence/legal texts (Belgium, Norway).
- Questionnaires/ forms (France, Germany, Italy, the Netherlands, Norway, Slovenia, the UK, the USA).
- Protocols for interviews in disability evaluation (the Netherlands).
- Computer programs for selecting possible jobs (the Netherlands).
- Job descriptions (the Russian Federation, Slovenia).
- Baremas (Spain). Baremas describe the loss of labour capacity for various types of anatomical damage.
- Lists for coding impairments (Ireland).

One of the instruments that attracted our attention was the use of lists of impairments that state which conditions entitle a claimant to a disability benefit. Such lists are used in the UK and the USA. It should be noted, however, that the list used in the UK is more limited than that used in the USA and focuses on serious conditions that do not require a personal capacity assessment. Note that the list that is used in Slovenia does not refer to work capacity. In Spain, the law requires that a list is made

⁷ See for instance Franche, 2002; Frueh et al., 2003; Innes & Straker, 2002.

describing all symptoms and their possible consequences for work and the benefit. However, the list has not yet been developed and doctors wonder whether it can indeed be realised. Another possibility is a list of diseases that do *not* entitle a claimant to a benefit. At present in the Netherlands, the possibilities of such a list are being investigated. We did not find any such instrument.

Finally, in the UK, it is planned to set up a computer program that will guide the assessor through the assessment.

5.4 Other factors that may influence the decision-making

In the Netherlands, it is accepted that several other factors may influence the decision-making. The factors that the respondents mentioned encompassed the following aspects:

- Time pressure and caseload: under time pressure, social insurance physicians are less inclined to consult other medical specialists. Under time pressure, it is also more difficult to reject disability claims: the rejection of a claim, with possible appeal procedures, takes more time than the acceptance of claims.
- Compassion for the claimant: rejection of a claim is more difficult when one feels compassion for the claimant.
- Aggression/pressure from claimant: rejection of a claim is more difficult when the claimant is aggressive or exerts pressure.
- Political climate. If the political climate is restrictive with respect to the allowance of disability benefits, the social insurance physician and labour expert may find it more difficult to accept disability claims.

Similar factors and many other factors were mentioned by the interviewed professionals in the other countries (see Table 5a), such as:

- Time pressure (Hungary). Under time pressure, it is more difficult to reject disability claims because more time is required for rejection than acceptance.
- Age of the claimant (mentioned in Germany, Finland, Ireland, Italy, Norway, Hungary). Older people generally seem more likely to receive disability benefits, although the reasons for this may diverge.
- Compassion (Hungary). As mentioned above, rejection of a claim is more difficult when one feels compassion for the claimant.
- Prospects of claimant in the labour market (Italy, Hungary, Norway). People with poor prospects of finding a job on the labour market seem more likely to receive a disability benefit.

- Political pressure/climate (Finland, the USA). The political climate may sometimes encourage an assessor to be milder, and, in the USA, may also influence the budget for administration.

Long-term disability arrangements

6 Quality Control

In addition to a good and robust organisation of the process, and in addition to external supervision, the Workers Insurance Authority (UWV) in the Netherlands has to monitor and manage the process of disability evaluation. We were curious about the development and functioning of this potentially strong influence on the assessments. Knowing that disability evaluation is a vulnerable and important process, one might expect an explicit system of monitoring.

In the controlling of the process of disability evaluation, different aspects may be discerned:⁸

- *Output.* The monitoring of output signifies that a specific product or service of the evaluation process, such as the assessment report, is evaluated.
- *Process.* The monitoring of the process denotes that the whole process of evaluation is evaluated, with special attention to critical aspects in the process.
- *Professional.* The monitoring of the professional signifies that the quality of the professionals involved (such as the social insurance physician, the labour expert) is controlled.
- *System/organisation.* The monitoring of the system means that a coherent set of processes within the organisation is evaluated.
- *Chain.* The monitoring of the chain means that the whole chain of different systems and organisations that are involved is considered.
- *Outcome.* The monitoring of the outcome signifies that the effects on society are evaluated, such as the number of disabled individuals.

6.1 Controlling institutions

In the Netherlands, the Workers Insurance Authority (UWV) is responsible for quality control. On top of that, external bodies control the quality control of the assessment process by the UWV, the Ministry of Social Affairs and Employment, and the Inspection for Work and Income.

In the countries examined, different institutions appear to be responsible for quality control (see Table 6). The different institutions include:

- Special audit organisations (Belgium, Germany).
- Responsible departments (France, Hungary, the Netherlands, Spain, and the UK).

⁸ See Willems (2000) or Boer et al. (2002).

- The professional organisation of doctors (Germany).
- The Institute of Social Insurance (France, Hungary, Ireland, Italy, the Netherlands, Norway, the Russian Federation, Slovenia, Spain, and the USA).
- Courts of appeal (Denmark, Finland).

It is remarkable that only in two countries was mention made of the role of the courts of appeal with respect to quality control. Appeal procedures are described in section 4.1.5.

6.2 Official quality system

In the Netherlands, there is no official quality system (such as ISO) to control or improve the accuracy of the assessor's decision. However, some social insurance agencies comply with ISO certification with respect to logistics.

Some countries have an official quality system (see Table 6): Finland (EFQM and balanced scorecard), the Netherlands (ISO, in some parts of the UWV), Spain (SERVQUAL), and the UK (ISO, IQAS). However, these official quality systems have generally not been designed for the purpose of controlling or improving the accuracy of the assessor's decision.

6.3 Evaluated aspects, criteria, and norms

In the Netherlands, various aspects are evaluated: the number of decisions, the time span, juridical legitimacy, professional legitimacy (including fulfilment of professional norms, transparency of the argumentation, and sufficient strictness), and customer orientation. For the number of decisions, the time span, and juridical legitimacy, norms have been formulated (see Table 6). For professional legitimacy, norms will be further developed. For customer orientation, norms have not yet been developed.

In the other countries investigated, the aspects that are evaluated by the controlling institutions generally refer to (see Table 6)⁹:

- Time span.
- Legitimacy.

⁹ One would expect outcome management as well; we excluded this, as it was not reported by our respondents. It has been amply described by Stone (1985), Swaan (1990), and Kohrman (2003). The present Dutch reform is an example of outcome management.

- Quality of the decision.
- Client satisfaction.

The criteria and norms for the quality of the assessment process, as reported by our respondents, are generally not defined in a very precise, detailed manner. Our impression was that this was particularly the case for the quality of the decision. This might indicate that quality control with respect to the decision often occurs in an implicit way, and that specific details are not well known to the professionals involved. Furthermore, it appears that the quality of the decision is generally controlled only by file inspection. One may wonder whether file inspection is an effective method for evaluating the quality of the assessor's decision, particularly when files do not have to be very elaborate. Aspects about the claimant's condition that medical assessors have not observed or have not written down in the report cannot be considered.

The general lack of precise criteria for determining the quality of the decision, in combination with the method of file inspection, indicates that quality control with respect to the decision is not in an advanced phase in many countries.

6.4 Feedback

In the Netherlands, assessors receive the results of quality control specified at an individual level. Feedback is also provided through discussions of progress with the staff social insurance physician and through discussion of cases among colleagues.

Individual feedback in relation to the results of quality control appears to be common practice in the majority of the examined countries (see Table 6). These countries include the Netherlands, Belgium, Denmark, France, Hungary, Italy, Norway, Slovenia, Spain, the UK, and the USA. Moreover, in Belgium and Hungary, the assessor's performance is compared with the performance of other assessors (i.e., benchmarking). In some countries, individuals may receive some individual feedback via additional assessors. This is the case in Hungary (second assessor), Slovenia (second board), and Spain (controlling multidisciplinary team). In addition, as is done in the Netherlands, feedback may be provided through discussion with colleagues. Inter-colleague consultation was mentioned by respondents in Belgium, Finland, Hungary, Italy, Spain, and the USA.

6.5 Other procedures to control quality

Respondents in the Netherlands mentioned several other procedures that are used to control the quality of the assessment process. These included a reference book containing information on work methods, work instructions, protocols, and standards. Furthermore, assessors are controlled through coaching, continuing education, and the discussion of cases among colleagues. After evaluation of the results of the assessment process, new objectives are set and a new plan of action is drawn up.

In the other countries, various other procedures to control the quality of the assessment were mentioned (see Table 6). These procedures include, among other things, inter-colleague consultation, professional and continuous education, coaching, forms, protocols, guidelines, books, and magazines.

In some countries investigated, quality control is promoted by the specific design of the assessment process. For instance, in some countries the quality of the assessment is controlled by additional assessors or additional boards: this occurs in Finland (decision maker from another institution), Hungary (second assessor), Slovenia (second board), and Spain (controlling multidisciplinary team). In Italy and the Russian Federation too, multiple assessors may serve as a kind of quality control, although this was not mentioned as such by the respondents. The use of multiple assessors or multiple boards can be considered an important tool for enhancing the quality of an assessment, notably its reliability. This may be particularly the case when additional assessors/boards not only inspect files, but also examine the clients.

In addition, respondents in Slovenia mentioned that appeal cases are used to ensure the quality of the assessment. Assessors in Slovenia are given feedback about appeal cases to improve the quality of their assessments. It is remarkable that Slovenia is the only country in which appeals were explicitly mentioned as part of quality control procedures. It is probable that this is current practice in other countries as well, although it was not mentioned by the respondents.

6.6 Advantages and disadvantages of quality control

Respondents in the Netherlands mentioned no advantages, but various disadvantages with respect to the way in which quality is controlled: The control with respect to logistics and professional accuracy is not completely integrated (see Table 6). In addition, norms and definitions with respect to quality control are not (yet) clearly stated. Moreover, too little statistical information is available, for instance, to assess the

effectiveness of interventions designed to reduce the number of delayed cases.

As practices in quality control vary considerably in the countries investigated, there is great diversity in the advantages and disadvantages put forward by the interviewed professionals (see Table 6). As with the advantages and disadvantages of the organisational process, it should be noted that the advantages and disadvantages with respect to quality control reflect the opinions of the respondents, and do not necessarily result from empirical studies investigating the effects of quality control. Moreover, in some countries (Denmark, France) respondents mentioned that quality control is still very recent, so little is known about actual advantages and disadvantages.

Important, recurrent themes in the disadvantages mentioned were, among other things:

- Limited control of decision/assessment (Belgium, Norway).
- Quality control not systematic enough (Belgium (peer review), Finland).
- Unclear guidelines, standards, protocols, or definitions (Hungary, the Netherlands, Slovenia).
- Poor integration of different aspects of quality control, such as logistics, professional accuracy, assessment procedure (Hungary, the Netherlands, the USA).

Considering the disadvantages reported, one might conclude that quality control could be considerably improved, in particular with respect to the quality of the decision.

7 Discussion

7.1 General conclusions

In this study, we sought to establish similarities and differences in the practice of disability evaluation in the general public scheme in 15 countries. We focused on practices in organisation, and on quality control. In this chapter, we present the most salient observations, covering the major characteristics of the arrangement, the actors involved, the organisation of the evaluation process, the decision-making process, and quality control. On the whole, we would say that, as far as disability evaluation is concerned, the legal texts show considerably more similarities than differences. The criteria that are applied by the different Institutes of Social Insurance, the operationalisations, are much more different. The organisation of the processes in order to carry out the evaluations differ greatly, with large differences in the various steps and in time consumption. In most of the countries investigated, quality control is in (early) development. We have the impression that this was particularly the case for the quality of the decision

7.2 Major characteristics of the arrangement for long-term disability

7.2.1 *Legal definition of disability*

Although the variation in the legal definitions of disability may seem bewildering, the common elements of the handicapped role in the legal definitions of disability can be discerned. These elements are clients' (in)abilities to do work that can reasonably be asked of them; health conditions that explain these (in)abilities; chances and opportunities of improvement / reintegration. Whereas the legal definition in all countries investigated contains the first two elements, only in some of the countries (Norway and Spain) is the element of reintegration explicitly stated in the definition of disability. As far as we could see, the concept of disability (labour capacity or earning capacity) does not make much difference in the organising and execution of the evaluations.

7.2.2 *Operationalisation of disability*

The operationalisation of disability also shows considerable variation. Virtually all countries have a theoretical approach, in which it is evaluated what a person theoretically could do, not what he/she actually does. Some countries have a purely medical operationalisation. A medical operationalisation is characterised by an emphasis on the

medical findings, such as diagnosis of symptoms and impairments, and these findings in themselves justify the making of a decision regarding whether a person is disabled or not. The term medical is slightly confusing as besides purely medical information, social and historical information is also gathered, but to doctors, this counts as medical information. Policy makers tend to use a more narrow definition of medical. In some countries, a medical operationalisation is combined with a functional operationalisation. A functional operationalisation is characterised by an emphasis on (restriction of) activity and these findings lead, by themselves or through job matching, to a decision on disability. In some countries, a medical operationalisation is combined with an operationalisation of rehabilitation. An operationalisation of rehabilitation focuses on the possibilities of and experiences with rehabilitation and these findings lead to a decision on disability. Finally, some countries combine all three operationalisations in a single evaluation process.

It is important to note that the operationalisation of disability does not seem to be determined by the definition. For instance, we could not find a relationship between the concept of disability (i.e., earning and labour capacity) and the way in which the definition is operationalised. Moreover, the actual practice of assessment may be more similar than the different operationalisations suggest (see also Donceel & Prins, 2001).

7.2.3 *Other characteristics of the arrangement for long-term disability*

The other characteristics of the arrangement for long-term disability also show considerable variation: the number of levels of disability varies between countries. Moreover, the length of time that elapses from the onset of sickness to application for disability benefit, as well as the time required for reassessments, varies greatly. Some countries have fixed time schedules, whereas others have flexible time schedules. A flexible time schedule for reassessments has the advantage that effective use is made of medical assessors' time: if it is not expected to be necessary, the medical assessor is not brought into action. Furthermore, with a flexible schedule, the recovery of a claimant who is expected to recover can be detected in an early phase.

7.3 **Actors involved**

It is believed by some that assessments take place only in the 'black box' of the medical doctor's consulting room. However, in the majority of cases, we were able to trace various actors that are involved in

assessments. We found interplay between the assessors, the organisation that contracts them, curative health care, and the employer. An external supervising body could not always be clearly identified. The influence of the involved parties was found to vary considerably, most notably with regard to the role of curative health care. Curative health care is sometimes closely, and sometimes less closely involved in the individual assessment process. The structural influence of curative health care, through professional education and in the setting of medical norms, is possibly much larger. The influence of the courts is important, too, but this was not investigated here. Interaction between client and assessor is also of major influence –according to many respondents, but that aspect was not elaborated here either. It is remarkable that in none of the countries investigated does a paramedical assessor, such as a nurse, perform the assessment of disability, although nurses may assist the assessors.

Our findings are in accordance with the script model by Hofstee (1999) and the extended script model (Boer et al., 2002). These models assume an interplay between the assessor, the organisation that contracts him, curative health care, and the external critic. Hofstee emphasises the need for checks and balances in order to have a proper functioning of evaluations. An administration might have a tendency to steer on efficiency only (e.g., Stone, 1985). It is in particular the external critic that provides the countervailing power. It is therefore interesting to note that the external critic was the source of influence least often mentioned by respondents.

7.4 Organisation of the assessment process

7.4.1 Primary goal of the assessment process

In many countries, the goal of the assessment is not only to check the entitlement of the claimant to the benefit, but also to promote rehabilitation/reintegration. This additional goal has advantages, but it also presents disadvantages. An obvious advantage is that reintegration is promoted. Limiting assessors to focus on the disability claim may result in insufficient attention for helping individuals to recover. However, the separation of rehabilitation and the assessment of disability ensures a more ‘pure’ assessment, in which empathy resulting from a ‘curing or caring’ relationship is likely to be limited.

7.4.2 Time span

The duration of the whole process differs greatly between countries. The interval between the submission of a claim and the making of the

decision varies from approximately 5 days (the Russian Federation) to 3 or 4 months (several countries). These intervals are difficult to compare, however, because sometimes an important part of the work is done by the health care institution in preparing the claim. And sometimes the start and end of the process are diffuse.

The production time of the assessment process, that is, the amount of time spent on the actual assessing by all assessors concerned, also shows quite some variation. Although production times in different countries are difficult to compare, it seems that the production time in the Netherlands is relatively long in comparison with that in other countries. Furthermore, in the Netherlands, compared with other countries, much time is spent on writing the medical report. This is related to the required extensiveness of the argumentation for the decision about disability in the Netherlands.

7.4.3 *Method of assessment*

In some countries, assessments are based on a paper file, rather than on a face-to-face examination. This is also the case for reassessments in some countries. Judging (some) cases on paper may be attractive for reasons of efficiency. Furthermore, assessors may feel less empathy for cases on paper than for claimants that are met during face-to-face examinations. However, the fact that the information present in the file stems from a personal encounter between the claimant and some kind of assessor should not be discounted. The robustness of the file information depends on this encounter in a comparable way as it does in countries that rely on face-to-face assessments.

7.4.4 *Medical assessors*

Several countries employ more than one medical assessor in the assessment process, apart from the general practitioner. This seems to be primarily dictated by reasons of reliability and may in this way serve as a tool for improving the quality of the decision: additional assessors may correct each other. However, it should be noted that, to our knowledge, it has not yet been empirically tested to what extent the use of several assessors increases the accuracy of the assessment (see also sections 4.4.1 and 4.4.2).

7.4.5 *Labour experts*

In many countries, labour experts are not routinely consulted. As labour experts are specialised in labour market conditions and job demands, they are used for establishing the relationship between disease, impairment, or functional limitation and participation in labour.

7.4.6 *Decision maker*

In many countries, the final decision is made not by the (medical) assessor but by a case manager or a person with a comparable function. Some people seem to believe that this would result in a more objective, less medical decision (Donner committee, 2001). However, the decision makers often follow the advice of the (medical) assessor.

7.4.7 *Process steps*

The process steps followed in the various countries investigated show quite some variation. However, there is a root process that is applied with many different specifications. A great many possibilities were described that offer many opportunities to fine-tune existing process designs (see Table 4c).

7.4.8 *Advantages and disadvantages of the organisation*

The advantages and disadvantages of the organisation of the assessment process that respondents put forward are various. Advantages that were mentioned pertained to, among other things high quality through additional assessors or multidisciplinary teams, a high level of quality control, the promotion of reintegration, and the speed of the assessment process. Disadvantages pertained to, among other things, a low level of quality control, a lack of incentives for reintegration, dependence on curative health care, and efficiency problems. It should be noted, as mentioned above, that these advantages and disadvantages reflect the opinions of the respondents, and do not necessarily result from empirical studies investigating the effects of the process. Our impression was that not all respondents were equally aware of the advantages and disadvantages with respect to the organisation of the assessment process. Respondents may also have varied in their willingness to disclose disadvantages and problems.

Some of the reported disadvantages can be conceived of as national preoccupations. For instance, if respondents mentioned that client satisfaction could be improved, this does not necessarily imply that clients are not satisfied with services. Rather, it might reflect a national concern for client satisfaction. We were not in a position to verify this hypothesis, as this would require much more research into current political debates in the countries investigated.

7.5 Decision-making process

7.5.1 Argumentation

In comparing the argumentation needed for the decision in the different countries, it was difficult to grasp the exact reasoning for determining incapacity for work. It remains hard to understand the dividing line between capacitated or incapacitated for work. This seems to be particularly problematic if partially disabled individuals are not entitled to disability benefits. Even when there are a number of levels of disability, it is often not clear what exactly constitutes the dividing line between the different levels. The Netherlands gives some insight into the argumentation in case of partial disability. The Netherlands is remarkable in the sense that the argumentation that the assessors have to provide must be very detailed and extensive. It should be noted, however, that the interviewers were living in the Netherlands. Therefore, they may have acquired more detailed information about the argumentation in the Netherlands.

7.5.2 Instruments

Following examination of the instruments that are used, it can be concluded that the Netherlands is unique with respect to interview protocols and the computer programs used for selecting possible jobs. A computer program is also planned for use in the UK. This computer programme will guide the assessor through the assessment.

One of the instruments that we were interested in was the use of lists that state which conditions entitle a claimant to a disability benefit. Such lists are used in the UK and the USA. It should be noted, however, that the list used in the UK is more limited than that used in the USA and focuses on serious conditions that do not require a personal capacity assessment. In Spain, the law requires that a list is prepared that describes all symptoms and their possible consequences for work. Doctors wonder, however, if it is indeed possible to make such a list. Another possibility is a list of diseases that do *not* entitle a claimant to a benefit. At present in the Netherlands, the possibilities of such a list are being investigated. We did not find any such list in the countries we investigated. It should be noted that the value of such a list would depend on its use, reliability, and validity.

7.5.3 Other factors influencing the decision-making

In the countries investigated, several factors were mentioned that influence the decision-making, some of which seem interrelated. These factors encompass time pressure, compassion for the claimant,

aggression / pressure from the claimant, political pressure / climate, and the claimant's age and prospects on the labour market. Although, formally, many of these factors should not influence the decision-making, it appears to be difficult to rule out their influence. These findings hint at the importance of factors beyond the legal criterion that influence, or rather distort, the decision-making process in the assessment of disability. In many cases, these factors indicate differences between theory and practice.

7.6 Quality control

Knowing that disability evaluation is a vulnerable and important process, we expected a well-established management circle in every organisation so as to monitor and correct the process of evaluation. The input into the process, the process itself, the professionals, the output, and the outcome all offer possibilities to control quality. This is only partly done. Nevertheless, this study has yielded a great many possibilities that may serve as inspiration to enhance existing quality management.

7.6.1 Criteria and norms

Quality control with respect to the decision is not in a very advanced phase in many of the countries investigated. Criteria and norms for the quality of the assessment process, as reported by our respondents, are generally not defined in a very precise, detailed manner. We have the impression that this was particularly the case for the quality of the decision: its validity and reliability. This may indicate that quality control with respect to the decision often occurs in an implicit way, in which the specific details are not very well known to the professionals involved. Furthermore, it appears that the quality of the decision is generally controlled only by file inspection. However, the effectiveness of file inspection as a method for evaluating the quality of the assessor's decision is questionable. This is particularly problematic if files do not have to be very elaborate.

It should be noted that quality control of the professional, especially the medical advisor, has a long history. In contrast, quality control of the process, in particular of the decision, is a relatively recent phenomenon. The time span is the only aspect that has long been subject to quality control. This may explain why quality control with respect to the decision is not in an advanced phase in many countries.

7.6.2 *Other procedures to control quality*

It should be noted that, in some countries, quality is promoted by the specific design of the assessment process. For instance, in some countries, the quality of the assessment is promoted by using additional assessors or additional boards. This may be particularly effective when additional assessors/boards not only inspect files, but also perform medical examinations.

Various other procedures to control the quality of the assessment were mentioned. These procedures vary from inter-colleague consultation, professional and continuous education, and coaching to using forms, protocols, guidelines, books, and magazines. It is remarkable that only in Slovenia was the use of appeals to improve the quality of the assessment mentioned. Hence, it seems that the information obtained from appeal procedures is generally not integrated in the quality control system.

7.6.3 *Feedback*

Individual feedback appears to be common practice in the majority of the examined countries. Moreover, in some countries, the assessor's performance is compared with the performance of other assessors (i.e., benchmarking). In some countries, individuals also receive individual feedback from additional assessors or through discussion with colleagues.

7.6.4 *Advantages and disadvantages of quality control*

As practices in quality control vary considerably in the countries investigated, there is large diversity in the advantages and disadvantages that the interviewed professionals put forward. Important recurrent themes in the disadvantages were, among other things, limited control of decision/assessment, unsystematic quality control, unclear guidelines, and poor integration of different aspects of quality control, such as logistics and professional accuracy. Having inspected the reported disadvantages, we conclude that quality control can be considerably improved, in particular with respect to the quality of the decision.

7.6.5 *Scientific foundation of disability evaluation*

As the evaluation of disability seems to be a particularly difficult task, one would expect a large scientific tradition to exist with regard to checking the validity and reliability of the evaluations. Although we did not systematically address these issues in the interviews, we have a strong impression that such a scientific tradition does not exist. The results of our literature search point in the same direction. This is not to say that the evaluations are done in an inappropriate manner, but it is

astonishing that such an important social activity seems so poorly funded with specific knowledge. One wonders if the socio-political function of the disability scheme might offer an explanation for the lack of interest in making the practice of the evaluations a more robust one. Furthermore, the lack of insight into the validity and reliability of assessments makes it difficult to predict the effects of changes in the organisation of the assessment. Yet, changes are often made (Prinz, 2003). As it is not known how reliable the assessments are, and what aspects promote their reliability, it is not known how changes in the organisation, such as efficiency measures, affect the quality of the assessment.

7.7 In sum

In this study, we investigated the variety in practices in the organisation and controlling of disability evaluations in 15 countries. The results of this study offer knowledge and insight to decision makers and other professionals working in the field of disability evaluation. For these professionals, the description of the different practices in the countries investigated may serve as an inspiration for fine-tuning or re-designing existing practices. Especially in the process of monitoring and correcting the evaluation, we believe that there is much to be gained. This study will, hopefully, also provide the Dutch Ministry of Social Affairs and Employment and the Workers Insurance Authority (UWV) with ideas and cautions in developing the evaluation practice in the Netherlands. The need for evidence-based instruments and techniques seems to be present everywhere.

The evaluations of disability remain elusive, however. It was difficult to clarify the intrinsic logic of these evaluations in the current study. Is there a logical set of criteria for and knowledge of ways in which the evaluations are carried out and monitored? Setting out to investigate the evaluations, we expected to find a common ground, not only in criteria but also in organisation and control. We did not find it. Perhaps more in-depth research is necessary, but the results of this study make us wonder if such a common ground can be found at all. Maybe it simply does not exist.

Further research, not only descriptive research but also experimental research with a longer time frame, is of major importance for gaining more insight into disability evaluations. A common frame of terms would be desirable to distinguish between real and apparent differences. Moreover, in-depth research should be conducted, for instance, into instruments and their effects on the decision-making process. In addition,

more research should be conducted into the validity and reliability of current and/or alternative practices in disability evaluation. This kind of research would foster the development of more robust practices of disability evaluation, in particular with respect to quality control.

In the European Union, there is a tendency to use experiences from other countries in order to improve one's policy. The OECD contributes to this (OECD, 2003), as does the European Foundation (Grammenos, 2003). In line with this, and taking into account the weight of disability evaluations in the journey from work to disability, we believe this kind of research to be important to further improve the understanding of disability evaluation at a European level.

8 References

Aarts, L., & Jong, Ph.R. de (2003). *The Dutch Disability Experience in* Prinz, C. *European Disability Pension Policies. 11 Country Trends 1970-2002*. European Centre, Vienna.

Arrelöv, B., Borgquist, L., Ljungberg, D., & Svärdsudd, K. (2003). *The influence of change of legislation concerning sickness absence on physicians' performance as certifiers*. *Health Policy*, 63, 259-268.

Baldacci, E., & Santis, G. de. (2003). *Disability Pensions in Italy: The Law and the Numbers in* Prinz, C. *European Disability Pension Policies. 11 Country Trends 1970-2002*. European Centre, Vienna.

Boer, W.E.L. de (2002). *Een perspectief op claimbeoordeling/ indicatiestelling in arbeid. [A perspective on sickness certification and disability evaluation]*. TNO Arbeid, Hoofddorp.

Boer, W.E.L. de, Duin, J.A., Hengreen, H. (1997). *Handleiding Methodisch Beoordelingsgesprek. [Manual for methodic interviewing in disability evaluation]*. NSOH, Utrecht.

Boer, W.E.L. de, Hazelzet, A.M., & Gerven, J.H.A.M. (2002) *Vademecum Beoordelingen Arbeidsmogelijkheden. [Catalogue of evaluations of capacities for work]*. TNO Arbeid, Hoofddorp.

Bolderson H, Mabbet D & Hvinden B. (2002) *Definitions of disability in Europe: a comparative analysis*. Brunel University UK

Bont, A.A., Boonk, M.P.A., Berendsen, L., & Brink, J.C. van den, (2000). *In de spreekkamer van de verzekeringsarts: een onderzoek naar het verzekeringsgeneeskundige deel van de WAO claimbeoordeling. [At the doctor's office: A study of medical assessment of incapacity for work]*. College van Toezicht Sociale Verzekeringen (CTSV) (Rapporten R00/03), Zoetermeer.

Bovenberg, A.L. (2000). *Reforming Social Insurance in the Netherlands*. *International Tax and Public Finance*, 7, 345-368.

Council of Europe (2001). *Final report of the working group on the assessment of person related criteria for allowances and personal assistance*. Strasbourg.

Croon, N.H.T., & Langius, S.W.T. (1993). *Arbeid en gezondheid: een studie van de verzekeringsgeneeskundige praktijk bij de bedrijfsverenigingen. [Labour and health: A study on the practice of social insurance physicians in sickness certification]*. Universiteit van Amsterdam.

Donceel, P., & Prins, R. (2001) *Taken en training van verzekeringsartsen, een internationale verkenning. [The tasks and training of insurance physicians, an international survey]*. Tijdschrift voor bedrijfs- en verzekeringsgeneeskunde, 9(11), 341-345.

Donner Committee (2001). *Werk maken van arbeidsgeschiktheid. Rapport van de commissie Donner (adviescommissie Arbeidsgeschiktheid). [Working on ability for work. Report of the state committee (Donner committee: Advisory committee of ability for work)]*. Elsevier, Doetichem, the Netherlands.

Eck, M.A.A. van (1990). *Het beslisproces van de medische functie van het GAK [Decision making in sickness certification]*. Dissertation. Universiteit van Amsterdam.

Franche, R.L. (2002). *Readiness for return to work after illness*. Journal of Occupational Rehabilitation, 12, 233-256.

Frueh, B.C., Elhai, J.D., Gold, P.B., Monnier, J., Magruder, K.M., Keane, T.M., & Arana, G.W. (2003). *Disability compensation seeking among veterans evaluated for posttraumatic stress disorder*. Psychiatric services, 54, 84-91,

Goor, A.G. Van de (1997). *Effects of regulation on disability duration*. Thesis Publishers, Amsterdam.

Gordon G. (1966). *Role theory and illness*. College and University Press, New Haven.

Grammenos, S. (2003). *Illness, disability and social inclusion*. European Foundation for the improvement of living and working conditions, Dublin.

Hofstee, W.K.B. (1999). *Principes van beoordeling. Methodiek en ethiek van selectie, examinering en evaluatie. [Principles of assessment. Methods and ethics of selection, examination and evaluation]*. Swets & Zeitlinger, Lisse, the Netherlands.

Innes, E., & Straker, L. (2002). *Workplace assessments and functional capacity evaluations: Current practices of therapists in Australia*. *Work: a Journal of Prevention, Assessment and Rehabilitation*, 18(1), 51-66.

Jong, Ph.R. de (2003). *Disability and Disability Insurance in Prinz, C. European Disability Pension Policies. 11 Country Trends 1970-2002*. European Centre, Vienna.

Kerstholt, J.H., Boer, W.E.L. de, & Jansen, E.J.M. (2002). *Psychologische aspecten van claimbeoordeling. [Psychological aspects of assessment of disability]*. TNO Technische Menskunde, Soesterberg.

Kohrman, M. (2003). *Why am I not disabled?* *Medical Anthropology Quarterly*, 17(1), 5-24.

Marin, B. (2003). *Welfare Studies and the OECD Report 2003*. In Prinz, C. *European Disability Pension Policies. 11 Country Trends 1970-2002*. European Centre, Vienna.

Meershoek, A. (1999). *Weer aan het werk [Back to work again]*. Thela Thesis, Amsterdam.

Organisation for Economic Co-operation and Development (OECD). (2003). *Transforming Disability into Ability. Policies to Promote Work and Income Security for Disabled People*. Paris.

Parsons T. (1951) *The social system*. Free Press Glencoe

Prinz, C. (2003) *European Disability Pension Policies. 11 Country Trends 1970-2002*. European Centre, Vienna.

Razenberg, P.P.A. (1992). *Verzekeringsgeneeskundige oordeelsvorming. Inzicht in de praktijk. [Decision making in assessment of incapacity for work. A study into practice]*. Dissertation. Universiteit van Amsterdam.

Sociaal Economische Raad (2002). *Werken aan arbeidsongeschiktheid: voorstellen WAO-beleid. [Working on disability: Proposals for policies with regard to disability for work]*. SER, Sociaal-economische Raad, Den Haag.

Spanjer, J. (2002) *Belastbaarheidsgerichte Beoordeling. [Capacity oriented interviewing]*. Not published.

Stone, D. (1985). *The disabled state*. London: MacMillan.

Swaan, A de. (1990). *In care of the state*. New York, Polity Press.

Veerman T.J., & Besseling, J.J.M. (2001). *Prikkels en privatisering: integrerende rapportage evaluatie wetgeving rond ziekteverzuim, WAO en reïntegratie. [Incentives and privatisation: Integrated report concerning policy evaluation with respect to sickness absences, disability for work and reintegration]*. Elsevier bedrijfsinformatie, Doetinchem.

Viaene, J. (1975) *Schade aan de mens. [Human damage]* Maklu, Antwerpen.

Waddell, G., Aylward, M., & Sawney, Ph. (2003). *Back pain, incapacity for work and social security benefits. An international literature review and analysis*. Royal Society of Medicine Press, UK.

WHO (1980) *International Classification of Impairments, Disabilities and Handicaps, ICIDH*. WHO, Geneva

WHO (2002) *International Classification of Functioning, Disability and Health*. WHO, Geneva

Willems, J.H.B.M. (2000). *Professionalisering van de verzekeringsgeneeskunde: een onderzoek naar de wensen en de mogelijkheden om de opleiding tot verzekeringsarts verder te professionaliseren. [Professionalising social insurance medicine: A study on the wishes and possibilities to further professionalise the education for social insurance physicians]*. TNO Arbeid/ Bureau As/tri. Min. Sociale Zaken en Werkgelegenheid, Den Haag.

Willems, J.H.B.M., & Kroneman, H. (2003). *Arts of advocaat: nieuwe WAO verandert de rol van de verzekeringsarts. [Doctor or lawyer: The new disability benefits act changes the role of social insurance physician]*. *Medisch Contact*, 58(9), 337-340.

Wijers, J.H.L. (1996). *Handicap en integratie [Handicap and integration]*. *Handicap en beleid*, 3(2), 20-22.

Wörister, K. (2003). *Disability Pensions in Austria. In Prinz, C. European Disability Pension Policies. 11 Country Trends 1970-2002.* European Centre, Vienna.

Appendix 1 Tables

The following tables are presented:

Table 2	Characteristics of the disability arrangement
Table 3a	Actors involved in the arrangement
Table 3b	Backgrounds of assessors
Table 3c	The employer
Table 4a	Process
Table 4b	Assessors
Table 4c	Process steps
Table 4d	Advantages and disadvantages of the design
Table 5a	The decision making: argumentation and information
Table 5b	The instrumentation in the decision making
Table 6	Quality control

Table 2 Characteristics of the disability arrangement

Country, Name of long-term disability arrangement	Definition of disability	Operationalisation of assessment (medical, functional, reintegration / rehabilitation)	Levels of disability	Waiting period from onset of sickness to application for benefit	Time schedule for reassessment
<p>Belgium, Invalidity Pension</p> <p>During the first year of sickness, a person can apply for a Primary Disability Benefit. After one year, this scheme is turned into an Invalidity Pension.</p>	<p>A person is considered to be incapacitated for work if (s)he has suspended all work activity as the direct result of the appearance or the aggravation of injuries or functional impairments which have been recognized as limiting his/her earning capacity to 1/3 or less.</p> <p>One third or less signifies what a (non-disabled) person of the same social class and with the same education and professional training can earn in the same category of occupations.</p> <p>Disability refers to earning capacity.</p>	<p>Medical.</p>	<p>There is only one disability category, requiring a 2/3 loss of earning capacity. There is no partial disability. However, partial work resumption is possible, but only if this is requested or accepted by the client.</p>	<p>After 1 year of sickness.</p>	<p>Flexible; After every assessment, the medical advisor determines the period of time after which a re-assessment is made.</p>

Table 2

Country, Name of long-term disability arrangement	Definition of disability	Operationalisation of assessment (medical, functional, reintegration / rehabilitation)	Levels of disability	Waiting period from onset of sickness to application for benefit	Time schedule for reassessment
Denmark, Disability pension act	Disability is considered to be a permanent reduction of ability to work that makes it impossible for the applicant to become self-supportive through ordinary or wage-subsidized work. 'Permanent' means that ability to work cannot be developed. Although not stated in the act, permanent refers to a period of approximately 5 years, implying that no social worker can oversee a period longer than 5 years. Disability refers to labour capacity.	Medical. Functional, Reintegration / rehabilitation. The emphasis is on reintegration / rehabilitation.	In the new system, there is only one disability category, requiring a 2/3 loss of earning capacity.	Flexible; mostly after 1 year or more.	The benefit is permanent. But before the benefit is granted, rehabilitation may last between 3 weeks and 5 years, during which time several 'rehabilitation assessments' take place.
Finland, Disability pension (disability pension is divided into a national pension and an employment pension)	A person is entitled to a disability pension if his/her capacity for work can be assessed to have decreased due to illness, handicap, or injury by at least two fifths for an uninterrupted period of at least a year. Disability refers to labour capacity.	Medical. Functional. Reintegration / rehabilitation.	The National Pension Act recognises full disability only. For Employment Pensions, there are two degrees of disability: 2/5 (partial) 3/5 (full)	Flexible; after a maximum period of 300 workdays	Reassessments are generally not part of the procedure to obtain a benefit. It is common to give a temporary benefit for approximately 9 months if recuperation is still possible. After this period, a new application is required. Such cases are called "continuing cases".

Table 2

Country, Name of long-term disability arrangement	Definition of disability	Operationalisation of assessment (medical, functional, reintegration / rehabilitation)	Levels of disability	Waiting period from onset of sickness to application for benefit	Time schedule for reassessment
France, Pension d'Invalidité (PdI)	<p>The individual is entitled to a disability pension if (s)he presents an incapacity that reduces his/her earning or working capacity by over 66 %, i.e., which makes him/her unable to earn a salary in any job of over one third of the wage that a individual would receive in the same area, in the same category of workers as (s)he belonged to before. The state of incapacity is determined, taking into account the working capacity, the general state of health, age, physical and mental faculties, and the aptness of the individual to follow a professional education.</p> <p>Disability refers to a combination of labour capacity and earning capacity.</p>	Medical. Reintegration / rehabilitation.	<p>There are three degrees of disability:</p> <ol style="list-style-type: none"> 1. the person is still able to do light and adapted work 2. the person is absolutely unable to work in any occupation (whereby any occupation refers to any occupation in the client's area) 3. the person is absolutely unable to work and needs the aid of a third person in daily activities. 	<p>Flexible; After maximally three years of sick leave, it is examined whether the situation has stabilized and whether the person should have an invalidity pension (MRPI). This usually occurs after 12-18 months of sick leave.</p>	Flexible but within 3 years.

Table 2

Country, Name of long-term disability arrangement	Definition of disability	Operationalisation of assessment (medical, functional, reintegration / rehabilitation)	Levels of disability	Waiting period from onset of sickness to application for benefit	Time schedule for reassessment
Germany, "Rente wegen Erwerbsminderung"	<p>Total incapacity ("voll erwerbsgemindert"): the situation of an insured person when, as result of sickness or infirmity, (s)he is not able to work during an indefinite period for at least 3 hours a day in regular labour market conditions.</p> <p>Partial incapacity ("teilweise erwerbsgemindert"): the situation of an insured person when, as result of sickness or infirmity, (s)he is not able to work during an indefinite period for at least 6 hours a day in regular labour market conditions.</p> <p>Disability refers to labour capacity.</p>	Medical. Reintegration/ rehabilitation.	There are two degrees of disability: 1. fully disabled: not being able to work for at least 3 hours 2. partially disabled: not being able to work for 3-6 hours.	Flexible.	Every 3 years, a new assessment must be made. After nine years, reassessment is limited to a questionnaire about the health situation of the person every two years.

Table 2

Country, Name of long-term disability arrangement	Definition of disability	Operationalisation of assessment (medical, functional, reintegration / rehabilitation)	Levels of disability	Waiting period from onset of sickness to application for benefit	Time schedule for reassessment
Hungary, Disability Benefits Act (Rny)	<p>A person is entitled to a disability benefit when, as a result of disease or impairment, the person has lost more than 2/3 (67%) of his/her labour capacity. Labour capacity refers to the capacity to perform any work (all work). Disability must be due to permanent health impairment that exists at least 12 months.</p> <p>Disability refers to labour capacity.</p>	Medical	<p>There are three degrees of disability:</p> <ol style="list-style-type: none"> 1. 100% disabled and need for care: unable to work in any job and in need of care. The loss of long-term working capacity is 100%. 2. 100% disabled but not in need of care. The loss of long-term working capacity is 100%. 3. 67% disabled with residual working capacity. The loss of long-term working capacity is 67%-99% (people who are 50-66% disabled receive a social allowance). 	Flexible; A person can claim a disability benefit at any time.	There is no set time for a reassessment (1, 2, 3 years or permanent). It depends on the impairments of the claimant. However, when the status is definitive, no reassessment occurs.

Table 2

Country, Name of long-term disability arrangement	Definition of disability	Operationalisation of assessment (medical, functional, reintegration / rehabilitation)	Levels of disability	Waiting period from onset of sickness to application for benefit	Time schedule for reassessment
Ireland, Invalidity Pension	<p>The definition of disability is incapable of work. The definition of full disability is not stated. 'Incapable of work' means that the person is incapable of work by reason of some specific disease or bodily or mental disablement, or deemed, in accordance with regulations, to be so incapable. A person must be regarded as permanently incapable of work, which is defined as</p> <ul style="list-style-type: none"> • Incapacity for work of such a nature that the likelihood is that the person will be incapable of work. • An incapacity which has existed for 12 months prior to the date of claim and which is expected to continue for at least 1 year. <p>Disability refers to labour capacity.</p>	Medical. Functional.	There is only one disability category. The outcomes are 'capable of work' or 'not capable of work'.	When the incapacity has existed for 12 months prior to the date of the claim.	The benefit is permanent. There are no reassessments in Ireland.

Table 2

Country, Name of long-term disability arrangement	Definition of disability	Operationalisation of assessment (medical, functional, reintegration / rehabilitation)	Levels of disability	Waiting period from onset of sickness to application for benefit	Time schedule for reassessment
<p>Italy, Invalidity Allowance (Assegno ordinario di invalidita)</p> <p>Disability Pension (Pensione di inabilita)</p>	<p>Disability is the consequence of a disease or defect or loss that affects the efficiency of the insured person and reduces the possibility of performing a working activity compatible with the person's personal working record.</p> <p>The invalidity must be permanent. The requirement of permanence denotes a stable condition that is unlikely to come to an end.</p> <p>Disability refers to labour capacity.</p>	<p>Medical.</p>	<p>Invalidity Allowance: reduction of total working capability is at least 2/3.</p> <p>Disability Pension: reduction of total working capability is total.</p>	<p>Flexible; A person can claim at any point in time during sickness.</p>	<p>Invalidity Allowance: Every three years reassessments are performed.</p> <p>Disability Pension: There are no reassessments. The pension is permanent.</p>

Table 2

Country, Name of long-term disability arrangement	Definition of disability	Operationalisation of assessment (medical, functional, reintegration / rehabilitation)	Levels of disability	Waiting period from onset of sickness to application for benefit	Time schedule for reassessment
Netherlands, Disability Benefits Act (WAO)	<p>As a direct and medically stated result of disease or impairment, a person is unable, fully or partially, to earn with customary labour the income of a comparable healthy person. Customary labour refers to all possible jobs for a person. Disability can be accepted after 52 weeks of sick leave and after employer and employee have shown sufficient evidence of trying to get the employee reintegrated.</p> <p>Disability refers to earning capacity.</p>	<p>Medical. Functional . Reintegration/ rehabilitation.</p>	<p>There are seven degrees of disability: 15%-25% 25%-35% 35%-45% 45%-55% 55%-65% 65%-80% 80%-100%.</p>	<p>After 1 year of sickness.</p>	<p>One year after the first assessment, a reassessment takes place. Four years after the first reassessment, a second reassessment takes place. Further reassessments are repeated every 5 years, but additional re-evaluations may be carried out between times. Claimants may request an additional reassessment.</p>

Table 2

Country, Name of long-term disability arrangement	Definition of disability	Operationalisation of assessment (medical, functional, reintegration / rehabilitation)	Levels of disability	Waiting period from onset of sickness to application for benefit	Time schedule for reassessment
Norway, Disability benefit (uførepensjon)	<p>The disability allowances are granted to persons whose working capacity has been reduced by at least one half, due to illness, injury, or defect.</p> <p>A person is entitled to a disability allowance if appropriate treatment and vocational rehabilitation have been tried in order to improve earning or work capacity. The disability must have been judged to be permanent. Permanent is not regarded as lifelong, but with an anticipated course of at least 7 years.</p> <p>Disability refers to a combination of labour and earning capacity.</p>	Medical. Reintegration/ rehabilitation.	There are six degrees of disability: 50% 60% 70% 80% 90% 100%.	Flexible.	There are no reassessments. The pension is permanent.

Table 2

Country, Name of long-term disability arrangement	Definition of disability	Operationalisation of assessment (medical, functional, reintegration / rehabilitation)	Levels of disability	Waiting period from onset of sickness to application for benefit	Time schedule for reassessment
<p>Russian Federation, The act of 1995 “On Social Protection of the Disabled”; The act of 1998 “On Order of Recognizing Citizens as Disabled People”.</p>	<p>Disability is approached as social insufficiency. Disability is a social insufficiency due to health worsening with the body’s stable malfunctions leading to limitation of activity for life and to the need for social protection.</p> <p>Disability refers to labour capacity.</p>	<p>Medical.</p>	<p>There are 3 degrees of disability:</p> <p>1. social insufficiency which requires social protection or assistance due to a health disorder with a <u>considerably expressed</u>, stable bodily malfunction due to disease, defect, or trauma. Third level of expression of (i.e., <u>highly expressed</u>) restrictions of activities. This group is the severest category.</p> <p>2. social insufficiency which requires social protection or assistance due to a health disorder with an <u>expressed</u>, stable bodily malfunction due to disease, defect, or trauma. Second level of expression of (i.e., <u>expressed</u>) restrictions of activities.</p> <p>3. social insufficiency which requires social protection or assistance due to a health disorder with a <u>poorly or moderately expressed</u>, stable bodily malfunction due to disease, defect, or trauma. First level of expression (i.e., <u>vague or moderately expressed</u>) of restrictions of activities.</p>	<p>Unknown.</p>	<p>Flexible; Determined by the doctors at the first time assessment.</p>

Table 2

Country, Name of long-term disability arrangement	Definition of disability	Operationalisation of assessment (medical, functional, reintegration / rehabilitation)	Levels of disability	Waiting period from onset of sickness to application for benefit	Time schedule for reassessment
<p>Slovenia, Act on Pension and Disability Insurance</p>	<p>“Pursuant to the present Act, invalidity shall be ascertained if due to changes in health condition which cannot be reversed by treatment or by measures of medical rehabilitation and have been ascertained pursuant to the present Act, the capacity of an insured person to secure or keep a job or to advance in career has been reduced.”</p> <p>Disability refers to labour capacity.</p>	<p>Medical. Reintegration / rehabilitation.</p>	<p>There are three degrees of disability:</p> <ol style="list-style-type: none"> 1. The insured person has lost the capacity to engage in organized gainful employment or, in case of occupational invalidity, (s)he has lost the remaining capacity for work. 2. The insured person’s capacity for work in the occupation (s)he was trained for is impaired by 50% or more. 3. The insured person, after prior occupational rehabilitation or without such occupational rehabilitation, has lost the capacity to work full-time, but is capable of working at a certain job on a half-time basis at the least. Or the insured person’s capacity for work in the occupation (s)he was trained for is impaired by less than 50% or (s)he can continue to work in his/her general occupation on a full-time basis, but (s)he has lost the capacity to do his/her former job. 	<p>Flexible.</p>	<p><i>No information available.</i></p>

Table 2

Country, Name of long-term disability arrangement	Definition of disability	Operationalisation of assessment (medical, functional, reintegration / rehabilitation)	Levels of disability	Waiting period from onset of sickness to application for benefit	Time schedule for reassessment
<p>Spain, Incapacity Pension (<i>incapacidad laboral permanente</i>)</p>	<p>An employee is considered permanently incapacitated (<i>incapacidad laboral permanente</i>) when (s)he has had appropriate medical treatment and still presents or displays serious anatomical or functional limitations which are objectively determined and are permanent for the foreseeable future. These limitations diminish the capacity to work.</p> <p>The term ‘objectively’ denotes that the limitation must be evident from the client’s medical history and/or the results of tests, echos, MRI scans etcetera..</p> <p>Disability refers to labour capacity.</p>	<p>Medical. Functional. Possibly reintegration / rehabilitation.</p>	<p>There are four degrees of disability:</p> <ul style="list-style-type: none"> - <i>Parcial</i>: permanent partial incapacity for habitual occupation. Labour capacity reduced by at least 33% due to illness or injury. - <i>Total</i>: permanent total incapacity for habitual occupation. - <i>Absoluta</i>: permanent total incapacity for work of any type. - <i>Gran invalidez</i>: total incapacity for work and, in addition, the recipient is unable to undertake daily activities (ADL: getting dressed, moving, eating, etc.) without the aid of another person. (Art 137 LGSS). 	<p>Flexible; An assessment has to be initiated at latest after 18 months of temporal disability (i.e., sickness), but it can take place at any point before this time.</p>	<p>Flexible; An assessment has to be initiated at latest after 18 months of temporal disability (i.e., sickness), but it can take place at any point before this time.</p>
<p>United Kingdom, Incapacity Benefit (IB)</p>	<p>Incapacity Benefit is paid to people who have an “incapacity by reason of some specific disease or bodily or mental disablement to perform such activities as may be prescribed”. These activities are set out in regulations.</p> <p>Disability refers to labour capacity.</p>	<p>Medical. Functional.</p>	<p>There is only one disability category: full disability.</p>	<p>After 28 weeks (Short-term IB) After 1 year or longer (Long-term IB).</p>	<p>Flexible; Advice on prognosis can be given for 3, 6, 12, 18 months, 2 years, or indefinitely.</p>

Table 2

Country, Name of long-term disability arrangement	Definition of disability	Operationalisation of assessment (medical, functional, reintegration / rehabilitation)	Levels of disability	Waiting period from onset of sickness to application for benefit	Time schedule for reassessment
USA, Social Security Disability Insurance (SSDI)	<p>Disability is defined as “Inability to engage in any substantial gainful activity by reason of any medical determinable physical or mental impairment which can be expected to result in death or which lasted or can be expected to last for a continuous period of no less than 12 months”.</p> <p>Inability to engage in substantial gainful activity relates to the inability of the person to engage in his/her own work activity or any other work activity which exists in the national economy and which the claimant is capable of performing by virtue of his/ her work experience, age, education, and the residual capacity (s)he retains to function physically and mentally.</p> <p>Disability refers to labour capacity.</p>	Medical. Functional.	There is only one disability category: full disability.	<i>Unknown.</i>	It is required by law that all cases be reviewed every 7 years.

Table 3a

Table 3a Actors involved in the arrangement

Country	Executor (private/public)	Assessor	Role of curative health care	Critic/Quality control (external)
Belgium	Various health insurance companies. There are 5. (public)	Medical advisor Higher Committee of the Council for Invalidity (in case of acceptance) Regional Committee of the Council for Invalidity (when in doubt)	<i>GP/Treating doctor:</i> Curative health care can be consulted for further medical information about the disease or impairment of the claimant, but cannot be consulted about the claimant's ability to work. The general practitioner and the medical specialist can accompany the client during the assessment of the Regional Committee and during appeals.	Under supervision of the state, the National Institute for Sickness and Disability Insurance (RIZIV) is responsible. They occasionally visit social insurance companies to check administrative and medical files on disability assessments.
Denmark	Municipality	Case manager Medical advisor or other experts if necessary	<i>GP/Treating doctor:</i> During the period of sickness, the treating doctor gives his/her opinion on the prognoses or a diagnosis in respect of certain health matters.	The Ministry of Social Affairs. Several times every year, the social courts of appeal (regional and national courts) evaluate 120-150 cases of lower instances (i.e., local social complaints court) at random in order to control the compliance of the decisions with the law.
Finland	Employment pension companies (public and private) and National pension Department (SII) (public) The treating doctor (medical assessor) may belong to a public, private, or occupational health organization.	Social insurance physician Decision maker (2)	<i>GP/Treating doctor:</i> The treating doctor is responsible for rehabilitation, the medical examination, and providing the certificate which is the basis for the medical assessment. If insurance doctors require further information, they can contact the GP/treating doctor. The health care sector is responsible for rehabilitation. SII may use the services of medical specialists', or more advanced rehab centers, or other special institutes for an expert opinion in very difficult cases.	The Ministry of Social Affairs and Health.

Table 3a

Country	Executor (private/public)	Assessor	Role of curative health care	Critic/Quality control (external)
France	The state health insurance office (Caisse Primaire d' Assurance Maladie: CPAM). This is a private organisation with a public function.	Medical advisor	<p><i>GP/Treating doctor:</i> The treating doctor fills in the sickness certificate and the application for an Invalidity Pension. In case of rejection of the latter, a third doctor, often from curative health care, may join to decide upon the final decision.</p> <p>The treating doctor and medical advisor often discuss the client's dependence on third persons. They sometimes also discuss the client's possibilities and rights when the client (partly or fully) returns to work. The medical advisor also has to approve the treatment proposed by the treating doctor in case of prolonged sick leave.</p>	No information available.
Germany	<p>The Bundesanstalt für Arbeit (public)</p> <p>Medical experts are hired per case on the free market.</p>	Social insurance physician Labour expert	<p><i>GP/Treating doctor:</i> Provides medical information to the pension institute. The assessment is based mainly on the medical information provided by the general practitioner (the claimant's dossier).</p> <p>The GP can advise the claimant to apply for a disability benefit.</p>	The Ministry of Health and Social Affairs is responsible for the results and the procession of laws. The public pension insurance is monitored by the audit organization (Bundesrechnungshof). Doctors are controlled by the organization of doctors (Ärztammer).

Table 3a

Country	Executor (private/public)	Assessor	Role of curative health care	Critic/Quality control (external)
Hungary	National Institute of Medical Expertise (public)	Social insurance physician Social insurance official	<i>GP/Treating doctor:</i> The general practitioner has to provide the necessary information on which the claim is based. This is requested by the claimant. Curative health care can be consulted for information on diseases or impairments of the claimant. They are not involved in the evaluation or in the decision.	The Ministry of Health (controls the adequacy of the medical professional). The Department of Health Care expertise at the National Health Insurance Fund (controls the whole medical assessment process). The Social Insurance Institute (controls the assessment arrangement).
Ireland	The Department of Social, Community and Family Affairs. (public)	Medical assessors Deciding officer	<i>GP/Treating doctor:</i> The GP provides the first certificate of incapacity. The doctor is asked to specify an 'incapacity' which is a medical diagnoses or description of symptoms. Also, a form may be issued to the certifying doctor informing him / her of the forthcoming examination and inviting him / her to supply up-to-date details of the person's illness.	The Department of Social, Community and Family Affairs (DSCFA).
Italy	National Institute for Social Provisions (INPS) (public)	Doctors and specialists	<i>GP/Treating doctor:</i> The role of the curative health care sector is limited. The general practitioner or specialist provides information (a certificate) that is used in the assessment process. If the client appeals against a decision, his/her practitioner or a doctor from the trade union will assist him/her.	The Ministry of Labour is responsible for economic and financial control . The National Institute for Social Provisions (INPS) is autonomous and responsible for its own quality control.

Table 3a

Country	Executor (private/public)	Assessor	Role of curative health care	Critic/Quality control (external)
Netherlands	The Workers Insurance Authority (UWV). (public) Medical doctors and labour experts may be hired on the free market.	Social insurance physician Labour expert	<i>GP/Treating doctor:</i> Curative health care can be consulted for further medical information about the disease or impairment of the claimant. The treating doctor cannot be consulted about the claimant's ability to work.	The Ministry of Social Affairs and Employment has tasks concerning the coordination of jurisdiction. Inspection for Work and Income (IWI, supervised by the Ministry of Social Affairs and Employment).
Norway	The National Insurance Administration (public)	Decision maker (administrative assessor) Special in-service doctor	<i>GP/Treating doctor:</i> The general practitioner does the main medical assessment and is required to produce a detailed certificate (ongoing treatment, plans for further treatment, possible rehabilitation measures). The GP is required to assess the impact of the impairment on the diminished work capacity. The doctor is also asked to give his/her opinion on whether any vocational rehabilitation measures ought to be initiated. The GP is supposed to judge what kind of work-related activities or operations the patient cannot perform. The doctor must also provide prognoses, i.e., estimate the expected durations of the medical condition, the impairment, and the diminished work capacity.	The Ministry of Health and Social Affairs. The National Insurance Administration (NIA) has supreme responsibility. NIA presents most results within the organization and the Ministry of Health and Social Affairs.

Table 3a

Country	Executor (private/public)	Assessor	Role of curative health care	Critic/Quality control (external)
Russian Federation	State Service of Medical Social Examination (public)	Medical social examination officers	<i>GP/Treating doctor:</i> The claimant has to produce a form filled in by treating physicians. These physicians usually take the initiative to claim a benefit, together with the patient.	There is an obligation to report to the ministry and to the bureau of statistics.
Slovenia	Pension and Disability Insurance Institute of Slovenia (public)	Board of examiners Case manager	<i>GP/Treating doctor:</i> Provides the medical information necessary to deal with the claim and can give advice about the type and degree of impairment.	The Ministry of Labour, Family and Social Affairs is in control but there is no quality control on a regular basis by an external authority.
Spain	The National Institute for Social Security (INSS) (public)	Multidisciplinary team Provincial Director of administration INSS doctor Labour expert	INSS doctors can consult curative health care for further medical information about the disease of the claimant. Furthermore, one of the core members of the multidisciplinary assessment team works as an inspector of the curative health sector and as such provides a link between social security and curative health care.	The inspection of the Ministry of Social Affairs and Employment investigates cases on a regular basis with regard to the efficiency of the process. The Secretariat-General of quality control is responsible for monthly quality reports and client surveys in the field of Social security.
United Kingdom	The assessment process (examination) is performed by medical doctors employed by SchlumbergerSema (private). The assessment is embedded in administrative procedures controlled by the Department of Work and Pension (DWP). (public)	Decision makers (at DWP) Medical services doctors at SchlumbergerSema.	<i>GP/Treating doctor:</i> The GP provides the initial certification (Med 4) of the incapacity which is the basis for the claim. The doctor provides additional information when requested to do so.	The assessment is embedded in administrative procedures controlled by the Department of Work and Pension.

Table 3a

Country	Executor (private/public)	Assessor	Role of curative health care	Critic/Quality control (external)
USA	<p>Administration: Social Security Administration (SSA) Field Office (public)</p> <p>Assessment: State Disability Determination Service (DDS) (public)</p>	<p>Disability examiner Medical or psychological consultant if necessary.</p>	<p><i>GP/Treating doctor:</i> The source of treatment (GP, psychologist, or other acceptable medical source) provides a medical report that is detailed enough to enable the adjudicative team to determine the nature, severity, and limiting effects of the impairment(s), its probable duration, and the claimant's remaining capacity to engage in work-related physical or mental activities.</p> <p>The source of treatment is neither asked nor expected to decide whether the claimant is disabled.</p>	<p>The federal Social Security Administration (central office, Baltimore) is responsible for supervision and quality control. Some of the control is administered through SSA's 10 regional offices. Management in the various DDSs and OHA offices are also responsible for supervision of their operations, as well as internal quality control.</p>

Table 3b Backgrounds of assessors

Country	Assessors' role	Backgrounds of Assessors
Belgium	<p><i>Medical advisor</i></p> <p>The examination is carried out by the medical advisor. If the medical advisor has determined that the criteria for the invalidity benefit are fulfilled, his report (the decision of 'disabled' together with the proposed date of the next assessment) is sent to the Higher Committee of the Council for Invalidity. This committee consists of medical advisors of the five health insurance companies and medical advisors of RIZIV (National Institute for Sickness and Disability Insurance). One member of the Higher Committee, carries out a peer review of the documents. If (s)he agrees with the decision of the medical advisor, the decision is communicated to the medical advisor and the client is entitled to an Invalidity Pension until the date on which (s)he has to undergo the next medical assessment. If the medical advisor of the Higher Committee has any doubts, (s)he firstly consults a colleague in the Higher Committee (this is usual practice; it is not a legal obligation to consult a colleague.) If the doubts remain, the decision is referred to the Regional Committee of the Council for Invalidity.</p>	<p><i>Medical advisors</i></p> <p>Medical Advisors need to have the standard medical degree ('basisarts') and two years additional education. They also need to be registered at RIZIV (The National Institute for Sickness and Disability Insurance).</p>
Denmark	<p><i>Case manager</i></p> <p>The case manager has to carry out the assessment, but (s)he can ask questions to experts on parts of the assessment. Experts are medical consultants, rehabilitation consultants, disability consultants, psychologists, job consultants, or any person whose advice is necessary. These consultants are mainly hired for this purpose.</p> <p>In some municipalities (depending on the size), assessment teams (including some of the above-mentioned experts as well as some case managers) decide on or control the individual assessments. In some communities, different types of case managers have to interact, for example, one case manager for sickness, one for rehabilitation, one for flex jobs, and one for long-term disability pensions.</p>	<p><i>Case manager</i></p> <p>The case manager may be educated 1) at the National School of Social Work or 2) through the municipality's own education provision.</p> <p>(Ad. 1) Today, the National School of Social Work offers both a Bachelor's in Social Work (3½ years), for which enrolment normally requires a high school degree, and a Master's in social Work. Enrolment in the Master's programme requires a medium-term educational degree (3-3½) e.g., a Bachelor's in Social Work and at least three years' experience in Social work. The Master's education is intended to be combined with a job, e.g., a person may work as a case manager while studying.</p> <p>(Ad. 2) A municipality-based education is education for people who already have a certain amount of on-the-job experience as "assistants" in a municipality.</p>

Table 3b

Country	Assessors' role	Backgrounds of Assessors
Finland	<p><i>Decision maker (2)</i> Makes a legal decision about the benefit based upon the advice of the assessing doctor, administrative information from social security contributions, and his/her knowledge of the social and economic situation of the patient. After this, (s)he negotiates with the decision maker of the other executing company in order to come to a common decision.</p> <p><i>The social insurance physician</i> The social insurance doctor makes a proposal for a decision on medical grounds (administrative assessment). His/her advice is based on the certificate from the treating doctor.</p>	<p><i>Decision makers</i> Decision makers have different backgrounds. Usually, (s)he is a lawyer, but medical degrees are possible. Additionally, the decision maker has an administrative training of 2 months.</p> <p><i>Social insurance physician (assessing doctor)</i> A physician in any clinical practice, medical background.</p>
France	<p><i>Medical advisor</i> The assessment is done by a medical advisor. The medical advisor fills in a PRMI (Premier Rapport Médical d'Invalidité, containing personal data, the history of the disease, medical observations, diagnosis, stabilization, decision 2/3 category, among other things). Within three years, the medical advisor has to decide on stabilisation of the condition; otherwise, a conclusion is legally forced and stabilisation has to be presumed. (S)He is directed to look at the person's potential for employment in the whole local labour market in order to make a decision about disability. Furthermore, the medical advisor takes into account the person's remaining working capacity, general condition, age, physical and mental faculties, capabilities, and education.</p>	<p><i>Medical advisor</i> The Medical advisor (Medecin de Conseil) is a medical doctor who usually has some clinical experience. In addition, the medical advisor has followed a 6-month additional training course for medical advisors.</p>
Germany	<p><i>Social insurance doctor</i> The social insurance doctor collects medical and administrative information from social insurance companies, general practitioners, hospitals, and rehabilitation institutions and makes a decision on the criterion for loss of labour capacity. (S)He may request further examination by other experts (e.g., medical specialists).</p> <p><i>Labour expert</i> The labour expert makes a decision about the benefit on the basis of the information provided by the insurance doctor and his knowledge of the labour market situation. (S)He has to investigate if there are professions still open to the claimant considering his/her impairments and if these are within reasonable travelling distance of the claimants home.</p>	<p><i>Social insurance doctor</i> The social insurance doctor is an academically trained doctor, with at least 10 years of experience in the curative sector.</p> <p><i>Labour expert</i> The labour expert is specialised in labour market conditions and job demands. The labour expert has a special administrative education designed by the labour market institution. The educational level is comparable to a college degree in administrative law.</p>

Table 3b

Country	Assessors' role	Backgrounds of Assessors
Hungary	<p><i>Social insurance physician</i> The social insurance physician assesses impairments and capacities. (s)He is the medical decision maker. The medical examination takes into account the medical information provided by the GP. The physicians work in pairs. One does the medical examination and the other is consulted. The other physician is not always present during the assessment, because of high caseload, but may be consulted afterwards.</p> <p><i>Social insurance official</i> The clerk facilitates the assessment process and evaluates the accuracy and completeness of the claim. (S)He checks the legitimacy of the decision, formulates the final decision, and informs the claimant of the decision. (s)He is the legal decision maker.</p> <p><i>Deciding officer</i> The final decision in relation to eligibility for benefits is taken by a clerical deciding officer, who considers the non-medical as well as medical qualifying conditions.</p>	<p><i>Social insurance physician</i> Academically trained medical doctors, specialised in different medical subjects (internal medicine, neurology, psychiatry, surgery, etc.) They have at least 5 years medical practice. There is, at this moment, no special education for social insurance expertise.</p> <p><i>Social insurance official</i> (case manager) The case manager has a qualification or a college degree in social insurance.</p> <p><i>Deciding officer</i> (clerical) Administrative person.</p>
Ireland	<p><i>The deciding officer</i> The final decision in relation to eligibility for benefits is taken by a clerical deciding officer, who considers the non-medical as well as medical qualifying conditions. No non-medical experts are involved in the determination of disability (referred to as 'medical eligibility').</p> <p><i>The medical assessors</i> The medical assessors carry out medical assessments of clients in order to provide an independent medical opinion with regard to eligibility on medical grounds to various illness- and disability-related benefits/ allowances and in order to assess the loss of faculty resulting from an occupational injury or disease, for the guidance of deciding officers. They provide a second opinion to that of the person's own doctor for the guidance of the departments' deciding officers.</p>	<p><i>Deciding officer (clerical)</i> Administrative person.</p> <p><i>Medical assessors</i> Medical assessors are registered medical practitioners but are full-time employees of the Department of Social, Community and Family Affairs. They have special training in Human Disability Evaluation. They must have at least 6 years satisfactory experience in the practice of medicine since registration. Many of the medical assessors have specialist post-graduate qualifications.</p>
Italy	<p><i>Decision makers</i> The local INPS doctor decides whether the claimant needs to go to a specialist to undergo a medical examination. The specialist unit communicates the result, which can be considered a consultation. The local INPS doctor remains responsible and takes the final decision (to accept or reject the claim).</p>	<p><i>Decision makers</i> The decision makers are doctors and specialists. Some are connected with a hospital (practicing) or university (teaching, researching) and some are also social insurance doctors.</p>

Table 3b

Country	Assessors' role	Backgrounds of Assessors
Netherlands	<p><i>Case manager</i> The case manager facilitates the assessment process. The case manager evaluates the accuracy and completeness of the claim and provides information about the claimant to the social insurance physician and the labour expert. (S)He also monitors the claimant's progress and arranges the meetings with the claimant. (S)He checks the legitimacy of the decision, formulates the final decision, and informs the claimant of the decision. It should be noted that the role and tasks of the case manager may vary in different divisions of the UWV.</p> <p><i>Social insurance physician</i> The social insurance physician assesses impairments and capacities. (S)He has the possibility to communicate with other experts (such as the claimant's general practitioner) and to request further examination by other experts (e.g., medical specialists).</p> <p><i>Labour expert</i> The labour expert assesses reintegration efforts, assesses the job requirements imposed on a claimant, consults with employers, assesses the standard salary for the claimant, and selects possible functions for a claimant using a computer programme (CBBS). On the basis of these possible functions and the claimant's standard salary, the labour expert computes the claimant's remaining earning capacity. Ideally, the labour expert should meet the claimant twice: the first time, to get acquainted and to get background information; the second time, to assess the claimant's degree of disability. In reality, the labour expert often meets the claimant only once. Occasionally, the labour expert meets the claimant before the social insurance physician does. The labour expert is not consulted if the social insurance physician registers full or no disability.</p>	<p><i>Case manager</i> The case manager is generally a legal expert, who has had Higher Vocational Education or has received a college degree in law.</p> <p><i>Social insurance physician</i> The social insurance physician is an academically trained physician, with four years specialisation in social medicine, and often with some years of experience in curative health care. The above education results in the qualification of social insurance physician.</p> <p><i>Labour expert</i> The labour expert is specialised in labour market conditions and job requirements. The labour expert often has some experience in industry, and has received a Technical College Education or a college degree in social studies. (S)he has also followed a special training course in disability evaluation of two years.</p>
Norway	<p><i>Decision maker</i> (administrative assessor) The decision maker makes the final decision about the claim based on the information provided by the person's own doctor (certificate) and / or advice from the special in-service doctors.</p> <p><i>Special in-service doctor</i> Special in-service doctors of the National insurance Administration may be consulted in order to review the quality of the information and assessment in the medical certificate produced by the person's own doctor.</p>	<p><i>Decision maker</i> Lay person.</p> <p><i>Special in-service doctors:</i> Special in-service doctors are recruited from general practice (they may be consulted).</p>
Russian Federation	<p><i>Medical social examination officers</i> On the examination date, the client is examined by at least 3 specialists. These specialists are selected according to the pathology presented on the form provided by the treating physician. After the examination, the doctors deliberate about the person's disability, the category of disability, and the possibilities of rehabilitation. They also determine when the person should have a re-examination.</p>	<p><i>Medical social examination officers</i> These officers are medical specialists who have different backgrounds. The specialists are selected according to the presented pathology. The officers follow courses to remain updated as far as medical knowledge is concerned. They also follow a teaching and training course in one of the expert centres.</p>

Table 3b

Country	Assessors' role	Backgrounds of Assessors
Slovenia	<p><i>Case manager</i> First, the case manager receives the application at the regional office and reviews it for correctness and completeness. (S)He also completes the file of the applicant with relevant information about the client's job. After the assessment by the board of examiners, the case manager receives advice from the board on which the case manager must make a final decision.</p> <p><i>Board of examiners</i> The actual assessment is performed by the board of examiners. This board consists of a chairman (medical doctor), two clinical specialists, and a labour expert. During the assessment, the board questions the claimant and the doctors of the board can do a medical examination. After the interrogation and medical examination, the board deliberates and formulates a recommendation. Using the criteria as input, the chairman checks if the recommendation is complete and decides whether to submit it to the board of examiners of the second degree or not.</p>	<p><i>Case manager</i> The case manager has a legal education.</p> <p><i>The board of examiners</i> The board consists of a chairman who is a medical doctor, a labour expert who is a safety expert or a technical engineer, and clinical specialists. The doctors have to meet the following criteria:</p> <ul style="list-style-type: none"> • Clinical specialist for adults or a specialist in occupational medicine; • At least 4 years of work experience; • Valid licence from the Medical Chamber of Slovenia.
Spain	<p><i>INSS doctor</i> Provides a medical report containing the medical evidence gathered during a medical assessment</p> <p><i>Labour expert</i> A labour expert provides a labour report containing information on the claimant's work (function, tasks, job characteristics).</p> <p><i>Case manager (Provincial Director of administration)</i> A final decision is made by the Provincial Director of administration based on the advice of the multidisciplinary team.</p> <p><i>Administrative employee of INSS</i> The administrative employee provides an administrative report.</p> <p><i>Multidisciplinary team</i> A recommendation is made by the multidisciplinary team and is based on medical evidence, an administrative report, and a labour report. The team consists of an INSS doctor, a medical inspector from the curative health sector, a labour inspector, a case manager, and an administrative employee of INSS.</p> <p><i>Optional: A rehabilitation expert</i> In case of presumed rehabilitation this expert helps assessing the claimant's functionality</p>	<p><i>INSS doctor</i> An INSS doctor has a medical education and experience. (S)He often works as a specialist.</p> <p><i>Labour inspector</i> A labour expert is a specialist in job characteristics, job requirements and the labour market.</p> <p><i>Case manager</i> The case manager has a legal and/or economic education.</p> <p><i>Administrative employee of INSS</i> The administrative employee has a legal and/or economic education</p> <p><i>Medical Inspector from the curative health sector</i> The medical inspector has a medical education and experience.</p>

Table 3b

Country	Assessors' role	Backgrounds of Assessors
United Kingdom	<p><i>Decision maker (DWP)</i></p> <p>The role of the decision maker is administration and decision making. (S)He determines the legal entitlement of the claimant to IB claims (legal assessment).</p> <p>In some cases, where the diagnosis is clear, the decision maker simply accepts the diagnoses on the Med4. In other cases, where the severity of the condition is an issue, the decision maker is advised by SchlumbergerSema.</p> <p><i>Medical services doctors at SchlumbergerSema</i></p> <p>Medical assessment: The medical services doctors help the decision makers to make fair and proper decisions on benefit entitlement, by providing advice which is legible and concise, fair and impartial, medically correct, consistent and complete, in accordance with the relevant legislation.</p> <p>The recommendation by the medical services doctors regards:</p> <ul style="list-style-type: none"> • Whether a client is suffering from certain conditions that would make it unreasonable to subject him/her to the PCA (exempt conditions); • Whether the physical and/or sensory functional limitations reported by the claimant on the questionnaire are consistent with the medical evidence. 	<p><i>Decision maker</i></p> <p>The decision maker is an appropriately trained officer acting under the Secretary of State's authority. This is a lay person with relevant training and experience who works according to protocol.</p> <p><i>Medical services doctors</i></p> <p>All doctors who give advice relating to Incapacity Benefit are approved by the Secretary of State. Approval involves specific training, successful completion of various stages of an approved process, and ongoing demonstration that the work being carried out meets a satisfactory standard.</p>
USA	<p><i>Disability examiner (lay person)</i></p> <p>The disability examiner takes decisions based on information provided by the sources of treatment (a claimant's own physician, psychologist, or other acceptable medical source who provides, or has provided, the claimant with medical treatment or evaluation). (S)He may consult psychological, medical, or speech and language pathologist consultants and performs, if necessary, a vocational analysis.</p>	<p><i>Disability examiner</i></p> <p>The disability examiner is a lay person, well trained in the medical legal, administrative, and other programme requirements. The disability examiner receives some training in the field of vocational analysis.</p>

Table 3c The employer

Country	Role of the employer in the assessment
Belgium	<p>Although the employer has to provide information on wages and wage continuation to enable the level of benefit to be determined in case of disability, (s)he does not have a role in the assessment process. Moreover, (s)he has no rights if the medical advisor states that a person is able to work and the employer finds this impossible.</p> <p>As long as the employee has not been dismissed, (s)he has to prove to the employer after every assessment that (s)he is still not able to work. The employee has to do this him/herself; the health insurance company will not communicate this information to the employer. The employee can be dismissed at any time, also during the period of sickness, but sickness can be a reason for dismissal only after 6 months.</p> <p>Employers have no right to appeal.</p>
Denmark	<p>Formally none. However, the employer can engage voluntarily in reintegration. (S)He can also create flex jobs and (s)he is encouraged to participate in occupational rehabilitation by offering training. It is politically promoted that employers take responsibility for the integration of disadvantaged groups in society.</p> <p>Employers have no right to appeal.</p>
Finland	<p>Employers may be asked to provide information about the working place of the claimant, his/ her tasks, etc. (employer's certificate). In addition, the employer can be asked by experts or claimants to undertake work adjustments according to the needs and possibilities of the claimant. In some cases, he might be asked to give an opinion about the working capacity prospects of the person.</p> <p>Employers often provide occupational health services that fulfill the same tasks as health care services. Instead of the health care service, the occupational service is then required to deliver medical information.</p> <p>Employers' organizations are represented in the board that controls the institute and may put pressure on the Social Security Institute.</p> <p>Employers have no right to appeal.</p>
France	<p>The employer has no formal role in the assessment. (S)He may have an informal influence, however. If the employer does not offer an opportunity for work resumption, this may influence the decision about the category of disability.</p> <p>Employers have no right to appeal.</p>
Germany	<p>The employer has no role in the assessment.</p> <p>Employers have no right to appeal.</p>
Hungary	<p>The employer's only role in the assessment is during the period in which the employee receives sickness benefit. The employer is obliged to investigate whether work place adaptations can be made. If the client can no longer be employed, (s)he is forwarded to the regional Rehabilitation Committee and continues to receive sickness benefit for a maximum of 52 weeks.</p> <p>Employers have no right to appeal.</p>
Ireland	<p>The employer has no role in the assessment. However, if the employer has a material interest in the case, he can give notice of appeal. An appeal to the High Court can be made by the employer on a point of law.</p>
Italy	<p>The employer has no role in the assessment. A person can apply for an allowance or pension without informing his/her employer. If the assessment reveals a loss of labour capacity which entitles the person to a benefit, the person can continue to work in the same job. The reason behind this is that keeping a job has to be promoted. The benefit can be considered a risk premium for keeping employment that compensates the risk of (future) unemployment or deteriorating health because of the work. INPS does not inform the employer owing to reasons of privacy.</p> <p>Employers have no right to appeal.</p>

Table 3c

Country	Role of the employer in the assessment
Netherlands	The employer has an important role in the period during which sickness benefit is received. The employer and employee are jointly responsible for the reintegration of the employee in case of sickness. In addition, if the employer has a clear interest in the decision about disability, he can make an appeal to the social insurance agency. If the employer is not satisfied with the ultimate decision of the social insurance agency, an appeal can be made to the administrative law department of the District Court. Decisions made by this court can be appealed to the Central Court of Appeals.
Norway	According to the Work Environment Act (<i>Arbeidsmiljøloven</i>), the employer has to provide an accessible work place and provide alternative job options or technical adjustments. Formally, employees on sick leave can be dismissed only if such measures have been implemented without success. The employer is obligated to implement such measures 'as far as possible'. In practice, many employers fail or neglect to make any such arrangements. The Labour Inspectorate (<i>Arbeidstilsynet</i>), and eventually the courts, are likely to accept this if the employer can prove that implementing such measures would jeopardize the economic viability of the company or make it necessary to dismiss other personnel. Employers have no right to appeal.
Russian Federation	The employer has no role in the assessment. Employers have no right to appeal.
Slovenia	The employer (or his representative) has the possibility to attend the assessment. The employer is asked by the board of examiners to declare what has been done so far to keep the employee at work and/or what other kind of work (s)he can offer the employee. Under the new law, the employer has to prove that (s)he cannot offer other work in order to dismiss an employee. A committee composed of representatives of the institute, the labour exchange, and the Ministry of Social Affairs reviews the request for dismissal. The employer can appeal only against the part of the decision concerning his legislative obligations as an employer.
Spain	The employer has no role in the assessment. Only in case of work accidents in which the employer is seen as legally responsible for the sustained medical damage can (s)he apply for additional medical assessments. Employers have no right to appeal.
United Kingdom	The employer has no role in the assessment of state benefits. Most employees are, however, entitled to a minimum 'Statutory Sick Pay' which the employer pays to employees for the first six months of absence. Ninety per cent of employers choose to pay more than the minimum and this is called 'Occupational Sick Pay'. Employers are responsible for monitoring payments in either case and ensuring that their employees are unable to work. Employers have no right to appeal.
USA	The employer has no role in the assessment. Employers have no right to appeal.

Table 4a

Table 4a Process

Country	Primary goal of the assessment process	Time span of total process	Estimated production time	Method first-time assessment and reassessment	Appeal
Belgium	To check the entitlement of the claimant to the benefit.	<p>Within 3 days of the onset of sickness, a person has to have an assessment to get a medical certificate (from any doctor). If the person is found to be disabled, the date of the first examination is determined.</p> <p>Within three weeks after entering the system of Primary Disability Benefit, the first medical examination has to take place (10-20 min for the medical assessment). If the person is considered disabled, the date of the next examination is determined.</p> <p>After 6 months (from the start of the disability), an examination (10-20 min) must take place because of a shift in criteria. If the person is found to be disabled, the date of the next examination is determined.</p> <p>After one year, an examination has to take place for the Invalidity Pension (20 min for the medical assessment p/p). If the person is found to be disabled, the date for the next examination is determined. If the medical assessor concludes that the claimant is disabled, the decision has to be checked by the Higher Committee (on average 100 cases are checked in 4 hours: some take less than a minute, others require more time), and when there is doubt, also by the Regional Committee of the Council for Invalidity (on average 30 min per case). In reality, there are small minor differences.</p>	<p>Estimated production time = 62 minutes (50 min x 1) + (2.4 min x 5).</p> <p>(Note: This is the production time when the claim is accepted and when there are no doubts. In case of doubt, production time is considerably longer as more time is invested by the Higher Committee and/or Regional Committee).</p>	<p>Method first-time assessments is face to face.</p> <p>Control by the Higher Committee is on paper.</p> <p>In addition, if necessary, a face to face assessment is carried out by the Regional Committee.</p> <p>Reassessments do not differ from first-time assessments. However, the amount of time required to collect data is usually less.</p>	<p>Appeal can take place against any decision concerning Primary Disability Benefit and Invalidity Pension. Appeals are handled by the Court of Labour. Sometimes the client, possibly supported by a person from the Trade Union, asks his doctor (general practitioner) to convince the medical advisor that his decision is wrong. The medical advisor or the Regional Committee tries to defend the decision. If the judge of the Court of Labour is not able to decide immediately on the appeal himself, he appoints an independent doctor (who is not employed by one of the health insurance companies) to carry out a medical examination. After this examination, the judge of the Court of Labour takes a decision.</p> <p>The claimant can again appeal against this decision, as can the medical advisor. Such cases are dealt with by the Higher Court. In most cases, a committee of experts is appointed to check the decision against which a claimant has appealed. Experts of the Court of Labour and the Higher Court are autonomous and can ask for additional (medical or labour) examinations. In addition, there is the possibility of cassation, in which not the decisions but the rules are the subject of the jurisdiction. Procedures can take a long time, on average about a year if only the Court of Labour is involved. If the Higher Court is involved, the procedure can last as long as four years.</p>

Table 4a

Country	Primary goal of the assessment process	Time span of total process	Estimated production time	Method first-time assessment and reassessment	Appeal
Denmark	<p>1. To make a resource profile of the applicant, to clarify his abilities, and to judge the possibility of having the applicant enter at least a flex job.</p> <p>2. To prevent the person from entering anticipatory pensions (i.e., pre-pensions).</p> <p>3. To investigate the need for vocational rehabilitation, or adjustments to work place and housing.</p> <p>4. To investigate additional requirements and the possibility of improving the applicant's capacity to work.</p> <p>5. To check the applicant's entitlement to the benefit.</p>	<p>A decision on award of the disability benefit must be accomplished within 3 months after the assessment of eligibility to the disability benefit has started. If this deadline is not met, the municipality must give a reason for the delay.</p> <p>The time that is spent on the process varies.</p>	<p><i>Not enough information available to estimate production time.</i></p>	<p>Method first-time assessments is face to face.</p> <p>In principle, there are no reassessments (see Table 2). However, if the medical information or the possibilities of reintegration change substantially, reassessment might be possible.</p> <p>'Rehabilitation assessments' do not differ from first time assessments.</p>	<p>The claimant can appeal against almost all public local decisions within a month to the Local Social Complaints Board and to the Regional Social Council (higher appeals board). In addition, many cases are monitored by the ombudsman.</p> <p>Appeal to the social board is free in order to provide an incentive for more control.</p>

Table 4a

Country	Primary goal of the assessment process	Time span of total process	Estimated production time	Method first-time assessment and reassessment	Appeal
Finland	To check the entitlement of the claimant to the benefit and to determine the level of the benefit.	<p>After 60 days of payment of sickness allowance, the Social Insurance Institute (SII) must check the rehabilitation needs of the person on sick leave. The 60-day time limit may be exceeded as many employees receive salary or wages from the employer for at least 1-2 months, which can mean that SII is informed about the case only after two months. After two months, the employer should announce the case to SII in order to be relieved of sickness payments. From that moment, SII pays the sickness benefit. In some cases, employers apply only after 4 months.</p> <p>After 150 days of payment of sickness allowance, information is provided to the claimant on rehab possibilities, or the claimant is recommended to claim a pension.</p> <p>After 300 days of payment of sickness allowance, the rehab possibilities are checked before a decision is made regarding the disability pension (the treatment chain imposes some restrictions in time owing to waiting lists. This implies that the application for a disability pension might be delayed (later than 300 days)).</p> <p>The total time schedule (from the moment the claim is received until the decision is made) is 72 days.</p> <p>The assessing doctor has to make his/her decision within one week. The assessing doctor makes 5-6 assessments per hour.</p> <p>Most cases are handled within the time limit; only if the information of the treating doctor is not sufficient (in about 5% of cases) the process is delayed.</p>	<p>First time assessment on paper:</p> <p>When 2 insurers are involved: 2 doctors x 10 minutes.</p> <p>Estimated production time = 20 minutes</p>	<p>The first selection is a paper assessment (based on information provided by the person's treating doctor (certificate)).</p> <p>The average time spent on a continuing case is longer than that spent on a first time assessment. This is because the number of papers and documents required for a reassessment is greater.</p>	<p>In principle, it is not necessary for the claimant to appeal. In Finland, it is possible to start a new claim process at any time, which is often faster than an appeal. But if the claimant disagrees, (s)he can appeal to a First Degree Appeal Court, and if (s)he disagrees with the decision of this court, (s)he may appeal to the Second Highest Degree of Appeal Court. Both appeal courts are independent of the SII.</p>

Table 4a

Country	Primary goal of the assessment process	Time span of total process	Estimated production time	Method first-time assessment and reassessment	Appeal
France	The goal of the assessment is partly to verify the condition and partly to ensure that appropriate medical treatment and rehabilitation is provided. This in order to prevent invalidity.	After 3 months of sick leave, it is decided whether the sickness will be long-term. After one year of sick leave, it is examined whether the situation has stabilized and whether the person should receive an invalidity pension. Within three years after the beginning of the work interruption, the situation is again evaluated and a decision about stabilization has to be taken. In general, the formal decision of invalidity is made within 6 – 8 weeks after the medical decision is made. The first consultation, drafting the Pires form (a detailed description by the treating doctor of the patient's health status, treatment, and prognosis) , takes approximately 30 minutes. Further consultations are somewhat shorter. 2 to 2 ½ hrs seems a fair estimate of the total time invested in one case.	Estimated production time from the onset of sickness = 135 minutes	Method first-time assessments is generally face to face. Reassessments do not differ essentially from first-time assessments.	A first appeal can be made to the regional office. This includes further medical evaluation. A second appeal can be made to the tribunal. The tribunal may call upon an expert if necessary.

Table 4a

Country	Primary goal of the assessment process	Time span of total process	Estimated production time	First- time assessment Paper/ face to face	Appeal
Germany	<p>To check the entitlement of the claimant to a benefit.</p> <p>In the assessment process, it is decided whether rehabilitation should take place first or if a benefit will be granted. In principle, a benefit is granted only if all possibilities for rehabilitation are exhausted. In practice, however, rehabilitation depends heavily on the motivation of the claimant.</p>	<p>An assessment has to be completed within 3 months after application. On average, assessments are completed within 60-70 days, and are no longer than 3 months.</p>	<p><i>Not enough information to estimate production time.</i></p>	<p>The first time assessment is on paper, but the insurance doctor may assign specialists to additional assessments to obtain more information or medical proof (this is the case in about 70% of all assessments). The first three times, reassessments do not differ from first time assessments (every 3 years, a new assessment has to be made). However, the execution differs with regard to the information collected. Only additional information of the last three years has to be gathered. After nine years, a reassessment is limited to a questionnaire about the health of the person every two years. The questionnaire can be answered by the person or by the general practitioner.</p>	<p>The claimant can appeal to the social court. A claim at the social court is free of charge in order to stimulate claimants to report wrong decision making.</p> <p>If rejected for a disability pension, the chance is great that a claimant will appeal to court in the hope of delaying the decision-making process (a claim at the social court takes on average 2-4 years).</p>

Table 4a

Country	Primary goal of the assessment process	Time span of total process	Estimated production time	First- time assessment Paper/ face to face	Appeal
Hungary	<p>To determine the entitlement of the claimant to the disability benefit and to determine its level.</p> <p>To make proposals for rehabilitation.</p>	<p>When the claim is handed in at the local office, the assessment has to be made within 2 or 3 weeks. Sometimes, because of the caseload, it takes 1-2 months. There must be a decision within 30 days (from application till report). The medical assessors deal with 12-15 cases per day. A report takes up to 20 min. An assessment can take 40-50 minutes in total (including the report). There are no standard times. The average duration of the first assessment is about 40-50 minutes.</p>	<p>(2 medical assessors x 45 minutes) = Estimated production time = 90 minutes</p>	<p>Method first-time assessments is face to face.</p> <p>Reassessments do not differ from first time assessments.</p> <p>Assessments and reassessments differ only in the number of documents: reassessments take longer. The method of the assessments is the same.</p> <p>When the caseload is high, the reassessment will be based on a paper file.</p>	<p>Appeal is possible on both medical and legal grounds (appeal to the case manager is also possible) There are 3 authorities:</p> <ul style="list-style-type: none"> • First board (performs the first time assessment); • Second board (second-level examination by NIME); • Labour Court (appeal, evaluation by independent medical expert). <p>A second opinion can be requested if the client disagrees with the outcome of the assessment. After being informed about the rejection of the claim, the claimant has the opportunity to appeal to the social insurance office for a new assessment process within two weeks. If the second board's decision is the same, the claimant can appeal to the Labour Court. The second level examination is applied by about one third of the persons with a refusal.</p>
Ireland	<p>To check the entitlement of the claimant to a benefit.</p>	<p>Under Social Welfare Law, a person must make an actual application for Invalidity Pension, within 3 months of the date of first entitlement.</p> <p>The general practitioner (GP) has to complete the report form and return it within 14 days.</p> <p>Examinations for IP are scheduled for 15 minutes. The actual time is often 15 minutes. However, the duration of the paper assessment depends on the volume and complexity of its contents.</p>	<p>Estimated production time: 15 minutes</p>	<p>Selection by Chief Medical Advisor is based on paper. Otherwise face to face.</p> <p>There are no reassessments.</p>	<p>The Social Welfare Appeals Office (SWAO) is charged with determining appeals by persons who are dissatisfied with decisions of deciding officers on questions relating to entitlement to social welfare payments. SWAO operates as an independent agency of the Department of Social, Community and Family Affairs.</p> <p>When the claimant is dissatisfied with a decision made by a deciding officer of the Department, (s)he may have the question referred to the appeals officer for determination. A notice of appeal must be given to the chief appeals</p>

Table 4a

Country	Primary goal of the assessment process	Time span of total process	Estimated production time	First- time assessment Paper/ face to face	Appeal
Ireland continued					<p>officer. The notice of appeal must be made within 21 days of the notification of the deciding officer's decision.</p> <p>The deciding officer is required to provide a statement to the chief appeals officer containing comments on why the decision should stand and why the arguments put forward by the appellant are refuted.</p> <p>In general, the decision of an appeals officer is final and conclusive. One can appeal to the High Court ONLY on a point of law.</p> <p>An Ombudsman is available to those who feel that they may have been treated unfairly by any government department or health board.</p>
Italy	To check the entitlement of the claimant to the benefit.	<p>There are no formalised time-paths in the medical process. The application can take place at any point in time (no waiting period). As a rule of thumb, the assessments need to be finished within 1 month. In most cases, this is the actual practice. The administrative process is usually more time consuming, in particular if the working history of the client consists of several employers.</p> <p>There is no standard amount of time invested in a claimant. It depends on the type of diagnosis and the difficulty of the diagnoses. The first medical examination lasts on average one hour.</p>	<p>When no specialist unit is involved: 60 minutes x 1 local doctor: Estimated production time for local unit = 60 minutes</p> <p><i>Estimated production time for specialist unit = unknown.</i></p>	<p>Method first-time assessments is face to face.</p> <p>Invalidity Allowance: Reassessments do not differ from first time assessments.</p> <p>Disability Pension reassessment: not applicable</p>	<p>Appeal may occur in two steps:</p> <ul style="list-style-type: none"> • Within the National Institute for Social Provisions (INPS), it is possible to appeal against a decision with the help of a doctor of the Trade Union or the general practitioner. An internal committee consisting of representatives of INPS and the Trade Union judge the appeal. • If the claimant still disagrees, the claimant can go to court (outside INPS). The judge appoints a specialist to evaluate the case in order to make an objective judgment. <p>Note: a claimant can request an assessment as often as (s)he wants.</p>

Table 4a

Country	Primary goal of the assessment process	Time span of total process	Estimated production time	First- time assessment Paper/ face to face	Appeal
Netherlands	To check the entitlement of the claimant to the disability benefit and to determine the level of the benefit.	<p>Employees must claim a disability benefit between the 7th and the 8th month of sickness. The final decision regarding the benefit should be made before the end of the 12th month of sickness. Once the assessment process has started (i.e., once a claim has been taken under consideration), the assessment process should take no more than 13 weeks (throughput time). As a result of the high caseload, the assessment process often starts too late and the claim is not answered before the end of the 12th month of sickness. In 1999, approximately 60% of the assessments were finished in time.</p> <p>Social insurance physician: the standard length of the first assessment is approximately 2 hours (in reality, approximately 3-3 ½ hours). The standard length of a reassessment is again approximately 2 hours (in reality also approximately 2 hours). The time required for completing the report and filling in the form (FML) is estimated at 75 minutes.</p> <p>Labour expert: the standard length of the first assessment is approximately 3 hours. In reality, these assessments take 3-4 hours, of which 2-3 hours are spent on the report and computer programme (CBBS). The standard length of a reassessment is approximately 2 ½ hours.</p>	(195 minutes x 1 social insurance physician) + (210 minutes x 1 labour expert). Estimated production time = 405 minutes	<p>Face to face</p> <p>The requirements are basically the same for first time assessments as for reassessments. The execution differs, however, because less information has to be gathered during reassessments. Face to face contact is, therefore, not always necessary and meetings are generally shorter than for first time assessments.</p>	If a claimant requests a review, extensive investigations take place, sometimes with reassessment by a specialized reviewing physician. On the basis of these investigations, the social insurance agency may review a decision. If the claimant still disagrees, an appeal can be made to the administrative law department of the District Court. Decisions made by this Court can be appealed to the Central Court of Appeals.

Table 4a

Country	Primary goal of the assessment process	Time span of total process	Estimated production time	First-time assessment Paper/ face to face	Appeal
Norway	To check the entitlement of the claimant to the benefit.	<p>Following application for the disability pension by the claimant, the local insurance office sends a form to the treating physician asking for his views. Usually, 2 months are given to the physician; thereafter the local insurance office starts the assessment process. The maximum time is stated to be 8 months.</p> <p>In some cases, the maximum time is passed, mainly owing to overload at some local offices.</p> <p>General practitioners (GP): The filling in of the assessment form is compensated with a sum suggesting 45-60 minutes' work. The actual time required, and the time required by other persons involved in the process, is not known.</p>	<p>Estimated production time for the GP = 45-60 minutes</p> <p><i>Since the time required by other persons involved in the process is not known, no other production times are available.</i></p>	<p>In general, a paper assessment based on information provided by the GP and rehabilitation information.</p> <p>There are no reassessments.</p>	<p>The applicant has the opportunity to appeal the decision. First, the county office can evaluate the case again. If the county office does not change the decision, the case is sent to the social insurance court for a final decision. This is an independent court of appeal. It is possible for the applicant to add new medical information provided by experts</p>
Russian Federation	To define the kind and level of disability so as to be able to propose an individual rehabilitation plan, and to determine the level of disability pension that is needed (entitlement).	<p>After application, the examination is executed in 3-7 days. The decision is formalized and the claimant is informed right away. Complicated cases may take up to 3 weeks.</p> <p>The total production time for the assessment at a local bureau is estimated at one hour (3 specialists who each spend about 20 min.)</p> <p>The procedure has a throughput time of 10 days. Twenty-four team decisions are made per day.</p>	<p>The total estimated production time for the assessment at a local bureau is estimated at 60 minutes (3 specialists who each spend about 20 min.)</p>	<p>Method first-time assessments is face to face.</p> <p>Reassessments do not differ essentially from first time assessments.</p>	<p>On appeal, a re-examination takes place at the Main Bureau. If disagreement continues, the case is presented to the court. The court may call upon a specialist of an expert center.</p>

Table 4a

Country	Primary goal of the assessment process	Time span of total process	Estimated production time	First- time assessment Paper/ face to face	Appeal
Slovenia	<p>1. To determine the entitlement of the claimant to the benefit.</p> <p>2. To determine the need for occupational rehabilitation</p>	<p>It takes the case manager some days or some weeks to gather the necessary information from the employer. After that, he passes the file to the chairman, who has a maximum period of two months to perform the assessment and formulate a recommendation in cooperation with the Board of Examiners. After that, the case manager has a maximum period of four months to make a final decision regarding the disability benefit and to inform the claimant about his entitlement.</p> <p>The total assessment process takes about 6 months (2 months to collect medical information and 4 months to come to a decision).</p> <p>The actual time needed for the whole assessment process is less than the formal schedule allows. About a half of all assessments (or a little more) are finished in a shorter time (in 2 to 3 months).</p> <p>The assessment itself generally takes between 15 and 30 minutes p/p.</p>	<p>Estimated production time: 25 minutes x 3 persons = 75 minutes</p>	<p>Method first-time assessments is face to face.</p> <p><i>No information available about reassessments..</i></p>	<p>The claimant can appeal against a decision by letter. This appeal is dealt with by the Board of Examiners of the second degree, which is established in the head office in Ljubljana. First, the appeal and the file are examined, with special attention to the diagnosis and to the functional status, which is much more important than the diagnosis.</p> <p>As with the first degree assessment procedure, at least two clinical specialists and a safety specialist are consulted for the assessment in appeal. The board decides if the decision was correct at the moment it was made. It is possible for the claimant to provide new information only if this information was not available during the first assessment.</p> <p>The Board of Examiners makes a recommendation, as in a first degree assessment, regarding the disabilities.</p> <p>In Slovenia, there are relatively few appeals. A reason for this may be that both the employer and the claimant are involved in the assessment procedure.</p>

Table 4a

Country	Primary goal of the assessment process	Time span of total process	Estimated production time	First- time assessment Paper/ face to face	Appeal
Spain	To check the entitlement of the claimant to the benefit and to determine the category (level) of the benefit.	<p>An assessment has to be initiated at the latest after 18 months of temporal disability (i.e., sickness), but it can take place at any point in time before this. The sickness benefit is higher than the disability pension, which gives Social Security an incentive to assess early. An early examination is cheaper for the Social Security Institution.</p> <p>The legal framework requires a decision to be made in 135 days. The average time needed to make a decision in Spain is 62 days at the moment; in Madrid, this is 52 days. The effective time depends on the difficulty of the case. In some cases, a process can be finished in just 15 days.</p> <p>An examination with the insurance doctor takes about 1-1½ hours including the examination of the historical information and the report (opinion) of the insurance doctor. There is no standardized norm. An examination takes as long as necessary.</p> <p>Next, the team meets to make a decision. In Madrid, the team decides on about 60-80 cases in 5 hours, (200,000 assessments per year, 400 physicians). These figures are considerably lower in smaller provinces.</p>	<p>(1 doctor x 75 minutes) = 75 minutes + (300 minutes/ 70 = 4,3 minutes per case) x 5 members of the team = 13 minutes.</p> <p>Estimated production time: 75 + 22 =97 minutes.</p> <p>Production times vary between provinces.</p>	<p>First-time assessment: Medical assessor: face to face. Multi-disciplinary team: paper.</p> <p>In principle, reassessments do not differ from first-time assessments</p>	<p>After having received notice of the decision, the client has 10 days to study his file and decide whether (s)he thinks that the decision is right. If the client does not agree, (s)he must inform the National Institute for Social Security (INSS) of his or her province. The decision is reconsidered. After that, the client can appeal to court (the usual juridical procedure from first instance until supreme court).</p>

Table 4a

Country	Primary goal of the assessment process	Time span of total process	Estimated production time	First- time assessment Paper/ face to face	Appeal
United Kingdom	To advise the Department of Work and Pension (DWP) in its decision about the entitlement of a claimant to a disability benefit.	<p>After 28 weeks of sickness, a questionnaire is sent to the claimant. (S)He has 6 weeks to return the questionnaire. When returned, SchlumbergerSema has 50 days to give advice and complete the report. Ninety-five percent of the assessments must be returned in a period of 50 days.</p> <p>Achievement of expected performance depends on local circumstances. A financial penalty may be imposed if the target is not achieved without good reason.</p> <p>DWP decision makers are required to provide a decision within 15 days. The time schedule allows doctors to see claimants for an average of 45 minutes. This time varies: when cases are clearly not appropriate for incapacity benefit, assessment may be much shorter (10 min), for example, if limitations belong to the list of exempt conditions. There is no statutory time for the length of an examination. There is an expectation that doctors will assess, on average, 5 clients within 3.5 hours.</p> <p>The DWP decision-making process sometimes takes longer because of a shortage in expertise and high turnover.</p>	Estimated production time: 1 doctor x 45 minutes = 45 minutes	<p>Method first time assessment is paper assessment in obvious cases. Face to face otherwise. NB: benefits are not declined without face to face examination.</p> <p>Reassessments do not differ from first-time assessments. Benefit recipients with mental health problems may be re-assessed using reports from their treating doctors, whereas all are medically examined at the first assessment.</p>	<p>Appeal is possible within 28 days of receiving the benefit decision. There is an independent tribunal service that looks at the argumentation. Additional evidence can be taken into account.</p> <p>In such procedures, doctors that made the initial assessment are not consulted or confronted after giving advice.</p>

Table 4a

Country	Primary goal of the assessment process	Time span of total process	Estimated production time	First- time assessment Paper/ face to face	Appeal
USA	To check the entitlement of the claimant to the disability benefit.	<p>There is no formal time schedule. High caseload has an impact on the time required for decision making . The average processing time from the initial application to an initial determination in 2002 was 104 days. In the past, it was in the range of 102-106 days.</p> <p>Social Security does not have a standard for the amount of time invested in one claim.</p>	<i>Not enough information to estimate production time.</i>	<p>Method first time assessment is paper.</p> <p>Reassessments do not differ from first- time assessments. DDS has to determine if the person's impairment has improved since the last favourable decision. Furthermore, it must be determined if the claimant can perform substantial activity.</p>	<p>If a claim is denied or the claimant disagrees with certain parts of the decision, the claimant may appeal the decision. (S)he has 60 days from the time (s)he receives the letter to file an appeal.</p> <p>Reconsideration within the State Disability Determination Service (DDS) is the 1st step in the appeal process.</p> <p>The 2nd step in the appeals process is a hearing before an Administrative Law Judge (ALJ) in the area where the claimant lives. Usually, the ALJ will hold a hearing, although the claimant may ask that his or her case be decided on the written record without a hearing. At the hearing, the claimant and witnesses testify under oath or affirmation, and the testimony is recorded. The ALJ is responsible for looking into all issues: documentary evidence as well as the testimony of witnesses. The ALJ will allow the claimant and/or the claimant's representative to present arguments and examine witnesses. If additional evidence is necessary, the ALJ may arrange for consultative examinations to be performed and may obtain additional medical evidence from sources who have treated the claimant. Once the record is complete after the hearing, the ALJ will issue a written decision. A copy of this decision is mailed to the claimant, along with a notice explaining the claimant's right to appeal the decision if (s)he is dissatisfied with it. This latter form of appeal is called the Appeals Council and is the final administrative appeal step.</p>

Table 4b

Table 4b Assessors

Country	Is a labour expert involved?	Medical assessors	Who takes the final decision?
Belgium	No.	<i>Medical advisor</i> In case of acceptance, the decision of the medical assessor is checked (on paper) by a member of the Higher Committee of the Council for Invalidity. If the medical advisor of the Higher Committee has any doubts, (s)he firstly consults a colleague of the Higher Committee. If doubts remain after this, the decision is referred to the Regional Committee of the Council for Invalidity (3 doctors: 2 medical advisors and one medical inspector). If the decision of the three experts of the Regional Committee is not unanimous, the case is sent back to the Higher Committee. The Higher Committee will deal with the case in a plenary meeting and take the decision. The higher committee consists of medical advisors of the five health insurance companies and medical advisors of RIZIV.	In case of rejection, the medical advisor. In case of acceptance, the Higher Committee of the Council for Invalidity.
Denmark	A labour expert may be consulted.	Experts such as medical consultants, rehabilitation consultants, disability consultants, psychologists, and job consultants may be consulted as necessary.	The case manager of the municipality (based on information provided by the experts or a multidisciplinary assessment team (case manager and experts)).
Finland	Only in exceptional circumstances.	The treating doctor (certification) One social insurance physician per insurance policy, so often 2 social insurance physicians are involved.	The decision makers. The two decision makers negotiate about the final decision on the basis of the proposals of the two social insurance physicians. Usually, the advice of the social insurance physician is followed.
France	No.	The treating doctor (certificate). The medical advisor.	The medical advisor (MC).

Table 4b

Country	Is a labour expert involved?	Medical assessors	Who takes the final decision?
Germany	Yes; The labour expert makes a decision about the benefit on the basis of the information provided by the insurance doctor and his knowledge of the labour market situation. (S)He has to investigate if there are professions still open to the claimant regarding his impairments and if these exist within reasonable travelling distance of the claimant home.	The GP (provides medical information about the claimant). The insurance doctor. Optional: Other medical experts such as experts in hospitals, and rehab institutions.	The labour expert (based on the information provided by the insurance doctor and his knowledge of the labour market situation).
Hungary	No.	The GP (provides medical information). Two physicians (medical experts). They work in pairs. One does the medical examination and the other is consulted. The other physician is not always present during the assessment, because of high caseload, but may be consulted afterwards. Usually, the two physicians agree but if not, a third expert is called for consultation.	The social insurance official (based on legal grounds and information provided by the physicians (medical decision makers)).
Ireland	No.	The GP (certificate) or the Chief Medical Advisor (determines if assessment is necessary). The medical assessor.	The clerical deciding officer from the Department of Social, Community and Family Affairs (based on advice from the medical assessor).
Italy	No.	The GP (certificate). At the local level, one local INPS doctor. In the specialists units, generally two specialists are involved.	The INPS doctor at local level (also when specialists are involved, the local doctor is responsible for the final decision).
Netherlands	Yes.	The social insurance physician.	The case manager formulates the final decision based on the opinion of the social insurance physician and the labour expert.

Table 4b

Country	Is a labour expert involved?	Medical assessors	Who takes the final decision?
Norway	No.	The general practitioner produces a detailed certificate providing information on the medical condition concerning treatment and rehabilitation. Special in-service doctors of the National Insurance Administration may be consulted in order to review the quality of the information. They can call the claimant for an interview.	A lay person from the National Insurance Office (medical advice is generally followed).
Russian Federation	No.	The treating doctor (provides medical information). Three medical social examination officers.	The medical social examination officers have to come to a consensus, which is the final decision.
Slovenia	Yes.	The treating doctor (provides medical information). The board of examiners are the examining doctors (2 clinical doctors and a labour expert).	The case manager (based on information provided by the chairman of the board and non-medical information).
Spain	Yes.	The medical doctor (INSS) (produces a medical report). The medical doctor in the multidisciplinary team (the multidisciplinary team consists of 5 people).	The formal decision is made by the Provincial Director of the administration based on the proposed decision by the multidisciplinary team.
United Kingdom	No	The GP (certification). The medical assessor (for non-exempt conditions).	The decision maker at Department of Work and Pension.
USA	No, but the disability examiner uses his or her knowledge of labour market conditions to decide about the claimant's chances on the labour market.	The treating doctor(s) (provides medical report). Optional: Medical consultants can be consulted. The Social Security Administration Field Office (if initial medical evidence is insufficient and additional analyses have to be done).	The Disability Determination Service (DDS) disability examiner (primarily based on information provided by the treating doctor).

Table 4c Process steps

Country	Process steps including flow charts
Belgium	<p>Every person that becomes sick needs a medical certificate (attest) to show his employer that he is sick. This certificate can be obtained from any doctor in Belgium and provides no information on the diagnosis (in Belgium, there is no one-to-one relationship between the client and the general practitioner; therefore, a person can choose a doctor himself). For the period of wage continuation (2-4 weeks), this certificate is sufficient.</p> <p>During the first year of sickness, a person can apply for a Primary Disability Benefit. After one year, this scheme is turned into an Invalidity Pension. However, the processes in the two schemes differ.</p> <p>1. Primary Disability Benefit</p> <p>In order to apply for a benefit, the client has to fill in an application form and must send this to the health insurance company two days before the end of the wage continuation period. The client must ensure that in the meantime his/her doctor sends a medical certificate to the health insurance company. This certificate contains information on the starting date of the disability and - in contradiction to the certificate for the wage continuation period - on the diagnosis of the client, and is sent straight to the medical advisor of the health insurance company.</p> <p>Assessment of the application and medical certificate</p> <p>Before the medical assessment, the medical advisor decides whether to accept the client's application and medical certificate or not. The assessment of the medical certificate must take place within three days. If (s)he does not accept the application, the medical advisor generally asks for more information, for instance, if the certificate is not complete. If (s)he accepts the application, (s)he determines a date to see the client for a medical examination. Until this date, the client is considered to be disabled and is entitled to benefits. In cases of doubt (depending on the history of absence owing to sickness, the diagnosis, and the reputation of the doctor), the date of the medical examination will be sooner. However, a medical examination within three weeks after the start of the Primary Disability Benefit is compulsory.</p> <p>Medical assessment</p> <p>The examination is carried out by the medical advisor and usually takes place at the office of the health insurance company, unless the client is hospitalised or not free to move. The criterion for a Primary Disability Benefit is a loss of earning capacity in the client's own job of at least two thirds. The outcome of the medical examination is 'disabled' (more than 66% loss of earning capacity) or 'not disabled' (less than 66% loss of earning capacity). A person can be sick, but if the medical advisor is of the opinion that the productivity of the client is still sufficient to carry out the job, this person is not assessed as being disabled.</p> <p>If a person has been assessed as 'not disabled', this decision is immediately communicated to the client at the end of the assessment. The date of work resumption is imposed. However, the client's benefits are paid until this date. If the outcome is 'disabled', the medical advisor determines a date for the next assessment. Until that assessment, the client is considered to be disabled. Work resumption by the client is possible but the permission of the health insurance company is needed. This process is repeated. After every assessment, the medical advisor determines the date of the following medical examination.</p> <p>After 6 months, the reference is no longer two thirds loss of earning capacity compared to the client's own job, but two thirds of earnings in a class of occupations the client could reasonably be expected to engage in.</p> <p>2. Invalidity Pension</p> <p>The transition from Primary Disability Benefit to Invalidity Pension is smooth in the sense that the client does not need to apply for an Invalidity Pension. The criteria for an Invalidity Pension do not differ from the criteria after 6 months of sickness in the Primary Disability Benefit.</p> <p>The main difference compared with the period of Primary Disability Benefit is that the assessment is not made solely by the medical advisor. If the medical advisor decides that a person is no longer disabled according to the criteria, the Disability Pension is stopped. However, if the medical advisor has determined that the loss of earning capacity is 2/3 or more, his report (the decision of 'disabled' together with the proposed date of the next assessment) is sent to the Higher Committee of the Council for Invalidity.</p> <p>The Council for Invalidity consists of medical advisors of the five health insurance companies and medical advisors of the National Institute for Sickness and Disability Insurance (RIZIV). One person of the Higher Committee, not belonging to the client's health insurance company, carries out a peer review of the documents. If (s)he agrees with the decision of the medical advisor (i.e., with the decision of disability itself and also with the proposed period of time the client is considered to be disabled), the decision is communicated to the medical advisor and the client is</p>

Table 4c

Country	Process steps including flow charts
Belgium continued	<p>entitled to an Invalidity Pension until the date of the next medical assessment. If the medical advisor of the Higher Committee has any doubts, (s)he firstly consults a colleague of the Higher Committee. If doubts remain after this, the decision is referred to the Regional Committee of the Council for Invalidity.</p> <p>The Regional Committee consists of three doctors (two medical advisors and one medical inspector from RIZIV). The client needs to visit the Regional Committee, which carries out medical reassessment. If the Regional Committee assesses the client as 'not disabled', this decision is immediately communicated to the client. If the Regional Committee is of the opinion that there is a situation of disability, it reports to the Higher Committee, which informs the medical advisor. If the decision of the three experts of the Regional Committee is not unanimous, the case is sent back to the Higher Committee. The Higher Committee will deal with the case in a plenary meeting and take the decision.</p> <p>This whole process is also repeated when the imposed period of disability has elapsed, including a medical assessment (the client is obliged to show up, if not in hospital, etc.). The medical advisor remains the same, but the person of the Higher Committee and the persons of the Regional Committee can be different.</p> <p>If the claimant is still disabled after one year, the medical assessor has to explain this (on paper) to the Higher Committee (peer review).</p>

Flow chart: Belgium

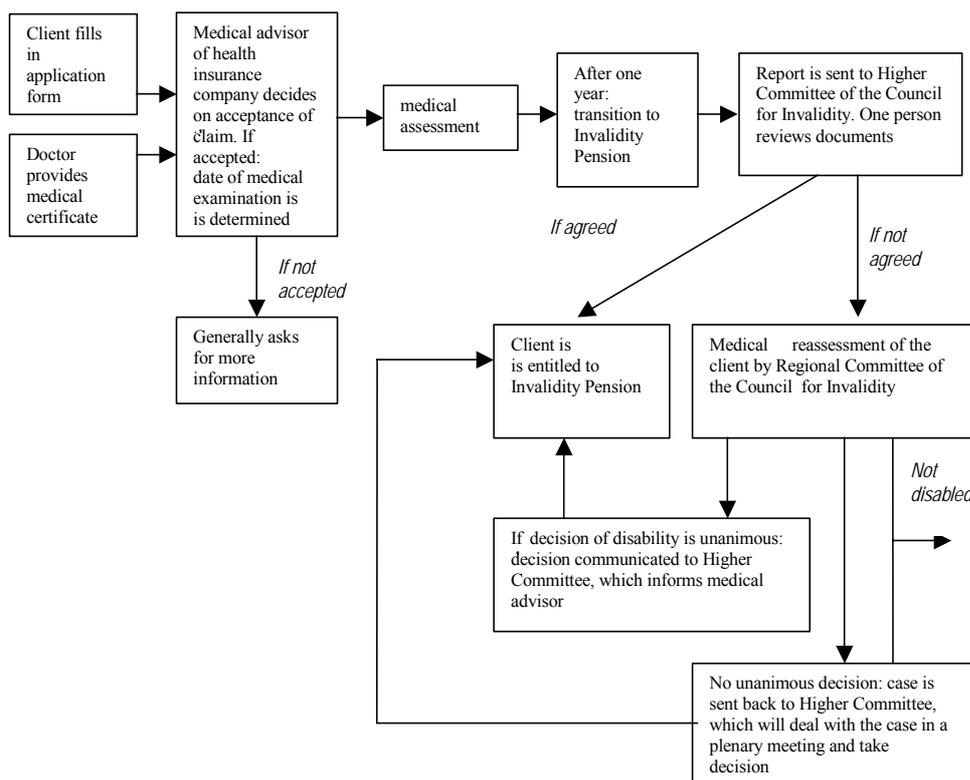


Table 4c

Country	Process steps including flow charts
Denmark	<p>In January 2003, the assessment of disability in Denmark underwent some profound changes. In line with the principles of a social-democratic political attitude, a process started which leads towards decentralisation and activation. An integrated approach has been adopted towards social protection including the whole population and is organised largely locally (per municipality). A case manager from the community deals with disability benefit applicants, who may “come from” sickness benefit, social assistance, vocational rehabilitation, etc. The case manager has to carry out a human resource profile after 8 weeks of sickness or the moment of application for disability benefits. The human resource profile is the basic instrument used in making decisions on the disability benefit, vocational rehabilitation, and flex jobs. These decisions include three aspects that have to be clarified:</p> <ol style="list-style-type: none"> 1. What are the claimant’s resources? 2. What are the claimant’s potential resources that can be developed? 3. Has it been proven that the claimant does not have enough resources to fulfil even the requirements of a flex job? <p>The human resource file is compiled according to a standardised twelve point assessment, including the person’s:</p> <ol style="list-style-type: none"> 1. former education (ability), 2. work experience (ability), 3. interests (potential abilities), 4. social competences (ability to fit into a work place), 5. abilities to reorient (abilities to adjust to a new situation), 6. ability to learn (practical/ intellectual orientation), 7. wishes for the future, 8. own expectations of future performance (ambition), 9. level of work identity (importance of work), 10. housing conditions/ economic conditions (possibilities of regaining energy), 11. social network (motivation and support), 12. health. <p>The case manager has to carry out the assessment, but (s)he can ask request information from experts concerning parts of the assessment. Experts are medical consultants, rehabilitation consultants, disability consultants, psychologists, job consultants, and any other person whose assistance is necessary. These consultants are mainly hired for the purpose from the free market. Experts must state a person’s condition and may not jump to conclusions on whether the person should receive a disability pension.</p> <p>In some municipalities (depending on size), assessment teams (including some of the above-mentioned experts as well as some case managers) decide on or control the individual assessments. The organisation of the assessment process is entirely the responsibility of the municipality. In some communities, different types of case managers have to cooperate, for example, one case manager for sickness, one for rehabilitation, one for flex jobs, and one for long-term disability pensions.</p> <p>As only one of the 12 points refers to health, the role of the doctor is less important than before, but is still an important part of the assessment. The new method focuses on resources and the development of resources, and the decision about award of disability depends on the functioning of the claimant in relation to the labour market and not the diagnosis in itself.</p> <p>Week X: Person reports sick or accident happens.</p> <p>Weeks 1-2: Employer is required to pay sickness benefit for two weeks.</p> <p>Weeks 1-4: The municipality should be notified about the sick leave. The employee is obliged to state (on a form) the type of illness that cause(d) the absence. In addition, the employer may require the employee to make a written statement saying that illness is the cause of absence. After 4 days of sick leave, the employer may require the employee to provide a medical certificate. At any time during sick leave, the municipality may require the employee to provide a medical certificate.</p> <p>Week 8: If a medical certification is not presented after 8 weeks of sick leave, the municipality is obliged to ask the employee to provide a certificate. Furthermore, the municipality is obliged to make a follow up evaluation within 8 weeks (and thereafter every 8 weeks) in order to assess the need for, e.g., medical and vocational rehabilitation.</p> <p>Weeks 3-52: Municipality pays sickness benefit, which can be extended for another 26 or even 52 weeks.</p> <p>Within six months, the case manager should make a follow up plan. If vocational rehabilitation is considered to be necessary, the municipality must make a vocational rehabilitation plan in cooperation with the client. Rehabilitation may last between 3 weeks and 5 years. Most rehabilitation activities last about 3 months, however.</p> <p>After rehabilitation, a final report states the success or failure of the rehabilitation measures. This is the main document required in order to grant disability pensions. An unsuccessful rehabilitation could lead to a new rehabilitation plan. If no other possibilities for rehabilitation are left, the person might be offered a flex job with the possibility of trying another flex job if (s)he does not succeed in the first flex job. If the person is not able to fulfil the requirements of (a) flex job(s), a disability pension is granted.</p>

Table 4c

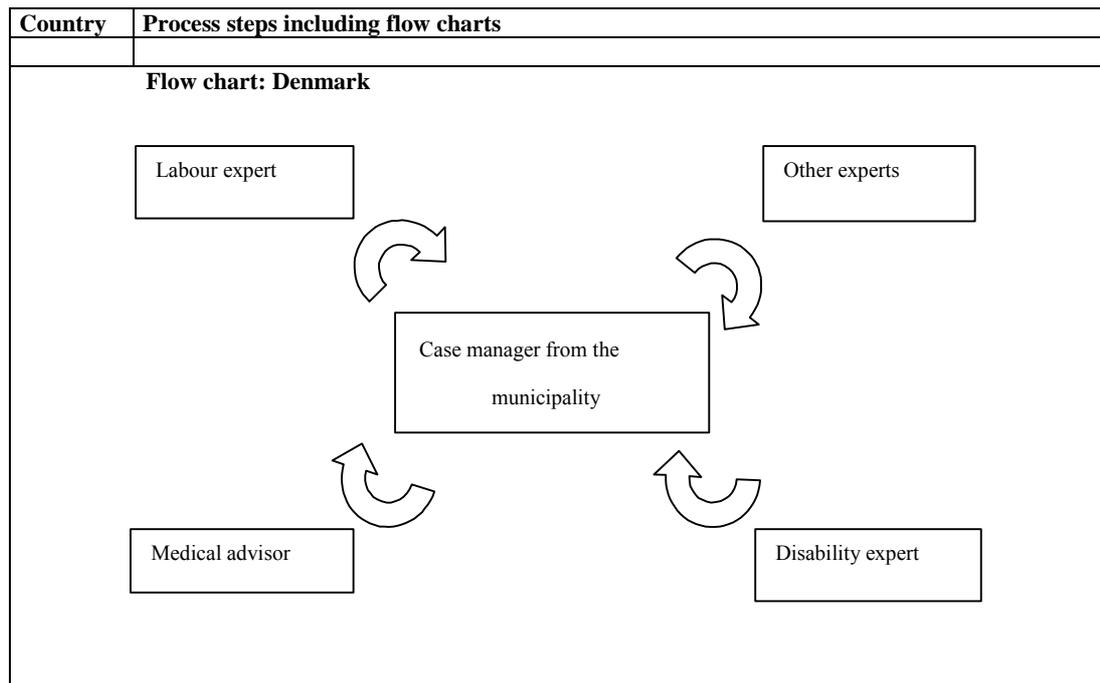


Table 4c

Country	Process steps including flow charts
Finland	<p>The assessment process is alike in all insurance organizations (private or public). It might differ on small details.</p> <p>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 (medical statement B: history, status, findings, assessment of functional and working capacity, chances to recover working capacity through rehabilitation, final conclusion) filled in by the treating doctor.</p> <p>Claims can be sent in by mail or submitted at the local SII (Social Insurance Institute) office.</p> <p>The pension provider determines whether the applicant's work capacity has decreased so much that (s)he is entitled to a full disability pension (or partial pension in case of earnings related pensions). 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 subjected to further medical examination at the pension provider's expense.</p> <p>The decision maker of SII and the decision maker of the earnings-related insurance on a common decision negotiate about the final decision given to the claimant.</p>

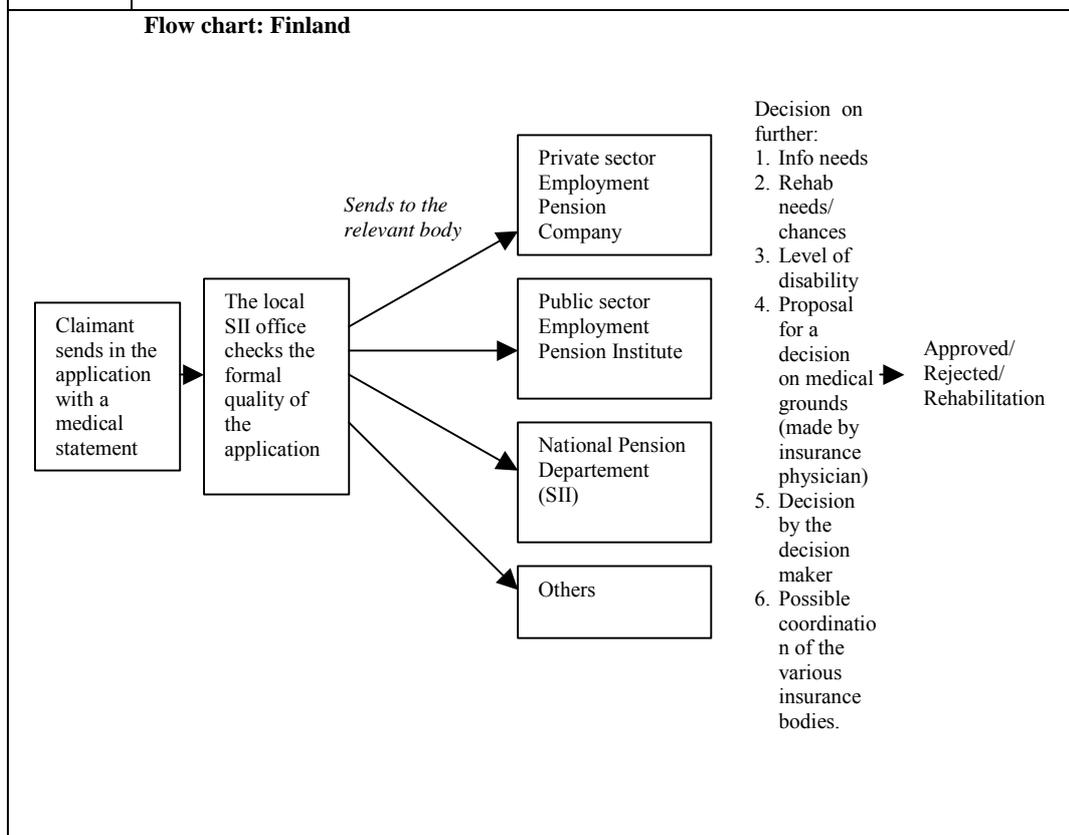


Table 4c

Country	Process steps including flow charts
<p>France</p>	<p>Sickness is initially certified by the treating doctor. For sickness benefits, the treating doctor must indicate precisely the medical justification for the claimant's not working: physical incapacitation. After 120 days, a detailed description is required of the patient's health status, treatment, and the prognosis (PIRES).</p> <p>The treating doctor has to answer questions from the medical advisor (MC) about the protocol (PIRES). The decision to apply for an invalidity pension is largely the responsibility of the treating doctors and is based on the idea of stabilisation of the condition. Generally, the treating doctor makes the decision to apply for an invalidity pension between 12 and 18 months of sick leave.</p> <p>A daily allowance of 50% of usual daily income is granted. This period cannot exceed 3 years. Part-time or therapeutical resumption is possible with a corresponding allowance. The consent of the company doctor is needed in all cases of work resumption. Rehabilitation, if necessary vocational, can be required from the client.</p> <p>The MC approves of treatment and sick leave on file and/or following a consultation. The MC performs an examination and decides on the need for special measures and the chances of full or partial recovery. After 12 months, the MC fills in a PRMI (Premier Rapport Médical d'Invalidité, containing personal data, the history of the disease, medical observations, the diagnosis, information on stabilisation, decision 2/3 category, among other things). For this report, the client is generally seen by the MC. The MC must decide on stabilization of the condition within three years; otherwise a conclusion is legally forced and stabilization has to be presumed.</p> <p>The MC is directed to look at the person's potential for employment in the whole local labour market to make a decision about disability. Furthermore, the MC takes into account the person's remaining working capacity, general condition, age, physical and mental faculties, capabilities, and education.</p> <p>For a person found to be in the first category of invalidity, the work/ occupational doctor is called upon to assess the possibility of (partial) resumption of work and to take measures to adapt the work to the worker's condition. In some circumstances, the work/ occupational doctor may also investigate the possibility of a return to work for a person in the 2nd category.</p>
	<p style="text-align: center;">Flow chart: France</p> <pre> graph LR A[Treating doctor provides detailed description of persons's health status, Treatment, and prognosis (PIRES) for sickness benefits. After 12 - 18 months of sick leave, treating doctor decides on application for disability pension] --> B[Medical advisor (MC) approves of treatment and sick leave on file and/or consultation] B -- "after 12 months" --> C[MC fills in PRMI, containing personal data, history of disease, observations, diagnosis, stabilisation, decision 2/3 category, among other things. For this report, client is generally seen by MC.] C -- "Within three years" --> D[MC decides on stabilisation of the condition] </pre>

Table 4c

Country	Process steps including flow charts
Germany	<p>There are 3 ways to a claim a disability benefit:</p> <ol style="list-style-type: none"> 1. The claimant applies for a disability benefit directly or on the advice of the general practitioner; 2. The health insurance company decides to apply for a benefit when the claimant has not recovered within 78 weeks; 3. The unemployment insurance can ask the person to apply. <p>The assessment is carried out by an insurance doctor and a labour expert. The insurance doctor first collects all medical information. If this information is not complete, he might assign medical experts to conduct a medical review. He completes the medical assessment with a decision on the claimant's capacity to work according to the criterion "not able to work 3 or 3-6 hours". In the second step, the labour expert decides whether there is work the claimant is able to do within reasonable travelling distance of his/her home.</p>
Flow chart: Germany	
<pre> graph TD subgraph Claims C1[Claim 1: Claimant applies for disability benefit directly or on advice of the general practitioner] C2[Claim 2: Medical service health insurance decides no recovery within 78 weeks] C3[Claim 3: Medical service unemployment insurance asks client to apply for the disability benefit] end C1 --> ID1[Insurance doctor collects medical and administrative information] C2 --> ID2[Insurance doctor checks case] C3 --> ID2 ID2 --> ID1 ID2 --> ID3[Eventually insurance doctor assigns expert(s) to perform medical review] ID3 --> ID1 ID1 --> ID4[Insurance doctor decides on whether rehabilitation or benefit is necessary] ID4 --> IR[Insurance doctor sends report to rehabilitation service] ID4 --> IL[Insurance doctor sends report to labour expert] IL --> LE[Labour expert assesses labour market opportunities and makes decision on benefit] LE --> AU[Administrative unit calculates benefit and informs client] </pre>	

Table 4c

Country	Process steps including flow charts
Hungary	<p>Sickness benefit is paid by the Health Insurance Fund (HIF), which amounts to 70% of average wages. This benefit is paid for maximally 52 consecutive weeks (if work incapacity is due to occupational injury, the payment of sickness benefit may be continued for a longer period: 2 years). An assessment is done by the client's attending physician, who certifies the absence from work to the HIF and the employer. The doctor's certificates, the result of the assessments, are valid for fixed periods (this period depends on the diagnosis). There are different handbooks for this type of assessments.</p> <p>Only the client can take the initiative to forward a disability claim. This can be done at any moment. It is not possible to claim for a disability benefit more than once a year unless the medical situation has deteriorated. The claimant must ask his or her GP to fill in the necessary information.</p> <p>The GP gives the necessary information to the client, who sends it, with the claim, to the social insurance official. First, this official (the case manager) checks if the claim is complete. The official then facilitates the assessment process and invites the claimant to attend a meeting with the social insurance physician. The official also passes the information to the physician.</p> <p>There is always a medical examination except when it can be stated that the medical situation is very serious. In the assessment, the focus is on the capabilities of the claimant, whereby age is taken into account for older people without work. The medical examination takes into account the medical information provided by the GP. A statement of the claimant's complaints is not a good basis for the benefit. The physician will also look at the opinion of the GP for consistency. The physicians (medical experts) work in pairs. One does the medical examination and the other is consulted. The other physician is not always present during the assessment, because of high caseload, but may be consulted afterwards. Usually, the two physicians agree but, if not, a third expert is called for consultation.</p> <p>During the assessment, (part of) the report is dictated to a secretary.</p> <p>The physician makes a report and sends it to the social insurance official. The social insurance officer makes the final decision based on legal grounds. His job is also to inform the claimant of the decision.</p> <p>The benefit is permanent but re-evaluations are necessary. If improvement is possible, the benefit is not permanent. The examination regards a period of eligibility (1, 2, 3 years or permanently). After this period, a re-examination must be carried out. A reassessment occurs after 3 years in most cases. A reassessment is always a medical examination. When the caseload is high, the reassessment is based on the paper file.</p> <p>The National Rehabilitation Institute (NRI) provides medical and vocational rehabilitation to partly disabled clients, handicapped persons, and other categories of patients.</p>

Table 4c

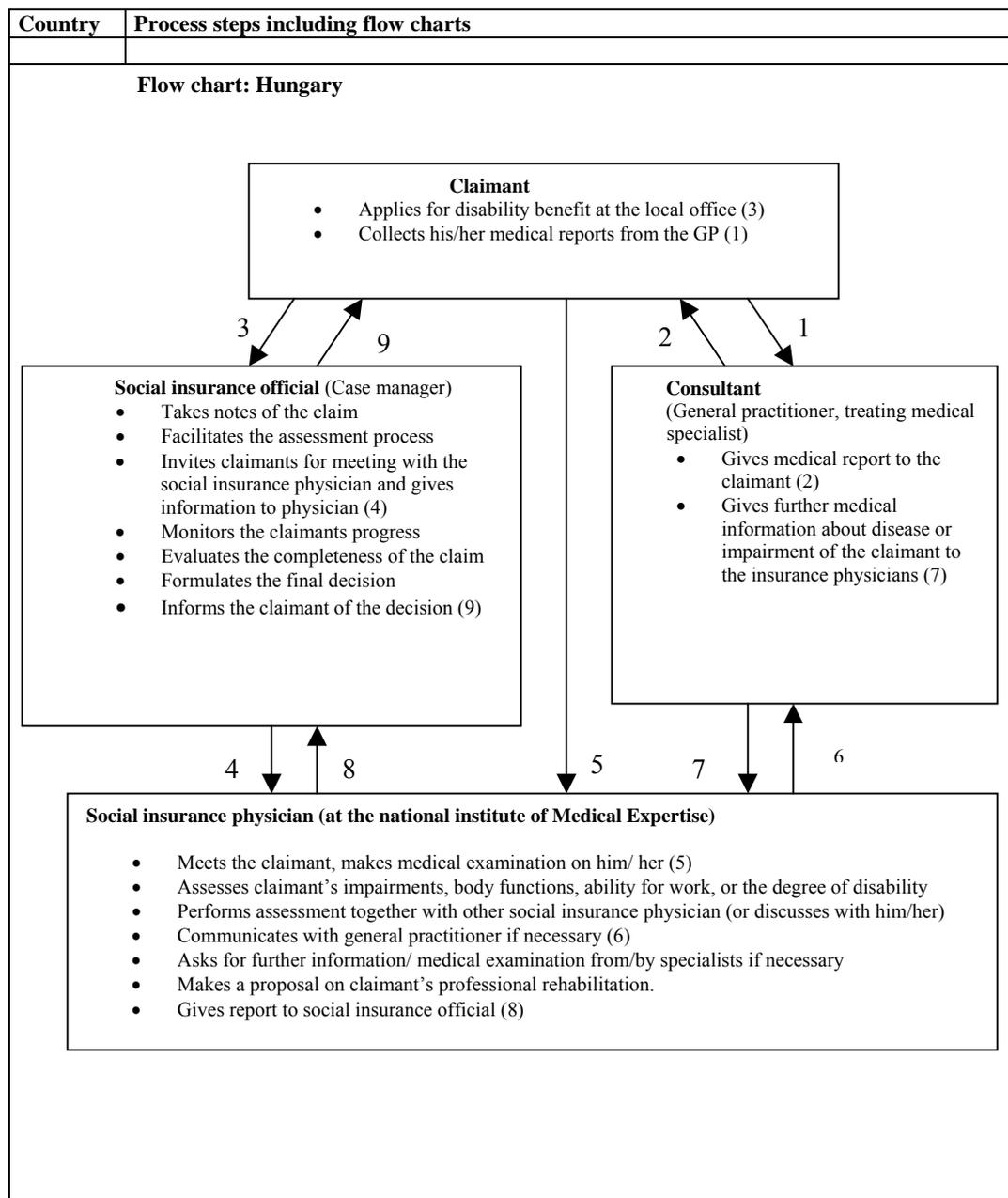


Table 4c

Country	Process steps including flow charts
Ireland	<p>The Department of Social Community and Family Affairs (DSCFA) administers the main income support payments for people who are ill and people with disabilities.</p> <p>When a working person gets sick, (s)he can claim Disability Benefit (DB). DB is payable after three 'waiting days'. Disability benefit provides the pathway to Invalidity Pension. For a claim which starts with sickness, the claimant's own doctor initially certifies incapacity (provided (s)he has been approved as a medical certifier under the Social Welfare Acts). The doctor is asked to give a specification of the 'incapacity' which is a medical diagnosis or description of symptoms. A list of common conditions is given on the 'first certificate of incapacity' form: these include abdominal pain, fracture, and cardiac disorders; space to specify the condition exactly is provided. The condition indicated by the claimant's doctor is referred to as the 'certified cause of incapacity' (CCI). Persons not already in receipt of DB are assessed by the Chief Medical Advisor to determine if a medical examination is required.</p> <p>Medical certificates from the claimant's general practitioner (GP) confirming incapacity for work must be submitted on a regular basis (usually weekly). Officials in the DSCFA code the condition and set a referral date according to the code. If the claim continues, the claimant is referred for medical assessment: the Medical Review and Assessment (MRA).</p> <p>The MRA procedure is undertaken by medical assessors. The medical assessor records the claimant's medical and surgical history. The assessor also notes the claimant's work history and educational and vocational qualifications, and records the claimant's statement about the medical condition and its effect on 'the performance of ordinary activities of life/ work related activity'. The assessor then provides a 'clinical description' of the effects of the claimant's condition in terms of the following functional areas: Mental health, Learning, Consciousness, Balance, Vision, Hearing, Speech, Continence, Reaching, Lifting/carrying, Manual dexterity, Bending/ kneeling/ squatting, Sitting, Standing, Climbing stairs, Walking.</p> <p>The method of assessment is clinical and functional.</p> <p>The guidance notes on the MRA system state that the medical assessor 'does not dispute the existence of the CCI'; instead (s)he assesses the degree of loss of function in work related activities and its effect on the claimant's ability to work. However, the MRA form includes a 'systems review and medical examination' in which the doctor describes the person's overall state of health in terms of medical areas (mental, nervous, respiratory, circulatory, alimentary, etc.) and summarises the 'relevant clinical findings'.</p> <p>The final part of the MRA process is the 'Work Capacity Assessment'. When the claimant has been out of work for more than 6 months and there is no job open, or if the claimant was never employed, the assessor considers whether (s)he is capable of fulfilling a function in any of the work categories specified. These categories are combinations of job effort (light, moderate, heavy) and skill level (lesser/ semi/ skilled), in a total of 9 categories from A (light/skilled) to I (heavy/ lesser skilled). Examples are given in each category (from professional, academic to construction, refuse collectors).</p> <p>The assessor should describe why the claimant is capable of work 'in functional terms', i.e., 'because claimant can sit for long periods without discomfort', etc. If incapable of work, brief reference to the functional assessment suffices.</p> <p>The assessor is also asked to indicate whether there is any non-functional incapacitating factor present. This refers to 'conditions which, although do not adversely affect the claimant's ability to perform any of the work related activities, can nevertheless be deemed to be incapacitating.' These include, e.g., malignant hypertension, cardiac arrhythmias, etc. It is possible for conditions which lead to general tiredness and fatigue to be recognised under this heading; situations in which a person's condition would be aggravated by work may also be recognised.</p> <p>In Ireland, the medical assessor must give his opinion on whether the person can be considered permanently incapable of work. The final decision concerning eligibility for benefits is taken by a clerical deciding officer, who considers the non-medical as well as medical qualifying conditions. No non-medical experts are involved in the determination of disability (referred to as 'medical eligibility').</p> <p>Rehabilitation before allowance does not apply in Ireland. Rehabilitation is a right of the individual but not necessarily a precondition for a benefit.</p>

Table 4c

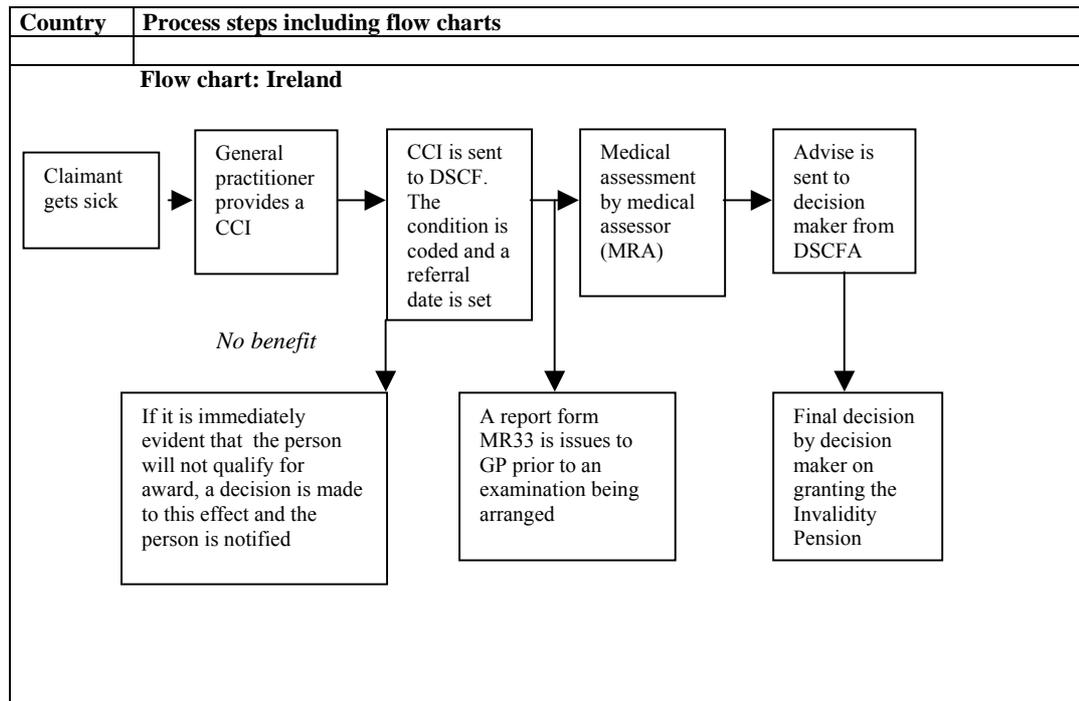


Table 4c

Country	Process steps including flow charts
Italy	<p>Applicants fill in a form from the National Institute for Social Provisions (INPS) and attach a medical certificate given by their own doctor or specialist. INPS carries out a medical assessment. Clear cases are dealt with at the local level. For more complicated or unclear cases, or if specialist expertise is called for, the client is referred to one of the five specialist units of INPS. At the local level, there are too few specialists to cover all diseases.</p> <p>The local doctor decides whether a person needs to go to a specialist unit. The client has the option to refuse. In such a case, the decision is based on the first-time assessment. However, if there is any doubt, the decision is likely to be unfavourable to the client.</p> <p>In the specialist units, which are in Rome, Bologna, Reggio Calabria, Palermo, and Milano, the client must again undergo a medical examination. At this level, two specialists are generally involved in every case.</p> <p>During the decision making process, the claimant visits an INPS doctor, who accepts/refuses the claim. If necessary, the claimant can have a second consultation with the participation of his/her medical doctor (collegial visit; the medical doctor is usually a medical doctor from the Trade Union organisation of the claimant).</p> <p>The specialist units communicate the result to the local INPS doctor. However, the local level remains responsible and takes the final decision.</p> <p>Few cases are assessed without the client being assessed. This is the case if the medical records and papers make the final decision clear (usually 100%). If a client is unable to visit INPS owing to (terminal) illness or a handicap, (s)he is visited in the hospital or at home. Also in this case, a medical form is filled in. The head of the office signs the results of the assessments.</p> <p>The assessment is repeated every three years at the claimant's request. If the claimant does not request reassessment, (s)he loses the benefit.</p> <p>After the medical examination, the administrative process starts. This usually takes more time and involves checking the reference period and determining the benefit level.</p>

Flow chart: Italy

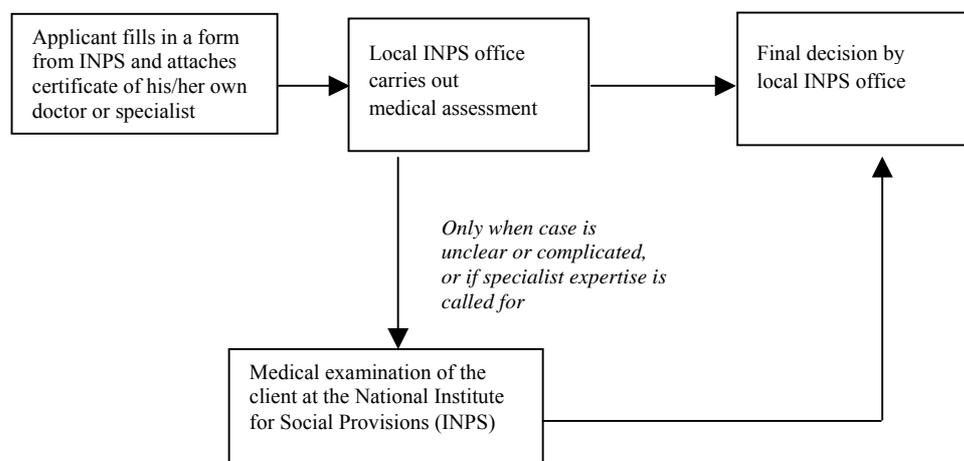


Table 4c

Country	Process steps including flow charts
Netherlands	<p>Employees must claim a disability benefit between the seventh and eight months of sick leave. This claim must contain a description of the client's impairments and disabilities, and his treatment and rehabilitation. The claim will not be processed if treatment and rehabilitation are inadequate. The final decision regarding the benefit should be made before the end of the twelfth month of sickness. Once the assessment process has started (i.e., once a claim has been taken under consideration), the assessment process should take no more than 13 weeks (throughput time).</p> <p>A multidisciplinary team carries out the assessment of disability for work. This team consists of a social insurance physician, a labour expert, and a case manager. The flow chart below shows the general organisation of the assessment process in the Netherlands.</p>
Flow chart: The Netherlands	
<pre> graph LR A[Claimant applies for disability benefit] --> B[Case manager checks case] B --> C1[Case manager invites claimant to meeting with social insurance physician] B --> C2[Case manager sends file and claim to social insurance physician] C1 --> D[Social insurance physician meets claimant and assesses impairments and capacities] C2 --> D D --> E1[Case manager invites claimant to meeting with labour expert] D --> E2[Case manager sends report of social insurance physician to labour expert] E1 --> F[Labour expert meets claimant and assesses loss of earning capacity/degree of disability] E2 --> F F --> G[Discussion between social insurance physician and labour expert (if necessary)] G --> H[Final decision] </pre>	

Table 4c

Country	Process steps including flow charts
Norway	<p>When a person gets sick, (s)he first receives a sickness benefit. In addition to sickness benefit (paid for a maximum of one year), rehabilitation benefits (medical and vocational) are payable to persons with long-term illnesses or disabilities. Medical rehabilitation allowance is paid for a maximum of one year, while vocational rehabilitation allowance can be paid for several years.</p> <p>The most common 'route' towards claiming disability pension involves one or several periods of absence owing to sickness and participation in rehabilitation measures. After 8 weeks of absence owing to sickness, the person's own doctor is required to produce a detailed certificate. The doctor is supposed to inform the National Insurance Administration about on-going treatment, plans for further treatment, and possible rehabilitation measures.</p> <p>The employer pays sickness benefit in the first two weeks of absence, after which the National Insurance Scheme takes over responsibility for the payments. However, during the whole period of sickness, the employer has a duty to consider and implement the practical arrangements necessary in order to promote the patient's return to work. Sick workers can, for instance, re-enter work gradually or through active sick leave. These arrangements are used for the purposes of ensuring that the employee does not lose contact with the workplace and of testing his/her capacity to perform regular work. The arrangements are voluntary, but frequently used and encouraged by both the National Insurance Administration and doctors. Formally, the employer also has a legal obligation to provide a written statement to the National Insurance Administration about the arrangements that can be made in the workplace to facilitate the patient's return to work (National Insurance Act, Section 25-2). However, this rule has little or no practical significance.</p> <p>Employers at the Local Insurance Office (the one assigned to an executive officer: the decision maker) are expected to refer claimants who may benefit from participation in vocational rehabilitation measures to the Employment Service. In certain cases of fatal or compound impairment (according to a standardised list of diagnoses), the National Insurance Administration will itself decide that further testing of work capacity and employment prospects is not necessary.</p> <p>The law does not state any explicit limitation regarding the kind of work the person is expected to take up, apart from the general requirement that this work should be 'suitable' for the person (National Insurance Act, Section 11-6). If the Employment Service comes to the conclusion that vocational rehabilitation is not necessary and appropriate, the person is referred back to the National Insurance Office for a final decision about the claim for disability pension.</p>

Table 4c

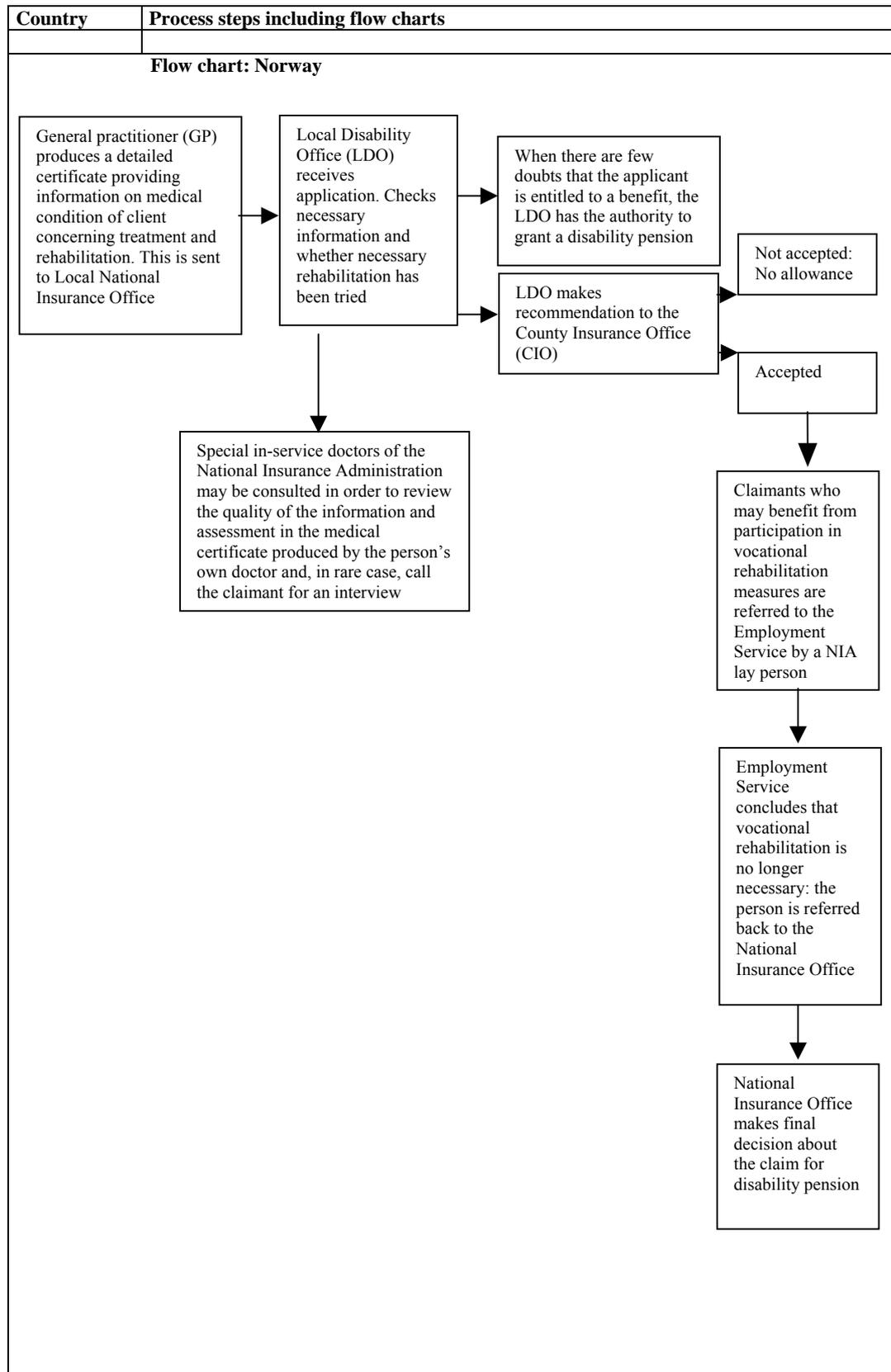


Table 4c

Country	Process steps including flow charts
Russian Federation	<p>The Health Institution (e.g., hospital) decides when a disability pension should be applied for. With the consent of the disabled person, the doctor of the health institution fills in a form on the health condition of the person. A social worker fills in a form about his/her social circumstances. The client, or the client's representative, delivers these forms to the Medical Social Examination (MSE) and the client is invited for an examination within a few days or a week. On the examination date, the client is examined by at least 3 specialists. These specialists are selected according to the presented pathology on the form. After the examination, the doctors deliberate about the person's disability, the category of disability, and the possibilities of rehabilitation. They also determine when the person should have a re-examination. Immediately after the specialists have reached consensus, the person receives the decision from the head of the team. The person receives the decision on paper also, and one copy is sent to the Social Fund for payment of the benefit. If the client agrees to it, (s)he is invited to participate in a rehabilitation programme. A detailed plan for the rehabilitation programme is made by the original team plus a team of rehabilitation experts.</p>

Flow chart: Russian Federation

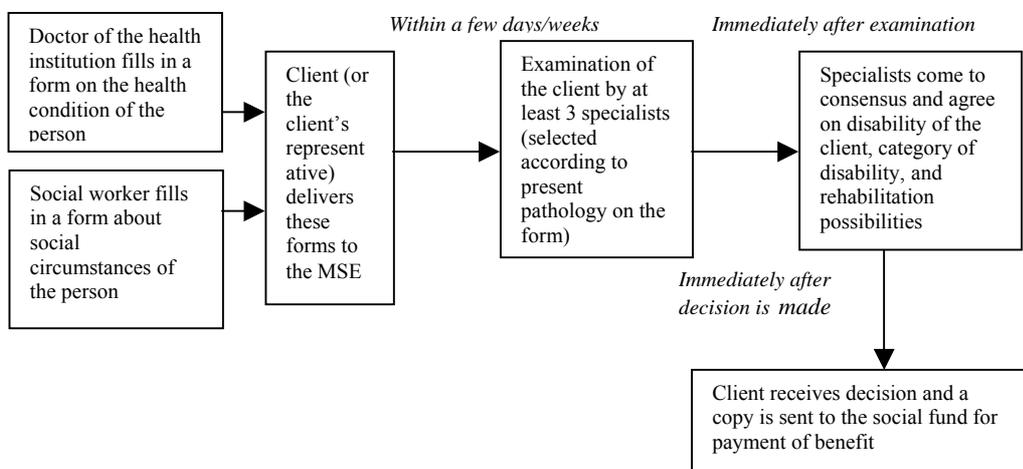


Table 4c

Country	Process steps including flow charts
Slovenia	<p>The Pension and Disability Insurance Institute of Slovenia has one head office (in Ljubljana), nine regional offices, and three local offices.</p> <p>At the regional offices, the assessments are performed by one or more boards of examiners (of the first degree).</p> <p>Each region has a chairman, who is the (examining) doctor.</p> <p>The assessment process is organised as follows:</p> <p>The claimant sends an application form to the regional office. The application form contains medical information provided by the treating doctor. This is usually a general practitioner and sometimes a clinical specialist from the hospital. At the regional office, the application is reviewed by a case manager. The case manager checks if the claimant is insured, if the claimant belongs to the population of this regional office, and if the non-medical information is complete. The case manager then passes the file to the chairman. The chairman checks if the collected information is complete and organises the assessment meeting. He decides which clinical specialists are needed in the examining board (e.g., an orthopaedic surgeon, a neurologist, a psychiatrist).</p> <p>The file is completed with relevant information about the work of the claimant, gathered by the case manager.</p> <p>The actual assessment is performed by the board of examiners, consisting in general of two clinical specialists, a safety expert or a technically educated expert (who acts more or less as a labour expert), and a typist. The claimant is invited to come to the meeting of the board of examiners. The board questions the claimant, and the doctors of the board can do a medical examination. In addition, (a representative of) the employer is invited for this meeting. In general, the claimant and employer are questioned together regarding non-medical topics. After the interrogation, the board deliberates and formulates a recommendation.</p> <p>Using the criteria as input, the chairman checks if the recommendation is complete and decides whether or not to submit it to the board of examiners of the second degree. Within a few years, every assessment will be performed by the first and the second board of examiners. If not, the recommendation will be passed to the case manager, who will make the final decision.</p>
	<p style="text-align: center;">Flow chart: Slovenia</p> <pre> graph TD Claimant[Claimant * Applies for disability benefit * GP/ treating doctor provides medical data] --> CaseManager[Case manager * Determines if claimant is insured * Determines if the claim has reached the right office * Checks if the non-medical information is complete * Describes the workload of the claimant] CaseManager --> Chairman[Chairman of the Board of Examiners * Checks if the necessary medical information is available * Determines if the changes in health condition cannot be reversed by treatment or rehabilitation * Decides which examiners will perform the assessment] Chairman --> Board1[Board of examiners of the first degree assesses and advises about: * The degree of loss of capacity for work * The cause and type of impairments * The necessity for occupational rehabilitation * The necessity for workplace adaptations * The necessity for timing of reassessment * Whether the loss of capacity for work is job-related] Board1 --> Chairman Chairman --> Board2[Board of Examiners of the second degree * Reviews 'positive' recommendations * Deals with appeals] Board2 --> CaseManager CaseManager --> Appeal[* Possibility of appeal against decision] Appeal --> Board2 </pre>

Table 4c

Country	Process steps including flow charts
<p>Spain</p>	<p>The assessment process can be initiated in four ways:</p> <ul style="list-style-type: none"> • By the client him/herself; • By the client’s doctor from the curative health sector; • By National Institute for Social Security (INSS) if the client receives temporal disability; • By the Mutua (private scheme organized by employer’s organizations) if the client receives temporal disability benefit. <p>There are three main documents on which the multidisciplinary team bases its decision:</p> <ol style="list-style-type: none"> 1. The medical report containing the medical evidence generated from the medical assessment performed by (first) INSS doctor; 2. The administrative report generated from a database containing essential information regarding the claimant’s file: contributions paid, salary, age, and current status with respect to (other) social security benefits. Additional expert analyses on the generated database file are carried out to confirm the validity of the claimant’s data. 3. The labour report by the labour expert containing information on the claimant’s work: function, tasks, job characteristics. <p>The multidisciplinary team (EVI) consists of five core members and one optional additional member:</p> <ol style="list-style-type: none"> 1. An INSS doctor (this is often not the doctor who has performed the medical assessment); 2. A medical inspector from the curative health sector; 3. A labour inspector; 4. A case manager: INSS sub- director of the administrative process; 5. An administrative INSS employee; 6. Optional: a rehabilitation expert from the corresponding Comunidad Autonoma (provincial administration) <p>The assessment process is slightly different in the independent provinces. In a small province, the assessment doctor is the same as the decision making doctor in the EVI. In large provinces such as Madrid, two EVI s make all decisions (60-80 cases a day). In total, 6 decision making doctors deal with all dossiers, including some of their own.</p>
Flow chart: Spain	
<pre> graph TD A[Initiation of assessment process for permanent incapacity] --> B[Medical assessment by INSS doctor] A --> C[Administrative assessment by administrative employee of INSS] A --> D[Labour assessment by labour expert] B -- Report --> E[Opinion and proposed decision (IMS) of team sent to Provincial administration director] C -- Report --> E D -- Report --> E E --> F[Multidisciplinary team determines disability] F --> G[Formal decision by Provincial Director of administration] </pre>	

Table 4c

Country	Process steps including flow charts
United Kingdom	<p data-bbox="499 309 1394 389">During the first 28 weeks of sickness, persons can get Statutory Sick Pay (SSP) from their employers (when they fall sick while at work) or Incapacity Benefit (IB) of the lowest level (certain deviations from IB terms may be applicable).</p> <p data-bbox="499 421 1394 555">If a person is entitled to a benefit, an incapacity test has to be taken. During the initial 28 weeks of illness or injury, the test of incapacity for work is based on the person's occupation. After 28 weeks, the test of incapacity is based on all work. This test is called the Personal Capability Assessment (PCA). An unemployed person or a person with a limited work history claiming IB is subject to the PCA at the beginning of the claim.</p> <p data-bbox="499 564 1394 775">The PCA is an objective test of incapacity, taking into account physical and mental parameters. It is a functionally based test which can be applied to the majority of medical conditions. The PCA assesses a person's incapacity under 14 specified activities in the area of physical and sensory functioning, with mental health being assessed as a separate area. The physical/ sensory areas are walking, sitting, lifting and carrying, speech, continence, walking up and down stairs, rising from sitting, manual dexterity, vision, remaining conscious without having epileptic or similar seizures during waking hours, standing, bending & kneeling, reaching, and hearing.</p> <p data-bbox="499 784 1394 828">For each of these activities, there is a set of ranked statements, known as descriptors, which illustrate different levels of functional limitation.</p> <p data-bbox="499 837 1394 940">A claimant receives the benefit if the threshold level is reached in the Personal Capability Assessment Test. This level represents an individual's condition in which it is unreasonable to expect the individual to work (however, it does not represent 100% loss of functional capacity).</p> <p data-bbox="499 972 1394 1016">After 28 weeks, the General practitioner (GP) provides the Department of Work and Pension (DWP) with medical information (Med 4), giving</p> <ul data-bbox="549 1025 1394 1196" style="list-style-type: none"> • A diagnosis of the main incapacitating condition, assessed by the PCA • Other relevant medical conditions • Information on the patient's current treatment or progress • An indication of whether the patient is able to travel to a site of examination • The advice given to the patient concerning his/her ability to perform his/her usual occupation. <p data-bbox="499 1227 1394 1532">The decision maker from the DWP determines if the claimant falls within exempt categories. In some cases, where the diagnosis is clear, the decision maker simply accepts the diagnosis on the Med4. In cases where the severity of the condition is an issue, the decision maker is advised by SchlumbergerSema. There is an extensive list of exempt conditions which enable the decision maker to award Incapacity Benefit without further evidence. For non-exempt conditions, the claimant is referred to SchlumbergerSema for further medical assessment. The decision maker from the DWP works fully in accordance with protocol. The benefit can be awarded without need for medical assessment if the decision maker is satisfied as to the level of disability on the basis of available documentary evidence. The benefit is never disallowed without the person being offered the opportunity of medical assessment.</p> <p data-bbox="499 1563 1394 1644">When referred to SchlumbergerSema, the claimant is sent a questionnaire to fill in and return within 6 weeks. If the claimant does not send it back within 6 weeks, his/her benefit could be stopped. About 90% of claimants send it back in time.</p> <p data-bbox="499 1675 1394 1832">In the questionnaire, the claimant is asked to select those descriptors that best describe any functional limitations (s)he may have in each of the physical and sensory areas listed. An approved doctor (all doctors who give advice relating to Incapacity Benefit are approved by the Secretary of State) considers the questionnaire and any other evidence, particularly the information provided by the certifying doctor in response to a request for a Med 4 statement or a GP factual report from records (form IB113).</p> <p data-bbox="499 1863 1394 1998">The doctor advises the decision maker whether the physical and/or sensory functional limitations reported by the claimant in the questionnaire are consistent with the medical evidence. When there is doubt about the stated level of incapacity, the claimant is called for a medical examination, and a person with a mental health problem is called for at least an initial examination.</p> <p data-bbox="499 2007 1394 2045">For incapacity benefit, SchlumbergerSema doctors have an advisory role that covers three domains:</p>

Table 4c

Country	Process steps including flow charts
<p>United Kingdom continued</p>	<ol style="list-style-type: none"> 1. Advising the DWP decision maker whether the client is suffering from certain conditions that would make it unreasonable to subject him/her to the PCA (exempt conditions); 2. Scrutinising medical evidence to advise whether incapacity can be accepted without examination; 3. Application of the PCA, to provide an objective and impartial assessment of the client’s functional ability in the form of a report for the decision maker. <p>The IB- approved doctor is required to provide advice to the decision maker in accordance with the current guidance issued by the DWP, to help the decision maker reach a fair and proper decision on benefit entitlement.</p> <p>In certain locations, the IB- approved doctor is required to complete two reports on a claimant summoned for a PCA examination - the Incapacity Report, which is the current IB85 report; and a Capability Report, which provides advice to a Personal Advisor. The Capability Report is not seen by the decision maker. The primary function of the approved doctor is to make an assessment of how a person's day -to -day life is affected by his/her disability, and to relate this to the legislative requirements.</p> <p>The assessment entails bringing together information gained from the questionnaire, any medical evidence, and information acquired during the examination in order to reach an accurate assessment of the disability of a claimant for the decision maker. It is a complex procedure, involving careful consideration, structured interviewing, and lateral thinking, as well as the application of medical skills.</p> <p>IB –Short -Term higher rate is payable from 29 to 52 weeks, after which time the incapacity benefit long- term rate is payable.</p>
<p>Flow chart: United Kingdom</p>	
<pre> graph LR A[Initial certification of incapacity by GP] --> B[After 28 weeks of sickness, the person is asked by the DWP to fill in a questionnaire about his/her incapacity] B --> C[DWP decides if the person should be medically assessed and refers person to Medical Services] C --> D[Assessment of functional capacity by doctor from SchlumbergerSema] D --> E[Final decision by decision maker at DWP] </pre>	

Table 4c

Country	Process steps including flow charts
USA	<ol style="list-style-type: none"> 1. The claimant applies to the SSA Field Office for DI benefit 2. The SSA Field Office sends the claim and documents to the State Disability Determination Service (DDS) 3. The DDS asks treating doctors for medical evidence 4. When the medical evidence is insufficient, a consultative examination can be ordered. The SSA usually considers a treating source (the claimant’s own physician, psychologist, or another acceptable medical source who provides, or has provided, the claimant with medical treatment or evaluation) to be the preferred source for performing the examination or test for his or her own patient. 5. The DDS disability examiner makes a decision (or not), sometimes after seeking advice from a Psychological or Medical Consultant. 6. If necessary, a vocational analysis is done, taking into consideration the claimant’s ‘remaining functional capacity’, age, education, and work experience. 7. “Pre-effectuation Review” within the DDS. (i.e., a check of accuracy of the decision). 8. The favourable or unfavourable determination is sent to SSA Field Office. 9. The SSA Field Office informs the claimant.

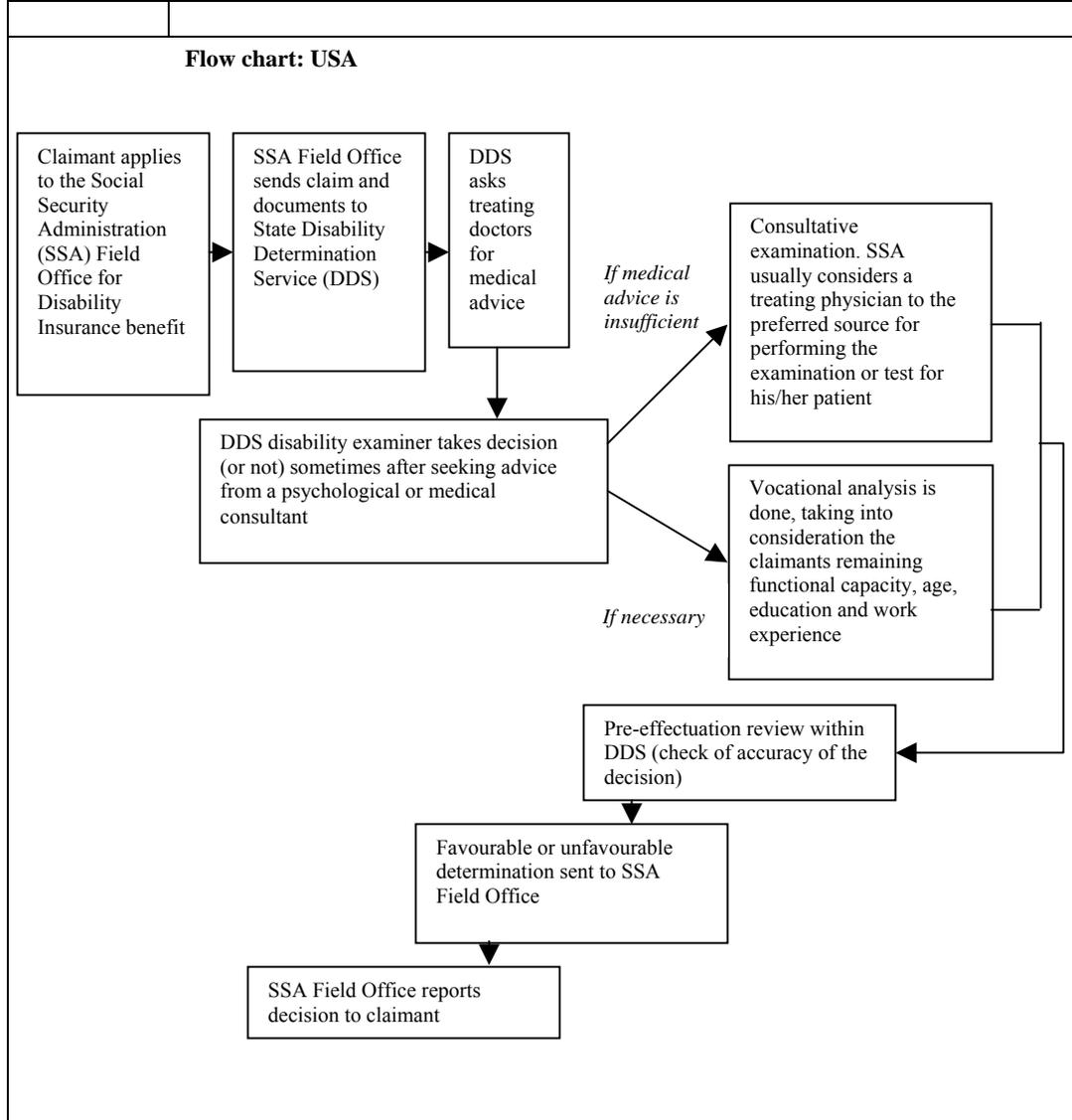


Table 4d Advantages and disadvantages of the design

Country	Advantages and disadvantages of the design (as reported by the respondents)
Belgium	<p>The high degree of autonomy of the medical advisor, especially during the period of Primary Disability Benefit, has advantages but also disadvantages.</p> <p>Advantages:</p> <ul style="list-style-type: none"> • There is little danger of problems occurring owing to poor communication; • The client has to deal with only one person, who knows the client's situation very well; • The medical advisor sees the client regularly and follows the development of the disease or handicap carefully; • Acceptance of the decision is relatively high in Belgium. Medical advisors have a certain status. Therefore, the decision does not have to be extensively founded and arguments based; • Re-examinations take place depending on the individual situation. <p>Disadvantages:</p> <ul style="list-style-type: none"> • The medical advisor may become too powerful. Acceptance of the decision might be greater when more persons are involved. However, there are possibilities for appeal and after one year there is a peer review; • The efforts for rehabilitation differ among medical advisors; • The role of the employer is inadequate. There is no institutional consultation of the company doctor, who can judge the labour situation of the client within the company; • There are relatively few incentives for employees to resume work. Also, employers do not have many incentives to keep disabled workers employed. Employers cannot be obliged to adapt workplaces. <p>Lack of transparency in the argumentation of the decision is not seen as a disadvantage. It can be an advantage that there are no rules for argumentation, e.g., in the case of the disease ME.</p>
Denmark	<p>Advantages</p> <ul style="list-style-type: none"> • The new system has not been evaluated yet. A possible advantage is that it moves the focus from disability to ability; • Measures are taken at a very early stage; • The funding system has been changed in such a way that municipalities have an incentive to promote early integration. They have to pay an increasing percentage of the sickness benefit and are refunded more for a flex job than for a disability pension. <p>Disadvantage</p> <ul style="list-style-type: none"> • Municipalities might push claimants into reintegration, thereby endangering the health of claimants and also affecting their social rights; • The success of integration depends on the ability and knowledge of the municipality or the individual case manager.

Table 4d

Country	Advantages and disadvantages of the design (as reported by the respondents)
Finland	<p>Advantages:</p> <ul style="list-style-type: none"> • The occupational health services play an important role with regard to early reintegration. This is especially the case when the services function well. The Act on occupational health services defines specific functions for the occupational health services: participation in maintenance of work ability, provision of advice on rehabilitation and referrals to rehabilitation. In practice, occupational health service may be the actual workplace counterpart for the organisation of rehabilitation, to communicate, and make proposals for the adjustment of the claimant's work tasks (ergonomically or otherwise); • The specialised rehab centres are responsible not only for the assessment, but also for rehabilitation. Multi disciplinary teams are used. The specialised rehab centres are used for both medical and vocational rehabilitation and working capacity assessments (not only "difficult cases"). In this way, individuals are given a second chance; • Local agencies/ the Social Security Institute fulfil an important task with regard to coordination of the different schemes. In general, cooperation goes very smoothly. Applications are usually sent directly to the relevant institutions. • 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 ('second opinion') for the assessing doctors. <p>Disadvantages:</p> <ul style="list-style-type: none"> • The information about the labour market and the profession is not very well implemented 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. Therefore, a local officer is not able to check the application in detail before sending it to the assessment unit. Transparent criteria are lacking; • 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.
France	<p>Advantages</p> <ul style="list-style-type: none"> • The persons concerned and the public seem content with the way the scheme works; • The cooperation between treating doctor (MT) and medical advisor in the prevention of disability is seen as a guarantee of the quality of the decision <p>Disadvantages</p> <ul style="list-style-type: none"> • Workload is a problem; • Clients are often seen late, partly owing to organisational insufficiency (i.e., administrative problems); • Early retirement for medical reasons should be possible for individuals between 55 and 60 years old, but this is not the case.

Table 4d

Country	Advantages and disadvantages of the design (as reported by the respondents)
Germany	<p>Advantages</p> <ul style="list-style-type: none"> • Monitoring of the decision making process and increased objectivity; there is always at least a second person to read the assessment. Assessment and decision are separated; • The decision is based on the claimant's whole medical background, which means that all past medical information is collected. <p>Disadvantages</p> <ul style="list-style-type: none"> • The insurance doctor cannot make a personal assessment by himself/herself. Note that other smaller insurance companies make personal assessments instead of paper assessments; • The insurance doctors depend on the quality of their specialists; • If more than one expert has to make an assessment, the dossier must be split or copies must be made. This means that an expert might not have all relevant information (s)he needs for a good assessment. <p>Preconditions for effectiveness are that all parties concerned, such as claimants, curative doctors, and other institutions, such as hospitals, cooperate fast and efficiently.</p>
Hungary	<p>Advantages:</p> <ul style="list-style-type: none"> • Insurance physicians work in boards: they can consult each other, so the quality of the decision is high; • These boards are independent of other medical staff, so decisions are more objective <p>Disadvantages:</p> <ul style="list-style-type: none"> • The social insurance physician meets the claimant for a short time and the assessment is based on the state of the claimant at that moment; • Information acquired during consultation (by GP and other treating doctors) may be insufficient. Twenty per cent of cases require extra consultation; • There are some problems with the law in the disability benefit: professional demands do not parallel legal demands. The law was enacted without input from social insurance physicians; • The Disability Benefits Act is sometimes used to solve social problems, for instance, poor labour market conditions are taken into account; • Because two physicians assess the claimant, or discuss the claimant, it is often not clear who is responsible for a specific decision (shared responsibility). Furthermore, issues such as authority might influence the decision.
Ireland	<p>Advantages:</p> <ul style="list-style-type: none"> • Procedures are relatively quick; • Procedures are simple and easily understood; • Procedures are relatively inexpensive to apply.

Table 4d

Country	Advantages and disadvantages of the design (as reported by the respondents)
Italy	<p>Advantages:</p> <ul style="list-style-type: none"> • The doctors involved have a high level of medical expertise, which leads to objective and uniform assessment results; • The system is customer friendly. Clients have all the medical examinations within one day, and they get the result within a month. The medical examinations are often for the purpose of verification (second opinion). The client receives all medical test results (free). <p>Disadvantages:</p> <ul style="list-style-type: none"> • The main problem is the law, which does not stimulate people to reintegrate. This is particularly true for the Disability Pension. If medical developments (e.g., new treatments, medicines) lead to better health (e.g., total recovery after a transplant), people continue to receive benefit until they are old enough to receive the old age pension. <p>Apart from the law, points of attentions remain:</p> <ul style="list-style-type: none"> • There is a shortage of paramedical staff; working conditions at the National Institute for Social Provisions (INPS) are not always attractive (e.g., salary, working hours); and INPS cannot hire staff on its own initiative at a local level because of application procedures implemented by the government; • If there are no INPS specialists at local level, INPS has to cooperate with private specialists and hospital staff who do not know much about social insurance assessments; • The quality of equipment is good in Rome, but this is not the case in the entire country; • Because of regional differences in economic and social situations (e.g., unemployment), it is difficult for social insurance doctors to realise homogeneous decisions at national level.
Netherlands	<p>Advantages:</p> <ul style="list-style-type: none"> • Because of a multidisciplinary team the quality of the decision is higher; • Because of a multidisciplinary team there is better acceptance of the final decision by the claimant. <p>Disadvantages:</p> <ul style="list-style-type: none"> • Extensive communication between professionals from different disciplines takes time and entails the risk of ‘translation errors’; • Mutual dependence may aggravate problems: disruptions in one part of the organisation may have repercussions for the rest of the organisation. <p>Problems in the organisation of disability assessment are the following:</p> <ul style="list-style-type: none"> • The labour expert does not always function optimally: the collection of information may be not conscientious, too little attention may be given to the unique situation of the claimant, or the computer programme may not be used effectively; • The records of social insurance physicians are often not adequate. The reasons for the decision are often not sufficiently explained; • Social insurance physicians sometimes register full disability for partially disabled claimants, when they foresee no earning capacity. This is officially not allowed, but it reduces the workload of the labour expert; • Many claimants do not understand the criteria for disability, which lowers their acceptance of the decision.

Table 4d

Country	Advantages and disadvantages of the design (as reported by the respondents)
Norway	<p>Advantages:</p> <ul style="list-style-type: none"> • The family doctor often has extensive knowledge of the patient and can provide a holistic assessment of his/her problems; • The family doctor and patient have a mutual understanding, often based on mutual trust. The doctor can often advise the patient early in the process as to his/her chances of being granted a pension, thereby avoiding many unnecessary applications; • In smaller communities, the doctor often has excellent knowledge of the labour market, thereby being able to assess the patient's possibilities of getting/holding a job. <p>Disadvantages:</p> <ul style="list-style-type: none"> • Family doctors have little education and interest in functional assessments and insurance evaluations; • Doctors frequently act as the patient's advocate and their certifications are skewed to increase the patient's chances of getting a pension; • The system makes it difficult to increase quality and impartiality; • Stability among doctors is very low in remote areas (they move often) Therefore, doctors have almost no personal relationship with the claimants.
Russian Federation	<p>Advantages:</p> <ul style="list-style-type: none"> • People seem to be content with the existing design; • According to the Spearman principle, a team decision is more robust than a single doctor's decision; • The strong relationship with health care is good for the use of equal norms; • The procedure is extremely fast. <p>Disadvantages:</p> <ul style="list-style-type: none"> • Proper staffing, particularly of non-medical experts, is a large problem, as is the provision of equipment for the professionals involved; • Rehabilitation and reintegration of people is difficult owing to poor conditions on the labour market; • The criteria are diffuse and are, therefore, a possible source of variation between Medical Social Examiners; • Because of the strong relationship with health care, the norms that are applied may be caring norms rather than evaluation norms; • A good system of quality assurance has yet not been constructed.
Slovenia	<p>Advantages:</p> <ul style="list-style-type: none"> • Because of the use of a board of examiners, the assessment may be less influenced by feelings of sympathy for the claimant; • Under the new law, there is an enlargement of the notion of ability to work: what the claimant can do is considered, taking into account his education and work experience; • Because of the use of specialists, almost any type of disability can be assessed within the institute; • The quality of multidisciplinary decisions is higher. • Both the employer and claimant are involved in the assessment procedure. This may be the reason why there are relatively few appeals. <p>Disadvantages:</p> <ul style="list-style-type: none"> • Insufficient uniformity in assessments, probably because the methods of providing information of people in curative health care are rather divergent; • The use of private doctors as members of the board of examiners might lead to less objective assessments: the degree of disability is sometimes exaggerated in favour of the claimant. <p>A very important precondition is good enlightenment of the general practitioners who give the medical information. It is one of the important responsibilities of the chairman in the region to keep the general practitioners informed about changes in the system, guidelines, new developments, et cetera.</p>

Table 4d

Country	Advantages and disadvantages of the design (as reported by the respondents)
Spain	<p>Advantages:</p> <ul style="list-style-type: none"> • Higher quality of the decision; • Faster throughput from 100 days to approximately 45; • Greater efficiency; • Second assessor. <p>Disadvantages:</p> <ul style="list-style-type: none"> • The labour inspector does not always function optimally: the information about labour conditions is not always correctly translated into the client's capacity for work; • The computer programme for administrative data does not always provide accurate data; • The records of INSS doctors are not always sufficiently explained; • The records of doctors from curative health care are not always objective, as these doctors may be emotionally involved in their clients' situations; • Many claimants do not understand the criteria for disability, which lowers their acceptance of the decision; • Finally, INSS thinks the throughput times could be shortened in some provinces.
United Kingdom	<p>Advantages</p> <ul style="list-style-type: none"> • Is independent (executed by SchlumbergerSema, a commercial organisation) • Is evidence-based and quality controlled • Is fully justified (substantiated), complete, and consistent, informed by information provided by the GP and the claimant. • Is cost effective <p>Disadvantages:</p> <ul style="list-style-type: none"> • Problems were mentioned in streamlining databases between public and private organisations. Corrective action mainly comes from the commercial organisation (addressing inconsistencies in public database); • Handwritten reports by doctors may be difficult to read, leading to rejections by the Department of Work and Pension; • Information provided by the general practitioner is very important. If the quality and quantity of this information were to increase, there could be a reduced need for formal examination.
USA	<p>Advantage:</p> <ul style="list-style-type: none"> • The assessment process is primarily based on getting medical evidence from treating doctors. This makes it possible to do assessments regardless of the geographical distance, which makes this method efficient. <p>Disadvantages:</p> <ul style="list-style-type: none"> • The most important problem is that claimants cannot be assessed as partially disabled. Claimants must have severe impairments to get into the programme. The system encourages claimants with relatively less severe impairments and no prospects of finding a job (because of their weak position in the economy) to behave as if they were seriously handicapped. As a consequence, it is difficult to get these people to work again: they are at great risk of losing their benefits without having a reasonable chance of finding stable, engaging jobs; • The illegibility for Medicare (i.e., a system of social medicine / national health service) after two years of receiving disability benefits can be seen as an incentive to claimants to maintain their status of being disabled.

Table 5a The decision making: argumentation and information

Country	Argumentation and information needed for the decision	Other factors that may influence the decision making
Belgium	<p>The assessment of the medical certificate contains two assessments:</p> <ol style="list-style-type: none"> 1. Is the information complete? If not, additional information is required (from client or doctor) before the claim can be assessed. 2. If the information is complete, can the claim be rejected without the assessment? If not, a date for the medical assessment is determined. This is based on the medical certificate. Information that plays a role for the decision consists of (see Donceel, 1999b): <ol style="list-style-type: none"> a. Diagnosis; b. History of absence owing to sickness (number of earlier spells of absence) and resumption of work (on client's initiative or imposed by the medical advisor?); c. Status (white-/blue-collar employee, self-employed); d. Reputation of the doctor who has written the medical certificate (some doctors are notorious for the ease with which they write certificates, though there is no blacklist). <p>In principle, the client's permission is not needed to acquire medical information from his/her general practitioner.</p> <p>The medical assessment is based on (see Donceel, 1999b):</p> <ol style="list-style-type: none"> 1. Information gathered in the medical assessment <ol style="list-style-type: none"> a. Anamnesis; b. Clinical examination; c. Technical reports; d. Expected duration until recovery. 2. Additional research data on the client <ol style="list-style-type: none"> a. Medical persons (general practitioner, specialist); b. Labour experts; c. Social experts. <p>To make the decision about disability, the decision maker must consider the following:</p> <p>Has the client stopped working as a direct consequence of the start or deterioration of injuries or functional impairments, which are acknowledged as restricting the earning capacity of the client to one third or less of what a person with the same educational level can earn or what a person in the different professions the client has or could have exercised can earn (reasonable reference professions). During the first 6 months of disability, the reference of the earning capacity is reduced to the person's own job, if (and only if) the person can recover from the impairment or injury within a reasonable period of time, i.e., if the impairment is reversible. If this condition is not fulfilled, the reference of loss in earning capacity is immediately (not waiting until 6 months have elapsed) related to reasonable reference professions.</p> <p>In making the decision to pay a Primary Disability Benefit, the claimant's history of absence owing to sickness and the reputation of the doctor who has written the medical certificate are taken into account. The criterion of two thirds of earning capacity stems from the time of Bismarck, when the productivity of workers in the factories could be determined relatively easily. Nowadays, this is much more complicated. The argumentation is, therefore, difficult.</p> <p>The medical advisor must answer the following question: is it reasonable for this person to carry out his/her job, given his medical situation, or is the absence legitimate?</p> <p>For example, a person who is able to work only half the normal number of hours is considered to be disabled, though 50% is less than two thirds. However, partial (or progressive) work resumption is possible, according to the client's wishes and with the approval of the medical advisor.</p> <p>After 6 months, the loss of earning capacity is related to reasonable reference professions.</p>	<p>The actual availability of a (reasonable) job is not necessary. This means that economic circumstances do not influence the decision making. Economic risks are part of the unemployment scheme. There are no differences between the health insurance companies in the sense of one being stricter than the other. As the disability rate in Belgium is low compared to international measures, there is no 'political pressure' to economise on disability benefits. The debate is more on health care costs. It is likely, however, that the discussion of disability will be more prominent in the near future. A first point of discussion may be the possibilities to promote rehabilitation, which in the future may lead to obligations for the client to use rehabilitation services (such as training).</p>

Table 5a

Country	Argumentation and information needed for the decision	Other factors that may influence the decision making
Belgium continued	<p>These can be:</p> <ol style="list-style-type: none"> 1. Professions the person has had in his/her working career; 2. Professions the person could have had with his/her educational background; 3. Professions that are closely related to the latest exercised profession. <p>Again, the criterion of two third loss of earning capacity is difficult to determine. If there is no reasonable reference profession but if such a profession can be obtained by training, the medical advisor has no choice but to take the decision 'disabled'. Downgrading, i.e., determining that a client is able to perform a lower classified job, is not possible. Rehabilitation (training, workplace adaptation) occurs in cooperation with the client. It is not compulsory, i.e., a refusal of the client to cooperate does not have consequences for the benefit. However, in practice, a relatively high number of work resumptions is imposed.</p> <p>In the decision of the medical advisor, the professions that can be carried out by the claimant are not explicitly mentioned; instead, the class of professions or the type of work is described.</p>	

Table 5a

Country	Argumentation and information needed for the decision	Other factors that may influence the decision making
Denmark	<p>A case manager from the community deals with a person from the moment of application, or from no later than the fourth week of sickness. Information is collected in order to make the decision of disability according to a standardized 12- point assessment. The assessment includes the person's:</p> <ol style="list-style-type: none"> 1. Former education (ability); 2. Work experience (ability); 3. Interests (potential abilities); 4. Social competences (ability to fit into a work place); 5. Abilities to reorient (abilities to adjust to a new situation); 6. Ability to learn (practical/ intellectual orientation); 7. Wishes for the future; 8. Own expectations of future performance (ambition); 9. Level of interest in work (importance of work); 10. Housing conditions/ economic conditions (possibilities to regain energy); 11. Social network (motivation and support); 12. Health. <p>Note that the resource profile is required only in cases of disability benefit, vocational rehabilitation, and flex jobs.</p> <p>The decision includes three aspects that have to be clarified:</p> <ol style="list-style-type: none"> 1. What are the person's resources? 2. What are the person's potential resources that can be developed? 3. Has it been proven that the person does not have enough resources even to fulfill the requirements of a flex job? <p>The case manager is required to provide evidence for his/her findings by argumentation. The argumentation must be clear to other case managers (e.g., the assessment team). Questions 1 and 2 are answered mostly before this stage of the assessment.</p> <p>The case manager must carry out the assessment, but (s)he can ask questions of experts concerning parts of the assessment. Experts are medical consultants, rehabilitation consultants, disability consultants, psychologists, job consultants, or any person whose opinion is considered necessary. These consultants are mainly hired for the purpose. Experts must state the person's condition and may not jump to conclusions on whether the person should receive a disability pension.</p> <p>On 1st January 2003, the role of the doctor in the assessment of disability changed because of a change in the law, which among other things introduced a new basic foundation for disability benefit awards. Of the 12 points, only one refers to health. In consequence of this, the role of the doctor is less important, but still an important part of the assessment. The new method focuses on resources and the development of resources and the decision about disability awards depends on the client's functioning in relation to the labour market and not on the diagnosis itself.</p> <p>It should be noted that the integrated process of assessment from onset of sickness to rehabilitation to receipt of disability benefit assessment has been followed since about 1999. Flex jobs are also not new. However, the formalization of the standardised procedure of assessment and the focus on ability only came into force on 1st January 2003. Below, the formal process is described (based on an example of a disability applicant coming from the sickness benefit scheme):</p> <p>Week X: Person reports sick or accident happens. Weeks 1-2: Employer is required to pay sickness benefit for two weeks (most employers pay wages during part of or the</p>	<ol style="list-style-type: none"> 1. The medical condition of the person is only one of the 12 points. All other factors are important too. 2. For the whole, integrated, decentralised social security system to work, it is important that the incentive structure is good. Municipalities must have an incentive to help clients in the best way, which is now considered to be to help them reintegrate. The national government currently pays 65% of a flex job and 35% of a social pension. Nowadays, municipalities also have to pay an increasing part of the sickness benefit. This should induce them to help clients earlier. 3. The quality of the education system plays an important role. The "new style" assessment is completely based on the experience and knowledge of a case manager. Most case managers are educated within the municipalities' social security system. There are large differences between municipalities.

Table 5a

Country	Argumentation and information needed for the decision	Other factors that may influence the decision making
Denmark continued	<p>complete period of sickness owing to either the White-collar act or collective agreements).</p> <p>Weeks 1-4: Within 4 weeks after the first day of incapacity for work, the municipality should be notified about the sick leave. The employee is obliged to state the type of illness that caused the absence on a form. As documentation of the illness is a precondition for sickness benefit receipt, this is an obligation. In addition, the employer may require the employee to make a written statement saying that illness is the cause of absence. Furthermore, after 4 days of sick leave, the employer may require the employee to provide a medical certificate (the certificate is financed by the employer). At any time during sick leave, the municipality may require the employee to provide a medical certificate.</p> <p>Week 8: If a medical certification is not presented after 8 weeks of sick leave, the municipality is obliged to ask the employee to provide a certificate (the certificate is financed by the municipality). The municipality is obliged to make a follow-up evaluation within 8 weeks (and thereafter every 8 weeks) in order to assess the need for, e.g., medical and vocational rehabilitation. Within six months, the case manager should make a follow-up plan.</p> <p>Weeks 3-52: Sickness payment by municipality:</p> <ul style="list-style-type: none"> • The White-collar Act requires employers to wage payments to white-collar employees during sick leave. The same is true for some blue-collar employees (regulated through collective agreements). In this case, the sickness benefit is paid to the employer as supplementary to the wage costs. The employer's obligation to wage payments ceases if the employee is dismissed. • The national government refunds 100% of the sickness benefit from weeks 3-5 and 50% after 5 weeks. • The sickness benefit can be extended for another 26 or even 52 weeks but the extension must be financed entirely by the municipality. <p>If vocational rehabilitation is considered necessary, the municipality must make a vocational rehabilitation plan in cooperation with the client. This plan must state the vocational rehabilitation measures and the expected outcome, e.g., ordinary employment. This plan is a precondition for payment of a vocational rehabilitation benefit.</p> <p>Rehabilitation may last between 3 weeks and 5 years. Five years is, however, an exception. Most rehabilitation activities last about 3 months. The average duration of vocational rehabilitation is approximately 2½ years according to a study from 2001 based on questionnaires sent to all municipalities. Educational activities is the most frequently used vocational rehabilitation instrument.</p> <p>- weeks: Following rehabilitation, a final report states the success or failure of the rehabilitation measures. This is the main document required in order to grant disability pensions. Success means that the person will get a job or receive ordinary unemployment benefits. An unsuccessful rehabilitation could lead to a new rehabilitation plan. If no other possibilities for rehabilitation are left, the person may be offered a flex job with the possibility of trying another flex job if (s)he does not succeed in the first flex job. If the person is not able to fulfill the requirements of</p>	

Table 5a

Country	Argumentation and information needed for the decision	Other factors that may influence the decision making
Denmark continued	<p>(a) flex job(s), a disability pension will be granted.</p> <p>In the sickness period: The employer and the municipality may ask the client to provide a medical certificate from a general practitioner stating the expected time for recuperation. The municipality may also ask for other medical information, e.g., certificates from specialists, or information from hospitals.</p> <p>In the rehabilitation and sickness period: Specialists may be required to give a medical opinion on certain health matters or a diagnosis, or to state the approximate period within which the claimant is expected to recover, at request of the case manager.</p> <p>Before the disability benefit decision: If not requested earlier, the case manager may ask the doctor to give an opinion concerning the time needed to recover on certain health matters. According to the resource profile, the case manager should assess the client's health and how it affects his/her ability to work, and the possibility of improvement of the client's health.</p> <p>The case manager collects medical information through the claimant. This usually occurs in the sickness or rehabilitation period (since a person can apply directly for a disability pension, it may be necessary to collect information at that stage). The claimant receives a medical form. (S)He is required to have his/her doctor fill in this form. Naturally, (s)he can provide medical information given by his/her doctors or name information sources at any point. A sound argumentation for why the person is not able to work in a flex job scheme is necessary.</p> <p>If no possibilities for rehabilitation are left, the client may be offered a flex job with the possibility of trying another flex job if (s)he does not succeed in the first flex job. If the person is not able to fulfil the requirements of (a) flex job(s), a disability pension will be granted.</p>	

Table 5a

Country	Argumentation and information needed for the decision	Other factors that may influence the decision making
Finland	<p>The information collected in order to make the decision of disability is Certificate B (the document for preparing a medical statement), provided by the treating doctors. The claimant should also describe his/her situation in the application form. In many cases, it is useful for the decision maker to have information from both sides. The claimant is responsible for delivering information but the insurance institute may ask for more information from the medical services used by the applicant or send the applicant to a specialist center in order to get more information (medical, social, work-related, environmental, etc.).</p> <p>The professionals consulted are the doctors responsible for the medical treatment of the claimant, and specialists or experts with regard to vocational training.</p> <p>The social insurance physician has to make a recommendation based on the certificate from the treating doctor. The recommendation should be based on functional limitations. The information typically includes;</p> <ol style="list-style-type: none"> 1. The diseases that affect the examinee's capacity for work; 2. The examinee's medical history (the initial stage and development of the disease); 3. Information on previous examinations, treatment, and rehabilitations as well as their results; 4. The results of any tests of the examinee's functional and work capacity (under prescribed medication), such as laboratory and imaging tests, as well as other tests; 5. A description of the examinee's functional status based on the tests performed and the doctor's professional judgement with regard to ADL and restrictions imposed by the health status. <p>The decision-maker/assessor must base his/her decision on the advice of the insurance physician and social, economic, and administrative information concerning the claimant. The decision needs to correspond with the decision of the decision maker of the earnings-related scheme. The claimant has to fulfil the necessary eligibility criteria. The assessment is always individually oriented, based on a medical proposition and final decision making.</p>	<p>In principle, no other factor should affect the decision (the social insurance physician does not see the claimant). The assessment is limited, based on administrative assessments only. The time required for an assessment is accurately calculated.</p> <p>The Social Insurance Institute (SII) assumes that the information provided by treating doctors would be better if there were some guidelines. However, age is a factor that may influence the decision making: disability benefits are more easily granted to older people with a low level of education. It was mentioned that the SII could face political pressure from social partners or the parliament if rejections are higher than 20%.</p>
France	<p>The médecin conseil (MC) approves of treatment, pregnancy, puerperium, sick leave, and disability on file and/or consultation. The MC performs examinations and decides on the need for special measures and the chances of full or partial recovery. After 12 months, the MC fills in an RMPI (Rapport Médical de Prévention d'Invalidité), containing personal data, the history of the disease, medical observations, diagnoses, and information on probable work resumption, the need for further sick leave, and stabilisation). For this report, the client is generally seen by the MC. The MC is directed to look at the person's potential for employment in the whole local labour market in order to make a decision about disability. Furthermore, the MC takes into account the remaining working capacity, the general condition, age, physical and mental faculties, capabilities and education of the person.</p> <p>Explicit argumentation for the decision does not seem to be needed. Incapacity is assessed globally, and the exact influence of the different factors that constitute the incapacity is not specified. The incapacity has to be acquired, not inborn. It is the authority of the MC that guarantees correctness. The findings of the doctor in relation to the file and the conclusion have to be consistent.</p>	<p>There are no formal or informal targets. A rate of 60% for decisions of stabilisation is supposed to be a good mean value and is promoted as such. Client pressure is supposed to be effectively handled by postponing a decision and performing a re-examination. There has been no research into this.</p>

Table 5a

Country	Argumentation and information needed for the decision	Other factors that may influence the decision making
Germany	<p>First, the information required to make the decision of disability is collected from general practitioners, hospitals, and specialists. Impairments have to be proven by medical tests.</p> <p>The claimant is obliged to deliver information. In practice, this is usually limited to the claimant asking his/her doctors to send the information to the pension insurance administration. The insurance doctor also asks doctors, hospitals, medical services, and other administrators of social insurances directly for information.</p> <p>Second, as part of the doctor's assessment, the doctor provides a description of the daily life of the person, including hobbies and family situation and a description of the working environment. The type of doctor required to do this depends on the necessary expertise in the assessment.</p> <p>Third, the insurance doctor assigns specialists the task of carrying out additional assessments to obtain more information or medical proof. This occurs in about 70% of all assessments. The pension insurance company does not perform these expert reviews itself, but assigns specially trained doctors in the regions to perform the reviews according to guidelines.</p> <ol style="list-style-type: none"> 1. The social insurance doctor checks the possibilities for rehabilitation; 2. Signs of disease or impairment are coherently connected at 3 levels: impairments with respect to physical and mental functioning, disabilities with respect to behaviours and activities, and handicaps with respect to social roles, in particular the working role; 3. The impairments, disabilities, and handicaps can be objectively and medically stated. Objectivity implies controllability, reproducibility, and consistency; 4. The moment the disability started is determined (necessary for insurance criterion); 5. Disability limits the working capacity to not more than 3 hours a day or 3 to 6 hours a day; 6. The labour expert may register full disability if (s)he can not find any job on the "common labour market" in the region that the claimant could still do with his/her limitation. (S)He also checks whether there are possibilities for the claimant to obtain a job in his/her profession, for example, if labour market reports state high unemployment in this profession; 7. The amount of benefit follows automatically from the number of contributions paid by the claimant, the number of contribution free months (s)he has a right to, and the size of the contributions in the past (income dependent contributions). 	<p>Age may influence the decision making process. This is sometimes the case when workers aged 58/59 become unemployed. If rejected for disability pensions, the chance is very high that such persons appeal to court in the hope of delaying the decision making process (a claim at the social court takes on average 2-4 years).</p>

Table 5a

Country	Argumentation and information needed for the decision	Other factors that may influence the decision making
Hungary	<p>All information on the claimant's health status (former illnesses, treatment in hospital, diagnoses, etc.) is needed to establish disability. The claimant is responsible for presenting all medical evidence. (S)He is the most important source of information. The general practitioner and other treating specialists are consulted for further documents if necessary.</p> <p>Rehabilitation precedes the granting of the allowance. The insurance physician has to determine the following:</p> <ol style="list-style-type: none"> 1. Impairments and functional capacities of the claimant; 2. Abilities and disabilities (especially disability for work); 3. Participation and handicaps. <p>The decision of disability on medical grounds is acceptable if:</p> <ol style="list-style-type: none"> 1. The claimant has a severe decrease in functional capacity due to severe impairments; 2. There is no chance of recovery within one year. <p>The assessor provides:</p> <ol style="list-style-type: none"> 1. Findings/medical documents; 2. The results of the patient's examination; 3. The diagnosis and argumentation in the medical dossier (the argumentation is short); 4. Proposal for rehabilitation. 	<p>Although they should focus on medical issues, doctors sometimes take social factors into account. For instance, in case of unemployment, an expert may feel compassion for the claimant. There are many differences between the districts, probably owing to social factors. Age could also be a factor that may influence the decision making. For older people, who have fewer opportunities on the labour market, there is more compassion.</p> <p>The behaviour of the claimant is not important. Excessive drinking, for instance, is considered to be a disease.</p> <p>The experts work under time pressure because of the caseload. In these circumstances, it is difficult to reject disability claims because rejection of claims takes more time than acceptance (because of the argumentation). There is no pressure on experts from the government.</p>

Table 5a

Country	Argumentation and information needed for the decision	Other factors that may influence the decision making
Ireland	<p>Invalidity pension (IP) may be awarded on the basis of a medical assessment by a medical assessor or on the basis of an appropriate medical report (desk assessment). The examinations are carried out by one of the 20 medical assessors employed by the Department of Social Community and Family Affairs. Their role is to assess a person's fitness for work, either with regard to his/her usual work or in respect of other categories of work.</p> <p>A medical assessor examines each report form to determine if the examination should go ahead or if an opinion on medical eligibility can be given at that stage based on the information supplied. The medical assessor considers all the information provided by the claimant and the claimant's own doctor. (S)He may ask questions about the person's disability and carry out an assessment of the person's medical condition which may include a physical examination. (S)He records details on the medical report form during the course of the examination.</p> <p>In each area, mental and physical, the effect of the condition is indicated by the following categories: normal, mild, moderate, severe, profound. The guidance notes indicate that, 'should the functional area seem unrelated to the certified cause of incapacity (CCI) or any significant condition noted in the history and no gross abnormality is observable', then the area can be indicated as normal. In other words, the assessor should not explore functional limitations which are not related to the CCI. The guidance also emphasises that the assessor's view should be formed 'not on the basis of how the claimant alleges (s)he is affected, nor necessarily on performance during the examination, but on your appreciation of the medical history, medical evidence furnished and relevant clinical findings.'</p> <p>The guidance advises the assessor that, should his/her opinion and that of the claimant differ as to the claimant's capacity in each functional area, the assessor should indicate, e.g., 'Claimant's symptoms not adequately explained by objective clinical findings'. Should the assessor and the claimant concur, 'state that findings are consistent with the symptoms'.</p> <p>The medical assessor must first decide if the person is incapacitated to the extent that (s)he does not need any further medical examination. In carrying out examinations, the medical assessor reviews the history of the case, considers any fresh medical reports received, and expresses an opinion based on the medical examination.</p> <p>The information needed:</p> <ul style="list-style-type: none"> • Medical history; • Surgical history; • Work history; • Educational/vocational history; • Claimant's statement regarding accident/illness, disablement, and resultant loss of function; • Medical examination and system review (general state of health, height and weight, blood pressure, urine (not always), systems "normal" or "abnormal" (mental health, nervous, respiratory, circulatory, alimentary, musco-skeletal, others), mental health assessment; • Relevant clinical findings; • Clinical description of effects of illness/ accident/disablement "normal", "mild", "moderate", "severe", "profound" (mental health, learning, consciousness, balance, vision, hearing, speech, continence, reaching, manual dexterity, lifting or carrying, bending, kneeling, squatting, sitting, standing, climbing stairs, walking); • Work capacity assessment (if appropriate). <p>The doctor must give an opinion regarding medical eligibility and rehabilitation.</p>	<p>For people with very serious conditions or people over the age of 60 with serious illnesses or incapacities, Invalidity Pension may be paid without the full intervening 12 months of Disability Benefit payments.</p>

Table 5a

Country	Argumentation and information needed for the decision	Other factors that may influence the decision making
Italy	<p>The assessment method is based upon:</p> <ol style="list-style-type: none"> 1. A detailed social and working history with enclosed employer's declarations about the wage and the kind of job, sometimes with job requirements; 2. A detailed clinical history, with enclosed copies of significant medical records; 3. A detailed clinical examination. Medical evidence is collected from the client's practitioner / specialist. If more specialist expertise is needed than is available at the local level, the client is referred to one of the five specialists units. <p>The argumentation needed for the decision:</p> <ol style="list-style-type: none"> 1. The disability is the consequence of a disease or defect or loss that affects the efficiency of the insured and reduces the possibility of performing work activities compatible with his/her personal working records. The work activities must be adequately paid and may not be distressing for the insured. Criteria used to analyse suitable activities for the claimant are the level of education and a 'normal' career. Important: for the invalidity allowance, the percentage of invalidity is related to the type of work (category, not actual job). For the disability pension, the previous job or category of work is not considered at all. 2. The invalidity must be permanent. Chronic disease, stabilised impairments, anatomical loss, and functional loss of limbs or senses fulfil the requirement of permanence. Other diseases with a discontinuous or cyclic evolution can be considered permanent when relapses are frequent or prolonged (i.e., Crohn, epilepsy, allergies). 3. The requirement of permanence denotes a stable condition that is unlikely to come to an end, although it is not necessarily a lifelong condition (i.e., chronic kidney failure is permanent, but a transplant may be possible). <p>The final decision is not explained/argued (on paper) by the social insurance doctor.</p>	<p>If the employee does not have good chances on the labour market (e.g., during economic recession), there is more pressure on the doctors to assess persons as having a reduced labour capacity of more than two thirds.</p> <p>For the assessment, age is also taken into account. Firstly, the assessor looks at the chances of recovery, which generally deteriorate with increased age. Secondly, age is related to the reference period. If the claimant has paid contributions for more than 35 years, (s)he may enter the (pre-)pension scheme. In this case, (s)he does not receive invalidity or disability benefits.</p>
Netherlands	<p>The social insurance agency is responsible for collecting the information needed to make the decision of disability. The most important source of information is the claimant. The information is gathered from a medical assessment (performed by a social insurance physician), a labour assessment (performed by a labour expert), and from the claimant. In addition, information about the claim and the medical dossier (provided by the company doctor) are used. Furthermore, the social insurance physician may get information from various other medical and non-medical officers: physicians, medical specialists, social workers, physiotherapists, psychologists, company doctors, speech therapists, therapists, nurses, etcetera. The social insurance physician may sometimes also get medical information from the insurance company. The labour expert may consult the representative of the employer and a labour specialist.</p> <p>To make the decision about disability, the social insurance physician has to determine:</p> <ol style="list-style-type: none"> 1. The functional capacities of the claimant; 2. The chance of recovery/the prognosis; 3. The adequacy of the claimant's recovery behaviour. <p>(Ad 1). Does the claimant have functional capacities? Disability can be registered when all conditions below are fulfilled:</p>	<ol style="list-style-type: none"> 1. Time pressure and caseload: under time pressure, social insurance physicians are less inclined to consult other medical specialists. Under time pressure, it is also more difficult to reject disability claims: the rejection of a claim, with possible appeal procedures, takes more time than the acceptance of claims; 2. Compassion for claimant: rejection of a claim is more difficult when one feels compassion for the claimant; 3. Aggression/pressure from claimant: rejection of a claim is more

Table 5a

Country	Argumentation and information needed for the decision	Other factors that may influence the decision making
Netherlands continued	<ul style="list-style-type: none"> • Signs of disease or impairment are coherently connected at three levels: impairments with respect to physical and mental functioning, disabilities with respect to behaviours and activities, and handicaps with respect to social roles, in particular the working role; • The impairments, disabilities, and handicaps are the direct result of disease or impairment; • The impairments, disabilities, and handicaps can be objectively and medically stated. Objectivity implies controllability, reproducibility, and consistency. <p>The decision of complete disability on strictly medical grounds is acceptable in the following cases:</p> <ul style="list-style-type: none"> • The claimant is/has been hospitalised/ institutionalised for a period of at least 3 months; • The claimant is confined to bed; • ADL-dependency: the claimant is dependent on others for daily activities; • The claimant is unable to function personally and socially; • The claimant is expected to lose functional capacity within 3 months or in the near future; • The claimant's functional capacity is fluctuating strongly and is at times severely limited. <p>(Ad 2). Can the claimant recover? This decision is based on: The course/development of the claimant's disease/impairment; The clinical picture; Epidemiological knowledge.</p> <p>(Ad 3). Does the claimant show adequate recovery behaviour to return to customary work? This decision is based on: The activity/passivity of the claimant's recovery behaviour; The effectiveness of the claimant's efforts to return to customary work.</p> <p>The labour expert may register full disability if (s)he cannot find at least 3 suitable functions for the claimant, together with at least 30 existing jobs on the labour market. The labour expert computes the remaining earning capacity of the claimant on the basis of possible functions and the claimant's standard salary. The degree of disability is calculated by comparing the claimant's income before disablement with his/her remaining earning capacity.</p> <p>The argumentation that the assessors have to provide must be very detailed and extensive.</p>	<p>difficult when the claimant is aggressive or exerts pressure;</p> <p>4. Political climate: if the political climate is restrictive with respect to the allowance of disability benefits, the social insurance physician and labour expert may find it more difficult to accept disability claims.</p>

Table 5a

Country	Argumentation and information needed for the decision	Other factors that may influence the decision making
Norway	<p>Information needed to make the decision of disability is collected by the decision maker at the local insurance office. This duty (to gather sufficient evidence to enlighten the decision) is settled by law. The claimant has (except for putting forward the claim) no responsibility to gather information. In the last years, however, considerable informal pressure has been put on the claimant to participate in the process, including helping in gathering information. Information on work requirements and the work situation is often collected from the claimant.</p> <p>The local insurance office requests medical information, including assessment of medical disability and work incapacity, from the treating doctor. In more complicated and/or uncertain cases, more detailed information is requested from independent specialists.</p> <p>The decision maker has to consider five prerequisites:</p> <ol style="list-style-type: none"> 1. Membership prerequisite: is the claimant a member of the national insurance scheme? There are some problematic areas here regarding immigrants and EEC membership; 2. Age prerequisite: the claimant must be between 18 and 67 years of age; 3. Rehabilitation prerequisite: has the claimant met the prerequisites for proper medical treatment and rehabilitation? The medical expert might be consulted to give his/her view. Vocational rehabilitation must have been tried. Rehabilitation before allowance: disability pensions should not be granted if there are any possibilities of work for the applicant. 4. Disease prerequisite: has the claimant an "accepted" disease/injury/illness (not accepted diseases are diseases not widely recognized as diseases within the medical profession in Norway)? Is this condition permanent? Does the claimant have functional limitations? Are these limitations the cause for reduced work capacity? <p>Reduced earning capacity prerequisite: the earning capacities before and after the occurrence of the medical disability have to be assessed. To test the client's capacity to perform regular work, the sick worker is encouraged to resume work.</p>	<p>In Norway, high age (over 55) can influence the decision about granting a disability pension, if the person is viewed as difficult to reassign to alternative employment. (S)He must still fulfil the medical criteria.</p> <p>Another 'route' to receiving the disability pension exists for persons experiencing long-term unemployment or persons who are socially disadvantaged. They must fulfil the stated medical criteria, which require that their earning capacity is reduced because of illness, injury, or defect, and not only through general life difficulties or lack of work.</p> <p>In recent years, the government has tried to limit the scope for taking into consideration personal and social circumstances, e.g., by emphasising more strongly the possibilities of geographical mobility in order to improve prospects for finding alternative employment. When the Employment Service has to decide on earning capacity or vocational rehabilitation, it is supposed to take into account the person's age, general abilities, education, work experience, and prospects for employment locally as well as elsewhere where it is reasonable that the person seek work. There is little systematic knowledge of how and to what extent staff in the two services make these discretionary judgements, e.g., whether all the factors mentioned in the law are given the same weight.</p>

Table 5a

Country	Argumentation and information needed for the decision	Other factors that may influence the decision making
Russian Federation	<p>The health care institution (or social assistance) generally starts the application and fills in the necessary data on the application form, which is legally designed for that purpose. This form contains detailed information on the disease and complications, the case history, the outcome of rehabilitation, the amount of sick leave taken in the past 12 months, and objective medical findings. In addition, a form is filled in by a social worker concerning the social situation of the claimant.</p> <p>Argumentation is required only in the team discussion when the doctors disagree. Argumentation is not reported. The general argumentation is that if three different specialists agree on a sufficiently documented case, the decision must be right.</p>	<p>Values and opinions of health care workers are said to be potentially very influential. In addition, local differences may exist.</p>
Slovenia	<p>The method of assessment is based on determining disability in combination with the analysis of job requirements. The claimant is responsible in that (s)he has to take care that information is given by the general practitioner/treating doctor.</p> <p>The following must be determined:</p> <ol style="list-style-type: none"> 1. If the condition of the claimant cannot be reversed by treatment or by measures of medical rehabilitation; 2. If the claimant can (still) do his/her own job; 3. If the claimant has lost all capacity for work; 4. If the claimant has lost his/her capacity for work in the occupation (s)he was trained for, by 50% or more; 5. If the claimant is able to work in any job or in the occupation (s)he was trained for, for at least 50%, if not able to do his/her own job (on a full-time basis); 6. In which category the claimant should be classified; 7. If and what kind of occupational rehabilitation is necessary; <p>If the loss of capacity for work is job-related or has been caused by occupational disease.</p>	<p>No other factors. The boards can do their assessments independently.</p>

Table 5a

Country	Argumentation and information needed for the decision	Other factors that may influence the decision making
Spain	<p>Information needed to make the decision of disability:</p> <ol style="list-style-type: none"> 1. Past medical information and information resulting from the examination of the insurance doctor. The client may be held responsible for the provision of information by the curative health sector. Various doctors and specialists working in the curative health sector may be consulted. In addition, specialists within INSS may be consulted; 2. Administrative information: contributions, age, income, other benefits; 3. Information about profession and current tasks. <p>To make the decision about disability, the social insurance physician must determine:</p> <ol style="list-style-type: none"> 1. The functional capacities of the claimant; 2. The chance of recovery/the prognosis; 3. The adequacy of the claimant's recovery behaviour; 4. The efficacy of treatment; 5. The remaining possibilities of recovery. 	<p>In general, there are not many problems. The INSS doctors recognize that time pressure may cause a situation in which doctors do not consult each other sufficiently, but this is not a problem at the moment. It was a problem ten years ago, but the number of insurance doctors, in Madrid, for example, was increased from 10 to 40. There are not many problems with regard to compassion, because the INSS doctors rely on their own consultants and they tend to be more impartial than treating doctors. The assessing doctors do not have a problem with aggression, although there is always some tension between the patient and the insurance doctor.</p>
United Kingdom	<p>The information collected for the decision about disability: A questionnaire filled in by the client. Clients have to fill in this form if they want the benefit; In addition, the general practitioner is required to provide factual information; An advisory report from the medical assessor; Any other information that the claimant chooses to present.</p> <p>Information about the points-based system has been published by the Department of Work and Pension and can be obtained from them.</p> <p>To make the decision about disability, the assessing physician has to decide about the functional capacities of the claimant. (S)He does not have to make a judgment about fitness for work. The Personal Capability Assessment (PCA) is the only tool applied. The PCA is set out in a Schedule to the Social Security (Incapacity for Work) Regulations 1995. It consists of 14 activities (walking, climbing stairs, sitting, etc.). Each activity has several 'descriptors' attached to it which indicate the frequency and severity of limitation to the activity (e.g., for speech, the descriptors range from 'cannot speak' (15) through 'strangers have great difficulty understanding speech' (10) to 'no problem with speech' (0)). Each descriptor has points attached (e.g., as indicated in the brackets).</p> <p>A main principle is working consistently according to the procedures. Application of the diagnostic categories is less important than the client's experiences on a day to day basis.</p>	<p>No other factors. The doctors of SchlumbergerSema have no relationship with the client and GP. Therefore, it is likely that the doctor will be able to provide an objective assessment. In addition, there seems to be no pressure to agree with the claimant or GP. A fee is payable to SchlumbergerSema based on the number of completed assessments, regardless of the outcome. They have no targets to keep claimants below a certain threshold. However, it is sometimes believed that SchlumbergerSema is paid on the basis of amount of benefit that is spent.</p>

Table 5a

Country	Argumentation and information needed for the decision	Other factors that may influence the decision making
USA	<p>The volume and kind of information depend on the number of steps, which have to be followed in the sequential decision-making process. The sequential decision-making process consists of (maximally) 5 steps:</p> <p>(1) Is the applicant engaging in substantial gainful activity (earning more than \$ 800)? Yes → denial No → (2)</p> <p>(2) Does the applicant have a severe impairment (or combination of impairments) that limits basic work activities? Yes → (3a) No → denial</p> <p>For steps 1 and 2 of this process, information is collected about: Illnesses, injuries, or conditions that limit the ability to work (including pain, onset of the disability, type of inability to work); Current work – if any – and rate of pay; Work history (including job characteristics and general function requirements as lifting, carrying, writing, kneeling, etc.); List of doctors, other medical professionals, hospitals, who have medical records or other information about the illnesses, injuries, and conditions; List of medications that are or have been used; List of medical tests the claimant has undergone; List of education and training, and of vocational rehabilitation. Do the limitations make sense? Are the limitations the result of the claimant’s medically determinable impairment(s)? Is the claimant able to do sustained work activities? Were the medical source statements and the claimant’s statements about his/her impairment-related limitations sufficiently considered and weighed?</p> <p>(3a) Does the impairment(s) meet the medical listings? Yes → allowance No → (3b)</p> <p>(3b) Does the impairment(s) equal the medical listings? (i.e., have comparable effects to the impairments on the listing) Yes → allowance No → (4): assessing residual functional capacity</p> <p>(4) Does the impairment(s) prevent the claimant from doing past work? Yes → (5) No → denial</p> <p>In steps 4 (and 5), the residual functional capacity (RFC) is considered. Did the claimant have work in the past? When did the client perform this work? How long did the work last? Was the client’s work at “sufficient gainful activity” (SGA) level? How was the claimant insured in the past 15 years? Was the client’s work permanent or seasonal; full-time or part-time?</p> <p>(5) Does the impairment(s) prevent the claimant from doing any other work that exists in the national economy? Consider applicant’s age, education, and work experience. Yes → allowance No → denial</p> <p>In step 5, it is determined whether the claimant can do any other work. The disability examiner considers the claimant’s RFC, together with his/her age, education, and work experience. If the claimant has the ability to perform other work which exists in significant numbers in the national economy, the claim is denied.</p>	<p>There are no factors other than the formal regulations.</p>

Table 5b The instrumentation in the decision making

Country	Instrumentation	Standard descriptions available for argumentation
Belgium	No lists are applied (no disease or impairment automatically gives access to the benefit). With respect to determining a reasonable profession for the client (after 6 months), there are no handbooks, etc.	No standard descriptions are used for argumentation.
Denmark	The human resource profile (the 12- point system) is the basic/only instrument used in making decisions on the disability benefit, vocational rehabilitation, and flex jobs. In many municipalities, the resource profile is made using a special computer programme or schedule.	No standard descriptions.
Finland	No instruments. However, SII requires physicians to use international classifications, ICD 10.	No standard descriptions.
France	The forms PIREs and RMPI govern the output. There are no specific standards apart from the standards of clinical medical science and practice.	No standard descriptions.
Germany	Instruments for the decision-making process are 1. Guidelines for the assessment, formulated by the Pension Insurance Organization, including questionnaires for each medical discipline. Specialists are strongly advised to use these in the medical assessment. 2. Handbooks for the most common problems with assessments, as well as for the determination of the need for rehabilitation, containing: a. General terms for the determination of rehabilitation for mental and psychosomatic impairments; b. Information on dealing with heart conditions; c. Information on dealing with breathing problems; d. Information on dealing with neurological illnesses. 3. Advice for the performance of an assessment; 4. Information on the use of international and national classifications, e.g., ICDH, OPD). The labour experts undertake their own research or use information provided by the unemployment institution (Arbeitsamt, quarterly reports) to perform the labour assessment.	The result of each assessment is laid down in a report, including the impairments, the anamneses, and the conclusion of the doctor. The argumentation has to be formulated in the physician's own words.
Hungary	Handbooks edited by the Ministry of Health contain instructions for the assessment process.	No standard descriptions. There were some standard descriptions on trial a few years ago, but it was in vain. Experts did not use them consequently.
Ireland	A list is used by the decision makers, which helps them code impairments.	There are no standard descriptions for assessors. However, there is guidance for medical certifiers (clients' own doctors issuing sick notes).
Italy	There are INPS application forms and medical assessment forms. During the assessment, advanced medical equipment is used (especially in the five specialist units).	No standard descriptions available. (The client receives the final decision, without argumentation.)

Table 5b

Country	Instrumentation	Standard descriptions available for argumentation
Netherlands	<p>The major legal standards for the social insurance physician are the standards of 'medical disability criterion' and 'no lasting residual earning capacity'. These standards are published in a handbook, together with instructions for the work processes.</p> <p>The medical doctor has to describe his/her opinion of the client's (in)capacities in a number of functions (sitting, standing, concentrating, etc.) on a detailed form. A computer programme (CBBS: Claim Assessment and Quality Control System) is used to help the labour expert in selecting functions that fit into the capacity pattern of the claimant.</p> <p>The insurance physicians are trained to use semi-structured protocols in interviewing claimants (Boer, Duin and Herngreen, 1997; Spanjer, 2002; Wijers, 1996). The scientific merit of these protocols is being investigated.</p> <p>At this moment, the possibilities of using a list of diseases that do <i>not</i> entitle the claimant to a benefit are being investigated.</p>	<p>For the argumentation about the functional capacities, the prognosis, and recovery behaviour, there are some standard descriptions, although the social insurance physicians should formulate the argumentation in their own words.</p>
Norway	<p>An electronically based assessment form for the decision maker at all local offices is used in 92% of cases.</p> <p>In addition, various legal texts and documents, as well as instructions from the National Insurance Administration, are used by the actors. For the medical assessment of disability, however, doctors generally have no guidelines whatsoever. They base their assessment entirely on experience and advice from colleagues.</p>	<p>Not available, except for a form the doctor must fill in for work incapacity, the phrasing of which gives some suggestions as to the required responses.</p>
Russian Federation	<p>There are guidelines that describe the relationships between diagnoses and their social impact. These guidelines are formulated in the expert centre in St Petersburg. For occupational injury, there are professionograms (job descriptions) and a handbook that describes the amount of loss in certain jobs as a result of certain diseases.</p>	<p>Not applicable.</p>
Slovenia	<p>Most important are</p> <ol style="list-style-type: none"> 1 Standardised questionnaires, e.g., those to be filled in by the general practitioner / treating doctor; 2 A list of physical impairments (whereby no reference is made to work capacity); 3 Guidelines: several clinical specialist branches have their own guidelines in which disorders and impairments, and the degree of disability that is associated with these impairments, are described. <p>A classification of professions (job descriptions) is also used to make the decision of disability.</p>	<p>No standard descriptions.</p>
Spain	<p>Doctors use baremas for partial disability. Baremas describe the loss of labour capacity for various types of anatomical damage. Small-scale experiments are undertaken to develop medical protocols and to include medical information in electronic data transfer systems. Computer programmes are used only for the creation of administrative and financial data on contributions, expected pension, and the income of the client.</p> <p>The law on the reform of the disability insurance from 1997 requires the INSS to make a list of all symptoms and the possible consequences of the symptoms for work and the benefit. However, such a list has not yet been developed. The doctors wonder whether this list can indeed be realised.</p>	<p>At the moment, there are no standard descriptions.</p>

Table 5b

Country	Instrumentation	Standard descriptions available for argumentation
United Kingdom	<p>There are guidelines for the doctor (process instructions, handbook). The guides for medical practitioners provide authoritative advice and guidance to doctors in England, Scotland, and Wales in relation to their role as certifying medical practitioners.</p> <p>Approved doctors are required to sign a declaration to the effect that their advice has been prepared in accordance with the current guidance. Incapacity Benefit legislation recognizes certain categories of severe disease whereby it is considered unreasonable that a person should be judged capable of work.</p> <p>Medical Services is working on an evidence-based computer system to produce reports of consistent quality. The intention is to roll this out to the organisation.</p>	<p>Standard descriptions are available for the argumentation by medical assessors.</p>
USA	<ol style="list-style-type: none"> 1. Forms: <ol style="list-style-type: none"> a. Application for DI-benefits; b. Several forms for residual functional capacity assessment. 2. Listing of Impairments (a list that contains impairments which are considered to prevent a person from performing any gainful activity); 3. Guides for Health Professionals (HIV, Musculoskeletal disease, Pulmonary functions, etc.). 	<p>The Disability Determination Service uses</p> <ol style="list-style-type: none"> a. Disability Determination Forms, on which the following data must be coded: Basis, Reason Code, Review Code, Diagnosis, and Diary Code; b. Personalized Decision Notice; c. Determination Rationale.

Table 6

Table 6 Quality control

Country	Who (institutions and professionals) controls what? (controlling institutions/professionals, aspects that are controlled, norms)	Feedback	Other procedures to ensure/ restore/ improve quality	Official quality system	Advantages and disadvantages/ discussion points with respect to quality control (as reported by respondents)
Belgium	<p>RIZIV (<i>National Institute for Sickness and Disability Insurance</i>) is responsible for the external quality control.</p> <ul style="list-style-type: none"> RIZIV occasionally visits social insurance companies to check administrative and medical files on disability assessments. Controls are formalistic and do not take place often. Throughput and output are monitored and evaluated and there are some norms. For example, forms for the Invalidity Pension need to be at the head office at least eight weeks before the Invalidity Pension. RIZIV controls the completeness of the file and the extensiveness of the argumentation :Is there enough argumentation for the decision? Also, what is the anamnesis? What additional examinations have been carried out? Has everything on the form been filled out correctly? No evaluation with respect to the decision itself is made by RIZIV. At the central level, RIZIV collects statistical information. This information is also used to divide the budget for administrative costs between the health insurance companies. Because this has financial consequences, only 'objective' measures are taken into account. This is a case of benchmarking in which the best scores of the five health insurance companies are the standard. However, the norms of RIZIV and the consequences for the budget are not transparent/public. Employees of RIZIV are also involved in the Regional Committee. 	<ul style="list-style-type: none"> Medical advisors receive statistical information and calculated performance indicators on their assessments. Every medical advisor is shown his/her performance compared to the average of the (local) group. The coordinator of the medical advisors of the local office (a medical advisor who is the manager of the other medical advisors) receives information about all medical advisors of his/her office. It is possible to participate in inter colleague evaluations. 	<p>At the level of the health insurance company local offices, inter-colleague evaluations are held in order to try to get consensus with respect to decisions. Training facilities and seminars are organized. Very occasionally individual medical advisors are suspended by RIZIV.</p>	None.	<p>Advantages:</p> <ul style="list-style-type: none"> Peer review is a acknowledged and trusted system; Positioning against colleagues provide useful information; The evaluations promote trust and openness; There is a uniform registration (to provide statistical information and performance indicators). <p>Disadvantages:</p> <ul style="list-style-type: none"> There is only moderate control on the quality of the decision itself; There is no systematic feedback concerning quality. This is depending on the individual vision of the assessor. <p>Discussion points: It is recognized that quality control is more seen as an important issue by the younger generation. It is more common for them, whereas older generations sometimes see it as a weakness to discuss, for example, their own decisions. Furthermore, RIZIV is reorganizing. It is expected that they will provide feedback to the medical advisors more directly.</p>

Table 6

Country	Who (institutions and professionals) controls what? (controlling institutions/professionals, aspects that are controlled, norms)	Feedback	Other procedures to ensure/ restore/ improve quality	Official quality system	Advantages and disadvantages/ discussion points with respect to quality control (as reported by respondents)
Belgium continued	<p>Internal evaluation of quality takes place at different levels and on different aspects.</p> <ul style="list-style-type: none"> • At the local level, information is collected on the working process of every medical advisor: number of medical certificates to assess, number of first time assessments, second time assessments, xth time assessments, number of work resumptions (at the insistence of the medical advisor or on client's initiative). Performance indicators are calculated on the basis of this information. At the local level, decisions on 'doubtful' (i.e., not standard) cases are evaluated within the team of medical advisors. This takes place during the payment of both the Primary Disability Benefit and the Invalidity Pension, and is not imposed by the head-office. • At the national level, the quality of the process is guaranteed by peer reviews of the Higher Committee and the assessments of the Regional Committee. 				

Table 6

Country	Who (institutions and professionals) controls what? (controlling institutions/professionals, aspects that are controlled, norms)	Feedback	Other procedures to ensure/ restore/ improve quality	Official quality system	Advantages and disadvantages/ discussion points with respect to quality control (as reported by respondents)
Denmark	<p><i>Municipalities</i> Quality control varies between different locations and subjects. The municipalities are responsible for the implementation of quality control.</p> <ul style="list-style-type: none"> • They have set up their own monitoring systems with regard to individual cases (assessment teams, intervision groups). Relevant experts (assessment groups) are used to control the individual decision. They usually meet once a week and go through the individual cases. The experts also evaluate if the information is sufficient (is there any need to see another specialist?). <p><i>Social courts</i></p> <ul style="list-style-type: none"> • Social courts are responsible for the jurisdiction of disability regulations. • Several times a year, the social courts of appeal (regional and national court) evaluate 120-150 cases of lower instances (i.e., local social complaints court) at random in order to control the compliance of the decision with the law. The evaluation includes a legal test of the decision, an evaluation of the collected information, a check of the procedure (have all rules been followed?), and an evaluation of the protection of the citizen's rights (this concerns the way in which clients are informed and when). • The quality control of the regional and national board concerns mainly qualitative norms. Special departments are concerned with statistics regarding quantitative norms. Quality control for statistical purposes is 	<p>The national and regional boards hold meetings with local and regional authorities in order to give feedback and to coach. The authorities involved receive the evaluation results of their decision as well as the overall quality report. Important recommendations, inferred at the end of each session of quality control are also published in circulars, which the municipal workers are supposed to read and act upon accordingly.</p>	<p>All doctors work within the framework of the universal public health care system, which is maintained by the municipality. Since January 2003, caseworkers are supposed to work according to the 12-point assessment procedure. The standard includes a national descriptive procedure and detailed regulations on information exchange with claimants. The objective of the procedure is to come to an "individually exact" investigation in each case, which means that a second person with the same education can understand the conclusions and would choose the same mix of vocational rehabilitation instruments. All municipal caseworkers have received several days' training in order to learn how to handle the procedure. Municipalities may have administrative procedures to handle the caseload. In the</p>	<p>Within the budgeting process, TQM-methods (Total Quality Management) are used. TQM is a Japanese method in which global agreements are made about the quality of a product and in which monitoring takes place.</p>	<p>As the new procedure has not yet been evaluated, the following answers are only presumptions:</p> <p>Advantages:</p> <ul style="list-style-type: none"> • Increasing quality and standardisation of quality of the case workers; • A better understanding of what is expected in vocational rehabilitation and decision-making; • More incentives for municipalities to put the advice of the social board into practice; • Appeal to the social board is free in order to give an incentive for more control. <p>Disadvantages:</p> <ul style="list-style-type: none"> • Differences in quality standards between municipalities (the difference in the quality of the implementation was under discussion prior to the implementation of the new standard); • A great deal of responsibility rests on the case manager. The case manager must have knowledge of a

Table 6

Country	Who (institutions and professionals) controls what? (controlling institutions/professionals, aspects that are controlled, norms)	Feedback	Other procedures to ensure/ restore/ improve quality	Official quality system	Advantages and disadvantages/ discussion points with respect to quality control (as reported by respondents)
Denmark continued	<p>collected using a standardised questionnaire.</p> <p><i>Professional organisation of doctors</i> Doctors are watched by the professional organisation.</p> <p><i>The Ministry of Social Affairs</i> Is responsible for the execution/ legislation</p>		<p>communication between municipalities and doctors, several certificates are used that have been agreed on by the doctors' organization and the municipalities.</p> <p>The agreement is seen as a kind of quality control of the information given by the doctors, by either the case worker or the municipal medical consultant, but the control has no effect on the doctors' medical assessments.</p> <p>The Ministry of Social Affairs makes contracts with regard to the quality of vocational rehabilitation, related to the budget.</p>		<p>great variety of subjects (but always can ask for the help of experts);</p> <ul style="list-style-type: none"> • Not all case managers have been trained to use the new procedure.

Table 6

Country	Who (institutions and professionals) controls what? (controlling institutions/professionals, aspects that are controlled, norms)	Feedback	Other procedures to ensure/ restore/ improve quality	Official quality system	Advantages and disadvantages/ discussion points with respect to quality control (as reported by respondents)
Finland	<p>There are internal control systems that operate under the responsibility of the director general. The quality of the assessment is not evaluated. There are only controls of a statistical nature and of a political nature, plus the decisions of the appeal court level.</p> <p><i>The Social Insurance Institution (SII)</i> has to give an account of its practices to the Parliament Appeal Systems. The Ministry of Social Affairs and Health is responsible for the social security legislation and controls the insurance bodies (inspection).</p> <p><i>The Social Security Law</i> states that a decision has to be made within 72 days. An attempt is made to decide 80% of the claims within 7 days.</p>	<p>The decision makers do not receive feedback from a controlling institution on the quality of their assessments (as this is not evaluated). However, they may receive individual feedback through inter colleague discussions. These discussions are held 4-5 times per year.</p> <p>Negotiations with the decision maker from the other insurance institution may provide individual feedback.</p> <p>No individual feedback is given to the treating physician. This occurs only through professional journals and educational approaches; not in individual cases.</p>	<p>Between bodies, when the institutions share clients, it is common practice to make assessments parallel and negotiate on the decision. The professional standards for insurance physicians apply. A standardised form is used (statement B). Decision makers have to follow an introduction course on Social Security Law. All doctors may use the Finnish "med line", which is a hotline for medical problems also providing detailed information on all kinds of illnesses and treatments. Insurance doctors may get a tutor for the first two months on duty. New quality assurance methods are being developed (electric documentation, EFQM). A training day is organized three times a year. This is a common training session for everybody who has an interest in pensions.</p>	The EFQM and balanced score card approach (client services and effectiveness, processes, economic resources, manpower development)	<p>Disadvantage:</p> <ul style="list-style-type: none"> Quality evaluations are not regulated. They should be more systematic; variations are not managed.

Table 6

Country	Who (institutions and professionals) controls what? (controlling institutions/professionals, aspects that are controlled, norms)	Feedback	Other procedures to ensure/ restore/ improve quality	Official quality system	Advantages and disadvantages/ discussion points with respect to quality control (as reported by respondents)
France	<p><i>The Department of Social Affairs</i> checks the statistics regularly.</p> <p><i>The General Accounting Office</i> evaluates the financial statistics.</p> <p>The medical supervisor evaluates the output.</p> <p>The quality assessment is called Evalqa. 30 files per medical advisor (MC) per year are randomly selected and verified by the Médecin Chef of the sector (manager of approximately 7 MCs): completeness, accuracy, and consistency in the medical report are the main items for verification.</p>	<p>In case of criticism, the medical supervisor enters into discussion with the MC. Doubtful cases may be presented in intervision sessions.</p>	<p>Use of forms. Professional education. The doctors receive coaching from the medical supervisor.</p>	<p>ISO certification is underway; it is being tested in four regions. A detailed description of services and instruments has been made.</p>	<p>The quality control is still very recent. Performance indicators are monitored.</p>
Germany	<p>There is no systematic method of quality control.</p> <p>Audit organization Like all public organizations, the public pension insurance is monitored by the audit organization (Bundesrechnungshof).</p> <p>The Ministry of Health and Social Affairs A special division of the Public pension insurance department of disability pensions (BfA) is responsible for monitoring the quality of the assessment and is responsible for the results and the procession of laws. The BfA usually uses peer reviews in which a doctor is the assessor in one case and evaluates his/her colleagues in other cases. BfA checks cases at random and evaluates the assessment from beginning (administrative check on the application form) to end (decision and payment). Aspects controlled are not only the medical assessment, but also the treatment of clients, the efficiency of the process, and the administration of each case.</p>	<p>There is no systematic process of quality control yet. BfA checks cases at random. If necessary, an assessor is informed in writing about his/her mistakes.</p>	<p>All cases that are noticed as being of very poor quality by anyone in the process of performing an assessment, but usually by heads of a division, are sent to BfA for further investigation. A quality check is implemented in the process by dividing assessment and decision. The decision is made by an administrative worker, the labour expert, who also checks the assessment carried out by the insurance doctor. An insurance doctor also has to discuss critical cases with the managing doctor (head of division). In this way, regular control is implemented in the system.</p>	<p>None. The different disability pension institutions in Germany use different programmes to control the quality of the assessment. These depend on the amount of the insurance and the structure of the assessment process. At the moment, a proposal for a common quality control procedure is being developed by a special commission for insurance medicine.</p>	<p>Not applicable. There is no systematic process of quality control yet.</p>

Table 6

Country	Who (institutions and professionals) controls what? (controlling institutions/professionals, aspects that are controlled, norms)	Feedback	Other procedures to ensure/ restore/ improve quality	Official quality system	Advantages and disadvantages/ discussion points with respect to quality control (as reported by respondents)
Germany continued	<i>Professional organisation</i> Doctors are controlled by the organisation of doctors (Ärztammer).		Experts that perform an assessment on behalf of the BfA are checked in about 10% of cases with regard to the validity of their assessment. They are also checked less often with regard to the time they need for making an assessment and the depth of the assessment. The check has to be done by the head of the division for these doctors, supported by medical staff. External experts are regularly given courses organized by the BfA. In addition, the assessment doctors of the BfA follow courses on topical subjects many times a year. Guidelines exist for the medical assessment of particular symptoms and for the assessment of the need for rehabilitation. Procedural guidelines and the literature for insurance medicine are accessible to all doctors.	The commission is due to report late in 2003.	

Table 6

Country	Who (institutions and professionals) controls what? (controlling institutions/professionals, aspects that are controlled, norms)	Feedback	Other procedures to ensure/ restore/ improve quality	Official quality system	Advantages and disadvantages/ discussion points with respect to quality control (as reported by respondents)
Hungary	<p>The assessment process is continuously controlled and evaluated. All aspects of the decision making process are evaluated, including:</p> <ul style="list-style-type: none"> • Professional adequacy (fulfillment of professional norms: correct argumentation, decision, and code); • Juridical legitimacy (accordance with the law) <p><i>The Ministry of Health</i> Controls the medical professional adequacy</p> <p><i>The Department of Health Care Expertise at the National Health Insurance Fund</i> Controls the whole medical assessment process Independent controllers (medical doctors from the main department) review 30 assessments by each expert every 3 months for argumentation, correctness of the decision, and correctness of the codes.</p> <p><i>The Social Insurance Institute</i> Controls the assessment arrangement.</p>	<p>The feedback is given to the manager of the physicians. (S)He gives it to the assessing doctors. The doctors are informed through discussion at all levels of assessment. The results are also given in written form: the doctors receive a report in which the performance of all evaluated doctors is presented.</p>	<p>The second assessor implies a form of quality control. Continuous education, special education of social insurance physicians, will start soon (a 2-year training period with theoretical and practical parts). This new education will focus on the possibilities of the client instead of his/her limitations. A second board doctor checks the quality of the first decisions (in case of appeal to the social insurance office). Discussion between colleagues (peer reviews). Reference books (handbooks). Consensus conferences are held every two months for the experts. It is possible to withdraw the premium payment when the doctor is found to perform poorly, but this is not common.</p>	None.	<p>Advantages:</p> <ul style="list-style-type: none"> • Well-trained experts, with many years' experience in assessment practice, are the controllers. If they find a capital mistake in the assessment process, or in the interview, they immediately know the best solution, so interviews can be corrected before the final decision. <p>Disadvantages:</p> <ul style="list-style-type: none"> • The control with respect to the assessment procedure and professional adequacy is insufficient: (output) is not completely integrated. • The controlling of the quality works, but not very well. The reason for this is that guidelines, protocols, and standards are not clear.

Table 6

Country	Who (institutions and professionals) controls what? (controlling institutions/professionals, aspects that are controlled, norms)	Feedback	Other procedures to ensure/ restore/ improve quality	Official quality system	Advantages and disadvantages/ discussion points with respect to quality control (as reported by respondents)
Ireland	<p><i>The Department of Social, Community and Family Affairs</i> The medical assessors work under the overall control of the Department's Chief Medical Advisor and Deputy Chief Medical Advisor. The Medical Assessors' report on the examination is submitted to the Chief Medical Advisor for approval.</p> <p>Examinations have to be conducted:</p> <ul style="list-style-type: none"> • In a fair, impartial, and independent manner; • To the highest standards in accordance with accepted medical practice and ethics; • In a manner which ensures that, when expressing opinions, full account is taken of any/all medical evidence submitted; • In a manner which displays full regard for the dignity and integrity of the person being assessed. <p><i>Head Office</i> The reports undergo quality control scrutiny in the Head Office by senior medical personnel. There is routine scheduling with a fixed time allotment and number of cases to be assessed per session.</p>	Should the quality of the assessment/report not attain an acceptable standard, there is personal contact with senior medical personnel to remedy the situation. (S)He may inform the medical assessor.	The medical assessors have an ongoing commitment to continuing medical education to ensure that standards are maintained and enhanced. All examinations are carried out in accordance with the accepted guidelines of the Irish Medical Council. Decision makers are bound by the provisions of the social welfare acts and regulations. Also, guidelines are issued to deciding officers to improve the quality of decisions and avert the danger of inconsistency in decisions between different scheme areas and even within the same office/ section. The guidelines include details of what is provided in the legislation, but in a more readable form than the technical language of the provisions in question. In addition, examples are given, administrative arrangements included et cetera.	None.	<p>Advantages:</p> <ul style="list-style-type: none"> • It is simple; • It is mostly effective.

Table 6

Country	Who (institutions and professionals) controls what? (controlling institutions/professionals, aspects that are controlled, norms)	Feedback	Other procedures to ensure/ restore/ improve quality	Official quality system	Advantages and disadvantages/ discussion points with respect to quality control (as reported by respondents)
Ireland continued			The claimants' certifiers are advised of the forthcoming examinations and invited to submit an appropriate medical report including references to any recent consultations/examinations. In addition, it is open to a certifier to attend an examination if (s)he so wishes.		

Table 6

Country	Who (institutions and professionals) controls what? (controlling institutions/professionals, aspects that are controlled, norms)	Feedback	Other procedures to ensure/ restore/ improve quality	Official quality system	Advantages and disadvantages/ discussion points with respect to quality control (as reported by respondents)
Italy	<p>Quality control is a continuous process</p> <p><i>INPS</i> INPS is autonomous and responsible for its own quality control.</p> <ul style="list-style-type: none"> Quality is controlled by taking samples for a second assessment by a special team of INPS doctors (to prevent the occurrence of mistakes in medical assessments); In addition, statistics (on the number of entitlements and the distribution of diagnoses) are reviewed at a regional level. If necessary, the regional manager has to provide additional information. <p>There are no quantitative norms.</p> <p><i>The Board of Directors of the Ministry of Labour.</i> Is responsible for the economic and financial control.</p>	<p>If the regional manager receives complaints, (s)he discusses them with the medical staff. This process has not been documented, however.</p> <p>Individual feedback is also provided through intervention.</p>	<p>The quality of the medical assessments is improved by coaching, intervention, participation at seminars, cooperation with hospitals and universities, and a committee at regional level with representatives of INPS and the trade union.</p> <p>Teaching at universities also improves the quality of future doctors at INPS.</p> <p>INPS publishes books and magazines.</p>	No.	<p>Advantages: INPS considers it to be an advantage that they themselves are in charge of the quality control. This enables them to look after uniformity and professional quality.</p> <p>Points of discussion: There is discussion of whether the information gained through assessments should be used for treatment in order to maintain and improve the knowledge level of the medical staff. To improve the quality and uniformity of assessment results, INPS wants to cooperate with INAIL and other related institutions (e.g., by rotation of medical staff between institutions).</p>

Table 6

Country	Who (institutions and professionals) controls what? (controlling institutions/professionals, aspects that are controlled, norms)	Feedback	Other procedures to ensure/ restore/ improve quality	Official quality system	Advantages and disadvantages/ discussion points with respect to quality control (as reported by respondents)
Netherlands	<p><i>Ministry of Social Affairs and Employment</i> Tasks of the Ministry include coordination of jurisdiction (output).</p> <p><i>IWI (Inspection Work and Income, supervised by the Ministry of Social Affairs and Employment)</i></p> <ul style="list-style-type: none"> • Tasks of IWI are currently not clear because of a reorganization; • The central issue is the design of the assessment. <p><i>The Workers Insurance Authority (UWV)</i> Controls the legitimacy, as well as the professional.</p> <p>The central issue is the legitimacy of decisions; Aspects which are evaluated:</p> <ul style="list-style-type: none"> • Time span: 90% of all decisions should be made within 13 weeks; • Juridical legitimacy: 99% of all decisions should be legally correct (in accordance with laws about grounds for disability benefit and computation of benefit level); • Professional legitimacy: fulfillment of legal and professional norms (norms will be further developed); • Customer-orientation: norms have not yet been developed. • Transparency argumentation. <p><i>Professional</i> Medical advisors supervise staff doctors; labour advisors supervise staff labour experts; and legal advisors supervise staff legal experts. Staff officers (such as the staff doctor) are also responsible for quality control. These professionals focus mainly on</p>	<p>Individual feedback is provided about the accuracy of the dossier by the supervisor (i.e., staff doctor or staff labor expert).</p> <p>Feedback is also provided through discussions of progress with the staff social insurance physician and through the discussion of cases among colleagues.</p>	<p>There is a reference book containing work methods, work instructions, protocols, and standards.</p> <p>The staff social insurance physician and the staff labour expert are coached by an advisor. There are 4 advisors in the Netherlands who consult each other on a regular basis.</p> <p>Continuing education and the discussion of cases among colleagues is officially required.</p> <p>After evaluation of the results of the assessment process, new objectives are set and a new plan of action is made.</p>	<p>Some social insurance agencies comply with ISO certification with respect to logistics.</p>	<p>Disadvantages:</p> <ul style="list-style-type: none"> • The control with respect to logistics and professional accuracy is not completely integrated. Management focuses mainly on the control of logistics, whereas the control of professional adequacy is mainly left to the professionals; • Norms and definitions are not (yet) clearly stated; • Too little statistical information is available. This makes it difficult, for instance, to assess the effectiveness of interventions designed to reduce the number of delayed cases.

Table 6

Country	Who (institutions and professionals) controls what? (controlling institutions/professionals, aspects that are controlled, norms)	Feedback	Other procedures to ensure/ restore/ improve quality	Official quality system	Advantages and disadvantages/ discussion points with respect to quality control (as reported by respondents)
Netherlands continued	professional accuracy and sufficient strictness. It should be noted, however, that quality control varies between different locations and social insurance agencies.				
Norway	<p><i>National Insurance Administration</i> Supreme responsibility is held by the National Insurance Administration. The National Insurance Administration has decentralised the practical work, with quality control now the task of the county offices.</p> <p><i>County Insurance Office</i></p> <ul style="list-style-type: none"> • Input, output, and process are carefully checked, but the professional assessments are not; • The County Insurance Office receives every assessment form from the local office. This is part of what is called “administrative quality control”; • There is no formal control of assessments of disability made by general practitioners. <p><i>The Ministry of Health and Social Affairs</i> receives the results from the National Insurance Administration.</p>	<p>The decision makers receive feedback when the county office disagrees with their assessments.</p> <p>There is no formalized feedback system for the GPs. If a flagrant weakness in quality is noticed in the work of one doctor, the local special in-service doctor takes up informal contact with him/her and discusses how quality can be improved.</p>	<p>The government is currently considering adopting more standardised descriptions of the type and form of impairments.</p> <p>In 1999-2000 and 2002-2003 two large projects were carried out, whereby the quality of decisions and the assessment process were checked in a large sample consisting of approximately 1/8 of all disability applications in one year. The conclusions of the two large projects initiated by the National Insurance Administration resulted in the new National Standard for Disability Assessment and the new electronic assessment form. It is hoped that these will improve quality.</p>	None.	<p>Advantage:</p> <ul style="list-style-type: none"> • All cases are continually evaluated. <p>Disadvantage:</p> <ul style="list-style-type: none"> • The medical disability assessment has not been evaluated, nor have the consequences of the present decision-making process.

Table 6

Country	Who (institutions and professionals) controls what? (controlling institutions/professionals, aspects that are controlled, norms)	Feedback	Other procedures to ensure/restore/improve quality	Official quality system	Advantages and disadvantages/discussion points with respect to quality control (as reported by respondents)
Russian Federation	<p><i>Medical Social Examination (MSE) and experts</i></p> <ul style="list-style-type: none"> • To control the quality of the application (input), the MSE can give feedback on the application form to the health institution concerned. The extent to which this takes place is not known and may vary between regions; • Controls quality of the professional and of the application (input) <p>The time schedule is monitored. The content of the decisions is not monitored as far as we could establish.</p> <p>Public accounting appears to be in a very early stage. There is an obligation to report to the ministry and to the bureau of statistics, Goscomstat, but there is no external accounting office for MSE. The reporting itself is hampered by technical difficulties, but also by a lack of a common understanding of what should be reported to what level (federal, regional, local).</p>	Not applicable.	<p>The quality of the professional (input) is controlled by having doctors undergo a teaching and training course in one of the expert centres (St Petersburg, Moscow, Rostov).</p> <p>There is a magazine that keeps the doctors informed about developments in the medical field.</p>	None.	<p>No information available on advantages and disadvantages.</p> <p>Discussion point: With proper statistical data a better quality assurance will be possible.</p>

Table 6

Country	Who (institutions and professionals) controls what? (controlling institutions/professionals, aspects that are controlled, norms)	Feedback	Other procedures to ensure/ restore/ improve quality	Official quality system	Advantages and disadvantages/ discussion points with respect to quality control (as reported by respondents)
Slovenia	<p><i>The Pension and Disability Insurance Institute of Slovenia</i></p> <p>The most important method of quality evaluation consists in performing second degree assessments (revisions). For 2003, the aim was to perform 315 second degree assessments per month (that is, about 15 % of the cases). In the future (in about two years), it is hoped that a second-degree assessment will be performed for every case;</p> <p>Evaluation of the working procedures and the legitimacy of the decisions.</p> <p>Few qualitative norms have been formulated.</p> <p>Quantitative norms are:</p> <ul style="list-style-type: none"> • The time it takes to make a decision (first degree); • The time it takes to review a decision (second degree): maximum 45 days. 	<p>The results of the reviews (i.e., 2nd degree assessments) and appeal cases are reported directly and face-to-face by the examiners of the second degree to the involved assessors.</p> <p>During the regional meetings, quality problems are discussed.</p>	<p>Second degree assessment by Second Board (see controlling institutions). A minimum of quality is guaranteed by using a multidisciplinary team in which at least two clinical specialists take part to formulate advices.</p> <p>Regular deliberations with the Ministry of Labour, Family and Social Affairs are directed to the interpretation of the law and the like. This happens on the basis of open legal issues regarding the implementation of the Act.</p> <p>Other measures taken to ensure the quality of the assessment process are</p> <p>The doctors in the examining board are not allowed to be the treating doctor of the claimant; Appeal cases are used to ensure the quality of the assessment.</p> <p>Individuals are provided feedback on appeal cases. In addition, the doctors in the appeal team are not allowed to take part in the review team for the same</p>	None.	<p>Advantage:</p> <ul style="list-style-type: none"> • The system of reviewing (part of) the recommendations at a central level provides more uniformity between the regions. <p>Disadvantages:</p> <ul style="list-style-type: none"> • Relatively few doctors are employed by the institute. For this reason, there is less loyalty to legislation and less attention for the consequences of certain choices and less knowledge is exchanged. • No written definitions regarding the criteria on disability assessment have been elaborated; • Although statistical data about different regions are available, the data are not sufficient for a powerful quality control system. <p>Discussion points:</p> <p>In the future, more doctors will probably be employed by the institute and there will be a reorganisation to make the Board of examiners more independent. Another point of discussion is whether a statistician/researcher should be employed to analyse statistical data regarding disability for work and disability assessment.</p>

Table 6

Country	Who (institutions and professionals) controls what? (controlling institutions/professionals, aspects that are controlled, norms)	Feedback	Other procedures to ensure/ restore/ improve quality	Official quality system	Advantages and disadvantages/ discussion points with respect to quality control (as reported by respondents)
Slovenia continued			<p>claimant; The Head Office regularly organises meetings for the chairmen of the regional boards of examiners to promote a uniform application of the criteria of the law; The chairmen regularly organise meetings in their regions to inform general practitioners about new developments and the consequences of new legislation; The chairmen are also concerned with the development of guidelines and manuals, which are laid down at the Head Office A (informal) coaching system is used for new examiners.</p>		

Table 6

Country	Who (institutions and professionals) controls what? (controlling institutions/professionals, aspects that are controlled, norms)	Feedback	Other procedures to ensure/restore/improve quality	Official quality system	Advantages and disadvantages/discussion points with respect to quality control (as reported by respondents)
Spain	<p>The quality is evaluated on a regular basis (each half year) by different organisations.</p> <p><i>The Inspection of the Ministry of Social Affairs and Employment</i></p> <ul style="list-style-type: none"> The inspection of the Ministry of Social Affairs and Employment investigates cases on a regular basis with regard to the efficiency of the process. A staff organ takes samples of dossiers from each province to investigate the quality of the assessment and the time span of the process; Benchmarking (each half year) includes quantities, productivities (throughput time), administrative procedures, and quality targets. For throughput time, the norm is the average throughput time in a province. <p>Norms for the assessment procedure are different in the provinces. They vary according to staff ratio and the local design of the assessment process.</p> <p><i>Secretaria General de Control de Calidad</i></p> <ul style="list-style-type: none"> The Secretaria General de Control de Calidad (the staff organ of INSS) is responsible for monthly quality reports and client surveys in the field of Social Security; The degree of acceptance is controlled (number of appeals / number of good decisions); Client satisfaction: 20% quality of requested information, 20% individual attention, 30% reliability, 24% perception of security, the physical environment <p><i>EVI (multidisciplinary team)</i> The five assessors (in a multidisciplinary team) who are permanent members of the EVI ensure control of the assessment process, because they assess the files of other INSS doctors.</p>	<p>There are three ways in which assessors are informed about the quality of their work:</p> <ol style="list-style-type: none"> Sub directors receive monthly statistical figures concerning throughput time and costs; Sub directors receive a document containing statistical information and developments regarding the client survey each month; Sub directors receive a bi annual report concerning the results of samples, which staff organs have taken from the different files. <p>This form of feedback is not provided at an individual level, but is provided for each multidisciplinary team (EVI). At an individual level, assessors receive feedback from the EVI and through discussion of cases with colleagues.</p>	<p>EVI (see controlling institutions). The EVI controls itself by the exchange of information (note that there are two doctors in a team).</p> <p>Discussion of cases among doctors (informal).</p> <p>Digitalization of administrative information and pension information.</p> <p>Intern education for all professions (doctors, administrators, financial personnel, actuaries).</p> <p>The development of protocols.</p>	<p>SERVQUAL is a formal quality system for client satisfaction: what is measured, and what is done with the results are investigated.</p>	<p>Advantages:</p> <ul style="list-style-type: none"> Second opinions are abundant because of the EVI structure and the sampling; The use of a structured survey ensures client feedback; An information system is used that calculates financial and logistical data. <p>Disadvantages:</p> <ul style="list-style-type: none"> Communication problems between staff organs and assessors; Sometimes, there are problems with the information system: it is difficult to acquire differentiated data for the different departments at INSS.

Table 6

Country	Who (institutions and professionals) controls what? (controlling institutions/professionals, aspects that are controlled, norms)	Feedback	Other procedures to ensure/ restore/ improve quality	Official quality system	Advantages and disadvantages/ discussion points with respect to quality control (as reported by respondents)
United Kingdom	<p>The quality of the assessment process is evaluated on an ongoing basis (random and targeted sampling). Monitoring data is collected at a regional and a national level. Data is monitored by location.</p> <p><i>Department of Work and Pension (DWP)</i> Extra validation to audit quality is performed by an independent team of internal experts and external input from the Department. The DWP regularly reviews performance against a level set out in the contract with SchlumbergerSema.</p> <p><i>SchlumbergerSema (Medical Services)</i></p> <ul style="list-style-type: none"> • SchlumbergerSema is responsible for controlling the internal quality standards of the medical assessments to a level set out in the contract with the DWP. There is a structured system of quality control, which involves random, target, and rolling (quality output) audits among all doctors. Reliability and consistency of assessments are keywords. Medical Services is not responsible for evaluating the decision making process. • SchlumbergerSema routinely samples client satisfaction. Medical Services has a Complaints Management System that informs the overall quality management system. 	<p>Feedback is provided regularly at Local and Regional level. The results of the random audits are communicated to the doctor in a meeting or, when there are no mistakes, by mail. In addition, the mentor provides feedback when the assessor makes mistakes or does not have sound argumentation.</p>	<p>In the UK, medical practitioners use guides and educational resources. These guides and educational resources provide authorised advice to doctors in England, Scotland, and Wales in relation to their role as certifying medical practitioners.</p> <p>All doctors who give advice relating to Incapacity Benefit must be approved by the Secretary of State. Approval involves specific training, successful completion of various stages of the approval process, and the ongoing demonstration that the work being carried out meets a satisfactory standard. If doctors fail to achieve and maintain the expert quality standards despite feedback, support, and appropriate training, their approval may</p>	<p>SchlumbergerSema achieved ISO certification in 1999. ISO certification concerns logistics. There is a structured system of quality control based on continuous improvement (IQAS).</p>	<p>Advantages:</p> <ul style="list-style-type: none"> • Clarity in the process; • Consistency in the approach to data collection; • Continuous quality improvement; • Regular feedback is considered important for continuous improvement of the work of the medical advisors. <p>Discussion points: Medical opinion changes over time and standards have to be adjusted accordingly. Continuous improvement (a learning organisation) is developed to bid for tender for the next period of five years.</p>

Table 6

Country	Who (institutions and professionals) controls what? (controlling institutions/professionals, aspects that are controlled, norms)	Feedback	Other procedures to ensure/ restore/ improve quality	Official quality system	Advantages and disadvantages/ discussion points with respect to quality control (as reported by respondents)
United Kingdom continued			be revoked. Discussion among auditors takes place at a national level, on a regular basis (regular audits are dependent on region).		
USA	<p><i>The federal Social Security Administration (central office, Baltimore) (SSA)</i></p> <ul style="list-style-type: none"> The federal Social Security Administration is responsible for supervision and quality control. Some of the control is administered through SSA's 10 regional offices. Management in the various DDSs and OHA offices are also responsible for supervision of their operations, as well as internal quality control. The whole process is controlled, including the accuracy of the decision and the question of whether there was enough evidence. A selection of claims is reviewed by quality control. Part of the American system is the "pre-effectuation review" (PER). A sample of disability determinations (by State-DDS (Disability Decision Services))-is reviewed by SSA regional review components before any action is taken to effectuate the determination, and is reviewed by SSA before the claimant receives the letter with the decision about disability. In the pre-effectuation reviews, all aspects of the claim are evaluated to make sure that the decision is accurate and the claim was sufficiently developed. SSA has a 97 per cent net decisional accuracy (NDA) goal. NDA measures the eventual accuracy of decision outcomes after any missing evidence (as 	<p>Cases with errors are returned to the DDS examiners. They are given annual reports on their accuracy. The DDSs are also given monthly accuracy reports.</p> <p>For DDS determinations, cases containing errors are returned to the adjudicating DDS for correction and preparation of a new determination. After correction, the case is then returned to the DQB for a second review. If the DDS does not agree that the disability determination is incorrect, the finding may be "rebutted".</p> <p>Within DDSs, there are supervisory and in line quality reviews, which furnish feedback to adjudicators on the quality of their work.</p> <p>Most feedback to Administrative Law Judges (ALJ) comes from Appeals Council review of unfavorable decisions that are appealed. For the small number of favorable decisions by the OHA that are reviewed in the</p>	<p>Decisions on DDS are supposed to have a 90.6% accuracy rate. Failure to maintain this accuracy rate, combined with failure to meet processing time standards for a sustained period, triggers intervention by Social Security</p> <p>In most DDSs, examiners work in examiner groups and branches. These teams meet frequently to discuss work methods. Periodically, one team member obtains training from SSA, for instance, in vocational evaluation and shares the knowledge with team members and other examiners.</p> <p>When quality review data reveal performance accuracy</p>	<p>None. The quality control process is an internal SSA process, but it is uniform throughout all state Disability Decision Services (DDSs). Each state has its own Quality Assurance (QA) process. Social Security Administration has its own process to sample the work done in the various states.</p>	<p>Advantage:</p> <ul style="list-style-type: none"> PER is effective in preventing erroneous allowance determinations. The continuing disability review (CDR) process contains a medical improvement standard (it has to be shown that a beneficiary has improved before (s)he can be removed from the disability rolls). It has been found that it is far more efficient and cost effective to prevent the occurrence of incorrect allowances before they are effectuated than to remove via the CDR process those whose original allowances were incorrect or questionable. <p>Disadvantages:</p> <ul style="list-style-type: none"> It has been said that PER can be a disincentive to adjudicators who may choose to process a denial rather than risk approving an allowance that may be returned

Table 6

Country	Who (institutions and professionals) controls what? (controlling institutions/professionals, aspects that are controlled, norms)	Feedback	Other procedures to ensure/ restore/ improve quality	Official quality system	Advantages and disadvantages/ discussion points with respect to quality control (as reported by respondents)
USA continued	<p>identified through the quality review process) has been obtained. SSA also has a goal for the accuracy of OHA decisions. There are also processing time goals. These are all measured and tracked at the Agency level. DDSs are also evaluated on the basis of how many determinations they make during a given period, as well as the cost effectiveness of those determinations.</p> <p>DDSs are evaluated every month as to their accuracy; they are supposed to maintain a 90.6% accuracy rate.</p>	<p>special OHA PER review described above, decisions that appear to be in error must be forwarded to SSA's Appeals Council to consider whether the council should take own-motion review. The Appeals Council must decide whether to take own-motion review within 60 days of the ALJ's decision. If the AC agrees that there is an error and takes own motion review, it has the power to vacate the ALJ's hearing decision and to change it or, more commonly, to "remand" the case back to the ALJ for additional actions, including a new decision.</p>	<p>problems, analysts investigate the deficiencies, summarise their findings, and make recommendations for corrective action. When localised problems are found on the process side, central or regional office officials provide management assistance and, if necessary, intervention to improve the situation.</p> <p>Work instructions and protocols- In the form of regulations, internal rules, and training manuals, SSA issues work instructions to all adjudicators disability examiners, medical consultants, and ALJs.</p> <p>Continuing education- both SSA and the National Association of Disability Examiners offer continuing education to disability examiners.</p>		<p>to them if it is selected for quality review. Overall, the reviews of DDS decisions are heavily weighted toward allowances, and the line adjudicators know this. Therefore, when faced with a borderline or questionable allowance, some adjudicators may tend to deny such a case;</p> <ul style="list-style-type: none"> • There is no integrated, balanced assessment of quality in the Agency. Quality consist of more than decisional accuracy and should include such factors as timelines and cost effectiveness. Recently, the development of a "balanced scorecard" approach to quality, has been investigated but at this point, it is not believed that there is a way to integrate all of the variables of quality. <p>Discussion points: During the past decade, there were major, lengthy contracts with two consulting firms in an attempt to improve the disability quality assurance process.</p>

Table 6

Country	Who (institutions and professionals) controls what? (controlling institutions/professionals, aspects that are controlled, norms)	Feedback	Other procedures to ensure/ restore/ improve quality	Official quality system	Advantages and disadvantages/ discussion points with respect to quality control (as reported by respondents)
USA continued			<p>Certificates. When disability examiners complete their training, they receive a certificate.</p> <p>Discussion of cases among colleagues: at all levels of the disability determination and appeals process; there is discussion of cases among colleagues. The office of Medical Policy, Office of Disability Programs holds telephone case discussions nationally with doctors who are involved in the Quality Assurance groups and branches. These teams meet frequently to discuss work methods. Periodically, one team member obtains training from SSA, for instance, in vocational evaluation , and shares the knowledge with team members and other examiners.</p>		<p>Different ways of managing quality other than end of line reviews have been investigated. Another point of discussion is the previously mentioned “balanced scorecard” issue, to somehow acknowledge the many factors involved in quality, beyond decisional accuracy.</p>

Appendix 2 Background information

Country	Background information
Belgium	<p>The social security consists of schemes to cover three types of risks:</p> <ul style="list-style-type: none"> • Health insurance risks (risque social, public); • Professional diseases (risque professionnel, public); • Accidents during work (risque professionnel, private). <p>Given the aim of the current research, we concentrated on the first. There are voluntary private insurances on top of the legal regulations.</p> <p>Both Primary Disability Benefit and Invalidity Pension cover risque social. However, health insurance companies can pass the claim on to different funds in cases of professional diseases and accidents during work. Benefits in cases of professional diseases and accidents during work are generally higher.</p> <p>The employee has dismissal protection for 6 months. The Primary Disability Benefit is 60% of the last-earned wage (55% for those who have a partner with an income). This regulation is the same for all health insurance companies. The Invalidity Pension is 65% for breadwinners (people who have a partner or children, all without income), 50% for single people, and 40% for those who have a partner with an income. All benefits are a percentage of the last-earned wage and a maximum amount is stated.</p> <p>For employees, the Primary Disability Benefit starts after a period of continued payment of wages (100%) by the employer, which is usually 2 weeks for blue-collar workers and 4 weeks for white-collar workers. For unemployed workers, there is obviously no continued payment of wages. The client can claim a Primary Disability Benefit immediately. For self-employed persons, the benefit is uniform, not depending on the income (which is usually difficult to determine). The waiting period is one month and the system is more or less comparable to the system for employees.</p> <p>Contributions from employer and employee to cover disability benefits are collected by a public institution (RIZIV) and divided among the health insurance companies to cover benefits and administration costs. Additional extra-statutory contributions are collected by the appropriate health insurance company.</p>

Country	Background information
Denmark	<p>The Danish system differs significantly from those of other countries:</p> <ol style="list-style-type: none"> 1. The Act on Social Pension (including disability benefits) is a universal act for the population, not a contribution financed employee insurance; 2. It is only applied in cases in which the person is absolutely not able to work; 3. The method of compensation is important (what a person needs to succeed in work, not the type of benefit); 4. The political emphasis with regard to the disability scheme has shifted from disability to ability. Therefore, the pension act has been amended and was implemented formally in January 2003; 5. Also the assessment is based on ability. All activities prior to the claimant's entering the pension act are directed to reintegration in the labour market, including rehabilitation, health care, assistance, and a needs assessment. Many aspects of disability are dealt with before a person enters the disability scheme. Rehabilitation starts during the sickness period or during enrollment in the social assistance scheme (the vocational rehabilitation scheme covers all people with reduced working capacity) and may be extended to 5 years or even longer. Rehabilitation assessment and reintegration activities take place prior to the claimant's entering the long-term-disability scheme; 6. The role of the medical assessment has been reduced to a minimum (1 aspect out of 12 aspects that have to be assessed). Doctors, rehabilitation assessors, and social workers are required to provide information not about limitations but about opportunities. Doctors are required to give the exact medical diagnosis without drawing conclusions on the chances of getting a disability pension; 7. The whole social protection system is much more integrated. Social benefits and activation measures as well as human resource profiling are united in a one-stop municipal agency; 8. Social protection (excluding unemployment benefits) are decentralised and are the responsibility of the local government. Municipalities have to finance a substantial part of the benefits themselves. They levy taxes for this. A special incentive structure in financing should lead to the fulfillment of national policy goals. To illustrate this, the national government refunds 65% of a flex job (subsidized working place) but only 35% of a disability benefit. <p>Note, although the emphasis is not on medical issues, it is nevertheless difficult to assess a case without a medical statement</p> <p>The disability benefit is the final stage when it is proven that vocational rehabilitation does not succeed and that the person is unable to work in an ordinary job or in a subsidised job. This occurs in most cases only after a number of years.</p>

Country	Background information
Finland	<p>The Finnish pension system consists of two statutory pension schemes providing employment pensions and national pensions. Employment pension can be granted to a person with past earnings from employment. Additionally national pension is paid in proportion to any other pension income to which the claimant is entitled. These two pensions make up the income security system which provides pensions in respect to, among other things, incapacity for work.</p> <p><i>National pension</i> The National Pension Insurance covers the basic pension for the whole working-age (16-65) population. The National Pension Insurance guarantees a minimum income. Since about 1996 the basic pension declines when earnings-related pensions are increasing. The pension is run by a public organization (SII or KELA).</p> <p><i>Employment pensions</i> The employment pension is an earnings-related contributory pension for employees, on top of the national pension. The earnings-related pension system is based on various acts and is run by various pension institutions. The different insurance companies are named below. In principle all insurance companies have the same assessment process, but they differ in small details. Insurances are directed to certain professional groups.</p> <p>The employment pension system is comprised of several public and private sector pension schemes: Private sector:</p> <ul style="list-style-type: none"> • The Employees' Pensions Act (TEL); • The Temporary Employees' Pensions Act (LEL); • The Pension Act for Performing Artists and Certain Other Employee Groups (TaEL); • The Seamen's Pensions Act (MEL); • The Self-Employed Persons' Pensions Act (YEL); • The Farmers' Pensions Act (MYEL). <p>Public sector:</p> <ul style="list-style-type: none"> • The State Employees' Pensions Act (VEL); • The Local Government Employees' Pensions Act (KVETEL); • The Evangelical Lutheran Church Pensions Act (KiEL); • Institutions under public law (Bank of Finland, SII). <p>Both public and private sector:</p> <ul style="list-style-type: none"> • Pensions paid under the Military Injuries; • Motor Insurance and Accident Insurance (Workers' Compensation) Acts (SOLITA). <p>Other benefits that are related to the disability scheme (excl. occupational schemes) are:</p> <ul style="list-style-type: none"> • The sickness allowance (covers the first year of disability/sickness, but is not part of the pension acts); • The rehabilitation benefit (temporary disability benefit).
France	<p>In France, there are two long-term pension schemes: the <i>Pension d'Invalidité</i> (PdI) and <i>Allocation pour l'Adulte Handicapé</i> (AAH).</p> <p>The contributive PdI is intended to compensate insured persons (employees) for loss of working capacity resulting from their invalidity. It is temporary but it may continue until the age of 60, when retirement takes place.</p> <p>The AAH is a non-contributive temporary benefit granted for periods of one to five years. It is a minimum income guaranteed by the state to any person who is not entitled to an old age benefit, an invalidity pension, or an industrial injury pension under a social security scheme and who is recognised by COTOREP (the Technical Commissions for Vocational Guidance and Resettlement) as:</p> <ul style="list-style-type: none"> • being permanently disabled for over 80%, or ; • being permanently disabled over 50% and unable to find work due to one's handicap.

Background information

Country	Background information
Germany	No further background information available.
Hungary	No further background information available.
Ireland	<p>In Ireland, there are different payments available for people who are ill or disabled.</p> <ul style="list-style-type: none"> • Disability Benefit (a short-term, contribution-based payment); • Disability Allowance (a long-term, non-contributory, and means-tested payment); • Invalidity Pension (a long- term contribution- based payment). <p>Disability benefit is a payment made to insured people who are unable to work due to illness. To qualify for Disability Benefit, a person must be incapable of work due to illness, be under the age of 66, and satisfy the PRSI conditions.</p> <p>Disability Allowance is a weekly allowance paid to people with a disability who are aged 16 or over and under the age of 66. The disability must be expected to last for at least one year and the allowance is subject to both medical suitability and a means test.</p> <p>Invalidity Pension is a payment made to people who are permanently incapable of work because of an illness or incapacity.</p> <p>In this research, we looked at the contributory Invalidity pension.</p>
Italy	No further background information available.
Netherlands	<p>As reducing the number of individuals receiving disability benefit is a major issue for the Dutch government, the government plans to implement major changes with respect to the Disability Benefits Act (WAO). The cabinet aims to reduce the number of individuals entering the disability scheme from 100,000 per year to 25,000. To achieve this reduction, the political discussion is strongly focused on renewing the WAO. It is proposed that only individuals who are permanently and totally incapacitated for work should receive a disability benefit. Furthermore, individuals younger than 45 years who currently receive a disability benefit should be reassessed according to the new criterion. Partly disabled (more than 35% loss of earning capacity) persons who are working will receive an allowance in addition to their salary. Partly disabled persons who are not working will receive an unemployment benefit (WW), followed by a welfare benefit. A separate, privately insured scheme will be introduced for professional risks.</p> <p>Another important change that is proposed concerns the period of sickness benefit. This period in which the employer has to continue paying wages (70% of the last-earned wage) will be extended to 2 years during sickness. This change is meant to increase the employer's responsibility for the reintegration of sick employees. It also means that individuals can apply for disability benefits only after 2 years of sickness.</p>
Norway	No further background information available.
Russian Federation	<p>In the Russian Federation, the acts that are relevant to the arrangement of long-term disability are the following:</p> <ul style="list-style-type: none"> • the act of 1995 "On Social Protection of the Disabled"; • the act of 1998 "On Order of Recognizing Citizens as Disabled people". <p>Both laws complement each other in matters of support, financing, criteria, and organisation. Resolutions have been made to further elaborate the programme. The part that is relevant here is the evaluation of disability that is done by the State Service of Medical Social Examination (SSMSE) by way of local (MSE) and regional bureaus (MMSE).</p>

Background information

Country	Background information
Slovenia	On 1 st January 2003, the law regarding disability assessment was renewed. Therefore, there has been too little experience of the consequences of this new law to allow comment.
Spain	<p>In Spain, there is a contributory incapacity pension (<i>incapacidad</i>) and a non-contributory invalidity benefit (disability pension). The arrangement for non-contributory invalidity benefit is executed by provincial administration ('<i>comunidad</i>', formerly by IMSERSO) and was not included in this research.</p> <p>The law governing both benefits is consolidated in the General Law on Social Security (<i>Ley General de la Seguridad Social</i>, LGSS).</p>
United Kingdom	<p>The main provision for income support for people unable to work due to illness or injury comes from employers. In addition, there are two state benefits. The first is the <i>Incapacity Benefit</i> (IB), a contributory income replacement benefit for employees. Second is the <i>Income Support</i> (IS), the UK equivalent of social assistance paid to those who are either not in work, or fall below the threshold for contributory benefits. Both IB and IS are paid by Jobcentre Plus, an agency of the Department for Work and Pensions.</p> <p>In 1995, IB provision replaced both Sickness Benefit and Invalidity Benefit for those unable to work. There are three levels of IB: Short-Term Lower rate (payable for the first 28 weeks of sickness absence), Short-Term Higher rate (payable between 28 and 52 weeks) and Long-Term (after 52 weeks). The Long Term (IB LT) is most relevant in the present study. IB LT can be claimed after 28 weeks when requirements in form SSP1 are satisfied although payments only start at 52 weeks.</p>
USA	The Social Security Administration (SSA) administers two disability programmes: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). SSDI is an insurance programme based on the claimant's earning history; SSI is a welfare programme for those with low levels of resources and covers both adults and children. The medical and vocational criteria for accessing both programmes are the same. However, the medical criteria for children (SSI) are different than those for adults when the particular effects of the disease processes in childhood are different, i.e., when the disease process is generally found only in children or when the disease process differs in its effects on children and adults.

Appendix 3 Questionnaire

1 Background information

- 1.1 *What is the name of the long-term disability arrangement you are working on?*
- 1.2 *Is this arrangement part of the health insurance scheme or the old age pension?*
- 1.3 *What is the definition of disability for work according to the arrangement you are working on? Is disability for work defined in terms of loss of labour capacity or earning capacity?*
- 1.4 *Are job-related health risks (i.e., *risque professionnel*) distinguished from socially- bounded health risks (i.e., *risque social*)?*
- 1.5 *What is the primary goal of the assessment process (to check entitlement to disability benefit, treatment, revalidation, or rehabilitation)?*
- 1.6 *What are the necessary conditions to apply for a disability benefit? Are there specific conditions apart from the disability?*
- 1.7 *What degrees of disability are distinguished?*
- 1.8 *Are assessments performed by public or by private institutions?*
- 1.9 *How many assessments and reassessments are performed yearly as part of the arrangement you are working on? How many of these assessments are rejected?*

2 Organisational design

2.1 Organisational structure

- 2.1.1 *How is the assessment process organised? What professionals are involved in the organisation of the assessment process?*
- 2.1.2 *What are the backgrounds of these professionals and what are their specific functions?*

2.1.3 *What are the reasons for the (unique) features of the organisation in your country?*

2.1.4 *What is the role of curative health care (e.g., general practitioner, treating medical specialists) in the assessment? To what extent are curative health care and the assessment of disability interrelated?*

2.1.5 *What is the role of the employer in the assessment?*

2.1.6 *Has the claimant influence on the cooperation/consultation with the curative health care sector?*

2.1.7 *What are the advantages and disadvantages of this design? What are the problems in the organisation of disability assessment in your country?*

2.1.8 *Are there preconditions for this design to be effective?*

2.2 Time schedule

2.2.1 *What is the formal time schedule of the assessment process? Is there a specific moment/period in which the disability for work is assessed? To what extent are reassessments performed?*

2.2.2 *Is the actual time schedule different from the formal time schedule? If so, what are the reasons?*

2.2.3 *What is the standard and actual amount of time invested in a claimant?*

2.3 Assessors

2.3.1 *What kind of information is collected in order to make the decision of disability? Is the claimant responsible for presenting medical evidence? What kinds of professionals are consulted to obtain information?*

2.3.2 *How do the involved professionals communicate with each other?*

2.3.3 *How effective is the communication between the involved professionals?*

2.4 Argumentation in decision-making

2.4.1 *What argumentation is needed for the decision-making process? What decisions have to be made that result in a final decision about disability?*

2.4.2 *Is the assessment of mental disability separated from that of physical disability? If the answer is yes, is the weight of mental and physical disability formally different in the decision-making process?*

2.4.3 *How detailed are the criteria for disability? How much decisional latitude do assessors have in interpreting the criteria?*

2.4.4 *Are there other factors that could influence the decision making (informal guidelines, targets with respect to the number of people who are entitled to benefits, time pressure, etcetera)?*

2.5 Instruments and tools

2.5.1 *What kinds of instruments are used to make the decision of disability? (e.g., lists, computer programs, handbooks, barema)*

2.5.2 *Are standard descriptions available for the argumentation of the medical assessor? Is this generally accepted? How can medical assessors show qualitative or quantitative limitations in their argumentation or decision?*

2.6 Reassessment

2.6.1 *In what ways do reassessments differ from first-time assessments?*

2.7 Appeal

2.7.1 *How can claimants appeal against a decision?*

2.7.2 *How can employers appeal against a decision?*

3 Quality control

3.1.1 *Is the quality of the assessment process evaluated? Is information collected on a regular basis? How often?*

3.1.2 *Which institutions/professionals are responsible for supervision/quality control? What is controlled (input, output, process, the professional)?*

3.1.3 *What aspects of the decision-making process are evaluated? Are there quantitative or qualitative norms (e.g., 30 assessments per week) for assessing the quality of the assessment process?*

- 3.1.4 *What are the procedures (work methods, work instructions, protocols, continuing education, promotion of shared values, professional standards, coaching, certificates, recruitment, performance policy, discussion of cases among colleagues, et cetera) used to ensure the quality of the assessment process?*
- 3.1.5 *Does your institution comply with any formal quality system, such as ISO certification?*
- 3.1.6 *How are assessors informed about the results of the controlling of quality?*
- 3.1.7 *What activities are undertaken to restore/improve the quality of the assessment process?*
- 3.1.8 *What are the advantages and disadvantages of the way in which quality is controlled?*
- 3.1.9 *What are the preconditions of quality control?*
- 3.1.10 *Are there points of discussion with respect to the quality control?*

Appendix 4 Respondents

Table of Respondents

Country	Respondents
Belgium	<ul style="list-style-type: none"> • Dr. Peter Donceel, Deputy Director of Medical Advisors, Confessional Health Service; Lecturer at Leuven University. • Dr. Jean-Philippe Mousset, medische directie Christelijke Mutualiteit, soon to be called RIZIV (National Institute for Sickness and Disability Insurance). • Dr. Luc Cools, medical advisor.
Denmark	<ul style="list-style-type: none"> • Mr. Mogens Wiederholt, Head of the Equal Opportunities Center for Disabled People and Secretary of the Council for the Disabled (the Equal Opportunities Center for Disabled People) • Ms. Pernille Moll, Policy Maker (Ministry of Social Affairs) • Ms. Britta Maar, Lawyer (Council of Administrative Law) • Mr. Jan Hogelund, Economic Researcher (The Danish National Institute of Social Research)
Finland	<ul style="list-style-type: none"> • Dr. Antti Huunan-Seppälä, Director of Medical Affairs, M.D. • Dr. Jorma Järvisalo, Deputy Director of Research, Med.Sc. • Dr. Katia Käyhkö, Senior Lecturer, Med.Sc. • Hilikka Haverinen, Decision Maker at the SII Pension and Income Security Department • Lauri Seppo, Psychologist at the Rehabilitation Foundation • Esko Matikainen, Medical Director at the local government pension institute. <p>All working at the Social Insurance Institution</p>
France	<ul style="list-style-type: none"> • Dr. Alex Plazanet, Médecin Conseil Régional, CRAM (Caisse Régionale d'Assurance Maladie) • Dr. Chabrier, Médecin Conseil • Dr. Gilles Reninger MR, Médecin-conseil chef de service, CRAM • Dr. Bernadette Ben Hassine, Médecin Conseil CPAM (Caisse Primaire d'Assurance Maladie)
Germany	<ul style="list-style-type: none"> • Fr. Dr. P. Schuhknecht, Insurance Doctor, Head of the division of medical assessments (Public pension insurance department of disability pensions) • Fr. Dr. Kosukewitz, Insurance Doctor (Public pension insurance department of disability pensions) • Herr Stichnoht, Division of work assessment and juridical questions (Public pension insurance department of disability pensions)
Hungary	<ul style="list-style-type: none"> • Dr. Ferenc Móricz: Head of main department, specialist, health care manager (National Health Insurance Fund Administration, Main department of Medical Expertise) • Dr. Ilona Kislaki: Medical Advisor, Head of the sub-department of medical expertise (National Health Insurance Fund Administration, Main department of Medical Expertise)
Ireland	<ul style="list-style-type: none"> • Dr. Michael Chambers, Chief Medical Advisor Medical Review & Assessment Section • Dr. Clement Leech, Deputy Chief Medical Advisor Medical Review & Assessment Section

Respondents

Country	Respondents
Italy	<ul style="list-style-type: none"> • Dott. Claudio Meloni, Senior Doctor in practice (INPS (Istituto Nazionale della Previdenza Sociale)) • Dott.ssa Sonia Principi, Senior Doctor in practice (INPS) • Prof. Maurizio Ceccarelli Morolli, Senior Doctor of the headquarters (General Coordinator) (INPS)
Netherlands	<ul style="list-style-type: none"> • Jan Veenboer, Quality advisor (UWV) (Dutch Workers Insurance Authority)) • Lex van de Ven, Staff physician (UWV) • Wim Otto, Policy Advisor, Insurance physician (UWV)
Norway	<ul style="list-style-type: none"> • Søren Brage, Medical officer - Research, Planning, and Education (National Insurance Administration)
Russian Federation	<ul style="list-style-type: none"> • Pavel Kaminsky, Kaminsky and Partners, Director • Sabine Horstmann, GvG Köln; Consultant • Leonid Sholpo, Medical Expert (SSMSE). (The State Service of Medical Social Examination) • Anatoli Sawelyev, Medical Expert (SSMSE) • Zinaida Kozyreva, Medical Expert (SSMSE) • Wyacheslav Melnikov, Director (SSMSE)
Slovenia	<ul style="list-style-type: none"> • Eva Kosta, M.Sc., JP, Chairman Board of Examiners (1st degree) (The Institute for Pension and Disability Insurance of Slovenia) • Aleksandra Mirtič, Specialist in Surgery, Chairman Board of Examiners (1st degree) • Marjan Rus, Specialist in internal medicine, Examining Doctor Board of Examiners (2nd degree) (The Institute for Pension and Disability Insurance of Slovenia) • Polona Čižman-Žagar, Head of Disability Insurance Department, Law Degree (The Institute for Pension and Disability Insurance of Slovenia) • Gabrijela Dšuban, Specialist in Occupational Medicine, Chairman Board of Examiners (2nd degree) (The Institute for Pension and Disability Insurance of Slovenia)
Spain	<ul style="list-style-type: none"> • Juan Antonin Martinez Herrera, Staff Doctor (medico evaluador jefe, medicos inspectors-evaluadores) • Emilio Jardón Dato, Coordinator of 52 teams of social insurance physicians (coordinador de equipos de valoración de incapacidades) • Martin Fernando Casero Suárez, Coordinator of administration (jefe de servicio de ordenación administrativa) <p>All working at INSS (National Institute for Social Security)</p>
United Kingdom	<ul style="list-style-type: none"> • Dr. Angela Graham, Medical Performance Manager (SchlumbergerSema) • Dr. Richard Gain, EBM Medical Manager, Preston location (SchlumbergerSema) • Nick Barry, District Manager (SchlumbergerSema) • Dr. Martin Gay, Professional Support, Quality Manager (SchlumbergerSema)

Respondents

Country	Respondents
USA	<p>The results from the USA were collected during a visit in 2002 of the Ministry of Social Affairs and Employment, together with the Dutch organization for social insurance (UWV), to the Social Security Administration (SSA) in Baltimore. Contact person:</p> <ul style="list-style-type: none"><li data-bbox="550 452 1182 506">• Dale Cox, Branch Chief of the Medical Policy Branch (SSA, Baltimore)<li data-bbox="550 510 1182 526">• Joan Hay, Medical Policy Analyst Branch (SSA, Baltimore)