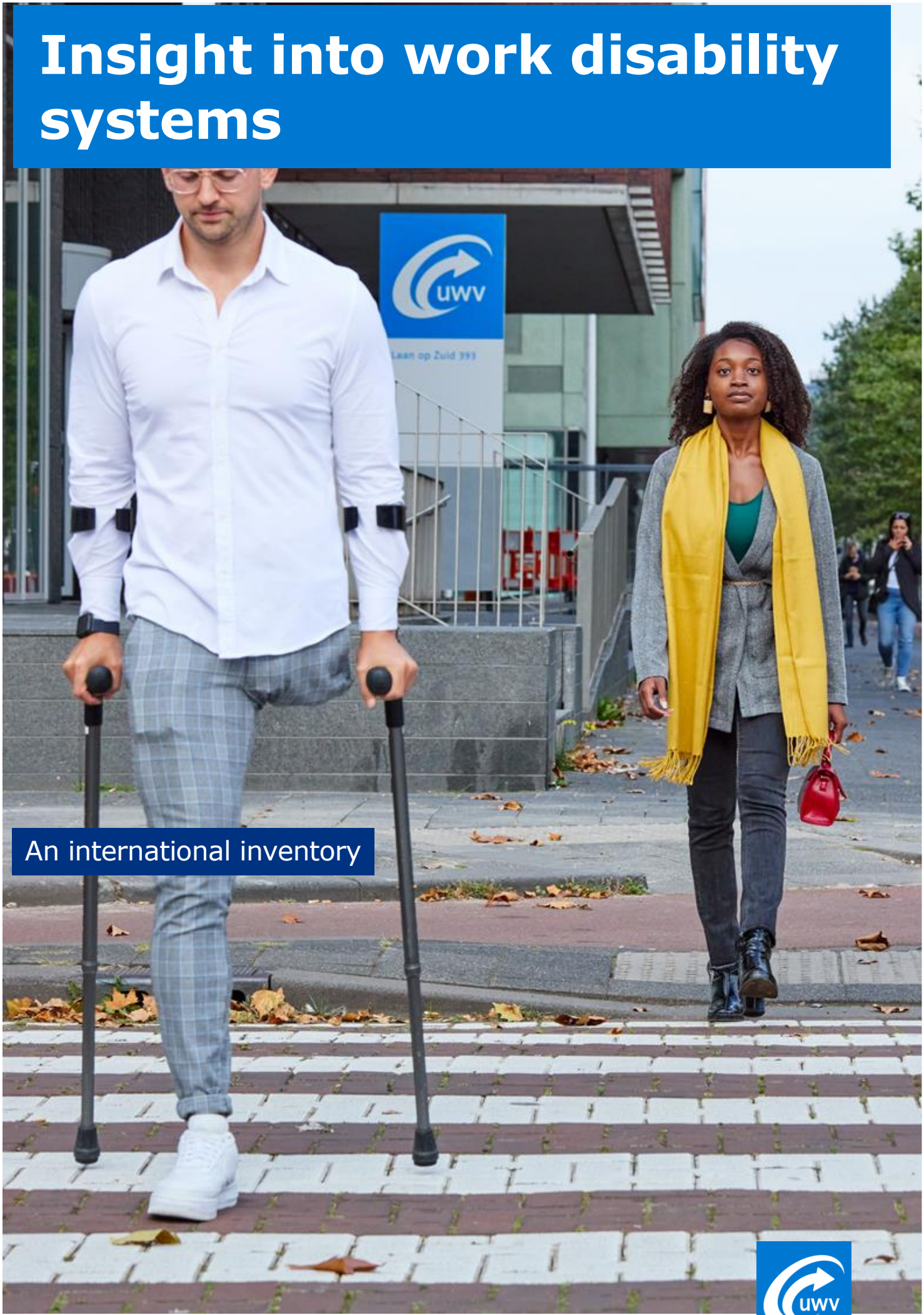
Insight into work disability systems



An international inventory

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Preface

The Netherlands Court of Audit earlier this year concluded that the current system under the Dutch Work and Income (Capacity for Work) Act (WIA) can no longer be sustained. This finding did not come out of the blue and reflects the problems UWV (Dutch Employee Insurance Agency) has been facing for some years now - problems that have an unacceptable effect on our claimants. They face (overly) long periods of uncertainty about their income, forming an impediment in many fields of life. UWV, in addition to implementing numerous measures to resolve the situation, would do well to gain inspiration about possible solutions from beyond our national borders. Over the past year, UWV researchers have investigated the work disability systems in force in eight European countries. The study is the result of the efforts of many parties, ranging from the researchers actually conducting it to the national and international parties supporting them. I would like to congratulate them on the valuable insights and results arising from this study. I sincerely thank you for that!

The work disability systems have, by way of qualitative research, been mapped from the moment of reporting sick, up to the work disability assessment, objections and appeals procedures, and the possible reassessments. In this connection specific attention has been given to the work disability criteria applied, the ways by which claimants could provide their input, the professionals involved and their roles, and data protection. The study shows interesting similarities and differences, enabling us to consider options for the Dutch system outside the beaten path, such as involvement from the curative sector or a focus on rehabilitation.

The present report provides a great many starting points. With respect to the countries studied, it was found that they, too, are facing mounting pressure on the system. Some of these countries have already implemented reforms, such as Ireland, which has replaced physical interviews with a desk assessment; the United Kingdom, which allows for medical professionals other than doctors, such as physical therapists, to perform a work disability assessment; and Denmark, which heavily focused on rehabilitation.

UWV will use the results of this study to get to work. We aim to consult with all stakeholders involved and discuss the opportunities and solutions we have found for the Dutch system. We envisage a system that revolves around the claimant, but is also practicable, so as to bring out the best in both the claimant and the professionals. For, ultimately, there is only one objective: to help people as quickly and effectively as possible!

Johanna Hirscher
Member, UWV Board of Directors

Summary

At present, UWV is facing a mismatch between the total number of requested socio-medical assessments and the available capacity. Given the ageing population and increase in pension age, UWV expects the demand for socio-medical assessments to increase in the future. The UWV 2022-2025 Knowledge Agenda includes "socio-medical and occupational professional development" as a knowledge theme. Within this knowledge theme, the question of the lack of capacity to perform all assessments plays an important role, as do supporting and further professionalisation of the quality, efficiency, and effectiveness of the services provided by all UWV professionals. In the context of this knowledge theme, the knowledge question of how other countries have set up their social security systems and which aspects from the systems of those other countries could be applied in the Netherlands, was posited. The Independent Committee for the Future of the Work disability System (OCTAS), established in 2022 by minister Van Gennip of Social affairs and Employment, has also requested an international comparison of the various social security systems and, more in particular, of the work disability systems.

The objective of this study is to provide inspiration for possible solutions to the capacity problem and to investigate opportunities to promote more fitting input by the claimant. The study's core question is: What work disability criteria are applied and what steps are taken by the claimant and the professional over the course of the work disability claim assessment process in the countries selected?

In mapping the various systems, we paid particular attention to the following sub questions:

- What various work disability criteria are applied?
- What does the input of the claimant prior to and during the work disability assessment consist of?
- Which professionals are involved in the work disability assessment and what do their roles entail?
  - How are cases of multimorbidity dealt with?
- How is data protection ensured in this context?

The study covered eight countries: Denmark, Estonia, Finland, Iceland, Ireland, Sweden, the United Kingdom, and the Netherlands. We arrived at this selection as it allowed us to study a wide range of work disability systems. The work disability systems have been mapped using multiple qualitative methods: desk research, a written questionnaire, semi-structured interviews, and consistency checks.

Work disability criteria and related aspects

Among the countries covered by this study, the Netherlands is the only one conducting the work disability assessment on the basis of a calculation of the loss of earning capacity. The other countries studied use various ways of assessing (in)capacity for work, mainly looking at the loss of ability to work. We also find that the assessment method used in the Netherlands is relatively heavily protocolised. We find that some countries assess the functional limitations and/or capabilities, while other countries also consider other aspects, such as environmental factors. In Denmark, for example, account is taken of the fact that an inability to work may have multi-factorial causes before assessing the degree of (in)capacity for work. The assessors also map the various barriers keeping the claimant from returning to work.

In the Netherlands, previously earned income is included in the calculation of the amount of the work disability pension on two occasions. First, the previously earned income is considered when assessing the remaining earning capacity; second, the pension amounts to a percentage of the previously earned income. Some other countries consider the previously earned income is one of the elements used to calculate the amount of the pension. In Finland, Iceland, and Sweden, a percentage of the previously earned income is used in this calculation. In Denmark, Estonia, and the United Kingdom, the work disability pension is a fixed amount, irrespective of the previously earned income. Ireland applies a fixed amount per income category.

The study shows that various countries apply the work disability criterion that all rehabilitation options must have been exhausted before a work disability assessment can take place. This criterion applies to Denmark, Finland, Iceland, and Sweden. This is impacting the term and flexibility of the period prior to a work disability pension being awarded. In these countries, the periods in which employers must continue paying wages and in which a sickness benefit is paid, is shorter than in the Netherlands. The length of the rehabilitation period may vary significantly. A rehabilitation plan is drawn up depending on the situation and what is possible for the claimant. If the claimant meets the work disability criteria in these four countries and is awarded a full work disability pension, in principle no reassessments take place, for no further rehabilitation options exist. Age often plays a role in this connection.

In the Netherlands, Estonia, Ireland, and the United Kingdom, the criterion that all reasonable and possible rehabilitation options must have been exhausted before a work disability pension can be claimed, does not apply. In these countries, a temporary work disability pension can be awarded for which reassessments will be conducted. This temporary pension can also be awarded in Finland and Iceland. Such a system does not preclude rehabilitation interventions. Claimants in the Netherlands, for example, must participate in vocational rehabilitation activities over a period of two years prior to the possible award of a pension under the Dutch Return to Work (Partially Disabled Persons)

Regulations (WGA) or Fully Disabled Persons Income Scheme (IVA). This means that a vocational rehabilitation requirement applies, albeit during the fixed qualifying period of 2 years.

Input by the claimant

In the Netherlands, the claimant is coached by the employer and/or an occupational health service during the period prior to the application for a work disability pension. The claimant is, in this connection, also to attend the interviews with an occupational physician. We find that, in a number of countries, the obligation by the employer to continue paying wages and coach the claimant is shorter in duration. In these countries, the claimant often visits their GP or a (treating) physician to have a medical certificate drafted. This certificate is required for the application of a sickness benefit with the social insurance body. Generally, no appointment with the social security agency is necessary for this purpose.

Multiple countries first award a rehabilitation benefit before allowing for the application of a work disability pension. Various rehabilitation options are to be tried out over the term this rehabilitation benefit is paid out. Coaching and consultation is in these cases performed by either an interdisciplinary rehabilitation team (in Iceland and Denmark), or the GP (in Sweden).

The Netherlands attaches great importance to the interview with the claimant when assessing the (in)capacity for work. This forms an important moment for the claimant to provide their input. This is not the case for all countries. In Ireland, Estonia, and Finland, for example, the assessment is conducted by way of a desk assessment. This means that, in principle, no contact is had with the claimant. However, the claimant does have the possibility to provide their input by other means, for example by way of a self-report questionnaire.

In the Netherlands, the self-report questionnaire is not a default document to be completed by the claimant. Most of the other countries studied do make use of the self-report questionnaire by default. This sometimes serves as a consistency check, to verify whether the available documents, such as those provided by the curative sector, match up with the answers provided by the claimant. Iceland and Sweden use the self-report questionnaire in this fashion. The questionnaire can also be used to help create an overall picture within the work disability assessment. While the document has no decisive force in this case, it does support the assessor in assessing the capabilities and limitations, as experienced by the claimant. In Estonia, for example, the questionnaire, together with the medical information and the medical certificate issued by the treating physician, stands at the basis of the assessment. By completing the questionnaire, the claimant is able to provide direct input in the work disability assessment. And by having to complete the questionnaire, the claimant is asked to consider their own physical and mental functioning at length. The claimant is invited for an interview by the assessing professional only in rare cases.

In the Netherlands, medical certificates by a treating physician from the curative sector are not considered in the context of the work disability assessment. Vocational rehabilitation reports by the employer and the occupational health service and/or the occupational physician are, however. The Netherlands differs from the other countries studied in this respect. In all other countries studied, use is made of a medical certificate drawn up by a (treating) physician. This certificate lists information on the affliction(s), limitations, expected term and prognosis, and, in some countries, also an overview of rehabilitation activities performed. The essential role played by the (treating) physician allows for various options to be considered: the assessment can be conducted by way of a desk assessment, or the assessment can be conducted by professionals other than a doctor. The overview of rehabilitation activities performed by a multidisciplinary team coaching the claimant during the sickness and rehabilitation period can also be submitted. This is the case in Denmark, Iceland, and Finland.

For all countries studied, we find that additional information can be requested from the treating physician. This requires the claimant's consent. Medical information may also sometimes be directly accessed with the claimant's consent. In Estonia, the social physician[1] is allowed to access the national electronic medical file of the claimant directly.

Professionals involved and their roles

Interviews with the claimant are possible at various times during the process, involving multiple different professionals. An “interview” in this context means an occasion where the claimant and the assessing professional(s) have physical, telephone, or digital contact as part of the assessment. We have not limited such an occasion to a specific length of time. We find that, in the period during which the claimant receives a sickness benefit (prior to receiving a work disability pension), the interviews are often held by a doctor employed in the curative sector. However, this is not always the case. In Denmark, for example, the interview is held by a non-medical professional. In the United Kingdom, interviews are held by a medical professional employed in the curative sector. This can be a doctor, but may also be a physical therapist or a nurse. When considering interviews held as part of the work disability assessment, we first of all note that far from all countries hold such interviews. In those countries where interviews are held, we find that a variety of professionals is involved. In Denmark, the interview is held by a case worker and an interdisciplinary rehabilitation team; in Sweden, by a non-medical professional; while in the Netherlands and Iceland, the professionals holding the interviews are social physicians.

[1] In view of the wide variety in titles used for the physicians involved in the work disability assessment in the countries studied, we opted to use the title "social physician" for all of them. This includes insurance physicians, medical advisers, social medicine physicians and occupational physicians. So as to make the report more easily understandable from a Dutch perspective, we did use the titles "insurance physician" and "occupational physician" when describing the Dutch processes.

When looking at the work disability assessment, we find that in most countries a supporting role is played by a non-medical professional. This non-medical professional may, for example, make sure that applications and the files are complete, or support a claimant with filing the application. The curative sector often plays an advisory role. In the Netherlands, such advice is given by the occupational health service or an occupational physician. When it comes to making the assessment, this is often performed by a social physician. Exceptions do exist: in some countries, the assessment is made by an interdisciplinary rehabilitation team, a non-medical professional, or a medical professional who does not have to be a doctor. The administrative decision is most often taken by a non-medical professional. The exception to this rule is Iceland, where the administrative decision is taken by the insurance physician.

The role and position of the social physician varies across most of the countries. In almost all the countries studied, the social physician is a medical specialist employed in that capacity in the curative sector while also serving as a social physician. The educational programmes followed also vary. We often find that the social physician is a medical specialist who completed additional training on the work disability assessment. Such training courses in the main take three to six months. Social physicians do not always meet with the claimant. This is the case when the assessment is conducted by way of a desk assessment, for example. In Sweden, the social physician serves an advisory role. If the non-medical professional performing the assessment has questions or if anything is unclear, they may consult the social physician.

The role of the non-medical professional in the work disability assessment varies, as well. Over the various countries studied, the non-medical professional can have a supporting, assessing, or deciding role. In the Netherlands, the assessment is partly performed by a non-medical professional: the labour expert. In Sweden, the work disability assessment is performed by an academically educated non-medical professional. This non-medical professional can, if need be, ask a social physician for advice. However, the non-medical professional remains responsible for the assessment. In Denmark, the assessment is performed a case worker and by the rehabilitation team, which is partly composed of non-medical professionals.

In cases where multiple diagnoses are at play (multimorbidity), we find few differences between the countries studied. In all eight countries, the relevant diagnoses are considered in the context of the assessment. The impact of the totality of the various diagnoses on the work ability is assessed.

Data protection

We find that differences exist between those countries studied that are part of the European Economic Area (EEA) (all of them, except for the United Kingdom) as concerns the handling of personal data. This on the one hand results from the fact that the General Data Protection Regulation (GDPR) allows for specific elaboration on the national level, both as relates to statutory exceptions to the prohibition against the processing of special categories of personal data and as concerns the use of "open norms" like necessity and proportionality. On the other hand, countries are also free to have additional data protection legislation in place.

One matter of agreement between all countries studied is that the retrieval of data from the curative sector requires the claimant's permission. One striking difference between the Netherlands and most other countries is that, should the claimant not grant consent to provide information from the curative sector to UWV, a work disability assessment must still take place. In most other countries, no assessment can be conducted when insufficient medical information is available; awarding a pension may even be prohibited should such information be lacking. This means that the claimant's decision whether to grant consent to the assessing body having access to data concerning health, is not always free of consequences. The decision not to do so may result in no pension being awarded.

Reflection

This study provides a qualitative description of the structure of the work disability system in eight European countries, including the Netherlands. We, by way of this study, aim to provide inspiration and to display the various possible ways to structure the work disability system. Each work disability system has aspects that could be interesting. When evaluating these aspects, it is important to keep in mind that this survey is not a study into the implementation of the system in practice. This means that the practical implementation may, in the countries studied, differ from what has been described in this study. In addition, one should keep in mind that no conclusions can be drawn about the effectiveness of the systems studied on the basis of this survey.

As was noted in the above, we, over the course of the study found that the Netherlands deviates from other countries in a number of ways, including the assessment on the basis of the loss of earning capacity, medical certificates or self-report questionnaires not being used by default, the emphasis on the interview in person to collect the claimant’s input, the relatively long period during which the employer must continue to pay wages, the position held by the insurance physician, and the length of the training to become an insurance physician. These various aspects provide starting points for follow-up research, such as an in-depth study into the claimant's experiences with other ways of providing input.

Finally: we studied a limited selection of countries for this study. The selection was made to ensure that various systems would be studied. Nevertheless, countries that have not been studied in this survey may provide additional interesting insights.

1. Introduction

1.1. Occasion

In the past few years, UWV has not been able to conduct all socio-medical assessments applied for. A great many efforts have been expended to as yet meet the demand. Nevertheless, at present, about 17,000 claimants have been waiting too long for an assessment.[2] This has individual, social, and economic consequences. Having to wait (overly) long for an assessment or reassessment of the right to a pension causes concern among claimants about their financial situation and may slow down the vocational rehabilitation process.

In addition, UWV expects the demand for socio-medical assessments to increase in the future. At present, the population in Europe is ageing and expectations are that this process will continue at a more fast pace over the decades to come, causing an increase of persons aged over 65, both as concerns absolute totals and their share of the total population.[3] This issue, as well as staff shortages and increasing social security expenditure, form some of the major problems faced by most European countries and have resulted in policy changes to (vigorously) encourage people to continue forming part of the workforce, such as increases in state pension age.[4] The total number of people in work aged over 55 has sharply risen over the past few years.[5] This also means that the likelihood of more employees becoming (temporarily) incapacitated for work, is rising, which in turn puts more pressure on the work disability systems.[6] [7]

While the demand for socio-medical assessments is rising, the number of assessing insurance physicians working for UWV has, in terms of FTEs, been decreasing over the past few years.[8] [9] In 2022, as well, the number of doctors leaving the employment of UWV was higher than the number entering it.[10]

Elements of the aforementioned issues have been included in the "socio-medical and occupational professional development" knowledge theme addressed in UWV 2022-2025 Knowledge Agenda. Within this knowledge theme, the question of the lack of capacity to perform all assessments plays an important role. At the same time, the importance of supporting and further professionalising the quality, efficiency, and effectiveness of the services provided by all UWV professionals, including insurance physicians and labour experts, is emphasised.[11] One of the specific knowledge questions addressed within the knowledge theme relates to a wish that has also been expressed int he April 2021 letter to the Dutch House of Representatives: increased input by the claimant in the context of the performance of socio-medical assessments.[12] More fitting input by the claimant may contribute to an assessment practice that is both more future-proof and more human-oriented.

This knowledge theme also includes the topic "learning from foreign practice". The knowledge question addressed under this topic is that of how other countries have set up their social security systems and which aspects of these systems can be applied in the Netherlands. This question is highly topical. Minister van Gennip of Social Affairs and Employment in 2022 established the Independent Committee for the Future of the Work disability System (OCTAS).[13] The Committee's objective is to issue a comprehensive and fundamental advice on a future-proof sickness and work disability system: A system that is practicable, affordable, and explainable to jobseekers, workers, employers, implementing organisations, and other people who rely on that system. OCTAS, too, has requested an international survey of the various social security systems and, more in particular, of the work disability systems.

In 2021, research agency Panteia on the instructions of the Ministry of Social Affairs and Employment conducted an extensive investigation, arriving at an international comparison of the organisational work and income infrastructures[14]. This investigation led to greater insight into how various countries have set up their organisational infrastructure to respond to various risks: sickness, work disability, unemployment, poverty, and old age. The present report provides the results of a more in-depth study of one of these topics: the work disability systems as they exist in various countries. The study focused on the specifics of these processes, such as work disability criteria, flows of information from the claimant to the professional, and the working methods used by professionals to assess (in)capacity for work. Even though the focus of the study was on the work disability assessment, this can only be properly investigated by taking

[2] Refer to UWV (2023).
[3] Refer to Eurostat (2019).
[4] Refer to MacEachen (2019).
[5] Refer to Eurostat (2019).
[6] Refer to Berendsen et al. (2019).
[7] Refer to MacEachen, E. (2019).
[8] Refer to UWV (2022a).
[9] Refer to UWV (2022c).
[10] Ibidem.
[11] Refer to UWV (2022b).
[12] Refer to Koolmees (2021).
[13] Refer to van Gennip (2022).
[14] Refer to Drijvers et al. (2021).

account of the context it is conducted in. This means that we have also studied the preliminary and subsequent stages and have, in so doing, aimed to map the entire process, from the moment of reporting sick to the assessment and any reassessments. In addition to this practical consideration, taking account of the context during the study may also be of help to gain inspiration on how to tackle the capacity question. For this question can also be approached, for example, from limiting inflow into the work disability-system by deploying rehabilitation early in the process.

We focused on a number of key areas in this study: which work disability criteria do the countries apply, what role does the input by the claimant play during the claim assessment, which professionals are involved in the work disability assessment, and what roles do they play? In addition, UWV's Board of Directors has requested to pay attention to other themes, to wit, how other countries deal with data protection and multimorbidity. We describe the results of our study in this report.

1.2. Research question and strategy

This study has two objectives. One is to provide inspiration for resolving the capacity question, the other is to promote relevant input by the claimant. As other countries work in different contexts, they can come up with solutions that are interesting to the Netherlands, that can provide inspiration, and that can allow us to look at our own practical situation with fresh eyes.

The study's core question is: What work disability criteria are applied and what steps are taken by the claimant and the professional over the course of the work disability claim assessment process in the countries selected?

In mapping the various systems, we paid particular attention to the following sub questions:

- What various work disability criteria are applied?
- What does the input of the claimant prior to and during the work disability assessment consist of?
- Which professionals are involved in the work disability assessment and what do their roles entail?
  - How are cases of multimorbidity dealt with?
- How is data protection ensured in this context?

In selecting the countries to be studied, we first looked at countries that allowed for the claimant to provide input in a fashion different than the Netherlands does. We then also looked into the differences between work disability criteria, the roles of the professionals, multimorbidity, and data protection. In so doing, we ensured that the countries ultimately selected offered a range in work disability systems to be studied. They for example apply different work disability criteria, deploy different methods and instruments to assess (in)capacity for work, have different professionals perform the socio-medical assessments, and differ in the way and degree to which the claimant can themselves provide input for the assessment. The ultimate selection was also impacted by the availability of interview participants in the various countries. We in the end selected the following countries: Denmark, Estonia, Finland, Iceland, Ireland, Sweden, the United Kingdom, and the Netherlands. The Netherlands was included to allow us to compare the context of the current work disability system to the other systems studied.

As was mentioned in the above, it is important, when mapping the various work disability systems, to study the socio-medical context in which the countries assess (in)capacity for work in a structured manner. So as to allow for this, we for this analysis employed a flowchart based on a model previously used for an international comparison of work disability systems.[15] The flowchart shows the various elements and steps the assessment may consist of, from the application until the award of a work disability pension and possible objections and reassessment procedures. For each country, we mapped all elements of the model, using various qualitative methods. This model has been included in Annexe I.

[15] Refer to De Boer et al. (2007).

We applied four research methods to each country:

1. Desk research
2. Questionnaire
3. Semi-structured interviews
4. Consistency check

We for each country first conducted a preliminary investigation by way of desk research and submission of a questionnaire. We looked for already available information in both academic literature and public sources, such as the websites of the various implementing organisations. The questionnaire was on the one hand submitted to the various countries in order to check the desk research for correctness and completeness and, on the other, to obtain more insight into the various ways claimant input is made possible, such as having the claimant complete a questionnaire or having them personally show up for an interview in the context of the work disability assessment. The questionnaire also contains questions about the work disability criteria, the professional involved in the work disability assessment, and the role they play. We next used the information from the responses returned to, inter alia, formulate the questions included in the interview schedule. The questionnaire has been included in Annexe II.

Next, we held semi-structured interviews with various stakeholders and experts from the selected countries.[16] Audio recordings were made of all interviews. These were then transcribed verbatim. We for each country strove to talk to people from various fields, such as employees of the various organisations involved, and from various perspectives, such as research, policymaking, management or implementation. The contacts could be existing contacts of the researchers, contacts registered in the PES network, or contacts found by snowballing from other interviewees. The aim of the interviews was, on the one hand, to verify the desk research and questionnaire results in the light of the mutable nature of policy and implementation in the field of sickness and (in)capacity for work and, on the other, to obtain deeper and additional insight into the work disability assessment process. During the interviews, we followed the steps from the model with the professionals concerned and asked the relevant questions from the model for each step. The number of interviews held differs per country, as we interviewed professionals from various fields of expertise and working within various organisational structures and, therefore, dealt with a diverse number of organisations involved.

Finally, we performed a consistency check of the results obtained. In two countries, this consistency check was carried out with a focus group. In addition, we (repeatedly) submitted the information retrieved in writing to all countries. In performing the consistency check, we first processed all information obtained, i.e., the information received from the desk research, the questionnaire, and the interviews. During the check, we submitted the processed information with the request to verify if all information is correct and to check whether anything was missing. We moreover asked additional written questions, doing so repeatedly in some countries, and have had additional telephone contact.

The response to the questionnaire and interviews is provided in the below table:

Table 1.1 Response from the countries studied to the questionnaire, interviews, and consistency check

	Questionnaire completed	Interviews held	Number of interviewees	Number of interviews	Consistency check
DEN	Yes	Yes	3	3	With focus group and in writing
EST	Yes	Yes	2	1	In writing
FIN	Yes	Yes	4	4	In writing
IRL	Yes	Yes	1	1	In writing and by telephone
ICE	No	Yes	2	2	With focus group and in writing
UK	No	Yes	3	2	None[17]
SWE	Yes	Yes	4	2	In writing
NL	No	No	N/A	N/A	In writing

[16] The interview flowchart has been included in Annexe I.
[17] Unfortunately, no response was received to the request for a consistency check made to the United Kingdom. This means that some caution must be observed with respect to the description of the United Kingdom's system.

1.3. Reading instructions

This report is composed of two parts. *In this translated version only part I is available*. Part I analyses the information obtained in the context of the research questions. Part II provides a detailed description of the work disability system of each country, from the moment of reporting sick to the assessment, possible objections & appeals procedure, and reassessment. Part I consists of five chapters. Chapter 2 provides a comparison of the work disability criteria used by the selected countries. Chapter 3 describes how the claimant is able to provide input in the selected countries. Chapter 4 describes the roles of the various professionals involved and discusses the topic of multimorbidity. Chapter 5 addresses data protection. Chapter 6 reflects on the results. Part II of the report consists of eight country reports: The Netherlands (Chapter 7), Iceland (Chapter 8), Sweden (Chapter 9), Denmark (Chapter 10), Ireland (Chapter 11), Estonia (Chapter 12), Finland (Chapter 13), and the United Kingdom (Chapter 14).

In view of the wide variety in titles used for the physicians involved in the work disability assessment in the countries studied, we opted to use the title "social physician" for all of them. This includes insurance physicians, medical advisers, social medicine physicians and occupational physicians. So as to make the report more easily understandable from a Dutch perspective, we did use the titles "insurance physician" and "occupational physician" when describing the Dutch processes.

PART I Analysis

2. Work disability criteria and related aspects

In this chapter, we map the differences and similarities between the work disability criteria applied in the selected countries. Table 2.1 (presented on the next page) provides a general overview of the differences and similarities in work disability criteria used and the related aspects. We will provide a more detailed explanation of the various components listed in the table in the below. Section 2.1 discusses the qualifying period - where it exists - and the course of the procedure up until the award of the work disability pension. Section 2.2 presents a more in-depth discussion of the work disability assessment. We in this section look into the minimum work disability percentages to be awarded a (partial) work disability pension and into the assessment instruments. Section 2.3 discusses which people are insured against work disability and the basis for determining the amount of the work disability pension.

Table 2.1 Summary table of the differences and similarities in work disability criteria used and the related aspects in eight countries

	DEN	EST	FIN	IRL	ICE	UK	SWE	NL
1. Work disability assessment based on the loss of:	Ability to work	Ability to work	Ability to work	Ability to work	Ability to work	Ability to work	Ability to work	Earning capacity
2. Assessment instrument	Inter-disciplinary exp. opinion & procedural assessment	ICF model and exp. opinion	Guidelines, practice of assessment and expert opinion	ICF model	IAS	WCA	DFA	FML, CBBS, expert opinion
3. Minimal % for full work disability pension	Not laid down by law[18]	N/A	60%[19]	N/A	75%	N/A	100%	80%
4. Partial work disability pension possible	[20]	Yes	Yes	Yes	Yes	No	Yes	Yes
5. Minimal incapacity for work % for partial work disability pension	N/A	N/A	40%[21]	N/A	50%	N/A	25%	35%
6. Qualifying period	No qualifying period[22]	No qualifying period[23]	52 weeks[24]	52 weeks[25]	26-52 weeks[26]	28 weeks	52 weeks	104 weeks
7. Rehabilitation benefit possible	Yes	No[27]	No	No	Yes	No	Yes	No
8. Temporary work disability pension possible	No	Yes	Yes	Yes	Yes	Yes	No	Yes
9. Term of the work disability pension	Permanent	0.5-5 years, or permanent	Permanent	Varies	1.5 years, or permanent	1-10 years, or permanent	Permanent	0.25 years - permanent
10. Reassessment	No[28]	Yes	No	Yes	Yes[29]	Yes	No[30]	Yes
11. Amount work disability pension	Fixed amount[31]	Fixed amount	Inter alia related to previous income & fixed minimum	Fixed amount	Inter alia related to previous income & fixed amount	Fixed amount[32]	Inter alia related to previous income & fixed amount	Inter alia related to previous income

ICF: International Classification of Functioning, Work disability and Health (ICF) of the WHO; IAS: Invalidity Assessment Standard; WCA: Work capacity assessment; DFA: diagnosis, limitation (funktionsnedsättning), activity restrictions; FML: Functional capacity report (functionelemogelijkhedenlijst); CBBS: Claim Assessment and Monitoring System (Claimbeoordelings- en Borgingssysteem).

2.1. Qualifying period and the course of the procedure up until the award of the work disability pension

Row 6 of Table 2.1 lists the minimum periods an employee has to have been sick for before a work disability pension may be awarded. These terms vary in length, from no qualifying period existing at all, like in Denmark and Estonia, up

[18] This percentage is not laid down by law. In practice, a specific percentage is (unofficially) applied.
[19] In Finland, this is not presented as a percentage, but as a 3/5 share.
[20] In Denmark, the claimant can apply for a partial benefit when permanently losing work capacity due to sickness (when working a flexi-job). However, this benefit is not comparable with the full work disability pension. The flexi-job can, for example, also be worked temporarily.
[21] In Finland, this is not presented as a percentage, but as a 2/5 share.
[22] In Denmark, no qualifying period before an application for a work disability pension can be submitted, exists. To claimants entitled to continued payment of wages (4 weeks) and/or a sickness benefit (22 weeks), it is usually more attractive to first make use of those options.
[23] In Estonia, no qualifying period before an application for a work disability pension can be submitted, exists. To claimants entitled to continued payment of wages and/or a sickness benefit, it is usually more attractive to first make use of those options. In such cases, the qualifying period is six months.
[24] Three hundred work days.
[25] A work disability pension awarded under work disability insurance on the basis of residence, also exists. No minimum qualifying period exists in this case, but the term of work disability must be expected to be at least one year.
[26] Iceland also features a work disability pension awarded to residents who have been resident for at least six months.
[27] Nevertheless, the claimant, under certain conditions, can claim a rehabilitation allowance of 33% on top of their temporary work disability pension.
[28] A reassessment is only conducted when special circumstances apply.
[29] Only when the work disability pension has been awarded for a limited term.
[30] A reassessment is only conducted if grounds exist to do so.
[31] Percentage of a fixed amount, related to the term of residence from age fifteen until time of award.
[32] The total fixed amount differs on the basis of the scheme applicable to the claimant (based on premium or residence) and, possibly, on additional allowances.

to two years, as is the case in the Netherlands. The minimum qualifying period also differs from the actual qualifying period in practice.

This is due to the differences in routes claimants in the various countries take before being awarded a work disability pension. In some countries, the programme to be followed before a work disability pension is awarded, is made up of an individual plan and can therefore vary in duration for each claimant. This is predominantly the case in countries that award a rehabilitation benefit before a work disability pension can be awarded, such as Denmark, which has not set a minimum qualifying period before a work disability pension can be applied for. In practice, however, the process until the award of the work disability pension is a long one and can take multiple years, as a claimant can only be declared incapacitated for work once all reasonable rehabilitation possibilities have been explored.

Roughly speaking, the countries studied feature five different phases, each with their own associated benefit or pension type, that can be gone through: (1) a period during which the employer will continue to pay wages; (2) a sickness benefit; (3) a rehabilitation benefit; (4) a temporary work disability pension; and (5) a (semi) permanent work disability pension. Among the countries studied, only Iceland features all variants.

The claimants in the various countries do not all go through the same phases before a work disability pension is awarded. The (work) situation of each claimant is different. Where such is possible, customised services are provided to a certain extent over the various phases in all countries studied. In addition, claimants are not always entitled to benefits or pensions from each phase in the various countries. In addition, a shortened qualifying period can in most countries apply under certain circumstances, for example in the case of a very serious affliction or condition.[33]

The aforementioned five phases are divided into two categories in the below. "Qualifying period" (period during which the employer continues to pay wages, and sickness benefit) and "Procedure after minimum qualifying period" (rehabilitation benefit, temporary and permanent work disability pension).

2.1.1. Qualifying period: period during which the employer continues to pay wages, and/or sickness benefit

The usual minimum qualifying period[34] in most of the countries studied is made up of the period during which the employer continues to pay wages and a period during which the sickness benefit is provided. In the Netherlands, a qualifying period of 104 weeks applies to most claimants. During these weeks, wages (partly) will continue to be paid by the employer or by UWV. After the lapse of this period, a (partial) work disability pension may be awarded. All other countries studied feature a shorter statutory minimum period during which the employer continues to pay wages and a sickness benefit is awarded.

Table 2.2 Overview of minimum qualifying periods until the work disability assessment

	DEN	EST	FIN	IRL	ICE	UK	SWE	NL
Qualifying period	No qualifying period[35]	No qualifying period[36]	52 weeks[37]	52 weeks[38]	26-52 weeks[39]	28 weeks	52 weeks	104 weeks

Period during which the employer continues to pay wages

The period during which the employer continues to pay wages in case of sickness is shorter in the countries studied than it is in the Netherlands, ranging from a few days, like in Estonia (4), Finland (10), and Sweden (14), to multiple weeks in the case of Denmark (4) and the United Kingdom (28). This period can also be flexible, depending on the agreements laid down in the employment contract and the length of the employment at a company, as is the case in Iceland (2-52 weeks). Ireland does not feature an obligation by the employer to continue to pay wages. In most of the countries studied, the payment to be made by the employer is based on the income earned by the employee prior to falling ill. Most often, a percentage, ranging from 70% to 100% of this amount is paid out. In the United Kingdom, a fixed amount, which is not related to the wages, is paid out.

Sickness benefit

In most countries, employees or insured self-employed persons can apply for a sickness benefit upon the lapse of the period during which the employer continues to pay wages. The assessment of the eligibility for and the award of such

[33] The assessment procedure itself has usually also been shortened in such cases. A work disability assessment is in such case performed on medical grounds, for example, with the sickness or condition being considered. This often requires an (underlying) diagnosis and medical information from the curative sector.
[34] Where no shortened qualifying period applies.
[35] In Denmark, no qualifying period before an application for a work disability pension can be submitted, exists. To claimants entitled to continued payment of wages (4 weeks) and/or a sickness benefit (22 weeks), it is usually more attractive to first make use of those options.
[36] In Estonia, no qualifying period before an application for a work disability pension can be submitted, exists. To claimants entitled to continued payment of wages and/or a sickness benefit, it is usually more attractive to first make use of those options.
[37] Three hundred work days.
[38] A work disability pension awarded under work disability insurance on the basis of residence, also exists. No minimum qualifying period exists in this case, but the term of work disability must be expected to be at least one year.
[39] Iceland also features a work disability pension awarded to residents who have been resident for at least six months.

sickness benefit is, in the countries studied, performed by social security agencies, municipal authorities, pension companies and/or unions. The length of the sickness benefit, too, differs per country.

In view of the length and nature of a benefit payment for 104 weeks in the case of illness, the Netherlands features a combined system. For it is possible that the employer will continue to pay (partial) wages to a claimant working under a permanent labour agreement and this employee will not have to apply for sickness benefits. On the other hand, in the case of claimants not permanently employed, the employer will continue to pay wages for a specific period, the claimant afterwards possibly being eligible for a sickness benefit from UWV.

Denmark currently features the shortest sickness benefit term, of 22 weeks. All other countries, except for the Netherlands, pay out sickness benefits for terms ranging from about six months to a year. For example, sickness benefits are paid out for a maximum term of 182 days in Estonia[40], for a maximum term of 300 office days in Finland, and for a maximum term of 350 days in Sweden. The maximum term varies between 6 and 12 months in Iceland. In most countries, this period can be extended where special circumstances apply.

The United Kingdom does not feature a sickness benefit payable after the lapse of the period of 28 weeks during which the employer must continue to pay wages. British claimants unable to work due to sickness or disability after the end of this period can immediately apply for a work disability pension before the period lapses.

In all countries studied, the sickness benefits paid out are based on the previously earned wages. In most cases - Iceland, Sweden, Denmark, Estonia, and the Netherlands - they constitute a percentage of the previously earned wages. Some countries apply income categories. This is the case in Ireland, where the categories are linked to a fixed amount to be paid, and in Finland, which predominantly uses a daily wage based on, inter alia, 70% of the income[41], albeit that a minimum amount has been set. In most of the countries studied, this period focuses on recovery and, where possible, a return to the claimant's job or to similar work. Reintegration into the regular labour market often forms the focus at a later stage of this period.

2.1.2. Procedure after minimum qualifying period: rehabilitation benefit, temporary and permanent work disability pension

After the lapse of any period during which wages are continued to be paid out and of eligibility to any sickness benefit, the countries studied offer a rehabilitation benefit, or a temporary work disability pension (which ends after a certain period, or which requires a reassessment to be conducted). In addition, most of the countries studied can award a permanent work disability pension, in which case, in principle, no reassessments are conducted.

Table 2.3 Benefits/pensions awarded after the minimum qualifying period

	DEN	EST	FIN	IRL	ICE	UK	SWE	NL
Qualifying period	No qualifying period[42]	No qualifying period[43]	52 weeks[44]	52 weeks[45]	26-52 weeks[46]	28 weeks	52 weeks	104 weeks
Rehabilitation benefit possible	Yes	No	No	No	Yes	No	Yes	No
Temporary work disability pension possible	No	Yes	Yes	Yes	Yes	Yes	No	Yes
Term of the work disability pension	Permanent	0.5-5 years, or permanent	Permanent	Varies	1.5 years, or permanent	1-10 years, or permanent	Permanent	0.25 years - permanent
Reassessment	No[47]	Yes	No	Yes	Yes[48]	Yes	No[49]	Yes

Rehabilitation benefit and permanent work disability pension

It is possible for the claimant to first be awarded a rehabilitation benefit before a (semi) permanent work disability pension is granted. During the period the claimant receives the rehabilitation benefit, the focus is strongly on rehabilitation. In some of the countries studied, a permanent work disability pension is only awarded once all reasonable rehabilitation efforts are expended. So as to bridge this period and to support the claimant with their rehabilitation, they may be awarded a rehabilitation benefit. Denmark, Iceland, and Sweden all feature such a rehabilitation benefit. Finland

[40] If the claimant has been diagnosed as suffering from tuberculosis, this period can be extended to 240 days.
[41] Annual income divided by three hundred days.
[42] In Denmark, no qualifying period before an application for a work disability pension can be submitted, exists. To claimants entitled to continued payment of wages (4 weeks) and/or a sickness benefit (22 weeks), it is usually more attractive to first make use of those options.
[43] In Estonia, no qualifying period before an application for a work disability pension can be submitted, exists. To claimants entitled to continued payment of wages and/or a sickness benefit, it is usually more attractive to first make use of those options.
[44] Three hundred work days.
[45] A work disability pension awarded under work disability insurance on the basis of residence, also exists. No minimum qualifying period exists in this case, but the term of work disability must be expected to be at least one year.
[46] Iceland also features a work disability pension awarded to residents who have been resident for at least six months.
[47] A reassessment is only conducted when special circumstances apply.
[48] Only when the work disability pension has been awarded for a limited term.
[49] A reassessment is only conducted if grounds exist to do so.

features a rehabilitation allowance.

Characteristically, the rehabilitation benefit is, in principle, paid out for a flexible term[50], allowing the claimant to rehabilitate for as long as is necessary. This term can be extended multiple times for a longer period, as is for example the case in Denmark, where the assessment includes surveying, with the claimant, what medical or social hurdles exist that keep the claimant from returning to the workforce and what options exist to remove those hurdles. Only once such options have reasonably been expended and it still is not possible for the claimant to return to the regular labour market may a permanent work disability pension be awarded. Depending on the hurdles identified with respect to the claimant, various rehabilitation activities can be scheduled and an associated benefit be awarded. The term of the rehabilitation benefit can be extended depending on the claimant's needs. This process can take multiple years.

In addition to Denmark, Iceland and Sweden also feature a rehabilitation benefit. Finland has imposed a rehabilitation condition before a permanent work disability pension can be awarded. It does not, however, grant a "traditional" rehabilitation benefit. Instead, it awards a temporary work disability pension, with no rehabilitation obligation attached. Nevertheless, the claimant, under certain conditions, may claim a rehabilitation allowance of 33% on top of this temporary work disability pension. The claimant may apply for the allowance when participating in (vocational) rehabilitation activities.[51]

In most of these countries, a rehabilitation benefit is awarded for a certain fixed term and ends after its lapse. No reassessment is conducted, but the claimant can apply for a new rehabilitation benefit. In such cases, the claimant must, upon request, submit (new) information and is subsequently reassessed.

If the claimant in countries that feature a rehabilitation benefit meets the condition of having expended all reasonable rehabilitation efforts yet still lacks sufficient ability to work, a permanent work disability pension may be awarded. No reassessment takes place in this case, for all reasonable options to recover the ability to work have been exhausted.

Temporary and permanent work disability pension

The Netherlands, Estonia, Ireland, and the United Kingdom offer no rehabilitation benefit. In these countries, a work disability pension is applied for immediately after the lapse of the minimum qualifying period. In Iceland, both a rehabilitation benefit and a work disability pension can be applied for. As was mentioned in the above, Finland features a temporary work disability pension with a voluntary rehabilitation component.

In the above-named countries, either a temporary work disability pension, featuring reassessments, or a permanent work disability pension, not featuring reassessments, can be awarded.

The fact that these countries offer a temporary work disability pension instead of a rehabilitation benefit, does not mean that no (vocational) rehabilitation activities are performed or that no (vocational) rehabilitation criteria are attached to the work disability pension. In most countries offering a temporary work disability pension, various rehabilitation activities are conducted during the term of the temporary work disability pension. In the Netherlands, for example, vocational rehabilitation is, to some extent, a condition for the award of a work disability pension. The difference with a rehabilitation benefit is that no flexible period for expending all reasonable rehabilitation efforts, is offered.[52] This means that a vocational rehabilitation requirement applies, albeit during the fixed qualifying period of 2 years.

Some countries award a temporary work disability pension if the criterion of being "permanently" incapacitated for work is not met and expectations are that the situation of the claimant can improve over time. In these countries, (semi) permanent work disability pensions are awarded only if the claimant is to a major degree and permanently incapacitated for work. In such cases, no reassessments take place. This option exists in Estonia, Ireland, Finland, and the United Kingdom. On the one hand, a medical interpretation of the term "permanent" is used, as the diagnosis and prognosis are assessed. On the other, some countries in practice take account of social aspects, like the claimant's age. The younger the claimant, the greater the prospects of increased ability to work in the future. Moreover, a present occupational impairment might not be an impairment in the future, due to technological developments and advancements in medical science.

Temporary work disability pensions may be awarded for the term of a few years. This may be followed up on by a reassessment, or the claimant may need to reapply for a work disability pension, providing (new) information upon request. A new assessment will then take place. Usually, the document stating the decision to award the pension will provide its term or a reassessment date. In Ireland, reassessments take place on the basis of an estimation of which cases a reassessment will be most fruitful for. A prognosis of the level of incapacity for work of the claimant plays a role in this respect.

[50] Such flexible duration is possible because multiple rehabilitation benefits (for various purposes) can follow each other.
[51] The Finnish social security agency (Kela) may offer rehabilitation activities. The pension funds may only offer vocational rehabilitation.
[52] In the Netherlands, a fixed term of two years to meet the vocational rehabilitation criterion applies.

2.2. Degree of incapacity for work: assessment instruments and minimum percentages for a (partial) work disability pension

This section details four aspects related to the degree of incapacity for work. First, the definition of incapacity for work applied in the countries studied. Second, the instruments used to assess the degree of incapacity for work. Third, whether claimants can apply for a partial work disability pension in the countries studied and, should this be the case, how high the level of incapacity for work must be for the claimant to be entitled to this partial work disability pension. Fourth, how high the level of incapacity for work must be for the claimant to be entitled to a full work disability pension.

The below table provides an overview of the assessment instruments and the minimum incapacity for work percentages. Because the definitions of and methods to assess incapacity for work in the countries differ, the percentages applied by the various countries are not comparable, however.

Table 2.4 Assessment instruments and the minimum incapacity for work percentages.

	DEN	EST	FIN	IRL	ICE	UK	SWE	NL
Work disability assessment based on the loss of:	Ability to work	Ability to work	Ability to work	Ability to work	Ability to work	Ability to work	Ability to work	Earning capacity
Assessment instrument	Inter-disciplinary expert opinion & procedural assessment	ICF model and expert opinion	Guidelines, practice of assessment and expert opinion	ICF model	IAS	WCA	DFA	FML, CBBS, expert opinion
Partial work disability pension possible	[53]	Yes	Yes	Yes	Yes	No	Yes	Yes
Minimal incapacity for work % for full work disability pension	Not laid down by law[54]	N/A	60%[55]	N/A	75%	N/A	100%	80%
Minimal incapacity for work % for partial work disability pension	N/A	N/A	40%[56]	N/A	50%	N/A	25%	35%

ICF: International Classification of Functioning, Work disability and Health (ICF) of the WHO; IAS: Invalidity Assessment Standard; WCA: Work capacity assessment; DFA: diagnosis, limitation (funktionsnedsättning), activity restrictions; FML: Functional capacity report (mogelijkhedenlijst); CBBS: Claim Assessment and Monitoring System (Claimbeoordelings- en Borgingssysteem).

2.2.1. Definition of incapacity for work: loss of ability to work or earning capacity

Of all the countries studied, only the Netherlands defines incapacity for work on the basis of the loss of earning capacity. The Dutch system first assesses functional capacity, then a theoretical link to the labour market is made. Next, the difference between the income earned by the claimant in the year before reporting sick and the income the claimant could presently - theoretically - earn when working a suitable job, is calculated.

In all other countries studied, incapacity for work is defined as the loss of ability to work. While this seems to be a uniform definition at first, what this means, exactly, varies between the countries, as the methods and instruments used to assess this loss of ability to work differ, for example. The systems of the countries studied differ on two core aspects.

[53] In Denmark, the claimant can apply for a partial benefit when permanently losing work capacity due to sickness (when working a flexi-job). However, this benefit is not comparable with the full work disability pension. The flexi-job can, for example, also be worked temporarily.
[54] This percentage is not laid down by law. In practice, a specific percentage is (unofficially) applied.
[55] In Finland, this is not presented as a percentage, but as a 3/5 share.
[56] In Finland, this is not presented as a percentage, but as a 2/5 share.

- The degree of protocolisation of the process
  In most of the countries studied, the claimant's functioning is assessed on the basis of a (theoretical) link to the labour market. An assessment is made of what suitable job a claimant could work and of whether the requirements of this job befit the functioning of the claimant. The assessment process may be laid down in laws, protocols, and instruments applied to assess the functioning, such as the mandatory use of a self-report questionnaire. In some countries, the method of assessing the claimant's functioning is not entirely laid down in legislation or protocols, with an expert opinion being sought instead of an instrument to assess the functioning being applied. This difference is not always that clear-cut in practice. Each system to some degree allows for the assessing professional or the professional drawing up a medical certificate in preparation of the work disability assessment to provide their expert opinion.
- Factors like age and geographical environment may also play a part in the method of assessing the level of incapacity for work of a claimant. This may have been laid down in law for specific ages, as is the case in Denmark, for example, where one of the two work disability schemes assesses incapacity to work the current job, instead of incapacity for work in the regular labour market, for claimants who reach state pension age within six years. Age can also be a factor that appears in the expert opinion, for example in the context of assessing whether a claimant is eligible for a work disability pension. The geographical environment may also be included in the expert opinion on the level of incapacity for work, as is the case in Finland, where the question of whether the claimant could find a suitable job in the local environment forms part of the work disability assessment. This, as there are more job opportunities in Helsinki than there are in Lapland, for example. The age component is also considered. The closer to state pension age the claimant is, the lesser the expected flexibility. Younger claimants can be expected to be more flexible and to, for example, travel or retrain in order to work a job. Some countries have not laid down the fact that age or environment may play a part in the work disability assessment in law. However, if the assessor can draw up an expert opinion, the assessor does have the discretion to include environmental factors to some extent.

2.2.2. Degree of incapacity for work: how is it assessed?

This section details the instruments used to assess the degree of incapacity for work of the claimant. The Netherlands heavily relies on protocols in this connection. In some other countries, the assessor draws up an expert opinion. In such cases, the professional assesses the available documentation, may consult with the claimant, and ultimately issues a recommendation on the claimant's ability to work. Countries that do use an instrument for conducting the assessment do leave room for an expert opinion to some degree. Within the systems of the countries studied, there are at least two points in time where an instrument and/or expert opinion can be applied or made use of in the context of the work disability assessment: when assessing the remaining ability to work of the claimant and when linking this ability to the labour market.

We find that the majority of countries do apply an instrument when assessing the claimant's functioning. In the Netherlands, this is the so-called functional capacity report (FML), completed by the insurance physician on the basis of the documents submitted and the information obtained during the interview with the claimant. Similar methods were found in other countries, like Iceland. Some other countries make use of a self-report questionnaire.[57] The reliability and consistency with the medical situation of this questionnaire is verified by the assessing professional in various ways. The results are then related to an assessment system using a points scale. In the Netherlands, the assessment of the claimant's functioning takes place on the basis of the claimant's functional capacity, using the FML. In some of the countries studied, the ability to work is also assessed on the basis of functional capacity or functional limitations. In addition, multiple countries studied have based the assessment instrument on the ICF classification. The International Classification of Functioning, Work disability and Health (ICF) of the WHO is a classification describing people's functioning and the factors impacting it. It describes how people deal with their health situation. Their health is described from a physical, an individual, and a social perspective. The ICF thus also considers environmental factors and goes beyond a sickness analysis. However, the environmental aspect is not always included as a factor in the instruments based on the ICF classification used in these countries.

The Netherlands also applies an instrument when establishing a (theoretical) link between the functioning and the labour market, to wit, the Claim Assessment and Assurance System (CBBS). The CBBS lists job descriptions that contain information about, inter alia, the working environment, the tasks relating to this job, the working hours, the required education and work experience, and the workload. In other countries, this link is sometimes established indirectly, as part of the assessment of the ability to work. Education is, among other things, considered in this connection. In some other countries, the expert opinion of the assessing professional plays an important role in establishing the link with the labour market. In these cases, the assessing professional draws up an advice on the extent the claimant can be expected to be able to work a certain job or within a certain sector. No instrument is applied when doing so. In some countries, the local instead of the national labour market is considered in this connection. In Denmark, this stage usually includes a procedural assessment, which has the claimant working a sort of "practice" job for a regular employer for a number of weeks. Next, an assessment is made by multiple parties, including the claimant and the employer, as to whether the claimant is or is not able to work in regular employment.

2.2.3. Full work disability pension and degree of incapacity for work

In the Netherlands, a claimant can claim a full work disability pension when assessed as being 80% or more incapacitated for work (on the basis of earning capacity).

[57] A questionnaire that has the claimant describe their own situation by answering various questions.

The degree of incapacity for work (based on ability to work) required for a claimant to be able to claim a full work disability pension is different in the other countries studied. The required degree of incapacity for work is expressed in percentages in some countries, like in Iceland, where a full work disability pension can be awarded upon the loss of the ability to work of 75% or more, or in Sweden, where a full work disability pension can be granted upon 100% loss of ability to work. Denmark has not laid down a statutory ability to work loss percentage for awarding a full work disability pension. Nevertheless, in practice, a percentage is sometimes (unofficially) applied when assessing the remaining ability to work once all (reasonable) rehabilitation efforts have been expended by the claimant. In Finland, the loss of ability to work is expressed in the legislation in terms of shares: a full work disability pension can be awarded from the loss of a 3/5 share of ability to work.

Some countries - Estonia, Ireland, and the United Kingdom - do not use a percentage or share of ability to work but express the degree of incapacity in words. Ireland, for example, awards a full pension if the incapacity for work of the claimant is assessed as being "profound".

2.2.4. Partial work disability pension and degree of incapacity for work

In the Netherlands, a claimant can claim a partial work disability pension when assessed as being 35% or more incapacitated for work. Multiple categories exist, corresponding to capacity losses of 35-45%, 45-55%, 55-65%, 65-80%, and 80-100%.

Some of the other countries studied also allow (some of)[58] the claimants to claim a partial work disability pension. In such cases, a part of the full work disability pension is paid out. Generally, the claimant is expected to work in addition to receiving such partial work disability pension and supplement their income from this work. The minimal degree of incapacity for work required to be able to claim a partial work disability pension, varies. In Iceland, this is possible upon 50-75% loss of ability to work. Sweden, like the Netherlands, applies a phased system: a partial work disability pension can be awarded upon an assessed loss of ability to work of 25% or over (25%, 50%, 75%, and 100%). In Finland, a partial work disability pension may be awarded if the loss of the ability to work is between 2/5and 3/5 shares[59]. Ireland awards a partial work disability pension if the loss of ability to work is assessed as "moderate" - in which case 50% of a full pension is awarded - or as "severe" - in which case 75% of the full pension is awarded. In Estonia, too, a claimant can be granted a partial work disability pension. This is possible if no full incapacity on any of the seven ICF-based health domains is scored, but the claimant does suffer from multiple disabilities spread over multiple domains.[60]

In Denmark, the claimant can apply for a partial benefit when permanently losing partial work capacity due to sickness. However, this benefit is not comparable with a share of the full work disability pension. For one, this benefit is temporary in nature, in contrast to the full work disability pension. No partial work disability pension exists in the United Kingdom. The degree of incapacity for work determines whether or not the claimant is required to participate in rehabilitation activities.

2.3. Insurance against incapacity for work and determination of the amount of the work disability pension

This section discusses which groups of people are insured against work disability and the basis for determining the amount of the pension. Refer to the following table, which will be explained in the below.

[58] Some of the countries studied feature both a work disability pension based on residence and a premium-based work disability insurance covering income loss. Even though an insured person paying premiums can often claim a partial benefit, this is not always the case for claimants insured by being resident.
[59] In certain situations.
[60] A points system linked to the severity of the afflictions is applied. Refer to the chapter on Estonia for more information on this calculation.

Table 2.5 Insured persons and pension amount

Country	Incapacity for work based on loss of:	System	Which persons are insured	Pension amount related to	Pension amount in case of full incapacity for work[61]
NL	Earning capacity	Single[62]	■ Employees and insured self-employed persons below pension age	■ Previous income	■ Percentage of previous income
DEN	Ability to work	Single	■ Residents (from 3 years of residence) aged between 18 and pension age	■ Resident percentage from age 15 until the moment of award	■ Fixed amount. A percentage thereof, based on term of residence
EST	Ability to work	Single	■ Residents aged between 16 and pension age	■ N/A	■ Fixed amount
FIN	Ability to work	Dual	■ Residents aged between 16 and 65 ■ Insured employees and self-employed persons aged between 17 and 68/70 who failed to pay sufficient premiums ■ Insured employees and self-employed persons aged between 17 and 68/70 who paid sufficient premiums	■ N/A ■ Previous income and pension accrual, starting from a fixed minimum amount	■ Fixed amount ■ Percentage based inter alia on previous income
IRL	Ability to work	Dual	■ Residents aged between 16 and 66 legally residing in Ireland ■ Employees and self-employed persons [63] aged between 16 and 66 who have (recently) paid a minimum in premiums	■ N/A ■ N/A	■ Fixed amount ■ Fixed amount
ICE	Ability to work	Dual	■ Residents aged between 18 and 66. From six months to one year's residence ■ Insured employees and self-employed persons aged between 16 and 70 Pension fund contribution (from 2 years)	■ N/A ■ Pension premium points	■ Fixed amount ■ Based on pension premium points
UK	Ability to work	Dual	■ Residents aged between 18 and pension age ■ Employees and self-employed persons aged between 18 and pension age who have recently paid premiums	■ N/A ■ N/A	■ Fixed amount ■ Fixed amount
SWE	Ability to work	Dual	■ Residents below pension age (from 3 years' residence) ■ Minimum in (recently paid premiums)	■ Term or residence and age component ■ Percentage of future income	■ Fixed amount ■ Related to 64.7% of calculated future income[64] [65]

2.3.1. Which persons are insured against incapacity for work?

The above table shows that various insurances exist in the countries studied. The Netherlands features a single system. Under this system, all employees and voluntarily insured self-employed persons (either insured with UWV or under private insurance) are insured against work disability. People not belonging to these groups, may claim social assistance. No separate work disability assessment needs to be performed in that case. Estonia and Denmark, too, feature single work disability systems. In contrast to the Dutch system, these systems are work disability insurances based on residence. People who are sick and have resided in the countries concerned for a specific term can claim the work disability pension.

Dual work disability systems exist, as well. Such dual systems are used in Ireland, Finland, Iceland, the United Kingdom, and Sweden. These countries feature both a work disability system based on residence and a system based on premiums paid by employees and self-employed persons below pension age. Under both systems, a work disability assessment must be conducted before a work disability pension can be awarded. Some of the countries studied also

[61] All countries allowing for a partial work disability pension pay out a share of the full work disability pension.
[62] A benefit based on residence does exist for youngsters and students: the Wajong.
[63] Some exceptions exist.
[64] Calculated on the basis of the situation in which the claimant would not be sick.
[65] Refer to Missoc (2022b).

feature a hybrid form, with the pension composed of parts paid out from the work disability pension based on residence and from the work disability pension based on premiums paid. If an employee or self-employed person has paid a premium to be covered by the work disability regime based on premiums, but has not paid enough premiums to be able to live off this work disability pension, the pension based on premiums can be supplemented from the work disability insurance based on residence. The countries with a dual system also feature a form of social assistance in addition to this dual work disability system.

2.3.2. Amount of the work disability pension paid to employees and insured self-employed persons

The way the amount of the work disability pension paid to employees and insured self-employed persons is calculated, differs between the countries studied. It is interesting to consider this in combination with the definition of incapacity for work, as this inter alia shows the effects of the various insurance types. Despite the fact that the countries studied often also feature work disability insurance based on residence, we opted to compare the situation of employees and (insured) self-employed persons. This choice was made because this is most easily compared to the Dutch situation, which has self-employed persons being voluntarily and employees being mandatorily insured against work disability. In concrete terms, this means that, where a dual work disability system exists, we only look at employees and self-employed persons who pay premiums. This applies to Finland, Ireland, Iceland, the United Kingdom, and Sweden. In the case of countries featuring a single work disability system under which all residents are insured against incapacity for work - Denmark and Estonia - we will consider all residents.

- Earning capacity in combination with a percentage of previous income: The Netherlands
  Claimants with the same ability to work but earning different pay can be assessed to come under different work disability categories. For the previously earned wages are also considered when calculating the degree of incapacity for work. This means that a claimant earning lower wages will generally be classified into a lower work disability percentage than a claimant with the same ability to work but earning higher wages. The previously earned wages are once more considered when calculating the amount of the pension. This means that a claimant earning lower wages will be paid lower benefits than a claimant with the same ability to work but earning higher wages. In practice, this means that claimants earning lower wages are, in the Netherlands, less likely to be awarded a work disability pension and that the amount of this pension will be lower.

- Ability to work in combination with a percentage of previous income: Finland and Sweden
  Claimants with the same ability to work are, in theory, assessed as having the same work disability percentage.[66] Income is not considered in this connection. The amount of the pension does differ between claimants with the same work disability percentage, as this is calculated on the basis of the previous and/or "future" income.

- Ability to work in combination with a fixed amount: Denmark, Estonia, Ireland, and the United Kingdom
  Claimants with the same ability to work are, in theory, assessed as having the same work disability percentage.[67] Income is not considered in this connection. The amount of the pension is in principle also the same for all claimants. It is not related to previously earned wages, but is a fixed amount. For various reasons, a part of this fixed amount may be paid in individual cases. This can be based on term of residence, as is the case in Denmark, or on the degree of incapacity for work, as is the case in Estonia and Ireland, where a percentage of the full amount can be paid. Different amounts may also be linked to various degrees of incapacity for work, as is the case in the United Kingdom, where a claimant who is unable to work receives a different pension amount than a claimant who is unable to work and to perform rehabilitation activities.

[66] This may, however, differ on the basis of work experience, education, geographical environment, and age.
[67] This may, however, differ on the basis of work experience, education, geographical environment, social circumstances, and age.

3. Input by the claimant

This chapter details how claimants themselves can directly and indirectly provide input for the work disability assessment. The below table provides an overview; in the following, we will discuss each item separately.

Table 3.1 Types of input by claimants

	DEN	EST	FIN	IRL	ICE	UK	SWE	NL
1. Sickness benefit interview	Yes	Yes	Yes	No[68]	Yes	Yes	Yes	Yes
2. Work disability pension interview	Yes	No[69]	No	No	Yes	Yes	Yes	Yes
3. Self-report questionnaire	Yes	Yes	Optional	Yes	Yes	Yes	Yes	Sometimes
4. Medical certificate from the curative sector	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
5. Report by the rehabilitation team	Yes	No	Sometimes	No	Yes	No	No	No
6. Can additional medical information be requested for?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
7. Is access to an electronic patient file possible?	Sometimes	Yes	Sometimes[70]	No	No	No	No	No
8. Party filing the application	Claimant or case worker	Claimant	Claimant	Claimant	Claimant and doctor	Claimant	Claimant	Claimant

3.1. Interviews

Claimants are able to provide their input on their incapacity for work during the interview held in connection with a sickness benefit, in the phase prior to the application for a work disability pension, and during the interview held in the context of the work disability assessment. Finally, in table 3.2, we for each country zoom in to the professionals: which professionals do claimants have contact with during physical, telephone or digital interviews?

Interview before the application for a work disability pension

The process of information collection usually starts the moment a person becomes sick and is not or no longer able to work. We find that the worker may, in the countries studied, be invited to an interview during the period a sickness benefit is paid out. Both the professional conducting such interviews with the claimant and their purpose differs between countries. An "interview" in this context means an occasion where the claimant and the assessing professional(s) have physical, telephone, or digital contact. We have not limited such an occasion to a specific length of time.

In the Netherlands, the responsibility for coaching and supporting employees is held by the employer and the occupational health service mandatorily engaged[71]. The claimant will have (telephone) interviews with the occupational health service, such with the aim of discussing the progress towards vocational rehabilitation and the recovery options. The vocational rehabilitation coaching can also be provided by UWV. This happens, for example, if the claimant is without an employer. The vocational rehabilitation report covering the first two years of sickness, as drawn up by the employer and the occupational health service, serves as input for the work disability assessment by UWV.

Various countries upon the lapse of the term of the sickness benefit first award a benefit paid out by the social security agency, the aim being to focus strongly on rehabilitation. This is often referred to as a rehabilitation benefit. The

[68] Only if the expected duration of the term of sickness is exceeded.
[69] In 1.5% of all applications, where the quality of the medical data is insufficient or the limitations in functioning indicated are inconsistent, the claimant is invited to an interview by the interdisciplinary team or, in rare cases, by the insurer's medical adviser.
[70] Not an opt-out, but due to direct voluntary action by the claimant.
[71] Arboportaal. Consulted on 15 August 2023 via: Verantwoordelijkheden werkgevers en werknemers | Arbowetgeving (Arbowet) | Arboportaal.

rehabilitation benefit may precede a possible work disability pension. Coaching the claimant is often the task of an interdisciplinary rehabilitation team (Iceland, Denmark) or of the GP (Sweden). The claimant has an interview with the rehabilitation team / GP with the objective of discussing the progress of the situation and make use of all possible rehabilitation options. Countries featuring such a scheme include Iceland, Sweden and Denmark. In these countries and in Finland, all reasonable rehabilitation options must have been exhausted before a work disability pension can be awarded. The period of time between the moment the claimant first reports sick and the application for a work disability pension can therefore be a long one, depending on the situation and what is possible for the claimant.

Some other countries do not focus on rehabilitation in this first period of sickness, or do so to a lesser degree only. In Ireland, for example, a worker who gets sick has to visit the GP for a medical certificate stating a diagnosis. An interview with the social security institution will only be scheduled if the duration of the sickness exceeds the duration estimated beforehand for the specific affliction. The systems used in Estonia and the United Kingdom are comparable. Upon getting sick, the worker has to contact their treating physician for a medical certificate. The medical certificate is sent to the social security ins or employer, after which the sickness benefit can be paid out. The claimant does not have an interview with the social security agency, but will be invited for an (telephone) interview with the treating physician. The period of sickness that must have lapsed before a work disability pension can be applied for, is relatively short in these countries.

Work disability pension interview

In the Netherlands, the interview held in the context of the work disability assessment forms an important moment for the claimant to provide their input. The claimant has an interview with the insurance physician for the purpose of establishing capabilities and limitations. If any ability to work exists, the assessment also includes an interview with an labour expert. The labour expert assesses which work activities the claimant can still perform and what the claimant could earn by performing them.

Some of the countries we studied conduct the work disability assessment by way of a desk assessment. No physical or telephone interviews are in principle held in these cases: the assessment is conducted on the basis of the required documents. Desk assessments are conducted in Ireland, Estonia, and Finland. Only when medical information required for the assessment is lacking or when inconsistencies are found will claimants be invited to an interview in Estonia. This applies to 1.5% of the cases.

Other interview types also exist in the context of the assessment. In Iceland, a claimant can be invited to an interview by a social physician - the doctor performing the assessment - should they deem this necessary. In Sweden, a non-medical professional employed by the social security agency conducts the assessment on the basis of the available documents, followed by a conversation with the claimant, usually held by telephone. In Denmark, the physical interview is conducted by the case worker and an interdisciplinary rehabilitation team. In the United Kingdom, the claimant has a physical or telephone interview with the assessor, who may be a doctor, but can also be another medical professional.

Table 3.2 Focus on the interview: professionals involved

	DEN	EST	FIN	IRL	ICE	UK	SWE	NL
Sickness benefit interview: physical					[72]	[73]		[74]
Sickness benefit interview: telephone					[75]	[76]		[77]
Work disability pension interview: physical		[78]				[79]		
Work disability pension interview: telephone						[80] [81]		[82]

Social physician
Doctor from the curative sector
Medical professional, not a doctor
Interdisciplinary team
Non-medical professional
Not applicable

3.2. Other types of input

A claimant can provide input not only during the sickness benefit or work disability pension interviews, but also in other ways, such as by completing a self-report questionnaire, providing input for the medical certificate by a doctor from the curative sector or the report of a rehabilitation team, and in the request for additional information.

Claimant self-report questionnaire

A number of UWV offices in the Netherlands ask claimants to complete a self-report questionnaire prior to the assessment. Not all offices make use of a questionnaire, however. Their use is not standardised nor laid down by law.

We find that almost all other countries do request the claimant to complete a questionnaire in the context of the work disability assessment. However, this is not always laid down by law. That said, it does often form a crucial part of the assessment and a possibility for the claimant to provide personal input. The way use is made of the questionnaire during the assessment, differs.

Some countries use it for a consistency check, as is the case for Iceland and Sweden. The assessors check if the other documentation submitted for the work disability assessment corresponds to the answers provided by the claimant on the questionnaire.

The questionnaire can also be used to obtain a picture of the situation during the assessment. While it has no decisive force in this case, it does support the assessor in assessing the capabilities and limitations. Denmark makes such use of the questionnaire during the work disability assessment. The questionnaire allows the claimant to indicate their personal wishes and their view on their capabilities. In Ireland, too, the questionnaire is part of the assessment, allowing the claimant to input their education and work experience, medical tests performed, and their physical and mental health. The questionnaire is used as part of the assessment in the United Kingdom, as well, the claimant being able to provide information about their work experience, affliction and medical treatment, and functional limitations.

In Estonia, the questionnaire, together with the medical certificate issued by the treating physician and the medical information, stands at the basis of the assessment. The claimant by way of the questionnaire provides an extensive view of their own physical and mental functioning.

In Finland, the claimant applying for a work disability pension may optionally also complete questions related to their own assessment of their work limitations. The claimant is not obliged to complete these questions. The questionnaire is therefore not an essential part of the work disability assessment.

[72] Only if the expected duration of the term of sickness is exceeded.
[73] This healthcare professional can be a doctor, but this is not a requirement.
[74] Optional: if the claimant's case is processed by UWV, an interview also takes place with a labour expert.
[75] Only if the expected duration of the term of sickness is exceeded.
[76] This healthcare professional can be a doctor, but this is not a requirement.
[77] Optional: if the claimant's case is processed by UWV, an interview also takes place with a labour expert.
[78] In 1.5% of all applications, where the quality of the medical data is insufficient or the limitations in functioning indicated are inconsistent, the claimant is invited to an interview by the interdisciplinary team or, in rare cases, by the insurer's medical adviser.
[79] This healthcare professional can be a doctor, but this is not a requirement.
[80] Ibidem.
[81] The interview can be held by way of a physical meeting, by telephone, or digitally. The mode is selected by way of triage.
[82] Ibidem.

Medical certificate by a doctor from the curative sector

In the Netherlands, medical certificates by a treating physician from the curative sector are not considered in the context of the work disability assessment. The Netherlands significantly differs from the countries studied in this respect. In all other countries studied, the medical certificate from a (treating) physician forms an important part of the assessment. This medical certificate lists information on the affliction(s), limitations, expected term and prognosis, and, in some countries, also an overview of rehabilitation activities performed.

Report by the rehabilitation team

In some countries, a report by the rehabilitation team forms part of the work disability assessment. The report serves to confirm whether all possible and reasonable rehabilitation options that could improve the work capacity of the claimant have been offered and exhausted. In Denmark, the claimant is coached by a case worker and a rehabilitation team during the rehabilitation period. The report by this team forms part of the work disability assessment. The same applies to Iceland: the rehabilitation team involved in the rehabilitation of the claimant provides a report for the assessment. In Finland, too, the rehabilitation report is one of the documents required for the assessment when the claimant has been awarded a rehabilitation allowance.

As was described in the above, Sweden features a similar system, with all reasonable rehabilitation options having to be exhausted before a claimant becomes eligible for a work disability pension. However, in Sweden, the claimant is coached by the GP, meaning the information concerning the claimant's rehabilitation provided before the assessment is not supplied by a rehabilitation team, but by this GP.

Additional medical information

In the Netherlands, additional medical information can, with the consent of the claimant, be obtained from a treating physician. The same system is in use in Iceland, Sweden, Denmark, Ireland, and the United Kingdom.

Some exceptions exist. Medical information may also be directly accessed with the claimant's consent: in Denmark, the social physician in the rehabilitation team can, in addition to requesting the submission of medical information, also request access to the hospital's medical file to view such information. This is possible, for example, if the claimant suffers from multiple afflictions and it is unclear which treatment or treatments are or have been provided. Access to medical information is deemed necessary to arrive at a proper assessment. The claimant grants consent to such access when applying for the work disability pension.

In Estonia, the social physician can access the national electronic medical file of the claimant. This is necessary for conducting the work disability assessment. The claimant grants the social security agency consent to such access when applying for the work disability pension. The social physician may only view documents relevant to the work disability assessment.

In Finland, the medical information required for the assessment can be requested from the relevant treating physician. No separate consent by the claimant is required.

Party filing the application

In the Netherlands, the claimant personally applies for the work disability pension. The same goes for most of the other countries. Help with filing the application and completing the required form can be provided, be it by a professional employed with the social security agency, a treating physician, or an organisation representing claimant's interests and supporting them. Denmark and Iceland allow the claimant to personally apply for a work disability pension, but the likelihood of the pension being awarded is greater when the application is submitted on the recommendation of a case worker (in Denmark) or a GP (in Iceland).

3.3. Analysis

We note differences between the countries when looking at the options available to claimants to provide their input. In the Dutch system, the interview forms an important moment for the claimant to provide their input. Our study has also identified countries where a desk assessment is used to assess work disability, however. In such cases, the claimant has no contact with the assessor. Finland, Ireland, and Estonia conduct the work disability assessment by way of a desk assessment. We find that, in Ireland and Estonia, the self-report questionnaire is an essential assessment component, allowing the claimant to provide extensive input for the assessment, without meeting with the assessing professional. Finland does not make use of a questionnaire by default. However, the claimant is granted the opportunity to describe their (work-related) complaints.

We also find that a medical certificate issued by the treating physician is often among the documents required for the work disability assessment. After the claimant has had an interview with the treating physician, this physician draws up a medical certificate that inter alia states the affliction, the treatments provided, an estimate of the ability to work, and a prognosis. The claimant in this fashion can provide indirect input for the assessment.

In countries that first award a rehabilitation benefit before a claimant is eligible for a work disability pension, we find that a report about this rehabilitation is considered in the context of the assessment. This, too, allows the claimant to provide indirect input for the assessment. No rehabilitation benefit exists in the Netherlands. The vocational

rehabilitation report drawn up on the basis of the first two years of sickness is, however, among the documents to be submitted when applying for a work disability pension.

We find that the weight attached to the various options to provide input in the context of the work disability assessment, varies. This is closely related to what the various countries deem to be the essence of the assessment and to what aspect is considered most important to the work disability assessment. In the Netherlands, great importance is given to the interview. Whenever a questionnaire is used, this is of lesser importance. Countries that do not hold interviews with the claimant attach greater importance to other components. Estonia, for example, does not hold interviews. Instead, the questionnaire, the medical information, and the medical certificate are given major importance. Finland, too, does not hold interviews; nor is a questionnaire completed in every case. Great importance is attached to the medical certificate.

The medical certificate as an information source, does form an important component in a significant share of the work disability assessments. It was found during the interviews that, in some of the countries, the quality and completeness of the medical certificates vary. These countries expend many efforts to improve matters by attaching more specific requirements to the certificate and by discussing the issue with treating physicians.

4. Roles of the professionals

One of the research questions covered by this report relates to the various professionals involved in the work disability assessment. We tried to make it clear which professionals are involved in the work disability assessment and what roles they play in this connection. We discovered that the roles and duties of the professionals varies greatly and have opted to extract a number of core categories from the range: supportive, advisory, assessing, and decision-making. In addition, we have attached an umbrella title or description to the professionals involved, such as "social physician", which is an umbrella term for doctors specialised in insurance medicine / occupational medicine / social medicine. The first section describes the professionals conducting a sickness benefit assessment. Next, the second section details the various roles of the professionals involved in the work disability assessment and resulting decision. Section 4.3, the final section of this chapter, describes how professionals involved in the work disability assessment deal with multimorbidity.

4.1. Assessing professionals in the context of the sickness benefit

In the Netherlands, employers must continue paying (part of) the wages of employees who fall sick for a term of two years before an application for a work disability pension can be submitted. During this period, the employee receives support from the employer and the occupational health service / occupational physician engaged. Some claimants are supported by UWV during this period. This applies to unemployed persons, for example. We find that, in the other countries studied, employers are often involved in the vocational rehabilitation but are not responsible for it.

Some of the countries studied first grant a benefit paid out by a social security agency, such as a sickness benefit, before a work disability pension can be awarded. Monitoring during this period is sometimes conducted by the curative sector, such as the GP. Assessments initiated by the social security agencies or municipalities in the context of a sickness benefit can be performed by non-medical professionals. This is the case in Sweden and Denmark, for example. In Sweden, the claimant is coached by their GP for the duration they receive sickness benefits. Assessments taking place in this period are performed by a non-medical professional: an academically educated employee who has completed a training course provided by the social security agency. This assessment is based on the available documents, such as the medical certificate issued by the curative sector. Similar systems are in use in Iceland and Finland, where non-medical professionals employed by the social security bodies assess the documents required in the context of a sickness benefit.

In Denmark, the assessments during the period sickness benefits are paid out are performed by a case worker employed with the municipal job centre. Usually, this case worker has received academic education, for example in the field of social work. Assessments in Denmark are conducted on the basis of conversations with the claimant. The case worker also assesses what follow-up steps to take in case the sickness absence lasts for longer than the 22 weeks a sickness benefit is paid out: will the sickness benefit be extended, will it be stopped, or will an appointment with an interdisciplinary team for drafting a rehabilitation plan be scheduled with the claimant?

In Ireland, the social physician may conduct an assessment during the period the claimant receives sickness benefits. This takes place only if the a priori expected term the claimant will suffer from the specific affliction is exceeded. In such cases, the social physician will assess whether the claimant is still too ill to work or would be able to work again. If the claimant recovers within the a priori expected term of the sickness, no assessment takes place.

4.2. Professionals involved and the roles they play in the context of the work disability assessment

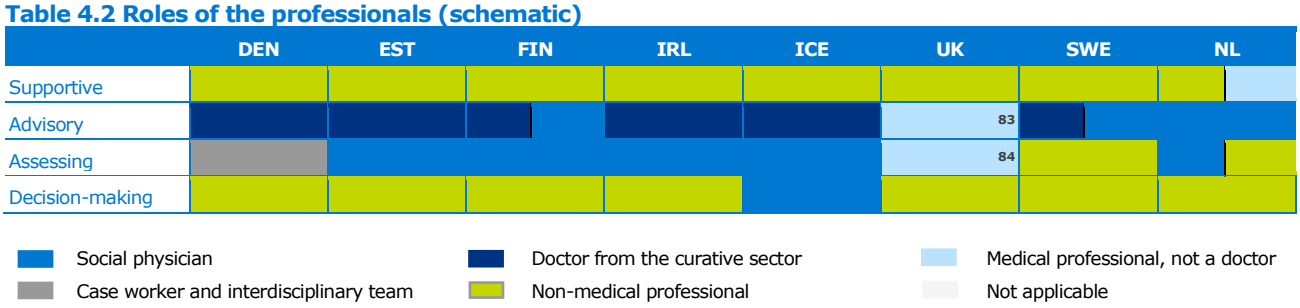
The below tables show the diverse range of professionals engaged in the work disability systems and the roles they play. The titles by which the professionals are known are different in the various countries. For this reason, the second table (Table 4.2) groups the professionals into the following categories: social physician (such as occupational physicians, medical advisers social medicine physicians and insurance physicians); doctor from the curative sector; interdisciplinary team; medical professional not being a doctor; and non-medical professional. These roles have next been explained in more detail. We in each case distinguish between the supporting, advisory, assessing, and decision-making roles.

Table 4.1 Roles of the professionals in the context of the work disability assessment (textual)

	DEN	EST	FIN	IRL	ICE	UK	SWE	NL
Supportive	Case worker	Case manager	Coordinator	Administrative assistant	Administrative assistant	Administrative assistant	Member of staff	TSS/SMN/MS
Advisory	Doctor from the curative sector	Doctor from the curative sector	Doctor from the curative sector / occupational health services	Doctor from the curative sector	Doctor from the curative sector	Doctor from the curative sector	Doctor from the curative sector/insurance physician	Occupational physician
Assessing	Case worker and interdisciplinary rehabilitation team	Medical adviser	Medical adviser	Medical adviser	Social physician	Healthcare professionals	Non-medical professional	Insurance physician/Labour expert
Decision-making	Municipal decision-making official	Work disability assessment specialist	Claim handler	Decision-making official	Insurance physician	Non-medical professional	Decision-making official	Process supervisor

TSS: team support staff; SMN: socio-medical nurse; MS: medical secretary.

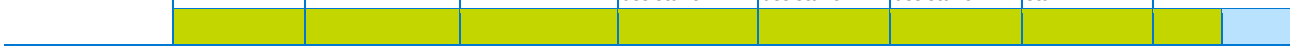
Table 4.2 Roles of the professionals (schematic)



4.2.1. Supportive role

Table 4.3 Supportive professionals

	DEN	EST	FIN	IRL	ICE	UK	SWE	NL
Supportive	Case worker	Case manager	Coordinator	Administrative assistant	Administrative assistant	Administrative assistant	Member of staff	TSS/SMN/MS



In the Netherlands, some of the insurance physicians engage the services of a medical secretary (MS) and/or a socio-medical nurse (SMN). The MS is a non-medical, administrative professional performing supportive activities. An SMN is a professional registered in the BIG online registry for healthcare professionals. This medical professional, who is not a doctor, performs their duties under the responsibility of the insurance physicians and can take over (part of) some tasks, such as holding (part of) interviews and summarising the information obtained. The team performing the socio-medical assessment has recently started receiving support from the team supporting staff (TSS), a non-medical professional performing supporting administrative activities.

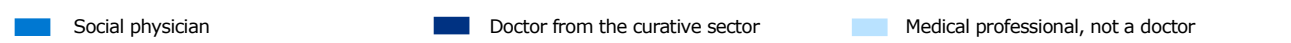
We found that the other countries studied all feature a non-medical professional who plays a supportive role during the assessment. This may be an administrative assistant who checks whether the application is complete. In some countries, non-medical professionals play a larger part in the work disability assessment and may, for example, support the claimant with applying.

[83] This healthcare professional can be a doctor, but this is not a requirement.
[84] This healthcare professional can be a doctor, but this is not a requirement.

4.2.2. Advisory role

Table 4.4 Advisory professionals

	DEN	EST	FIN	IRL	ICE	UK	SWE	NL
Advisory	Doctor from the curative sector	Doctor from the curative sector	Doctor from the curative sector / occupational health services	Doctor from the curative sector	Doctor from the curative sector	Healthcare Professionals	Doctor from the curative sector / social physician	Occupational physician / labour expert



Social physician | Doctor from the curative sector | Medical professional, not a doctor

We found that, in many of the countries studied, a (treating) physician from the curative sector must prepare a medical certificate that is to be submitted when applying for a sickness benefit, for a rehabilitation benefit, and for a work disability pension. This certificate is an essential document and often provides the basis for the assessment. The certificate often lists information about the affliction, the treatments provided, the prognosis, and the occupational impairments. In the United Kingdom, this certificate can also be drawn up by a medical professional who is not a doctor, such as a physical therapist or a nurse. In Finland, the occupational physician coaching the claimant during the first three hundred days of sickness also plays an advisory role in this sense. Assessing professionals may also request advice during the work disability assessment, as is the case in Sweden, for example. The assessing (non-medical) professional may consult with a social physician of the social security agency when conducting the assessment, for example in case anything is unclear or when they need to interpret medical data.

The Dutch system is organized differently. No use is made of a medical certificate in the socio-medical assessment. The guideline of the Royal Dutch Medical Association on the exchange of information provides the basic principle that the insurance physician is to arrive at a well-considered socio-medical opinion and recommendation on the basis of (personal) contact with the claimant.[86] It is possible to obtain additional data from a treating physician, provided the claimant grants their consent. UWV does not by default exchange data with the curative sector.

4.2.3. Assessing role

Table 4.5 Assessing professionals

	DEN	EST	FIN	IRL	ICE	UK	SWE	NL
Assessing	Rehabilitation team	Social physician	Social physician	Social physician	Social physician	Medical professional	Non-medical professional	IMA and OC

Social physician | Case worker and interdisciplinary team
Medical professional, not a doctor | Non-medical professional

The level of incapacity for work is in the Netherlands first assessed by an insurance physician. This is followed up on by an assessment by an labour expert, who is a non-medical professional. In some of the countries studied, the work disability assessment is performed by either of these two professionals, or by a social physician, or a non-medical, academically educated professional.

In Estonia, Finland, Iceland, and Ireland, the work disability assessment is conducted by a social physician. The social physician in Estonia, Finland, and Ireland conducts the assessment on the basis of a desk assessment. This means that the social physician does not, in these countries, meet with the claimants, such in contrast to the insurance physician in the Netherlands. In Iceland, the social physician may invite the claimant to an interview. This is not always held, however. For example, no meeting is held with the claimant in case of a serious affliction where it is clear that the claimant has no ability to work. The same applies to the United Kingdom.

In Sweden and Denmark, the work disability assessment is performed by a non-medical professional. We found that, in Sweden, a non-medical, academically educated employee of the social security agency performs the assessment on the basis of the medical certificate issued by the treating physician. In Denmark, the assessment is conducted by a case worker and an interdisciplinary rehabilitation team, which are the same professionals provide general coaching to the claimant during the rehabilitation period. This interdisciplinary team is composed of both medical and non-medical professionals, including a social physician employed by the regional hospital (who is responsible for rehabilitation interventions at the hospital) and various representatives from the employers' sector, social sector, municipal health

[85] This healthcare professional can be a doctor, but this is not a requirement.
[86] Refer to the guideline of the Royal Dutch Medical Association (2022).
[87] This healthcare professional can be a doctor, but this is not a requirement.

department (which is responsible for the rehabilitation interventions outside of the hospital), and, sometimes, a representative from the educational sector. The composition of the team is not laid down in law. It may be composed of doctors, occupational therapists, social workers, nurses, care assistants, company advisers, or school advisers. The case worker involved - who is a non-medical professional - directs the preparation of the rehabilitation plan.

Various medical professionals can be responsible for performing the assessment in the United Kingdom. In some cases, it is conducted by a doctor, but it may also be performed by a nurse, a physical therapist, an occupational therapist, or a psychologist.

4.2.4. Decision-making role

Table 4.6 Decision-making professionals

	DEN	EST	FIN	IRL	ICE	UK	SWE	NL
Decision-making	Municipal official	Work disability assessment specialist	Claim handler	Decision-making official	Social physician	Non-medical professional	Decision-making official	Process supervisor

Social physician Non-medical professional

In most of the countries, the final administrative decision is taken by a non-medical professional. Often, this is a professional from a legal or administrative background, who verifies whether the recommendation given by the assessor is in line with the applicable legislation. Iceland forms an exception: here, the decision is taken by the insurance physician.

The professional making the decision may deviate from the opinion given by the assessing professional. In some countries, like the Netherlands, the decision is predominantly an administrative one: is the assessment a correct one, given the appropriate legal frameworks? In Iceland, the decision-making professional consults all available documents and may, on the basis of the information therein, deviate from the opinion of the assessor. The Irish decision-making professional, too, may deviate from the opinion of the assessing professional. However, such deviation is not based exclusively on administrative grounds, for the decision-making professional considers both the medical certificate supplied by the treating physician and the assessment made by the social physician and then decides whether to agree to the work disability assessment. This decision by the decision-making official is a binding one. Things are different in Denmark and Estonia: if the decision-making professional disagrees with the assessor, the case is resubmitted to the rehabilitation team (Denmark) or the medical adviser (Estonia).

4.2.5. Highlight: the rehabilitation team, the social physician, and the non-medical professional

The rehabilitation team

Our study shows that the claimant is coached by a rehabilitation team during the rehabilitation period in some countries, to wit, Denmark, Finland, and Iceland.

The Danish case worker and interdisciplinary rehabilitation team are also responsible for performing the work disability assessment. We found that the rehabilitation team is composed of various professionals, both medical and non-medical. This allows for providing tailor-made services: depending on the claimant's situation and capabilities, those interventions that are most appropriate at the time are deployed, be it medical treatment or vocational rehabilitation-focused interventions. The case worker, rehabilitation team and the claimant jointly discuss the substance of the rehabilitation plan. The professionals involved all provide input on the basis of their own expertise.

The social physician

The social physician, or the occupational physician / insurance physician, plays an important role in the work disability assessment in the Netherlands. We over the course of our study noted comparability's and differences as to the role played by the social physician. This section specifically describes the roles of the social physician.

Table 4.7 Roles of the social physician

	DEN	EST	FIN	IRL	ICE	UK	SWE	NL
Supportive								
Advisory								
Assessing								
Decision-making								

Social physician Not applicable

The social physician plays various roles. In the Netherlands, the occupational physician coaches the claimant during the first two years of sickness and draws up a rehabilitation report covering this period. The occupational physician therefore plays an advisory role in the context of the work disability assessment. In Finland, an occupational physician of an occupational health service coaches the claimant during the period they receive a sickness benefit - which, in the Finnish case, is paid out over the first three hundred days of sickness. The Finnish occupational physician also plays an advisory role in the context of the work disability assessment.

In the Netherlands, the social physician (insurance physician) conducts the assessment together with the labour expert and has (physical) contact with the claimant in this connection. The social physician is responsible for the assessment in four other countries. In Estonia, Finland, and Ireland the social physician does so by performing a desk assessment. In Iceland, too, the assessment is conducted by a social physician, who may invite the claimant to an interview.

The social physician may also serve an advisory role, as is the case in Sweden, for example. Whenever the non-medical professional finds that something is unclear when performing the assessment, they may ask the social physician for advice.

The social physician may also play a decision-making role. In Iceland, the final decision about whether or not a work disability pension is to be awarded, is made by the insurance physician.

We also found differences as concerns the education of social physicians. In the Netherlands, insurance medicine is a certified four-year study programme. Students who have completed their studies in general medicine can, in principle, immediately start the advanced insurance medicine programme. This Dutch situation differs from that in the other countries studied. In many of the other countries - such as Sweden, Ireland, Finland, and Estonia - the social physician was already employed as a medical specialist before following a social physician training course. The social physicians also often remain partially employed as a doctor in the curative sector. Whenever the social physician has previously worked as a medical specialist, we find that the social physician training course is relatively short. In Ireland, for example, the initial supplementary training course takes six weeks; in Sweden, it lasts six months.

The social physician plays a less prominent role in the context of the assessment in some of the countries. Various medical professionals can be responsible for performing the assessment in the United Kingdom. This does not necessarily have to be a (social) physician.

In Denmark, a social physician is part of the interdisciplinary rehabilitation team coaching the claimant during rehabilitation. The rehabilitation team's social physician determines whether a clear diagnosis has been established and whether the correct treatments are provided. They may also render advice on further treatment to be provided in order to improve the claimant's ability to work and can offer guidance on whether vocational rehabilitation interventions may intersect with this treatment or not.

The non-medical professional

The non-medical professional during our study was found to play various roles. In the Netherlands, non-medical professionals play supportive and assessing roles in the context of the work disability assessment and are responsible for making the final decision on whether to award a work disability pension.

Some of the countries studied first award a sickness benefit for a certain period, before a work disability pension can be applied for. We found that, in Sweden, Denmark, Iceland, and Finland, non-medical professionals of the social security agency independently perform the sickness benefit assessments. Such professionals are often academically, but not medically, educated and have completed a training course provided by the social security agency.

Non-medical professionals are often found to play supportive, assessing, and decision-making roles in the work disability assessment. They often provide administrative support and sometimes help claimants with completing their application in a supportive capacity. In the Netherlands, the assessment is partly performed by a non-medical professional, the labour expert, who assesses which work activities the claimant can still perform and what the claimant could earn by performing them. In Sweden, the work disability assessment is performed by an academically educated non-medical professional. This non-medical professional can, if need be, ask a social physician for advice. However, the non-medical professional remains primarily responsible for the assessment. In Denmark, the assessment is performed by an academically, but not medically, educated case worker and a rehabilitation team, which is partly composed of non-medical professionals. In almost all countries, the final decision is taken by a non-medical professional. The exception is Iceland, which has an insurance physician make the decision.

4.3. Multimorbidity

The population of people suffering from chronic afflictions in the Netherlands is increasing due to ageing. In addition, people more often suffer from multiple chronic afflictions, or multimorbidity.[88] This is also evident from the Trend Scenario of the Dutch National Institute for Public Health and the Environment.[89] The percentage of persons registered with their GP as suffering from two or more chronic afflictions will increase from close to 25% in 2015 to 30% in 2040. These figures cover the entire Dutch population, including people above state pension age. Nevertheless, multimorbidity is increasing among all age groups, including among people of working age.

Multimorbidity may also play a role in the context of the work disability assessment. We have provided attention to the matter during the interviews. We asked the interviewees from the various countries how they, in their work disability systems, deal with multimorbidity and whether this issue requires a different approach with respect to the work disability assessment.

In the Dutch system, the insurance physician makes use of the Functional Capacity Report (FML) when performing the work disability assessment. This tool allows the insurance physician to assess the capabilities and limitations of the claimant. For completing the FML, it is irrelevant whether the capabilities and limitations of the claimant are the result of one or more diagnoses. In the countries studied, as well, we find that the assessment is not conducted differently if a claimant suffers from multiple diagnoses.

We also find that, in those countries where a medical certificate from the treating physician is considered as part of the work disability assessment, multiple certificates may be required in case of multiple diagnoses. This is not always the case. Where a treating physician is involved who maintains a full overview of the claimant's medical situation, such as a GP or an occupational health service, a single medical certificate may suffice in the case of multiple diagnoses, as well.

[88] Refer to Rijken and Korevaar (2021).
[89] Refer to the National Institute for Public Health and the Environment, Ministry of Health, Welfare and Sport (2018).

5. Data protection

Seven of the eight countries studied have to take account of the General Data Protection Order (GDPR) and national data protection legislation at multiple occasions during the work disability assessment procedure. Denmark, Estonia, Finland, Ireland, the Netherlands, and Sweden are European Union (EU) Member States and have to comply with the provisions of the GDPR. Iceland, being a member of the European Economic Area (EEA), must also comply with the GDPR. The United Kingdom is neither a member of the EU, nor of the EEA, and does not have to take account of the GDPR in the context of the work disability assessment procedure. The way the European countries deal with data protection, varies.[90] This chapter discusses a number of these differences and their causes.

The GDPR was adopted and signed by the European Parliament and the Council of the European Union in April 2016 and entered into force in May of that same year. As from 25 May 2018, the GDPR has direct applicability in all EU Member States. The Netherlands has effected national implementation of the GDPR by way of the General Data Protection Regulation (Implementation) Act (UAVG).The Regulation serves to safeguard two interests: the protection of natural persons in connection with the processing of their data and the free movement of personal data within the EU.[91] The Regulation provides that the right to the protection of personal data is not an absolute right and that the principle of proportionality applies: the right to data protection must be considered in relation to its function in society. The right to the protection of personal data must be balanced against other fundamental rights.[92]

Six lawful bases for the processing of data apply to the processing of regular personal data, like a person's name, address, and telephone number. These lawful bases serve as the conditions for processing personal data. Two of the bases applied by UWV are: "The data subject has given consent to the processing of his or her personal data for one or more specific purposes" and "Processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller". However, stricter requirements must be met to process special categories of personal data, such as data concerning health.[93] For the processing of data concerning health is prohibited in principle. Article 9 of the Regulation provides when the processing of such data is legitimate. Some of the statutory exceptions to the prohibition of the processing of special categories of personal data include:

- The data subject has given explicit consent to the processing of their personal data.
- Only when enshrined in law: Processing is necessary for the purposes of carrying out the obligations and exercising specific rights of the controller or of the data subject in the field of employment and social security and social protection law.
- Only when enshrined in law: Processing is necessary for reasons of substantial public interest.
- Only when enshrined in law: Processing is necessary for the purposes of preventive or occupational medicine. Such as the assessment of the working capacity and/or the provision of healthcare.[94]

For the processing of special categories of personal data to be allowed, the processing must be based on at least one legal basis and one statutory exception.[95] In addition, the GDPR requires persons processing data concerning health for these purposes to maintain confidentiality.[96] UWV meets this requirement by imposing a duty of confidentiality on all its staff. This is laid down in the Dutch Work and Income (Implementation Organisation Structure) Act (Wet SUWI).[97]

5.1. EEA countries and the GDPR: room for variance

The GDPR is in force in all seven EEA countries we studied, i.e., in Denmark, Estonia, Finland, Iceland, Ireland, the Netherlands, and Sweden. Even though the nature of the Regulation is such that it must, in the main, be directly implemented in the Member States, some room for national legislation is left with respect to specific subjects, as becomes apparent from the above-named statutory exceptions. Of note in this context is the condition "only when enshrined in law". In addition, room exists for Member States to specify certain aspects in greater detail.[98] This also applies to the statutory exceptions to the prohibition against the processing of special categories of personal data. The GDPR furthermore applies "open norms" like necessity and proportionality, providing room for laying down more specific national regulations on certain aspects.[99] In addition, Member States are free to introduce supplementary data protection legislation. These elements results in a varied privacy legislation landscape within the EEA.[100]

[90] Refer to Association of European Border Regions (2021).
[91] Refer to Schermer et al. (2018).
[92] General Data Protection Regulation. Consulted via https://eur-lex.europa.eu/eli/reg/2016/679/oj.
[93] Refer to the Dutch Data Protection Authority. *Grondslagen AVG uitgelegd.*
[94] Ibidem.
[95] Ibidem.
[96] General Data Protection Regulation, Article 9.3.
[97] Work and Income (Implementation Organization Structure) Act, Section 74.
[98] Refer to Association of European Border Regions (2021).
[99] Refer to Winter, H. et al. (2022).
[100] Refer to Association of European Border Regions. (2021).

5.1.1. Professional action in the context of the socio-medical assessment: national legislation

Which professionals perform the work disability assessment, and which professionals are allowed to access or process special categories of personal data, is determined by national law. In the Netherlands, national law provides that anyone not being an insurance physician may not independently conduct a socio-medical assessment. The Dutch Data Protection Authority has also informed UWV of that fact. The assessment has to be conducted by an insurance physician or by an employee acting under the responsibility of an insurance physician. "Normal staff" are, according to the GDPR and the UAVG, allowed to independently process other data, however.[101] [102] An insurance physician (or a "normal" employee acting under their responsibility) will conduct the functional limitations assessment and a labour expert - a non-medical professional - will next assess if the insured person is capable of performing (common) general work.

We found that, in some of the EEA countries we studied, some non-medical professionals are also allowed to access special categories of personal data or to independently conduct the assessment, both in the preliminary stage (sickness or rehabilitation benefit) and during the work disability assessment.

During the assessment for a sickness or rehabilitation benefit prior to the application for a work disability pension:

- Denmark and Sweden: A non-medical professional conducts the assessment, also on the basis of medical information provided by the curative sector
  In Denmark and Sweden, the limitation or sickness is established by a (treating) physician. The diagnosis and other relevant information, including the prognosis and functional limitations advice, are laid down in a medical certificate. This certificate is forwarded to the responsible implementing organisation (the municipality and Försäkringskassan, respectively) with the express consent of the claimant.[103] Once this has happened, contact (in person or by telephone, respectively) between the claimant and a non-medical, academically educated professional is scheduled. This non-medical professional next, on the basis of the medical information and information provided by the claimant, independently assesses whether the claimant meets the criteria for a sickness or rehabilitation benefit. This professional does not act under the responsibility of an insurance physician or a social physician.
- Estonia: A treating physician or GP conducts the assessment
  In Estonia, the sickness benefit assessment is conducted by the GP. A medical document is drawn up on the basis of an interview, either by telephone or in person. This document is directly forwarded to the implementing organisation (Tervisekassa) responsible for the administrative decision by a non-medical professional. While the assessment is conducted by a doctor, this is not a doctor specialised in social medicine. Too, the assessment is performed within the curative sector, not by the social security agency.

During the work disability assessment:

- Sweden: A non-medical professional conducts the work disability assessment
  In Sweden, the work disability assessment, too, is performed by an academically educated non-medical professional. This assessment is based on a medical certificate and information provided by the claimant. Advice can in the context of the assessment be obtained from a social physician. This physician plays an advisory role and is not responsible for the assessment. The non-medical professional is the ultimately responsible assessor.
- Denmark: Interdisciplinary rehabilitation team with shared responsibility
  As has already been described in the above, a limitation or sickness is established by the treating physician. The medical certificate can be forwarded to the relevant municipal authorities upon request. The assessment is then conducted by a case worker and an interdisciplinary rehabilitation team composed of medical (doctors and non-doctors) and non-medical professionals. The team members have shared responsibility for the assessment. If at least one team member indicates that rehabilitation options are still available from the perspective of their field, no work disability pension is awarded. Certain professionals are allowed to access medical information. The social physician, for example, may base their opinion on whether specific rehabilitation activities can be recommended for the claimant on the medical information.

5.1.2. Provision of data from the curative sector

The processing of data concerning health covered by medical confidentiality in the Netherlands is not governed only by the GDPR and the UAVG, but also by legislation on medical confidentiality.[104] Doctors are, in principle, prohibited form sharing data entrusted to them by a patient in the practice of their profession, unless the data subject expressly consented to the sharing of data concerned.[105] The treating physician may, under medical confidentiality, only provide such data to the insurance physician to the extent the data subject has granted their permission to do so. UWV facilitates this process by asking the claimant to sign a form granting the treating physician consent to provide their data to UWV's insurance physician. Such consent allows the treating physician to break medical confidentiality. However, occupational physicians are obliged by law to provide relevant data to the insurance physician. This means a legal basis exists and the claimant's consent is not required.[106] One striking difference between the Netherlands and most other countries is that, should the claimant not grant consent to provide information from the curative sector to UWV, a work disability assessment must still take place. In most other countries, no assessment can be conducted when insufficient medical information is available; the award of a pension may even be prohibited should such information be lacking.

[101] Refer to UWV (2020).
[102] Refer to the Dutch Data Protection Authority (2017).
[103] The interviewees indicate that claimants capable of granting consent never, or only very rarely, fail to do so.
[104] Refer to UWV (2020).
[105] Section 88 of the Dutch Individual Health Care Professions Act and Section 7(1) of the Dutch Civil Code.
[106] Section 54(3) of the Work and Income (Implementation Organisation Structure) Act.

This means that the claimant's decision whether to grant consent to the assessing body having access to medical data, is not always free of consequences. The decision not to do so may result in no assessment taking place and no pension being awarded.

Medical certificate issued by the curative sector

Except for the Netherlands, all EEA countries studied require a medical certificate for the work disability assessment. This certificate is drawn up by a treating physician or a doctor of the occupational health service and often at the least contains a diagnosis and prognosis. It also regularly contains an estimate or recommendation on the impact the sickness or limitation established has on the claimant's ability to work. The claimant often personally submits this document to the assessing organisation, or grants consent to share the document with the assessing organisation.

Additional medical information: documents and access to the file

Claimants are in multiple studied countries asked to submit medical information to the assessing body themselves, in addition to the medical certificate. Consent to grant the assessor (partial) access to the electronic medical file may also be requested. The EEA countries studied allow for requesting (relevant) medical information from the treating physician. This is done either directly with the express permission by the claimant or indirectly, via the claimant. In the latter case, the claimant will themselves contact the treating physician. The claimant or treating physician will then submit the medical information to the assessing body.

In Estonia, the assessor, who is a social physician also employed in the curative sector, has access to the electronic medical file of the claimant. The claimant is asked to grant express consent to such access when filing the application.[107] The electronic file logs who has accessed what data at what times. This is visible to the claimant. In Denmark, too, one of the assessing professionals (the social physician from regional hospital) can access an electronic medical file with the claimant's permission.

In line with the Regulation, assessing physicians in Estonia and Denmark may only inspect relevant medical information and can only access this information: it may not be downloaded. The consent to access medical information is often renewed once a year and can be expanded if necessary.

5.1.3. Statutory exceptions

The insurance physician and UWV staff do not process medical data on the legal basis of consent, but on the legal basis of the processing being necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller.[108] In view of medical confidentiality, for the curative sector to be allowed to provide medical information, the claimant's consent is required.

This is also the case in the other Member States studied. Some of these Member States do not make a strict distinction between the curative and assessing sectors. These states often listed both legal basis: 1. The claimant was asked to grant express consent to access the medical information; 2. The information is necessary for the performance of a statutory obligation and/or task carried out in the public interest or in the exercise of official authority: the performance of a work disability assessment. Moreover, in some of the countries studied, it is prohibited to arrive at a decision on the work disability pension if insufficient medical information is available, except for the decision that the claimant is to file a new application after visiting the relevant doctor.

5.2. United Kingdom

The United Kingdom is neither a member of the EU, nor of the EEA, and does not, therefore, have to comply with the GDPR. Data protection is handled with care here as well. Except for the submission of a medical certificate - the "fit note" - the exchange of data with the curative sector is limited. If additional information is required for the assessment, this is usually retrieved via the claimant. In some cases, the curative sector is contacted directly. This requires the claimant's consent.

[107] The interviewees indicated that they have never had a claimant who refused to grant their consent.
[108] Refer to UWV (2020).

6. Reflection

6.1. Reflection on the results

We conducted this study with the objective of discussing the structure of the work disability systems in various countries. We in this connection draw no conclusions on the practical implementation of the schemes applied in the countries studied. This means that deviations from our findings are possible in practice. We studied the work disability criteria applied, the input by the claimant, the professionals involved in the work disability assessment, and the roles they play in this connection. We also paid attention to multimorbidity and the GDPR. UWV on the one hand is facing difficulties performing socio-medical assessments due to the mismatch between the total number of assessments applied for and the available capacity. Both UWV and the OCTAS committee are looking into various solutions for the work disability system in place in the Netherlands. In addition, a desire to increase the input of the claimant in the work disability system exists. The purpose of this description is to provide inspiration and to show that various ways of assessing capacity for work exist, different in terms of what professionals are involved, what roles they play, and how the claimant provides input.

It became apparent that the performance of socio-medical assessments is or was under strain in some other countries, as well. This study may provide inspiration on how to cope with this strain, how to deploy other professionals, how professionals can be deployed differently, and whether the claimant can be involved in another ways. Ireland is an example of a country that had been facing difficulties with conducting socio-medical assessments. Ireland then implemented the desk assessment, to replace the interview in person. The United Kingdom, too, was facing a mismatch. It solved the issue by allowing a medical professional who is not a doctor to perform the assessment.

Although many of the process steps in the work disability assessments are similar in the countries studied, the Dutch situation differs somewhat in multiple other aspects. One example is the position taken by the insurance physician and the length of the training programme. In almost all the countries studied, the social physician is a medical specialist employed in that capacity in the curative sector while also serving as a social physician. The associated training course in the main takes three to six months. The Netherlands features a four-year training programme, which is to be followed after having completed medical school. This significantly deviates from the situation in the other countries studied where the social physician was already employed as a medical specialist before following a social physician training course. In all other countries studied, a medical certificate issued by a treating physician from the curative sector is a default component of the work disability assessment. While this is not the case in the Netherlands, the report drawn up by the occupational health service / occupational physician is. Major importance is given to the interview (in person) in the Netherlands, while some other countries make use of a desk assessment and deploy questionnaires. One final difference is that the Netherlands is the only country among those studied that conducts the work disability assessment on the basis of a calculation of the loss of earning capacity. All other countries studied assess (in)capacity for work on the basis of the loss of ability to work.

This study is not a study into effectiveness. Our report does not, for example, reflect the effect the various criteria applied by the various countries in their systems has on the number of people receiving work disability pensions. Nor does the report indicate how many social physicians are available compared to the population size and/or whether other countries, too, are facing mismatches. It is challenging to compare countries on the basis of figures on (in)capacity for work. Because of the different structures of the work disability systems and the diversity in the context countries are operating in, comparative work disability percentage figures may show a skewed picture. We did include information about the amount of the work disability pension in our report, for example. However, in order to interpret the amount of the pension and the differences between countries, information should also be provided on, for example, average wages within a country, purchasing power, and other possible allowances available to the claimant. We cannot, on the basis of our study, arrive at any conclusions on the effectiveness or costs of the systems described. The description serves to provide inspiration and ideas on how to organise work disability criteria, the involvement and roles of the professionals, and the input by the claimant differently.

6.2. Reflection on the realization of the results

A total of eight countries were studied over the course of this project. We strove to investigate a wide range of work disability systems. There are of course other countries, not included in the present study, that could provide interesting insights.

In order to describe the work disability systems in use in the countries studied, we conducted desk research, submitted questionnaires, and held interviews. After processing, the information was also submitted to the interviewees for a consistency check. As was also described in the strategy section, the number of interviews held was limited in some of the countries studied. It did not always prove possible to schedule multiple interviews in each country. In such cases, much information was obtained from the completed questionnaires. The questionnaire addressed the options available to claimants to provide their input at length. In addition, attention was paid to checking consistency between the

information retrieved from the three methods (desk research, questionnaires, interviews). This information was combined and submitted for a consistency check to the professionals concerned.

All information processed - as provided in the following chapters on the individual countries - was submitted to the interviewees. In addition, additional substantive questions were asked for each of the countries on multiple occasions, so as to present the information as completely and correctly as possible. Nevertheless, we cannot guarantee the completeness of the information obtained.[109]

We found the questionnaires and interviews with experts to be very valuable, in particular in connection with obtaining the information described. In addition, the consistency checks were of great value in verifying the accuracy of the information obtained. Over the course of the study, we found that some of the information laid down in the literature was (partially) incorrect or outdated. The desk research we conducted prior to holding the interviews was sometimes corrected during said interviews. Conducting interviews with professionals and experts on the different topics studied was therefore of major value to our study.

6.3. Follow-up study

This study has identified multiple aspects that may be interesting for a follow-up study. A study into whether other options exist in the Netherlands to offer a (vocational) rehabilitation benefit would, for example, be interesting. Various countries studied focus heavily on rehabilitation, which is a joint effort by the curative sector and the social security agency or municipality. It would be interesting to conduct further research into the rehabilitation interventions they deploy, the professionals and parties involved, and the structure of this cooperation. In addition, a study into the impact of the focus on rehabilitation on claimants no longer requiring a pension, the well-being of claimants, and the ultimate cost for society, would be interesting.

We over the course of the study have also noted differences in the way claimants are involved in the assessment. For example, the assessment could include an interview or consist of a desk assessment, while claimants in some countries complete a self-report questionnaire, but not in others. A follow-up study could focus on the experiences with these forms of input: How does the claimant experience their involvement with the assessment when these various forms of providing input are offered, what are best practices, and how does the use of other forms impact the workload of the professionals and the waiting times?

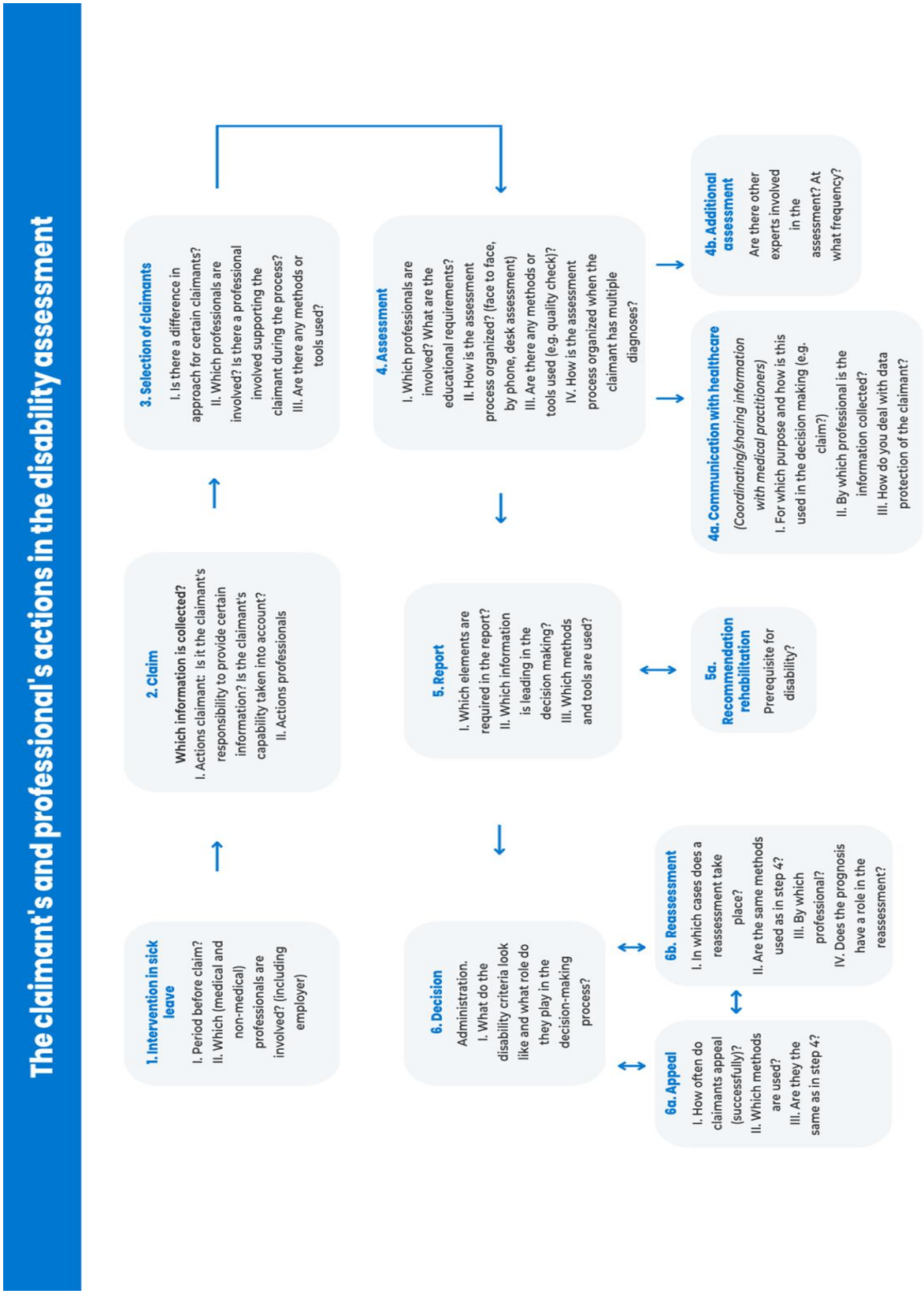
The study shows that the Netherlands differs from the countries studied in various aspects. These aspects offer starting points for follow-up studies. It could be interesting, for instance, to investigate what role the curative care sector could play in the context of the work disability assessment. Too, among the countries covered by this study, the Netherlands is the only one assessing (in)capacity for work on the basis of the loss of earning capacity. Other countries applying this basis include France and Switzerland. It could be interesting to study how work disability assessments are conducted in these countries and what experiences have been obtained in this connection.

6.4. In conclusion

In the present report we provide an extensive description of the work disability systems in use in eight countries. We studied the work disability criteria applied, the ways by which claimants could provide their input, the professionals involved and the roles they play, multimorbidity, and data protection. We find that the Netherlands differs from the other seven countries examined over the course of this study in a number of aspects, such as the use of a medical certificate issued by the curative sector, the length of the training programme followed by the social physician, the assessment on the basis of earning capacity instead of on the basis of a loss of ability to work, the structure of the interview, and data protection. In addition, the individual country reports describe the various steps in the system concerned, from the moment of reporting sick to the work disability assessment, possible objections and appeal procedures, and reassessment. We in the light of the approach and study strategy opted for not drawing any conclusions on the effectiveness or costs of the systems studied. The information obtained provides inspiration and shows how other systems contrast to the Dutch one, giving pointers for follow-up research, which may contribute to reducing the mismatch existing in the Netherlands.

[109] Unfortunately, no response was received to the request for a consistency check made to the United Kingdom. This means that some caution must be observed with respect to the description of the United Kingdom's system.

Annexe I Interview guideline: Work disability assessment from application to award[110]



[110] The interview guideline was based on the work disability schedule provided by de Boer et al. (2007).

Annexe II Work Disability assessment questionnaire: Work disability criteria, claimant input, and professionals

Thank you for taking the time to fill-out this questionnaire. Recently UWV (Dutch institute for employee benefit schemes) has set the main priority on finding solutions for the mismatch on the number of clients needing a disability assessment versus the availability of professionals who can perform this assessments. As part of a study on the disability assessment procedure for invalidity/disability pensions within various social security systems in Europe, we have studied the disability assessment procedures of 13 countries. We have selected 8 of those countries for more in-depth research: Belgium, Denmark, Estonia, Iceland, Ireland, Finland, the United Kingdom and Sweden. This questionnaire is adaptive: you can skip certain questions if they are irrelevant to your situation. You can answer the yes or no questions by colouring in the small square boxes or by removing the answer that does not apply to the situation in your country.

If you have any questions, please contact Djoeke Petter (djoeke.petter@uwv.nl) or Marije Masereeuw (marije.masereeuw@uwv.nl).

Disability assessment for invalidity/disability pension

1. Which criteria is the assessment of disability or invalidity based on? Please specify the job titles and roles of the professionals involved in this process.

2. Is a self-report questionnaire used in the assessment procedure?

☐ No ▸ Please go to question 3.
☐ Yes ▸ Please answer the following sub questions (a.-g.) if possible.

a. When is it used in the process?

b. What are the clients' answers used for?

c. What role does the questionnaire play in the (definitive) assessment? (Is it supportive or decisive or other?)

d. What is/are the objective(s) of the questionnaire?

e. Is any documentation on the design of the questionnaire publicly available?

☐ No ▸ Please go to sub question f.
☐ Yes ▸ Could you please explain how the questionnaire has been designed?

f. Is the questionnaire adaptive?

☐ No ▸ Please go to sub question g.
☐ Yes ▸ Please elaborate on how this adaptivity is integrated into the questionnaire.

g. Could you perhaps send a copy of the questionnaire?

3. Is an interview with the client part of the assessment procedure?

☐ No ▸ Please go to question 4.
☐ Yes ▸ Please answer the following sub questions (a.-g.) if possible.

a. By whom is the interview being held?
☐ Medical professional, please specify the title of the job function below.
☐ Non-medical professional, please specify the title of the job function below.
☐ Other… please specify the title of the job function below.

b. In what manner are the interviews conducted? I.e.: in person, through video calls, over the telephone.

c. What are the educational requirements of the interviewer?

d. Could you perhaps give some additional information about the profession of the interviewer and role of the interviewer in the disability assessment?

e. When does the interview take place in the process of the disability assessment?

f. What role does the questionnaire play in the (definitive) assessment?

g. Is any tool or method used in the interview?

4. Is medical information about the client being collected?

☐ No ▸ Please go to question 5.

☐ Yes ▸ Please answer the following sub question if possible.

a. How is the medical information about the client collected? (Via E-health, the treating physician, the client, other…)

5. In your country, does the treating physician write a specific medical report or advice for the assessment procedure?

☐ No ▸ Please go to question 6.
☐ Yes ▸ Please answer the following sub question if possible.

a. Does this medical report or advise play a supportive, decisive or other role in the assessment procedure?

6. Has the efficacy of the assessment procedure in your country been included in any (scientific) research?

7. In the (near) future, are there going to be changes in the assessment procedure of your country?

8. Are any possible changes in the assessment procedure currently being researched and/or explored?

9. In your opinion, which elements of the assessment procedure in your country are the most valuable? I.e.: elements that are highly reliable or efficient.

10. Are you interested in taking part in an interview with us to share more information about your country's assessment procedure and the use of self-report questionnaires in particular?

☐ No
☐ Yes

11. Are you interested in aiding us in finding out more about the topic of rehabilitation in your country via another questionnaire? Or do you know someone who would want to partake?

☐ No
☐ Yes ▸ Could you please give us contact details?

12. Although we ideally would like to share all given answers among the participants via an Excel-document, we understand if you would rather want to keep your answers private. If so, please tick the box below and we will only use your answers for our own research project.

☐ I want my answers to remain private from the other participants.

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Abbreviations

CBBS	Claimbeoordelings- en Borgingssysteem
DFA	Diagnose, functionele beperking en activiteiten restricties
EEA	European Economic Area
ESA	Employment and Support Allowance
FML	Functionele mogelijkhedenlijst
GDPR	General Data Protection Regulation
HCP	Health Care Professional
IAS	Invalidity Assessment Standard
ICD-10	tenth edition of the International Statistical Classification of Diseases and Related Health Problems
ICF	International Classification of Functioning, Work disability and Health
IP	Insurance physician
IVA	Inkomensvoorziening volledig arbeidsongeschikten
LCW	Limited Capability for Work
LCWRA	Limited Capability for Work-Related Activity
LE	Labour expert
LiMA	Logic Integrated Medical Assessment
MRAS	The Medical Review and Assessment Service
MS	Medical secretary
PS	Process supervisor
RIV	Re-integratieverslag
SMN	Socio-medical nurse
TSS	Team supporting staff
UAVG	Uitvoeringswet Algemene verordening gegevensbescherming
Wajong	Wet arbeidsongeschiktheidsvoorziening jonggehandicapten.
WCA	Work Capacity Assessment
Wet SUWI	Wet structuur uitvoeringsorganisatie werk en inkomen
WGA	Werkhervatting gedeeltelijk arbeidsgeschikten
WIA	Wet werk en inkomen naar arbeidsvermogen

Definitions

Ability to work
The (remaining) degree to which a person is able to perform (suitable or general) work activities.

Acceleration measures
UWV has adopted nine acceleration measures to reduce work disability assessment and reassessment waiting times. These measures still require evaluation. More information is available via this link.

Adaptive questionnaire
An extensive questionnaire, the questions included in which are adapted to the answers provided by the candidate.

Ajutise töövõimetuse hüvitis
Estonian sickness benefit.

Aktivitetsersättning vid nedsatt arbetsförmåga
Swedish activation (rehabilitation) benefit for claimants aged below 30.

Arbejdsgiverperioden
Period in Denmark during which the employer must continue to pay wages.

Assets test
An investigation of the assets of a benefit applicant. Social (work disability) benefit applications often feature such an investigation.

Biopsychosocial model
This model is an expanded version of a model of human functioning, providing attention not only to biomedical aspects, but also to psychological and social factors that help determine sickness and the recovery process.

Case worker
In this report: often an academically educated, non-medical professional.

Claim Beoordelings- en Borgingssysteem
A system listing job descriptions that contain information about, inter alia, the working environment, the tasks relating to this job, the working hours, the required education and work experience, and the workload. The job descriptions are supplemented and updated by operational labour analysts.

Occupational physician
A physician active in the field of sickness prevention, the identification of occupational illnesses, coaching during sickness absence, and rehabilitation.

Consistency checks
A check of the consistency of information obtained.

Interview
An interview in this report means an occasion where the claimant and the assessing professional(s) have physical, telephone, or digital contact. We have not limited such an occasion to a specific length of time.

Curative sector
Treating sector.

Work disability criteria
The criteria that must be met before a claimant can be classified as being incapacitated for work.

Work disability insurance on the basis of residence
A work disability insurance based on the term of residence in a country.

Desk assessment
An assessment conducted without the claimant being met or interviewed.

Desk research
A study of sources not limited to scientific literature but also considering factual data and existing research data.

Diagnosis, functional limitation, and activity restrictions

Försäkringskassan (Sweden) deploys this tool to assess a claimant's incapacity for work percentage.

Work disability Allowance
Social work disability pension in Ireland.

Dual work disability system
A work disability system that allows for applying for both a work disability pension on the basis of income insurance and a work disability pension based on the term of residence.

Earning capacity
The percentage of the wages earned before reporting sick that a claimant can, in theory, still earn. The degree of incapacity for work is determined on the basis of this capacity.

Employment and Support Allowance
Work disability pension in the United Kingdom.

Epicrisis
An analytic summary of the history of the sickness.

ESA50
Self-report questionnaire used for the work disability assessment in the United Kingdom.

Expert opinion
Opinion of an expert.

First-track rehabilitation (Wet verbetering poortwachter)
Programme that has the sick employee be coached by the employer in order to resume work within the current organisation. In the first instance, the aim is to have the claimant resume their current job, possibly with adjustments in working hours or activities to be performed. If this proves to be impossible, other jobs with the current employer are considered. Should this initial programme produce no results, a second-track rehabilitation programme will be started up.

Fit note
Medical certificate in use in the United Kingdom.

Flexi-job
A flexi-job or fleksjob is a Danish type or work with special account being taken of the decreased ability to work due to sickness or a limitation. Customised services are provided in this connection.

Forlængelse af sygedagpengeperiode
Extension of the sickness benefit in Denmark. This is awarded only in special cases.

Førtidspension
Danish work disability pension.

Functionele mogelijkhedenlijst (FML)
The insurer's medical adviser by way of completing the FML draws up a physical capacity profile as part of the assessment. The list contains six categories.

Garantiersättning
A Swedish work disability pension, funded from taxes, a claimant can claim when they have earned too little or have not worked at all.

General Data Protection Regulation
The General Data Protection Regulation is a European regulation standardising the rules for the processing of personal data by private companies and government bodies in the EEA Member States.

Legal bases
These are the conditions for processing personal data under the GDPR.

Holistic
In this report: taking account of the entire situation of the claimant, not only the socio-medical background.

Illness Benefit
Sickness benefit in Ireland.

Income assessment
When determining the possible award of a (work disability) pension, account can (in part) be taken of the income earned by the applicant and/or their partner, if any.

International Statistical Classification of Diseases and Related Health Problems
This is an internationally used list of sicknesses, maintained by the World Health Organisation.

Invalidity Pension
Premium-based work disability pension in Ireland.

Knowledge base
The knowledge base lists a range of professions and the requirements for being able to work a specific profession. The knowledge base supports staff in assessing functional capabilities and limitations in the view of existing professions. This tool is used during the sickness benefit assessment in Sweden.

Labour expert
In this report: the LE is one of the two professionals conducting the work disability assessment in the Netherlands.

Medical certificate
A medical report containing information on the claimant's medical situation. It covers the affliction(s), limitations, expected term and prognosis, and, in some countries, also an overview of rehabilitation activities performed.

Medical secretary
A non-medical, administrative professional performing supportive activities in the context of the work disability assessment in the Netherlands.

Minimum qualifying period
Period of sickness upon the lapse of which a work disability pension can be applied for.

Multimorbidity
Simultaneous presence of multiple chronic afflictions.

Occupational health service
The occupational health service inter alia supports employers with respect to their absence policy.

Örorkumat
Work disability assessment in Iceland.

Participatiewet
The Participatiewet is a Dutch Act of Parliament that serves to have more people, including persons with an occupational impairment, find work. Three types of support are provided: the job arrangement indication, the sheltered employment indication advice, and the Wajong benefit.

Period during which the employer continues to pay wages
Period during which the employer continues to pay a fixed amount or a percentage of the previously earned wages to a sick employee.

Permanently incapacitated for work
A claimant is permanently incapacitated for work if their incapacity is based on a medically stable or worsening situation or on a medical situation that does features only a low likelihood of recovery in the long term.

PES network
Public Employment Services network.

Process supervisor
This professional is, in the Netherlands, responsible for the administrative decision to be taken on a work disability assessment.

Rehabilitation criterion
The criterion that a claimant must have exhausted all reasonable possible rehabilitation options.

Rehabilitation benefit
A benefit that may be awarded for the period during which a claimant follows rehabilitation activities.

Ressourceforløb
Danish rehabilitation period consisting of various customised activities, with a view to having the claimant resume work, follow a traineeship, or pursue studies.

Ressourceforløbsydelse
Danish rehabilitation benefit awarded during the ressourceforløb.

RIV assessment

Assessment of the Dutch vocational rehabilitation report. Once the vocational rehabilitation report is complete, the labour expert and the insurer's medical adviser verify if sufficient vocational rehabilitation efforts have been expended by the claimant and the employer.

Second-track rehabilitation
Over the course of this programme, the claimant is supported with looking for work within the regular labour market.

Self-report questionnaire
A questionnaire that has the claimant answer questions about their own situation.

Semi-structured interview
An interview where use is made of a list of questions, but that also allows the interviewer to derogate therefrom or to ask additional questions.

Seniorpension
Seniorpension is a Danish work disability pension linked to the claimant's employment history. Claimants aged less than six years below state pension age can possibly claim this pension.

Shortened qualifying period
In special circumstances, the "minimum qualifying period" before a work disability pension can be applied for, can be shortened.

Single work disability system
A work disability system that allows for applying for either a work disability pension on the basis of income insurance or a work disability pension based on the term of residence.

Sjukersättning
Swedish work disability pension.

Sjukpenning
Swedish sickness benefit.

Sjukpenning på fortsättningsnivå
Extended sickness benefit in Sweden.

Social physician
In this report: an umbrella term for doctors specialised in insurance medicine / occupational medicine / social medicine.

Socio-medical nurse
The SMN is a professional registered in the Dutch BIG online registry for healthcare professionals who is working under the responsibility of the insurer's medical adviser and may (partially) perform specific tasks prior to the work disability assessment.

Special categories of personal data
Special categories of personal data are privacy-sensitive data. This includes medical data. As the processing of such data may have a major impact on a person special personal data receive additional protection under the GDPR.

Statutory exceptions
The processing of special categories of personal data not only requires a legal basis: a statutory exception must also apply. More information on statutory exceptions is available via this link.

Statuary Sick Pay
Amount paid by the employer to the sick employee in the United Kingdom.

Sygedagpenge
Danish sickness benefit.

Team supporting staff
The team performing the socio-medical assessment is supported by the team supporting staff (TSS), a non-medical professional performing supporting administrative activities.

Temporary work disability pension
A work disability pension awarded for a specific period, upon the lapse of which a reassessment is conducted or a new application is filed.

Töövõimetoetus
Estonian work disability pension.

Työterveyshuolto

Finnish occupational health service that can be engaged by most employers. The service promotes employee health and helps prevent sickness and incapacity for work.

Universal Credit
A social scheme in the United Kingdom for low-income claimants.

Wet arbeidsongeschiktheidsvoorziening jonggehandicapten (Wajong)
A Dutch national insurance covering insured persons who became incapacitated for work before reaching age 18 and still incapacitated when reaching age 18. This insurance also applies to people who became incapacitated for work when aged between 18 and 30 and have been pursuing studies for at least six months in the year immediately prior to the day of becoming incapacitated for work.

Wet SUWI
The Wet SUWI (Work and Income (Implementation Organisation Structure) Act) organises the system of the implementation of social securities to provide people in the Netherlands with work and social and economic security.

Wet verbetering poortwachter
This Dutch Act of Parliament requires employers and employees to cooperate with the occupational health service or occupational physician to endeavour to have the employee resume work as quickly as possible.

Wet werk en inkomen naar arbeidsvermogen (WIA)
Dutch employees who are 35% incapacitated for work after two years of sickness can claim a pension under this Act.

Work capacity assessment
Work disability assessment method used in the United Kingdom.

Ziektewet benefit
An employee may claim this Dutch benefit when they are not entitled to the continued payment of wages by the employer. Persons not working for an employer can, in certain situations, voluntarily insure themselves under the Ziektewet. The Ziektewet benefit is paid out by UWV.

Colophon

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