STATES OF JERSEY

ADVISING THE STATES OF JERSEY, SOCIAL SECURITY DEPARTMENT ON WORKING-AGE INCAPACITY: A REPORT BY PROFESSOR BRUCE STAFFORD, SEPTEMBER 2017

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Advising the States of Jersey, Social Security Department on Working-Age Incapacity

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Contents

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The views in this report are the author’s own and do not necessarily reflect those of the Social Security Department.

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Summary

Introduction

The Social Security Department has commissioned this review on the assessment of incapacity and the (financial and non-financial) support that benefit claimants may require.

It is a desk-based literature review of the international evidence on:

- Assessment of incapacity
- Financial support for those with incapacity (replacement of wages vs compensation for loss of faculty)
- Non-financial support for those with incapacity

The scope of the review is limited to people of working age and English language documents.

Defining incapacity, sickness and disability

There is no common definition of incapacity. Conceptually, incapacity can be distinguished from ill-health and disability. Unfortunately, how these terms are used in practice can be confusing.

People with and without a disability can suffer ill-health. An illness refers to the symptoms that people experience, whilst a disease is a medical condition that medical science can diagnose. People can feel ill, but doctors are unable to diagnose a disease, and *vice versa*. Sickness is the social role adopted by someone with an illness or disease. In most (but not necessarily all) cases, people taking on a sick role have an illness and/or a disease. Studies show that sickness is influenced by factors other than health status, such as gender, age, socio-economic status, ethnic group, level of family supports, work environment, type of employment, and levels of human capital.

Incapacity is an administrative concept. Countries define it differently. De Boer *et al.* (2004:47) in their cross-national study of disability/incapacity identify the following themes in the definition of incapacity, there are:

> '… (in)abilities to do work that can be reasonably be asked of them', and secondly, 'health conditions … explain these (in)abilities.'

Most of the literature takes as a given that incapacity refers to an inability to do paid work. However, a broader definition is possible, an incapacity to participate in society more generally. Here incapacity begins to take on characteristics associated with some definitions of disability.

Definitions of disability are contested. There are a number of different theoretical models underpinning definitions of disability, and the review considers the following three:

- The **medical model** defines disability in terms of a person's impairment. The presumption is that medical science can treat the disability. As such it individualises disability by focusing on the individual's inabilities and incapacities.
- The **social model** was developed by disability writers, in part as a response to the shortcomings of the medical model. Disability arises from social barriers due to the 'attitudinal, economic, and/or environmental factors that prevent disabled people from experiencing equality of opportunity with non-disabled people' (Joint Committee, 2004:20-21). Policy should tackle these social barriers so that disabled people can fully participate in all aspects of life.
- The **biopsychosocial model** could be seen as an integration of the social and medical policy. It has been influential at the international level, underpinning the World Health Organisation's classification schema the International Classification of Functioning, Disability and Health (ICF). It has also influenced policy developments in a number of countries. The ICF, itself, is not suitable for assessing work incapacity. However, the ICF does serve to highlight that disability is the outcome of a complex interaction between body structure, body function, activity, participation, environmental factors and personal factors.

The Capability Approach is a relatively complex model, and it is not always clear how it might impact on policy. Nonetheless, it does underpin the United Nation's Human Development Index. The approach, developed by the economist Amartya Sen, is used as a normative framework for considering poverty, inequality and human development; but it can be applied to incapacity and disability. There is a focus on what people can do (functioning) and what they could do (capabilities). It emphases the freedoms people require in order to make choices from amongst the opportunities available to them in their capability set. Democratic states are seen as having a responsibility to make available an 'adequate income' to guarantee 'minimal functioning'. The primary goal of public policy should be expanding human capabilities.

Assessing incapacity

A useful distinction can be made between the *assessment* and the *claim or assessment process*. Key findings from the review of the assessment process are:

- The primary aim of assessments is to verify entitlement to benefit. However, countries differ on the extent to which the medical assessment is used only to determine the level of benefit or to also promote or assess the need for vocational rehabilitation.
- How benefits are structured varies across countries. Notable differences relate to:
    - the responsibility of employers for paying sick employees – from paying them for a few days to two years in the Netherlands – and their degree of involvement in rehabilitation activities;
    - whether there is one benefit to cover short and long term periods of sickness or two; and

Benefits for an incapacity are differentiated from those for unemployment, because the recipient's incapacity means that they are unavailable for work.

- Timescales for the assessment process, which may be specified in regulations, vary between countries.
- Other than claimants, the principal actors in the assessment process are employers, general practitioners, medical assessors, social security officials, and labour market experts.
- Assessments may be desk-based exercises and/or involve face-to-face meetings with medical assessors.
- Assessing incapacity is challenging for general practitioners and medical assessors. There is a substantial literature on the sickness certification process that highlights the problems general practitioners can encounter in assessing a patient's fitness for work. Difficulties include observing some conditions (for instance, back pain), a lack of training in occupational health matters, the complex nature of the patient-doctor relations which can lead to negotiations over the issue and content of sickness certificates, administrative delays, and communication problems between actors.
- The actual content of assessments also varies. Typically, an assessor considers the health status of the claimants – including medical history and diagnosis. Anner *et al.* (2012) identify the four 'core features' of assessment reports as:

  > '… 1) the functional capacity of the claimant; 2) the socio-medical history, including the development and severity of the claimant's health condition, his/her previous efforts to regain health and return to work, and his/her job and social career; 3) the individual prognosis of work disability; 4) the feasibility of interventions to promote recovery and return to work.'

- If and when reviews or re-assessments of entitlement to benefit are conducted differs between countries.
- All reviewed countries have an appeals process. However, they differ on timescales for making an appeal, whether an internal re-consideration is required before an appeal is permitted, and the extent to which appeal judgements are subsequently used to inform guidance to staff and medical assessors.
- Countries have quality assurance processes, but two cross-national studies, de Boer *et al.* (2004) and Cousins *et al.* (2016), find that the criteria and processes used could be much improved.

The variation between countries outlined above means that in reforming the assessment process in Jersey, policy makers have several choices to make about how the process will operate.

There are three broad approaches used by counties to assess incapacity:

- loss of functional ability;
- loss of earnings; and
- loss of faculty.

Loss of faculty assessments focus on anatomical, physiological or psychological conditions, and are typically made using Baremas scales or impairment tables where percentages are assigned to, say, the loss of a hand. Use of Baremas scales is controversial and heavily criticised.

Loss of functional ability considers the claimant's (in)capacities with respect to set functions such as, walking, sitting, concentrating. The rationale is that a person's medical condition affects their functional abilities and this can create a mismatch between their abilities and the demands of their job leading to sickness absence in the short-term and possibly incapacity longer term. How countries measure functional ability differs.

Work incapacity in loss of earnings assessments is related to determining the extent to which their capacity to earn has been limited by their health condition.

Loss of functional ability appears to be the approach used in most countries. Fewer countries use a loss of earnings, and in the case of the Netherlands it is informed by a prior functional assessment. Loss of faculty tends to be used for assessing compensatory benefits for industrial diseases and injury claims, and for war benefits/pensions. Loss of faculty is used in Jersey to assess eligibility for Long-Term Incapacity Allowance.

In assessing incapacity three key issues for policy makes are, first, what is the reference or benchmark job or work in the incapacity assessment? The comparators used vary within and between countries and include: own job, 'normal work', 'regular work', 'substantial gainful activity', any job, and subsidised wage jobs. Secondly, is the outcome of the assessment a binary 'capable ' or 'incapable' of work, or are degrees of (in)capacity permissible? The latter then allows partial benefit awards to be made so that people can (at least in principle) combine paid work with benefit receipt. Thirdly, are there certain medical conditions (such as cancer) that mean that a claimant is automatically awarded benefit and no medical assessment is required?

The review of models of disability and the Capability Approach demonstrate that work incapacity cannot be simply equated to a medical condition or a functional limitation. Other factors influence a person's ability to work. A useful distinction can be made between non-medical personal characteristics (such as education qualifications and experience) and environmental factors (for instance, job vacancies) in assessing work (in)capacity. The literature review shows that some countries have incorporated non-medical/functional factors in their assessment of work incapacity. Whilst in practice there have been occasions when the state of the labour market has been taken into account in assessing incapacity, the review concludes that policy makers and decision makers should not do this because it confuses incapacity with unemployment. Whilst unemployed people may have health problems, they have been judged as available for work. Incapacity benefit claimants have been assessed as being able to do only limited, or no, work. Baumberg *et al.* (2015:55-6) identify two policy options for maintaining a distinction between incapacity and unemployment:

- a benefit eligibility requirement that a claimant's functional impairments are caused by a medical condition; and

- explicitly excluding the state of the local labour market as a consideration when assessing work (in)capacity.

Financial support

In theory, market provision of incapacity insurance would be economically efficient and maximise social welfare. However, in practice there is 'market failure' and the state needs to offer social insurance programmes. State provision is required because:

- Some individuals would not purchase the insurance, as they would underestimate the value of the product.
- The size of the population that needs to be covered means that private providers are unable to offer viable schemes and only the state has the necessary resources and revenue raising powers to meet potential claims.
- The occurrence of incapacity (and disability) and its associated losses are difficult to predict and so difficult to insure privately. A lack of information about potential insurees (known as adverse selection) means that insurers pool across different risk groups and set premiums at an average rate. However, this produces:

> '… an outcome where it is beneficial for high risk people to buy full coverage at average premium rates, whereas low risk people will decide not to take (full) insurance. This form of self-selection implies a continuous adaptation of initially misspecified premium rates until private insures fail, and the market collapses.'
>
> de Jong (2000:30)

- People with insurance cover may alter their behaviour in such a way as to increase the insurer's losses (this is known as moral hazard). Private insurers may be reluctant to offer products for illness, incapacity and disability because the risk of moral hazard is too high.

Market failure means that the private sector provision of incapacity is likely to lead to socially unacceptable 'gaps' in coverage. In contrast, social insurance ensures adequate coverage of the working population by making the scheme compulsory. However, social insurance programme cannot avoid moral hazards, for example, when someone who is capable of work successfully claims an incapacity benefit.

Policy responses to moral hazard in social insurance programmes include:

- Making the benefit less attractive or accessible. Policy options include having employers pay sick pay/wages for an initial period of sickness absence. This may reduce public expenditure and, depending upon the obligations and costs placed on employers, may incentivise them to intervene early and support a worker's return to work.
- Co-insurance, which is when less than full or comprehensive social insurance is provided to the working population, can include paying benefits at a rate less that a person's (potential) earnings, and allowing partial benefits to be awarded.

- Making the extent of the coverage depend upon the accuracy of assessments.
- Using experience rating, that is, relating social insurance contributions to workers' behaviour. The Dutch use experience rating to incentivise employers to manage sickness absence by relating the employers' social insurance contributions to the employees past claims for incapacity/disability benefit. For every employee awarded a disability benefit, the firm's insurance contribution rate increases for up to ten years. However, their contribution rate falls if they employ a disability insurance recipient. Businesses have objected to the resulting increase in their re-insurance premiums.
- There is policy modelling (Low and Pistaferri, 2010) that suggests that: 'Incentives for false applications are reduced by reducing [benefit] generosity and increasing reassessment …'; and a less generous benefit and more frequent re-assessments '… have a large impact reducing the number of false applicants at little cost in terms of reduced coverage for those in need.'

Some countries have privatised aspects of their social insurance programmes. A distinction can be made between privatising the collective insured risk and the administration and delivery of social insurance. The former is problematic (c.f. the discussion above on private provision). The latter may create incentive structures that engender economically efficient behaviour, service innovation and increased choice. However, contracting out services creates its own versions of adverse selection and moral hazard that can be difficult to manage.

Social insurance programmes are typically funded by contributions rather than general taxation. Each method of funding has its advantages and disadvantages. The key benefits of contributions are that they promote social solidarity, and make a strong link between benefit entitlement and paid work. Their main shortcomings are that groups not in work or in low pay will not have sufficient contributions to be entitled to social insurance programmes, even if they have a work incapacity; and it is a model of funding that is incompatible with the demands of the 'flexible' labour market. The key benefit of funding via general taxation is that it provides the opportunity to include those groups that can be excluded by having no or insufficient social insurance contributions. However, electorates may be unwilling to vote for tax increases to fund benefits and tax funded benefits are likely to be means-tested and this can lead to low take-up rates and create significant work disincentives.

Incapacity benefits can aim to maintain or replace loss income, or compensate for the extra costs of having a disability or the loss of faculty. The former promotes social cohesion and inclusion, because no dramatic drop in income incurs. Benefit expenditure should be less than for a compensation for loss of faculty benefit as the income replacement ceases when the person finds employment. Income replacement benefits can be earnings related or flat-rate. There appears to be a trend against loss of faculty compensation benefits, and towards encouraging people to engage in the labour market.

Some countries can award partial benefits. This reflects that work incapacity is not an 'all or nothing' affair. Partial benefits fit well with systems that seek to encourage (early) returns to work. However, unless appropriate policies are in

place, partial benefits can lead to significant work disincentives and may over time lead to an expansion in the benefit caseload.

Governments have offered a variety of financial incentives to encourage people to move from benefit into paid work. These measures include time limited return to work payments, rules a that allow someone an easy and quick return to benefit if a job does not work out, wage supplements, subsidised employment (such as the Danish 'flex-jobs') and grants for workplace adaptationa. However, the evidence base on financial incentives could be better. Not all evaluations include an impact analysis. Some studies show positive impacts and others do not.

Non-financial support

Non-financial support comes in many and varied forms. If incapacity benefits are to be effective in helping people return to, and stay in, employment then two pre-conditions are that people have access to high quality healthcare and there are anti-disability laws in place.

Measures where there is some evidence that they are effective are: vocational rehabilitation services; supported employment (notably the Individual Placement and Support model; although the extent to which it is effective outside of the USA remains unclear); stricter screening of claims for benefit (the exemplar is the Netherland's Gateway Protocol); and providing personalised support.

Conclusions

Developing incapacity policies is challenging. The policy area is characterised by disagreements over the definition of key concepts, there is a wide range of options that policy makers can consider both for the overall design of the system and at each stage in the assessment process, and empirical studies tend to provide mixed findings. Judgements have to be made about difficult policy trade-offs.

The review suggests that there are some key questions for Jersey policy makers to consider when deliberating on the future of its incapacity benefit system.

First, *how is work incapacity to be defined*? The key decision here is whether to include non-medical/functional ability factors (such as education) in the assessment of work (in)incapacity. Other countries have achieved this.

Secondly, *how should the health aspects of incapacity be assessed?* The answer to this question is critical for the design of the assessment process. Both this and the earlier review (Stafford, 2007) propose that incapacity should be assessed by loss of functional ability.

Thirdly, *what should be the objectives of incapacity benefits?* The choice here is between benefits designed to maintain and replace loss of income and benefits that compensate for having an impairment.

Fourthly, *how best to tackle the inevitable moral hazards?* Various policy responses are possible (for instance, privatisation of Short-Term Incapacity Allowance), but their desirability and feasibility vary.

Fifthly, *how early in the process should interventions be made to support a return to work?* Early interventions could be voluntary or mandated, made by employers and/or governmental providers, and work-related activities could commence before, during or after a claim for benefit.

Countries have answered these questions in different ways, and are continuing to review and revise their policies. Policy transfer, in the sense of there being a system that Jersey could take from another country and apply to the island, is not possible. This is because context is important. The differences between countries – and even within countries over time – mean that polices for Jersey have to be bespoke. Nonetheless, there will be ideas, measures and tools in other countries that can inform Jersey's policy discussions. In developing policy, Jersey policy makers might find that the Netherlands is an interesting case study of the possibilities for action.

1 Introduction

Governments have increasingly recognised the importance of sickness, incapacity and disability payments. In 2010 the OCED described the barriers that people with medical condition face in engaging fully in the labour market as a 'social and economic tragedy' (OECD, 2010:9). The associated economic and financial costs of has led to a policy focus on improving work retention and early returns to employment. Moreover, there is evidence that work is beneficial for people's health and well-being:

> 'There is a strong evidence base showing that work is generally good for physical and mental health and well-being. Worklessness is associated with poorer physical and mental health and well-being. Work can be therapeutic and can reverse the adverse health effects of unemployment. That is true for healthy people of working age, for many disabled people, for most people with common health problems and for social security beneficiaries. The provisos are that account must be taken of the nature and quality of work and its social context; jobs should be safe and accommodating. Overall, the beneficial effects of work outweigh the risks of work, and are greater than the harmful effects of long-term unemployment or prolonged sickness absence. Work is generally good for health and well-being.'
>
> Waddell and Burton (2006:ix).

Incapacity benefits provide insurance against a rare but potentially live changing event. For instance, econometric studies of the long-term effects of accidents show that they have a detrimental impact on labour market outcomes for those hurt (García-Góme *et al.*, 2011:148-9).[1] Yet the design and implementation of incapacity benefits is problematic because work capacity is only imperfectly observable. There is also no 'off the shelf' system that governments can simply adopt and implement. Countries approach the assessment and management of incapacity differently. Governments reviewing their work incapacity provision have enormous scope, a wide range of potential choices, in reforming current arrangements.

1.1 Review aims

It is within this context, and the State of Jersey's Strategic Plan 2015 to 2018 and its Social Security Review (2016) consultation *Living Longer: Thinking Ahead*, that this review on the assessment of incapacity and the (financial and non-financial) support that people may require has been commissioned.

The review is designed to drawn upon international evidence and offer assistance to the Department of Social Security to explore:

- Assessment of incapacity

[1] The inter-relationships between labour market participation and health is complex. Accidents provide a 'health shock' that allows analysts to look at subsequent labour market effects.

- Financial support for those with incapacity (replacement of wages vs compensation for loss of faculty)
- Non-financial support for those with incapacity

The scope of the review is limited to people of working age.

In the conclusions for Chapters 2 to 5, an attempt is made to relate the literature review findings to an earlier review of incapacity benefits in Jersey, *Review of the Changes to the Incapacity Benefit System States of Jersey* (Stafford, 2007).

1.2 Methodology

The review is a desk-based narrative review of the international literature. Sources used in the review were either already available to the author or were obtained by online searchers and the resources of the library at University of Nottingham. Only English language sources were included in the review.

The report includes examples from a wide range of countries, although there are more cases drawn from Australia, the Netherlands and the United Kingdom (UK). Examples have to be drawn from many countries because of the steer range and diversity of practices across countries. A small-n, case study approach would not capture adequately the heterogeneity in policies and practices.

1.3 Structure of report

The next chapter discusses definitions of incapacity, sickness/ill-health and disability. The Chapter serves to demonstrate that these three concepts are distinct, although the terms can be used interchangeably in practice and there are no common definitions. Chapter 3 discusses how (in)capacity is assessed across countries. It does this by first considering the assessment process and then the criteria that can be used to determine incapacity. Chapter 4 considers aspects of financial support, including the moral hazard, benefit objectives and the use of partial benefits. The various types of non-financial support available is discussed in Chapter 5. The final Chapter provides some conclusions and recommendations. The latter includes reconsidering the recommendations made in the earlier commissioned review on incapacity (Stafford, 2007).

1.4 Terminology

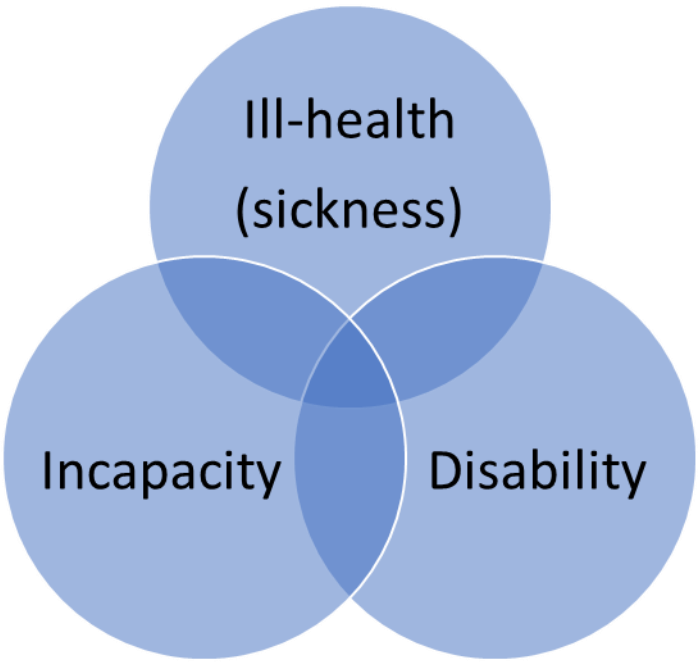
The lack of agreement on definitions, especially of the meaning of incapacity and disability, is highlighted in the next chapter. The brief for this review refers to incapacity. However, what would be termed incapacity or an incapacity allowance in Jersey is likely to be called a disability or disability benefit (or pension) in other countries. The evidence base can refer to disability, when for the purpose of this review, it is discussing a work incapacity. Thus there is potential for confusion, especially when using international examples. The practice adopted in the report is to use the given English translation of a named benefit, even if 'disability' is part of the title. In all such cases, eligibility for the benefit requires the recipient to have a work incapacity. In some instances, however, it has been necessary to refer to 'disability and incapacity' (or

disability/incapacity) when reporting on a source. This is to reflect that whilst the source uses 'disability', the issue(s) raised apply to work incapacity as it is understood from a Jersey perspective. It is not the intention of the report to suggest that the terms disability and incapacity can be used interchangeably. As the next chapter makes clear, they are conceptually different.

2 Defining Incapacity

Ill-health, incapacity and disability are three separate but inter-related concepts (see Figure 2.1). For instance, disabled and non-disabled people can become ill (say, catch flu) but members of both groups can also be healthy. Across countries there can be different uses of the terminology, which can be confusing (for instance, de Boer *et al.* (2004:9) define disability as the 'long-term inability to work owing to a health problem', a notion that elsewhere (and in this report) is referred to as (long-term) work incapacity).

Figure 2.1: Sickness, Incapacity and Disability



Source: Author's own.

This chapter discusses in turn the concepts of ill-health and sickness (including the sick role), incapacity and disability. The analysis of disability considers three models of disability: medical, social and biopsychosocial. The last of these is discussed in more detail because of its influence on policy at national and international levels. An alternative approach to conceptualising incapacity, the Capability Approach, is also outlined.

2.1 Sickness and ill-health

People tend to have an everyday understanding of what is meant by ill-health or sickness (and the two terms are often used interchangeably). There is some dispute in the literature about the precise meanings of 'sickness' and associated terms such as disease (Scully, 2004).

Nonetheless, illness refers to the symptoms that people experience, whilst a disease is a medical condition that medical science can diagnose (Alexanderson and Norlund, 2004:16; Waddell and Aylward, 2005:7). Whilst these two notions can overlap, they are not necessarily the same. A person may have an illness that a doctor is unable to diagnose as a disease, and someone may have a disease but not feel ill. Both these concepts can be distinguished from 'sickness', which is the social role adopted by someone with an illness or disease. In most (but not necessarily all) cases, people taking on a sick role have an illness and/or a disease.

The concept of the sick role was developed by an American sociologist, Talcott Parson, in 1951. It has fours aspects (or postulates); the sick person:

- is exempt from fulfilling their 'normal social obligations' (such as work);
- is not responsible for their ill-health;
- is responsible for getting well as quickly as possible; and
- must seek help and agree to any medical care.

Parson's saw sickness as legitimate but deviant behaviour. However, changes in medicine (for instance, development of preventative medicine) and in healthcare provision (such as the emergence of consumer choice) have undermined the sociological value of the 'sick role' for contemporary society (Burnham, 2012). Nonetheless, it serves to remind that sickness is a complex construct which includes social as well as medical aspects.

What is considered as an illness can change over time (for instance, the change in attitudes towards homosexuality). Stendahl (2000:258-9) points out that the legal definition of sickness for sickness insurance in Sweden has changed over time. It moved from a narrow medical interpretation to a broader understanding in the 1980s, which was reversed in the 1990s.

Studies show that sickness is not simply a product of ill-health, rather it is affected by wider socio-economic factors (Cousins *et al.*, 2016:8; García-Góme et al., 2011:150-1; Rowlingson and Berthoud, 1996). Factors other than health status known to affect sickness include gender (rates are higher for women), age, socio-economic status, ethnic group, level of family supports, work environment, type of employment, levels of human capital, firm size and stage of the business cycle. For example, an international study by Benítez-Silva *et al.* (2010:486) confirmed single country findings that work incapacity benefits are '… used to cushion recessions and to alleviate transitions into economic inactivity in regions and times of high unemployment across most OECD countries.'[2] García-Góme *et al.*, (2011:150-1) in reviewing the literature on the growth in caseload for the Disability Insurance programme in the USA find that increases in benefit levels are the main reason for increases in numbers of claims.

Moreover, employers have responsibility for employees' working conditions, and there is some evidence that there is an association between some working conditions and sickness absence (Allebeck and Mastekaasa, 2004:56-61).

[2] Benítez-Silva *et al.* (2010) make a distinction between 'health disability' and 'work disability' (called here work incapacity). They find that work disability (incapacity) is related to the business cycle but not health disability.

Allebeck and Mastekaasa (2004:60-61), in their systemic review of the physical workplace risk factors for sickness absence, conclude that ergonomic factors (such as uncomfortable working positions) can lead to higher sickness absence. Furthermore, workers with less control over their work situation are likely to have higher levels of sickness absence (Allebeck and Mastekaasa, 2004*;* see also Coats and Max, 2005)

Unsurprisingly, across countries the rate of sickness certification varies; from, for example, 0.18 per person per year in Norway to 2.1 in the UK (Letrilliart and Barrau, 2012:219). Ill-health (or sickness) can affect everyone. Thus people with and without a disability and/or incapacity to work can suffer ill-health. Equally, a person with, say. hay fever, can be considered as having a health problem, but is unlikely to be assessed as either disabled or incapable of work. The duration of the spell of sickness can vary and, for those in paid work, it may entail absence from work. The first few days of sickness absence may be self-certificated, but after that the sickness has to be validated/confirmed by a health professional. Employers (rather than the State) can continue to pay their employees for up to a maximum number of days, although thereafter the State can take on responsibility for paying a (time-limited) benefit.

2.2 Incapacity

Incapacity is an administrative and relational concept. It is defined differently in different countries, the definitions reflect the countries' history and social security systems. The concept is relational because it is an incapacity to being able to do something. In most cases it is defined in relation to the inability to carry out paid work due to a health condition, which is operationalised in terms of, say, the ability to earn a minimum amount or to work for a minimum number of hours. However, the literature also includes a broader notion of incapacity, an incapacity to engage in social participation. Here incapacity is extended beyond the world of paid work to encompass other activities such as participating in leisure pursuits, political processes and so on. So, for instance, Etherington (2017:377) is critical of the UKs Work Capability Assessment (WCA) because it is essentially a functional assessment of incapacity, and ignores social barriers to claimants obtaining employment.[3] For example, it ignores disability discrimination by employers and their possible reluctance to implement reasonable adjustments in the workplace (Etherington, 2017:378). As Baumberg *et al.*, (2015:13) state:

> Despite its name, the WCA simply does not assess claimants' capability for work. It assigns points to functional impairments, but never considers whether there are any actual jobs that a claimant could do. Nor does it directly consider whether a person can undertake work-related activity, or the employment support that a person might need. It is a standardised test, but one that consistently measures the wrong thing.
>
> … In practice, qualifications affect the types of jobs you can do, as do skills, work experience and age, and even the sorts of jobs that are available in the local labour market.'

[3] The significant of social barriers is discussed in Section 2.3.2; and the WCA is discussed in Section 3.2.4

Having a work incapacity is also likely to mean that an individual has some difficulties in engaging in other social activities, even if only for a short period of time. However, whether the focus is work or social participation will impact on the criteria used to assess incapacity and the benefit system. A broader conception implies taking into account a wider range of factors, for instance, an individual's educational qualifications alongside their health-related issues.

This highlights a key issue for the Social Security Department, to what extent health-related factors are to be the primary, or even sole, criteria for its understanding and legal definition of incapacity, or should other personal characteristics also be considered? The remainder of this report assumes that the thrust of the State's incapacity policy will be based on an incapacity to work, although Sections 2.3 and 2.4 will discuss models (such as the social model and Sen's Capability Approach) that could be used inform policy on an incapacity to socially participate.

Capacity and incapacity for work are ambiguous concepts. How incapacity relates to sickness and disability is often unclear. Spicker (2011:176) highlights a difference between sickness and (longer-term) incapacity. With incapacity, the sick role is 'eroded'; the allowances made for a sick person no longer apply. Moreover, the 'point of reference' for assessment changes as the incapacitated person may be unable to do their own job, but possibly they could to a different job.

Incapacity and disability are social and legal constructs that are contested. Depending upon the definitions adopted in a country, people assessed as having an incapacity to work may also meet the legal criteria for being regarded as having a disability. There can be a significant overlap in the two populations, people with a disability may also be in-receipt of incapacity benefits.

Nonetheless, someone may be incapacitated but not meet the legal criteria for a disabled person, and *vice a versa*. In the UK, for example, under the Equality Act 2010 a person is defined as disabled if they have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on their ability to undertake normal daily activities. So someone with, say, an amputated limb would be considered as a disabled person under the Act, but this does not mean that they have a work incapacity (although adaptations to enable employment may be required depending on the nature of the job). However, someone at the early stages of the onset of dementia could conceivably be classed as having a limited capacity for work, but not be considered disabled because the effect on their life was not yet substantial.

Some commentators (for instance, Gibbs (2005)) contend that using the notion of incapacity in social security is a flawed approach. Essentially, the argument is that the notions of sickness and disability are useful, but incapacity combines aspects of both and so is an 'overloaded' concept. The implication is that there is only a need for sickness and disability benefits. However, Baumberg *et al.*, (2015:30-1) argue that abolishing incapacity benefits would result in 'lower levels of support and worse outcomes for disabled people'. In part this is because:

> 'Abandoning the category of 'incapacity' will eventually result in a reduction in the popularity and generosity of support for disabled people.'
> Baumberg *et al.*, (2015:31)

Across countries, the definition of incapacity varies, but an underlying theme is that it involves, firstly, '(in)abilities to do work that can be reasonably be asked of them', and secondly, 'health conditions … explain these (in)abilities' (de Boer *et al.*, 2004:47). In addition, in some, but not all countries, there is a third element to the definition, that there are opportunities for rehabilitation/re-integration. Work incapacity can be operationalised differently, in terms of (De Boer *et al.*, 2004:18):

- a loss of functional capacity – an incapacity to do work;
- a loss of earnings capacity – an inability to earn an income; or
- a loss of faulty - anatomical damage, such as the loss of a limb.

The first two of these can also be combined in a single definition. These operational definitions are considered in more detail in Section 3.2. Comparatively, the criteria used for work capacity does not appear to influence how the assessment system is organised or how the assessments are conducted (de Boer *et al.*, 2004:47).

2.3 Disability

There are many different definitions of disability. Indeed, the definitions are contested; they change over time, and they vary from country to country (Mabbett, 2005; Mitra, 2006). There are different theoretical models of disability, and the three main models most relevant to a discussion of incapacity are discussed below (see also Oliver, 1996).

2.3.1 Medical model

The medical model defines disability in terms of a person's impairment. Disability is seen to reside within the individual (that is, their impairment) rather than within society. Medical treatment, care or support provided by professionals is seen as the solution to the 'condition'. Thus the inclusion of disabled people in society is achieved by 'curing' or 'adjusting' the individual, rather than by adjusting society to accommodate the disabled person.

Proponents of the medical model of disability claim that for assessment it provides a degree of 'objectification' for benefit decision-making; and so undermines any allegations that benefit recipients are malingers (Bolderson and Mabbett, 2002:67).

Disabled people have been highly critical of the medical model. A criticism of the medical model is that it focuses on a person's inabilities and incapacities. Moreover, it locates the problem in the individual – it individualises disability (Barnes and Roulstone, 2005:319). As Bolderson and Mabbett, 2002:54) observe:

> "'Individualistic' or 'medical' models are seen to create dependency, pity, and to lead to oppression …'

2.3.2 Social model

The social model, developed through the writings of disabled people, sees disability as a social construct. It is the way in which society is organised that disables people with impairments and health conditions and excludes them from life in the mainstream (Barnes, 2000; Oliver and Barnes, 1998). Unlike the medical model, disability is not an attribute of a person's functional abilities. Instead, disability is due to the 'disabling barriers' that arise from the 'attitudinal, economic, and/or environmental factors that prevent disabled people from experiencing equality of opportunity with non-disabled people' (Joint Committee, 2004:20-21). The social model:

> '… is a deliberate attempt to switch the focus away from the functional limitations of impaired individuals onto the problems caused by disabling environments, barriers and cultures.'
>
> Barnes and Roulstone (2005:319)

Collective social action is required so that disabled people can participate fully in all aspects of life. Hence disability becomes a question of human rights and a political issue. However, like the medical model, there is recognition that the disabled person has a body structure or function (or an impairment) that acts differently from that for non-disabled people. Whilst it recognises that individual interventions can be of value, it also seeks to highlight '… their limitations in terms of furthering disabled people's empowerment and inclusion in society …' (Barnes and Roulstone, 2005:319).

2.3.3 Biopsychosocial model

The biopsychosocial model could be viewed as an integration of the social and medical models. In policy terms is it a very influential model.

In the bio-psychosocial model, disability viewed as a process, and it deals with the complexity of disability by incorporating the physical, psychological, and social factors of other models. The model also gives people some scope for agency through their own effort, behaviour, and motivation. A literature review by Peters *et al.* (2003:10) concluded that the 'old medical model of disability assessment does not work as well as the bio-psychosocial approach'.

The International Classification of Functioning, Disability and Health (ICF) is based on the biopsychosocial model. The ICF was approved by all World Health Organization (WHO) member states in May 2001. The ICF provides a standardised and common framework for classifying health and health-related domains.[4] In the ICF, disability and functioning are seen as the outcome of interactions between health conditions (diseases, disorders and injuries) and contextual factors. The interacting components of the framework are body structure, body function, activity, participation, environmental factors and personal factors (see Figure 2.2). The last two represent contextual factors. In brief,

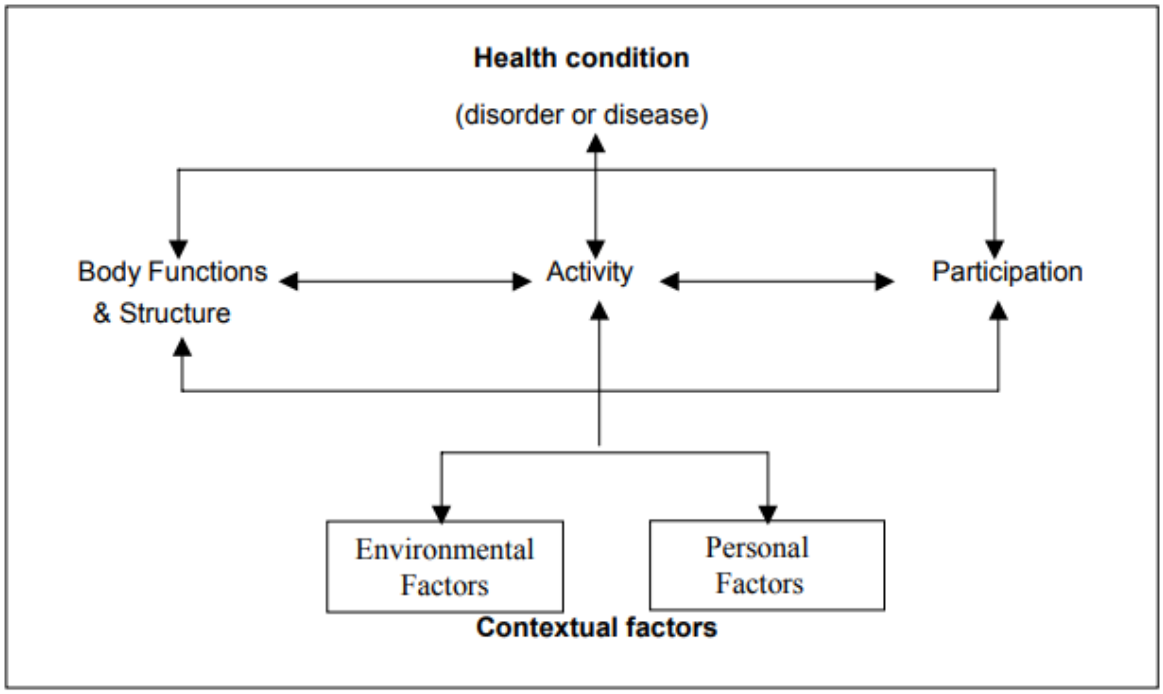
> 'Body functions are physiological functions of body systems (including psychological functions). Body structures are anatomical parts of the body such as organs, limbs etc. Activity is the execution of a task or

[4] See http://www.who.int/classifications/icf/en/

> action by an individual and participation is involvement in a life situation. Activity and participation can be described as performance (when considering the real life situation/environment) and capacity (when considering a standardized environment). Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives … They can be either a facilitator or a barrier to the individual. Personal factors refer to the particular background of an individual's life and living and comprise features that are not part of a health condition or health states'
>
> Anner *et al.* (2012)

Within this framework, an individual's 'performance' (what s/he currently does in their current environment) and their 'capacity' (or ability to execute a task or action in a standard or uniform environment). The difference between performance and capacity provides guidance on what can be done to the environment to improve performance.

Figure 2.2: Model of disability based on the ICF



Source: WHO (2002:9)

Further information on these factors is provided in Table 2.1.[5] Problems with bodily function and structure can be referred to as impairments or loss of faculty.

In the ICF, disability is defined as:

[5] 'Participation' replaces what the WHO use to call handicap, but this is a term that is nowadays is considered unacceptable my many in the disability community (Spicker, 2011:164).

> 'An umbrella term for impairments, activity limitations and participation restrictions. Denotes the negative aspects of the interaction between an individual (with a health condition) and that individual's environmental and personal context.'
>
> Üstün *et al.* (2010:79)

Table 2.1: List of chapters in the ICF

Body	
Function:	**Structure:**
Mental Functions Sensory Functions and Pain Voice and Speech Functions Functions of the Cardiovascular, Haematological, Immunological and Respiratory Systems Functions of the Digestive, Metabolic, Endocrine Systems Genitourinary and Reproductive Functions Neuromusculoskeletal and Movement-Related Functions Functions af the Skin and Related Structures	Structure of the Nervous System The Eye, Ear and Related Structures Structures Involved in Voice and Speech Structure of the Cardiovascular, Immunological and Respiratory Systems Structures Related to the Digestive, Metabolic and Endocrine Systems Structure Related to Genitourinary and Reproductive Systems Structure Related to Movement Skin and Related Structures
Activities and Participation	
Learning and Applying Knowledge General Tasks and Demands Communication Mobility Self Care Domestic Life Interpersonal Interactions and Relationships Major Life Areas Commmunity, Social and Civic Life	
Environmental Factors	
Products and Technology Natural Environment and Human-Made Changes to Environment Support and Relationships Attitudes Services, Systems and Policies	

Source: WHO (2002:16)

And functioning is:

> 'An umbrella term for body functions, body structures, activities and participation. Denotes the positive aspects of the interaction between an individual (with a health condition) and that individual's environmental and personal context.'
>
> Üstün *et al.* (2010:80)

The ICF sees disability as a multi-dimensional concept and is the product of impairments, activity limitations and participation limitations (see Table 2.2).

Table 2.2: Levels of functioning and disability in the ICF

Level of functioning	Parallel level of disability
Body functions and structures	Impairments
Activities	Activity limitations
Participation	Participation limitations

Source: Üstün *et al.* (2010:11), Table 2.1.

Although the ICF is widely used, it is too extensive and complex to be used directly in work capacity assessments. Indeed, it was not developed to be a work (in)capacity assessment tool. However, a ICF Checklist has been developed (WHO, 2003), which WHO describes as a simple and time efficient 'practical tool' for recording disability.

The WHO has also developed the WHO Disability Assessment Schedule (WHODAS 2.0) from the ICF as an assessment tool to measure health and disability across countries (Üstün *et al.*, 2010).[6] WHODAS 2.0 covers six domains (Üstün *et al.*, 2010:4):

1. Cognition – understanding and communicating
2. Mobility – moving and getting around
3. Self-care – attending to one's hygiene, dressing, eating and staying alone
4. Getting along – interacting with other people
5. Life activities – domestic responsibilities, leisure, work and school
6. Participation – joining in community activities, participating in society.

Each domain provides a summary measure of functioning and disability. WHODAS 2.0 does not include questions on impairments or environmental factors, which may limit its usefulness in assessing work (in)capacity.

In 2004 a working group of the European Union of Medicine in Assurance and Social Security (EUMASS) produced a core set of ICF categories for functional assessment in disability/incapacity claims in European social security systems (Broersen et al., 2011). This core set comprises 20 categories: five for body functions and 15 for activities and participation. No category from environmental factors was included. It contains common definitions for expressing functional capacity and individual countries can supplement these categories according to their own standards and legislation. Anner *et al.* (2012) suggest such core sets are useful for describing functional capacity, and so have a role in, say, social insurance statistics.

Anner *et al.* (2012) appraise the extent to which the ICF captures the core features of work (in)capacity assessments. They find that it is welcome in that it

[6] There are seven versions of WHODAS 2.0. The full version has 36 questions and the short version 12 questions; and it can be self-administered, by interview and by proxy (see Üstün *et al.*, 2010, Part 3).

moves medical assessors away from the medical model of disability, and places work (in)capacity in a wider bio-psycho-social setting. However, they identify a number of limitation in the ICF from a work incapacity perspective. ICF does not fully deal with how a person's experience of disability can change over time, allow a causal link between a health condition and a functional incapacity to be identified, nor provide statements about a person's work ability.

2.4 Capability Approach

The Capability Approach provides another perspective on how to conceptualise people's well-being, social arrangements (Robeyns, 2003, 2005) and disability. The Capability Approach was developed by Amartya Sen with others, notable Martha Nussbaum, and has been used as a framework for thinking about poverty, inequality and human development. Underpinning the framework is a concern with human capability and freedom (Cark, 2005:2). It underpins the United Nation's Human Development Index.

The approach focuses on what people are able to do and be ('doing and being'), their well-being, and removing barriers so that they have the freedom to realise the life they value. Clark (2005:4), citing Sen, outlines the key concepts in the framework:

> '• *Functioning* - A functioning is an achievement of a person: what she or he manages to do or be. ... Achieving a functioning (e.g. being adequately nourished) with a given bundle of commodities (e.g. bread or rice) depends on a range of personal and social factors (e.g. metabolic rates, body size, age, gender, activity levels, health, access to medical services, nutritional knowledge and education, climatic conditions, etc). A functioning therefore refers to the use a person makes of the commodities at his or her command.
> • *Capability* - A capability reflects a person's ability to achieve a given functioning ('doing' or 'being') … For example, a person may have the ability to avoid hunger, but may choose to fast or go on hunger strike instead. (Note that Sen typically uses the term capability in a much broader and more general sense to refer to capabilities in plural or the actual ability to function in different ways …).
> • *Functioning n-tuple* - A functioning n-tuple (or vector) describes the combination of 'doings' and 'beings' that constitute the state of a person's life. … Each functioning ntuple represents a possible life-style.
> • *Capability Set* - The capability set describes the set of attainable functioning n-tuples or vectors a person can achieve. … Sen … emphasises that capabilities reflect a person's real opportunities or positive freedom of choice between possible life-styles.'

An example of a functioning is being able to work, and a capability is being able to fulfil that functioning (what the person *can* do or *can* be). A person's functionings are a sub-set of their capability set, and represent what they have chosen to achieve. In work incapacity terms, a capability is not a physical or mental ability, but a real opportunity. So providing rehabilitation services means that a person's capability set includes an 'opportunity freedom', a freedom of choice, to improve their quality of life. The capability set will be influenced by

the commodities (such as food) available to a person; their physical, social, cultural economic and political environment; and their personal characteristics (for example, age and health status). Accordingly, the primary goal of public policy should be expanding human capabilities (rather than, say, maximising economic growth) (Clark, 2005:10). Policy should ensure that people have an 'adequate income' to guarantee 'minimal functioning'; although how individuals' capabilities are to be identified for support is less clear. Nussbaum (whose approach does differ from Sen's formulation) has sought to specify the ten capabilities (or substantive freedoms) that democratic societies should value and support. They are: '(1) Life; (2) Bodily health; (3) Bodily integrity; (4) Senses, imagination and thought; (5) Emotions; (6) Practical reason; (7) Affiliation; (8) Other species; (9) Play; and (10) Political and material control over one's environment' (original in italics in Clark, 2005:6).

Mitra (2006) considers the application of the Capability Approach to disability. She argues that the Capability Approach is '… a useful framework for defining disability and understanding its economic causes and consequences. (2006:236).[7] As:

> '… disability can be understood as a deprivation in terms of capabilities or functionings that results from the interaction of an individual's (a) personal characteristics (e.g., age, impairment) and (b) basket of available goods (assets, income) and (c) environment (social, economic, political, cultural).'
>
> Mitra (2006:237)

Mitra (2006:237) points out that the Capability Approach gives a formulation of disability that is related to the ICF framework discussed above (Section 2.3.3). The Capability Approach can be used to distinguish disability at two level: the capability level (or potential disability); and the functioning level (or actual disability).

In terms of disability and employment a Capability Approach leads policy to look beyond a person's characteristics (notably any functional limitations arising from an impairment) to other personal characteristics (for instance, educational attainment), resources and the environment (such as discrimination by employers) that may contrive to create a work incapacity. This perspective has implications for how incapacity assesses and how barriers to work are identified and tackled. As Mitra (2006:244) observes:

> '… the question under the capability approach is as follows: Does the person have the practical opportunity to work given her personal characteristics (age, impairment, education, work experience), environment (local economy, transportation, laws), and resources (assets, income)?'

It implies a highly personalised and wide ranging assessment of work (in)capacity.

[7] See also Terzi (2005) on the Capability Approach and disability and special educational needs.

Sen's thinking has developed organically, and the Capability Approach is seen as being flexible. One of the criticism of the approach is that it is not easy to understand and is difficult to operationalise (see Goerne, 2010).

2.5 Conclusions

This review provided a more extensive and in-depth account of the relevant concepts – ill-health/sickness, incapacity and disability – than in the earlier review of Jersey's incapacity system (see Stafford, 2007).

As noted in Stafford (2007) Jersey's usage of loss of faculty for assessing eligibility for Long-Term Incapacity Allowance resembles the ICF definition of impairment.

The findings of this review support the position presented in Stafford (2007) that because disability is the outcome of complex interactions between personal characteristics and the environment (cf social model, ICF and Capability Approach), non-health factors as well as medical considerations are important in determining incapacity. Some other countries do take into account non-medical personal characteristics when assessing incapacity. Such factors are currently excluded from Jersey's definition of incapacity and loss of faculty. This important issue is discussed further in Section 3.2.6.

3 Assessing incapacity

A useful distinction can be made between the *assessment* (often conducted by a medically qualified professional) and the *claim or assessment process*, from initial claim to decision, that involves a number of other staff. This chapter follows this distinction, the next Section explores countries different approaches to the claims/assessment *process*. Section 3.2 focuses on the *criteria* used in the assessment of incapacity.

3.1 Approaches to assessment

How assessments arrangements are organised varies between countries. De Boer *et al.* (2004:20, 47-8) identify three typologies:

- Medical – the presence of certain diseases or impairments is assumed to affect labour market participation, and so the emphasis of the assessment is on the severity of the symptoms, and the presence of diseases or impairments. The outcome can be a binary 'capable or not capable' decision.
- Functional capacities – the ability to undertake certain functional activities (for instance, walking a set distance, or being able to feed oneself) is assumed to affect labour market participation. This link may be taken to be direct or jobs are matched to activities.
- Rehabilitation and re-integration – the assessment is based on the options for, and any outcomes of, rehabilitation. Where rehabilitation is possible the individual is deemed capable of work. The time period over which the person's likelihood of rehabilitation is considered is limited.

In practice, these approaches can be used in combination and De Boer *et al.* (2004:21) identify four assessment regimes:

- solely medical (for example, Belgium, Italy, Russia and USA);
- medical combined with functional (for example, Ireland, Spain and UK);
- medical combined with rehabilitation/re-integration (for example, France, Germany and Norway); and
- medical combined with functional and rehabilitation/re-integration (for example, Denmark and the Netherlands).

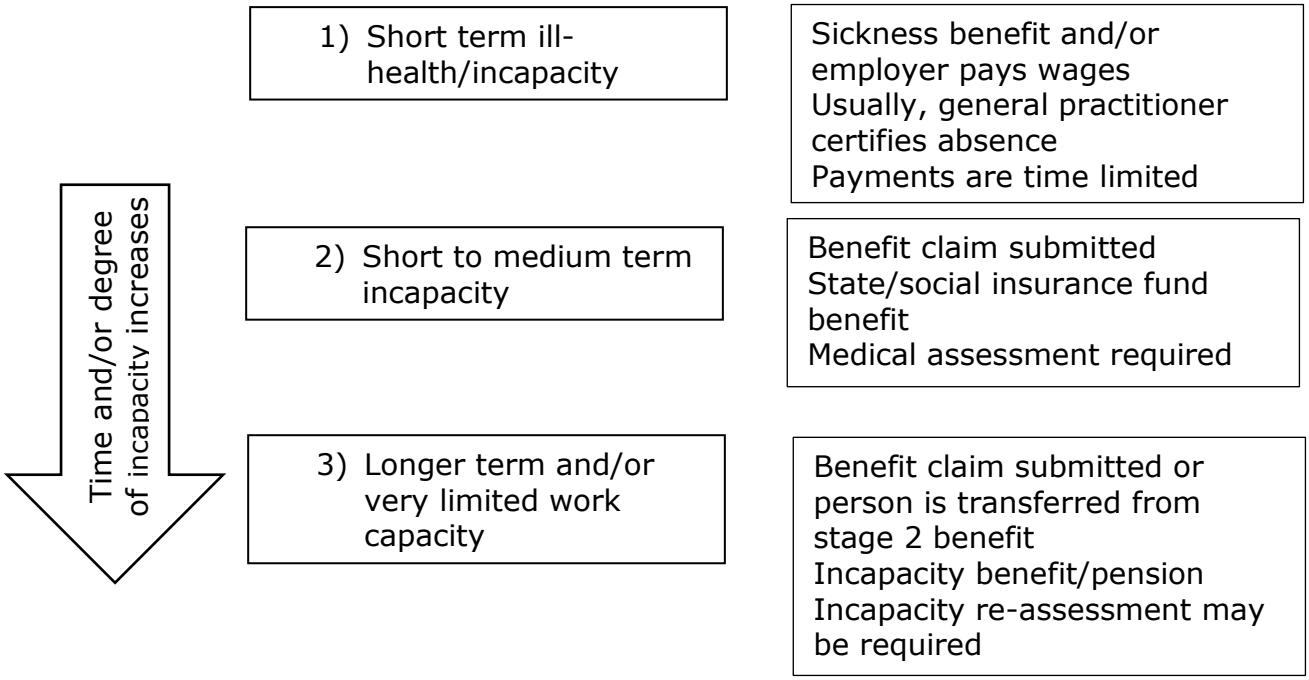
The remainder of this section discusses a number of characteristics of the assessment process. Relevant examples are used from the four assessment regimes to illustrate the diversity of approaches adopted.

3.1.1 Aim of the assessment process

A key goal of the assessment process across all countries is to check entitlement to a benefit. In, for example, Finland, Hungary and the Netherlands, the assessment is also used to determine the level of the benefit (de Boer *et al.*, 2004:93, 96, 98). In some countries (such as Denmark and France) the intention is also to promote, even assess the need for, rehabilitation/re-integration (de Boer *et al.*, 2004:29). In Denmark the aim includes investigating how to improve a claimant's work capacity (see de Boer *et al.*, 2004:92).

3.1.2 Benefit structures and processes

Different countries have different arrangements for sickness, incapacity (and disability) benefits. Notwithstanding, considerable variation between countries a three tier structure characterises most of the countries looked at:



Source: Author's own

This is an abstract model of incapacity benefit structures, but does show how duration of incapacity and/or degree of incapacity can be categorised in benefit terms. Most countries' benefit arrangements make a distinction between short-term and longer-term incapacity for work.

Frequently, when an employee is unfit to work due to ill-health employers can continue to pay (a proportion of) their wages for a set period (OECD, 2003:108 and Table A4.3). The duration of this period varies across countries and in some instances will vary by collective agreements. There are few countries (for example, Canada and Mexico) where employers are not obliged to continue paying wages during periods of sickness absence. For the first few days of sickness absence the individual may effectively be able to self-certify their incapacity, but at some point (usually after a few days) a certificate is required (often, but not always) from a general practitioner.[8] The sickness certificate

[8] A notable exception is the Netherlands, who separate the *control* from the *treatment* of sickness. The reason for this is that:

> 'The confidential relation between a patient and his or her doctor should not be burdened with checking the medical legitimacy of absence from work. Therefore, every company is obliged to contract an occupational physician.'
>
> De Jong (2012:8)

provides independent evidence that the individual is not fit for work. Payment of sick pay/wages by the employer and/or state will be time limited.

The maximum duration for employer payments for sickness absence varies between countries, for example, from 28 weeks for the UK under the Statutory Sick Pay scheme (although employers may operate an occupational sickness scheme that is more generous than this legal minimum) to two years in the Netherlands (Cousins *et al.*, 2016:12). Unusually, full-time employees in Australia are only entitled to a maximum of ten paid days per annum of sick leave. Beyond this period whether sick pay is paid and for how long depends upon the employee's contract. (A means-tested Sickness Allowance is available in Australia for those with a temporary (expected to last less than two years) condition) (Cousins *et al.*, 2016:13).)

On the termination of sick leave, most people return to work but some will transition to higher tier benefits.[9] There are terminological differences for benefits for 'medium-term' work incapacity. They are often labelled as a disability benefit, rather than called an incapacity benefit. However, this use of 'disability' does not change the substantive reason for the award of the benefit, namely, a work incapacity. At this (and the next) stage social security administrations and medical assessors have a leading role, with the former collating relevant information.

Where the incapacity to work is for a longer period of time, or at the outset it is clear that the person is unlikely to return to work (in the foreseeable future), benefit recipients may be awarded what is often termed an invalidity pension or disability pension (tier 3).

Not all countries have different benefits for that is termed above tiers two and three. One benefit might cover both tiers, as in the UK where the Employment Support Allowance has two distinct groups the Work-Related Activity Group (tier 2) and the Support Group (tier 3). Other countries do have different benefits, for instance, Belgium has a Primary Disability Benefit (tier 2) and an Invalidity Pension (tier 3) (de Boer, *et al.*, 2004:107). Moreover, more than two gradations may be recognised, for instance, the Netherlands has seven levels of incapacity ranging from a loss of earnings of 15 per cent to a 100 per cent (je Jong *et al.*, 2011:109). As the degree of incapacity increases, moving from tier 2 to 3, higher rates of benefit may be paid.

In general, there are no time limits on the duration of long-term incapacity benefits (or pensions) (up to state retirement age) (Cousins *et al.*, 2016:12).

An employee must report their ill-health to their employer who in turn contacts an Arbodienst (or certified company doctor, who often work for private occupational health businesses) to assess and monitor the incapacity of the employee (Cousins *et al.*, 2016:22). They do not treat the employee, but will support returns to work.

[9] There will also be some who leave the labour market but do not claim incapacity benefit (for instance, those retiring), and some will still be active in the labour market but unemployed.

These are not three discrete stages, and an individual's journey is not necessarily linear, for instance, someone with cancer is likely to immediately receive the benefit associated with having a longer-term incapacity.

Typically, benefits for an incapacity are differentiated from those for unemployment, because the recipient's incapacity means that they are unavailable for work. Claimants can only be in-receipt of either unemployment benefit or disability/incapacity benefit, not both. However, recent developments in the UK, with the rollout of Universal Credit, begin to undermine this distinction. The social insurance versions of Jobseeker's Allowance (for unemployment) and Employment Support Allowance (for incapacity) continue, but the social assistance versions of both are being replaced by Universal Credit. Those with an incapacity to work will receive a 'work capability amount' in their Universal Credit. Similarly, in Sweden the distinction between incapacity and unemployment can be blurred (Garsten and Jacobsson, 2013). For the public and recipients this risks confusing two distinct concepts – unemployment and incapacity. The former includes the condition that the individual is available for work (that is, assessed as have a work capacity, even if they are suffering ill-health or an injury), and the latter requires that they are unavailable for work (that is, have a work incapacity).

3.1.3 Assessment timescales

Some countries have waiting periods between the onset of the medical condition and when a claim for benefit will be processed. For instance, the waiting period for Disability Insurance in the USA is five months so that people with short-term sickness have time to recover (Low and Pistaferri, 2010:9).

Cross country comparisons of the time taken from claim to assessment and the duration of the assessment are problematic because of differences in the actors, organisational arrangements and regulations involved. Unsurprisingly, there are wide variations. De Boer *et al.* (2004:30) reports timescales for claim to assessment ranging from five days to four months; and assessment timings ranging from 15 minutes (Ireland) to 405 minutes (the Netherlands), with most lasting 60 minutes.

Regulations may specify the time period between claim submission and assessment; although in practice these are not always met due to, say, high workloads (see de Boer *et al.*, 2004). Italy appears to be unusual in having no clear set timescales for the assessment process (see de Boer *et al.*, 2004:97).

Time delays in determining benefit entitlement and commencing rehabilitation can be a feature of countries with more than one (private/public) insurance provider involved in the assessment process (for instance, Finland (de Boer *et al.*, 2004:129)).

3.1.4 Participants in capacity assessment

A range of different actors can be involved in the assessment of work incapacity (de Boer *et al.*, 2004). The key actors involved are discussed below.

Individuals

Individuals (or users) may self-certify spells of ill-health for short periods of sickness absence, claim benefits, and provide evidence to social security

decision-makers, general practitioners and medical assessors to support their claims for sickness/incapacity benefit. The claimant is typically seen as an important source of information for judging a claim. In most countries (but not all) the claimant is legally obliged to provide information as part of the assessment process.

Employers

Employers may pay sick pay/wages during periods of sickness absence, insure workers, manage sickness absences, and provide occupational health services and rehabilitation support. The extent to which there are legal obligations on the employer (and in the Netherlands also on the employee) to take actions to facilitate the re-integration of the employee varies; in most countries there is a requirement to make reasonable adaptations to facilitate a return to work. In most countries the employer has no formal role in the assessment process (for example, Belgium (de Boer *et al.*, 2004:89)). However, employers may have to provide information (for instance, on wages) to the social security organisation as part of the assessment process (for example, in Finland, the Netherlands and Slovenia) (de Boer *et al.*, 2004:26). In Slovenia an employer can attend the assessment (de Boer *et al.*, 2004:90). Exceptionally, employers in Finland can in some instances be asked for their opinion on the work capacity of the employee (de Boer *et al.*, 2004:89). In Italy a claimant does not have to tell their employer about their claim, nor does the social security agency inform the employer about the assessment; this arrangement is designed to protect privacy (de Boer *et al.*, 2004:89). In the Netherlands and Ireland, but not elsewhere, the employer can, under certain circumstance, appeal the assessment decision.

General practitioners

General practitioners may certify periods of sickness absence (but see allied health professionals below) and provide supporting evidence to medical assessors and benefit decision-makers. When certifying sickness, general practitioners are making a decision about an individual's fitness for work, and declaring that they have a work incapacity for medical reasons. In most countries it is the individual who initiates a claim for benefit. However, in France the treating doctor tends to make the decision about whether an application for an invalidity pension should be made following 12 to 18 months of sick leave (de Boer *et al.*, 2004:112). In Germany the general practitioner can advise the person to apply, the person can apply on their own, the health insurance provider can apply, or the unemployment insurance provider can ask the person to apply (de Boer *et al.*, 2004:113). The treating general practitioner may also be allowed to accompany the claimant to the medical assessment and/or help with any appeal. In Italy, claimants making appeals are supported by a doctor from the person's trade union (de Boer *et al.,* 2004:79).

When the medical condition is longer term and information is sought by a third party (such as a medical assessor), practices varies as to whether the general practitioner is required to only provide a prognoses and/or diagnosis (as in, for instance, the Netherlands), or if they are also asked to supply an assessment of the patient's work capacity (as in, for instance, Norway) (see de Boer *et al.,* 2004:80; see also OECD, 2010:84-5). The onus for requesting information from the general practitioner may rest with the claimant or the social security agency. De Boer *et al.*, (2004:34) found that in some countries (for example, Finland, Spain and the UK) the quality of the information provided by general

practitioners to assessors could be poor. This is important because higher quality information can reduce the need for medical assessors to undertake examinations.

General practitioners can find assessing a person's fitness for work challenging, because of the complex nature of the doctor-patient relationship (see Section 3.1.7). In systems where general practitioners are asked to assess or comment on rehabilitation possibilities, there can be a lack of knowledge about the patient's ability to undertake other work (as in Finland (de Boer *et al.*, 2004:129)). However, in small (rural) communities the general practitioner may have a good understanding of the labour market and hence the likely of a return to work.

Writing in 2003, the OECD (2003:85) observed that in countries where treating doctors had an important role in the assessment process, benefit caseloads and inflows continued to increase.

Allied health professions

In some countries sickness certification can be conducted by allied health professionals. For instance, in Australia medical certificates can be issues by ten types of 'registered health practitioner', including pharmacists, acupuncturists, chiropractors and traditional Chinese medicine practitioners. However, general practitioners continue to have a key role in the return to work process (Mazza *et al.*, 2015).

Medical assessors

In most countries assessments for disability/incapacity benefit are conducted by specialist medical assessors (OECD, 2010:84).

Medical assessors are seen as a way of ensuring that independent medical opinion helps determine the work capacity status of claimants. Formally, they make a judgement of the claimant's work capability the assessor by applying the relevant rules and regulations. Medical assessors can review sickness certification cases (for example, in Finland, the Netherlands and Sweden), and typically assess long-term incapacity/disability claims (Cousins *et al.*, 2016:27-8). In some countries (for example, Hungary and Ireland) the medical assessor (rather than a labour expert or administrator) make proposals for the claimant's rehabilitation (Boer *et al.*, 2004:141-2). Unusually, in Norway the claimant's general practitioner is also the main medical assessor (de Boer *et al.,* 2004:26). This arrangement is meant to provide more holistic assessments.

Medical assessor are professionally qualified doctors (possibly with post-qualification experience in work (in)ability assessment). In some countries (for example, Belgium, France, Ireland, the Netherlands, the UK, and the USA), medical assessors also need to have undertaken formal training in undertaking medical assessments (de Boer *et al.*, 2004:25). They are also bound by codes of professional conduct, values and ethics.

Assessors are recruited or selected, instructed and supported by the relevant social security agency. They are usually employed directly (for example, in France and the Netherlands), or contracted (for example, in the UK) by the relevant social security agency (Cousins *et al.*, 2016:28).

Medical assessors may work on their own (for example, in France, Germany and the UK), or in (multidisciplinary) teams (for instance, in the Netherlands) (de Boer *et al.*, 2004:32). In some countries, for example, Hungary the assessors work in pairs; here the second assessor is consulted on the assessment made and may not be present at the assessment due to high workloads (de Boer *et al.*, 2004:85). However, this 'second opinion' approach can mean that assessment decisions are based on 'negotiation or authority', rather than 'argumentation' (Boer *et al.,* 2004:34). Initial assessments may be scrutinised by others. In Belgium the assessor's decision for the Invalidity Pension is peer reviewed by a member of the committee comprising medical advisors from the five health insurance companies and the National Institute for Sickness and Disability Insurance (which organises and financially manages compulsorily insurance for healthcare and benefits in Belgium) (de Boer *et al.*, 2004:107-8).

The claimed benefits for (multidisciplinary) team-based assessments are improved quality of assessment decisions (as they are more robust), the opportunity to promote early on the rehabilitation/re-integration of claimants and the greater likelihood that claimants will accept the assessment decision (de Boer *et al.*, 2004:33). Disadvantages include the increased risk of miscommunication between assessors (especially, if from different disciplinary backgrounds), process delays and claimants not understanding the incapacity criteria. In some team-based systems there can be a lack of transparency in that the assessment report will not record any disagreements between team members.

The case for a sole assessor is that a claimant has to deal with only one examiner, and, by definition, it avoids the risk of potential miscommunication between team members. The shortcoming is that there is limited scope (other than internal reviews/external appeals) to test adequately work capacity decisions in (complex) cases where doctors' judgements would differ. If decisions on rehabilitation are also sought in the assessment, there is a risk that different medical assessors will have different understandings and knowledge about return to work options and so a degree of arbitrariness is present in decisions.

Medical specialists/consultants

Medical specialist in some cases may be asked to provide evidence to the medical assessor over and above that provided by a general practitioner.

Social security officers (benefit case managers)

Social security officers administer the claim process (including referrals to the medical assessors), gather medical and other evidence, communicate with the claimant, and may determine if benefit is to be awarded on grounds of a work incapacity. A case management approach may be adopted, for instance, in Denmark cases are managed by qualified social workers (de Boer *et al.*, 2004:83). The administering social security agency is typically national and in the public sector (de Boer *et al.*, 2004:24). However, in Denmark the administration is municipalised, and in Italy the final decision on awarding a benefit is taken locally rather than at one of the regional centres where medical assessments are conducted.

Social insurance officers
The administration of the benefit claim may or may not be organisationally separate from the staff administering the social insurance fund; for private insurance there will be a different set of insurance actors from the social security staff. There may be one or more bodies administering social insurance fund(s) within a country.

Labour market expert
The job title and role can vary, but the process can involve someone with expertise in the provision of vocational rehabilitation/re-integration support and/or knowledge of labour market conditions and job demands. For systems based on a percentage loss of earning approach to work incapacity (see Section 3.2.5), they may calculate the claimant's loss of earnings. Provision of support to help claimants return to work may be provided in-house or contracted out. In some countries labour experts have a role in the assessment (for example, in Germany and the Netherlands) or can be consulted (in Denmark) (de Boer *et al.*, 2004:31). In Germany, the labour experts take the decision on whether benefit is to be awarded. In the USA, the 'disability examiner' must possess some labour market expertise. Countries with a more of medical approach to incapacity assessment are less likely to involve labour market experts in the process.

Legal representatives
Lawyers, advisers, judges and court officials can be involved if the claim for benefit is refused and an appeal to a tribunal or the courts is made.

Decision maker
For claims where appeal processes are not invoked, the final decision on whether someone has a work incapacity may be taken by the medical assessor (for example, in Belgium and France) or a recommendation is made to a social security/social insurance official for determination (for example, a case manager in the Netherlands and Denmark, or the labour expert in Germany) (de Boer *et al.*, 2004). Separating the work capacity assessment from the decision on benefit entitlement introduces some degree of objectivity into the process as the capacity assessment is reviewed by another person.

3.1.5 Modes of assessment
Processes vary in whether initial assessments are desk-based, involve a face-to-face meeting or (depending upon circumstances) both. Countries that include an initial desk-based assessment include Finland, Germany and Norway (de Boer *et al.*, 2004:30). Belgium requires that the first assessment is conducted face to face (de Boer *et al.*, 2004:91).

Some claimants' conditions fluctuate, even on a day-to-day basis, and systems attaching a relatively high importance to face-to-face meetings/examinations risk over-estimating the work capacity of people having a 'good day', when their performance is not representative of their underlying capacity. This in turn may generate relatively high numbers of appeals, which are upheld.

In general, how re-assessments are conducted does not substantially differ from first assessments, although less information is collected (de Boer *et al.*,

2004:31).[10] Accordingly, re-assessment can be of shorter duration and less likely to involve a face-to-face meeting with the assessor. However, in Hungary re-assessments take longer, and are desk-based when caseloads are high (de Boer *et al.*, 2004:96).

3.1.7 Nature of the assessment

Assessing work capacity and incapacity is very difficult:

> In practice, it is exceedingly difficult to distinguish those who are able to work from those who are not …'
>
> OECD (2003:83)

There are numerous studies of the sickness certification process (see Letrilliart and Barrau (2012) and Wynne-Jones *et al.* (2010) for reviews). These tend to show that certification is an important aspect of doctors', especially general practitioners', workload. However, a range of factors, other than those directly related to work capacity, can affect capacity assessment decision making. These studies highlight a number of difficulties with the sick certification process, including (Letrilliart and Barrau, 2012:221-4; Cousins *et al.*, 2016:9 21-22; de Boer *el al.*, 2004:38-9; Money *et al.,* 2015:528-9; Mazza *et al.*, 2015; Wynne-Jones *et al.*, 2010):

- Difficulties in assessing the need for sick leave and its length from a functional perspective. Himmel *et al.* (1995:161) provide an insight as to why doctors have difficulties assessing of work incapacity, because it:

  > '… constitutes a difficult situation for doctors as they not only have to decide if and to what degree a patient is ill but also if illness influences the patient's occupational role. Especially in new cases and unclear disorders (such as low back pain) the decision about sickness certification will often be based on patients' reported symptoms. The amalgamation of medical tasks – based on a trusting relationship - and certification following administrative requirements may put additional stress on the patient-doctor relationship.'

  In part this is attributed to a lack of clarity about, or training in, occupational certification matters and/or general practitioners not always attaching sufficient importance to the role. For instance, in 2002 the UK's Department for Work and Pensions issued guidance on recommended durations for sickness absences for several conditions, but an evaluation showed low awareness (36 per cent) and use (20 per cent) of the guidelines. Certifying doctors can also have limited knowledge of benefit rules (Cousins *et al.,* 2016:21). Suggested solutions include training for general practitioners based on the International Classification of Functioning, Disability and Health (ICF) derived 39 item checklist, use of two pain questionnaires (SF-36 and ALBPSQ) and getting occupational health physicians or multi-disciplinary teams (see Section 3.2.4) to undertake sickness certification. Money *et al.,* (2015) compared the certification practices of UK general practitioners trained to Diploma level

[10] Re-assessments and reviews are discussed in Section 3.1.8.

in Occupational Medicine of the Faculty of Occupational Medicine with those who had not been trained. The statistical analysis showed that, in general, general practitioners (especially female and older doctors) with training in occupational medicine were more likely to have positive attitudes towards their patients returning to work than those not trained (Money *et al.,* 2015:535-6).

- Difficulties in the doctor – patient relationship:

> 'GPs frequently feel that they fulfil a 'dual role,' being both the patient's advocate and a medical expert for the insurance system. They often have conflicts with patients about the need for sick-leave, either when the patient demands a sick leave perceived as irrelevant by the physician or when the patient refuses the sick leave prescription. Some solutions for difficult situations have been suggested, such as using institutional support and getting help from more experienced colleagues, but these proposals have never been assessed.'
>
> Letrilliart and Barrau (2012:221)

Patients demanding sickness certificates is known to be a 'common cause' of conflict in doctor-patient consultations (Wynne-Jones *et al.* (2010:68, 71-2). There is a body of research that shows:

> 'The pressure to certify sickness absence within the traditional doctor–patient relationship has long been acknowledged as a barrier in the sickness certification system, with GPs prioritising their role as patients' advocate above their role as gatekeeper …'
>
> Money *et al.* (2015:536)

Indeed, in Australia and Finland there are allegations of 'doctor-shopping' whereby individuals will contact health practitioners until they obtain their desired sickness certificate outcome (Mazza *et al.*, 2015; (de Boer *et al.*, 2004:129). It can be more difficult for an assessor to find someone fit for work if they have empathy or compassion for the claimant. Assessors can find it difficult to determine that someone is capable of work if they exhibit intimidating behaviour towards them. Several studies show a degree of 'negotiation' between doctors and patients over the issuing of sickness certificates (Monneuse, 2015 and Nilsen *et al.*, 2015 *cited* in Cousins *et al.*, 2016:9; Wainwright *et al.*, 2015). Cousins *et al.* (2016:9) found examples of such studies in Sweden and the UK and to a lesser extent in Australia, Finland and France.

Whilst such 'shopping around' is not evidence of fraudulent behaviour, it is a potential enabler of employees falsely claiming sickness absence. Independent assessments for incapacity benefits by medical assessors should help minimise the risk of a fraudulent claim being successful.

- Difficulties related to healthcare systems, notably poor communication between general practitioners and occupational health physicians; delays in referrals, treatment and aids; limited time for conducting assessments, filling in certificates correctly and encouraging patients to return to work; and lack of support from health authorities. Time pressures and high

workloads can mean that assessors are less inclined to consult medical specialists and/or more likely to determine a claimant as having an incapacity in order to avoid future delays for themselves (such as those arising from appeals).

- Difficulties in the socioeconomic environment included lack of adaptions by employers and labour markets not providing suitable employment given patients medical status. If the wider social and political discourse is hostile towards social security, then assessors can find it more difficult to accept claims. In some countries (for example, Germany and Italy) there appears to be a bias towards older people being granted incapacity status. Claimants with poor job prospects in, for example, Italy and Norway, appear to be more likely to be assessed as having a work incapacity.

Letrilliart and Barrau (2012:219) conclude:

> 'Sickness certification represents a procedural as well as a relational, organizational and political challenge. Well-validated tools or procedures to support doctors in this task are lacking. The development of functional assessment and cooperation with occupational practitioners requires appropriate training and education for present and future GPs.'

Before a medical examination is undertaken by a medical assessor, claims can be screened by social security officials to check that all relevant information has been provided and to determine whether a claim can be determined (rejected or accepted) without an assessment being required. In Belgium, this screening process includes considering the reputation of the treating doctor who authorised the sickness certificate, because some are renown for 'the ease with which they write certificates' (de Boer *et al.*, 2004:134). But there is no formal list of doctors with a poor reputation.

The factors that medical assessors consider in an assessment can vary between countries (c.f. four assessment regimes discussion above). Typically, an assessor considers the health status of the claimants – including medical history and diagnosis. Cross-national studies have considered the key features of assessments. For example, Anner *et al.* (2012) identify the four 'core features' of assessment reports as:

> '… 1) the functional capacity of the claimant; 2) the socio-medical history, including the development and severity of the claimant's health condition, his/her previous efforts to regain health and return to work, and his/her job and social career; 3) the individual prognosis of work disability; 4) the feasibility of interventions to promote recovery and return to work.'

In addition,

> 'The medical report must also follow legal requirements, such as to establish a causal relation between a claimant's health condition and his/her functional capacity. … Medical examiners must also provide a general statement about work ability; this can be expressed as a percentage, degree of disability or in working hours.'

Table 3.3: Main features in social insurance work (in)capacity assessment cases across European countries

Core features for assessing work (in-)capacity	Countries required to report the core features
1) Functional capacity of the claimant	BE, CH, CZ, DE, FI, FR, GB, IT, NL, NO, SE, SI, SK[1]
2) Health condition (disease, symptoms, complaints)	CH, FI, NL, NO, SE
3) Socio-medical history (claimant's development and severity of ill health condition, his previous efforts to regain health and return to work, job and social career)	BE, CH, CZ, DE, DK, FI, FR, IT, NL, NO, RO, SE, SI, SK
4) Prognosis of work disability (Prognosis of disease and functional capacity)	BE, CH, CZ, DE, FI, FR, GB, IT, NL, NO, RO, SE, SI, SK
5) Feasibility of therapeutic and rehabilitative interventions	BE, CH, DE, FI, FR, GB, IT, NL, NO, RO, SE, SI, SK
6) Causality: functional incapacity exclusively caused by a health condition	CH, DE, FR, NL
7) Consistency between impairments, activity limitations and restrictions in work	CH, DE, NL
8) Ability to work	Expressed as percentage in BE, CH, FR
	Expressed as degree of disability in CZ, NL, SL, SI, RO
	Expressed as hours of work: DE

BE = Belgium, CH = Switzerland, CZ = Czech Republic, DE = Germany, FI = Finland, FR = France, GB = Great Britain, IT = Italy, NL = Netherlands, NO = Norway, RO = Romania, SE = Sweden, SI = Slovenia, SK[1] = Slovakia. According to international abbreviation: http://www.iana.org/domains/root/db.

Source: Anner *et al.* (2012, Table 1)

Based on an analysis of social insurance medical reports, Anner *et al.* (2012) have identified the main features in work (in)capacity cases across European countries (see Table 3.3)

De Boer *et al.* (2004:18-19, 21-22) also identify variations in how incapacity was operationalised across 15 countries:[11]

- The causes of the incapacity can reference a number of different factors, such as disease, injury, and impairment. However, these wording differences do not (according to the authors) lead to any substantive differences in policy intentions.
- The expected duration of the incapacity may be specified in regulations, and this can be linked to re-assessment timescales. In some cases, the duration of an impairment prior to the claim is considered.
- The timing of any re-assessments
- Whether undertaking some form of re-integration or rehabilitation activity is mandatory (see below).

In a few countries information on claimants' social and work status are also considered. An example of a comprehensive (fourth) regime is the Netherlands. Here assessors (from the social insurance funder) determine:

> '… (1) the functional capacities of the claimant, (2) the chance of recovery / prognosis, (3) the adequacy of the claimant's recovery behaviour. For all these decisions, several questions need to be answered …'
>
> de Boer el al. (2004:35)

However, the rationale for these differences between countries is not always clear.

[11] De Boer *et al.* (2004) use the term 'disability', but in the context of this review, they are referring to (long-term) incapacity.

Moreover, de Beor *et al.* (2004:37) categorise the different instruments used in capacity assessments as follows:

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

Claimants can be anxious and critical of the assessment process, in particular the way in which they are treated and accuracy of the assessment (WPC, 2011:10-12, 19-25; Litchfield, 2014). In the UK, for example, administrative problems include delays getting through to call centres, overbooking of appointments, and poor access and facilities at assessment centres.

3.1.8 Re-assessments and reviews

Assessment regimes may award incapacity benefits permanently (that is, there is no re-assessment) or require periodic re-assessments (or reviews) to be conducted (de Boer el al., 2004:22). Benefits awarded permanently may be referred to as disability or invalidity pensions/allowances. Before becoming eligible for such benefits, claimants face a waiting period. The case for awarding a benefit permanently is that:

- in order to maintain human dignity, it is unreasonable to require claimants with certain conditions (for instance, a terminal condition) to undergo re-assessment; and
- it provides claimants with certainty about their future benefit income, allowing them to make realistic plans about other aspects of their lives.

The case against is that rapid advances in medicine, changes in workplace technology and changing attitudes of society and employers mean that someone's capacity for work may change over time. Whilst re-entering the workplace will undoubtedly be difficulty, medical, technological and social change implies that periodic re-assessment, in certain cases, are appropriate. The OECD (2010:113-5) detects a trend whereby an increasing number of countries are awarding benefit for a time-limited period or payments are temporary. For example, benefits are awarded initially for up to two years in Austria and up to three years in Germany and Italy. Part of the Dutch reforms include a more robust approach to re-assessments.

In continental Europe there has been a trend to more strictly control of short-term sickness absences and this can include more frequent reviews (Cousins *et al.*, 2016:26). For those countries requiring a re-assessment, the timescales for another assessment can be laid out in legislation and/or determined more

flexibly. Where dates are specified they tend to occur sometime between every one and three years; although it can be longer (seven years in the USA).

The time periods between re-assessments can be the same (for example, annually) or vary. Timescales that allow more flexibility tend to be based on the medical examiners' judgement or the nature of the medical condition. Fixed and flexible approaches to re-assessment can also be combined in a scheme.

The Netherlands also allows claimants to request a re-assessment (de Boer el al., 2004:71).

3.1.9 Appeals

All countries examined by de Boer *et al.* (2004:31) and Cousins *et al.* (2016:28) included a right to an appeal to a tribunal or court on legal and/or medical grounds. In some countries the appellant body also has a quality assurance role. The appeal body in some countries will take into account a re-assessment or other new information.

The pre-appeal process may involve an internal review (or 'reconsideration') process within the social security agency. If the claimant is still unhappy with the decision the case may then enter the legal system. There may be more than one level of appeal allowed.

The impact of appeal decisions on subsequent assessments varies by country. For example, in the UK the Upper Tribunals interpretations of the law are incorporated in guidance issues to decision makers. However, in France appeal decisions do not set general principles or guidance for incapacity assessments (Cousins *et al.*, 2016:28-9).

The review and appeals process typically includes strict timescales for when claimants must lodge an appeal. Review and appeal procedures need to be timely. In Germany lodging an appeal can be used to delay a final decision on a case, as appeals can typically take two to four years to come to a decision (Boer *et al.*, 2004:140).

3.1.10 Quality assurance

A vital component of any assessment process is a robust quality assurance mechanism. There are various aspects of the assessment process that might be monitored (see de Boer *et al.*, 2004:41):

- the coherence and integrity of the whole *system/organisation* and the wider *network* within which it is embedded;
- the skills, knowledge and experience of *professional and other staff*;
- the assessment *process*;
- *outputs* (such as the quality of any reports); and
- the *outcomes* (or wider impacts on society) of the assessment process.

The institutions with responsibility for delivering quality assurance vary across countries. Quality assurance procedures may be conducted in-house by (other) social security staff and/or by an external body (such as, a ministry, professional body, the courts, the social insurance agency or a specialist audit unit) (de Boer *et al.*, 2004:41-2).

Measures used to assure quality include (de Boer *et al.*, 2004:44):

- handbooks and guidelines,
- protocols and standards,
- staff development - training, coaching and CPD,
- case discussions,
- using more than one assessor for each case,
- using feedback from court cases.

However, for these mechanisms to be effective they need to be systematic, clear and precise. Countries can use (for at least part of the assessment process) official quality systems, for example, ISO, EFQM, SERVQUAL, IQAS and balanced scorecard) (de Boer *et al.*, 2004:42). However, a potential shortcoming with such systems is that they are not specifically designed for monitoring or improving assessment systems.

Different performance indictors can be utilised by countries, for example, 'customer' satisfaction and processing times (de Boer *et al.*, 2004:42-3). Nonetheless, de Boer *et al.* (2004:43) find that:

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

Cousins *et al.*, (2016:24) reports that since the de Boer *et al.* study not much had changed. The focus was on the inputs to processes (such as the qualifications of staff), rather than quality control mechanisms and the incentives to make accurate decisions.

3.2 Incapacity criteria

The criteria used by countries to assess eligibility for disability/incapacity benefits varies considerably. Table 3.4 is taken from a 2003 OECD report and shows the (then) differences between countries, whilst Table 3.5 provides some more detail on the approaches and criteria used to assess work capacity in Australia, the Netherlands, Sweden and the UK.

Nonetheless, two broad approaches can be identified:

- functional assessments of work ability (in Table 3.4 this is referred to a 'work capacity'); and
- loss of earnings assessments

A third approach, used mainly for industrial diseases and injury claims, is a loss of faculty assessment. All three types are discussed in more detail below.

As already mentioned in Section 2.2, a critical consideration is whether assessments of work capacity are to be solely based on medical factors or if other factors are taken into account. The former would only require medical assessments. The latter sees work incapacity as a complex phenomenon with intricate interactions between social, physical and psychological factors and so not simply an outcome of a medical condition. (The sorts of other factors taken into account is discussed in Section 3.2.6). How incapacity is conceived will influence the criteria to be used in an assessment system. In other words, the criteria should reflect the causes of work incapacity.

Another key consideration is whether the result of the assessment decision is a binary 'capable' or 'not capable', or allows for varying degrees of partial incapacity (see Section 4.6).

In looking across countries, De Boer *et al.* (2004:36) observe that

> '… it seems difficult to grasp the exact reasoning for determining incapacity for work ... Although in most countries, it is specified on which aspects decisions have to be made, it remains hard to understand the dividing line between capacitated and incapacitated for work. For instance, what is the exact criterion for determining that a person is below or above a particular percentage (e.g., 67 %) of loss of labour or earning capacity? This seems to be particularly problematic when partially disabled individuals are not entitled to disability benefits. Even when there are a number of levels of disability, it is often not clear what exactly constitutes the dividing line between the different levels.'

So whilst countries may have explicit criteria for assessing work capacity, the threshold (or thresholds) between capacity and (degrees of) incapacity are not justified. Nevertheless, countries that can make partial awards of benefit (to reflect degrees of incapacity) tend to set a low percentage for gaining a partial award, but often have a very high percentage for being awarded benefit in full (OECD, 2003:84).

Before discussing the three operational approaches to setting criteria for incapacity, two other issues are considered: possible cases that are exempt from an assessment, and the job/work comparator, or reference point, to be used when assessing incapacity.

Table 3.4: Incapacity criteria by OECD country, 2003

	Definition of disability	Mandatory waiting period
Australia	Two criteria: having a disability that results in a score of at least 20 points on the impairment tables, and continuing inability to work 30 hours or more a week or be re-skilled for work at full wages within the next two years	None (but mandatory waiting period of ten years for people who acquire their disability before moving to Australia)
Austria	50% work-capacity reduction (earnings-capacity reduction for unskilled workers); critical role of court decisions due to imprecise legal definition	None, but health restriction must have lasted six months
Belgium	66.6% earnings-capacity reduction in the usual occupation	One year
Canada	Severe and prolonged disability that prevents doing any work on a regular basis	None
Denmark	50% work-capacity reduction (over age 50, such reduction can be due to social reasons only)	None, but rehabilitation must be completed
France	66.6% earnings-capacity reduction, but full benefit also requires loss of work capacity	None, if condition has stabilised, but often only after three years
Germany	25% work-capacity reduction; partial disability determined in relation to hours a person can work (0-3 hours or 3-6 hours)	None, but disability must have lasted 26 weeks
Italy	66.6% work-capacity reduction (for partial benefit referring to suitable job)	None
Korea	Medical criterion (four precisely defined degrees of disability)	Waiting period of about 50 days (sickness benefits not available)
Mexico	50% earnings-capacity reduction in previous job	None
Netherlands	15% earnings-capacity reduction (25% for self-employed and disabled youth); degree of disability determined as the wage in job matching the functional limitation relative to pre-disability wage	One year
Norway	50% work-capacity reduction; but earnings-capacity reduction determines the benefit level	None (after completion of proper vocational rehabilitation)
Poland	Temporary or permanent work-capacity reduction (for benefit for partial disability referring to the usual occupation)	None
Portugal	66.6% earnings-capacity reduction in the usual occupation	None, but in practice usually after three years (end of long-term sickness)
Spain	33% work-capacity reduction in usual occupation for a partial lump sum benefit; inability to carry out "usual"/"any" work for "total"/"absolute" disability	One year (but earlier claiming for clearly permanent cases possible)
Sweden	25% work-capacity reduction; degree of partial disability determined in relation to daily hours a person can work (0-2/2-4/4-6 hours)	None (after proper vocational rehabilitation)
Switzerland	40% earnings-capacity reduction; for inactive persons, degree of disability is determined in relation to the current activity (*e.g.* housework or education)	One year
Turkey	66.6% work-capacity reduction, with a strong medical focus	None
United Kingdom	Limitations in everyday activities that are relevant to work (*i.e.* predominantly medical "personal capability assessment"); but own occupation test for first 28 weeks (sickness benefit receipt)	28 weeks
United States	Earnings-capacity reduction: inability to engage in substantial gainful activity (*i.e.* to earn US$ 740 per month)	Five months (not always covered by short-term benefits), and 24 months period for Medicare coverage

Source: OECD (2003:202), Table A3.7.

Table 3.5: Examples of approaches and criteria used to assess work capacity

Country	Australia	Netherlands	Sweden	UK
Short-term support	Paid sick leave/Sickness Allowance	Paid sick leave	Sickness benefit	Statutory Sick Pay
Name of long-term payment	Disability Support Pension	Dutch Disability Pension Scheme / Wet Werk en Inkomen naar Arbeidsvermogen (WIA)	Disability Pensions	Employment and Support Allowance
Definition of long-term incapacity	Recipients have to be: either permanently blind, or have been assessed as having a physical, intellectual or psychiatric impairment and unable to work for 15 hours or more per week within the next 2 years because of the impairment.	A person must be 35% or more work-disabled. If an employee can earn more than 65% of his/her former salary with generally accepted work (this includes work duties other than his/her former work duties), he/she is not entitled to receive WIA benefits.	Sickness compensation (*sjukersättning*): Permanently full or partial incapacity for work (by at least 25%), on grounds of illness, or other impairments to the physical or mental capacity for work. Activity compensation *(aktivitetsersättning)*: Long-term (at least one year) full or partial incapacity for work (by at least 25%), on grounds of illness, or other impairments to the physical or mental capacity for work.	Incapacity for work based on functional criteria known as Work Capability Assessment.
Incapacity threshold as % of previous work capacity	-	65% or less of earnings capacity	75% or less	-

Country	**Australia**	**Netherlands**	**Sweden**	**UK**
How assessed	Impairment Tables are used to assess the functional impact of medical conditions on work capacity.	Earning capacity as % of previous wage	Assessment by social insurance officer of work capacity	The WCA assessment is points-based and is based on 'descriptors' which describe a restriction in activity.
Who certifies – short term payments	Mainly own GP. Could be pharmacist, acupuncturist etc.	Company doctor or an Arbodienst (from a licensed private occupational health and safety organisation)	GP or other doctor	Own doctor, mainly GP (Statutory Sick Pay)
Who certifies – long-term payments	Disability medical Assessments – government-contracted doctor reviews supporting medical evidence Job Capacity Assessments - Health/allied health professionals from agency of Dept of Human Services do desk or face to face assessment	Insurance doctor	Own doctor's report reviewed by social insurance officer. May be referred to doctor of social insurance agency for a second opinion	Fit Note – GP Work Capability Assessment – health care professional from contracted agency
Summary of test of long-term disability	Physical, intellectual, mental health impairment scoring > 20 points and unable to work more than 15 hours a week in next 2 years at or above minimum wage	Loss of 35% or more of work capacity, as measured by earning capacity relative to former work	Full or partial (at least 25%) incapacity due to illness or impairment	Incapacity for work

Country	**Australia**	**Netherlands**	**Sweden**	**UK**
Capacity to Work formula	Impairment Tables assess extent to which medical condition has functional impact on capacity to work.	Scores on Functional Ability List (70 items) matched against computerised list of requirements in 7,000 occupations	Activity Capacity Assessment model used after 6 months of absence	Points-based Work Capacity Assessment on restrictions in activity under various descriptors
Desk assessment by social security office?	Interview by Disability Support officers for Disability Support Pension	Desk assessment of medical and employer reports, plus face to face check	Yes	Yes. May be called for face-to-face assessment

Taken from: Cousins *et al.* (2016:14-9).

3.2.1 Exemptions from assessment

Countries can include criteria whereby the nature of a person's medical condition means that they do not have to undergo a medical assessment, but are awarded benefit. Medical conditions that can trigger this 'fact-tracking' of a benefit decision include being terminally ill, cancer and certain progressive illnesses. Australia, for instance, has a 'manifestly eligible' procedure that allows a Disability Support Pension to be awarded without a Job Capacity Assessment being conducted. The circumstances when a 'manifest grant' is permitted are specified in regulations and are as follows (Cousins *et al.*, 2016:73):

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

3.2.2 The point of reference – work comparator

In assessing work capacity, a comparison is required for the type of work that the incapacity relates too. Comparators used vary within and between countries. They include: own job, 'normal work', 'regular work', 'substantial gainful activity', any job, and subsidised wage jobs (De Boer *et al.* (2004:18-19). Typically, for sick pay and short-term benefits the work comparator is the individual's own job, but this comparator is broadened to, say, any job, over time (Cousins *et al.*, 2016:13; OECD, 2010:105).

In Sweden, for instance, work capacity is assessed against the person's existing job or other temporary suitable work provided by their employer for the first 90 days. If incapacity continues, then for up to the 180th day the assessment is against an alternative job with the same employer or trying out another job with a different employer, and thereafter against all jobs in the regular labour market. This policy, known as the 'rehabilitation chain', was introduced in Sweden to shorten the time period before a broader definition was used. It was a controversial reform (because previously sickness benefit was paid for an unlimited period). However, sickness absence rates have fallen in Sweden, and the OECD (2010:105) says:

> '… that there is great potential in trying to transfer people on long-term sick leave to other jobs earlier'.

3.2.3 Loss of faculty

Benefits with a focus on anatomical, physiological or psychological abnormality or loss tend to be limited to industrial injury/disablement benefits. The eligibility criteria used relate to loss of faculty, that is, bodily functions and structures; and

not to functional ability. Assessments of loss of faculty are typically made using Baremas scales or impairment tables.

An example is the UKs Industrial Injuries Disablement Benefit. The benefit is limited to accidents at work and certain diseases. People are assessed by a medical assessor on a scale of one to 100 per cent; typically, applicants must score 14 per cent or more to be awarded benefit. The assessor has to ignore the effects of any unrelated or pre-existing condition when assessing the disablement. The definition of loss of faculty used is:

> 'Loss of physical or mental faculty means some loss of power or function of an organ of the body. Loss of faculty can include disfigurement even when this causes no bodily handicap. Whether a loss of faculty results in disability is decided by comparing your condition as a result of the accident with the condition of a normal healthy person of the same age and sex.'
>
> DWP (2017)

Percentages for degrees of disablement for certain injuries are prescribed in regulations; where an injury is not listed the condition is compared to those listed. Examples of the percentages are as follows:

Injury	**Degree of disablement (%)**
Loss of a hand and a foot	100
Absolute deafness	100
Amputation through feet proximal to the metatarso-phalangeal joint	80
Loss of four fingers of one hand	50
Loss of one eye	40
Loss of ring finger	7
Loss of part of great toe	3

Source: DWP (2017), Appendix 2.

Barmas scales are controversial and have a number of shortcomings. Stafford (2007: par 2.21) summarised these criticisms as follows:

- 'Baremas scales are less satisfactory at assessing mental health conditions than physical conditions.
- A partial percentage award can be difficult to interpret in terms of the person's ability to work – what does, say, 50 per cent mean in this context?
- How are different impairments to be compared and a percentage derived – how can, for instance, the loss of a finger be compared with depression?
- Determinations are difficult to justify.
    - The percentages assigned to given impairments can appear to be arbitrary. In cross-national comparisons different percentages can be allocated to the same impairment. Indeed, in some countries different schemes can have different percentages for the same condition. The set percentages for impairments can also vary over

time, reflecting advances in medicine, increase use of aids and adaptations and changing public perceptions about certain conditions.
    - The logic for determining the overall score for someone with more than one impairment is unclear. Should the percentages be simply summed, or should certain impairments be weighted or should the total percentage be determined in a more holistic fashion?
    - Assessment is not simply a technical matter. Some argue that unless the schemes are subject to public scrutiny they lack legitimacy or public support. A related point is that the development of the assessment instruments can be seen as granting power to certain professional groups (doctors and administrators), because it appears to be a technical, scientific issue. However, who receives compensation, for what and at what percentage are matters of public concern and hence also 'political' issues.
- Assigning percentages give the assessments a *'flair of objectivity'* (Marin, 2003:10).
- Compared to other approaches to assessment, they can generate a relatively high number of complaints / disputes and (successful) appeals.'

3.2.4 Loss of functional ability

In a functional assessment, the claimant's (in)capacities with respect to set functions such as, walking, sitting, concentrating and so on are evaluated. The basis for a functional assessment is that a person's medical condition affects their functional abilities and this can create a mismatch between their abilities and the demands of their job leading to sickness absence in the short-term and possibly incapacity longer term. The criteria have to go beyond a functional description, there has to be an evaluation of what the person can do or might do in relation to (job) demands and their (work) environment. As discussed above, what is regarded as 'their job', the work comparator, can vary between countries and over time.

Functional assessments are etiologically neutral, that is, independent of the background medical conditions. Thus assessment of an individual's functioning is separate from that of their health condition. The functional approach can be contrasted with the clinical diagnostic approach loss of faculty assessments.

As it is not feasible to compare all functional abilities with all job demands for individuals it is necessary to develop an assessment tool or instrument that uses a restricted number of indicators to provide a reliable, valid and accurate measure of loss of functional capacity. Developing an instrument to assess loss of functional capacity involves identifying key functional abilities and job types. The difficulty is that many functional abilities are not statistically independent of one another. Each item in, for instance, a functional capacity questionnaire, needs to be statistically independent (or not correlated) with other items in the questionnaire, otherwise 'double (or more) counting' could occur and the instrument will be invalid.[12]

[12] A similar problem can arise with the job demand side, in that many job demands are not statistically independent. Broersen *et al.* (2011) report that studies have clustered

Functional assessment tools can draw on the International Classification of Functioning, Disability and Health (ICF) produced by the World Health Organisation (see Section 2.3.3), such as the Netherland's List of Functional Abilities (LFA) (Broersen *et al.*, 2011). Functional assessments can be self-administered via questionnaires or by qualified assesses using structured instrumentation which may completed with or without a meeting with, or examination of, the claimant.

Activities of Daily Living

A starting point for functional assessment is assessed by the difficulty a person has in carrying out basic Activities of Daily Living (ADLs) or more complex Instrumental ADLs (IADLs). ADLs are the basic self-care tasks of everyday life that are necessary for independent living and include eating, bathing, dressing, toileting, transferring (say from a chair to a bed) (Wiener, 1990; Mlinac and Feng, 2016). IADLs are activities related to independent living in the community and include using the telephone, managing finances and medications, and remembering appointments. The ability to perform ADLs and IADLs is dependent upon cognitive, motor and perceptual (including sensory) abilities. A number of different approaches and tools for measuring ADLs and IADLs are available (see Wiener, 1990; Mlinac and Feng, 2016).

ADLs and IADLs tend to be used to assess a person's ability to live independently and are used in social and health care rather than in assessing work ability.

Functional assessments used to assess incapacity

Different countries use different measures of functional work capacity. Moreover, being assessed as having a functional inability does not necessarily mean that an individual will be awarded benefit, or full benefit or the highest rate of benefit. Three country examples will be used to illustrate different approaches and the complexity of work incapacity assessment – the Netherlands, the UK and Australia.

In the Netherlands, the result of the functional assessment is used by a labour market expert in a calculation of *loss of earnings* in order to determine entitlement to benefit (see below). A person's functional capacity is assessed using a standardised test, the List of Functional Ability (LFA), which the insurance doctor uses to record the individual's work limitations and their extent (de Boer *et al.*, 2004:35; Cousins *et al.,* 2016:22, 103-110; Broersen *et al.*, 2011). The test comprises 70 mental, physical and social items grouped under six functional domains (see Table 3.6). Some of the items are dichotomous (the specific ability is either present or absent) and the others are polytomous (with a ranking scale score of three to five to indicate the severity of the incapacity).

job demands into two to nine dimensions (such as a simple binary physical demands and mental demands) and these in turn lead to four to 15 different occupational categories.

Table 3.6: Domains and items of the Functional Ability List, the Netherlands

Domain		Number of items
I	Personal functioning	9
II	Social functioning	12
III	Adjusting to physical environment	10
IV	Dynamic movement	24
V	Static movement	11
VI	Working hours	4

Source: Cousins *et al.* (2016:108)

The UK's Work Capability Assessment comprises two assessments. The first, the Limited Capability for Work (LCW) Assessment, determines whether someone has a work incapacity and so will be awarded benefit and have access to work and health related support. This functional assessment covers a range of physical, mental, cognitive and intellectual activities.[13] For each activity there are a number of 'descriptors' relating to how difficult it is to do a task. Each descriptor is scored between 0 and 15 points. For example, the descriptors for manual dexterity include:

- Cannot single-handedly use a suitable keyboard or mouse. (Score 9 points); and
- Cannot pick up a £1 coin or equivalent with either hand. (Score 15 points).

The scores for the activities are summed and if the person has score of 15 or more, then they are deemed to have a limited capability for work.

The second, the Limited Capability for Work-Related Activity (LCWRA) Assessment, determines whether someone is placed in the Support Group or the Work-Related Activity Group. The group to which a person is allocated determines their level of benefit and any associated work-related conditions for receipt of benefit.[14] For instance, those in the LCWRA are expected to take steps towards moving into employment. The assessment, like the LCW, comprises physical, mental, cognitive and intellectual activities and descriptors. However, claimants only have to satisfy one of the descriptors to be allocated to the Support Group. For example, the descriptor for manual dexterity is: 'cannot press a button (such as a telephone keypad) with either hand or cannot turn the pages of a book with either hand.'

[13] A copy of the self-administered questionnaire (ESA50) is available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/631921/esa-50-capability-for-work-questionnaire.pdf

[14] The two assessments are also used in Universal Credit, which is replacing the means-tested version of Employment Support Allowance. Claimants can receive an additional amount, the 'work capability amount', if as a result of the WCA they have a 'limited capability for work and work-related activity' (that is, effectively they would have been allocated to the Support Group).

Both assessments are conducted by health care professionals (doctors, nurses and physiotherapists) employed by a private contractor.

The WCA is highly controversial in the UK and has been subject to independent review (Shakespeare *et al.*, 2017). Criticisms include concerns about the extent to which the WCA can be used to assess mental health conditions (due to a lack of suitable descriptors) or fluctuating conditions (because of the reliance on 'snapshot' face-to-face interviews); the adverse impact of the assessment on some claimants; and the poor reliability of the decision making process given the high number of decisions overturned on appeal (POST, 2012:2-4; Etherington, 2017:372-4; Citizens Advice, 2014; Baumberg *et al.*, 2015). Indeed,

> 'The WCA is politically sensitive. Disability organisations cite cases of suicide where the coroner has mentioned denial of benefit as a contributory factor.'
>
> POST (2012:2)

Notwithstanding various changes to the WCA, the fifth and final official review found:

> '… there remains an overwhelming negative perception of the WCA's effectiveness amongst people undergoing an assessment and individuals or organisations providing support to them.'
>
> Litchfield (2014:4)

In Australia, eligibility for a Disability Support Pension (DSP) requires claimants meet three key work capacity tests (Department of Human Service, nd; SSA 1991, Section 94):

- They are either permanently blind or have a permanent physical, intellectual or psychiatric impairment of 20 points or more as assessed against the Impairment Tables. This is known as the Job Capacity Assessment (JCA), and is a functional assessment of a person's work capacity based on their medical condition (see below); and
- They have an inability to work at or above minimum wage, or to be retrained for work, for at least 15 hours a week within the next two years because of the impairment. This is known as the Continuing Inability to Work (CITW) test, and is essentially a time-based work capacity assessment (Morris *et al.*, 2015); and
- Unless exempt, they have taken part in, or completed, a Program of Support for at least 18 months over the last three years (Australian Government, 2015, Section 1.1.A.30). This requirement forms part of the CITW test. It is a tailored programme to help people 'prepare for, find or maintain work' (SSA 1991, Section 94(5)) and is used to determine whether a claimant can obtain employment without assistance. (The Program of Support is discussed further in Section 3.3.6).

Since 2015 all new claims must also undergo a Disability Medical Assessment (DMA). The DMA it is a review of the supporting medical evidence for a claim for DSP; it does not involve any diagnosis of conditions, medical advice or

treatment. The assessments are conducted by a government-contracted doctor; they cannot be carried out by the claimant's own doctor or specialist.

JCAs can be conducted face-to-face, by telephone/video-conference or be paper-based by assessors employed by Centrelink, the public employment service.[15] The preferred method is face-to-face interviews. The assessments are conducted by a relevant Allied Health Professional using Impairment Tables. There are 15 Impairment Tables (see Table 3.7). Each Table comprises five functional descriptors, specifying what 'no', 'mild', 'moderate', 'severe' and 'extreme' impacts would look like. Each descriptor has an assigned impairment rating (or point ranging from 0 to 30); and the points awarded are summed to give the claimant's overall impairment score. To achieve 20 points requires that the claimant has a 'significant impairment' (Yeend, 2002:4).

Table 3.7: Australian Impairment Tables

Table 1 - Functions requiring Physical Exertion and Stamina
Table 2 – Upper Limb Function
Table 3 – Lower Limb Function
Table 4 – Spinal Function.
Table 5 – Mental Health Function
Table 6 – Functioning related to Alcohol, Drug and Other Substance Use
Table 7 – Brain Function
Table 8 – Communication Function
Table 9 – Intellectual Function
Table 10 – Digestive and Reproductive Function.
Table 11 – Hearing and other Functions of the Ear
Table 12 – Visual Function
Table 13 – Continence Function
Table 14 – Functions of the Skin
Table 15 – Functions of Consciousness

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

There are criticisms of functional assessments. A functional ability does not necessarily equate to work ability, because the latter is a complex issue influences by many factors. As Corden (2005:123) observes: 'Being able to work is not an 'all-or-nothing' concept'. Moreover, functional assessments have problems measuring fluctuating conditions, with some recipients wanting to some work for some periods of time. Functional ability is important, but countries may also define work ability to also include education, skills and motivation (see discussion on other factors in assessments in Section 3.2.6).

3.2.5 Loss of earnings capacity

A person's work capacity can be determined by assessing the extent to which their capacity to earn has been limited by their health condition. Work

[15] The assessments had previously been conducted by a mix of government and private providers. However, concerns about the accuracy of the assessments led to them being taken in-house.

incapacity can be measured as a percentage of loss of earnings.[16] For example, in Belgium benefit is awarded if the claimant has been assessed as having 66 per cent or more loss of earnings capacity for their own job, assuming recover within a reasonable period is possible (de Boer *et al.*, 2004:134-5). After six months, the criteria changes to two-thirds or more loss of earnings capacity for occupations the person could be reasonably be expected to engage with. These occupations can be jobs the person has had in the past, jobs the person could have given their educational background, or jobs closely related to their current occupation. That the claimant might be capable of the occupation with training is not a relevant factor in the assessment. Similarly, if the work they could do is of a lower classification than their current job, then the claimant is deemed to have a work incapacity. Presumably, this is because a lower classified job means lower earnings. This case illustrates one of the potential difficulties with a loss of earning approach; depending upon the work comparator used, it restricts future employment options for claimants. The Belgium case would also appear to narrow the scope of rehabilitation activities to those that will lead to employment paying similar earnings.

In the Netherlands a labour market expert uses a computer programme (the Claim Assessment and Monitoring System) to calculate the loss of earnings using information from the medical assessor's assessment of the claimant's functional capacity (the LFA, see above) and the person's standard salary (de Boer *et al.*, 2004:35; Cousins *et al.,* 2016:22, 103-110; see Table 3.5). The labour market expert explores what the person could earning (their residual earning capacity), given their work limitation, using the computer programme to match the identified work limitations against a database of 7,500 occupations. The earnings threshold for receiving benefit is 35 per cent or more (OECD, 2007).[17] If the loss of earning is between 35 and 80 per cent (or more than 80 per cent with a possibility of recovery) claimants are eligible for the WGA partial or temporary benefit replacing up to 70 per cent of gross earnings; although there is strong encouragement to return to work.[18] If loss of earnings is 80 per cent or more and there is no likelihood of recovery claimants receive a full and permanent (disability) benefit, The Income Provision Scheme for People Fully Occupationally Disabled (IVA), replacing 75 per cent of gross earnings (subject to a maximum).

Countries can also have an earning maximum threshold for social insurance benefits. For example, the USA has an earnings threshold and if the applicant's earnings are more than threshold then the claim for benefit is denied.

3.2.6 Other factors taken into account in assessments

A key question is whether assessments for incapacity should be based solely on medical considerations, or if other factors should be included in assessments. The Capability Approach (Section 2.4) and the ICF (2.3.3) suggest that a useful distinction can be made between non-medical personal characteristics (such as

[16] German and Sweden do not assess loss of earnings, but rather the number of hours a claimant can still work. This is effectively an indirect measure of loss of earnings.
[17] This threshold was raised from 15 per cent in 2006.
[18] Werkhervatting Gedeeltelijk Arbeidsgeschikten (WGA) is the 'Regulation governing the re-employment of partially incapacitated individuals'.

education qualifications and experience) and environmental factors in assessing work (in)capacity.

Non-medical personal characteristics

Alongside activity limitations due to a medical condition, some countries explicitly include other personal characteristics that affect the ability of someone to obtain and sustain employment. In France medical assessors take into account a range of factors including the person's general condition, age and education (de Boer *et al.*, 2004:84). Similarly, the Canadian federal incapacity system takes into account a claimants age, education and work experience (Baumberg *et al.*, 2015:45).

In Denmark, the medical condition of the claimant is only one of 12 factors considered in the assessment (see Table 3.8) (de Boer *et al.*, 2004:136). This is notwithstanding that health is a critical factor in 95 per cent of cases (Baumberg *et al.*, 2015:40). There is a focus on the claimants' resources and potential resources (their resource profile) so that re-integration is facilitated. The Danish system serves to highlight that non-health factors can be included in an incapacity assessment.

Table 3.8: Denmark's 12-point assessment schema ('resource profile')

Former education (ability)
Work experience (ability)
Interests (potential abilities)
Social competences (ability to fit into a work place)
Abilities to reorient (abilities to adjust to a new situation)
Ability to learn (practical/ intellectual orientation)
Wishes for the future
Own expectations of future performance (ambition)
Level of interest in work (importance of work)
Housing conditions/ economic conditions (possibilities to regain energy)
Social network (motivation and support)
Health

Source: Table 5a, Boer *et al.* (2004:136)

Similarly, the Australian functional assessment (JAC, see Section 3.2.4) explores claimants' barriers to paid work and what support might help improve their work capacity.

Countries also differ on when rehabilitation/work-related activities are required to have commenced. Evidence that an individual has engaged in vocational rehabilitation or other work-related activities may be required in advance or be a condition of ongoing benefit receipt (see de Boer *et al.*, 2004, Table 2). The aim of pre-award work-related activity is to demonstrate that claimants have sought to improve their earnings or work capacity. For example, in Hungary, rehabilitation precedes, not follows, the award of benefit; although further rehabilitation may follow post-award (Boer *et al.*, 2004:141). In the Netherlands the claim for benefit must include not only details of the person's medical condition and treatment but also what rehabilitation activity has been undertaken (de Boer *et al.*, 2004:119). In the USA the assessment process may include a vocational analysis covering functional capacity, age, education and work experience before a decision to award benefit is taken (de Boer *et al.*, 2004:127).

In Australia, claimants for the Disability Support Pension must, unless they are severely disabled, demonstrate that they have engaged in a Program of Support for 18 months. Programs of Support are delivered by a 'designated provider' and must cover at least one of the following: job search, job preparation, education and training, work experience, employment, return to work, vocational or occupational rehabilitation, injury management, an activity designed to assist the person to prepare for, find or maintain work (Cousins *et al.*, 2016:65).

Decisions to award incapacity benefit may also depend upon whether there is a job that the claimant could do. In the Netherlands and the USA, this is undertaken by using databases of occupations that indicate whether there are occupations, given the applicants functional limitations, that they could do. This is neither a job-search or job matching exercise, nor is it taking into account local demand for labour, rather it is used to assess whether employment is possible in the circumstances. The OECD (2010:106) observe a move towards this approach, with:

> '… most countries today refer to a "theoretical" labour market when assessing disability benefit eligibility, i.e. to jobs that exist in principle in the economy, rather than actually available jobs.'

However, that there are occupations that the person could do, of course, does not mean that in practice they will be successful in obtaining one.

Environmental factors

In general, work capacity systems focus on the individual claimant, they have an individualised approach to the incapacity problem. The social model, in contrast, is helpful in highlighting how a person's ability to do work can be adversely affected by social barriers, for example, employer discrimination and public transport that cannot cater for people with mobility problems. It highlights that a wider range policies and legislation are a necessary condition for incapacity policies to be being successful. Thus anti-disability discrimination laws can be viewed as enablers or preconditions for people with a work incapacity to return, or stay, in employment.

However, these wider social environment barriers do not need to be included as factors in incapacity assessments. Nevertheless, there have been, and are, occasions when assessments for incapacity have taken into account the state of the local labour market. For instance, Bolderson and Mabbett (2002:57) report that in the UK between 1948 and 1951 the availability of work could be taken into account in determining incapacity.

Indeed, in practice, claims for incapacity benefits can be counter-cyclical – that is, they rise during recessions. In practice, social security administrations (for example, the UK during the 1980s) can, for politically expedient reasons, knowingly oversee an increase in the incapacity caseload in order to limit increases in the unemployment count (Bolderson and Mabbett, 2002:54; Corden, 2005:129-30; Beatty and Fothergill, 2010). This 'hidden unemployment' is also found in other countries such as the Netherlands during the 1990s (García-Góme *et al.*, 2011:1578; Koning and Lindeboom, 2015:156) and in Sweden (Garsten and Jacobsson, 2013). In the Netherlands incapacity/disability benefit was also used as a route to early retirement for older workers when it was transforming from an industrial to a service economy (Koning and Lindeboom, 2015:156).[19] However, such 'hidden unemployment' cannot solely account for the increase seen in incapacity benefit caseloads across countries, other factors are also influential (see Baumberg, 2014).

Taking into account the local demand for labour is problematic. It ignores the dynamics of benefit receipt and creates longer term caseload and expenditure problems. (In such circumstances, it also means that caseload statistics for incapacity benefits are unreliable measures of incapacity.) It also confuses, as mentioned in Section 3.1.2, two distinct analytical categories: incapacity and unemployment. In essence, whilst some of those in receipt of unemployment support may have a health problem, they have been judged fit for work, and those in receipt of an incapacity benefit are (possibly temporarily) able to work in a limited way or not at all.

Some countries formally rule out consideration of the state of the local labour market. For instance, the Canadian federal incapacity rules require that socio-economic conditions, such as local labour demand, are excluded from determining work (in)capacity (Baumberg *et al.*, 2015:45). Similar, rules operate in Australia, the Netherlands and the USA.

Notwithstanding the distinction between incapacity and unemployment, it needs to be recognised that the delivery of incapacity benefits, rehabilitation services and jobseeking support does mean that '… in the real world incapacity is intrinsically linked to employability …' (Baumberg *et al.*, 2015:55). However, there are two approaches to maintaining a workable distinction between incapacity and unemployment (Baumberg *et al.*, 2015:55-6):

- a benefit eligibility requirement that a claimant's functional impairments are caused by a medical condition; and

[19] Disability and incapacity benefits have also been used as a route to early retirement in other countries, for example, Austria, Portugal Sweden, Denmark and Germany (Pearson and Prinz, 2005:142).

- explicitly excluding the state of the local labour market as a consideration when assessing work (in)capacity.

3.3 Measurement issues

In assessing work (in)capacity the instruments used should be assessed a against some statistical criteria so that policy makers, claimants and the public can have confidence that the measures are robust. Briefly, the measurement instruments should score highly on:

- Reliability – this can refer to the measure being internally consistent or reproducible, that is, does it give similar results under consistent conditions.
- Sensitivity (or responsiveness) – can the measure record changes over time.
- Validity – does the measure actually measure what it is meant to measure.

3.4 Conclusion

The literature review confirms a number of the findings and recommendations of the 2007 review of incapacity in Jersey (Stafford, 2007). The earlier review's finding of the complex nature of the patient-doctor relationship is mirrored in the broader literature. Patients can, and do, negotiate with general practitioners over the issuing of sickness certificates.

Jersey does have procedures for reviewing Short-Term Incapacity Allowance and Long-Term Incapacity Allowance claims. However, this literature suggests that a more formal, frequent and robust system is required.

The review confirms the finding of Stafford (2007) that an impairment or loss of faculty need not lead to incapacity. Adopting such an approach could mean someone with a severe impairment is assessed as incapacitated even if they had recently been in employment and so demonstrated an ability to work. The earlier review quoted from Rowlingson and Berthoud (1996:22), and the quote remains salient:

> 'The view that incapacity is directly related to severity of impairment therefore ignores the relationship between type of work task and type of impairment. Someone who is very severely impaired in one way may nevertheless be able to perform some tasks … It therefore makes little sense to talk in general about incapacity to work. The same person will have different levels of (in)capacity for different types of task.'

Personal characteristic other than those related to medical conditions/functional ability should also be included in assessments of work (in)incapacity.

4 Financial support

This Chapter explores some of the complex issues in the financing of an incapacity benefit system. There is a strategic issue of to what extent the state should be involved in the provision and delivery of incapacity benefits, or could competitive markets provide and as good, or even, better service? This is discussed in Section 4.1, and a key concept to understanding the need for some state intervention is moral hazard.

In some state involvement is required because of market failure this still leaves the issue of whether incapacity benefits should be funded via contributions (as a social insurance benefit) or by general taxation (as a social assistance benefit). These issues are considered in Section 4.2).

As a matter of good public policy, individual benefits require a purpose or objective that they address. Two possible objectives for incapacity benefits – maintaining or replacing income or compensating for a loss of faculty – are discussed in Section 4.3.

As already mentioned in Chapter 3, some countries reject the binary capacity : incapacity outcome and allow someone to be assessed as having a partial incapacity. The pros and cons of partial benefits are discussed briefly in Section 4.4.

The main types of financial support that governments may make available to incapacity benefit recipients (other than benefits) and employers in order to ease transitions from benefit to paid work are discussed in Section 4.5.

4.1 Social vs occupational/private insurance provision

This section provides an overview of private and social insurance. It then discusses in more depth information asymmetries in both private and social insurance that give arise to adverse selection and moral hazard and why these mean that the state has to have some role in the provision of incapacity benefits. There is also a brief discussion of privatisation of social insurance.

Table 4.1 shows some of the key differences between private and social insurance. This is a stylised representation. Reforms promoting privatisation (see Section 4.2.3) mean that some countries social insurance programmes are taking on private sector characteristics. Moreover, in some countries social insurance programmes are provided by mutual organisations, and not by government; although the state may have oversight of independent insurance funds.

With the distinction between social insurance and private insurance to some extent becoming blurred, de Jong (2000:39) proposes that the defining features of a social insurance system are that:

- participation in a scheme is compulsory; and
- risks are pooled across a nation or a sector.

Table 4.1: Characteristics of private and social insurance

Characteristics	Social	Private
Consumption	Mandatory	Voluntary
Policy conditions	Uniform	Negotiable
Premium rates	Solidaristic	Risk-dependent
Financing method	Pay-as-you-go	Funding
Insurance	Public monopoly	Private competitors
Administration	Public monopoly	Private competitors

Source: de Jong (2000:38), Table 1.2.1.

Pooling across risk groups is possible with social insurance because scheme membership is compulsory. The resulting (averaged) contribution rate is lower than what would be the premium for high risk workers, and the scheme should be financially sustainable because workers with a low risk cannot opt out of contributing. It is the sharing of risks in social insurance that makes in solidaristic in nature.

Compulsion also allows governments to break the link between contributions and benefits (Walker, 2005:76-7). Benefits can be used to promote, say, vertical or horizontal redistribution.

Private insurers operate by providing policies to individuals and by working with firms where employers offer occupational benefits. (States may also require employers to provide and fund minimum statutory sickness pay.) The key feature of private insurance is that whilst the insurer has a contract with the insuree that offers financial security against a given risk, the insurer seeks to make a profit. To do this the insurer sets premiums that cover the underlying risk for an individual, overheads and other costs, and a profit margin.

In a marketised system, premiums for workers will vary according to their assessed risk for ill-health/incapacity/disability. Private insurers will pool insurees with similar levels of risk, but across the population there will be premium differentials. However, if premiums were to be averaged across all risk groups, because insurers lack relevant information about people, then those insurees who are low risk will seek to move to other insurers offering lower premiums, or not insure – this problem (known as adverse selection) is discussed further in Section 4.2.1 and below.

Where there is only market provision of incapacity insurance, the demand for policies from individuals could be very high. People of working age are likely to be risk adverse, they will want to insure against the risk of losing their income due to incapacity. In theory, a free market with many insurance providers and workers will produce an optimum outcome, where social welfare is maximised. Moreover, competition between private insurers will increase choice for insurees, generate innovation in insurance products and lead to premiums tailored to

individual risk.[20] This market outcome is economically efficient. Unless a mandatory social insurance scheme replicated this outcome then, again in theory, overall social welfare will be less.

However, this theory is somewhat abstract and involves making some unrealistic assumptions (such as actors having perfect information, they are rational and so on). In practice, markets may not work as suggested above (that is, there will be market failure).

First, demand for insurance to cover loss of earnings due to incapacity may be lower than optimal, because not everyone is the best judge of what is in their own interests. That is, privately insuring against incapacity may be a 'merit good', where people under-consume the good as they prefer to consume other goods in the present rather than insuring against a future risk. So some myopic workers would be under-insured against incapacity.

Secondly, the sheer size of the population to be covered means that private providers are unable to offer viable schemes (de Jong, 2000:30). In practice, only the state has the necessary resources and revenue raising powers to meet potential claims.

Thirdly, the occurrence of incapacity (and disability) and its associated losses are difficult to predict and so difficult to insure privately (de Jong, 2000:29; Walker, 2005:72). Insurers deal with this by basing premiums on the historic incidence of risk – but this does require risks to be reasonably stable over time.

In summary, the outcomes of market provision are likely to be socially unacceptable, because, in contrast to social insurance, it offers limited coverage of (vulnerable) populations. As de Jong (2000:29) observes:

> '… the risk of losing one's capacity to earn an income due to disability [or incapacity], can only be provided through social insurance. For obvious reasons, persons who are handicapped from birth, or in need of permanent care, or chronically ill are not insurable through the private market.'

Similarly, people working in high risk occupations would face very high premiums (which may be unaffordable) or be uninsurable.

A key feature of social insurance is that it can offer 'universal' coverage (amongst those of working age). The case for social insurance is that not only does it address the gaps created by market failure but it is more equitable. Social insurance benefits help alleviate poverty (assuming the payment supports a decent standard of living) for those (temporarily) out of paid work due to sickness, work incapacity or a disability. Social insurance can promote social solidarity and redistribution when workers make earnings related contributions and benefits are flat-rate. The more affluent worker is assumed to be prepared to pay their contributions knowing that, not only are they insured, but social

[20] In a competitive market, insurance firms that did not tailor premiums to a person's risk, but levied an average premium, would lose its low risk customers to other insurers. Thus premiums in a competitive market should be actuarially 'fair'.

insurance mitigates against possible socially undesirable consequences (for instance, begging) that could materialise if unfit for work lower paid workers were not insured. However, notions of social solidarity can be undermined if public support and confidence in the social insurance programme is reduced; for instance, if there is a suspicion that healthy people have successfully claimed incapacity benefit.

A further advantage of social insurance is that earnings-related contributions and risk pooling means that for employees paying into a social insurance scheme should be affordable. Individuals in high-risk industries are not priced out of the market.

Social insurance contributions can be flat-rate or (more unusually) earnings related. Scheme costs are covered by pooling members' risks at the national or sectoral level. However, as a consequence social insurance contributions are not actuarially correct – they do not reflect the individual risk of incapacity or ill-health – and so, technically, economically inefficient. They break the link between premiums and individual risk found in insurance markets. The solidaristic nature of social insurance also aggravates the moral hazard problem (which is discussed below) (de Jong, 2000:36).

Moreover, social insurance programmes only cover those who have an employment record, as it is usually through doing paid work that contributions are made; although credits may be given to, say, carers. This limits its 'universality'. For instance, women out of the labour market who are incapacitated through domestic work may not be covered due to insufficient contributions. Accordingly, policy makers should consider what arrangements are required for those with no, or insufficient, social insurance contributions.

Insurance, whether or not provided by the state, can be viewed as a transaction between a principle (the insurer) and an agent (the insuree). In terms of insurance for incapacity the various possible actors are as follows:

Social insurance	Principle	The State
	Agents	Employers, self-employed and employees
Private insurance	Principle	Insurance provider
	Agents	Self-employed and employees
Occupational insurance	Principles	1) Insurance provider for the employer / self-employed 2) Employer for insured employees
	Agents	1) Employers and self-employed 2) Employees

This schema is a simplified representation, as in practice there is likely to be various regulatory bodies (who are agents of the government, but who act as

principles when overseeing insurance providers). Similarly, if the state contracts out part of the incapacity system (such as medical assessments or delivery of employment support), then the relevant contracting (social security) agency is the principle and the contracted provider its agent. Moreover, the three types of scheme – social, private and occupational – are not mutually exclusive, but rather can be combined. For instance, the state may provide a statutory (minimum) insurance scheme, which employers can supplement as part of their overall benefits package to attract talented staff, and individuals may choose to 'top-up' this provision with their own private insurance policy.

Principle Agent Theory, developed by economists, provided a means to assess the relative merits of social and private insurance provision. Transactions between principles and agents involve information asymmetries, in particular principles lack perfect information about the intentions and behaviour of agents. This gives rise to two problems:

- **Adverse selection** – arises pre-contract, for example, prior to an individual taking out private insurance or prior to an employee submitting an incapacity benefit claim. Adverse selection (or 'hidden information') results from the principle not knowing the full circumstance or potential of the agent. An insurer does not know whether they are going to insure (what has been called) a 'lemon' (Akerlof, 1970) or a good risk. The agent knows more about their health status and work capacity than the potential insurer.

- **Moral hazard** – arises post-contract, for example, a benefit recipient not engaging in rehabilitation programme, or a contracted provider focusing its efforts on those most likely to obtain employment and not adequately supporting those participants furthest from the labour market. Moral hazard (or 'hidden action') results when a principle is unable to monitor or observe sufficiently an agent's behaviour. The agent may not behave according to the conditions agreed when the principle and the agent agreed their contract. Moral hazard is a particular problem for incapacity cases because many medical conditions (such as back pain) are difficult to observe.

Both problems increase the principle's transaction costs. Policy makers should consider possible adverse selection and moral hazard problems and seek to minimise them when developing policies. Both problems are discussed in more detail below.

4.1.1 Adverse selection

Adverse selection has different implications for private and social insurance schemes.

Adverse selection is likely to lead to market failure. Private insurers lacking full information about the precise risks for individuals will set initial premiums at an average rate – between the rates for high and low risk groups. However, this produces:

> '… an outcome where it is beneficial for high risk people to buy full coverage at average premium rates, whereas low risk people will decide

> not to take (full) insurance. This form of self-selection implies a continuous adaptation of initially misspecified premium rates until private insures fail, and the market collapses.'
>
> de Jong (2000:30)

So because private insurers lack information on the risk characteristics of individual workers, some people are over-insured and others are under-insured (at least until the market collapses).

Social insurance tackles adverse selection by making membership of the programme compulsory for workers. In this way it provided a more equitable solution than private insurance. Mandating that workers take out incapacity policies with private providers (as with car insurance) addresses the 'merit good' problem – people not knowing what is in their best interest. However, the size, predictability and informational (adverse selection) problems mentioned above remain for private insurers.

The standard strategy for dealing with adverse selection is 'screening'. In this context, this means ensuring that the principle has access to better information about the agent before insuring them. For instance, an insurer may want information about a person's health status before agreeing to illness/disability insurance. Given likely patient confidentially and privacy concerns, this raises questions about what information insurers are entitled too.

In general, principles' transaction costs can be reduced when less cumbersome information systems are used, and the more transparent the terms of the contract.

4.1.2 Moral hazard

An agent knowing that they have insurance cover for incapacity may alter their behaviour in such a way as to increase the principle's losses. For private insurers this might mean that an insured worker engages in more risk behaviour that could, say, result in an industrial injury. For a social insurance programme moral hazard might mean someone who is capable of work successfully claiming an incapacity benefit. There is a potential for moral hazard because work capacity status is private information and observing agents' behaviour is difficult in practice and/or costly. Insurance programmes covering sickness absence and incapacity are inevitability subject to some degree of moral hazard.

Private insurers may be reluctant to offer products for illness, incapacity and disability because the risk of moral hazard is too high. In the absence of private insurance products, governments have provided social insurance programmes and so taken on the associated moral hazards, which may be considerable (de Jong, 2000:32).

The design of social insurance programmes can exacerbate moral hazard. For instance, if entitlement to an incapacity benefit is based on a list of specified medical conditions (such as diseases or anatomical damage) there will 'grey areas' in the rules and guidance that allows benefit decisions to be contested.

One policy response to moral hazard is to make a social insurance benefit less attractive or less accessible. For example, having employers pay sick pay/wages

for an initial period of sickness absence. This may reduce public expenditure and, depending upon the obligations and costs placed on employers, may incentivise them to intervene early and support a worker's return to work. Some countries such as the Netherlands and the UK have undertaken reforms to transfer costs from the state to employers, a process that has been referred to as privatisation. On OECD review (2003:108) suggests that the impact of such reforms on sickness absence rates is short lived. They found no association between obligations placed on employers to pay wages during sickness absences and sickness rates. However, studies of the Dutch incapacity system see the transfer of costs to employers as a crucial part of a generally successful reform package. (The Dutch reforms are discussed elsewhere in this report.)

In the Netherlands employers continue to pay the sick employee's wages, a minimum of 70 per cent of their salary, for up to two years. In addition, collective labour agreements can include payments that supplement this statutory minimum (Koning and Lindeboom, 2015:156). Such a relatively generous scheme, if not checked by other institutional arrangements, risks undermining sick workers' incentives for returning to work. Employers and employees could also seek to exploit the scheme so that the worker does not have to claim the more onerous unemployment benefit and the firm can avoid (substantial) redundancy costs. However, the Dutch have, as discussed elsewhere in the report, successfully implemented arrangements (notably, the Gateway Protocol) to counter possible adverse effects from their lengthy waiting period and relatively generous sick pay. This case also illustrates the importance of adopting a systemic approach to reform, as reforming individual elements without regard to their possible spill-over effects could be costly.

Another policy response to moral hazard is co-insurance (de Jong, 2000:33-25). Co-insurance occurs when less than full or comprehensive social insurance is provided to the working population. Partial coverage, or co-insurance, provides agents with an incentive to take care to reduce their potential financial losses. Taking care involves taking both preventative actions and rehabilitation, as these can reduce losses. Co-insurance should operate in those areas where moral hazard is most likely and ideally is tailored to the individual and the level of risk. Ways of introducing co-insurance include:

- For social insurance programmes that cover loss of earnings have a replacement rate of less than one, that is, the benefit does not fully replace the claimants' earnings. This is a feature of many social insurance incapacity benefit programmes.
- Monitoring the claimants' behaviour and terminating benefit in order to penalise 'careless' behaviour. However, other than regular re-assessments, it is practically difficult for principles to monitor agents' behaviour – which is the reason for the moral hazard in the first place.
- Allow for partial benefits in the social insurance programme (see Section 4.4). Partial benefits provide a financial incentive for those able to do some work to combine part-time work (at reduced earnings) with benefit receipt. This assumes, of course, that income disregards and tapers provide the necessary work incentive.
- Making the extent of the coverage depend upon the accuracy of assessments. This would mean that certain medical conditions (for instance, stress) received no, reduced (partial) or shorter durations of

> benefit. Such an approach is likely to be controversial – why is condition X covered but not condition Y – and to the extent that assessment tools contain some 'grey areas' they open a space for interpretation and hence appeals.

Experience rating can also be used to address moral hazard in social insurance programmes. Experience rating operates in the private sector, whereby premiums are tailored to the risk (expected losses) for an individual. For social insurance it involves relating social insurance contributions to agents' behaviour. In 1998, the Dutch introduced experience rating to incentivise employers to manage sickness absence by relating the employers' social insurance contributions to the employees past claims for incapacity/disability benefit (Koning and Lindeboom, 2015:158). For every employee awarded a disability benefit, the firm's insurance contribution rate increases for up to ten years. However, their contribution rate falls if they employ a disability insurance recipient (García-Góme *et al.*, 2011:154). The scheme gives business 'discretion' on how they tackle sickness absence. Experience rating has led to a statistically significant fall (15 per cent) in incapacity benefit claims in the Netherlands (Koning, 2009). There was a time delay between its introduction and its impact on sickness rates because employers were initially unware of their new responsibility. Although not initially opposed when introduced, employers (especially small business) objected to the scheme as their re-insurance premiums (to cover their contributions) began to increase. One employer response has been to increasingly hire temporary workers, as they are not subject to the experience rating rules if they become sick (Koning and Lindeboom, 2015:159). However, Koning and Lindeboom, (2015:170) report that the Dutch government were planning to extend the Gateway Protocol and experience rating to temporary and flexible workers.[21]

De Jong (2000:36) concludes:

> 'Co-insurance and experience rating are the two private insurance devises that may improve the viability of social insurance, because they confront the insured with the social costs of their (lack of) care-taking behaviour.'

However, policy-makers need to be cautious in implementing these measures, because if they go too far they will eliminate the equity and efficiency advantages of social insurance (de Jong, 2000:36).

Moral hazard: Insurance and incentive trade-offs

Insurance programmes (whether social or private) entail a trade-off between insurance and incentives. Healthy insured workers may have a financial incentive to claim an incapacity benefit and once in receipt be reluctant to return to work. However, in making decisions about whether to award an incapacity benefit, decision makers risk making two types of error (see Table 4.2):

- False negatives – denying benefit to applicants with a work incapacity (Type I Error or Rejection Error)

[21] The Gateway Protocol involves a stricter screening process of claims in the Netherlands. It is discussed further in the next Chapter.

- False positives – awarding benefit to fit for work applicants (Type II Error or Award Error)

Type I Error leads to an 'insurance problem' as people who should be insured and covered by the scheme are not, whilst Type II error reflects an 'incentive problem' in that those that should not claim do so because of the attractiveness of the scheme.

Table 4.2: Error trade-offs

Claimant really has a …	**Insurer:**	
	Awards benefit	**Does not awarded benefit**
Work incapacity	Right decision	Type I / Rejection Error – the 'insurance problem'
Work capacity	Type II / Award Error – the 'incentive problem'	Right decision

Source: Author's own.

Policy reforms designed to decrease the probability of one type of error can increase the probability of the other type of error. For instance, making the medical assessment stricter will reduce the number of false positives, as it reduces the incentive for healthy people to claim benefit, but it increases the probability of false negatives by increasing the likelihood that people with a work incapacity will not be covered by the insurance scheme when they should be. Here a reduction in the incentive problem is accompanied by an increase in the insurance problem.

There is a literature is on the incentives for people to make a false application for an incapacity benefit and the disincentive effects of incapacity benefits on labour supply (see Low and Pistaferri, 2010:3-5). Low and Pistaferri (2010) are concerned with the growth in the USA's Disability Insurance programme, and whether it is a route to early retirement rather than acting as an income replacement benefit for people with a work incapacity. They develop a theoretical framework to investigate the trade-offs between insurance and incentives and then provide estimates of Type I and II Errors using data from the 1986-1993 Panel Study of Income Dynamics. They find 'substantial false rejections', with a Type I / Rejection Error rate of 0.43. The probabilities of incorrectly rejecting a claim vary by age, from 28 per cent for older workers to 68 per cent for younger workers. In contrast, the Award Error rate is less problematic at 0.1, with the Type II errors ranging from 0.2 per cent (for young non-disabled claimants) to 14 per cent (for older workers with a moderate level of work incapacity).

Low and Pistaferri (2010) also use the model to stimulate policy changes to improve insurance coverage and reduce adverse incentive effects. Three of

these stimulations are revealing as they highlight trade-offs that policy makers need to consider:

- *Increasing the strictness of the medical assessment*
  One possible policy response to the 'incentive problem', of healthy people not participating in the labour market but falsely claiming incapacity benefit instead, is to increase the threshold in the medical assessment before benefit can be awarded. In principle, the policy measure should reduce the extent of the incentive problem (that is, the probability of false positives), but it will also reduce the extent of insurance provided (that is, increases the probability of false negatives).

  The policy stimulation shows (see Table 4.3) that increasing the strictness medical test results in a significant increase in Rejection Error. This increase in Type I Error occurs because the reform reduces the probability of people with a severe work incapacity being awarded benefit and it reduces the proportion of people with no or a partial incapacity from applying for benefit.

Table 4.3: Results for Increasing the Strictness of Disability Insurance Admissions

Award rate	Declines
Rejection error (Type I error)	Increases
Award error (Type II error)	Declines
False applications	Declines
Fraction severely disabled who are insured	Declines
Fraction moderately disabled who are insured	Declines

Based on: Low and Pistaferri (2010:34-7).

As a consequence, there is a fall in number of false applications (implying a fall in the number of people who are fit for work being rejected). Accordingly, there is a fall in Award / Type II Errors as the proportion of claimants who are healthy or have a partial incapacity receiving an award declines. Overall, increased strictness means fewer applicants make successful claims (the award rate fall).

However, this desired reduction in the incentive problem is at the expense of increasing the insurance problem – in particular, the proportion of people with a severe work incapacity awarded an insurance benefit falls. More people with a (severe and moderate) work incapacity will then participate in the labour market.

Conversely, making the assessment *less* strict will increase the number of false applications, but will also expand coverage to those that might be considered in most need of the protection offered by the insurance.

- *Increasing the generosity of payments*
  Increasing the generosity of incapacity benefits is a possible measure to address the insurance problem. Greater generosity encourages claims for benefit (here Disability Insurance) and individuals leave the labour force. The proportion of claimants with no or moderate work incapacity increases 'sharply' when payments are increased (see Table 4.4). Whilst this does improve the coverage of the insurance scheme amongst these groups, it also results in an increase in Type II / Award Errors. The modelling reveals little change in the proportion of those with a severe work incapacity in receipt of a benefit, because this group are insensitive to changes in the generosity of Disability Insurance.

  The decrease in Type I / Rejection Error is arithmetical – the increase in the number of false applications means that the proportion of those denied benefit who are severely incapacitated falls.

Table 4.4: Results for Increasing the Generosity of Disability Insurance Admissions

Award rate	Declines
Rejection error (Type I error)	Declines
Award error (Type II error)	Increases
False applications	Increases
Fraction severely disabled who are insured	Unchanged
Fraction moderately disabled who are insured	Increases

Based on: Low and Pistaferri (2010:37-8).

A more generous incapacity benefit implies higher taxes and/or social insurance contributions and so lower consumption of goods and services.

Alternatively, reducing benefit generosity leads to a fall in false applications, but claims from those with a severe work incapacity do not fall.

- *Re-assessment of benefit recipients*

Table 4.5: Results for Increasing the Re-assessment Rate of Disability Insurance Admissions

Award rate	Increases
Rejection error (Type I error)	Increases
Award error (Type II error)	Declines
False applications	Declines
Fraction severely disabled who are insured	Declines
Fraction moderately disabled who are insured	Declines

Based on: Low and Pistaferri (2010:38).

A further policy response to the incentive problem is to increase the re-assessment rate. More frequent re-assessments address moral hazard, because they are a mechanism for increasing the amount of information available to the insurer. The policy stimulation shows that this discourages false applications from those people who are healthy or have a moderate work incapacity. As consequence, Type II / Award Error falls, as does the proportion of claimants with a moderate incapacity in receipt of benefit.

However, the insurance problem increases, with reduced coverage for those with a severe work incapacity and applications are discouraged.

The cost of this is the reduced coverage for those with the most severe disabilities: reassessment causes some severely disabled people to be removed from the benefit roll and this directly reduces coverage, as well as discouraging applications, as the frequency of reassessment increases.

So in summary: 'Incentives for false applications are reduced by reducing generosity and increasing reassessments and these improve welfare, despite the worse insurance implied.' (Low and Pistaferri, 2010:1). Whilst a less generous benefit and more frequent re-assessments '… have a large impact reducing the number of false applicants at little cost in terms of reduced coverage for those in need.' (Low and Pistaferri, 2010:3).

4.1.3 Privatisation

The claimed benefits of privatising social insurance programmes are that it:

- Creates incentive structures for actors (workers, employers and administrators) that promotes economically efficient behaviour.
- Promotes innovation and investment in services and products.
- Reduces costs and hence public expenditure.

A distinction can be made between privatising a collective insured risk and the administration and delivery of social insurance (de Jong, 2000:36).

The extent to which the insured risk can be privatised is limited because of the market failures mentioned above (especially moral hazard). There is a limit to the extent to which private insurers would want to insure the working population against sickness, incapacity and disability. Or, if these risks were privatised the resulting gaps in provision are likely to be controversial, and have undesirable social consequences. In essence, risks covered by sickness, incapacity and disability require public funding to ensure adequate coverage of the population.

Nonetheless, elements of the insurance risk have been effectively privatised in a number of countries by transferring the financial cost of benefits on to employers and/or employees, for example:

- Increasing the 'qualifying period' before claimants can submit a benefits claim (the example of transferring a larger share of financial costs of sickness absence from the state to employers in the Netherlands and the UK was given in Section 4.1.2).

- Limiting the maximum duration of the benefits (for example, the UK has for certain recipients' time limited their entitlement to contributory Employment Support Allowance to one year).
- Excluding previously covered groups or conditions.
- Cutting the (real) value of benefits (by, for instance, restricting indexation for inflation, or cutting the replacement rate).

However, the 'targeting efficiency' of these reforms may be limited if claimants losing entitlement to incapacity benefits claim another benefit instead.

Countries have privatised (or rather contracted out) elements of the social insurance administrative function, such as medical assessments and delivery of rehabilitation programmes. Here a case by case approach is required and the benefits and costs of contracting out carefully considered. Contracting out does not avoid adverse selection and moral hazard. For example, Stafford (2015) applies these two concepts to two UK contracted out employment support programmes for incapacity benefit recipients, the New Deal for Disabled People and Pathways to Work. He finds that outcome related funding gives providers a financial incentive to devote their time and resources on those most likely to enter employment, and those in greatest need of support, who are furthest from the job market, are poorly served.

4.2 Funding

There are two broad mechanisms for funding the large sums required to project people against adverse contingencies:

- Insurance – where people in return for a payment (a premium or contribution) have an entitlement to certain benefits.
- Collective transfers – where, effectively, governments make cash transfers to those in need. Such transfers are funded from general government revenues. (The focus here is government transfers, but collective transfers can also be made by non-state actors, such as family and voluntary organisations.)

4.2.1 Social insurance contributions

As discussed Section 4.1 above, insurance can be provided by the private or public sectors. The focus here is on the contributions made to fund social insurance programmes.

Social insurance contributions, like benefits, can be either flat-rate or earnings related. Following the second world war (national) insurance contributions in the UK were flat-rate.[22] The drawback of flat-rate contributions is that they have to be low enough for those on low incomes to be able to contribute, but this means benefits are then low (assuming little, or no, cross-subsidy from general taxation). Earnings related contribution, a feature of continental European social insurance programmes, allow more generous benefits to be paid.

[22] Earnings related contributions were introduced in the UK in 1959.

Underpinning social insurance is the 'contributory principle', that people have an entitlement to benefit if they have paid contributions whilst at work. The advantages of the contributory principle are as follows:

- Equitable provision – only those who could potentially benefit from the scheme contribute; non-beneficiaries do not contribute. This does not preclude notional contributions, but does mean that non-beneficiaries do not pay for benefits for which they are not entitled.
- Comprehensive coverage –employees, employers and the self-employed can all make contributions
- Simplicity – it is an easy to understand principle (but see below).
- Assurance of security – contributors know that if the insured contingency arises then they have entitlement to financial assistance.
- Promotion of self-esteem – social insurance avoids the stigma associated with social assistance as people have made contributions and consequently take-up of contributory benefits is higher than it is with means-tested benefits.
- Ease of administration – contributory benefits are paid regardless of household income, and so unlike means-tested benefits the incomes of household members does not have to be identified by the social security agency.
- Reinforcement of the value of paid work – contributions maintain a link between the labour market and gaining an entitlement to a 'social right' to benefits.
- Flexibility in policy – the principle is compatible with various other possible policy objectives, such as poverty alleviation, protection of living standards, and so on.
- Avoidance of the need to means-test benefits.

The disadvantages of the contributory principle are:

- Exclusion of certain groups - non-contributors who might need a replacement income can be excluded from benefit receipt. Access to social insurance benefits is denied to those who have not worked, or are so poorly paid so that they do not earn enough to pay contributions. Countries have expanded their schemes to include some of those who would not otherwise be entitled to benefit. However, these reforms, which will have popular and political support, serve to undermine the contributory principle and the insurance basis of the scheme. Ultimately, it is a matter of political judgement as to whether certain groups who could require a replacement income should be excluded from a social insurance scheme. Nevertheless, women because they tend to have low labour market participation rates and are disproportionately represented in lower paid jobs are more likely than men to lack sufficient contributions to be entitled to benefits.
- Incompatibility with the demands of a flexible labour market – the payment of contributions assumes full-time continuous participation in paid employment. However, the increase in temporary, part-time and self-employment limits people's contributions and so restricts their entitlement to benefits.
- Contributions are effectively a hypothecated tax on labour and so may depress employment levels.

- Lack of transparency – there is a lack of public awareness of what people receive in return for their contributions (see, for instance, Corden (1998) and Stafford (1998)).

4.2.2 General taxation

Cash transfers are typically used to fund social assistance programmes. The extent to which government revenues are used to fund total social security spending varies between countries (see Walker, 2005:82-4). The proportion in Australia is very high, because benefits are means-tested and funded by the federal government. In Sweden and Germany, the proportion is relatively low because social insurance contributions have a larger role in the social security system.

The advantages of general tax funding are (Walker, 2005:82):

- It enables speedy responses to social and economic changes (whether unanticipated or planned).
- Benefits can be uprated in line with inflation (or earnings) and so allow benefit recipients to share in raising national prosperity.
- It creates financial security for those unable to save or have had the opportunity to make social insurance contributions. The latter is salient for people whose onset of a work incapacity was before they were old enough to enter the labour market.

Issues arising from funding social protection from general taxation are:

- The system needs to have political legitimacy as governments have to raise tax and transfer monies to what are likely to be less powerful groups, who may also be vulnerable (Walker, 2005:82). This concern is less likely to be relevant for sickness and incapacity benefits, as taxpayers may realise that they can unexpectedly suffer from poor health, in which case they may be willing to pay taxes for benefits.
- Receipt of tax funded benefits may be stigmatising and prompt feeling of shame.
- Tax funded benefits tend to be means-tested. And the disadvantages of means-testing include:
    - low take up rates for benefits;
    - work disincentives – both 'benefit' and 'poverty' traps. The former arises when the income from paid work is not significantly more than from benefits (that is, a low replacement ratio) and financially people are trapped on benefit. The latter arises due to the withdrawal or loss of benefit as recipients' earnings increase and this reduces their incentive to increase their hours of work or move to a higher paying job. Expanding means-testing at the expense of contributory benefits can be seen as weakening the link 'between work and reward' (Burchardt, 1999:17);
    - savings disincentives – people may decide not to save for a contingency if the state provides a benefit that will be reduced because means-testing takes into account savings/income from savings; and

- an increase in administrative complexity and costs because of gathering and verifying evidence on households' income and savings.

4.3 Benefit objectives

Social security systems have many objectives ranging from poverty alleviation to nudging behaviour (see Sainsbury (1999) and Walker (2005)). With respect to incapacity benefits there are two salient objectives: to maintain and replace loss income due to an incapacity, or to compensate for the adverse effects of an impairment. These two objectives for incapacity benefits are discussed in turn.

4.3.1 Income maintenance and replacement

Providing claimants with a substitute income when they are not active in the labour market due to sickness or incapacity is a feature of many social insurance systems.[23] The benefit is for loss of earnings. Where the aim is income maintenance the benefit tends to be earnings-related so that the payment is similar to that obtained through paid work. Walker (2005:30) describes seeking to maintain/replace income as a more ambitious social security aim than alleviating poverty. This is because the intention is not to provide the recipient with a minimum income, but an income that will allow them to enjoy a standard of living (broadly) similar to that before they claimed benefit. A high rate of replacement income may assist people cope with the ill-health/incapacity that lead to the loss of their main income (Walker, 2005:117).

Income maintenance and replacement benefits will help to promote social cohesion and inclusion, because no dramatic drop in income is incurred. However, they tend not to be redistributive as they seek preserve existing income patterns (and hence any income inequalities).

Benefit expenditure should be less than for compensation for loss of faculty benefit as the income replacement ceases when the person finds employment. A compensation for loss of faculty benefit would be paid regardless of whether the claimant was or was not in paid work; although it could be means-tested.

However, ending the replacement income after a return to work is likely to engender work disincentives. Remaining on incapacity benefit may be more financially attractive than returning to work – encouraging benefit dependency. If financial considerations are paramount, this disincentive will depend upon the replacement rate – that is, benefit as a proportion of wages. A high replacement rate can act as a work disincentive. But this will not be important in individual cases where the non-monetary benefits of work (such as enjoying social contacts) and/or psychic factors (for instance, a desire to be independent) prompt people with work incapacities to return to work.

Even if receipt of an incapacity social insurance benefit is time limited, the protection it offers against income loss provides recipients with certainty, which may not only help combat anxiety, but also promote risk-taking in the form of

[23] Although the literature tends to refer to *income* replacement benefits, social insurance programmes in practice replace *earnings* and not overall income, which comprises earnt and non-earnt income.

participating in rehabilitation activities. That is, high benefits may engender adaptive behaviour that is socially beneficial (Walker, 2000:117).

Earnings related or flat rate benefit

Determining replacement rates is 'not straightforward' (Walker, 2000:117). There are two broad approaches:

- Bismarckian approach were benefits are wage related and this allows claimants to some extent to maintain their standard of living. Earnings related benefits are a common feature of social insurance programmes.

- Beveridgean approach were benefits are paid at a flat-rate. Flat-rate benefits overcome a possible shortcoming of earnings-related benefits – people on low incomes will receive a low benefit. Flat-rate benefits offer a degree of horizontal redistribution.

As already mentioned (Section 4.1) both approaches prioritise equity over equating premiums to an individual's risk.

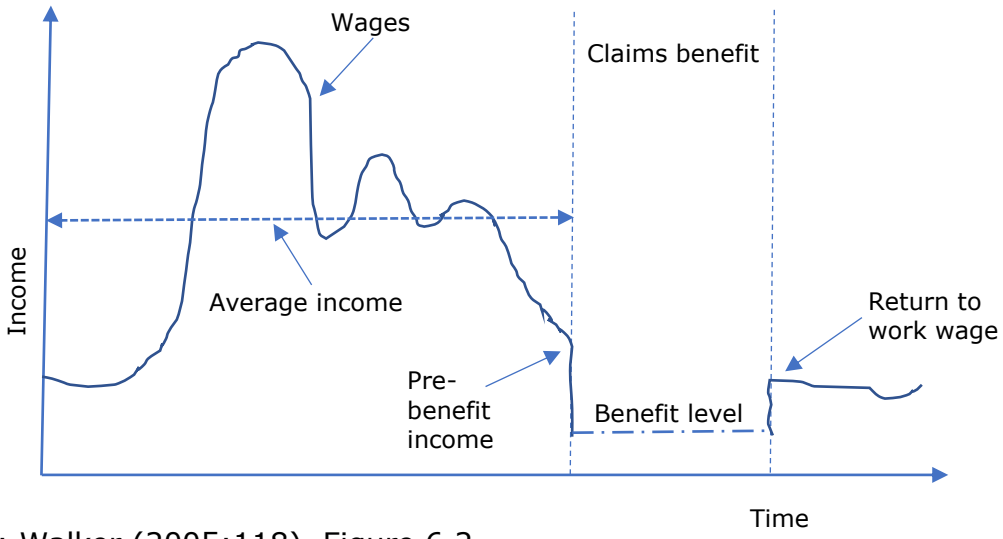
Determining the replacement income is ultimately a political decision. The decision involves considering the trade-off to be made between maintaining claimants' standard of living and advoiding work disincentives. If the former is prioritised this could lead to a higher rate of benefit being set than if the latter is seen as paramount.

Australia and UK have flat-rate benefits with increases for specific purposes. These schemes traditionally have less of a connection with the labour market and are more focused on poverty reduction. Continental European benefit schemes are more closely related to employment and seek to provide a replacement income (Cousins *et al.*, 2016:12).

If the benefit is earnings-related, a reference wage must be identified. Figure 4.1 shows that the choice of reference wage will affect the level at which benefit is set. Here a replacement proportion based on the individual's income prior to claiming benefit will give a lower benefit than one based on average income, maximum income or lifetime earnings. In Figure 4.1, the return to work wage is also lower than before the benefit claim, and if the priority was addressing work disincentives, then this would also need to be considered when determining benefit levels.

Short-term income replacement benefits tend to be based on recent earnings (the average over the last 12 months) (Walker, 2005:118). Programmes may also vary rates by family type with, say, families with children having a higher replacement income rate. Programmes may also include maximum and/or minimum benefit amounts.

Figure 4.1: Measuring income replacement



Source: Walker (2005:118), Figure 6.2

4.3.2 Compensation benefits

There are two types of compensatory benefits for people with a disability/incapacity: those for extra costs and those covering a loss of faculty.

Extra costs benefits compensate people with a disability/work incapacity for the additional costs that they incur, for example, for health and personal care and mobility (Barnes and Baldwin, 1999:161-2). Meeting these extra costs lowers people's standard of living. Some costs will be one-off (for example, adaptations to the home or moving to a care home), but others will be on-going (such as special diets, higher home heating costs or paying for a personal assistant). The underlying assumption is that, in contrast to the social model of disability, the additional costs arise from the claimant's mental or physical impairments (Walker, 2005:124). However, these extra costs are difficult to assess, as they vary by the nature of the medical condition, the nature of the health and social care provided, family support, personal circumstances and income level (Walker, 2000:126).

There are two main variants of benefit compensating for extra costs incurred. First, a benefit that may have a standard care component and, say, a separate payment to help cover mobility needs where these arise. Such benefits can be paid regardless of the economic status of the claimant. The UKs Personal Independence Payment is an example of such an extra cost compensation benefit (WPC, 2012). Secondly, a system with a mix of short-term and long-term benefits, where the latter are paid at a higher rate to recognise, for example, that white goods deteriorate over time and will need replacing.

Typically, benefits to compensate for a **loss of faculty** are workers' compensation schemes for industrial injuries and illnesses and for war veterans. They may by industry or injury specific. The benefit compensates for the inability to fully participate in society. In some countries (for example, the Industrial Injury Disablement Benefit in the UK) the amount of benefit is related

to the assessed percentage of impairment. The rationale for compensating for loss of faculty is, first, that there is evidence that people with a disability tend to have lower incomes than non-disabled people (Walker, 2005:124; Eurostat, 2015), and it is 'fair' that they are compensated for this economic disadvantage. Secondly, it avoids using legal action and tort to obtain private compensation, which requires fault to be established. Thirdly, there is a 24/7 'loss of amenity' for the people concerned, whereas income maintenance or replacement benefits relate to earnings from working 'eight hours a day' five days a week (Bolderson and Mabbett, 2002:60). The notion of 'loss of amenity' due to an impairment implies that benefit should be paid regardless of whether recipients are in paid work. As it can be paid whether or not the person is in employment, it can be a more expensive benefit than an income replacement incapacity benefit. However, it may address potential work incentive problems associated with income replacement incapacity benefits.

Both governments and disabled people groups have objections to loss of faculty compensation benefits (Bolderson and Mabbett, 2002:60-1). First, benefit eligibility is based on establishing the cause of the injury or disease. When some claimant cannot establish causality, individuals with similar needs and circumstances obtain different outcomes. Secondly, the benefit individualises the compensation, and, from a social model of disability perspective, this can mean governments feel they are under no obligation to address the wider social barriers that give rise to disability. In general, loss of faculty benefits are not compatible with the social model of disability. Thirdly, government funded compensation benefits subsidise the *status quo* – possibly including firms responsible for the worker's injury or illness. Collective resources are redistributed from those that benefit from current social and economic arrangements to those who may have been unwittingly harmed by them.

Writing in 1999, Sainsbury (1999:40-1) acknowledged that the UK did operate an industrial compensation benefit, but concluded that '… compensation is not now viewed as a legitimate aim or function of the social security system.' Compensation stood 'apart' from other (income maintenance and replacement) benefits in the system. Similarly, Thornton and Lunt (1997:381) in their examination of employment policies for disabled people in 18 countries record that there is a move away from the compensatory principle and towards promotion of participation in the labour market.

4.4 Partial benefits

In some countries, such as the UK, the result of an incapacity assessment is binary, either the person is capable of work or they are not. Berthoud (2011) summarises why this may be problematic:

> 'The difficulty is in defining a neat dividing line between those who are capable and incapable. Many of the best-known disabled people in Britain – a Professor of Theoretical Physics, a former Home Secretary – are famous for their work, even though they would have been straightforwardly entitled to ESA [an incapacity benefit] if they had lost their jobs, because their impairments would have been judged to render them incapable of work. But many other people have found themselves

> out of the labour market for reasons associated with disability, even though their impairments are apparently not so severe as to prevent others, with similar conditions, from retaining their jobs. The all or nothing concept of incapacity needs to be replaced with a sliding scale of disadvantage.'

Indeed, some countries (for example, the Netherlands, Norway, Sweden and Switzerland) have a more granular benefit system than a simple capable vs not capable for work dichotomy.[24] The Swedish system, for instance, allows incapacity to be set at 25 per cent, 50 per cent, 75 per cent, or 100 per cent (Baumberg *et al.*, 2015:43). The assessment is based on the number of hours a person can work.

Awarding partial benefits recognises that some people with a work incapacity may be able to do paid work, and so combine earnings with benefits to secure an adequate standard of living. For those with a partial work incapacity staying in work, or returning as soon as possible, is seen as beneficial because work is seen as building a person's confidence, can allow new skills to be developed and allows an individual to consider their longer term working options.

Even countries that operate a binary incapacity assessment system, like the UK and the USA, have arrangements that allow some combination of (therapeutic) work and benefit receipt (Kennedy, 2017) (see Section 4.5.3).

Cousins *et al.* (2016:13) finds that Scandinavian countries tend to have partial incapacity benefits that allows people to combine part-time work with benefit receipt. They cite evidence that '… these part-time benefits have some positive impact on return to work and reducing sickness absence at least for some claimants and in some periods'. (Cousins *et al.*, 2016:13).

Partial benefit may also help tackle fraudulent claims. De Boer *et al.* (2004:133) report that in the USA there is a concern that only having a binary outcome for the assessment, and no partial capacity benefit, means that claimants with less severe impairments and poor job prospects are encouraged to over-emphasis their condition and work incapacity.

However, partial benefits may have (politically) unintended effects. In the Netherlands partial benefit can act as a wage supplement for firms. Moreover, recipients may differ systematically from those awarded full benefit. De Jong and Thio (2002 *cited in* García-Góme *et al.*, 2011:156) find that in the Netherlands partial benefit recipients have a higher socio-economic status than those on full benefit, as they '… are older, better schooled, more often male, married and main breadwinner, have a longer tenure with their current employer and work in large, financially healthy firms.'

Moreover, an OECD (2003:65-7 and 2010:110) study found partial benefits can lead to work disincentives (to a 'benefits trap'), whereby recipients have a financial incentive to remain on (partial) benefits rather than be solely reliant on paid work. Countries with partial benefits tend to have high benefit caseloads.

[24] Table 4.1 in OECD (2010:109) summarises the use of partial benefits for OECD countries.

This is due to the dynamics of benefit receipt – claimants flow on (and can do so because partial awards are allowed at a lower level of incapacity), but fewer people flow off benefit and so the caseload increases over time. In practice, a relatively high proportions of people with partial awards can be out of work, and have a lower standard of living as a consequence. The OECD recommend that regular re-assessments are required if partial benefits are used, and possibly a work-availability requirement for the remaining work capacity.

Furthermore, de Jong (2000:34-5) observes that partial benefits in Germany, the Netherlands and Sweden have had only a limited impact on reducing benefit expenditure. The reasons for this are unclear – whether it reflects labour market conditions or an unwillingness of decision-makers to award partial benefits.

In 2003, Denmark replaced its partial benefits and with a wage subsidy scheme, known as 'flex-jobs' (which are discussed further in Section 4.5.3).

4.5 Financial incentives

Countries can have programmes that use financial incentives to induce employees to move into work or employers to make workplace adaptations for workers with an incapacity. However, designing benefit and tax regimes to provide people with the financial incentives to obtain or stay in employment is challenging (OECD, 2010:117). The incentives considered below are measures aimed at individuals to ease the transition from benefit to work, 'making work pay', allowing paid work that can be done without losing benefit ('permitted work'), and subsidised employment.

4.5.1 Easing the transition from benefit to work

For recipients with some capacity to work, making the transition from benefit to employment can be financially risky (Corden, 2005:124), especially if it means that an income maintenance and replacement benefit ceases. Financial worries can focus on meeting housing costs and getting into debt in order to pay for everyday expenses (especially as future earnings tend to be paid in arrears). They may also fear that in moving towards work they risk losing all of their benefit (say, via a re-assessment), or that if having tried a period of work which does not work out they find returning to benefit delayed and/or difficult. People with fluctuating conditions in particular can be concerned about their ability to sustain work and hence future earnings. Possible policy measures include:

- Partial benefits that allow recipients to combine paid work with benefits (see Section 4.4).
- Time-limited return to work payments/bonuses.
- Linking rules that for a specified time period allow a quick and easy return to a person's benefit as it was pre-employment (Corden, 2005:129).

An example of a return to work payment is the UKs Return to Work Credit. It was worth £40 per week for up to 52 weeks to new incapacity benefit claimants returning to work for 15+ hours per week and earning less than £15,000 per annum (Clayton *et al.*, 2011). A systematic review by Clayton *et al.* (2011) concluded:

> 'Overall, the studies concluded that whilst the Credit may have provided an incentive or support for claimants already thinking about returning to work, there was no clear evidence that their return to work depended on it.'

4.5.2 Making work pay

One issue is the generosity of benefits relative to paid work (c.f. the replacement rate) can create work disincentives. OECD (2010:118) are concerned that:

> 'Generous and easily accessible payments can erode the willingness to work of individuals with health problems. ... [D]isability benefits which are relatively more generous than other income support schemes may more generally attract people of working age who are facing labour market difficulties.'

Their concern is confirmed by a statistical analysis of OECD countries that showed that (OECD, 2010:92):

> '… changes in accessibility to disability benefit programmes and benefit generosity are both positively associated with disability beneficiary rates. This is also confirmed by single-country experiences, with a sharp drop in beneficiary rolls in the aftermath of a reform introducing a much more restrictive approach to granting permanent disability benefits (Poland after 1999) or much stricter access to disability benefit for people with partially-reduced work capacity (Luxembourg after 1997).'

The OECD (2010:117-8) found replacement rates for low earners with a work incapacity of between 70 per cent and 110 per cent. In part these rates are high because of interactions with other benefits, for example, support for housing costs.

One possible work incentive policy is to make incapacity benefits less generous. However, this may have socially unacceptable consequences, namely, increased levels of poverty and social exclusion amongst member of a groups that is seen as vulnerable. An alternative approach is to supplement the wages of those in low paid work.

Wage supplements, or in-work benefits, may be required because the loss in income through taxes and reductions in benefit means that work does **not** pay in many countries for people with a work incapacity (see OECD, 2010:120-1). Wage supplements have been used in Finland, France, Sweden and the UK (Thornton and Lunt, 1997:393). They can be used to top-up earnings for wages below a threshold or number of hours.

However, the OECD (2010:121) calculate that such schemes are not very effective due to the interplay between earnings, taxes and benefit withdrawal:

> 'Overall, incentives to take up work or to increase the number of hours worked vary hugely both across countries and across (previous) income levels and working hours within countries. The interplay between (gradual) benefit withdrawal and increasing taxes produces, for most

countries, a range of situations in which working or working more hardly pays.'

The UK introduced tax credits, effectively a means-tested wage supplement, in 1999. An evaluation of the Disabled Person's Tax Credit (DPTC) found that (Atkinson *et al.*, 2003):

- 79 per cent of survey respondents said DPTC had been either essential or very helpful;
- of those finding DPTC helpful, 32 per cent claimed it had allowed them to work, or made employment more worthwhile financially for themselves or their partner.
- 72 per cent were already working when they found out about DPTC, and for 56 per cent of those **not** working it was a positive incentive to work (that is, PDTC had influenced them a lot or somewhat);
- There was '… a high impact group, of 23 per cent, who claimed that they would not be doing their present job without DPTC. Furthermore, among them, DPTC was often the decisive factor in their decision to work or keep working. Women, older people, the self-employed, and most particularly, single parents, were over-represented in this high impact group.' (2003:98).

The evaluation findings tentatively suggest that wage supplements can help some incapacity benefit recipients move into employment. [25] However, a systematic review by Clayton *et al.* (2011) of the Disabled Person's Tax Credit found:

> '… recipients reporting that it provided extra financial security which helped movement into work, but overall take up was low'.

The credits replaced Disability Working Allowance, which also did not work as a financial incentive for people to leave benefit for employment, although it helped people stay in employment (Thornton, 2003:8).

Thornton (2003:11) challenges the idea that incapacity benefits act as a work disincentive, because:

> 'There is no direct evidence from many years' research that the main disincentive to leaving incapacity benefit for paid employment is the possibility of being little or no better off financially. The 'benefit trap', where a working person is little or no better off as a result of earning additional income because they pay more tax and receive less benefit, is often thought to be a major disincentive but this is hard to demonstrate.'

[25] Note, this impact evaluation is based on a survey of DPTC recipients' opinions and experiences, it is not a formal summative impact assessment where their outcomes were compared with the outcomes of a counterfactual comprising a similar group of disabled people not in receipt of DPTC.

4.5.3 Permitted work

Permitted work is UK nomenclature for allowing people on incapacity benefit undertake some paid work without losing their entitlement to benefit (Kennedy, 2017). Previously, and in other countries, this may be called therapeutic work.

The UK allows 'permitted work' for Employment Support Allowance recipients, whereby since April 2017 recipients can earn up to £115.50 per week if working for less than 16 hours per week for an unlimited period. Universal Credit, the replacement for means-tested Employment Support Allowance, goes not include permitted work. However, claimants with an incapacity will be able to earn up to a 'work allowance' (effectively, an income disregard). Earnings above this threshold face a taper of 63 per cent. Unlike the permitted work rules there is no hours' limit for work in Universal Credit. A mixed methods evaluation found that the permitted rules worked for some claimants, especially those new to paid work. Moreover:

> 'There is clear evidence that, for a (not insignificant) minority of clients, the permitted work rules have acted as a stepping stone to employment, and as a shift away from benefits. …
>
> Clients with musculo-skeletal difficulties and mental health conditions appear to be the most likely to have moved into sustained employment over time than people with progressive illnesses who seem to have gained the least from the new permitted work rules.'
>
> Dewson *et al.*, (2004:xiv)

Where countries have partial incapacity benefits there is no need for permitted or therapeutic type work, as paid work can be combined with benefit receipt. However, where benefit rules require that paid work is not undertaken, then some form of permitted work may be appropriate.

4.5.4 Subsidised employment

Subsidises could be paid to employers hiring or retaining people who would otherwise claim an incapacity benefit. Countries that have subsidised employment programmes include Austria, Denmark and Sweden (OECD, 2003:113-4). The latter's subsidy varies with the person's degree of incapacity.

Subsidises may be designed to (Thornton and Lunt, 1997:392-3):

> '… to compensate for reduced productivity or costs associated with employing a disabled person; to provide a reward or bonus for taking on a disabled person; and to cover all or some of the costs of adapting the workplace or working environments to meet the circumstances of disabled workers.'

Productivity compensation subsidies may be an assumed amount, or assessed on a case-by-case basis. The duration of subsidies varies, and some taper off over time. The subsidy may take the form of a reduced employer social insurance contribution, rather than a direct cash transfer. In some countries the employer can receive a lump sum grant for hiring a disabled/incapacity benefit recipient (Thornton and Lunt, 1997:393).

One well-known approach to wage subsidises is the Danish 'flex-job' programme. Denmark developed flex-jobs in 1998 as its main form of provision for people whose work capacity is reduced by at least 50 per cent (Etherington and Ingold, 2012). They are subsidised jobs with personal adviser support and a crucial element of Denmark's occupational health system (Etherington and Ingold 2015:151). Within eight weeks of sickness absence, local authorities use a variety of methods to help people return to work, including counselling, vocational rehabilitation, job training and phased returns to work. If a return to ordinary work is not possible, the claimant may be offered a flex-job. If the first flex job is unsuccessful they may be offered another. If the individual is unable to do a flex-job, then they will be awarded a disability pension. Flex-jobs include in-work support, and reduced working hours. Those people with a severe disability who are unable to take on a flex-job will be offered a place in sheltered employment.) The flex-job subsidy, paid by the local authority, is relatively generous, covering a half to two-thirds of salary costs up to a maximum threshold (Etherington and Ingold, 2012:36).

The number of flex-jobs has expanded rapidly (from 13,00 in 2001 to 51,862 in 2010 (Etherington and Ingold, 2012:36)). Evaluations are slightly mixed about the impact of flex-jobs on moves onto regular employment, but are generally favourable in that participants would not be in employment without the programme (see Etherington and Ingold, 2012:36).

However, there are problems with the programme (Etherington and Ingold, 2012:36-7). Having a flex-job can be stigmatising. There is a waiting list for flex-jobs, because demand exceeds supply, but this may reflect that the scheme is poorly targeted. Some flex-jobs are seen as being of a poor quality.

Nonetheless, the OECD (2010:15) believes employers need subsidies to compensate them for employing people with a work incapacity (especially those with no work experience). They find that employer subsidies are more effective when restricted in scope (and so not like the flex-job programme). However, care is required to avoid the moral hazard whereby a job is wrongly transformed into a subsidised job.

4.5.5 Funding workplace adaptations

Another approach is to help employers and workers with any extra costs of moving into, or staying in, employment. All of the 18 countries looked at by Thornton and Lunt (1997:393) offer employers grants to help them make changes to the workplace. Disabled workers may also receive grants in some countries (for example, Austria, Belgium, Germany and the UK) to cover travel costs, work tools and so on (Thornton and Lunt, 1997:394). The UKs Access to Work programme provides funding for workplace adaptations and on-going support (such as Support Workers or work-related travel costs). The scheme is discretionary, and awards are made for up to three years and usually reviewed annually. The Sayce Review (2011:14-5) found in 2009/10 it helped 37,300 people, at an average cost per person of around £2,600. And that there was 'overwhelming support' for the programme.

However, there are some lessons to be learnt from a parliamentary inquiry into Access to Work (WPC, 2014). The committee found that, whilst the programme was provided an important element of support:

- take up was low – more information about the programme was required in accessible formats;
- there was a misunderstanding that it was primary for people with a physical disability – whereas it should be supporting more people with mental health problems, and intellectual, cognitive and developmental impairments;
- guidance for the self-employed needed to be improved;
- its administration was poor – it was paper-based, the telephone call centre did not provide a flexible or friendly service and staff administering the programme required disability awareness training;
- officers needed to be more transparent about why award decisions were made and make clearer complaints and review procedures;
- the Department for Work and Pensions needed to engage more effectively with the programme's users prior to making significant changes.

4.6 Conclusion

The literature review highlights the crucial role of moral hazard in insurance, in general, and in social insurance, in particular. The potential lack of insurance coverage that would arise from market provision, is a key justification for social insurance. However, moral hazards also operate in social insurance programmes. The review identified some policies, such as co-insurance, that can be deployed to minimise moral hazard.

In Jersey, Short-Term Incapacity Allowance is an income replacement benefit payable for up to one year and recipients are not allowed to undertake any work. Long-Term Incapacity Allowance, in contrast, is an in-work benefit that compensates for a loss of faculty. The literature review suggests that benefits compensating for loss of faculty are controversial with disability groups, and sit uneasily in modern social security systems. Other countries have income maintenance and replacement benefits for short and long-term periods of incapacity. However, if Long-Term Incapacity Allowance became an income maintenance/replacement benefit, there would be a case for a compensatory 'extra cost' benefit to meet the additional expenses that disabled people incur as a result of social barriers and their medical condition.

As an in-work benefit, Long-Term Incapacity Allowance has features resembling partial benefits. Indeed, the amount of benefit paid is related to the assessed percentage loss of faculty.

Stafford (2007) called for employers on the island to have a more active role in sickness management. He also called for more research on employers' management of sickness absence. Whilst the report mentioned the use of financial incentives for getting employers more involved it did not recommend that employers should take responsibility for funding (short) periods of sickness leave, nor privatising Short-Term Incapacity Allowance. However, this review suggests that the earlier recommendation may have been too cautious.

The evidence base on 'what works?' for financial incentives is relatively weak. Not all evaluations include an impact analysis. Some studies show positive impacts and others do not.

Jersey does have funding for workplace adaptations, an Adaptation Grant. The issues Stafford (2007) identified with the grant are similar to those identified in this review for the UKs Access to Work.

5 Non-financial support

It has been long recognised that people with a work incapacity may require non-financial support in obtaining employment. In recent years, the policy rhetoric has shifted '… from paternalistic state intervention to a policy that encourages independence and responsibility' (Thornton and Lunt, 1997:381). Alongside this has been a policy focus on increasing disabled people's participation in the labour market – closing the so-called disability gap. However, there have been concerns that this change in the debate and policy is a cover for other objectives, such as cutting public expenditure.

A further shift in policy debates is the increased emphasis on cross-sector partnerships and collaborative working, and on user involvement. Indeed, ensuring that disabled people have a greater voice in the formulation and implementation of relevant policy is a feature of many countries (Thornton and Lunt, 1997:383), for example, Australia, Ireland and the UK.

The literature can refer to 'non-financial' support as rehabilitation and as '(re-)integration', and associated policies (across OECD countries) are often combined with the financial support discussed in the previous chapter to create a return to work package. Such policies seek to 'activate' benefit recipients with some capacity to work to that they can engage in employment, and protect those who do not.

The terms 'return to work programmes' and 'vocational rehabilitation' can also be used interchangeably.

This Chapter gives an overview of the services and provision that countries have sought to provide.

5.1 Types of provision

5.1.1 A human rights approach – the right to health

Typically, when incapacity benefit recipients are asked what is their main barrier to obtaining employment they say their poor health status (Corden, 2005:131). If incapacity benefit recipients are to return to work, they need access to high quality health care. One possible perspective on this is – following the Capability Approach – to see the issue in human rights terms.

International human rights law supports a 'right to health'. The clearest statement of this right is provided by Article 12.1 of the International Covenant on Economic, Social and Cultural Rights which states 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.[26] This right to health is an inclusive and indivisible human right (Office

[26] The Convention is online at: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx. There is also a Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health: see http://www.ohchr.org/EN/Issues/Health/Pages/SRRightHealthIndex.aspx.

of the United Nations High Commissioner for Human Rights, 2006:1). The Committee on Economic, Social and Cultural Rights (2000:1) outlines the right as follows:

> 'Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.'

The Committee's general commentary provides some principles that could help the States of Jersey develop policy. It highlights that the right to health does not mean a right to be healthy (Committee on Economic, Social and Cultural Rights, 2000:3; WHO and Office of the UN Commissioner for Human Rights, 2007:1). However, the right includes various freedoms and entitlements and the latter, in the context of this review, includes '… the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.' It is a right that takes into account a state's maximum available resources and recognises that a government cannot guarantee good health. However, a government cannot use a lack of resources as a justification for not fulfilling its legal obligations (Office of the United Nations High Commissioner for Human Rights and WHO, 2008:5). Hence:

> '… the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.'
>
> Committee on Economic, Social and Cultural Rights (2000:3)

This could be interpreted as a right to an incapacity support system.

Article 12.2(d) of the Convention ('The creation of conditions which would assure to all medical service and medical attention in the event of sickness') is taken to include a right to rehabilitation services (Committee on Economic, Social and Cultural Rights, 2000:6)

The WHO has adopted a humans-right approach to health, and this:

> '… provides strategies and solutions to address and rectify inequalities, discriminatory practices and unjust power relations, which are often at the heart of inequitable health outcomes.'
>
> WHO (2015b)

In accordance with this approach, 'progressively improving' adherence to the following principles and standards is sought (Committee on Economic, Social and Cultural Rights, 2000:4-5; WHO and Office of the UN Commissioner for Human Rights, 2007:2; WHO, 2015b):

1. Availability. There must be a 'sufficient quantity' of facilities, goods and services within a country.
2. Accessibility. 'Health facilities, goods and services have to be accessible to everyone without discrimination …'. There are four aspects to this:
    a. non-discrimination and equal treatment – services must be available to everyone;

   b. physical accessibility – facilities, goods and services must be within 'safe physical reach' of people. This consideration could have implications for the venue and location of incapacity services on the Island;
   c. economic accessibility – 'facilities, goods and services must be affordable for all'. Regardless of the provider, payments for healthcare must be based on the principle of equity. This element could influence debates on who should contribute to paying for incapacity benefits;
   d. information accessibility – a right health information and education, without undermining an individual's confidentially or privacy.
3. Acceptability. 'All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.'
4. Quality. Systems must be of a good quality, for instance, they include use of medically qualified staff.
5. Accountability. States and office holders are answerable for adherence to human rights
6. Universality. Human rights are universal and inalienable.

An incapacity policy framework informed by the right to health could include:[27]

- Promote health equity (for example, ensuring vulnerable groups or rural populations are not disadvantaged by policy or services).
- Ensure that there are no financial barriers to clients accessing medical and rehabilitation services. Coverage must be 'affordable for all'.
- Provide a comprehensive and holistic service.
- Ensure that services were 'accessible, available, locally acceptable and of quality' (see above).
- Be non-discriminatory – and would include equal opportunities and diversity monitoring.
- Ensure that regardless of provider (State or third/private sector), the State has primary responsibility for ensuring 'providers fulfil their role on behalf of the government'.
- Involve the community in the development of the policy.

5.1.2 Vocational rehabilitation

Vocational rehabilitation and training can have a vital role in returning an incapacity claimant to employment (OECD, 2003:108). Rehabilitation involves looking at what someone can do and their potential. Although writing in 2010, the OECD (2010:105) observes:

> '… several countries have recently made efforts to move away from assessing a person's disability to exploiting better the person's remaining work capacity. Such a change in orientation also shifts the focus of supports and resources to rehabilitating people back to part or full-time work rather than supporting them to stay out of work.

[27] This list is based on observations in WHO (2015a).

Statistical analysis by the OECD shows that rehabilitation and re-integration policies do reduce benefit caseloads:

> 'With respect to integration, the expansion of employment programmes and vocational rehabilitation is correlated with a decreasing number of persons receiving a disability benefit.'
>
> OECD (2010:92)

Yet only a few countries (for instance, the Netherlands) legally oblige employers to be involved in vocation rehabilitation programmes (OECD, 2010:107). Countries approaches to rehabilitation vary in a number of respects (OECD, 2003:108-10):

- Whether claimant participation is voluntary or mandatory before benefit is awarded – benefit claims are regarded as a 'request' for rehabilitation support in Austria, Denmark, Spain, Sweden and Switzerland.
- Access to rehabilitation services may be restricted to those on disability/incapacity benefits or open to others.
- The timing of the rehabilitation – whether the intervention is (very) early (for instance, Germany) or later on (for instance, Norway). In some countries rehabilitation is provided after the claimant's medical condition has stabilised but this can be 'too late'.

There is widespread agreement that vocational rehabilitation services should be provided early on in a benefit claim.

The rehabilitation/reintegration of claimants can be difficult in buoyant labour markets, as employers have access to a plentiful supply of labour for whom adaptations are not required. In such circumstance, financial incentives and/or legal obligations may be required to ensure that sufficient weight is given by employers to rehabilitation services.

In some countries, differences in local or regional labour markets can mean that similar cases living in different areas receive different rehabilitation support packages. However, this is probably not a consideration for the States of Jersey.

5.1.3 Individual Placement and Support model (supported employment)

Whilst support employment developed in the USA, as an alternative to traditional rehabilitation programmes, it has been adopted in other countries including Australia, Canada and the UK. There is no single model for supported employment.

Individual Placement and Support (IPS) is an approach to supported employment. It was developed for people with severe mental health conditions and/or substance misuse (Drake, 1998). The primary aim of IPS is that participants enter or stay in competitive employment. The IPS model is underpinned by eight principles (Bond, 1998 and 2004; Marshall *et al.*, 2014):

- Securing competitive employment is the primary goal.

- Everyone who wants to work is eligible for employment support – eligibility depends upon individuals' interest/desire and not their 'work readiness'.

- Job search and contact with employers commences early – as opposed to (lengthy) pre-job assessments, counselling and training.

- Employment/rehabilitation services and mental health services are integrated - employment specialists are based within clinical teams.

- Services and jobs sought reflect the participants', and not the providers, preferences.

- On-going (that is, unlimited) personalised support is provided.

- Personalised benefit advice is provided.

- Employment specialists develop relationships with employers to help meet participants' preferences.

IPS is seen as different from the traditional vocational rehabilitation approach.

The IPS model is well supported by research (included randomised controls) conducted mainly, but not exclusively, in the USA. A recent systematic review of the evidence for IPS supported employment for people with mental health problems or with mental and substance misuse problems found (Marshall *et al.*, 2014:16):

> 'Supported employment consistently demonstrated positive outcomes for individuals with mental disorders, including higher rates of competitive employment, fewer days to the first competitive job, more hours and weeks worked, and higher wages. There was also strong evidence supporting the effectiveness of individual elements of the model.'

Here supported employment may:

> ' … include rapid job search, integration of rehabilitation and mental health services, job development, benefits counseling, and individualized follow-along supports that are necessary to sustain employment.'
>
> Marshall *et al.* (2014:17)

The IPS supported employment model has been found to increase competitive employment by 30 to 60 per cent (Howard *et al.*, 2010). However, these impacts may in part reflect the nature of the North American welfare regime. Howard *et al.* (2010) query whether the model is as effective in societies with higher levels of unemployment and more generous benefits. The authors' report on a randomised control trial conducted in London which found that whilst IPS participants had, one year after the intervention, a higher rate of competitive employment (13 per cent compared to seven per cent), this difference was not statistically significant. A result that Howard *et al.* (2010) attribute to implementation problems with the IPS model. Howard *et al.* (2010) highlight that the IPS supported employment model is likely to be context dependent,

accordingly 'it may be difficult to achieve even moderate rates of competitive employment in some settings.' This was because, firstly, as Burns *et al.* (2007) show in their randomised control trail of IPS in six European countries, the effectiveness of IPS was affected by socioeconomic context (especially local unemployment rates). In general:

> 'IPS workers seemed more able to find jobs for individuals with severe mental illness in unskilled, support positions (such as warehouse or catering work), in the context of a buoyant local economy.'
>
> Burns *et al.* (2007:1151)

Moreover, irrespective of service (IPS or traditional vocational rehabilitation) more participants obtained employed (lasting at least one day) when the economy (GDP per head) was growing, there was a low rate of long-term unemployment and benefit work disincentives were small (Burns *et al.*, 2007:1150-1). Benefits with high replacements rates acted as an 'impediment' to successful vocational rehabilitation.

Secondly, the Howard *et al.* (2010) study recruited people who wished to work but they did not test the depth of their motivation, and so the study may have included people who were not actively engaged in jobseeking.

Thirdly, the London trial was 'not structurally or managerially integrated with community mental health services', and this will have undermined the effectiveness of the model.

Fifthly, employers' attitudes towards employing people with mental health problems may vary geographically. To be successful vocational rehabilitation does require that employers do not discriminate against people with a (severe) mental health condition.

Further research is required on the effectiveness of IPS supported employment for sub-groups, notably '… young adults, older adults, people with primary substance use disorders, and those from various cultural, racial, and ethnic backgrounds.' (Marshall *et al.*, 2014:16). Moreover, the review was unable to say anything about costs and benefits of IPS.

Delivery of the IPS model of supported employment can be underpinned by a Fidelity Scale (see Bond *et al.*, 1997; Becker *et al.*, 2011).[28] The scale provides feedback on the extent to which a given programme adheres to the IPS standard.

5.1.4 Sheltered employment

Thornton and Lunt (1997:399) define sheltered employment as follows:

> 'Sheltered provision is a job-creation measure, established in order to create work for certain disabled people who otherwise would not be catered for in the open employment market.'

[28] The fidelity scale can be accessed online at: http://www.dartmouth.edu/~ips/page19/page21/files/se-fidelity-scale002c-2008.pdf.

Most OECD countries operate sheltered employment programmes (OECD, 2003:114). Such employment may be provided in sheltered workshops, special businesses or protected areas in ordinary companies. Typically, the intention is that the employees will make the transition to open employment. However, this is 'rarely realised to any degree' (Thornton and Lunt, 1997:399). In recent years' provision of sheltered employment has been increasingly seen as 'inappropriate', with a desire to it being replaced by supported employment-type provision (OECD, 2003:114; see also Thornton and Lunt, 1997:399). This is because it can act a 'trap' for people with more potential (OECD, 2010:158). It can fail to develop workers' skills and knowledge required for the regular labour market. Sheltered workplaces often rely on public subsidies. Yet sheltered employment is still widely used. However, in some countries, such as the Netherlands, Spain and the UK, attempts have been made to make the sheltered sector more competitive, flexible and business-like. In the USA, sheltered outcome is no longer seen as a successful outcome (OECD, 2010:80).

5.1.5 Voluntary work

There is some UK evidence that allowing recipients to undertake voluntary work does aid their return to paid employment (Corden, 2005:125). It is claimed that voluntary work allows people to improve self-confidence and acquire skills and expertise.

5.1.6 Quota schemes

Quota schemes tended to be introduced during a period of post-war recovery, and are were initially aimed at finding employment for disabled veterans (Thornton and Lunt, 1997:388). Mandatory employment quotas are used in some OECD countries (OECD, 2010:79). However, several countries have abolished or reformed their quota schemes. As Thornton and Lunt (1997:389) state, the idea of quotas is somewhat out of step with a focus on promoting a 'right to work':

> 'Although the principle of setting a target percentage of disabled workers remains, there are observable shifts in both the guiding philosophy and the application of quota systems, leading to new approaches. The shift in employment policies away from compensatory principles and towards facilitating the right to work is apparent in approaches to quota systems. There is a growing acceptance of the rights of disabled people to work, rather than the duty of the country to compensate for injuries obtained through war-service or for the harm caused by society.'

In practice, quotas can be a 'blunt instrument'. Indeed, overall they may be counter-productive. An evaluation of the quota scheme in Austria found that the quotas help some workers who develop an incapacity to retain their job, but at the expense of people with a work incapacity not in employment, and the overall net impact is negative (OECD, 2010:135). In addition, compulsory employment quota may not be enforced by authorities. Employers can regard any penalties for not meeting the quota 'as a minor additional non-wage cost' (OECD, 2010:134).

5.1.8 Improving return to work planning

An increasing policy focus has been on what people can do, rather than what they cannot. This approach is potentially compatible with the social model of disability, provided it focus on removing social barriers to employment. However, its adoption in, say, the UK has tended to focus on the individual and the results have been at best mixed. Two UK policies are discussed below, the introduction of the 'Fit Note', which sought to encourage general practitioners to support patients return to work, and the introduction in 2000 of a separate Capability Report as part of a functional assessment (the then Personal Capacity Assessment).[29]

In April 2010, the UK replaced its 'sick note' with a statement of fitness to work (known as a 'fit note'). It allows doctors to observe that although the person is not fit for normal work they could work if the job was modified in some way (such as phased return to work, altered hours, amended duties and workplace adaptations). Early evaluations have produced mixed results (Money *et al.*, 2015:529). One study found '… an impact over one year, with employees taking an average of 5.0 days of sick leave in 2010 compared with 6.7 days in 2007.' (cited in Letrilliart and Barrau, 2012:225). However, the 2013 Sickness and Rehabilitation Survey of companies revealed that the 'early optimism' for the fit note amongst firms was diminishing (EEF and Westfield Health, 2013:18-9; see also Money *et al.*, 2015:536). After three years of operation the proportion of businesses claiming that employees were not returning to work earlier increased from 36 per cent in 2011 to 40 per cent in 2013. Moreover, more firms believed that the fit note had not improved the quality of general practitioners' advice about the fitness for work of employees. Hussey *et al.* (2015) undertook a statistical comparison of the proportion of cases with sickness certification over the four years before the introduction of the fit note with cases over the three years afterwards. The authors' find Hussey et al. (2015:182):

> 'Pre-fit note introduction 50% of cases were certified sick. There was no change in the proportion of cases certified sick in the first year post-fit note, despite 13% of cases classified as 'maybe fit'. However, in the second year, the proportion of cases certified sick had reduced significantly (41%) and a larger proportion (19%) was advised on workplace adjustments. In the third year post-introduction, there was a slight rise in the proportion of cases certified sick [(48%)]; therefore, although there was a fall of 2% per annum in certification rates, this was not significant.'

That is, over the seven-year period there is a decrease in the proportion of cases issued with a sickness certificate, but this fall is not statistically significant. Over the three years of the fit note, the proportion of cases where general practitioners had advised that the person was fit for work with a recommended workplace adjustment was 16 per cent.

In the Capability Report medical assessors were given the opportunity to indicate what work-related activities the claimant might undertake and any help

[29] The WCA discussed elsewhere in this report replaced the Personal Capacity Assessment.

or adjustments that they might require.[30] The reports were used by public sector job caseworkers (Jobcentre Plus Personal Advisers) to help support incapacity benefit recipients return to work. The Capability Report did not affect benefit entitlement. A qualitative evaluation found (Legard *et al.*, 2002):

- Although medical assessors adopted different approaches to include the considerations of capacity in the function assessment, they experienced few problems in being able to consider both 'incapacity' and 'capacity'. However, they felt more feedback from the Personal Advisers on cases would have been beneficial, and they could lack the necessary occupational health expertise to complete parts of the report.
- Personal Advisers reported being unsure why the Capability Reports had been introduced and what they were expected to do with the information. This probably reflects a lack of training and relatively poor communications between the assessors and the advisers. Personal Advisers had doubts about the value of the information because it was gathered during a one-off examination. Nonetheless, some advisers were making extensive use of the reports prior to meeting with claimants.
- The report was potentially of value to claimants who were unsure about whether work was an option for them.

Legard *et al.*, (2002:6) conclude:

> 'The accounts of clients and Personal Advisers suggest that the Capability Report can have a role to play. However, there are concerns that the type of information contained in it does not adequately meet their needs, particularly for a clear steer about whether work is viable, how it might be structured and possible vocational directions.'

The Government suspended the Capability Report procedure in July 2010.

A more positive measure to ensure improved return to work planning is the introduction of stricter screening.

5.1.9 Stricter screening of claims for benefit

One policy response to avoid adverse selection for social insurance benefits is to introduce stricter screening arrangements in order to address information asymmetries. Evaluations of the Netherland's Gatekeeper Protocol suggest it is successful in increasing returns to work (Cousins *et al.*, 2016:26; Koning and Lindeboom, 2015:160). The Gatekeeper Protocol in the Netherlands was introduced in 2002, and it specifies legal responsibilities and a timetable for employers and employees (Cousins *et al.*, 2016:26; de Jong *et al.*, 2011:110-11). After a maximum of six weeks of sickness absence an assessment of medical cause, functional limitations and prognosis regarding work resumption must be conducted by an occupational physician. The employer and employee must then draft a return-to-work (or re-integration) plan specifying an aim (resumption of current/other job under current/accommodated conditions) and the actions needed to reach that aim. They appoint a case-manager, and fix dates at which it should be evaluated, and revised if necessary. The re-

[30] Formally, the Capability Report was of the Work Focused Health-Related Assessment and was introduced in October 2008.

integration plan, which is binding on both parties, should be ready by the eighth week of sickness. After week 13 the employer has to inform the National Social Insurance Institute (NSII) about the employee. Only after 39 weeks can the employee make a claim for Disability Insurance and will only receive the benefit, if awarded, after 52 weeks. Benefit will not be awarded unless claims are accompanied by the original return to work plan, a re-integration report and an assessment of why the employee has not returned to work. The Dutch case is unusual in the onus it places on employers, and on employers working with employees. Indeed, caseworkers can sanction employers for delayed or incomplete paperwork or poor re-integration plans and employers can continue to be liable for paying the employee's wage beyond two years. In effect, it places the responsibility for ensuring that sick workers return to work on the employer and not the social security agency during the two years prior to any permitted benefit claim. However, the majority of employers do not submit re-integration plans because they are unsure what actions should be proposed (OECD, 2003:107).

The Gateway Protocol is believed to affect the behaviour of both employers and employees:

> 'The protocol forces employers to focus their attention at the onset of sickness, when the opportunities for recovery and work resumption are probably most substantial. The stricter screening also triggers mechanisms of self-selection and self-screening among applicants with less-severe health conditions …'
>
> Koning and Lindeboom (2015:161)

Here, self-screening arises when claimants consider whether to request a reconsideration or, later on, an appeal of a denied claim. Choosing to withdraw an incapacity benefit claim arises because:

> '… an increase in the rigor of initial eligibility screening may discourage potential applicants (i) because they are not fully aware of appeal prospects and (ii) because the eligibility decision is delayed, as denied applicants are forced to pursue their claims in the appeals process.'
>
> Parsons (1991:860)

Indeed, 'any reduction in the attractiveness of the insurance program is likely to improve self-screening performance, although at an obvious cost to the well-being of the target group.' (Parsons, 1991:861). The Koning and Lindeboom (2015) study confirms the finding of the earlier USA study by Parsons (1991:868) that '… an increase in initial denial rates has a significant, negative effect on application rates.'[31] However, increasing claim rejection rates (via a screening process) so that some people self-select to drop their application may be politically controversial, and to the extent that it delays when some successful appellants receive benefit is likely to cause undue harm and unnecessary suffering to those affected. The possibility of self-selection needs

[31] Parsons (1991) found that a 10 per cent increase in the initial denial rate led to a four per cent decrease in Disability Insurance application rates after two years (between 1978 and 1980).

to be considered if proposals to tighten the screening procedures are taken forward.

Introduction of the Gateway Protocol included a 2003 pilot where in two areas caseworkers were instructed to screen return to work plans more strictly than in other areas (de Jong *et al.*, 2011). Thus employers and/or sick employees were always contacted or visited unless it was 'absolutely clear' that suitable re-integration efforts were underway. Reported benefits of the stricter screening are (de Jong *et al.*, 2011):

- reduced long-term sickness absenteeism due to self-screening by potential claimants[32]
- fewer disability insurance applications due to increased work resumption rates during sickness absenteeism as a result of employers' increased re-integration efforts
- no negative spill-over effects of the stricter screening on the inflow into unemployment insurance.

It the stricter screening was applied nationally the estimated reduction in benefit applications was 4.8 per cent (de Jong *et al.*, 2011:121). De Jong *et al.* (2011) argue that for stricter screening to be effective the eligibility criteria for the benefit must be well-defined and the screening must be accompanied by a sanctions scheme for employers with 'substantial financial penalties for noncompliance' (de Jong *et al.*, 2011:128).

The authors conclude (de Jong *et al.*, 2011:128):

> 'With little screening, workers and employers can decide to devote none or only minimal effort to try and get the worker back to work. Stricter screening is a policy measure to reduce such moral hazard as it forces employers and workers to increase reintegration effort. This reduces the attractiveness of the DI [social insurance] program …'

As the costs of a stricter screening regime are likely to be low, the benefits are likely to exceed the costs.

Other authors have also reported similar positive outcomes for the Gateway Protocol (see Cousins *et al.*, 2016:27; Koning and Lindeboom, 2015:160).

In addition to the Netherlands, with its Gateway Protocol, other countries (Finland, France and Sweden), that have introduced earlier reviews or re-assessments of sickness absence report positive impacts (Cousins *et al.*, 2016:27).

However, as mentioned in the discussion on moral hazard in Section 4.1.2, policy stimulations suggest that stricter screening may deal with the 'incentive problem' but it is at the expense of the 'insurance problem'. In other words, the reduction in the in number of false applications risks a fall in the proportion of people with a severe work incapacity being granted an incapacity.

[32] Here long-term refers to sickness absence at week 13.

5.1.10 Personalised support

Evaluations of employment programmes show that personalised support is strongly supported by claimants and employment advisers (see, for instance, Stafford with others, 2007; Clayton *et al.*, 2010). The independent Sayce Review (2011:12) observed:

> 'Evidence from across learning disability, mental health, physical rehabilitation and beyond shows consistently that support that is flexible, personalised, long lasting when needed, with a rapid focus on job search, is more effective than a series of stepping stones to employment. It also shows support must be available to the employer.'

5.1.11 Anti-discrimination legislation

Anti-disability legislation provides an over-arching, comprehensive framework to help people with a work incapacity to obtain or remain in employment (see Thornton and Lunt, 1997:380). Legislation has been adopted in a number of countries including Australia, Canada, USA and the UK (Thornton and Lunt, 1997:387).

5.2 Conclusion

There is a wide range of non-financial support that can be provided to assist incapacity return to, or stay in, employment. However, there is a notable lack of evidence on how and why programmes work, and in particular on their impact on employment outcomes. This makes it difficult to say with any certainty 'what works?'

Jersey does have a supported employment programme known as Workwise. However, it is not clear from Stafford (2007) the extent to which the IPS model is followed for claimants with mental health conditions. Rehabilitation services on the island recognise the need for early intervention, albeit they do not intervene as early as in some countries covered in this review. Some countries require rehabilitation to have commenced before a claim for benefit can be made, for recommendations on rehabilitation to be included in medical (functional) assessments or for services to be used very shortly after the commencement of the benefit.

The move away from traditional sheltered employment observed in other countries has also occurred in Jersey. Stafford (2007) states that the Jersey Employment Trust has been shifting its focus from traditional workshops toward development training.

Both this report and Stafford (2007) highlight the need for strong anti-disability discrimination legislation

6 Conclusions and recommendations

The aim of this chapter is to consider the findings of the literature review in the light of the earlier Stafford (2007) review. Not all of the latter's recommendations can be covered, not least because they relate to issues not covered here, or the evidence base is poor.

The literature reviewed here confirms sentiments expressed in the earlier review. The models, concepts and ideas underpinning incapacity benefit systems are highly contested. The evidence on the effectiveness of policies and programmes is typically lacking, and results from studies can be mixed.

Policy makers confront trade-offs when designing policy, a judgement is required as the pros and cons of options have to be balanced. Moreover, there is no 'off the shelf' system that Jersey can simply adopt. Other countries experiences provide a palette from which Jersey policy makers can examine; but ideas, policies, and practices will need to be carefully adapted to Jersey's circumstances if they are to be successfully implemented and effective.

There are some general lessons that can be taken from this literature review:

- involve disabled people from the outset in the design of any reforms
- the Social Security Department and employers need to work in close collaboration both on policy development, but also on the delivery of services and even at the level of individual cases
- Financial incentives on employers and providers of rehabilitation services should encourage an early return to work. However, equally, benefits must provide a decent standard of living to those that are unable to do so.
- Moral hazards in the system must be addressed. How far policy goes in tackling moral hazards needs to be carefully weighed, some policies if developed and implemented would be controversial (see below).
- Improving the quality of information used in benefit and assessment decisions required clearly stated criteria, and transparency between the actors involved.
- A whole systems approach to reform is required – in particular reform of incapacity benefits should not be considered in isolation from the impasts on unemployed people
- Quality of decision making can be undermined by imprecise criteria, high workloads, incomplete information, staff shortages, poor quality assurance processes …. (see de Boer *et al.*, 2004).

In addition, the literature suggests that claimants (and the publics) misunderstandings and anxieties about incapacity benefits could be addressed by:

- improved transparency and communications between all the stakeholders involved in incapacity benefit processes;
- having a departmental champion for mental, intellectual and cognitive impairments who is responsible for ensuring that claimants with these conditions are not disadvantaged in existing or future processes;

- staff training so that claimants experience more empathy as they journey through the claim and assessment process. This will involve explaining in accessible and user friendly way the process, what is expected of them, what the outcome of assessment means, and what support going forward is available to them.

The following Sections consider in more detail specific challenges and reforms. However, a degree of humility is also required about what can be achieved. The limits of what can be achieved must also be acknowledged:

> 'It is also important to remember that some disabled people will not be able to work, regardless of the accommodation and provisions designed to help them into employment … Society must accept that work is not always appropriate or possible, and that for many disabled people humane and supportive alternatives to work are needed. These must not stigmatise those who are so supported, nor should non-working disabled people have to suffer poverty and social exclusion.'
>
> Shakespeare *et al.* (2017:36)

6.1 The wider context

As observed in Stafford (2007), incapacity benefit system does not operate in a vacuum. Policy makers need to consider this wider context. The counter-cyclical nature of claims for incapacity benefits needs to be considered when designing policies, as policy instruments may vary in the extent to which they address the upturn in claims during an economic downturn. The increase in claims occurs (Benítez-Silva *et al.*, 2010:523):

> '… because 'work capacity' assessments are applied in a more discretionary manner at a local level according to economic conditions – anecdotal evidence suggests that 'capacity to work' is assessed less stringently in regions where employment opportunities are scarce and where particular individuals are 'hard to place'. Moreover where local managers of re-employment centres are under strong pressure from central government to keep unemployment figures down or to raise outflow rates from the unemployment register in times of recession, assigning individuals to the disability register is one mechanism for achieving these goals.'

Flows onto incapacity benefits during a recession can be more likely where these benefits are a route to early retirement and/or paid at a more generous rate than unemployment benefits. During periods of economic growth, there will be outflows, as some claimants move into paid work. However, the outflows tend to be less than the inflows. Overtime the net effect is to an increase in the stock of claimants on incapacity benefits. Attempting to tighten eligibility criteria for incapacity benefits during a recession can appear to be 'politically heartless' (Benítez-Silva *et al.*, 2010:524). Benítez-Silva *et al.* (2010:524-5) suggest an alternative approach to reform. If incapacity benefit is a replacement for loss of income due to worklessness, rather than compensation for loss of function, then benefit entitlement ceases when individuals return to work. An alternative approach would be to continue to pay benefit in whole or in part once the person

has found employment, at least for a short period of time. Such an approach may help address work disincentives for benefit claimants.

More generally, if poor health (especially for older workers) is a route to withdrawing from the labour market then public policies that encourage participation are required.

6.2 Challenges, issues and questions

6.2.1 Broadening the definition of work incapacity

A key finding of the earlier review by Stafford (2007) is that Jersey uses a narrow medical definition of incapacity and uses Impairment Tables to measure loss of faculty for Long-term Incapacity Allowance. However, work incapacity is not simply the outcome of medical conditions, a number of other (personal) factors also influence a person's ability to work.

This review demonstrates that other countries have successfully found ways of combining these other factors into incapacity assessments (see Section 3.2.6). The review also clarifies that in extending what is taken into account in assessing work incapacity, it is important to restrict these factors to other personal characteristics. Extending the definition of incapacity should not include environmental factors, notably the state of the labour market. Underpinning any policy reforms should be a clear understanding of the conceptual difference between benefits for incapacity and for unemployment (and retirement). Incapacity benefits should not be a *de facto* unemployment benefit and unemployment benefits should not be supporting people unable to work. This does not mean that unemployed people will not have health problems, nor does it mean that support to address those health problems should not be provided.

Environmental barriers to people returning to work need to be addressed through other policies, such as anti-disability discrimination legislation.

6.2.2 Incapacity criteria

An issue related to the discussion above, concerns the criteria to be used in assessing incapacity. The review considered three main approaches: loss of faculty, loss of functional ability and loss of earnings.

Stafford (2007) reported that Jersey's assessment approach, using Baremas or impairment tables, is used elsewhere. However, a percentage loss of faculty relates to the severity of the impairment and not the potential work capacity of the claimant. The report also highlighted that Baremas scales are controversial and have a number of shortcomings. It recommended that The States of Jersey adopt a loss of functional approach to assessing incapacity.

This report illustrates that other countries have developed instruments for doing functional assessments. A loss of functional ability approach overcomes the shortcomings of the loss of faculty approach. A loss of functional ability is both more easily understandable by the public and claimants, and it focuses on what a person can and cannot do. Consequently, the earlier recommendation that a functional approach to incapacity assessment be adopted remains unchanged.

Jersey would need to develop its own assessment instrument. The proviso (reflecting the discussion above) is that the overall assessment of work incapacity is not limited to functional ability, but also includes other personal characteristics (such as educational attainment). This will probably mean that decisions on incapacity will need to be taken by more than one actor. Labour market and occupational health expertise will be required alongside medical opinion.

6.2.3 Benefit objectives

Two key policy objectives for incapacity benefits are to maintain or replace lost income, or to compensate for either loss of faculty or for the extra costs incurred in having an incapacity.

In Jersey, Short-Term Incapacity Allowance is an income replacement benefit and Long-Term Incapacity Allowance compensates for loss of faculty. For those claimants meeting the eligibility criteria moving from the short-term to the long-term benefit is relatively straightforward. Stafford (2007) did not comment on the objectives of the two benefits, and proposals on policy aims were limited to improved signalling to the public and claimants by changing the names of the benefits.

However, this literature review raises questions about the purpose of the two benefits, in particular whether Long-Term Incapacity Allowance should remain a compensatory benefit for loss of faculty. The ease of the transition from Short-Term Incapacity Allowance to Long-Term Incapacity Allowance possibly leads to a blurring of, if not, confusion about, policy objectives. Long-Term Incapacity Allowance is a partial in-work benefit that allows recipients to combine paid work with benefits. Yet it is not an income replacement benefit.

Policy makers may wish to consider whether the benefit for those who have had a work incapacity for longer than one year should be an income replacement benefit. This is the arrangement in most European social insurance programmes. It would be compatible with both a functional assessment of work capacity, and supporting returns to work. There would need to be associated policies to promote rehabilitation and re-integration, and re-assessments of work incapacity, and attention would need to be paid to possible work disincentives. But the 'prize' is a more coherent and cohesive social insurance programme for those with a work incapacity.

Long-Term Incapacity Allowance could be seen as a proxy extra costs compensation benefit. However, it is not clear that the awards made on the basis of the percentage loss of faculty accord with the actual extra costs that claimants incur. If a longer term income replacement benefit for incapacity was introduced, there would still be a need for an 'extra costs' benefit. This should be seen as a disability benefit, which is available to both those in and out of employment, including children and pensioners. Eligibility for this disability would require a separate functional assessment.

6.2.4 Addressing moral hazard

A key finding of this review is the importance of moral hazard in social insurance. Indeed, it is the potential for moral hazard that is one of the key

reasons why the state (rather than the market) has a role in insuring workers against incapacity.

Moral hazard cannot be eliminated from social insurance programmes. The challenge to policy makers is, first, to be alert to the risk and when formulating policy to consider carefully where moral hazards might lie. Secondly, evaluating the policy trade-offs that arise when addressing moral hazard (see, for instance, the incentive : insurance problem trade-off discussed in Section 4.1.2). Thirdly, what level of political, cultural and economic resource can be devoted to tackling moral hazard.

The review does identify some approaches to tackling moral hazard. Stafford (2007) reports that general practitioners in Jersey tend not to discuss patients' return to work. This is problematic because to claim Short-Term Incapacity Allowance requires a medical certificate from a general practitioner. The UK has attempted to address this lack of discussion on work capacity through the introduction of fit notes. However, studies of the fit note find, at best, mixed results. This is clearly a difficult area for policy to navigate. Stafford (2007) recommended that the Social Security Department should promote a culture where general practitioners were more active in encouraging patients to return to work. However, the reviewed literature shows that problems with the patient-doctor relations in terms of assessing work (in)capacity are commonplace. Implying that awareness raising campaigns and publicity may not be a sufficient policy response to the underlying moral hazard. More radical policy action may be required. The potential moral hazard of fit for work claimants obtain benefit (False positives/Type II Errors) could be addressed by privatisation - requiring employers to continue paying employees for period of time during periods of sickness absence. Not only would this combat the moral hazard associated with medical certificates and Short-Term Incapacity Allowance, it would also give businesses a financial incentive to better manage sickness absence and promote rehabilitation. (The presumption is, of course, that job protection laws are robust enough to prevent employers simply making sick workers redundant.) This would represent a major policy change in Jersey. Nonetheless, policy makers should consider the case for and against a reform along these lines. The waiting period before a claim for benefit varies in other countries. The Netherlands with a two year waiting period, alongside a requirement for employers and employees to engage in return to work planning is an unusual example, but does illustrate what policy makers can do.

Similarly, the moral hazard associated with inflows to Long-Term Incapacity Allowance can be tackled by stricter screening procedures and regular re-assessments. The Netherlands experience of the Gatekeeper Protocol which involves stricter screening of benefit claims, as well as return to work plans, is worthy of further consideration.

6.2.5 Supporting early returns to work

The review shows that context is important. Even if there is evidence of a positive impact, the policy or programme is unlikely to be simply transferrable to the States of Jersey. Whilst this may be a frustrating conclusion for policy makers, it does mean that it opens an opportunity to experiment and revise models as findings emerge.

Long-Term Incapacity Allowance is a partial benefit. Short-Term Incapacity Allowance claimants are not allowed to undertake any work, even voluntary work. The UK evidence on permitted work, although not conclusive, as well as the discussion of partial benefits, implies that some relaxation of the no-work rules may be appropriate. This change would allow claimants to try paid work placements, phased returns to work, rebuild self-confidence through voluntary work and so on. The OECDs caution about possible unintended consequences of partial benefits also needs to be considered. Any policy change would need to be alongside the introduction of a robust re-assessment procedure.

There is a broad consensus that early intervention to facilitate returns to work is a crucial ingredient of sickness management and work capacity policy. Stafford (2007) noted that the Social Security Department followed good practice in having early intervention procedures. It recommended that the screening for early intervention for Short-Term Incapacity Allowance claims be brought forward (to day 35), and for Long-Term Incapacity Allowance claims that consultations on introducing mandatory work-focused interviews be held. This literature review shows that some other countries can have gone a lot further. For example, evidence of having engaged in work-related activities for 18 months is a condition of benefit receipt in Australia. There is also a question about the extent to which the scope for rehabilitation or work-related activities should be included in the medical assessment. The Dutch and the Danish experience would suggest that as a minimum consideration should be given during the assessment as to what support should be given to facilitate an early return to work. In other words, assessments about rehabilitation and delivery of relevant services need to be closely integrated into the work capacity process. However, the UKs experience with the Capability Report (Section 5.1.9) suggests that care needs to be exercised and medical assessors may not be best placed to make such recommendations – so reinforcing the case for a multi-disciplinary approach to incapacity assessment and active case management.

The literature finds that provision of funding to enable adaptations of workplaces is found in many countries. The issues identified with Jersey's Adaptation Grant in 2007 are not unique. The then recommendations for reforming the Adaptation Grant are in accordance with the wider literature.

6.3 Which country?

A possible expectation of a cross-national review is that it will identify a country that provides 'best practice' from which policy learning is possible. However, two caveats must be considered. First, the one already mentioned about the importance of context and so the limitation of the desirability and feasibility of transposing policy and practice from one country to the other. In other words, 'best practice' only applies to a specific context. Secondly, and as is typical in public policy, there is no such thing as the 'perfect policy'. Policies and programmes have pros and cons, there are likely to be trade-offs to be made – see for example, the incentive vs insurance problem in making incapacity decisions, or the strengths and shortcomings of flex-jobs, or the relative merits and demerits of replacement and compensation benefits. Political judgements have to be made.

Nevertheless, with these provisos firmly in mind, if the States of Jersey wishes to study more closely lessons that could be learnt from another country, then the reforms conducted in the Netherlands are worthy of consideration. Since about 2002, the Netherlands has experienced a dramatic fall in both the proportion of the insured population with awards for its incapacity benefit (Disability Insurance) and its award rate (Koning and Lindeboom, 2015:151-2; see also de Jong, 2012 and OECD, 2010). Not only has the inflow onto benefit decreased, but the outflow has increased. There has been a corresponding reduction in benefit expenditure. Koning and Lindeboom (2015:153) identify three main areas of reform in the Netherlands:

- increasing the incentives for employers to reduce employee flows onto benefit (for example, privatising sickness pay for the first two years and introducing experience rating (see Section 4.1.2));
- increased gatekeeping (that is, stricter screening of claims under the Gatekeeper Protocol (see Section 5.1.9); and
- tightening benefit eligibility criteria (with introduction of WIA in 2006).

All three reforms have had a positive impact, with stricter screening having the largest impact, and tightening eligibility the smallest (Koning and Lindeboom, 2015:164). These reforms have involved transferred costs and responsibilities to employers, so incentivising them to address employees' sickness absence and support their return to work. As already mentioned above, employers (not the state) continue to pay wages for up to the first two years of a person's sickness absence. Only then can the individual claim Disability Insurance.

However, there are concerns about some of the consequences of the reforms, notable that employers may be less likely to hire people with a health condition (Koning and Lindeboom, 2015:153). There has also been an increase in benefit awarded to people with flexible or temporary jobs. This may reflect that this type of employment, at the time, did not result in experience rated premiums being impose on the employer, and so did not increase their costs.

One possible outcome is that falls in the number of incapacity benefit recipients are offset by increases in other benefits, especially for unemployment (c.f. Section 6.1). Koning and Lindeboom (2015:153-4) find mixed evidence and are unable to conclude whether or not this substitution effect has occurred.

Koning and Lindeboom (2015:154) highlight a, qualified, key learning point from their analysis:

> '… probably the most important lesson is that employers should be stimulated and facilitated in finding ways to prevent long-term sickness and absence … The experiences with intensified gatekeeping during the sickness period show that employers can be pushed to take on this role. Indeed, the success of the Dutch disability reforms largely depends on the use of early interventions when a worker becomes sick, in the waiting period before they enter the disability rolls. At some point, however, employer obligations may become too sizeable, raising questions about the ability of employers to influence DI [Disability Insurance] risks. Also if the obligations are too large, there is the risk that employers will try to evade incentives created by this kind of disability program reform.'

The approach also requires that a relatively high proportion of the incapacity benefit inflow are employees – the role of employers is limited if moves onto incapacity benefit tend not to come from employees.

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