Quality of evaluation of work disability

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Chapter 1

Evaluation of work disability
**Evaluation of work disability**

People engage in society by participating in various groups and activities. For many individuals, work is very important for their health and social participation [1]. Among people that work, some may get sick and stop working temporarily, but people usually recover and start working again. When people return to work they may start by working only part-time or with a reduced work-load. The sick employee with his or her employer most often find solutions for problems that may arise in the resumption of work. In this process, the sick employee follows the sick role: he reports sick, renounces his work duties, and does his utmost to recover [2]. If necessary, those who do not recover and are unable to return to work quickly, receive professional aid from a health service provider, including a physician, physiotherapist, or medical specialist. Alternatively, help may be provided by personnel management, an occupational health physician, or another professional [3]. In the Netherlands and in many other countries, a system of social insurance has been created that regulates exemption from work and protection against wage loss. This system organises and finances support to return to work [4, 5, 6]. This support is offered to, and if necessary, urged upon, the sick employee because of the interest that the group takes in the participation of the individual [7]. According to the legislation, the first objective of the social insurance is to promote participation in work. The explanatory note that accompanies the law on Work and Income according to Labour Capacity (WIA) [8], paragraph 3.1 states:

"Sick and partly disabled employees are expected to do their utmost to return to the labour-market. In turn, these employees can expect to be given the chance to participate in the work process and to get the chance to develop themselves in it. Consequently, the government expects employers to provide these chances. All parties concerned – employees, employers, insurance companies and the UWV – have to exert their strength to promote durable participation of sick and partly disabled employees in the work process. They should give reintegration a maximum chance of succeeding. At the end of the period of wage payment employer and employee together draw up a reintegration report. There they set forth the activities undertaken in order to reach resumption of work. The summary has to convince the benefit agency that employer and employee have done everything possible for reintegration."

A small portion of those that report sick do not recover and are unable to resume work promptly. After one year of absenteeism, approximately one percent of employees are still unable to work. These persons follow the handicapped role [9]: the expectation shifts from complete recovery to partial recovery at most. They are expected to work according to their abilities and to account for their not working. They are released from...
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obligations they cannot cope with and their pay is continued, but may be adjusted. If all goes well, these individuals and the assisting professionals have done everything that is reasonably possible to help the worker recover and resume work. In this case, the worker’s non-participation is not to be blamed on the worker, but rather on his having disabilities. Using this argument, these persons call upon the second objective of the social insurance system: protection from poverty and marginalisation as a consequence of abandoning work participation. People who do not earn enough to support themselves are protected by a benefit, for as much and as long as their incapacity justifies. The explanatory note with the Work and Income according to Labour Capacity act [8], paragraph 3.1 states:

*If the reintegration report shows that the employee is fully and permanently disabled for work, he can claim a benefit from the arrangement of this law for income replacement for fully and permanently disabled people. If the reintegration report shows that employer and employee have sufficiently exerted their strength to realize reintegration, but have not succeeded, a partially work-disabled person can claim a benefit on the ground of the arrangement work resumption of this law for people who are partially fit for work.*

In the history of Dutch social insurance, these objectives are not new. The legislation has emphasised the objectives of promotion of participation in work and of protection of income in both the Law on Work Accidents (1901) and even more clearly in the Legal Insurance for Work Disability (1967) [7].

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It is not easy to determine who does and does not need the protection of a benefit. The existence of benefits can generate an unintended demand for protection, which results in the second objective pressuring the first objective: protection from marginalization pressures promotion of participation in work. In a system that functions ideally, one can assume that everyone endorses the goal of the system and that all people act to support reintegration optimally. This means that those claiming a benefit would only need to be evaluated minimally. In reality, however, it is difficult to evaluate the sick worker’s activities, or his treatment and support. In reality, in the Netherlands and other OECD countries, long term sick leave and work disability are a trap from which people cannot easily escape, with considerable damage to the individual and society [5]. Thus, requests for benefits or support in maintaining or returning to the job are evaluated, the so-called evaluations of work disability. Employees are evaluated on several aspects, including: sickness and handicaps, working capacity and incapacity, prognosis, and recovery-behaviour [10]. Other factors can be part of the evaluation too, such as the contribution of the employer, treatment of the physicians and coaching of the occupational physician.
These principles represent notions that are valid but at the same time they create a number of dilemmas [4, 11, 12]:

− freedom of choice of the individual concerning his recovery and reintegration versus the ground rules that social insurance wields out of solidarity;
− the capacities and incapacities of the individual and the opportunities versus restrictions of the appropriate work for him or her;
− clinging too long to the hope of full recovery and work resumption, and surrendering too early by accepting handicaps;
− diagnosing in a relationship of help versus evaluating disability in a relationship of justifying claims on provisions and benefits;
− the need of the contractor to maintain an efficient system versus the need of the evaluating social insurance physicians and labour experts to thoroughly evaluate the claim and support the claimants.

A benefit could be provided based on the declaration of a claimant and the testimonies of the professionals that have coached him. This is common in the case of short-term absenteeism. In these situations the employee reports sick and the occupational physician advises the employer and employee about possibilities and restrictions in work. For long-lasting absenteeism and permanent disability, the Institute for Employees Benefit Schemes (Uitvoering Werknemersverzekeringen or UWV) examines whether everything has been done to facilitate recovery and furthermore whether the potential to earn wages has decreased significantly. SIPs and labour experts evaluate the claim of disability for work. In the Appendix to this thesis this evaluation is described in more detail.

The client, an employee who submits a claim, has an interest in the evaluation being correct: his social and economical position greatly depend on it in the short-term, and often in the long-term as well. The client’s health is best served by participating in the labour market, rather than being excluded [1]. Clients have organised themselves into groups, including associations of patients that exchange information and give each other support. Clients are often unsure whether the evaluations are being performed correctly [13].

The quality of the evaluation is also of great importance to the people who execute the evaluation, including the social insurance physicians (SIPs) and labour experts, as it is their responsibility legally. Their societal value and existence depend on the degree to which they perform the evaluations well. Over time, this role has become professionalised, now including a legally recognised specialisation for which post-graduate education, continuous professional development, and guidelines have been created [7, 14]. Many SIPs are unsure of the quality of their work [12], and furthermore, find it difficult to do their work well within the conditions posed by their employer [15, 16]. This is further complicated by the fact that they lack consensus about what quality criteria should be applied during the evaluation process.
They also have differences of opinion with their contractor the Dutch benefit agency UWV [12, 15, 16]. UWV is the organisation that allows or disallows the benefit to the client. UWV strives to implement the laws safeguarding both the financial and the social support for the law. Implementing the law has to provide a certain social justice. Consequently, UWV prescribes requirements for the evaluators and conditions for their work. These have to warrant a legally correct and qualitatively high standard of evaluating work disability. The effectiveness of these requirements is unknown.

All in all, the implementation of the legislation on work disability is a complex matter in which evaluations are a central item. The quality of these evaluations has not yet been established and an actual overview how to evaluate work disability is still lacking. The central subject of this thesis is therefore the quality of the evaluation for work disability. In the literature the terms ‘evaluation’ and ‘assessment’ are used interchangeably. Here the former is used, as it suggests a less objective measurement.

**Research questions**

In this thesis, the following main questions will be addressed:

1. What is the object of the evaluation of work disability?
2. What is to be understood by the quality of the evaluations of work disability?
3. How can the quality of evaluation of work disability be controlled?

To answer these questions, a number of theoretical viewpoints have been used. Six studies have been conducted, relating to the Netherlands and among other countries. As stated, social insurance is not uniquely Dutch. Studying other approaches in different countries can help identify better solutions than those that would be found in the Netherlands alone. In return, Dutch approaches can be valuable in other countries.

**Theoretical viewpoints**

Evaluation of work disability is not a simple and isolated measurement of some unambiguous characteristics of an individual. They are evaluations of characteristics of people within a legally determined institutional frame after a process of sick leave, treatment, and attempts to get better. The evaluations are a complex whole that can be analysed from different viewpoints. These viewpoints are described in relation to the three research questions of this thesis.
Object of the evaluation

Differing views exist about the evaluation of long-term work disability. The legal criterion of work disability is "being, as a direct and medically determinable result of disease or handicap, unable to earn more than 35% of the earnings a comparable healthy person earns with customary work" [17]. This definition leaves a lot of room for interpretation. This flexibility is needed to allow tailored evaluations [11], but simultaneously constitutes a threat to a univocal and legally equal application of the law [18]. Many SIPs seem to focus on filling in the Functional Capacity List [12], which leads to the suggestion that functional capacity is the sole subject of the evaluations. SIPs do not agree on this point: some think that the evaluation should encompass much more [12]. Three viewpoints are described in the literature.

One viewpoint is expressed by the Health Council of the Netherlands (HCN), who divided the evaluation of work disability into four tasks [10]. This leads to four objects of evaluation: social-medical history, actual functional capacities, current treatment and coaching, and finally, prognosis. This division encompasses the content of the Guidelines for SIPs. The General Introduction to these Guidelines [10] states that the four tasks together constitute the evaluation of work disability. The relationship among the tasks is not described, however. The evaluation of the social-medical history implies that the client’s environment is assessed as far as treatment and coaching are concerned.

A second viewpoint is the handicapped role [9, 19]. The handicapped role describes expectations and obligations between the individual and his environment if support is needed due to long-term sickness and handicap with no prospect of recovery. The individual is expected to rehabilitate and return to work as soon as possible, and his environment is expected to support this process. The handicapped role fits with the opinion that sick leave is a form of behaviour under certain conditions. The handicapped role may provide a way out of the discussion about capacity or incapacity by implying that both are important.

A third viewpoint is found in the International Classification of Functioning and Health (ICF) [20, 21, 22]. The ICF is a classification of related consequences of disease, including: impairments, activity limitations and participation problems. With environmental determinants and personal factors these consequences have a multi-relational connection. The ICF was designed to make international research on consequences of disease comparable. It also drafts a picture of what work disability entails: not just the medical diagnosis but also the relationship between the disabled person, their work and, for example, health care or social insurance. This approach is sometimes termed biopsychosocial [19]. Though ICF is not designed for evaluation of work disability, it can provide a framework within which such an evaluation can occur. In that case, the evaluation includes the disease, therapy, existing impairments, activity limitations, as well as...
contribution of the person and the contribution of the environment, such as the company he works for. All in all, it is not self-evident precisely what is evaluated in the evaluation of work disability. This is problematic when studying the quality of the evaluations.

II  Expert definition of quality

Answering the question of quality requires identifying who defines quality. In the case of professional judgments, quality is primarily defined by experts in the field [23, 24, 25, 26]. The Dutch Society of Insurance Medicine (NVVG) claims such a role [27]. Professional discretion is demanded in all situations where relevant grounds for the decision are determined by the situation itself, more than by rules or knowledge. Judges, in their verdicts, call this "the facts and circumstances of this particular case." This discretion can be handled in a qualitatively sufficient fashion by ensuring the competence of the experts who perform the evaluations and by ensuring that they agree [24, 28]. A more direct way of enhancing evaluators' agreement is to do evaluations in committees. This is an application of the mechanism of Spearman and Brown that explains that a group opinion from experts is more likely to be right than the experts' individual opinions [24]. Following this line of thought, the quality of evaluations is found in the degree of agreement between experts, either in individual cases or using guidelines and other practice tools [28]. Thus the criterion is internal and intersubjective rather than external and objective. In the case of social insurance, the experts are not free to define quality as they please; rather, other parties are included in the process. These will be presented and discussed in IIIb.

IIIa  Quality model of the evaluation

Evaluations can be analysed, following Donabedian [23], in terms of structure (people and means present for the evaluation), process (actions in the individual case), output (product), and outcome (result) [29]. Such an analysis permits a more precise identification of quality aspects as compared to when evaluations are considered a black box. In the Netherlands this can be filled in as follows:

The structure contains all that is at the disposal of the evaluator. The client puts forward his individual situation and claim. The evaluator puts forward criteria and guidelines for the evaluation, instruments, and his professional knowledge. In the Netherlands, the SIP and labour expert perform the evaluation. There are also written materials, such as the reintegration reports and medical reports.

The process includes the interaction with the client and all other actions needed to complete an evaluation. A large part of that is the disability evaluation interview, if necessary, completed with a medical examination, the testing of functional capacity, consultation with others, and involvement of specialist expertise [30, 31].
Evaluations result in an output, which includes an advice to the contractor of the evaluations, the UWV. This advice is produced in a report form. In the Netherlands, the report of a SIP contains a specification of the client’s functional capacities in the so-called Functional Capacity List (FML). A protocol has been designed to check if SIPs comply with the report format. Individual evaluations lead to individual decisions by UWV. Taken together, these decisions lead to an outcome in society. This outcome can be defined in terms of social costs and benefits. Benefits are, for example, labour participation, health, and social legitimacy of claims that are granted or denied. Costs are, for example, benefits paid, transaction costs of UWV, but also a lack of participation and a deterioration of health because of exclusion from work. What is ultimately important and how that is weighted is mostly a matter of public and political debate [32, 33].

IIIb Parties involved in disability evaluation
Disability evaluations are not independent activities between the client and evaluator; rather, they are executed within a network of involved parties. Consequently, the definition of quality cannot be determined solely by the experts [23, 25]. The parties involved can be described in a basic script of evaluation [24]. The basic script model states that a formal evaluation of people by people involves not only a client and evaluator, but also the contractor of the evaluation and an external supervisor. For this thesis the following parties are of interest: the client, the evaluator, the contractor of the evaluation, the legislator, the professional group of evaluators, the supervisor, and the tribunals [29]. All these parties influence the evaluations and all have expectations about the quality of the evaluations.

The client is not simply a passive object, but an active subject who can gain or lose with the evaluation. Furthermore, as a citizen and payer of premiums, the client is part of the society that installed social insurance. The evaluator has to work according to standards that are not his personal standards, but instead ones that are valid in his profession [26, 28]. The client and evaluator often feel a natural tension during the evaluation between the individual claim and the general rules of the scheme. The evaluator and contractor feel a different tension between professional quality and demands from the administration of the contractor for an efficient process.

The contractor, UWV, is responsible for quality and efficiency of deploying the scheme. The contractor contracts the evaluators and provides means for their work while demanding efficiency.

The tribunals and the medical disciplinary courts check individual cases and make case laws that set standards for later evaluations. The supervisor, the Ministry of Social Affairs and Employment, checks the system and thus makes touchstones like the Protocol of Social-Medical Actions. The supervisor prevents the client, evaluator and contractor from making deals like the ones made in the 1970s and 1980s when the disability scheme was used to force large numbers of workers to retire [32]. In this
thesis the script model is used to identify the actors that are relevant for quality control [29].

IIIc Sick leave and coaching of sick leave
Disability evaluations occur after a period of sick leave; specifically, in the Netherlands this starts after about 18 months. Part of the evaluation includes an analysis of the way the client’s sick leave has been spent, as well as the treatment and coaching that have been applied. Consequently, the evaluations do not stand apart from the social-medical history of the client. Veerman [34] designed a model of the start and continuation of sick leave. Knegt et. al. [3] described the relevant actors of ongoing sick leave. The Guidelines for SIPs implicitly use a model of sick leave for the evaluation of the social-medical history.

Outline of the thesis
To answer the questions, six studies have been conducted, described in the following chapters.
In chapter 2, a study is presented on how the evaluation of work disability is organised and of how quality is controlled in different countries. This is realised using a combination of questionnaires and interviews in fifteen participating countries. The tables show aspects of what is evaluated, how the evaluations are organised, and how quality is ensured. Central to this is the script model, a process model of sick leave and disability, and the Donabedian frame of quality analysis. This study provides material to answer questions 1 and 3.
In chapter 3, a study is presented describing how SIPs reason when evaluating work disability in different countries. This is realised using a case description in focus groups, composed of SIPs, in four countries. The object of the evaluation and the grounds that are legitimate are compared among the four participating countries. The results have been presented to a larger group of SIPs in each country, with questionnaires. Here, the expert definition of quality is central. This study provides material to answer questions 1 and 2.
In chapter 4, a study is presented on how work disability is evaluated in different countries and the use of guidelines therein. With questionnaires, presented to twelve participating countries, the object of evaluation is specified. In those countries that use guidelines, interviews have been conducted concerning the use of these guidelines. The frame of analysis of Donabedian is central in this study, providing material to answer questions 1 and 3.
In chapter 5, a study is presented regarding guidelines that exist in Germany and the Netherlands for the medical part of the evaluation. These guidelines are tested to evaluate the quality of their development. The expert quality definition is central to this study, together with the frame of analysis of Donabedian and the script model. The study provides material to answer questions 2 and 3.
In chapter 6, a study about the disability interview protocols that have been published in the Netherlands is presented. The knowledge and opinions of the people who designed these protocols are based on and compared to the literature. The object of the evaluation, the expert definition of quality, and the Donabedian frame of analysis are central in this study. The study provides material to answer questions 1, 2, and 3.

In chapter 7, a study is presented on the adherence in practice of Dutch SIPs to the interview protocols and their underlying principles. This is a questionnaire study in a selected population of SIPs. Here, too, the object of the evaluation, the expert definition of quality and the Donabedian frame of analysis are central. The study provides material to answer questions 1, 2 and 3.

In chapter 8, the general discussion, conclusions and recommendations are presented.
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