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THE PREVENTION OF PROBLEMS RELATED TO DISALLOWED DISABILITY PENSIONS

A report commissioned by the Parliamentary Trustees of the Social Insurance Institution, Finland

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Abstract:
The granting of a disability pension is always an individual, judicial decision which must be legal, valid, fair and consistent with other claims. When making a decision on the claimant's eligibility for disability pension, several socio-economic aspects and issues relating to the claimant's employment are considered. However, according to current legislation an incapacity for work must be based on a medically diagnosed illness. The Director of Medical Affairs from the Social Insurance Institution was commissioned by the Parliamentary Trustees of the Social Insurance Institution to head a survey on the protocols used in Finland in medical decision making regarding disability pensions. The survey should particularly address the impact that differing viewpoints held by the treating doctor and the doctor working in insurance medicine might have played in the cases of disallowed disability pensions.

The International Classification of Functioning, Disability and Health (ICF), revised and approved by the World Health Organization in 2001, is a systematic glossary and classification system which provides means for uniform and standardised analysis of human functional ability. This type of terminology will probably prove beneficial in the comprehensive development of incapacity assessment methods. However, significant work still needs to be carried out to define the differentiation between the various components of functional and work ability. Personal Capability Assessment, which tests the incapacity of a person, was developed in the United Kingdom and has been used both there and in Iceland during the last few years. It appears that this tool might solve some of the problems faced in the current Finnish system. The Working Group has also, in addition to incapacity assessments and the level of pension claims, addressed issues relating to the prevention of incapacity and rehabilitation. These issues cannot be ignored when the chain of events leading to incapacity for work is being examined. The survey takes into account the viewpoints of the insured claimant, the treating doctor, the insurance doctor and the social insurance. Based on this classification of viewpoints, the Working Group presents recommendations which it believes will lead to a reduced incidence of incapacity as well as reduced numbers of disallowed disability pensions.

CONTENTS

Abbreviations used in the report:

CSD = Council of State Decision (Valtioneuvoston päätös)
FIM = Functional Independence Measure
GP = Government Proposal
HIA = Health Insurance Act (sairausvakuutuslaki)
ICF = International Classification of Functioning, Disability and Health
KKL = Act on Rehabilitation Administered by the Social Insurance Institution
KM = Committee Report (komiteanmietintö)
LEL = Temporary Employees' Pensions Act (lyhytaikaisissa työsuhteissa olevien eläkelaki)
MYEL = Farmers' Pensions Act (maatalousyrittäjien eläkelaki)
NPA = National Pensions Act (kansaneläkelaki)
PCA = Personal Capability Assessment
SII = Social Insurance Institution, Finland (Kansaneläkelaitos, Kela)
SVA = Health Insurance Decree (sairausvakuutusasetus)
TEL = Employees' Pensions Act (työntekijäin eläkelaki)
TELA = Finnish Pension Alliance (Työeläkelaitosten Liitto)
VEL = State Employees' Pensions Act (valtion eläkelaki)
WHO = World Health Organization
YEL = Self-Employed Persons' Pensions Act (yrittäjien eläkelaki)

1 INTRODUCTION

Retirement due to incapacity for work, and the rejection of disability pension claims, have over the last few decades caused much public debate. One of the points raised has been the inconsistency in the allocation of disability pensions. From time to time, great variation has been seen both in the allocation of disability pensions and in the rejection rate of claimed pensions. The statutory prerequisite for a disability pension is that the claimant has an illness which renders him/her incapable for work. In the 1950s, tuberculosis led to incapacity in many cases, but today it plays an insignificant role in this regard. Cardiovascular diseases caused problems for incapacity assessments in the 1970s. Musculoskeletal illnesses were prominent in the 1980s. Thereafter, mental health problems, particularly depression, have resulted in disability pensions in increasing numbers.

In addition to the illness itself, incapacity for work is influenced by many factors, i.e. age, gender, occupation, unemployment and changes to the structure of employment. Social changes have also increased the number of people retiring in Finland, particularly after the pension provided by the Statutory Earnings-Related Pension Scheme started to offer an alternative income of a sufficient level. Factors relating to the working environment and the employee's own motivation are important elements in the disability pension process. A particular medical condition may lead to retirement due to incapacity for one person but not for another.

The changes seen in the number of disability pensions are not solely explainable by changes seen in morbidity. Nevertheless, doctors, and the statements issued by them, have been prominent in the public debate. It has been criticized that an insurance doctor may propose a disability pension claim to be rejected without even seeing the patient, issueing a statement differing from the one issued by the patient's own doctor.

The Parliamentary Trustees of the Social Insurance Institution commissioned a Working Group under the Director of Medical Affairs, Antti Huunan-Seppälä, to clarify the medical problems associated with the rejection of disability pension claims. The Parliamentary Trustees further specified that they felt the problems related particularly to the person writing the medical statement and the insurance doctor. The commissioners also wanted the Working Group to explore efficient methods to measure work and functional capacity, which methods should also be fair from the claimant's viewpoint.

The Director General of the Social Insurance Institution appointed the Working Group, which included: the Chief Medical Officer Antti Huunan-Seppälä, who acted as the chairman, Deputy Department Head Jorma Järvisalo from the Research Department, Occupational Health Care Manager Arto Laine from the Health and Income Security Department, Medical Adviser Raili Pirttimäki from the Pension and Income Security Department, Medical Adviser Paavo Rissanen from the Health and Income Security Department's rehabilitation section, Benefits Manager Marja-Leena Seppälä from the Pension and Income Security Department and Senior Researcher Seija Talo and Medical Scientist Lauri Virta from the Research and Development Department.

Furthermore, in its report the Working Group has endeavoured to address such non-medical issues which it considers impose a significant effect on the perceived high rejection rate of disability pension claims. The Working Group has also looked at opportunities offered by preventative intervention and rehabilitation, as well as legislation and terminology relating to incapacity. Furthermore, the Working Group has studied incapacity assessment models which are operational in other countries.

The Working Group did not address issues relating to Partial Disability Pension or Individual Early Retirement Pension since eligibility for these pensions does not require a preceding period of Sickness Allowance payments. Partial Disability Pension can only be granted under the Statutory Earnings-Related Pension Scheme. Moreover, non-medical issues play a more important role when decisions are made on the eligibility for Individual Early Retirement Pension, as compared with disability pensions. Both the number and importance of Individual Early Retirement Pensions have also significantly decreased during the last few years. During the latest revisions they only concern those born in 1943. Neither did the Working Group include in its survey any incapacity for work, albeit longstanding, covered by accident insurance, i.e. incapacity for work due to occupational, military or traffic accidents.

It is not possible to fully understand the reasons behind disallowed disability pensions if one is not aware of certain prevailing factors which almost act as a deterrent to gainful employment. The eligibility criteria for the allocation of a disability pension must also be understood. One must also be aware of the factors affecting the treating doctor's viewpoint regarding incapacity for work as well of those on which the insurance doctor bases his/her assessment. The examination of medical issues is essential since, in accordance with legislation, incapacity for work must be based on an illness. However, the concept of 'incapacity for work' contains many factors and dimensions, the collective effect of which should be recognised before entering into public debate. Various activities over recent years to maintain work ability have highlighted the diversity of the components which make up work ability. Decisions about incapacity, and the prevention of rejected pension claims, require therefore a wide variety of procedures to be implemented and interaction between various parties.

In the incapacity debate it is often forgotten that about 80% of all new claims for a disability pension are approved. It is noteworthy that the public debate has not considered the possibility that a positive outcome of a pension claim might also have been wrongly granted. In an international comparison, the proportion of the Finnish population in receipt of a disability pension is high.

The Working Group presents recommendations that it believes will remove some of the problems highlighted. These proposals include the concept of transparency, the introduction of criteria or standards for incapacity assessments, and their use in a way which will make it more apparent for the claimant, the treating doctor and the insurance doctor how the decision was reached.

2 PENSION PROVISION IN CASE OF INCAPACITY

During the 20th century, the western welfare states have strived to provide all their citizens with a framework for a life consistent with human dignity, and the management of such a life. Social insurance plays an integral part of this framework – financial income is guaranteed to an insured person in case of illness, disability, unemployment, old age etc. The reformed Finnish constitution (731/1999) provides the Finnish people with a right to substantial social security (its section 19).

Disability pensions have become a significant part of the welfare system of Finnish society. Statutory pensions guarantee an income in case of incapacity of over 12 months' duration, whereas any income loss due to incapacity of less than 12 months' duration is compensated for by the National Health Insurance, supplemented by wage practices of various collective labour agreements. Disability pensions are divided into the Disability Pension, Rehabilitation Subsidy (called Fixed-term Disability Pension until 1996), Partial Disability Pension and Individual Early Retirement Pension. A disability pension is granted for an indefinite period if

it is considered that medical or occupational rehabilitation will not restore the claimant's work capacity.

However, disability pensions are not the only pensions available to those wishing to retire before the general statutory retirement age of 65. For several decades Finnish citizens have been able to use other forms of early retirement schemes. These include the so-called reduced retirement-age pensions covering both wage and salary earners in municipal employment and public service, as well as early old-age pensions, unemployment pensions, part-time pensions, the Front-veteran's Pension, the Front-veterans' Early Retirement Pension as well as the Change-of-Generation Pension and Farm Closure Pension payable to farmers.

2.1 Statutory pension schemes

In principle there are two statutory pension schemes in Finland: the Statutory Earnings-Related Pension Scheme and the National Pension Scheme. In addition to the two schemes, legislation provides benefits similar to pensions in certain situations, e.g. statutory compensation paid under the Accident Insurance, Motor Insurance and Military Injuries Act (SOLITA). The Statutory Earnings-Related Pension Scheme has arrangements both for the private and public sectors. The Statutory Earnings-Related Pension Scheme covers all employees who, under certain conditions, have received income either from short-term or permanent employment, or from self-employment. The amount of the earnings-related pension is determined according to the duration of employment and the size of the person's earnings-related income. A National Pension is granted to those incapable of work, or to those over the age of 65, and who are not eligible to any other pension provision, or whose income from any other pension scheme is insufficient. The aim of the National Pension Scheme is to safeguard a minimum income, whereas the Statutory Earnings-Related Pension Scheme aims to ensure a consumption potential relative to that maintained during the person's working life.

Social insurance provision pursuant to the National Pensions Act (NPA, kansaneläkelaki 347/1956) and the Health Insurance Act (HIA, sairausvakuutuslaki 364/1963) is administered in Finland by the Social Insurance Institution (SII, Kansaneläkelaitos, Kela). The Statutory Earnings-Related Pension Scheme is administered in the private sector by employee pension providers, and in the public sector principally by the State Treasury or the Local Government Pensions Institution.

2.1.1 History of disability pension legislation

It can be considered that statutory disability pension provision did not come into being in Finland until the 1940s following the enactment of the NPA in 1937[1]. The pension it initially offered was low and did not cover everyone. It became a true national pension when its income-related principle was abolished in the mid 1950s, and it provided a flat-rate basic amount to all citizens. This influenced the emergence of the Statutory Earnings-Related Pension Scheme (Niemelä 1988).

[1] Germany pioneered statutory disability insurance – the first laws came into force as early as in the 1880s under Chancellor Bismarck (Kuusi 1931). In the Grand Duchy of Finland, there were benefit funds for craftsmen and some factory owners set up funds for their employees in the early 19th century; participation was voluntary. In 1897 a decree was passed regarding the above funds, but the historical importance for Finland is regarded as insignificant. The first act which can be considered to relate to disability insurance was passed in Finland in 1895; it related to the responsibility of the employer, should his employee suffer bodily injury. During the first few decades of the 20th century several committees worked towards improving disability insurance for the workforce, but no legislation was passed. However, some municipalities started voluntarily to provide a disability pension for their employees and officials, and in 1924 an act was passed which provided the basis for a disability pension to be provided for employees in public service.

The Seamen's Pension Act of 1956 was the first piece of legislation to provide a pension under the Statutory Earnings-Related Pension Scheme in the private sector. The employees' pension provision improved significantly when the Employees' Pensions Act (TEL) and the Temporary Employees' Pensions Act (LEL) entered into force in 1962. In the public sector the Local Government Employees' Pensions Act (KVTEL) has been in force since 1964 and the State Employees' Pensions Act (VEL) since 1967. The pensions acts for the self-employed (YEL and MYEL) have been in force since 1970.

In the 1970s, the assistance amount (tukiosa) of the National Pension became proportional to the Statutory Earnings-Related Pension. This led the focus of pension politics to be shifted towards the Earnings-Related Pension Scheme. When gradual cuts were introduced to the flat-rate basic amount (perusosa) of the National Pension in 1996 it became a minimum pension. This led to the Statutory Earnings-Related Pension Scheme taking over the majority of the decisions on disability pension claims (see 2.2, Changes in the number of disability pensions).

2.1.2 Legislative definitions of incapacity

Incapacity for work is a judicial concept associated with social insurance and it is used to, for example, justify decisions regarding disability pensions. Its basic meaning relates it to an illness, i.e. the person's capacity for work must be impaired by an illness diagnosed by a doctor. However, when a person's capacity for work is assessed other factors are also evaluated. In addition to the illness itself, the final decision may be based on the claimant's socio-economic status, in particular in the case of a disability pension.

The HIA (section 14) defines incapacity as a state caused by an illness "during which the insured person is *incapable* of performing his/her regular work or other comparable work". By way of compensation the SII pays a Sickness Allowance (HIA, section 19) "up to the end of the calendar month which precedes the month during which the payment period of the Sickness Allowance would reach 300 days". The person receiving Sickness Allowance will become eligible for the Disability Pension in accordance with the NPA (section 39) "at the earliest as from the beginning of the next month following that during which the applicant was last entitled to Sickness Allowance".

The NPA (section 22) defines a person *incapable for work* if he/she "due to an illness, impairment or injury, is incapable of performing their regular job or other comparable employment considered to be suitable for them and considered to ensure a reasonable income, having regard to age, professional skills and other circumstances. Persons permanently blind or unable to move or otherwise reduced to such a state of incapacity due to an illness, impairment or injury that they cannot manage without another person's help shall always be considered disabled."

The legislation for the Statutory Earnings-Related Pension Scheme for the private sector does not state incapacity as a prerequisite for a pension; the legislation refers to the concept of *reduced work capacity*. The Employees' Pensions Act (TEL) (section 4, subsection 3) states that an employee becomes eligible for a disability pension when "taking into account the time already lapsed, his/her capacity for work can be estimated to have been continuously reduced, due to an illness, impairment or injury, by at least 40%. When reduced work capacity is assessed, the employee's remaining capacity to earn an income through such available employment which he/she can reasonably be expected to perform is taken into account, with further consideration given to his/her education, previous work, age, living conditions and other comparable factors." The Disability Pension is granted to an employee when his/her work capacity is assessed to have been reduced by at least 60%, for 12 months or more. When the work capacity has been reduced by at least 40% a Partial Disability Pension is granted.

Under the Statutory Earnings-Related Pension Scheme, both wage and salary earners have a right to a disability pension in the public sector if, during the employment contract, the person ”has, due to an illness, impairment or injury, become *incapable* of performing his/her regular employment”. This is considered to be occupational incapacity. If, on the other hand, the incapacity appears after the employment contract has ceased, the eligibility for pension is still considered, in relation to employment considered to be suitable, and offering reasonable income, for the claimant, having regard to the claimant's age, professional skills and other circumstances.

The payment of a disability pension under the NPA and the Statutory Earnings-Related Pension Scheme can be commenced at different times. In certain circumstances an earnings-related disability pension may commence at the start of the month following the month when the incapacity occurred. In principle, the National Pension becomes payable only at the end of the maximum payment period, i.e. 300 weekdays, of the Sickness Allowance. If the claimant is not eligible for Sickness Allowance, or has not claimed for it, the entitlement for a disability pension under the NPA will not start until after the period of time corresponding to the maximum payment period of the Sickness Allowance has lapsed.

2.2 Changes in the number of disability pensions

The introduction of comprehensive disability pensions covering the entire workforce, and offering reasonable income, led to a significant increase in the number of people claiming for a disability pension in Finland. It is true to say that at the turn of the 1960s and 1970s, the number of disability pensions also increased in many other industrialised countries.

In Finland, the number of *newly granted* disability pensions was particularly high between 1972 and 1974 – over 40,000 people were in receipt of a newly granted pension from the SII. The number of *existing* disability pensions was at its highest in 1976; 256,000 people were in receipt of a disability pension from the SII. The number of disability pension recipients almost doubled in the time period from 1966 to 1976 (Figure 1); at the start of the ten-year period less than 5% of the population of working age were in receipt of a disability pension, when the corresponding figure at the end of the period was over 8%.

From 1978 onwards the annual number of newly granted disability pensions by the SII started to decrease; the figure fell to 20,000 (Figure 2). The number of people receiving disability pension from the SII also stabilised for a long time at around 240,000. Disability pensions had become a significant feature in Finnish society, both from the economic as well as socio-political viewpoint.

The so-called flexible early retirement pensions, which were offered in the mid-1980s, reduced the proportion of actual disability pensions among the total number of all early pensions. In early 1996, legislation was passed to gradually make the entire National Pension means-tested against the earnings-related pensions. As a result, the majority of the decisions regarding disability pensions were made by the Statutory Earnings-Related Pension Scheme. The annual number of disability pensions provided by the SII decreased by almost a half, as compared with the previous years; in 2000, only 12,000 people were in receipt of a disability pension from the SII, whereas the corresponding figure under the Statutory Earnings-Related Scheme was 20,000. The total number of people receiving a disability pension from the SII also started to decline. In August 2000, the number dropped below 200,000 for the first time since the early 1970s. The final cut was made to the flat-rate basic amount (pohjaosa) of the National Pension in early 2001, and less than 142,000 people were in receipt of a disability pension from the SII in February 2001.

Figure 1. The number of disability pensions provided by the SII in 1970–2000, by main illness groups.

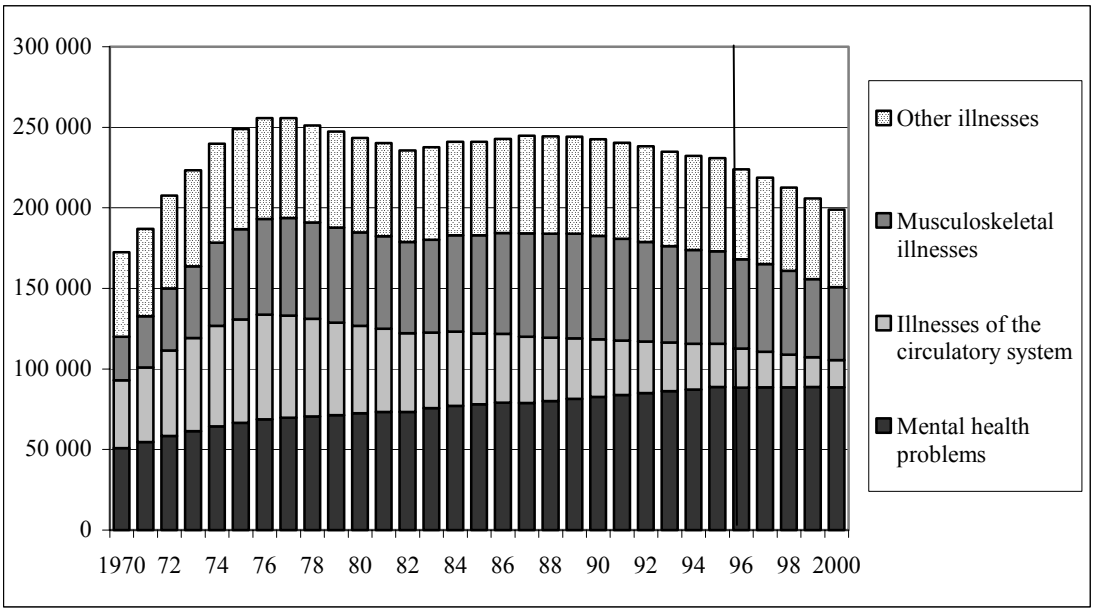
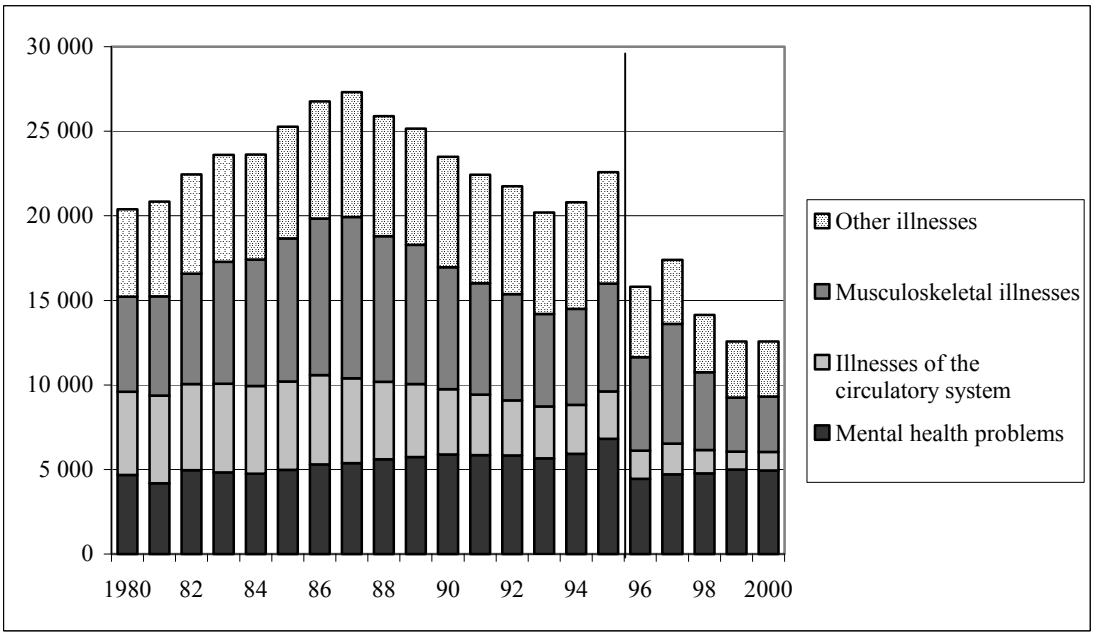


Figure 2. The number of new disability pensions granted by the SII in 1980-2000, separated into main illness groups.



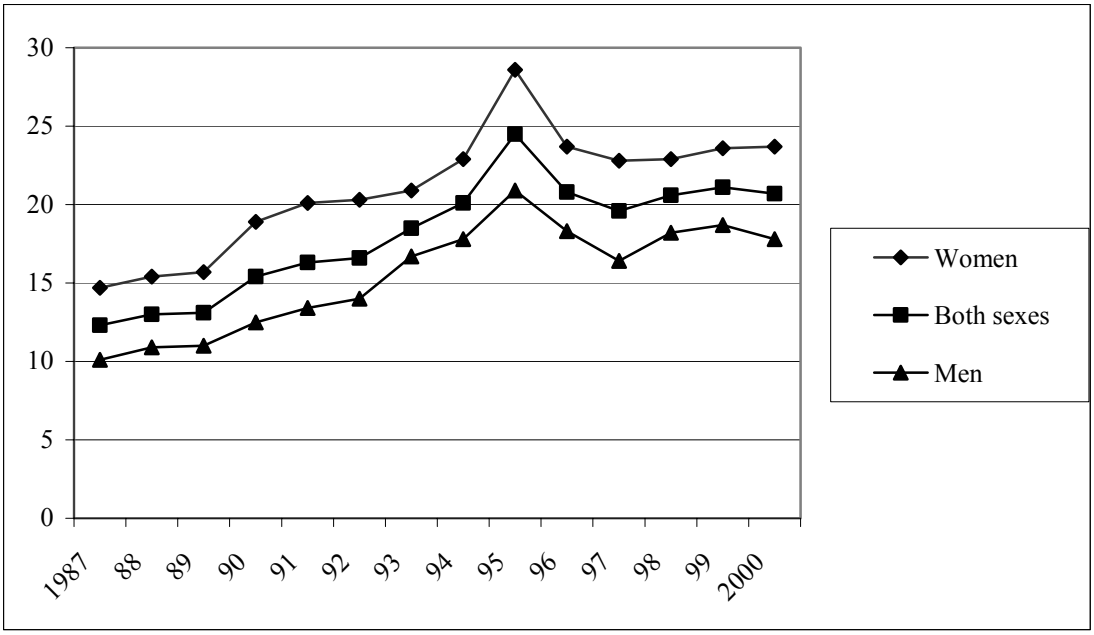
In general, less than 10% of all valid disability pensions are granted for a fixed term only (named Rehabilitation Subsidy since 1996). The proportion of fixed-term pensions among newly granted pensions has increased over the decades: of the newly granted pensions by the SII the average of about 20%, 30% and 40% were granted for a fixed term in the 1970s, 1980s and 1980s, respectively. In 2000, the proportion of Rehabilitation Subsidy is so far the highest ever, i.e. 48%, which is almost half of all newly granted disability pensions.

2.3 Changes in the rejection rate of disability pensions

In the majority of the cases the claimant's incapacity, caused by an illness, is straightforward and the matter is processed quickly and an affirmative decision for a pension is issued with no problems. The protocols used to decide on a new claim slightly differ from those used on claims for continuation of a pension. The decisions made on claims for the continuation of a fixed-term pension are largely based on the previously issued affirmative decision. The proportion of rejections is therefore significantly lower for claims for a continuation of a pension than for new claims. During the last few years, over 60% of the claims for a disability pension, pursuant to the NPA, are for new pensions. This report will concentrate mainly on factors associated with those new claims for a disability pension which are disallowed.

After the mid-1970s, the rejection rate of new claims for a disability pension, pursuant to the NPA, increased markedly, i.e. to 20% in 1978 when the corresponding figure had been below 10% in the early 1970s. This was followed by a period, which lasted throughout the 1980s, when the rejection rate gradually stabilised around 11–12%. Another clear increase in the number of pension rejections was seen in the early 1990s (Figure 3): at the beginning of the decade the rejection rate was around 16%, and since 1994 it has persistently been around 20–21%. The highest figure of 24% was seen in 1995.

Figure 3. The rejection rate of new claims for a disability pension from the SII in 1987–2000, by gender.



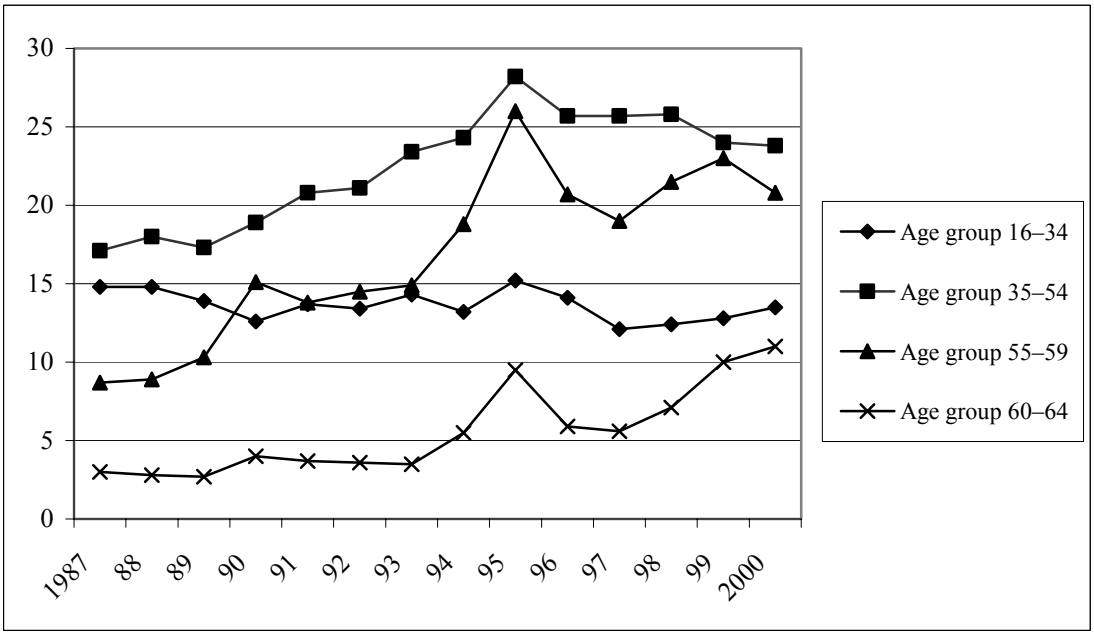
The pension statistics from the SII cannot be directly compared with those from the Statutory Earnings-Related Pension Scheme. The Finnish Centre for Pensions (the Statutory Earnings-Related Pension Scheme) differentiates between a new claim and a repeat claim whereas this would be classified as one new claim in the SII statistics. During the 1990s, the rejection rates in the National Pension Scheme were roughly a few percentage units lower than in the private sector of the Statutory Earnings-Related Pension Scheme and a few percentage units higher than in the public sector of the Statutory Earnings-Related Pension Scheme.

2.3.1 Socio-demographic factors in relation with the rejection rate

According to pensions' statistics the average rejection rate of disability pension claims submitted by women is approximately 5 percentage units higher than that of claims submitted by men (see Figure 3), although the actual number of claims submitted by men is higher than that of claims submitted by women.

The age of the claimant also plays a part in the proportion of rejected claims. In the 1990s, the largest proportion of claims were rejected in the age group of 35–54, whereas the rejection percentage was lowest in the age group of 60–64 (Figure 4). Few claims were rejected in the age group of 16–34. The rejection rate in this age group did not increase during the 1990s to the same extent as in the other groups. In fact, little variation has been seen in this group from year to year.

Figure 4. The rejection rate of new claims for a disability pension from the SII in 1987–2000, by age group.



In the 1990s, female gender and aging played a clear part in the rejection of disability pension claims: the rejection rate of new claims for a disability pension was almost 10 percentage units higher for women aged 50–59 than for men in the same age group. The rejection rate did not show clear gender difference in the younger age groups.

In the early 1990s clerical personnel stood out in the SII statistics when different professional groups were analysed: the rejection rate among clerical personnel aged below 55 years was somewhat lower than that in other professional groups, even though the number of disability pension claimants in this group was higher than it had been hitherto (Hytti 1998, 127). The rejection rate among clerical workers who were in the older age groups was, on the other hand, higher than that among several other professional groups.

The increase seen in the curve representing the rejection rate of disability pension claims in the early 1990s coincided with the sharp increase in the unemployment curve, and, furthermore, the proportion of the unemployed among the disability pension claimants increased. The rejection rate in the age group 50–59 was higher among the unemployed than among the employed (Gould and Nyman 1998). On the other hand, the number of claimants in the age group 55–59 was smaller among the recipients of income-related unemployment

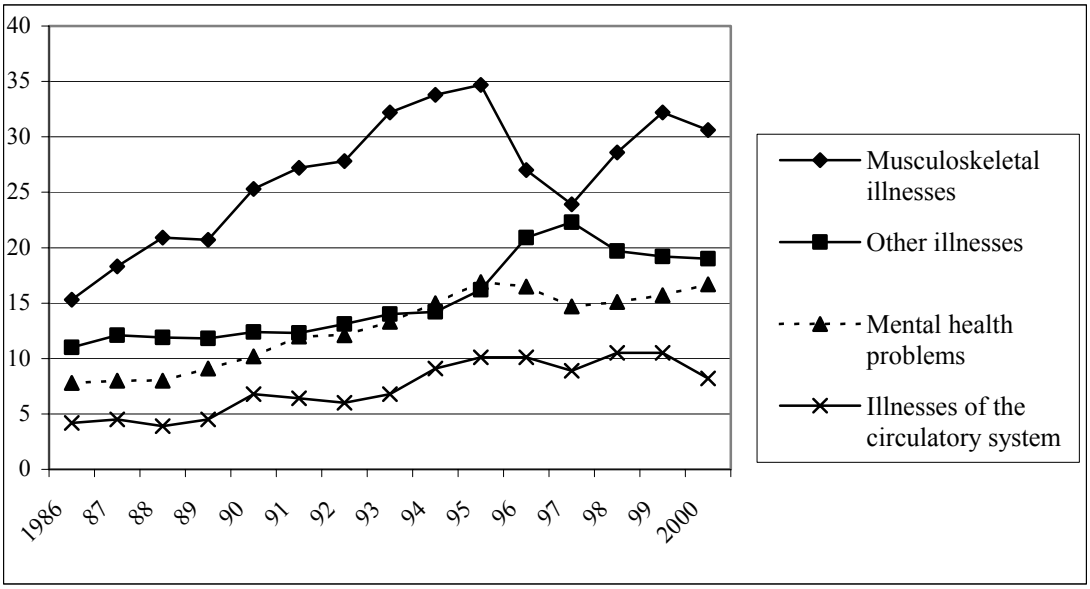
allowance than in the other groups. The difference might be explainable by the fact that older unemployed persons are able to continue drawing the unemployment allowance for a longer period than the usual statutory period (’työttömyyseläkeputki’).

2.3.2 Insurance medicine in relation to the rejection rate

In most of the cases which result in a negative decision the period of Sickness Allowance payments, which precedes a disability pension claim, is longer and more interrupted than in those cases which result in a positive decision (Työkyvyttömyyseläkettä hakeneiden sairauspäivärahan… 1994). There is apparently no difference in the proportion of those whose claim for Sickness Allowance has been turned down among the claimants who receive a positive disability pension decision compared with those who receive a negative decision. In the follow-up data used, the proportion of those whose claim for Sickness Allowance had been turned down was only around 5–7%. According to the above mentioned report, the SII is able to identify, already during the Sickness Allowance payment period, some of the people whose disability pension claim will be rejected. The SII will collect further information on these people and organise rehabilitation. It is possible that these measures are introduced at too late a stage (see also Chapter 3.2). The authors of the report state that they would find it more difficult to interrupt an incapacity process than to identify borderline cases.

According to the pension statistics, the average rejection rate of pension claims for musculoskeletal illnesses is twice as high as that for the other illnesses. For example in 1995, the rejection rate of new claims for a disability pension under the SII was 35% for musculoskeletal illnesses, 17% for mental health problems, 10% for illnesses of the circulatory system and 16% for other illnesses. Of the musculoskeletal illnesses, back problems, in particular, have attracted a lot of rejections. The rejection rate has been noticeably smaller, for example, in cases of tumours, psychosis, myocardial infarction and stroke.

Figure 5. The rejection rate of new claims for a disability pension from the SII in 1986–2000, by main illness group.



3 PREVENTION OF INCAPACITY THROUGH VARIOUS PROGRAMMES, AND THEIR RELATIONSHIP TO DISABILITY PENSION DECISIONS

3.1 The 1990 Pension Committee and pension changes of 1996

A broad-based Pension Committee, appointed by the Finnish Government at the end of the 1980s, proposed an increase to the retirement age in Finland of approximately one year per each decade, during the time period between 1990 and 2020 (Committee report 1991:41). One of the proposals put forward was an increased earnings-related pension accrual rate for persons who remained in gainful employment, over the age of 60, to discourage early retirement. Many of the Pension Committee's proposals have influenced both the framework and the objects of later social policies in Finland, and it can be considered that the majority of the proposals were implemented between 1993 and 1996. For example, as from early 1995 the age limit for the Individual Early Retirement Pension has been gradually increased from the previous 55 years to 58 years.

The changes implemented in 1996 to the pensions' legislation affected the relationship between the National Pension Scheme and the Statutory Earnings-Related Pension Scheme by reducing the significance of a disability pension pursuant to the NPA. When the basic amount (pohjaosa) of the National Pension was gradually cut between 1996 and 2001, the National Pension became a minimum pension which is means-tested against any earnings-related pension (GP 119/1995). At the same time, staying longer in gainful employment was encouraged by changing the calculation methods for an earnings-related pension in the private sector (GP 118/1995).

The aim of these changes was to guide those who were at risk of being unable to continue working towards rehabilitation and activities geared towards maintenance of work capacity. The chain of events leading to a disability pension could thus be broken. The Fixed-term Disability Pension was renamed the Rehabilitation Subsidy. The definition of 'incapacity for work' was not changed as such, but Rehabilitation Subsidy was restricted to cases where the injury or illness could be expected to be remedied with appropriate treatment, or the capacity for work could be restored with active rehabilitation. Rehabilitation Subsidy is only granted on presentation of a personalised treatment or rehabilitation plan. Before Rehabilitation Subsidy is granted the authorised pension provider must verify the appropriateness of the plan. It must be evident from the plan how the claimant's work capacity can be restored. Partial Disability Pension is offered under the Earnings-Related Pension Scheme to enable the full utilization of the claimant's remaining work capacity. Nowadays, a forecast can be obtained for Partial Disability Pension in the same way as for the Individual Early Retirement Pension.

The Medical Certificate 'B' and the guidelines for its use were revised at the time of the introduction of the above pension changes. Two different versions of the Medical Certificate 'B' were introduced to cover the different usages of the form. The authorised pension providers recommend the use of the more extensive, four page Medical Certificate 'B2' for assessments of work capacity and rehabilitation needs. This will give more detailed information about the claimant's remaining work capacity and provide an idea of his/her potential to improve through rehabilitation.

3.2 Harmonisation of definitions relating to incapacity (Letka and Tymä Working Groups)

In 1995, the Ministry of Social Affairs and Health appointed the Letka Working Group to examine problems associated with disability pensions (Working Group report 1998). The

principal task was to harmonise definitions regarding incapacity for work, both in the public and private sectors of the Statutory Earnings-Related Pension Scheme.

The Working Group felt that the poor accrual rate of the Partial Disability Pension is a problem since it does not encourage the utilisation of the person's remaining work ability in the form of part-time employment, whilst in receipt of the pension. The return to gainful employment was also seen to be problematic in situations where the claimant had received a negative decision for a disability pension claim at the end of the maximum payment period of the Sickness Allowance. The claimant often feels ready to retire at this stage, since more than twelve months might have lapsed since the claimant was last employed gainfully. The situation is also often seen as problematic at the workplace and among the rest of the workforce.

The Letka Working Group presented that an assessment of rehabilitation needs should be the responsibility of public health care as a part of the patient's general medical care. Measures to improve work ability should also primarily be the responsibility of public health care. Furthermore, occupational health service should, as early as possible, evaluate the individual's need for supportive measures. To force the implementation of such procedures the Working Group proposed the consideration of amendments to the health insurance legislation. Under these amendments the employer should submit, as early as possible during the Sickness Allowance period, an evaluation of measures available, or on offer, at the workplace, pursuant to the Occupational Health Care Act, to maintain the employee's ability to work. The Working Group further proposed that a provision should be included in section 31 of the HIA: if necessary, an assessment of rehabilitation needs could be carried out as part of a routine work capacity evaluation.

An advisory board with members from trade unions and employer organisations proposed in the Letka Working Group report the following: the introduction of a development model for rehabilitation under the Statutory Earnings-Related Pension Scheme as outlined by the Letka Working Group, the harmonisation of definitions relating to incapacity for work and the extension of the so called 'last institution principle'[2] to cover the public sector. In the summer of 1997, trade unions and employer organisations appointed the Tymä Working Group to continue the work of the Letka Working group and to further process issues not fully resolved.

The Tymä Working Group emphasised the importance both of vocational rehabilitation and of an early introduction of the rehabilitation process through improved interaction between the various parties involved as well as through amendments to appropriate legislation. An assessment of rehabilitation needs should be a subjective right of an employee and rehabilitation should be considered preferable to a pension. The concept of 'a risk of lowered work ability' should be introduced into legislation. Should an employee's work ability be at risk he/she would be entitled to an assessment of his/her rehabilitation needs, and should the rehabilitation plan be put into practice the employee would be entitled to benefits equal to the present Rehabilitation Allowance. It has been estimated that if the Tymä Working Group's proposals were to be implemented, 6,000–15,000 employees would be entitled to rehabilitation annually under the Statutory Earnings-Related Pension Scheme (Antti-Poika et al. 2000). This translates to a 10-fold increase in the number of rehabilitation assessments from the 1990s.

The Puro Working Group proposed in the autumn of 2001 that the assessment methods for disability pensions should be reviewed. The review should start in 2004. The assessment of those aged 60 and over should be work-focused. This will coincide with the plans of the Statutory Earnings-Related Pension Scheme for the private sector to abolish the Individual

[2] In the private sector, a pension is granted and paid by the pension institution where the person was last insured.

Early Retirement Pension and alter the age-related regulations of the Partial Disability Pension (GP 45/2002). Plans have also been put forward to introduce a flexible retirement age; retirement could occur anywhere between the ages of 62 and 68.

3.3 Maintenance and restoration of work ability – a joint venture of the SII and the Statutory Earnings-Related Pension Scheme

A separate working group was appointed by the SII and the Statutory Earnings-Related Pension Scheme to prepare the implementation of the measures introduced by the Letka Working Group. The task of this Jenkka Working Group also included the exploration of possibilities of the SII and the Statutory Earnings-Related Pension Scheme to work together in order to improve both activities to maintain work ability and the timing of rehabilitation.

Furthermore, the Working Group explored the means of introducing consistent and unambiguous terminology, for both pension schemes, to be used in all information and guidelines regarding any legislative changes (Working Group Memorandum, 16 February 1996). The Working Group addressed separately the need for intervention to improve a person's work ability during a short-term Sickness Allowance payment period (less than 60 days) and during a long-term Sickness Allowance payment period (over 60 days). Important viewpoints and suggestions included:

– In order to obtain, as early as possible, a medical evaluation of an employee's illness, and his/her ability to continue working, the public health care system should intervene at the early stages of the Sickness Allowance payment period. The aim is to actively include, at an early stage, all necessary parties in the 'work ability process'; this includes occupational health departments and representatives from the personnel departments.

– A comprehensive evaluation of the insured claimant's illness and work capacity must be carried out not later than after 60 days of Sickness Allowance payments, since the person's willingness to retire will increase as time progresses. Should the period of incapacity for work be expected to be prolonged, measures to support work capacity should be instigated at an early stage. Particular attention should be paid to musculoskeletal illnesses and mental health problems, both of which are difficult to diagnose, at the early stages of the illness.

The time period for retroactive claims for Sickness Allowance was shortened in early 1996 from six months to four months. This was carried out in order to improve both the monitoring of the period of incapacity and the assessment of rehabilitation needs. A new Medical Certificate 'A' (SV 6) was introduced in the autumn of 1996. Moreover, the guidelines for processing and granting Sickness Allowance were reviewed (The Benefit Guidelines of the SII 11/1996): for example, Sickness Allowance based on a limited medical certificate, such as certificate 'A', can be granted for a maximum of 60 days. A medical certificate submitted using the certificate 'B' would be required thereafter.

The HIA was further amended in early 1996 so that after a Sickness Allowance payment period of 150 days the SII may, instead of automatically referring the claimant for retirement, choose to offer the claimant information regarding either rehabilitation or retirement. The SII and the Statutory Earnings-Related Pension Scheme have produced joint publications about the various rehabilitation alternatives available, aimed at maintaining work capacity. For example, the leaflet 'Työ kunnosta kiinni' (Your job depends on your fitness) is presented, at the discretion of the personnel, to Sickness Allowance recipients when an evaluation of their rehabilitation needs/potential is considered appropriate. The leaflet is sent to the beneficiary usually when the number of Sickness Allowance payment days exceeds 60.

The SII and the employee pension institutions have agreed on a workload division and co-operation in issues relating to vocational rehabilitation (Working Group Memorandum, 7 November 1996). When Sickness Allowance has been paid for 150 days or more, the SII will confirm the so-called 'period of primary benefits' which will allow the determination of the starting date of a disability benefit pursuant to earnings-related pensions legislation. At the same time the SII will send the beneficiary a letter asking him/her either to claim for a disability pension or, alternatively, clarify his/her rehabilitation needs. The SII has attempted to improve communications between all the authorised pension providers by, for example, informing the earnings-related pension providers of the nature of the rehabilitation information the beneficiary has been provided with by the SII. This is done in connection with the confirmation of the period of primary benefits.

The SII and the other authorised pension providers have continued their joint advance notification and negotiation method when processing claims for Rehabilitation Subsidy or a disability pension, which are pending simultaneously in both systems (General letter from the Central Pension Security Institute 18 November 1996). The number of these jointly processed claims remains high even though the number of pension claims from the SII has reduced since the basic amount (perusosa) of the National Pension became proportional to the earnings-related pension.

3.4 Training and information programmes to improve work ability

The task of the Disability Pension Working Group (i.e. the so called Tola Working Group), which included representatives from the trade unions, employer organisations and employee pension institutions, was to examine, during the spring of 1995, the grounds for granting disability pensions and the opportunities available to improve rehabilitation so that the employee could better utilise his/her remaining work capacity for gainful employment. In its report (3 April 1995) the Working Group proposed that rehabilitation should be offered at an earlier stage under the Statutory Earnings-Related Pension Scheme. It also proposed the introduction of a work ability evaluation programme, which was further divided into a training project and an improvement of the assessment of rehabilitation needs during pension claim decisions.

3.4.1 Work Ability of Tomorrow (Huomisen työkyky)

In the autumn of 1995, the Finnish Pension Alliance (TELA) launched a comprehensive training project which was named Work Ability of Tomorrow (Huomisen työkyky). The main part of the project took place in 1997–1998. Labour market organisations, the SII, the Ministry of Social Affairs and Health, and the Ministry of Labour were all involved in the project. One of the project's principal tasks was to provide training for work ability assessment with the focus on work and working life. Doctors who issue the assessments were also encouraged to submit the statements with rehabilitation and work ability supporting processes in mind. New means and operational models were sought for public health services to incorporate treatment and rehabilitation into patient care, instead of a pension and prolonged incapacity (Nikkarinen et al. 1998). For the project, approximately 250 trainers were appointed by the SII, various medical associations and public health care organisations. During 1997, approximately 4,700 participants took part in the work ability assessment training and about 75% of the participants were doctors. The other participants consisted of social workers and psychologists from public health care, employees from the SII and human resource personnel from employment offices.

In addition to the above, training was also organised separately for occupational health care personnel and for workplaces (Klementti 1998) with the idea to promote interaction and equip

personnel with the necessary skills to plan, implement and monitor the actions taken to enhance and maintain work ability (such action is described in Finnish by the acronym TYKY). The aim of the Work Ability of Tomorrow project was to provide 'TYKY' training to all stakeholders throughout Finland, at their place of work, within two years from the commencement of the project.

In 1995, a follow-up working group appointed by the Ministry of Social Affairs and Health (Working Group Memorandum 1998) compiled a report on the overall implementation and effect of the above project. The proposals presented by the follow-up working group included: the authorised pension providers should increase the amount of support they offer to their client companies regarding actions taken to maintain work capacity, the SII and other authorised pension providers should increase their co-operation in the assessment of work ability and of training needs, and the labour market organisations should improve related training at workplaces.

Towards the end of the 1990s the training provided by the SII concentrated on the assessment and safeguarding of work ability. In 1996, the SII organised six training seminars in the university hospital municipalities. The almost 1,000 participants consisted of doctors from public health care whose work involves issues relating to work ability and rehabilitation (Työkyvyn arviointi- ja ylläpitoseminaari 1996).

3.4.2 Development of customer services and interaction at local level – SII's projects

In 1998, the SII implemented a training programme named 'Tyke', which aimed to improve both the SII's local organisation's customer services, as far as promoting work ability is concerned, and interaction at a local level. The implementation of the training programme was partially influenced by the pension changes of 1996 and the increased emphasis placed on the Sickness Allowance paid by the SII in the assessment of work capacity and the provision of rehabilitation facilities. At the same time, the SII was responding to the expectations and challenges put forward in the feedback submitted during the training projects, organised by other pension providers, in 1996–1997 (Nikkarinen et al. 1998). For example, it was suggested that the co-operation between the public health care and the SII was too little and doctors were asking for more information about the operations of the SII, since it processes and administers issues relating to work ability.

The 'Tyke' training concentrated on the definitions of work ability and on extending assessments to encompass activities to support work ability instead of "search for the most apt benefits". The training further covered methods needed in developmental work and how to implement them (Broms and Brommels 1999). The training was followed by implementation of local projects in 1999. This phase lasted almost one year during which various insurance districts and the SII continued, through their own local developmental projects, to improve customer services and the interaction between the various interest groups in order to promote work ability. This project phase was called 'Working together to improve working lives' (Yhteistyöllä työkykyä) – developing customer services and local interaction towards enhanced work capacity in the Social Insurance Institution. The training attracted a total of 126 benefit advisors from the SII, and 82 written final reports were submitted covering a total of 78 insurance districts. Each project tried out and described a new model or other concrete scheme which improved customer services and local interaction in order to promote work ability in the local organisation of the SII (Laine and Islander 2001).

The Department of Public Health at the University of Helsinki evaluated the implementation and success of both parts of the programme (Broms and Brommels 1999 and 2001). The results of the evaluation revealed that, for example, local employees can influence customer services and both internal and external interaction, in accordance with the aims set for the

programme. As the project progressed it changed from a traditional training project into a participant-centred development project and the participants felt the improvements achieved met with the practical needs. Both the internal interaction and the benefit-orientated external interaction improved. Moreover, it was noted that as internal interaction improved so did the external. The overall approach to customers and the processing of various evaluations improved as did the quality of medical certificates etc. As a net result activities to support work ability were introduced at an earlier stage than hitherto.

4 THE ADMINISTRATION OF BENEFITS AND PREVENTION OF INCAPACITY BY THE SII

Many social insurance benefits which are administered by the SII contain the core meaning of promotion of work ability and an opportunity to influence the work ability of the nation. The principle of promotion of work ability – the synonym 'support of work ability' is also often used – was already included in the NPA of 1937 and 1956. The benefit allocation pursuant to the HIA of 1964 also included the notion of preventing incapacity, and aims and methods relating to the maintenance of work ability as part of social policy, to guarantee the supply of the workforce.

The benefits administered by the SII, and its various other operations, have been further developed during the last few years to correspond with changes seen in society and the working life. The SII has been an active partner during the reform and development of legislation and operational models, regarding different benefits (Järvisalo et al. 2001). Chapter 4 looks at the connection between decisions made on disability pension claims and the actions taken to promote work ability in occupational health care, income-compensating insurance and rehabilitation.

4.1 Promotion of work ability in occupational health care

Medical treatment paid by the employer has been compensated, under the HIA, since 1964. Since 1979 the principal task of statutory occupational health care has been the prevention of occupational health risks. No detailed statutes regarding the assessment and evaluation of work capacity are included in the legislation but the monitoring of an employee whose ability to work is impaired, and referral to treatment and rehabilitation, has been a part of occupational health care since the legislation was enacted (Act 743/1979).

Maintenance of work ability has been included in the occupational health care legislation since the 1990s; the Occupational Health Care Act was amended in 1991, at the same time as rehabilitation legislation was reformed. In addition to rehabilitation advice and referral to treatment and rehabilitation, occupational health care was to be involved in activities aiming at maintaining of work ability at the work place. Health promotion and work ability were also listed as the principal tasks of occupational health care in 1995, in association with a reform of the compensation system which covers occupational health care (HIA 782/1994, CSD 951/1994). At the same time good occupational health care practice was defined as the principal operational method of occupational health care (CSD 950/1994, Decision by the Ministry of Social Affairs and Health 1348/1994).

A reformed Occupational Health Care Act came into force in early 2002. The above principles were defined so that they enable occupational health care, in the best possible way, to conduct preventative work and maintain, promote and monitor employees' health, as well as work ability and functional capacity, for the duration of their working lives (GP 114/2001). Maintenance of work ability is defined in the new legislation as activity to be carried out at the workplace by the occupational health care personnel who will exercise their professional,

statutory task as a part of comprehensive occupational health care which covers the work environment, work community and the individual (Act 1383/2001, Government decree 1484/2001).

In accordance with the objectives and obligations pursuant to the new Occupational Health Care Act, action should be taken to maintain an individual's ability to work before the diagnosis of a medical illness/illnesses. For example, based on information gained from work environment evaluations, or if the employee feels that his/her workload is excessive, measures to support his/her ability to work should be instigated and implemented before the employee's work ability is reduced and he/she is at risk of becoming incapable for work. One of the occupational health care personnel's tasks, relating to the maintenance of work ability, is to evaluate individual rehabilitation needs. Furthermore, they are expected to work together with other health care providers and the SII when health promotion at the workplace is not sufficient, to support the person's work ability and prevent incapacity for work (Act 1383/2001, section 12, GP 114/2001).

4.2 Promotion of work ability during the Sickness Allowance payment period

Sickness Allowance is a benefit payable under the HIA. It compensates for loss of income caused by incapacity. At the same time the payment will enable the treatment of the illness, which is crucial for the maintenance of work ability, recovery and return to work. When a person's work capacity is assessed it is considered, for example, whether sick leave is necessary for successful treatment and whether it supports the return to work after the appropriate treatment period.

The starting point for the benefit allocation, and the customer services at the SII, is that a comprehensive assessment and, if necessary, an evaluation of the factors affecting the client's work ability is carried out at a sufficiently early stage. The evaluation of relevant factors is often needed in association with Sickness Allowance payment, but information about the client's need for support to enable him/her to carry on working may be necessary also when processing other claims. In practice most claims for Sickness Allowance are for a short period only and usually the need for work ability support is not considered when allocating individual benefits. In current practices the prevention of incapacity is not directly linked to the granting of benefit under income-compensating insurance.

A more detailed evaluation is carried out particularly in cases when the Sickness Allowance payment period consists of frequently repeated periods, and when the illness status of the claimant, as stated in the incapacity evaluation, is not expected to require prolonged periods of incapacity or retirement. A similar evaluation is also carried out when, for example, the claimant has had prolonged periods of incapacity and/or when other significant factors leading to reduced ability to cope at work have become apparent. A comprehensive evaluation of these cases requires not only the assessment of the person's incapacity but also the evaluation of the need for various measures to support and enhance the person's work ability.

When the claimant's case is evaluated in association with the Sickness Allowance payment/claim the core issue is to obtain information about the illnesses affecting the person's ability to work and about the functional restrictions these illnesses may pose. Furthermore, information is needed about the claimant's occupation, work environment and the demands set by the employment. Should the evaluation of the person's incapacity so demand, the claimant may be referred, at the SII's expense, for further tests to clarify his/her work ability and state of health (HIA section 31).

If it becomes apparent during the processing of a Sickness Allowance claim that the claimant is at risk of a prolonged period of incapacity or that a return to work might be difficult, his/her rehabilitation prospects should be explored and, if necessary, the claimant is referred to rehabilitation or other measures to support his/her work ability are considered. In accordance with legislation regarding rehabilitation, the SII must evaluate the claimant's rehabilitation needs, at the latest, when the number of Sickness Allowance payment days exceeds 60. Rehabilitation needs are also assessed, if necessary, when Sickness Allowance has been paid for 150 days. The evaluation of rehabilitation needs may also be necessary at the point of retirement. The SII has a statutory duty to ensure, if necessary, that the claimant's rehabilitation prospects have been evaluated before it grants a disability pension. All authorised pension providers must request an individual treatment or rehabilitation plan before granting rehabilitation assistance.

4.3 Rehabilitation organised by the SII

Legislation regarding rehabilitation was totally reformed in the early 1990s and it gave provisions to rehabilitation to be provided by the SII. The relevant legislation includes the Act on Rehabilitation Administered by the Social Insurance Institution (laki Kansaeläkelaitoksen järjestämästä kuntoutuksesta, KKL 610/1991; A 1161/1991) and the Act on Rehabilitation Funding (kuntoutusrahalaki 611/1991; A 893/1991). At the same time the maintenance of work ability was defined as a statutory task of occupational health care (743/78, section 2, subsection 6, amendment 608/91).

- The SII organises **vocational rehabilitation for persons with impaired work ability,** when the person's work ability and ability to earn an income have *significantly* been reduced due to an illness, impairment or injury. When the reduction in work ability and earning potential are considered, particular attention is paid to the limitations set by the illness as well as difficulties in coping with work and finding work or – in the case of young people – the fact that the illness or injury may cause significant limitations when choosing a profession or looking for work. After the rehabilitation needs and prospects have been evaluated the rehabilitation is carried out either as job preparation, 'TYK' activity or training, by providing funding for equipment needed for study and work, or a business subsidy may also be granted for a business activity or for a self-employed person.

- The SII is under obligation to arrange **medical rehabilitation for a severely disabled person,** unless the rehabilitation is the responsibility of another facility. The aim and purpose is the maintenance or improvement of the person's work and functional ability.

- Furthermore, the SII may use its **discretionary** power to allocate the annual sum granted by the government for any such vocational or medical rehabilitation the legal status of which is not statutory. This would include treatment in a rehabilitation clinic, rehabilitation courses (e.g. Aslak, which is a form of early rehabilitation provided by the SII), ADL training (ADL = activities of daily living), psychotherapy, neuropsychological rehabilitation or rehabilative treatment at a hospital of the Rheumatism Foundation, as well as vocational training (rehabilitation courses, mechanical aids needed in work, work preparation).

- The SII pays a **Rehabilitation Allowance** to persons aged 16–64 who are taking part in some form of rehabilitation.

The rehabilitation provided by the SII is mainly aimed at insured claimants of working age and those who are employed. In principle, the rehabilitation means available are sufficient for this target group with the aim to enhance and restore the person's work capacity.

The early evaluation of rehabilitation needs is a task that has clearly been allocated to the SII. The need for rehabilitation should also be assessed during each treatment event both in secondary and primary care. Based on sufficient information from the public health services and client interviews the SII can act proactively and assess the rehabilitation needs of insured claimants at the early stages of sick leave. The Medical Certificate 'A' now contains a box which a doctor in the public health service can simply tick, and this will prompt the SII to instigate an assessment of the patient's rehabilitation needs.

The assessment of rehabilitation needs have not developed in practice in the expected way. The public health care services rarely instigate an assessment and when they do it usually is at the stage when the patient's state has deteriorated and become complicated. The initiatives from the occupational health care do not often fulfil the criteria of early referral. Short, often recurring periods of sick leave do not lead to rehabilitation assessment either because the absences from work are too short to attract Sickness Allowance and are therefore not registered at the SII or because allowance is claimed only several months after the event. What is significant for the SII is the fact that almost 75% of all rehabilitation assessments are carried out under the discretionary funding stipulation (KKL section 4) because the criteria for vocational rehabilitation of those with impaired work capacity, in accordance with appropriate legislation (KKL section 2), presupposes a significant reduction in the person's work capacity caused by an illness. The aim of carrying out assessments under the discretionary funding has been used to introduce the practice of early referrals.

It is vital for effective rehabilitation work that the number of early referrals increases greatly from the present. In 2000, there were a total of 4,400 early referrals, but the figure should have been 10,000–15,000. According to research, the most effective single factor in rehabilitation is early intervention – irrespective of the mode of rehabilitation. Work is being carried out to amend the paragraph of the KKL referring to vocational rehabilitation. The aim of the amendment is to introduce early intervention by making the risk of losing work capacity enough to instigate the rehabilitation process. It has also been suggested that rehabilitation under the Statutory Earnings-Related Pension Scheme should include a subjective right to vocational rehabilitation.

The rehabilitation provided by the SII has developed over the years, and the activities to maintain and promote work ability (TYK activity), which are mainly aimed at the older workforce, and the vocationally orientated medical rehabilitation (ASLAK®) for the younger people have increased year by year. The patients have also been active in seeking employment and the services of occupational health care. The 'TYK' activity is vocational rehabilitation and is funded by estimated appropriation; therefore supply meets demand. ASLAK® activity, however, is defined as early rehabilitation and is dependent on the amount of discretionary funding, and therefore demand exceeds supply. No other facility offers this type of rehabilitation, with a particular aim on the maintenance and improvement of work capacity and carried out on the conditions of working life. In 2000, the number of participants in the 'TYK' activity was 7,250, and the corresponding number for the ASLAK® activity was 13,800. The median age of 'TYK' participants was 53 years, and the age of those taking part in the early rehabilitation was five years less.

Other rehabilitation aimed at those of working age has also been developed so that it would work with the conditions set by the workplace and the working life in general. Rehabilitation should be interactive between the workplace and the occupational health care services. The threshold to rehabilitation provided by the SII is increased somewhat by the Rehabilitation Allowance, paid by the SII, being less than the corresponding payment received during rehabilitation under the Statutory Earnings-Related Pension Scheme. A new legislation reform will balance this difference in 2004. The Rehabilitation Allowance becomes payable exceptionally promptly, i.e. on the day after the rehabilitation was commenced.

Rehabilitation of mental health problems has increased greatly over the last few years; the need for it is real but the rehabilitation practices are not established yet. The SII has offered a great variety of rehabilitation for patients with mental health problems: in 2000 about 3,000 people participated in vocational rehabilitation and 9,200 in discretionary rehabilitation. The SII is the main organiser of psychotherapy for patients of working age, but rehabilitation is offered to a far greater number of patients. Rehabilitation of mental health problems requires national development to enable it to better keep in touch with the changes in society and particularly in the working life. For its own part, the SII is participating in this initiative.

5 INTERNATIONAL ASSESSMENT OF INCAPACITY

5.1 Reports on disability pensions

The International Social Security Association (ISSA) and the US Social Security Administration (SSA) have, among others, systematically analysed the disability pension provisions in different countries. The SSA has compiled a comprehensive analysis covering disability pension provision worldwide (An analysis of other disability… 1998). Concern has been expressed in the industrialised countries regarding the increase in the number of people in receipt of disability pension, and various methods have been introduced to curb the increase (e.g. Laitinen-Kuikka and Bach 1999). One way to try to curb the increase in the number of disability pensions has been the medicalisation of the concept of incapacity for work (NB. This does not refer to the medicalisation of work and functional ability). Table 1 shows changes introduced by some countries to their disability pension provision.

Table 1. Changes in the disability pension provision in the EU/EEA countries, the USA and Canada in 1990–2000 (Eläketurvakeskus/Laitinen-Kuikka 7 June 2000).

EU/EEA countries USA and Canada	Change in the definition of incapacity	Fixed-term pension	Tightening of other allocation criteria	Reduction of size of pension	Combination of work and pension, return to work	Administrative changes
Belgium	-	-	-	-	-	-
Spain	-	-	-	-	-	-
Netherlands	x	x	x	x	x	x
Ireland	-	-	-	-	-	-
Great Britain	x	x	x	-	x	x
Italy	x (in 1984)	x	-	x	-	-
Austria	-	x	x	x	x	-
Greece	-	-	-	-	-	-
Luxembourg	-	-	-	-	-	-
Portugal	-	-	-	x	-	-
France	-	-	-	x	-	-
Sweden	x	-	-	x (nat. pen.)	x	x
Germany	x (planned)	x (planned)		x (planned)	x (planned)	-
Denmark	-	-	-	-	x	x
Iceland	-	-	-	-	-	-
Norway	x	-	x	x	x	x
Canada	x	-	x	x	x	-
USA	x	(x)	-	-	-	-
Finland	x	x	x	x	x	x

In the USA, the Permanent Impairment guide, issued by the American Medical Association, is being used. The first edition dates back to 1971, and the latest edition is from 2001 (Guides… 2000). It incorporates detailed medical information onto which disability benefit allocations can be based. Some other countries also use similar tables. The following summary is based on a fairly new report submitted by Westat and on study visits of the disability systems in operation in the United Kingdom and Australia.

In the report to the SSA Westat recommends, after a comprehensive study and analysis, familiarisation with the systems operational in the United Kingdom, the Netherlands and Australia. The systems contain elements which could prove beneficial in the development of the American system and in abolishing acknowledged problems. The majority of the countries surveyed by Westat base their disability pension systems on medical reports issued by doctors who have no detailed principles and guidelines at their disposal. Some countries used standardised systems as far as medical findings (Permanent Impairment) or the assessment of functional capacity (Functional Capacity Assessment) are concerned. The SSA showed interest in finding different means to measure functional capacity and wishes to introduce a decision making process which is simple to manage, straightforward to use and also easy for the claimant to understand.

5.2 United Kingdom

Disability pension is called Incapacity Benefit in the United Kingdom and it is administered by the Department for Work and Pensions (DWP) (previously known as the Department of Social Security, DSS). Benefit Agencies are located throughout the country and serve as local service providers. The DSS developed an 'All Work' test which was introduced in 1995. This is now renamed Personal Capability Assessment (PCA).

A PCA-based assessment of a person's incapacity is carried out as follows. After an insured claimant has been off sick for 28 weeks he/she will be asked to fill in a claim for Incapacity Benefit. A medical report from a treating doctor must be enclosed. Eligibility for Incapacity Benefit will be assessed by a doctor who works for a medical services company (the SEMA Group) contracted by the DWP. SEMA acts as an independent enterprise and is paid for its assessments. If a SEMA doctor finds the person incapable for work, the claim will be forwarded to the decision makers at the DWP.

Should the SEMA doctor find that the evidence presented is not sufficient, the claimant is invited to fill in a standardised PCA form which has simple questions regarding functional capability. The questions cover activities such as sitting, rising from sitting, kneeling, standing, walking and walking up and down stairs. The claimant is then referred for a medical examination carried out by a SEMA doctor. The SEMA doctor will fill in a form during the medical examination, the contents structure of which is similar to the one filled in by the claimant. In addition to general information, the doctor's form also includes descriptions of various physical functions as well as sensory and mental functions. The form also contains pages with information regarding functional capacity as well as medication, social functioning, life management and prognosis. If the doctor does not find the claimant incapable for work he/she will be referred to a local personal adviser, employed by the DWP, whose task is to guide the claimant towards local employment services.

SEMA employs approximately 200 doctors and the company outsources capability assessments to about 2,000 part-time doctors. The DWP expects the management of SEMA to systematically monitor the operations of the doctors and the medical reports issued. Furthermore, for quality control purposes the DWP samples the medical reports. The DWP and SEMA organise training for the doctors on a continuous basis. They also store comprehensive material to support and assist the assessments carried out by the doctors. A

doctor is eligible to apply to work for SEMA if he/she has at least five years post-registration experience in general practice or at least three years post-registration experience in psychiatry or occupational medicine, and is successful in an interview which will focus on various aspects of functioning. Furthermore, the doctor must complete appropriate training which includes a written examination which must be passed. The doctor must also be able to demonstrate appropriate practical skills. The Secretary of State will make the final appointment. The doctors who are appointed will undergo a four-part training programme in addition to their work and will have to perform satisfactorily in an audit of 12 cases. The work of a doctor continues to be monitored by more experienced colleagues. Areas to be monitored are presentation and process management. This monitoring can also be undertaken by a non-medical person, since medical issues are not involved.

The DWP also organises training for General Practitioners and provides teaching material relating to capability reports and prevention of incapacity. Good practice and evidence-based practice are key issues. The DWP is compiling evaluations on incapacity caused by various medical procedures. It has also taken part, with the Royal College of Physicians and the Faculty of Occupational Medicine, in the introduction of a course entitled Diploma in Disability Assessment Medicine. The course will examine the assessment of impaired functional capacity and is aimed at doctors working with issues relating to incapacity, rehabilitation and insurance. The long-term aim is that SEMA doctors, who carry out Personal Capacity Assessments, will obtain this qualification.

The DWP instigated in 2001 a nationwide programme to prevent incapability for work. With extra funding, the aim was to introduce all available interventions to restore the person's work capacity at an early stage, i.e. between week 6 and 12 of the sick leave. The background for the programme was two-fold; on one hand the high cost of incapacity for society and, on the other hand, the prevailing shortage in the workforce in the United Kingdom. The plan is to target 10 most prevalent incapacity-causing illness groups, and those suffering from these illnesses will be offered, after an incapacity period of more than six weeks, all necessary, appropriate local services. The extra funding and services from private providers (healthcare services, rehabilitation, employment services) will be used as necessary.

The practice of using PCA may solve many of the problems that Finland is facing at the moment. The system is transparent; the questions relating to functional capacity are very similar in the form filled in by the claimant and in the form used during the PCA examination. Should there be any unclear issues, they can be negotiated immediately with the claimant. There is no need to a change in the work of the treating doctor. The PCA assessments are carried out by specially trained doctors. Quality control, information flow and training are all integral parts of the programme. Incapacity for work is assessed according to the same criteria nationwide.

5.3 The Netherlands

In the Netherlands, the Administration of Social Insurance (ASI) administers the provision of insurance against incapacity. The assessment of incapacity for work is based on a functional capacity assessment carried out by doctors employed by the ASI. The ASI programme recognises eight different levels of incapacity. A claimant is entitled to incapacity pension after a sick leave period of 52 weeks. The claimant fills in a claim form and he/she will be designated a personal Medical Advisor who will act as a 'Case Manager' and obtain appropriate evidence for the case. The Medical Advisor is a doctor who has clinical expertise in insurance issues, which is obtained through a 4-year postgraduate training which focuses on ergonomics, labour legislation, psychology, interview techniques, detail of social security and rehabilitation. The Medical Advisor will have information about any workplace specific interventions at his disposal as well as the treating doctor's medical report and previous data

relating to the claimant's social insurance history. The determination of the person's ability to work includes an assessment of medical findings and functional capacity.

The treating doctor is not required to carry out an assessment of functional capacity, but can do so if he/she so wishes. The Medical Advisor will determine the claimant's functional capacity for work by concentrating on 28 different tasks required in different occupations. The subgroups of these tasks include the following: sitting, standing, walking, climbing stairs, climbing, kneeling, crawling and squatting, bending, short cyclic bending and turning, lifting, pushing and pulling, carrying, use of the neck, reaching, working above the head level, hand-finger dexterity, environmental aspects e.g. reactions to heat, cold, damp, draught, contact with skin e.g. allergy, skin problems, vibration, use of special tools on the body, e.g. masks, personal risk e.g. accident proneness and psychological criteria e.g. working with others, tempo, stress tolerance, responsibility etc. For some tasks the Medical Advisor has to provide an estimate of the maximum duration that the claimant can perform the tasks. For all others, he/she merely indicates the claimant's ability to perform (e.g. 'normal ' or 'not normal'). The programme incorporates a computerised system which compares the claimant's capacity to 8,000 functions. An expert in labour issues consults the Medical Advisor and will try to define at least three types of employment in which the claimant could still engage. Otherwise the claimant is declared incapable for work.

5.4 Australia

Australia has approximately 20 million inhabitants and social security is administered by the state. No special social security contributions are collected but the system is entirely funded by taxation. A government organisation called Centrelink was founded in 1997. Centrelink operates under the principle of a 'single point of contact'. Centrelink administers tasks originating from eight different ministries and works under the Ministry of Family and Community Services.

As far as size and turnover are concerned, Centrelink is amongst the hundred largest enterprises in Australia. It pays out annually AUD 44 billion in social security benefits. Centrelink has 6.1 million customers, employs 22,000 people, has 1,000 service points, sends over 100 million letters to its customers annually, carries out 300,000 home visits annually, has over 500,000 office appointments every month, processes 3.5 million new claims annually, receives over 22 million phone calls annually and takes approximately 700,000 decisions every week. Centrelink therefore serves people at every stage of their lives. This entity also incorporates incapacity assessments, which also take into consideration factors that are not purely medical.

When a person becomes ill, he/she is entitled to Sickness Allowance. This is a means-tested benefit for those who are temporarily unable to work or study due to an illness and have a job or study to return to after their recovery. Those who have no work or study to return to (e.g. the unemployed) are paid different benefit payments, such as the Newstart Allowance and Youth Allowance, which is payable for claimants under the age of 21. The latter two form a comprehensive entity with the Sickness Allowance.

Sickness Allowance must be based on an illness or injury and the person's incapacity for work must be entirely due to a medical condition, and the nature of the incapacity must be of a temporary nature. Sickness Allowance can be paid for approximately two years, but the person should start to consider claiming for Disability Support Pension (DSP) after one year of payments. One criteria for DSP is a duration of incapacity of at least two years.

A treating doctor must provide a medical report in support of a Sickness Allowance claim. The report is written on a form provided and standardised by Centrelink. At the same time,

the claimant fills in a form, also provided by Centrelink, which contains questions which are partly similar to those in the form filled in by the treating doctor. One medical report can cover a maximum incapacity period of 13 weeks. Usually the treating doctor meets the person every three months and provides him/her with a new medical report to enable the person to continue receiving the Sickness Allowance. At months 9 and 21 a person in receipt of Sickness Allowance will be referred to an independent doctor for examination. This Independent Medical Advisor will compile a statement of the nature and duration of the person's incapacity for work The Independent Medical Advisor is usually employed by Health Services Australia. Centrelink makes the final decision on the person's eligibility for Sickness Allowance. Usually around month 9, the person's eligibility and possibility for DSP is broached.

The aim of DSP is to guarantee disabled people an adequate income, and maximum opportunities to participate in society. DSP is allocated to a person who is unable to work or who cannot be retrained for work and who has been incapable of work for at least two years.

DSP can be applied for directly. This applies to the so-called 'clear cases', which have been separately defined, and DSP can be allocated in these cases without a period of Sickness Allowance payments. The usual criteria for DSP is that the person is either permanently blind (presumably a historical tradition, as in Finland) or has permanent impairment which attracts an impairment rating of at least 20 points on the Work-Related Impairment tables and is unable to work or cannot be retrained for work for at least two years.

The treating doctor will fill in the same form indicating incapacity for work as is filled in for Sickness Allowance Payments. When DSP is being claimed the person is referred for a medical examination by an independent specialist doctor. The independent doctor fills in a different form, also compiled by Centrelink, with standardised questions. These question are partly similar to those in the forms filled in by the claimant and the treating doctor. The form has a designated area for the independent specialist's reasoning should his/her view differ from that of the treating doctor as far as incapacity for work is concerned. The Work-Related Impairment tables are used, and a person is usually declared incapable for work, if his/her score is at least 20 points. This does not, however, automatically mean that the person is considered eligible for DSP. The appropriate Centrelink office, which employs no specialist doctors, makes the final decision. The above mentioned 20 points are strongly suggestive of a person's eligibility for a pension but are not binding on Centrelink. For example, the nature of many illnesses has changed, and DSP is not necessarily allocated even if the patient's score exceeded the 20 points (e.g. deafness). Treatments for some illnesses, e.g. asthma and AIDS, have developed so that patients who were easily considered eligible some years ago do not necessarily qualify for DSP today. It is noteworthy that the rejection rate is around 35%.

The disability pension system in Australia is transparent and the patient/claimant usually has the right to access all information and papers regarding his/her case. Impairment tables which are specially designed for this purpose are in operation, but they are not binding on the Centrelink office. Forms standardised by Centrelink are used in the assessment of incapacity for work, but it is clear that Centrelink feels that the actual assessment of incapacity must be carried out by a specialist doctor. However, Centrelink makes the final decision about the person's eligibility for DSP.

6 CONCEPTUAL STUDY OF FUNCTIONAL CAPACITY AND WORK ABILITY IN RELATION TO INCAPACITY

Pension decisions are based on an opinion of the person's *incapacity for work*. However, the concepts of *work ability* and *functional capacity* are also considered since it is the impairment of these that causes incapacity for work. There are several definitions to explain the exact

meaning of incapacity for work, work ability and functional capacity. However, one concept may have several definitions and the understanding of a particular concept varies according to the definition. The legislative definitions of incapacity for work were discussed in chapter 2.1.2.

6.1 What is work ability?

Work ability is one of the principal values of our society and several models and definitions have been given which describe work ability and its impairment, using a variety of criteria: Mäkitalo and Palonen (1994) have described a) a *medical model* of work ability which sees it in relation to illness, impairment and injury, b) a *balance model* of work ability which describes work ability as a relationship between an individual's physical, psychological and social capacity and the characteristics of work and c) a *integrative model* of work ability which, in addition to the characteristics of the individual and work, also considers factors relating to the work environment and the rest of the workforce. Heikkilä (1996) describes a *dynamic work ability model* which emphasises the importance of personal characteristics particularly in a situation where there is a conflict between the individual's capabilities, demands set by society and work, nature and the cultural surroundings and the way the individual experiences human relationships. Järvikoski (1988) has examined different types of work ability which are developed by the different emphasis placed on *individual and social context*: ability to work is therefore a process influenced by factors relating to the individual, social factors – involving the entire society – and surrounding events, and it often is a long-term process (accidents, treatment and rehabilitation of a progressive illness, difficult life situations, burdens set by work, social and labour policy strategies, judicial decisions etc.). Talo (1997) describes the relationship between functional and work ability from the *viewpoint of biopsychosocial framework* which emphasises possibilities of realising an individual's *work capacity* on the conditions set by his/her surroundings.

On the general level, impaired work ability is understood as a condition which may lead to incapacity for work, and it will be referred to in a pension claim as the basis for the person's incapacity. The consideration of the various definitions of work ability is important since, depending on the definition used, the description of impaired work capacity in different pension claims may be based on inconsistent criteria. If impaired work ability is used as a decisive criteria when deciding on a person's incapacity for work, which will then lead to retirement, those who submit statements and those who act on these statements should agree which conceptual model of work ability is being used.

6.2 What is functional ability?

6.2.1 From physical performance to a broad-based definition of functional ability

A uniform definition of functional capacity has been lacking from clinical practice for decades. Therefore, it is not surprising that legislation regarding social security refers to 'functional capacity and its impairment', in association with incapacity and disability allowances, without offering a definition for these terms. It is essential to have a uniform understanding of the term functional capacity since, for example, according to a government report of 1998 on rehabilitation, functional capacity is of paramount importance in relation to rehabilitation. The report considered rehabilitation as a tool to be used in social policy to enhance and improve functional capacity. However, it is difficult to specify what 'enhancing functional capacity' means unless it is known what functional capacity refers to.

According to the traditional view functional capacity refers to physical performance and an ability to cope with activities of daily living. The reviewed *International Classification of*

Functioning, Disability and Health (ICF) by the WHO (2001) offers a wider framework. It divides the various domains of functioning into three categories: 1) bodily functions and structures, 2) activities (related to tasks and actions by an individual) and participation (involvement in a life situation) and 3) environmental factors. The degree of impairment of an individual's functional capacity, i.e. disability, is given a code according to functional disturbances and limitations as well as participation problems. It is particularly noteworthy that the ICF classification considers external factors, in addition to factors relating to the individual, as influential to functional capacity: the classification lists a whole host of environmental factors which can be understood to enhance or hinder the tasks, actions and participation of a person.

The ICF classification is a systematically organised glossary of functional capacity, and it offers a uniform definition for functional capacity and its impairment. This can be utilised when making decisions on sickness allowance and disability pension claims. However, providing a definition for a concept does not equal to an assessment or measurement, which would require an evaluation of assessment methods available and their further development.

6.2.2 The relationship between functional ability and work ability

The individuals claiming for incapacity pension or benefits relating to decreased work ability, those submitting relevant statements and the final decision-makers must have a similar understanding of the relationship between functional capacity and work ability. If this is not the case, confusion will prevail over the assessment of functional and work ability and the subsequent action plan. It is interesting to consider how the functional ability glossaries treat work ability. The ICF classification by the WHO offers an answer by enabling the definition of work ability as a level of functional capacity, described with different domains of functional ability relating to work and working life. Within the ICF framework, work ability can therefore be described either as a limited or a more extensive concept depending on how many domains are used in its definition.

What is important for decision making on disability pensions is the fact that the ICF classification could give a uniform definition of work ability and its impairment, provided that an agreement is reached on the work capacity domains to be used. On the other hand, the use of the classification as a tool for the selection of work ability criteria enables the tailoring of the work ability assessment to suit either a limited professional group or a larger multi-professional group. The classification has been compiled so that it can be utilised to assess the physical, psychological and social aspects of functional capacity and work ability in a systematic and multi-faceted manner. The extent of assessment is dependent on the needs of each particular assessment event.

6.3 Assessment of functional capacity and work ability

The methods chosen to assess and measure functional capacity, work ability and incapacity for work are related to the definitions of these concepts. For example, a medical approach to incapacity would only assess the illness, impairment or injury in relation to tasks to be performed at work. However, when an assessment of a person's capacity to function and work is requested the situation usually would warrant a broader evaluation. An assessment of functional and work ability should include an evaluation of the need for actions such as the support and maintenance of functional and work ability, prevention of incapacity, evaluation of rehabilitation needs, setting out a rehabilitation plan and rehabilitation itself.

Several methods to assess and measure functionality are offered by various text books, scientific literature and clinical practice, but the usefulness and reliability of these methods is

not unambiguous. The relationship between these methods and the conceptual definitions of functional and work ability are not often explored. Some of the methods are only randomly related to the phenomena of functional and work ability, and cannot be relied upon to provide a logical picture of the person's functional and work ability on which to base decisions regarding benefit allocation. The WHO has chosen a different approach: it first created a classification system to describe the domains of functional capacity, and will now develop related assessment methods.

It has often been suggested that all concerned should be equipped with common tools for the assessment of functional and work ability to obtain consistent and reliable results. On the other hand, doubts have been raised on the ability of certain specific methods to assess functional capacity which is a broad concept and closely related to the individual's life situation. The key question will be whether the method provides information required for the decision making. More important than choosing a specific indicator is to agree on issues to be taken into account when assessing functional capacity. These issues will vary according to each specific need; e.g. the contents and methods of an assessment of functional capacity when deciding about a disability pension are different from those used when deciding about disability benefits.

A dictionary of functional capacity terminology will not, not even the ICF classification, offer assessment methods. It has only been compiled to assist in choosing the correct terminology. The FIM (Functional Independence Measure) system, used to measure the functional capacity of those with severe disabilities, is a more restricted classification system (almost an assessment tool) (The Association of Finnish Local Authorities 1998). The PCA system (Personal Capability Assessment, see Chapter 6) is used in the United Kingdom not only as an assessment tool of functional capacity but also as criteria for claim decisions. A joint research project by Orton Rehabilitation, the Research and Development Department of the SII and the Department of Psychology at the University of Tampere is underway. Based on clinical practice and literature searches, the project aims to identify assessment methods currently in practice and their appropriateness in the assessment of functional capacity. However, the project is limited only to methods suitable for the assessment and measurement of domains relating to *activities* (tasks and actions by an individual, physical and psychological) in the ICF classification system.

7 PROBLEMS AND AREAS IN NEED OF DEVELOPMENT

This chapter will discuss the areas, related to disability pension claims and decisions made thereof, that the Working Group felt could be improved. They will be discussed at three different levels: incapacity prevention, impaired work ability as well as the claiming and processing of disability pension claims. Where possible the chosen improvements are discussed from the viewpoint of the insured claimant, the local service provider, the insurance institutes and the insurance doctor.

Ability for work consists of the person's education, experience, knowledge and skills and also of the demands of the work, the organisation of the work, environmental issues as well as issues relating to the workplace. The working environment is changing all the time, and today the entire workforce is expected to continuously update their skills, both those relating to individual professional skills and new procedural practices.

The amendments made, in Finland, in the pensions' legislation of 1996 saw the National Pension become a secondary pension which only provides a basic income. In practice this means that the employment history of those who receive a disability pension from the SII differs distinctly from that of those who are entitled to a disability pension from the insurance companies and foundations which operate under the Statutory Earnings-Related Pension

Scheme. Some of those who might be eligible for a disability pension from the SII are people with poor and intermittent employment history. Atypical employment relationships and a poor employment history may be burdensome for the employee, which on its own may lead to new problems in his/her ability to continue working. People in this group have less access to services which are usually linked to permanent employment relationships, such as occupational health care, workplace health promotion and vocational training. This also poses a problem from the viewpoint of incapacity prevention.

7.1 Incapacity prevention

Incapacity prevention refers to all activities relating to workplace promotion of health and work ability and vocational skills. It also covers self motivation to further develop oneself and one's work, and other measures taken to support appropriate work allocation, job retention and, if necessary, changing employment to safeguard a person's work ability.

Maintenance of work ability particularly relates to the promotion of the health and functional capacity of an employee, the improvement of the working environment, the development of social conditions and the improvement of vocational skills. Maintenance of work ability has been defined as an activity to be carried out by the employer, employees, collaboration organisations of the workplace and the occupational health care, with the aim to enhance the work participation of the entire workforce for the duration of their working lives. These activities should cover all those employed, also those whose work ability is impaired and those who are at risk of losing their work ability. Large employers usually have resources, skills and the supply of appropriate personnel at their disposal to organise workplace health promotion activities. Smaller employers continue to need external assistance to organise similar activities. It is likely that all employers will need external services at some point, e.g. for treatment and diagnosis of illnesses, rehabilitation, career change and training. In this situation the good management and coordination of local services (e.g. health and social services, employment offices, social insurance, training schemes, rehabilitation schemes) is essential.

Many issues may be related to the **subjectively experienced impairment of work ability**: e.g. increased demands set by work, inadequate job orientation or skills, poor personal skills, excessive workload, inadequate support from colleagues or managers, events in private life, illness or accident or resultant long-term impairment of work ability, prolonged absence from work or working life, and unemployment. Support and solutions should be available for all these problems, provided either by the workplace itself or by external facilities. It is important not to classify all these as medical problems. There is no need to investigate and treat a non-existent illness. These problems can be solved by training, job re-allocation, re-tasking, medical treatment, different forms of rehabilitation, health services at the workplace, health and safety measures and managerial intervention. The requirements of successful incapacity prevention include the improvement of work and working conditions, the unburdening of an excessive workload, as well as other measures – either individual or communal – which must be taken before the person's work ability has reduced. Risk factors, and other factors affecting the person's capacity for work, should be identified early, problems should be solved quickly and any extra help needed should be provided at an early stage.

As far as **the insured claimant** is concerned the nature and place of employment is important. A good employer will provide good personnel services, fully functioning occupational health care, health and safety at work and activities to support job retention as well as line management with sufficient skills to deal with issues relating to work ability. If these facilities are not available or are poorly accessible the employee is often left alone to cope with his/her problems, or the employee must rely on external help. Access to services

provided by employment offices, the social welfare office, social insurance or various training schemes might be difficult for the employee due to the lack of co-operation between the different facilities. Participation requires knowledge of the services available and skills that in practice are not usually possessed by everyone.

The management of **the local organisation** (the workplace and its services, health and social services as well as services provided by personnel departments, social insurance, training and rehabilitation facilities) requires a great deal of information and good contacts. Furthermore, the organisation does not function together as an entity but each department functions according to its own rules and regulations. Each different department may recognise the need of workplace health promotion at different times, because the criteria and methods, used to monitor and evaluate the health, functional capacity and work ability of employees during different stages and situations of their lives, are inadequate or aimed to be used in narrow and specific situations. The co-operation between the different facilities is also hindered by the fact that there are no common rules on which to build an organised and well co-ordinated partnership. At workplaces, the monitoring of the employees' ability to cope at work is insufficient, and the development of appropriate rules and methods has been inadequate. Employers of small enterprises lack, particularly when employment is intermittent or otherwise atypical, systems to monitor employees' health and functional and work ability as well as absences from work. Such systems would assist and support those employees who are in particular need of guidance, treatment or counselling due to absences from work and impaired work ability.

As an administrator and developer of **social insurance** the SII has a great deal of opportunities to participate in and influence society towards improved work ability of its citizens. The benefit allocation system of the SII works together, in particular, with the occupational health care system towards reduced incapacity. The other services provided by the SII have also attempted to incorporate local co-operation so that incapacity could either be prevented or, at least, its duration could be shortened. The SII will strive towards prevention and will recognise the needs and expectations of its target population as well as the risks imposed to work ability. Action will be taken by working together with the other local service providers.

7.2 Management of impaired work ability

Management of impaired work ability refers here to all measures taken to restore the work ability of a person with a history of long, or frequently reoccurring, absence from work due to ill health, and to reinstate him/her back into working life. These measures are a joint venture of the workplace and various local service providers.

Ideally an employee should be monitored and cared for by the occupational health care system throughout a prolonged sick leave. This would enable the occupational health care staff to establish what changes are needed in the person's work due to the possibly reduced work ability, brought on by an illness or accident. They could also assess the need for other measures to support the employee's capacity to continue working. Even when a person is in steady and long-term employment the care of his/her illness or injury may be the responsibility of another health care institute, such as care by a specialist, health centre or a private physician. Contact with the workplace becomes largely the responsibility of the employee or the facility providing the treatment. Contact with other services, such as other health care providers, social services, the SII and the employment office is also dependent on the knowledge, information and initiative of the facility providing treatment and the person him/herself. Other problem groups are the young long-term sick and those with reduced work capacity and who are also unemployed or whose employment history is intermittent or otherwise unstable. These groups are not included in the routine operations of workplaces and

occupational health care, and the number of established services for special groups is insufficient.

Waiting lists in health care and other services are a problem. A waiting list of several months for an investigation, a medical procedure, rehabilitation or career choice advice can always be explained by lack of resources, but as far as maintenance of work ability is concerned waiting of this kind can lead to a submission of an increased number of disability pension claims and this will be reflected as an increased number of rejected claims. Waiting will lengthen the time of incapacity and usually weakens the links with the workplace. The situation may become particularly problematic when the continuation of the incapacity period, after investigations and treatment, is no longer justified but the links with the workplace have deteriorated to such an extent that return to work is no longer possible in the normal way.

The reasons for the unnecessary prolongation of incapacity periods – and waiting lists – may also include various factors relating to different sectors' internal and mutual work practices. So far, health care has not paid enough attention to the long-term monitoring of work and functional capacity and assessment of work ability is not systematically included, for example, in good investigational and treatment practices. Social insurance practices are also often centred around benefits and individual sectors, and the preparation and decision making of a claim concentrates principally on one benefit event at a time. i.e. the benefit is either allocated or not. In such a situation the claimant's needs are not explored in a holistic way or such studies are instigated too late or further measures are introduced which may not meet the claimant's needs or baseline situation. If incapacity assessments are insufficient, or alternative measures to support job retention are prolonged or prove to be ineffective, it is likely that the problems related to negative decisions on pension claims will also increase. Furthermore, background factors and mechanisms will change with time and become more complicated and problematic.

From the viewpoint of **the insured claimant** what is most important is that he/she recovers from the illness or injury and usually that the return to work is successful, after a sufficient recovery. Non-specific diagnoses and lack of treatment and rehabilitation plans can further reduce a person's reserves and therefore reduce his/her willingness to continue in gainful employment. Investigational and treatment processes are also often far removed from the person's everyday life and work environment. The assessment of reduced work ability does not take this into consideration and its importance is not rated highly enough.

This may lead not only to problems with specific treatment and rehabilitation procedures but to the ignorance or undervaluing of social support and individual approach. The insured claimant may also feel that in certain situations the treating doctor or care facility is not providing enough information about the extent of the impairment to his/her work capacity and what treatment or other facilities are available.

The situation is made worse for both the claimant and the entire system by the evaluation of job retention needs being introduced at too late a stage. When a person first notices signs and early symptoms of reduced work ability, no measures are usually taken or the introduction of supportive measures do not have a legislative go-ahead. Therefore it is not uncommon that the understanding and views of the person needing help and those of different service providers and specialists differ. They differ as to what procedures are needed, what are the aims and what tasks belong to whom, and who is responsible for what. The need to support work ability is often recognised too late or the support offered to promote work ability is unsatisfactory, because the understanding of the person needing rehabilitation and the person providing it differ too much as to the overall situation and the choice and realisation of the various procedures.

If appropriate occupational health care services are not available, and if the various facilities offering help to someone whose work ability has reduced, cannot give correct information or refer the person to appropriate services, the result will be not only an increased risk of incapacity but also problems associated with incapacity assessments. The idea of incapacity pension as an income provider may be tempting if employment is associated with conflicts as well as changes and threats at the workplace, or if the person is unemployed.

The local organisation (the workplace and its services, health and social services as well as services provided by personnel departments, social insurance, training and rehabilitation services) needs to be developed further as far as treatment of impaired work ability is concerned. Otherwise impaired work ability will be perceived as incapacity for work. The local organisation should provide a seamless service chain. This would presuppose the clarification of the job allocation and responsibilities of different facilities. For this purpose tools would have to be developed to monitor and assess impaired work ability. These tools would serve as guidance, and also as criteria and the basis for collaboration between the different facilities (e.g. assessment of work ability in different situations). Furthermore, the systematic development of practices and methods which would support and assist the collaboration between different facilities has been inadequate. The same is applicable to data systems etc, which would improve communication. Each entity functions within its own specialist area, or within a specific area of responsibility, with the result that all procedures remain unconnected and it is impossible to assess their impact. The tasks and responsibilities of various facilities have therefore remained poorly defined. In Finland a personal advisor and/or department (case manager, rehabilitation instructor, named advisor etc.) has not usually been allocated to a patient. This is the practice in some European countries, e.g. the United Kingdom and the Netherlands.

The assessment methods used to assess incapacity are also inadequate and their use is inconsistent. Consultation with specialist medical services is fairly rare, and assessment of work capacity does not enjoy adequate recognition in the investigational and treatment practices of specialist medical care. Primary health care services also lack resources, and sometimes the necessary skills, to carry out such assessments. A reformed occupational health care legislation came into force on 1 January 2002. In accordance with the legislation the monitoring of the health, functional capacity and work ability of an employee is the statutory task of the occupational health care. Development in this section is therefore only just coming into being. Since 1996, several training and development projects have been organised to improve the skills of various health care sectors in the assessment of work ability and rehabilitation needs, but the results have so far been inadequate. The roles of the Labour administration, the SII and authorised pension providers in the assessment of work ability need further development.

From the viewpoint of social insurance the principal player is the local SII office, the task of which is to assess the claimant's work ability, any risks to his/her present work ability or incapacity, based on the submitted Sickness Allowance claim and any enclosed certificates, statements and other evaluations. The need for work capacity support may manifest itself also in association with other benefits or through the patient's own initiative.

If a person's incapacity for work is not explainable through an illness, the reason for incapacity or need for rehabilitation should be evaluated as early as possible. The realisation of such evaluations remains difficult. The treating doctor does not always hold a correct or adequate picture of the person's ability for work. In particular, information relating to work and the work environment is often insufficient. The information submitted together with a claim often fails to mention the claimant's occupation and no description is given of the disadvantage caused by the illness, or the functional capacity of the person in relation to the demands of his/her work. The missing information needs to be obtained either from the claimant and/or his/her employer and, if necessary, from the doctor or the care facility

submitting the statement. Obtaining information this way requires much manpower and is often not very straightforward. The situation is particularly difficult if the claimant no longer is in fixed employment and when he/she is not under the care of a fully functioning occupational health care system or some other type of monitoring/care system.

The SII can fund evaluations of the claimant's health and work capacity during the Sickness Allowance payment period (HIA, section 31). The rehabilitation needs must be evaluated at the latest when the Sickness Allowance payments, pursuant to the HIA, have been paid for 60 consecutive days, or during shorter periods totalling 60 days (KKL, section 6). Ideally the evaluation is instigated 4–6 weeks after the start of the sick leave, but the instigation and carrying out of the evaluation often meet with problems which hinder both the evaluation of work capacity and rehabilitation need. This causes delays and prolongs the entire process. In the worst case scenario the instigation of evaluations and support activities may take from six to twelve months. At this stage any measures to maintain work ability are usually too late, and such measures are introduced at a stage when the employee already has clear difficulties with coping at work.

The SII strives to clarify each customer's overall situation before a decision is made. This is undertaken through requesting extra assessments and statements as well as through contacting, for example, customer care groups and other local organisations. What is crucial in the evaluation of a person's work and functional capacity is a fully functioning co-operation within the SII itself and between the SII and various official bodies, workplaces, occupational health care services etc. During the last few years, the SII has trained its employees at the local level to equip them with the skills and means to assess work ability, become more aware of activities relating to workplace health promotion and to process the cases more efficiently. However, improvements are still needed. Experience and follow-up data from customer services, with an emphasis on workplace health promotion, and improved benefit processing, strongly support the view that the number of pension rejections can be reduced during the Sickness Allowance payment period. This is achievable through improving the operations of the SII at the local level, and through developing local co-operation. It is possible to assess and evaluate the overall situation of the customer before the decision is made. This way, even if a rejection is expected, supportive measures can be introduced in anticipation and with the customer's own goals in mind. The fact that the HIA does not recognise the concept of partial disability may also hinder the return to work by someone whose capacity for work has been reduced. The time limit of 300 days, during which Sickness Allowance can be paid for one particular illness, may also cause problems in some cases.

In reality, such a time limit pushes the individual towards a disability pension, not towards exploring various rehabilitation prospects. Neither is the limit appropriate in cases where the person needs to be absent from work, due to an illness or rehabilitation, for longer than 12 months with the plan to return back to work. Problems can also be caused by the different definitions of work incapacity offered by health insurance and pension legislation. When the Sickness Allowance has been paid for the maximum number of days one might be faced with a situation where the person has been classified as incapable of working under the HIA, but the same does not apply in accordance with the NPA or legislation referring to earnings-related pensions. A particular problem as far as rehabilitation is concerned is that the legislation in force emphasises the significant impairment of a person's capacity for work due to an illness, impairment or injury. In practice this is interpreted as almost total incapacity. This might be one of the reasons why rehabilitative measures are introduced too late and the persons targeted are not always those who would necessarily need rehabilitation for impaired work ability.

7.3 Assessment of incapacity and claiming for the appropriate pension

The claiming for disability pension is not restricted in Finland. The claimant will fill in and sign a pension claim form, and enclose an appropriate medical certificate stating his/her health state. The medical certificate must not be older than 12 months. The claimant may initiate the pension claim him/herself, or it may be done by the treating doctor, employer etc. Furthermore, the SII is under obligation to inform a person of various pension and rehabilitation options when the period of incapacity exceeds 150 days of Sickness Allowance payments.

Over 90% of new disability pension claims are submitted to the SII offices where the appropriateness of the form and the enclosures is checked. At this stage it is not possible to check the adequacy and scope of the medical statements in view of deciding on the person's right to a pension. The pension claim will then be forwarded to the Pension and Income Security Department of the central administration of the SII and/or the appropriate employee pension institution. Some of the pension processes are initiated soon after the illness has occurred, e.g. if the person is claiming pension under the Statutory Earnings-Related Pension Scheme. Some of the claims will not be acted on until the end of the Sickness Allowance payment period. Pension claims under the Statutory Earnings-Related Pension Scheme and the National Pension Scheme can be acted on at different times.

Statutory criteria of an illness giving entitlement to disability pension. Incapacity for work must be caused by an illness, impairment or injury. The illness must be such that it can be diagnosed with investigations and tests. The illness must have been appropriately managed, i.e. treated according to good medical practice. However, the same illness does not always generate the same degree of incapacity because the assessment of incapacity also considers the illness in relation to other individual statutory parameters.

The Ministry of Social Affairs and Health has issued a decision on 'a classification of handicaps' to be used when assessing a permanent handicap for the purpose of accident benefits. Similar criteria are lacking for incapacity assessment. The above classification is also used when calculating income-tax allowance for the disabled and as a general guideline when defining the degree of handicap for Disability Allowance payments. More illness-specific information and guidelines about the effects of an illness or injury on work and functioning capacity and the reasoning behind assessments can be found, for example, in the book Vakuutuslääketiede ('Insurance Medicine', Aro 1999). The aim has been to create uniform guidelines to make the assessment of functional capacity, when evaluating a person's degree of incapacity, easier both for the patients' own doctors and for those working in insurance medicine.

A recent development has been the introduction of a principle of transparency, i.e. both the patient's own doctor and the insurance doctor assess work ability using the same open principles. Groups of specialists have compiled, on the instructions of authorised pension providers, guidelines and recommendations for some illness groups to be used in the assessment of work and functional capacity (e.g. Pohjolainen et al. 2001). The aim is also to introduce measurement tools to be used in the assessment of functional capacity.

The definitions of incapacity for work have not changed over the last few years, but the proportions of different illness groups in incapacity statistics have changed. The three most common illness groups have not changed. Cardiovascular diseases used to be common, but the number of cases where cardiovascular diseases cause incapacity for work have decreased sharply. This coincides with epidemiological data on the prevalence of these illnesses in people of working age. Incapacity for work due to pain caused by musculoskeletal problems increased from the 1970s until the 1990s. However, there is no epidemiological data on the increase of musculoskeletal illnesses to support the increase: The prevalence of

musculoskeletal illnesses has remained unchanged for the last few decades. This is also applicable for mental health problems; mental disorders have not increased according to epidemiological data, but more disability pensions, based on these illnesses, are claimed and approved than hitherto.

Statutory socio-economic criteria of a disability pension. When a decision is made regarding a disability pension, in addition to the illness itself, socio-economic factors are also considered. These factors are listed in appropriate legislative texts. The NPA (section 22, subsection 1) defines a person as incapable for work if he/she due to an illness, impairment or injury, is incapable of performing his/her regular job or other comparable employment considered to be suitable for him/her and to ensure a reasonable income having regard to his/her age, professional skills and other circumstances. The legislation for the Statutory Earnings-Related Pension Scheme refers to the concept of reduced work ability. When reduced work capacity is assessed the employee's remaining ability to gain an income through such available employment which he/she can reasonably be expected to perform is taken into account, with further consideration given to his/her education, previous work, age, living conditions and other comparable factors. A full disability pension is granted if the work capacity is assessed to have been reduced by at least 60%, for 12 months or more, and a partial disability pension if work capacity is reduced by at least 40%. The National Pension Scheme does not recognise partial disability pension. It is common practice that a disability pension under the NPA will be rejected if an earnings-related pension has been granted as a partial disability pension.

Reduced work ability, caused by an illness, is so evident in the case of many of the disability pension claims that the decision itself is straightforward and socio-economic factors play an insignificant part. However, before some of the decisions are taken a thorough consideration must be given to all relevant factors. In addition to medical data, information regarding other issues is also needed. The claimant should include in his/her pension application not only medical information but also information about his/her education, work, work conditions, employment status, employment history and his/her own view of rehabilitation prospects.

The application sometimes has an enclosed statement from the employment office describing the problems the claimant is facing when looking for employment. A statement from the employer is only enclosed if the claimant is concurrently claiming for Individual Early Retirement Pension. A statement from the employer could also be beneficial in disability pension claims. This would provide information about the claimants ability to cope at work, the work environment and the possibilities to change the working conditions or consider job re-allocation under the current employer. When one is considering the allocation of a disability pension one should consider not only the claimants ability to cope in his/her present job, but one should form an idea of possible alternative but corresponding work and how the claimant would cope with this type of work.

The viewpoint of the insured claimant. Each insured person is entitled to claim for a disability pension if he/she wishes to do so. The appropriate forms are available at the SII offices and the staff will give assistance in completing the forms. It is beneficial to the claimant if adequate information is supplied as regards his/her health status, work and other necessary issues stipulated in the form. Whilst the claim is pending, and the process may take some time, the claimant might spend the time by simply waiting for the decision instead of trying to work out possible alternatives. The Sickness Allowance payment period is not always sufficiently long to allow for recovery, and to cover the entire recovery period a fixed-term pension, i.e. Rehabilitation Subsidy, may be granted, perhaps just for one month.

It is also beneficial to the insured claimant that the preliminary investigations are thorough because the allocation of a disability pension can never rely on inadequate data. Requests for further data, or referral for further investigation funded by authorised pension providers,

causes delays. This could be prevented by carrying out the necessary evaluations during the statutory Sickness Allowance payment period.

The viewpoint of the local organisation / treating doctor. Any doctor can issue a statement, if requested to do so by the claimant, to be included in the disability pension claim. Health care plays an important role when deciding on incapacity issues. However, the issuing of statements for pension claims is often seen as unpleasant and poorly paid extra work, particularly when allocated resources are limited for ordinary patient care. The treating doctor is not always aware of the assessment criteria for functional capacity required by the pension providers. The social insurance system has no power to ensure that appropriate investigations and treatment are carried out in time. Time is often wasted by unnecessary waiting and absence from work.

The treating doctor is not often aware of the issues which influence the allocation of pensions. Their information about the claimant's work and work history might be insufficient. The effect that the illness has on the claimant's work ability might be more influenced by the claimant's own opinion than information based on appropriate evaluations. The treating doctor is often unaware of the contents of pension legislation and the allocation procedures used by the pension providers. The role of the treating doctor is often seen as that of a patient's advocate, but at the same time he/she is expected to issues statements relating to objective investigations and treatment results.

The viewpoint of the insurance doctors. The insurance doctors have been criticised and they have been likened to pension gatekeepers and working in the interests of insurance companies. The work of an insurance doctor must be impartial. They must have no links with the authorities and must possess professional skills to apply legislation and interpret the consequences of illnesses. All pension claim decisions are centralised and the number of insurance doctors is fairly small; this means that the decision making is consistent. The insurance doctors can usually access a broad range of data relating to various decision models and principles to aid comparison. Most insurance doctors also work in clinical practice and are therefore well versed in clinical problems and the position of the treating doctor. The prejudice against the work of the insurance doctors might be alleviated if the criteria for allocating disability pensions were made public, the assessment of work and functional capacity were improved and the general public were made aware of the processes associated with disability pension allocation. Openness about the criteria needed to qualify for a disability pension would be in the interest of the claimant, treating doctors and the insurance institutions; a decrease in the number of unnecessary claims would also decrease the rejection rate.

An insurance doctor's assessment of the claimant's incapacity for work is based on the information supplied with the claim and on any extra medical evaluations requested. This practice, of allowing a decision to be made solely based on paperwork and without seeing the patient, has been criticised, particularly in cases where the final decision differs from that issued by the treating doctor. Adequate data, relating not only to the claimant's illness and functional capacity but also to the claimant's education and employment history, are needed for the decision to be as objective and just as possible. A specialist doctor will issue his/her own view and justify the decision. The final decision will be made by the person who has been issued with the power to do so. He/she may consult a specialist doctor and/or the authorised pension providers before issuing the final decision.

If the claim is rejected the grounds for rejection must be explained in a way that the claimant can understand. The claimant needs to know which illnesses and other factors influenced the decision. Only after receiving a detailed account of the grounds of the decision is the claimant able to assess the fairness of the decision, and consider the need for legal redress.

Ensuring the quality of pension decisions. The SII and the employee pension institutions play a different role in supporting a person's income in incapacity due to illness, impairment or injury. The SII provides basic income when the person is incapable of engaging in employment which provides reasonable income, even if he/she has not been employed before and is not covered by the Statutory Earnings-Related Pension Scheme. The earnings-related pension, on the other hand, compensates for the lost income. Pension decisions must be legal, just and consistent regardless of the person in charge of the case.

The SII and the employee pension institutions have for a long time been using a system of advance notification and negotiation. This has improved the consistency of disability pension allocation and, at the same time, has provided quality control. The relevant legislation was revised in 1996 with the result of the National Pension becoming proportional to an earnings-related pension. This reduced the need for the joint system of advance notification and negotiation. The system is now applied to those people whose pension is likely to consist of both the National Pension and an earnings-related pension.

In addition to the system of advance notification and negotiation, appeals and relevant decisions act as quality control measures. When an appeal is pending, the pension providers may hold unofficial negotiations. If a pension provider receives new information, negotiations may also be held to evaluate the impact of the new information on the decision.

8 WORKING GROUP'S RECOMMENDATIONS FOR DEVELOPMENT

This chapter introduces the proposals by the Working Group which it feels would reduce the problems associated with the rejection of disability pension claims. Not all of the proposals are intended as practical advice but it is envisaged that the practical application of the proposals will be carried out by those making relevant decisions and the pension providers. Development recommendations are divided in this chapter in the similar manner as the areas in need of development presented in Chapter 7, i.e. they are discussed in the context of incapacity prevention, impaired work ability, incapacity assessment and the claiming of disability pensions.

8.1 Recommendations regarding prevention of incapacity

1. The local organisation (workplace resources and internal practices, occupational health care, health and safety at work, municipal social and health services, services provided by the social insurance and employment offices, rehabilitation services and educational measures etc.) should be developed into a functioning network with incapacity prevention as its aim. It should be developed into a seamless service entity which is easily accessible by anyone at any stage of the working life.

2. Services and measures aimed at maintaining work ability should be realised and developed in such a manner that all advisory, educational and other measures taken to maintain and promote work ability are based on a customer-orientated approach. Such measures must also strengthen the possibilities and opportunities of each entity's success in the creation and development of mutual policies. This presupposes that the evaluation of the customer's situation and needs, and the consideration and choosing of appropriate supportive measures, as well as the implementation thereof, are all based on mutually accepted criteria and co-operation. The co-operation must be functional in practice with mutually agreed job designation and operational practices.

3. Persons not in permanent employment, or those who are unemployed, are not included in the occupational health care services provided by an employer, activities to maintain

work ability, health and safety at work or various training programmes. The size and nature of this target group should be evaluated first. Secondly, the possibility of offering such services, to incorporate job retention, training etc., as a joint venture between the public health care, employment authorities and the SII should be considered. Consideration should also be given to the financing of such a venture. Thirdly, the need and means of introducing the services of a personal advisor or rehabilitation instructor should be considered. Such services would be administered at the local level, taking into account the tasks, responsibilities and operational abilities of all those involved, with the aim to instigate and carry out work capacity supporting activities.

4. a) A system to monitor employees' ability to cope at work should be introduced at workplaces. Such a system should be developed to be used by the employer, other parties involved and those active at the workplace. The system should assist the recognition of an employee's needs for support as far as his/her ability to cope at work is concerned and the introduction of workplace health promotion. Furthermore, it would enable timely referral to rehabilitation and to other activities, outside the workplace, aimed at job retention.

   b) Monitoring an employee's ability to cope at work is an essential part of the task of the occupational health care system in the monitoring and assessing of the employee's health, functional and work capacity throughout the person's employment. The monitoring of the coping at work should therefore be included in the tasks of organisations responsible for health and safety at work and personnel departments. It should also be included in the managerial tasks, leadership work and staff development projects.

   c) The activities to maintain work ability must be further developed in collaboration between the workplace and the occupational health care with the aim to promote the psychological, physical and social well-being of the employees. Special targets should include the development of the skills needed in the work and the self-development of the employees. The possibility of interaction between employees should be further developed as should the opportunities of employees to affect their own work, working conditions and organisation, and the operations of the workplace.

5. The SII should support the introduction of measures which support job retention in its benefit allocation and customer services. The recognition of the need for any supportive measures should be improved through working together with the customer when job retentive measures are first introduced and through evaluation of the effect and success of any instigated measures. The development of job retentive benefit allocation, customer services and co-operation at the local level should be secured through training. Furthermore, skills should be improved, job organisation and tools improved and the quality of operations, as well as job retentive methods and models, should be developed. The development of the SII itself should be realised through collaboration between its Central Administration, regional departments and insurance districts.

All five proposals presuppose the allocation of resources by the various parties towards development and training and co-operation at the local level.

8.2 Recommendations referring to impaired work ability

1. A well functioning occupational health care system is the obvious facility to co-ordinate issues relating to impaired work ability. However, if such facilities are not at the disposal of an employee the local organisation becomes responsible for guidance and counselling in issues relating to impaired work capacity. If the person's employment history is intermittent and temporary (or the person is unemployed repeatedly or for long periods) the evaluation of impaired work ability requires co-ordination at the local level.

Familiarity of the operational methods of the various parties involved, and fully functioning co-operation, will be ensured by the allocation of a personal advisor or rehabilitation instructor. The legislation must be amended so as to allow the extension of rehabilitation customer services to cover the entire social security, rehabilitation and adult education sector. An alternative would be the enactment of a totally new act.

2. The role of public health care, local health care providers, specialist medical services, rehabilitation facilities and other care providers in the assessment of rehabilitation needs must be clarified. The skills base of the above should also be improved. The Insurance Rehabilitation Association (Vakuutuskuntoutus VKK) and employee pension institutions have undertaken projects with correct developmental ideas. However, practices must be further developed so that the entire social security system and the Labour administration can access correctly timed, efficient and adequate work capacity assessments. At the same time, it should be decided whether Finland should introduce an accreditation system for work ability assessments, which is based on education, multidisciplinary skills and adequate experience, in order to improve skills and ensure quality.

3. Clarification is needed in the role, timing, selection criteria used, goals and co-ordination of the Labour administration, and the rehabilitation programmes administered by the Statutory Earnings-Related Pension Scheme and the SII, in the treatment of impaired work ability.

4. The SII should develop means to allow an immediate assessment of work ability. This is particularly needed in cases when decisions have to be made regarding the granting of Sickness Allowance during prolonged sick leave based on unclear diagnoses, or symptomology alone.

5. The assessment of rehabilitation needs should be developed. In accordance with the Act on Rehabilitation Administered by the Social Insurance Institution, section 6, such an assessment is carried out after a 60 days' payment period of the Sickness Allowance. In accordance with the above legislation it is possible to carry out an assessment at an earlier stage. The timing of the assessment should be brought forward and more assessments should be carried out during the Sickness Allowance payment period. At the same time, principles should be laid down for the provision of the service without delay if necessary. It should be possible to carry out an adequate assessment of work ability and rehabilitation at the same time. Moreover, it must be evaluated to what extent an assessment of impaired work capacity and rehabilitation needs can be included in the good practice of public health care and in the operations of all facilities offering rehabilitative services.

6. It should be evaluated whether the time limit of 300 days for Sickness Allowance payments should be made flexible in cases where it can be expected, due to the nature of the illness or other reasons, that a pension claim is not going to be appropriate or likely, and the person is planning to return to work in any case.

7. It should be evaluated whether return to gainful employment could be encouraged though the introduction of a partial sickness allowance during periods of illness or rehabilitation.

8. The terminology relating to incapacity for work, in accordance with the HIA and NPA, should be unified.

8.3 Recommendations regarding incapacity assessment and disability pension claims

1. Definitions and the framework of incapacity for work should be clarified. Furthermore, medical criteria should be compiled for different illness groups for the assessment of incapacity. Other essential criteria should also be compiled. This would unify the opinions of the doctor issuing a statement for a pension claim and an insurance doctor, assessing the submitted statement, as far as the claimant's incapacity is concerned.

2. The SII should improve its advice services relating to personal incapacity issues. This would assist in the identification of clear cases in need of a disability pension, and advice could be given regarding the completion of the pension claim form. In unclear cases, advice could be given for the person to obtain more comprehensive investigations and evaluations. This would prevent an application for a pension with inadequate grounds.

3. The pension form should be improved so that the claimant can successfully present his/her own understanding of his/her illness, symptoms and work and functional capacity. This would convey the claimant's own view of his/her situation and problems to those who will decide on the pension allocation, and it would also prevent the submission of claims where the claimant solely refers to enclosed medical statements.

4. The medical certificate 'B' should also be improved as far as conclusions are concerned. The treating doctor should not be able to grant a pension to a patient. The present statement "In my opinion the patient is incapable for…." should be changed and be more a recommendatory statement, for example: "I suggest that the patient is allocated…."

5. The tools of incapacity assessment should be improved. It is therefore recommended that the SII should test the Personal Capability Assessment (PCA) tool, which has been developed in the United Kingdom and has been used both there and in Iceland. The disability pension claimant and a doctor of an accredited assessment unit fill in the forms relating to the same domains of work capacity. These forms establish the person's work capacity using publicly available criteria. Whilst the assessment tool is tested, its appropriateness as well as advantages and disadvantages could also be assessed.

6. The supply of accredited multidisciplinary groups of specialists, who are well versed in incapacity assessments, should be ensured through education, agreements with service providers and administrative procedures. These groups would provide incapacity assessments, and pension providers could consult the groups in unclear or problematic cases, before a pension decision is granted.

7. It should be evaluated whether a partial disability pension should also be introduced into the National Pension Scheme.

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