Quality Services for Social Inclusion:

Mapping Quality Regulations, Requirements and Trends in Vocational Rehabilitation for Persons with Disabilities

COMPARATIVE REPORT AND COUNTRY CASE STUDIES

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Contents

Author: Lara Bezzina, Policy Impact Lab

Case Study Authors:
Fabio Belafatti (UK, CZ, NL)
Lara Bezzina (MT, FI)
Ieva Giedraiytė (HR)
Jessica Strunkeit (AT)
Laima Pranskūnaitė Užpelkienė (SE)

Research Manager and Editor: Laura Jones, EPR

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A. Introduction and Methodology

The study mapping quality regulations, requirements and trends in vocational rehabilitation (VR) for persons with disabilities (PWDs) in Europe (hereafter – the Study), commissioned by the European Platform for Rehabilitation (EPR), was elaborated during the last quarter of 2020 by Policy Impact Lab. The Study has two main objectives:

1. To better understand the current obligatory and voluntary regulations, requirements and trends in VR for PWDs across different European countries
2. To inform the relevant stakeholders and policy-makers on the current gaps and needs in quality standards for VR.

This study built on the one carried out in 2019, which looked at the quality trends of social services in 11 EU countries. The present study focused more specifically on VR (for PWDs) and looked at the quality trends in a further eight European countries: Austria, Croatia, Czech Republic, Finland, Malta, Netherlands, Sweden and the United Kingdom.

Data collection in each country included desk research and interviews. For desk research, case study authors consulted a range of secondary sources, including service provider and policy reports, national legislation and guidelines, as well as academic articles. The interview program in each country targeted VR service providers and regulators responsible for this sector, and included between three to six interviews per country. The interviews helped fill the gaps in, as well as triangulate, the data gathered through desk research. Interviewees in each country received draft case studies for validation of findings.

This report presents the findings emerging from the above-mentioned sources. The first part presents general observations that emerge from the comparative analysis and formulates recommendations regarding VR quality standards and guiding principles. The second part of the report includes a description of each country case, delving into further detail on the operationalisation, governance and provision of VR as well as the related quality regulations and monitoring.

B. Governance and Provision of VR Services

The **governance** of VR services in the countries explored is generally the responsibility of:

- ministries responsible for labour, social affairs and/or health (i.e. healthcare systems, public employment services, etc.);
- local / regional authorities;
- social insurance institutions;
- pension / insurance companies;
- employers.

In some countries, VR services are governed/organised by more than one of these entities, for example depending on the degree/cause of impairment (Austria) or the employment status of the person (Finland, Sweden).

Regulations surrounding VR services differ from country to country, and most countries do not have specific regulations or legislation on VR, but rather ones relating to employment and / or disability (e.g. Austria, Malta) and rehabilitation in general.

VR is provided by a **range of different service providers** across countries, ranging from hospitals (Malta, UK) to sheltered workshops (Croatia), NGOs (Czech Republic) and companies specialising in vocational rehabilitation (Czech Republic, UK, Finland).

While **VR** generally encompasses a series of measures aimed at integrating / re-integrating PWDs in the labour market, it **is operationalised differently** in the various countries. For example, while in Austria VR is preceded by medical rehabilitation and comprises vocational training and financial subsidies besides the regular measures in supporting persons in finding work and work try outs, in Malta VR is part of general occupational therapy services and thus more medical in nature.

C. Quality Regulations and Trends in VR[1]

The majority of countries explored in this study **do not oblige VR service providers (SPs) to hold quality certifications.** While in some countries (Czech Republic, Malta) social service providers have to adhere to quality standards, this study found no evidence of specific quality certifications applicable to VR SPs. Nonetheless, quality standards in VR are achieved and maintained through other means, including stipulations in contracts/agreements; educational standards; standardised assessment and tools; monitoring systems; and goal attainment/beneficiary satisfaction, each of which is in turn explored briefly below.

One of the main practices (Austria, Finland, Sweden) in ensuring quality are the **stipulations laid down in contracts or agreements between funding entities and SPs**, or using track records of previous service delivery as a pre-condition to award contracts (Netherlands, UK). Stipulations vary and can include quality standards, accessibility (e.g. of premises), capacity to provide services (financial or otherwise), and proven track records. However, in most countries explored, service providers are left to their own devices as to how to ensure quality within their own entities. At the same time, there exist great disparities between such countries as Finland (where quality is ensured in every step of the VR process) and the UK, where VR is highly deregulated.

Other countries (Austria, Malta, Netherlands) ensure that the **professionals providing VR** hold certain **required qualifications and / or educational standards**; and interviewees in countries such as Sweden and the UK confirm that they are either planning competence-enhancing initiatives to increase staff's knowledge of PWDs (former) or addressing gaps in staff knowledge (latter). The use of **standardised assessments and tools** help ensure quality in others (e.g. Finland, Malta, Sweden). In Sweden, for example, service providers make use of such self-assessment tools as the Individual Placement and Support (IPS) Fidelity Scale and QUL[2], a national management assessment and certification model developed by the Swedish Institute for Quality. Further, in some of the countries which were studied, various **monitoring systems** exist (e.g. Sweden, UK), such as regular visits by monitoring entities to VR providers.

Most countries use – to different extents – **beneficiary job placement / satisfaction as quality dimensions for provided VR services**. Findings emerging from interviews demonstrate that beneficiary PWDs are increasingly gaining more awareness of their rights and expecting more professional and tailor-made services (Czech Republic, Finland).

Other elements such as funding indirectly impact VR quality in such countries as the Netherlands, where, the fact that employers and insurers are expected to carry the financial burden of the rehabilitation effort by funding the necessary rehabilitation procedures, creates a major market-based economic incentive for employers and insurers to maximise their investment by choosing providers who can ensure the best quality of rehabilitation.

Challenges encountered

Funding, or the lack of it, can also be the cause of challenges countered in VR service provision. Lack of financial investment in VR services is one of the reasons VR service providers in Malta do not always have the means to ensure quality of services through, for example, the use of standardised tools / assessments.

The challenges to lifelong learning mentioned earlier is another challenge encountered by service providers and regulators in the countries explored with regard to achieving and maintaining quality in VR services. While regulators in the Czech Republic also mention gaps in staff training, VR service providers in Austria and Croatia are facing over-bureaucratisation in reporting (on quality issues) to regulating entities, resulting in less emphasis on the actual goals of rehabilitation. In

[1] For more in-depth information on quality trends and regulations regarding vocational rehabilitation for persons with disabilities in each of the countries studied, please refer to the Country Case Studies found in Section F of this report.

[2] Acronyms for Swedish words meaning Quality, Development and Leadership.

Austria, for example, due to an increase in focus on logging and assurance procedures, VR service providers feel that less attention is being paid to the individual outcomes of rehabilitants and their needs. Meanwhile, in Finland, service providers are merging into bigger ones which have more power in setting their own rules with regard to VR, rather than abiding by those set by regulating entities. While merging into bigger service providers means less providers and thus less competition in the provision of services; big service providers also have more 'power' in disregarding quality standards set by quality-regulating institutions like Kela (the Social Insurance Institution of Finland). While Kela details sanctions in its standards for VR service providers, these are practically impossible to impose with the large (and few in number) service providers who are monopolising the VR market.

Adequacy of current quality regulations

Views on the **sufficiency of current quality regulations** vary, with providers and regulators in countries like **Austria and Finland stating that the existing ones are enough to ensure VR quality**: in Finland, for example, quality standards are inbuilt in social security legislation and rehabilitation guidelines. On the other end of the spectrum, one finds countries like **Malta – where no quality frameworks on VR exist**. In between are countries like Croatia where quality criteria and monitoring are not clearly defined, and the Czech Republic, where some NGO providers only fulfil minimum quality criteria on paper, not in practice. In view of this, service providers in countries like Malta, Croatia and the Czech Republic are interested in developing or acquiring quality control frameworks specifically for VR.

D. Role of Voluntary Quality Standards and Certifications

VR service providers in at least six of the eight countries studied use ISO certifications. Use of other voluntary standards is not consistent. The study found evidence of SPs in VR using quality standards such as the EFQM - European Foundation for Quality Management (Austria, where use of quality standards is widespread) and the CDMP - Certified Disability Management Professional (UK – mainly Scotland – where use of quality standards (including ISO) is rare.) Countries like Malta, meanwhile, use no international or regional quality standards for VR services.

The roles of EQUASS and EPSR

This study zoned in on the use of the voluntary quality framework European Quality in Social Services (EQUASS) and the guiding principles of the European Pillar of Social Rights (EPSR). Both EQUASS and EPSR are specific to the social services sector: EQUASS is an initiative of EPR and aims at guaranteeing quality services in the social sector[3]; while the EPSR comprises 20 principles, launched by the European Commission in order to deliver more effective rights for citizens including in the labour market and in social protection.[4]

The **majority of service providers and regulators of VR consulted in this study were unaware** of EQUASS and the EPSR. For countries like Malta, where VR is simply part of the more general occupational therapy services governed mainly by healthcare, frameworks and principles relating to social services might not reach professionals working in the field; while the UK's cultural habits might keep stakeholders back from adopting guidelines and principles emerging from the Continent.

However, in countries like Malta, service providers and regulators feel that the current quality standards are not sufficient, and feel the need of quality assurance and standards which are aligned with EU ones; while in Croatia, service providers observe that current regulations lack clear and specific quality criteria. Thus, **stakeholders in** such countries as **Croatia, the Czech Republic and Malta are open to adopt standardised quality frameworks for VR services**, so

[3] European Quality in Social Services. 2017. *About EQUASS*. Available: https://equass.be/index.php/about-equass

[4] European Commission. n.d. *The European Pillar of Social Rights in 20 principles*. Available: https://ec.europa.eu/commission/priorities/deeper-and-fairer-economic-and-monetary-union/european-pillar-social-rights/european-pillar-social-rights-20-principles_en

much so that in the Czech Republic, the Labour Office (which funds and organises VR) has shown an interest in EQUASS – which, it feels, is more relevant to VR service providers than ISO – only putting the process of exploring this standard on hold because of the COVID-19 pandemic.

When it comes to EPSR, some of the countries covered in this study confirm that whether service providers and regulators are generally unaware (e.g. Finland) or aware (e.g. Croatia, Czech Republic) of its principles; they believe they are reflected in national VR-related guidelines, quality criteria and / or legislation.

E. Conclusions and Recommendations

Based on the findings emerging from this study, it is evident that the maintenance and assurance of quality of VR services differs across countries. While some countries like Finland have inbuilt quality standards, others ensure quality through measures like professionals' educational standards, monitoring systems and stipulations laid down in agreements. However, the role of voluntary quality standards is less widespread (with the exception of ISO): in most countries explored, these are not used. This includes the use of EQUASS, which is unknown by most SPs and regulators alike. One of the common reasons cited for the lack of adoption of EQUASS is lack of knowledge of these standards, either by service providers or by regulators / policy-makers, or both. However, in some countries it is recognised that more needs to be done to ensure quality VR services. It is also clear that the EPSR is not known to many stakeholders. It is thus evident that:

- → The Action Plan to implement the Pillar[5] must include awareness-raising of the Pillar among key stakeholders
- → The references to quality in the European Pillar of Social Rights provide an opportunity for work on quality; initiatives in the Action Plan to implement the Pillar should mainstream and take into account how to promote and support quality services, and referencing the European Voluntary Quality Framework;
- → The European Commission should develop dialogue with stakeholders about quality in sectors additional to that of long-term care – including those explicitly mentioned in the EPSR – education, childcare, housing;
- → In the context of implementing the EPSR, the European Commission should develop calls for proposals in the field of quality social services targeted at policy makers, service providers and service users; supporting understanding of and the implementation of quality services in different fields;
- → more awareness of quality standards and frameworks needs to be cultivated, as well as their use and benefits. Such awareness-raising might encourage policy-makers and service providers in countries which are open to – and interested in – adopting EQUASS or quality standards for VR in general to start the process;
- → since not all countries appear to be interested in adopting such frameworks (one of them being that the existing (national and international) quality standards are seen to be sufficient in ensuring VR quality), other incentives for adopting such frameworks as EQUASS might need to be propagated. Should there be a need for or interest in standardising or benchmarking the quality of (some) VR services / VR-related services for PWDs across Europe EQUASS would be particularly relevant, particularly in countries where VR services fall under social ones;
- → it might be beneficial to render EQUASS more accessible to service providers (e.g. in terms of costs to small providers)
- → it would be advantageous to collect good practice examples of adopting EQUASS in order to disseminate among policy-makers and potential service providers.

[5] https://ec.europa.eu/social/main.jsp?catId=1487

F. Country Case Studies

Austria Case Study
Quality Regulations, Requirements and Trends in Vocational Rehabilitation

At a glance

- *Austria's Public Employment Service, the social insurance institutions, the Social Affairs Ministry Service and the federal states are the main bodies providing access and funding to VR.*
- *Quality in VR is ensured through contracts or agreements between funding authorities and providers, required qualifications of staff members, educational standards and voluntary certifications.*
- *Quality certifications are not mandatory for providers of VR but the use of voluntary quality frameworks (mainly ISO and EFQM) is widespread.*

Governance and provision of VR services

Within the Austrian social security system, the responsibility for providing access and funding to rehabilitation measures is mainly divided among the **Public Employment Service** (*Arbeitsmarktservice*, AMS), the **social insurance institutions**, the **Social Affairs Ministry Service** (*Sozialministeriumservice*, SMS) and the federal states.[6] Depending on the degree of disability, the cause of impairment, the occupational group of the rehabilitants and the aim of the VR measures, different institutions are responsible for each application for rehabilitation. In standardised 'Competence Centres for Assessment' the ability to work and the need for rehabilitation are determined. Depending on which problems are at the forefront, medical rehabilitation, vocational rehabilitation and different forms of financial support are granted.[7] The funding agencies are obliged to coordinate vocational rehabilitation measures. When an agency is contacted, an occupational rehabilitation plan is initiated and relevant agencies become involved.[8] Currently, in many cases of VR, the total costs are shared between the pension insurance institutions and the Public Employment Service.[9] The agencies also cooperate with providers of advisory services and other support-services through **Fit2Work**, an initiative by the Austrian government that seeks to facilitate access to early, preventative measures.[10] Through this initiative, rehabilitants together with case managers can create an individual plan of rehabilitation measures, which may include adapting the workplace or taking up a new job after appropriate training. Fit2Work then accompanies clients in the implementation of this plan.

VR in Austria is provided separately from other forms of rehabilitation, such as medical rehabilitation. Medical rehabilitation should generally be completed before the start of VR, and the

[6] Egger-Subotitsch et al. 2015. *System und Methoden der Beruflichen Rehabilitation in Österreich*. p. 15. Available: https://ams-forschungsnetzwerk.at/downloadpub/AMS_PH_System_und_Methoden_der_Beruflichen_Rehabilitation_in_Oesterreich_3c.pdf
[7] Ibid. p. 20.
[8] Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz. 2020. *EIN:BLICK 3 – Rehabilitation Orientierungshilfe zum Thema Behinderungen*. p. 49. Available: https://broschuerenservice.sozialministerium.at/Home/Download?publicationId=332p
[9] Egger-Subotitsch et al. 2015. p. 15.
[10] Ibid. p. 19.

latter should not be interrupted by longer-term medical measures.[11] On the other hand, VR in Austria can be distinguished from regular educational measures by the fact that VR seeks to provide multidisciplinary support together with the rehabilitation measures. The aim of VR is to enable people to take up work, to continue to work, or to return to work. According to § 198 of the General Social Security Act (*Allgemeines Sozialversicherungsgesetz*, ASVG)[12] measures of VR in Austria can include:

- vocational training and other qualification measures to regain or to increase working capacity;
- measures that support persons in finding work;
- financial loans, grants and subsidies towards vocational rehabilitation measures and wages;
- counselling services;
- employment projects such as inclusive workplaces;
- work try-outs and transit-workplaces.

The **Social Law Amendment Act** (*Sozialrechtsänderungsgesetz*, SRÄG) stipulates changes to a number of laws, such as the ASVG. In 2014 the principle of 'rehabilitation before retirement' was reinforced through the SRÄG with the intention to reduce the number of pensions by granting rehabilitation measures as long as there is a possibility of restoring the person's ability to work.[13] Since then, any application for invalidity, occupational invalidity or for a disability pension is first considered to be an application for rehabilitation and the possibility of such services has to be examined in each case. In addition, new methods of rehabilitation are being developed, such as the combination of medical and occupational rehabilitation, which since 2018 is being provided by the pension insurance under the new concept RehaJET (rehabilitation for jobs, earning capacity and participation).[14] There have been increased efforts to interlink occupational and medical rehabilitation in Austria but they largely remain separate processes.[15]

The AMS, the SMS and the social insurance institutions provide VR services as defined by the ASVG themselves but also contract a number of public, private as well as non-profit organizations. They conclude framework agreements with rehabilitation providers and with vocational training institutes, finance projects and provide individual funding. These organizations can deliver a wide range of rehabilitation measures, such as (re)trainings, work try-outs, counselling and multidisciplinary support. The largest and most important contractual partner in providing vocational rehabilitation measures is the **Vocational Training and Rehabilitation Centre (BBRZ),** which was established in 1975.[16] The BBRZ group provides multidisciplinary VR measures (medical support, counselling, individual training schemes) to people who are no longer able to work due to an illness or accident on their way back to work. Lastly, some measures in the context of vocational rehabilitation (such as integrative companies) are administered directly by the **Federal Ministry of Social Affairs, Health, Care and Consumer Protection (BMASK)**.[17]

[11] Berufsförderungsinstitut OÖ & Berufliches Bildungs- und Rehabilitationszentrum. 2002. *Grundlagen der beruflichen Rehabilitation*. p. 2. Available: https://docplayer.org/3173376-Grundlagen-der-beruflichen-rehabilitation.html
[12] Egger-Subotitsch et al. 2015. p. 11.
[13] EASPD. 2018. *Report on the comparison of the available strategies for professional integration and reintegration of persons with chronic diseases and mental health issues*. p. 70. Available: https://www.easpd.eu/sites/default/files/sites/default/files/Projects/PATHWAYS/wp4_full_report.pdf
[14] Pensionsversicherungsanstalt. 2020. *PV 2019*. p. 17. Available: https://www.pv.at/cdscontent/load?contentid=10008.678689&version=1561985891
[15] Interview with Manfred Herbst.
[16] Öffentliches Gesundheitsportal Österreichs. 2018. *Berufliche Rehabilitation*. Available: https://www.gesundheit.gv.at/gesundheitsleistungen/kur-reha/berufliche-rehabilitation
[17] Egger-Subotitsch et al. 2015. p. 23.

Regulation of VR Services and their Quality

There is no one legal framework that addresses VR and its quality specifically; rather a number of acts related to rehabilitation, PwDs and employment which specify the scope and priorities of VR measures as well as the responsibilities of key institutions in this area:

- The **General Social Insurance Act** (Allgemeines Sozialversicherungsgesetz, ASVG)[18] was issued in 1955 (amended multiple times). It regulates the responsibilities, benefits and procedures of the social insurance institutions regarding employment and defines the types of rehabilitation. It also stipulates that all appropriate means must be used to help rehabilitants to pursue their previous profession or, if this is impossible, a new one.
- The **Public Employment Service Act** (Arbeitsmarktservicegesetz, AMSG)[19], which came into force in 1994, forms the basis for vocational rehabilitation in the Public Employment Service.
- The **Austrian Disability Employment Act** (Behinderten-Einstellungsgesetz, BEinstG)[20] defines the term 'beneficiary disabled person', which is applied by the Social Affairs Ministry Service when providing employment subsidies and employment protection provisions.
- The **Federal Disability Act** (Bundesbehindertengesetz, BBG)[21] came into force in 1990 and regulates the coordination of rehabilitation between the different funding agencies. It stipulates that it is the obligation of these agencies to determine which one of them is responsible for providing access to vocational rehabilitation and to coordinate appropriate measures. In addition, federal states have their own disability acts, which define measures related to PwD as well as their priorities.
- The **Work and Health Act** (Arbeit-und-Gesundheit-Gesetz, AGG)[22], emphasizes the principle of earliest possible rehabilitation and extends early support for employees whose job is at risk due to health problems and for people who are likely to be unable to work in the future.

Based on the legal acts, guidelines regarding PwDs and employment are developed by the Federal Ministry of Social Affairs, Health, Care and Consumer Protection, the Public Employment Service and the social insurance institutions which in turn define the implementation of VR measures. These guidelines serve as the basis of regulations regarding VR among funding authorities and providers when it comes to the objectives of VR and types of measures as well as required qualifications of key personnel.[23]

Organizations providing VR are not required to hold quality certifications, but the use of voluntary quality frameworks is widespread. Contracts or agreements between funding authorities and providers, required qualifications of staff members and educational standards contribute to the maintenance of quality in this sector. Each of these are in turn detailed below.

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[18] Laws of Austria. 1955. *General Social Security Act 1955 (ASVG) (BGBl. No. 189/1955)*. Available: https://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=35898

[19] Laws of Austria. 1994. *Federal Labour Market Service Act (No. 313/1994)*. Available: https://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=&p_isn=37808&p_classification=08

[20] Laws of Austria. 1969. *Employment of Persons with Disabilities Act (BEinstG) (BGBl. No. 22/1970)*. Available: https://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=42258&p_count=96150&p_classification=08.01&p_classcount=1624

[21] Laws of Austria. 1990. *Federal Act concerning advice, support and special assistance for persons with disabilities (Federal Disability Act - BBG) (BGBl. I Nr. 283/1990)*. Available: http://ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=91401&p_country=AUT&p_count=1088&p_classification=08.01&p_classcount=17

[22] Laws of Austria. 2010. *Arbeit-und-Gesundheit-Gesetz – AGG (BGBl. N0 111/2010)*. Available: https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=20007058

[23] Interview with Uli Rebhandl.

Central to the regulation of quality of VR services are the contracts or agreements which the funding agencies establish with providers. They contain specific requirements reading the types of measures, their target groups and objectives as well as qualifications of employees.[24] Moreover, providers are expected to provide detailed descriptions of the measures they provide as well as of their quality-management systems. These descriptions are based on the legal acts and on the guidelines provided by the regulators.[25] The contracting authorities collect user information and measure the satisfaction of the recipients of VR measures. Providers are obliged to prompt recipients to submit their opinion directly through e.g. an online system, with questions related to the premises, the staff as well as on the practicability of the provided measures.[26] In addition, authorities, particularly the Public Employment Service and the Social Affairs Ministry Service, keep track of the employment situation of clients after they have received VR. If the collected data shows low satisfaction or if the job placement rate is low, providers have a duty to provide further reports.[27] Interviewed providers note that maintaining a high level of user-satisfaction and a high job placement rate is important when obtaining further contracts or project funding from authorities. Regardless of the feedback collected by the contracting authorities, interviewed providers report conducting their own surveys on client satisfaction, the quality of services and on staff members, which they personally feel are more detailed and target oriented. Providers use the information obtained through these surveys to implement changes regarding their provision and quality.[28] In addition, the BBRZ commissions its own research institution to conduct research on client satisfaction and based on its results develops and assesses VR services together with the Public Employment Service.[29] According to interviewees, the placement rate and employment situation of clients after the completion of VR measures is a relevant indicator for the applicability of VR services and their quality.

Depending on the types of services provided, there may be requirements regarding the minimum qualifications of staff members, such as in the cases of social workers and occupational therapists[30], both of whom require a university degree in Austria. In addition, occupational therapy is linked to a professional license. In order to obtain this, registration in the Health Professional Register (Gesundheitsberuferegister) is a professional obligation for occupational therapists.[31] In the case of tenders, contracting authorities provide mandatory qualification requirements for staff. However, staff qualification criteria are highly dependent on the specific VR services provided and in some cases authorities may leave it up to the providers to hire qualified staff as long as the standards outlined in the implementation guidelines are met.[32] Providers of VR also cooperate with specialists from the medical, psychological and social sector in order to meet the demands of multidisciplinary support and in order to facilitate rehabilitation.[33] At the planning stage of the individual VR measures, this may involve a comprehensive examination, which is carried out by medical professionals.[34]

[24] Interviews with providers.
[25] Interview with Ulli Utri.
[26] Interviews with providers.
[27] Interview with Manfred Herbst.
[28] Interview with Ulli Utri.
[29] Interview with Manfred Herbst.
[30] These two professions are examples of those who can provide VR. In Austria, there does not seem to be a specific group of professions that are allowed to provide VR; rather, there is a wide range of different professions involved depending on the type of measure provided and the kind of support needed.

[31] Ergotherapie Austria. *Berufsberechtigung*. Available: https://www.ergotherapie.at/berufsberechtigung
[32] Interview with Uli Rebhandl.
[33] Interview with Manfred Herbst.
[34] Egger-Subotitsch et al. 2015. p. 29.

As vocational training in Austria can also be part of VR measures, educational standards also contribute to the maintenance of quality in this sector. When VR clients take part in apprenticeships or other professional qualifications there are legal obligations regarding the practical and theoretical content of the vocational training, accredited through a final qualification exam under the supervision of an accredited examination board.[35] The Vocational Training Act (*Berufsausbildungsgesetz*, BAG) forms the legal basis for apprenticeship training in Austria. It establishes regulations for each recognised apprenticeship, which define their educational standards, credentials, training lengths and occupational profiles. These regulations are binding for companies and vocational schools offering apprenticeship training.[36] In Austria, since 2017, all young people under the age of 18 who have completed compulsory schooling, are obliged to pursue education or training, including PwDs.[37] This involves multi-stage procedures that seek to return young people to school or on to vocational training in cooperation with the Public Employment Service, the Social Affairs Ministry Service (SMS) and youth coaching. A 'personal perspective plan' or 'support plan' is created with the clients, which states how the training obligation can be fulfilled through e.g. school, apprenticeships, further training or partial qualification.[38] This process underlines the principles of prevention as well as earliest possible support and rehabilitation. Ideally, coaches work closely together with schools or school support systems, such as student and educational counsellors, school psychologists and, if desired, also with the parents of the client.[39] Youth coaching is a service provided by NEBA (Professional Assistance Network)[40], an initiative by the Social Affairs Ministry Service. The Federal Ministry of Social Affairs, Health, Care and Consumer Protection establishes guidelines[41] for the implementation of the services by NEBA regarding e.g. eligibility criteria for funding, reporting, applicant profiles and aims. These guidelines are implemented through the contracts or agreements with providers of youth coaching. A national standard regarding youth coaching is applied through the central control of the SMS, while the implementation of the individual providers in the federal states takes regional conditions into account.[42]

Interviewed providers and regulators generally feel that the current regulations and requirements support the quality service provision in the VR sector. However, one interviewed provider notes that they increasingly feel an 'over-bureaucratization' taking place, particularly in the field of VR. They emphasise what they perceive as an increasing focus on logging and assurance procedures, with less attention being paid to the individual outcomes of rehabilitants and their needs. An interviewed provider also points out that there should be more developments in Austria regarding the EU-wide recognition of lower-skilled qualifications of staff. Austria has introduced a National Qualification Framework (NQR), based on the recommendations of the EU to establish a common European reference framework for different qualifications levels. However, currently, this recognition does not extend to lower-level qualifications in Austria, which according to the interviewee, can undermine the occupational integration of PwDs in particular.[43] As PwDs are more likely to obtain lower-level qualifications, which include those obtained through VR, their mobility

[35] Wirtschaftskammer Österreich. 2020. *Gesetzliche Auswahlkriterien für Kommissionsmitglieder bei Lehrabschlussprüfungen*. Available: https://www.wko.at/service/ooe/bildung-lehre/Gesetzliche_Auswahlkriterien_fuer_Kommissionsmitglieder_be.html
[36] Qualität in der Lehre. 2016. *Lehrlingsausbildung in Österreich*. Available: https://www.qualitaet-lehre.at/duale-berufsbildung/lehrlingsausbildung-in-oesterreich/
[37] Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz. 2020. p. 47
[38] Ibid. p. 48.
[39] Bundesministerium Bildung, Wissenschaft und Forschung. 2019. *Jugendcoaching*. Available: https://www.bmbwf.gv.at/Themen/schule/beratung/psus/jugendcoaching.html
[40] https://www.neba.at/
[41] Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz. 2015. Richtlinie NEBA – Angebote. Available: https://www.sozialministerium.at/dam/jcr:589a48e8-a67c-4930-87ca-281221456827/Richtlinie%20Neba-Angebote_BMSGPK.pdf
[42] NEBA. Anbieter/innen. Available: https://www.neba.at/anbieter-innen
[43] Nationale Koordinierungsstelle für den NQR in Österreich. *NQR-Zuordnungen*. Available: https://www.qualifikationsregister.at/nqr-register/nqr-zuordnungen/

across the EU is limited if the NQR does not extend to their qualifications. The interviewed provider states that they are currently implementing a project which seeks to extend the NQR to lower-level qualifications.

Role of voluntary quality systems

Although it is not mandatory for providers of VR to hold quality certifications, the use of voluntary quality frameworks is widespread. The most frequently used frameworks are ISO and the European Foundation for Quality Management (EFQM). An example regarding the use of EFQM is the Public Employment Service, that has been applying the EFQM model as framework for its management system since 1999 and was awarded the certification 'Recognized for Excellence 5 Star' by the EFQM in 2019.[44] Other interviewed providers name the EFQM as an important basis from which to draw improvements for their own systems of quality management. Regarding the use of ISO, the BBRZ in 1992 was the first institution for vocational rehabilitation in Europe to be certified according to the criteria of ISO 9001.[45] Moreover, through training certification as 'Process Manager in Vocational Rehabilitation', BBRZ staff members have specialised knowledge, certified through ISO 17024. Based on interviews, providers do not use the European Quality in Social Services (EQUASS) framework and are unaware of it.

When asked for the reasons for using voluntary quality systems such as ISO, providers in interviews emphasise the importance of its guidelines to the continuous improvement of their own practices as well as external recognition, which increases their organisations' reputation and which is seen as advantageous when obtaining contracts and funding for projects. The EFQM is noted as providing the most far-reaching and explicit guidelines (more so than ISO) in respect to quality management. Regulators and providers are unfamiliar with the European Pillar of Social Rights (EPSR) or the European Voluntary Quality Framework and generally do not perceive that these have an impact on VR quality or regulation in Austria. However, interviewed regulators and providers point to the European Disability Strategy on the basis of the United Nations Convention on the Rights of Persons with Disabilities as providing guidelines for the development of national frameworks related to PwDs and employment. Examples of such frameworks are the Austrian National Disability Action Plan 2012-2020 which also supports the objectives and content of the EU Disability Strategy 2010-2020.[46]

Interview List

Service Provider / Regulator	Interviewee	Organisation & Department	Designation	Date of Interview
Provider	Manfred Herbst manfred.herbst@bbrz.at	Vocational Training and Rehabilitation Centre (BBRZ)	Quality development ; Coordinates quality management	09.11.2020

[44] Quality Austria. 2019. *Arbeitsmarktservice Österreich*. Available: https://www.staatspreis.com/exzellente-unternehmen/ams/
[45] Egger-Subotitsch et al. 2015. p. 34.
[46] Ibid. p. 12.

			in the BBRZ	
Regulator	Uli Rebhandl ulrike.rebhandl@sozialministerium.at	Federal Ministry of Social Affairs, Health, Care and Consumer Protection (BMASK)	Head of sub-division IV/A/6 for the promotion of professional participation of PwD	12.11.2020
Provider	Ulli Utri ulrike.utri@chanceb.at	Chance B	Quality Manager	18.11.2020

Croatia Case Study
Quality Regulations, Requirements, and Trends in Vocational Rehabilitation

At a glance

- *Since 2015 four governmental vocational rehabilitation centers have been responsible for the delivery of VR services. However, some of the VR services are provided by sheltered workshops.*
- *The past five years have marked a governmental effort to create a more standardised system of vocational rehabilitation and employment of PwDs.*
- *European-level benchmarks for social service quality are inserted into the Croatian legislation.*
- *Service providers are not obliged to have any external certifications; however, most sheltered workshops hold ISO 9000.*
- *All interviewees sustain that there is a market for EQUASS in Croatia.*

Governance and provision of VR services

The key players in the delivery and oversight of vocational rehabilitation services in Croatia are: **Ministry of Labour, Pension System, Family and Social Policy,** which oversees the delivery of social services, including vocational rehabilitation;

- **Institute for Expertise, Vocational Rehabilitation and Employment of Persons with Disabilities** (the Institute)[47], responsible for the coordination of professional development in the field and develops standards for vocational rehabilitation services;
- **Four vocational rehabilitation centers (VR centers), created by the state in** Zagreb, Rijeka, Split, and Osijek and governed by the **Ministry of Labour, Pension System, Family, and Social Policy**. These centers seek to "train persons with disabilities systematically and in line with the labor market requirements, as well as to provide professional support to employers when recruiting persons with disabilities."[48] These centers are contracted by different state organisations (such as the Pension Fund) or private employers to evaluate the needs of PwDs and certify their disability, or help them retrain and go back to the labour market.
- **Sheltered workshops,** *de jure* are not delivering VR. However, given the lack of capacities in the vocational rehabilitation centers, *de facto*, some sheltered workshops are offering some VR activities as a part of their work integration programs.

[47] Zavod za vještačenje, profesionalnu rehabilitaciju i zapošljavanje osoba s invaliditetom, https://www.zosi.hr/
[48] The Government of the Republic of Croatia (2017) National Strategy for Equalization of Opportunities for Persons with Disabilities 2017 - 2020 , p. 75 < https://www.un.org/development/desa/disabilities/wp-content/uploads/sites/15/2019/10/Croatia_National-Strategy-of-Equalization-of-Opportunities-for-Persons-with-Disabilities.pdf>

Pursuant to the Final Recommendations of the UN Committee on the Rights of Persons with Disabilities (2015), the *Croatian National Strategy for Equalization of Opportunities for Persons with Disabilities 2017-2020* (*further - National Strategy*)[49] puts a particular emphasis on vocational rehabilitation measures, as well as on the measures for including women with disabilities into the labour market[50].

The key documents regulating Vocational Rehabilitation in Croatia are the already mentioned *National Strategy,* as well as the *Act on Vocational Rehabilitation and Employment of Persons with Disabilities (hereafter – the Act)*[51]*, and the Regulation on Vocational Rehabilitation and Vocational Rehabilitation Centers for Persons with Disabilities (hereafter - the Regulation)*[52] (other relevant acts listed in Box 1).

Box 1: some legislative acts, relevant for VR

- Regulation on incentives for employment of persons with disabilities (Official Gazette No. 75/18, 120/18)
- Regulation on sheltered workshops and integrative workshops for Employment of persons with disabilities (Official Gazette No. 75/18) –
- Regulation on setting quotas for employment of persons with disabilities (Official Gazette No. 75/18, 120/18, 37/20)
- Regulation on the content and method of keeping the record of employed persons with disabilities (Official Gazette No. 75/18)

According to the *Act*, vocational rehabilitation includes the following measures and activities:

1. Participation in determining remaining working and general abilities;
2. Vocational information, counselling, and evaluation of vocational opportunities;
3. Analysis of the labour market, employment opportunities, and labour participation;
4. Assessment of the possibility of conducting, developing, and improving vocational training programs;
5. Vocational training, education, and programs for the maintenance and improvement of working and working-social skills and competences in the pre-employment period;
6. Informing and advising on the application of various efficient learning and working techniques;
7. Individual and collective programmes to improve employment and social inclusion in the community;
8. Informing and advising on the possibilities offered by assistive technology in learning and working;
9. Development of motivation and training of persons with disabilities in the use of the selected technology;
10. Technical assistance and support in the implementation of professional rehabilitation services, monitoring and evaluation of professional rehabilitation results;
11. Information and support regarding sources of funding[53].

According to the Act*,* vocational rehabilitation is carried out by vocational rehabilitation establishments, secondary schools, or other legal persons that meet training criteria. Currently, services are provided by the VR Centers independently or in cooperation with other legal entities. Since 2018, the VR centers are supposed to deliver the following services:

[49] The Government of the Republic of Croatia (2017) National Strategy for Equalization of Opportunities for Persons with Disabilities 2017 - 2020 , p. 75 < https://www.un.org/development/desa/disabilities/wp-content/uploads/sites/15/2019/10/Croatia_National-Strategy-of-Equalization-of-Opportunities-for-Persons-with-Disabilities.pdf>

[50] The Government of the Republic of Croatia (2017) National Strategy for Equalization of Opportunities for Persons with Disabilities 2017 - 2020 p. 75 < https://www.un.org/development/desa/disabilities/wp-content/uploads/sites/15/2019/10/Croatia_National-Strategy-of-Equalization-of-Opportunities-for-Persons-with-Disabilities.pdf>

[51] Zakon o profesionalnoj rehabilitaciji i zapošljavanju osoba s invaliditetom, <https://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=62769&p_country=HRV&p_count=631>

[52] Pravilnik o profesionalnoj rehabilitaciji i centrima za profesionalnu rehabilitaciju osoba s invaliditetom <https://narodne-novine.nn.hr/clanci/sluzbeni/2018_08_75_1548.html>

[53] Zakon o profesionalnoj rehabilitaciji i zapošljavanju osoba s invaliditetom, <https://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=62769&p_country=HRV&p_count=631>

1. Rehabilitation assessment of the level of working ability, knowledge, skills, work habits, and professional interests;
2. Assistance in overcoming various difficulties that prevent inclusion in further vocational rehabilitation services;
3. Creating perspectives (a set of structured activities and methods which help the user in choosing the most appropriate education program. It is carried out after the rehabilitation assessment service and consists of: general professional orientation, occupation analysis and finding an occupation.)
4. Analysis of a specific workplace and work environment;
5. Professional support and monitoring in a specific workplace and work environment;
6. Development of a plan for the adaptation of the workplace and the working environment, and the necessary adjustments of equipment and means of work;
7. Education, training or advanced training with a shorter educational program;
8. Professional support and monitoring during education and training or advanced training with a shorter educational program;
9. Strengthening work potentials and professional competencies (work center);
10. Strengthening work potentials and professional competencies (virtual workshop);
11. Performance appraisal;
12. On-the-job training.[54]

So far, for two of them – *strengthening work potential and professional competences (Work center)* and *strengthening work potential and professional competences (Virtual workshop)* – the VR Centers hire sheltered workshops as subcontractors. Hence, some rehabilitation services are still implemented in sheltered workshops, despite not having a right to do that *de jure*. One interviewed provider sustains that this situation has a negative effect on the VR situation in the country. However, another observes that even before the establishment of the VR centers, sheltered workshops offered only a small part of VR services, and, in general, their offer was limited. Currently, the government sees as a priority strengthening the capacities (training professionals, improving the premises) of the VR centers in order for them to be able to deliver all the services themselves.

As claimed by the interviewed regulator, until 2015, vocational rehabilitation in Croatia was conducted only sporadically. This was done by the Pension fund, the Croatian Employment Service, and two vocational rehabilitation centers. Some sheltered workshops also provided on-the-job training. The adoption of the Act in 2013 and the establishment of the governmental VR centers reflected the efforts to create a "more stimulating employment system of persons with disabilities."[55] At the same time, to unify the quality of VR, the Institute adopted the *Standards of Vocational Rehabilitation services (hereafter – the Standards*). Since 2018, these *Standards* have been an integral part of the *Regulation*. Hence, the past five years **marked an attempt to create a more coherent system of vocational rehabilitation and create uniform standards for its delivery**. This may also be related to the growing demands of the clients. In the words of one provider, the clients demand more varied services, and this is reflected in the regulations: the Standards published in 2015 listed 10 services to be delivered by the VR centers; while in 2018, this number increased to 12 (adding *on-the-job training* and *education, training or advanced training with a shorter educational program*). This change also reflected the overall governments' attempts to increase the employability of the PwDs.

[54] Standardi usluga profesionalne rehabilitacije (2018 https://www.zosi.hr/docs/standardi_usluga_profesionalne_rehabilitacije_2018_2.pdf

[55] The Government of the Republic of Croatia (2017) National Strategy for Equalization of Opportunities for Persons with Disabilities 2017 - 2020 p. 75 < https://www.un.org/development/desa/disabilities/wp-content/uploads/sites/15/2019/10/Croatia_National-Strategy-of-Equalization-of-Opportunities-for-Persons-with-Disabilities.pdf>

Regulation of VR services and their quality / Quality trends

Based on *the Act*, an establishment delivering VR must fulfill some requirements regarding space and equipment. Meanwhile, *the Regulation* sets the overall quality standards for vocational rehabilitation. Article 11 of the document establishes the principles of the implementation of measures and activities of vocational rehabilitation; the VR center (and sheltered workshop) is obliged to apply the following principles:

- interdisciplinary approach
- individual approach to people with disabilities
- respect for the privacy of persons with disabilities
- impartiality in assessment and evaluation procedures
- ensuring active participation and involvement of users
- adaptation of the procedure to the level of understanding of persons with disabilities
- cost-effectiveness of the procedure.

Article 13 of the same document foresees that vocational rehabilitation services should be provided in the manner and to the extent determined by *the Standards of Vocational Rehabilitation services (hereafter – the Standards*). These Standards, elaborated by the Institute with input from the VR providers, refer to the principles of *European Quality in Rehabilitation Mark*[56] (preceding system to EQUASS, principles presented in box 2) and include an ethics code for the service providers in the field of vocational rehabilitation, employment and social inclusion of persons with disabilities. They set requirements for the professional teams delivering rehabilitation services, establishing its minimum composition: a social worker and a psychologist. The rules also require that each user is assigned a case manager and that VR takes place based on the individual plan.

Moreover, the Standards foresee a triple evaluation that must be conducted by VR centers (and sheltered workshops in case some part of VR is taking there):

Box 3: Principles guiding the Standards (EQRM)

1. Leading role of providers (in terms of good practices, innovation etc.)

2. Protection and promotion of rights of beneficiaries

3. Ethics

4. Partnership with different stakeholders

5. Participation and involvement of PwDs in all levels within the organisation and community.

6. Turning to the individual, involving them into the process of VR.

7. Complexity of services

8. Focus on results

9. Continuous improvement

- The **Expert team should** evaluate each user and develop a proper VR plan. The implementation of this plan is evaluated at the end of the VR process. The final report should be submitted to the client.
- The **beneficiary-level evaluation** is carried out by the case manager and the beneficiaries themselves, as they are required to assess how satisfied they are with the process of VR, goals, and their progress. The provider must ensure an anonymous evaluation.
- **Evaluation at the level of the entity that ordered the VR service** - the satisfaction of the procuring entity is evaluated once a year. For that purpose, a specially constructed evaluation instrument is used, which must be submitted by the provider of VR to the procuring entities. The evaluation includes an overview of the achieved results, a

[56] a previous version of European Quality in Social Services, < https://www.electio2014.eu/european-quality-social-services/>

cooperation analysis, and recommendations for possible changes.[57]

The vocational rehabilitation provider is obliged to evaluate the rehabilitation process's effectiveness at all levels at least once a year (by no later than March 1 for the previous year), report to the Institute, and take appropriate measures based on these results. Following the Standards, both interviewed providers measure the same quality dimensions of their services:

- number of PWDs who have successfully completed vocational rehabilitation (i.e. found a job)
- number of PWDs who were employed after successfully completing vocational rehabilitation
- number of PWDs who managed to keep their jobs after employment
- customer satisfaction index
- employer satisfaction index.

It is necessary to define clear, precise, unambiguous, measurable criteria for the quality of professional rehabilitation services, and to apply them systematically during the monitoring and evaluation of the results of the work of experts in this field.
Interviewed provider

VR providers report about the process to the Institute. One interviewed provider observes that the process of reporting is too complicated, **there is too much regulation and bureaucracy**. Both providers consider that current standards still do not adapt well to the VR activities "on the ground."

Moreover, both interviewed providers sustain that the quality of VR strongly depends on the expertise of providers, the organisation of their work, together with content and universality of quality criteria. Currently, at all levels of evaluation, providers can use their own methodology "until the adoption of a unique evaluation methodology and instruments by the Institute[58]." **Nonetheless, this methodology is not yet created.** As observed by one interviewed provider, current regulations still lack clear and specific quality/evaluation criteria. Moreover, their monitoring and evaluation are not sufficiently clearly defined. Another provider sustains that the quality standards are actually quite clear, however, the VR centers are lacking capacities to provide a full package of services, relying instead on the sheltered workshops, who have longer experience in vocational rehabilitation.

European-level quality principles are included in Croatian legislation. As mentioned, the Standards refer to the European Quality in Rehabilitation Mark. Moreover, all interviewed providers and a regulator confirm that they are familiar with the European Pillar of Social Rights (EPSR). They are reflected in the existing Croatian legislature, especially important being the category on equal opportunities and access to the labor market. As observed by one interviewed provider, the guidance of EPSR also is important in the process of elaboration of new forms of VR and employment models for PwDs.

Role of voluntary quality systems

Currently, the providers of VR are not asked to hold any quality certifications. Nonetheless, the VR center in Zagreb and **the majority of sheltered workshops have ISO 9000 certifications**. The reasons for choosing ISO 9000 are related to the provider's wish to improve the delivery of services and the overall popularity of ISO certifications in Croatia. In the words of one interviewed provider, "people know what ISO is; they know that if services have it, they are

[57] Response of the Croatian Authorities regarding the Human Rights Council resolution 37/22 on the rights ohttps://www.ohchr.org/Documents/Issues/Disability/Article26/Croatia.docxf of persons with disabilities persons with disabilities
[58] Standardi usluga profesionalne rehabilitacije (2018), p. 4 https://www.zosi.hr/docs/standardi_usluga_profesionalne_rehabilitacije_2018_2.pdf

good." Another provider also observes that ISO has many modalities and, in some aspects, is more comprehensive than other certificates.

Other certifications such as EQUASS have not gained popularity in Croatia, despite the fact that all interviewed providers know of it. Moreover, both interviewed providers agree that it is more focused and, potentially, more suitable for VR services. One interviewed provider states that sheltered workshop professionals were willing to acquire EQUASS and make the necessary preparations. Their desire to obtain the certification is related to the wish to verify the existing internal quality and monitoring system. However, they lack approval and understanding from the management of organisations and national-level authorities. The interviewees indicate that the lack of popularity of EQUASS is due to the lack of knowledge among the public and lack of support from policymakers.

Both interviewed providers believe that there is a market for EQUASS in Croatia. They point out that what is needed is more and better information about EQUASS and its benefits at the decision-making level. At the same time, the interviewed regulator sustains that Croatia is considering applying for EQUASS certification after building the capacities of the VR centers.

Interview List

Service Provider / Regulator	Interviewee	Organisation & Department	Designation	Date of Interview
Provider	Darko Sobota <Darko.Sobota@cprz.hr>	The Center for Vocational Rehabilitation "Zagreb"	Rehabilitation technologist	10 26
Provider	Višnja Majsec <visnja.majsec-sobota@uriho.hr>	URIHO Zagreb, Institution for vocational rehabilitation and employment of persons with disabilities	Head of Department for Rehabilitation	11 06
Regulator	Zrinka Špoljarić <zrinka.spoljaric@mrms.hr>	Ministry of Labor and Pension System	Head of the Active Employment Policy Service	11 14

Czech Republic Case Study
Quality Regulations, Requirements and Trends in Vocational Rehabilitation

At a glance

- *Vocational rehabilitation (VR) for PWDs is regulated and mainly provided under employment policy and, in some cases, through social services.*
- *There are no quality standards specific to VR, but quality is ensured through:*
  - *General standards applicable to all social services.*
  - *Labour Office verifications and ministerial inspections.*
  - *Internal evaluation mechanisms of providers.*
  - *Local evaluation systems, used on a voluntary basis.*
- *Interviewees feel that the general quality standards and the monitoring/evaluation mechanisms are sufficient. However, they also point at the need to define VR-specific standards that can apply to all providers.*
- *There is awareness of European quality frameworks, but they do not play a major practical role. EU/UN principles, however, inform national legislation.*

Governance and provision of VR services

Vocational Rehabilitation (VR) in the Czech Republic is regulated by the Employment Act No. 435/2004.[59] Once a person with disability (PWD) requests support, after **prevocational rehabilitation need assessments** and **positive work recommendation** ("ergodiagnostic")[60] by medical specialists, they can be recommended to enter a VR programme; based on the severity of disability and the mental/physical ability of the PWD, a **personal occupational rehabilitation plan** is defined in collaboration between the PWD and the Labour Office.[61] VR services can include:

- **counselling activities** to help users choose a profession, including job clubs and psychodiagnostics for further evaluation of work potential;
- **job placement activities** and those aimed at **maintaining and changing jobs**, such as consultation with a psychologist, individual counselling, employment mediation;
- **job adjustment interventions** to adapt job places to PWDs' needs, such as contributions to employer to create a job place, or to help employers cover the costs of a work assistant;
- **qualifications/competence development activities,** such as vocational training and retraining.[62]

These activities are funded by the Labour Office, which can contract their provision to NGOs or private companies with a tender for each activity and client.[63]

VR is the responsibility of the **Ministry of Labour and Social Affairs (MPSV)**, which defines criteria for employment of PWDs. Services are delivered by around 200 **Labour Office** sections, which also define the individual VR plans, and their **contracted NGOs/private companies** (some of which specialise in narrower areas of disability), including ergodiagnostic centres, educational or counselling facilities.[64] In practice, **providers' coverage (public and private) varies massively by region.**[65] A high-ranking Labour Office official notes that in peripheral areas (smaller towns in particular), few contractors are available; in particular, NGOs tend to concentrate mainly in cities and larger towns.[66]

NGOs can also provide PWDs with supportive, pre-VR activities (such as help developing social skills needed for work), or provide help to PWDs by setting up "labour assistants" programmes. Part of NGOs' work, such as social skills building, is classified as **social rehabilitation** (to which the Labour Office can refer PWDs when they are not yet ready for VR) in Czech law, and fits in the

[59] Interview with high-ranking staffers of the Labour Market Department, MPSV (Ministry of Labour and Social Affairs of the Czech Republic / Ministerstvo práce a sociálních věcí) (7 Nov 2020)

[60] "Ergodiagnostics" is a term used extensively in the Czech Republic to refer to diagnostic procedures aimed at defining the impact of disabilities on work potential. See: https://www.prolekare.cz/en/journals/medical-revision/2019-3-19/ergodiagnostics-as-a-constituent-of-working-and-social-rehabilitation-121045

[61] Interview with high-ranking staffers of the Labour Market Department, MPSV; Svestkova, O., Sladkova, P., System of prevocational rehabilitation in the Czech Republic; http://www.euroblind.org/convention/article-27/czech-republic#9; The Labour Office of the Czech Republic falls under the oversight of the MPSV.

[62] Interview with Petr Džambasov, Head of Social Services, Association of Vocational Rehabilitation of the Czech Republic, 30 Oct 2020; Interview with high-ranking staffers of the Labour Market Department, MPSV.

[63] https://www.mpsv.cz/web/en/disability; Interview with Petr Džambasov, Association of Vocational Rehabilitation of the Czech Republic;
https://cumulus.cedefop.europa.eu/files/vetelib/2019/Vocational_Education_Training_Europe_Czech_Republic_2018_Cedefop_ReferNet.pdf

[64] Interview with high-ranking staffers of the Labour Market Department, MPSV; http://www.euroblind.org/convention/article-27/czech-republic#9;
https://cumulus.cedefop.europa.eu/files/vetelib/2019/Vocational_Education_Training_Europe_Czech_Republic_2018_Cedefop_ReferNet.pdf p. 16

[65] http://kl55z182axe1ezol670tdk15.wpengine.netdna-cdn.com/files/2015/02/Kanova-Employment-in-Czech-Republic.pdf; http://www.euroblind.org/convention/article-27/czech-republic#9

[66] Interview with Jan Buba, Labor Office of the Czech Republic, General Directorate.

country's broader de-institutionalization objectives,[67] although in practice the difference between VR and social rehabilitation is blurred.

Following two nationwide projects in 2006-2008 and 2012-2014, authorities created 13 centres for **multidisciplinary diagnosis of psycho-sensory and motor functions** for the possibility of employment, defining standardized methodologies for assessing PWDs' health for VR.[68] Since Jan 2020, the MPSV and the Labour Office are also piloting new VR centres with the support of the European Social Fund,[69] and in collaboration with the Association of Vocational Rehabilitation of the Czech Republic.[70]

Regulation of VR Services and their quality

Act No. 134/2016, which regulates public tenders, sets qualification requirements to take part in tenders but does define criteria specific to VR.[71] In order to deliver services in VR, special authorisations are needed only for job-oriented **psychodiagnostics**, which requires psychodiagnostics certifications, **retraining**, which requires an accredited and licensed educational program granted by authorities depending on the field of study, and **employment mediation**, which requires the MPSV's authorization.[72]

The Social Services Act No. 108/2006 defines bureaucratic obligations for accreditation and sets **compulsory nation-wide quality standards for social services**. These must be followed in the provision of *social* rehabilitation;[73] private providers of VR are not bound to them, although they may apply these standards voluntarily.[74] There is however lack of consensus regarding the extent to which the quality standards from Act No. 108/2006 are followed: VR specialists note that when delivered by an NGO through a contract with the Labour Office, VR ceases to be considered a social service, and Act No. 108/2006 becomes unapplicable.[75] However, **in practice, some non-profit organisations still follow these standards**, since they consider vocational rehabilitation as a part of either social rehabilitation or socio-therapeutical workshops, which fall firmly within the scope of Act No. 108/2006's quality standards.[76]

The standards in Act No. 108/2006 focus primarily on **material, operational and human resources aspects**,[77] detailed in 15 criteria and 49 sub-criteria, 17 of which are considered fundamental: non-compliance can lead to the revocation of accreditation.[78] The key quality provisions require providers to:

- **set objectives, method, and planning of interventions**, defining mission, goals and target groups, and creating individual development plans;
- **guarantee the rights of users**, including **data protection**;
- follow rules on **service agreements and their negotiation**, including location and availability of services, and on the **handling of users' complaints**;

[67] Interview with Jan Buba, Labor Office of the Czech Republic, General Directorate (12 Nov 2020); Interview with Romana Belova, Slezska Diakonie; http://www.euroblind.org/convention/article-27/czech-republic#9
[68] Interview with high-ranking staffers of the Labour Market Department, MPSV. "Rehabilitation-Activation-Work" in 2006-2008 and "Regional networks of cooperation in occupational rehabilitation" in 2012-2014.
[69] Call: Operational Programme Employment (Social Innovation applicable in public administration).
[70] Interview with Petr Džambasov, Association of Vocational Rehabilitation of the Czech Republic.
[71] Interview with high-ranking staffers of the Labour Market Department, MPSV.
[72] Interview with Petr Džambasov, Association of Vocational Rehabilitation of the Czech Republic.
[73] Interview with Romana Belova, Slezska Diakonie, Petr Džambasov, Association of Vocational Rehabilitation of the Czech Republic, and high-ranking staffers of the Labour Market Department, MPSV.
[74] Email exchange with Petr Džambasov, Association of Vocational Rehabilitation of the Czech Republic (25 Nov 2020).
[75] Email exchange with Petr Džambasov, Association of Vocational Rehabilitation of the Czech Republic (1 Dec 2020).
[76] Interview with Romana Belova, Slezska Diakonie.
[77] Interview with high-ranking staffers of the Labour Market Department, MPSV.
[78] Interview with Petr Džambasov, Association of Vocational Rehabilitation of the Czech Republic.

- abide by **HR, organizational and management requirements**, such as professional qualification, minimum size of facilities, working conditions;
- **hold regular evaluation** and
- establish mechanisms to **monitor and increase the quality of services** provided.[79]

Quality monitoring and enforcement

Providers and the Labour Office conduct **internal quality controls and evaluations;** the Labour Office also conducts **regular monitoring visits of providers**, based on the length of the VR programme contracted: 1-2 controls for programmes of up to three months; 2-3 controls for those of up to 6 months; up to 4 controls for year-long ones.[80] The MPSV in turn carries out inspections of the Labour Office.[81] Labour Office services are regulated based on the individual plan of VR, which also establishes time frames for interventions and procedures to assess their effectiveness via **regular and final evaluations** in collaboration with the **user and/or the providers who worked with the user**, to measure achieved results or define additional goals.[82] Key performance indicators checks are also conducted on Labour Office staff, taking into account the PWDs' feedback when possible.[83]

A high-ranking staffer of a large NGO notes that **quality criteria for private providers are sufficient**, but some will only fulfil the minimum requirements to continue working, while other find ways to fulfil criteria "on paper", but not in practice. An **inspectorate of the MPSV** tries to conduct quality monitoring activities on providers of social rehabilitation, but capacity is insufficient: the interviewee notes that the Inspectorate is only able to monitor a single-digit percentage of all the social services their organisation provides.[84]

Even though the Labour Office conducts quality checks, commitment to quality beyond the minimum legal requirements **depends heavily on the initiative of providers themselves**; a large NGO typically organises regular monitoring of the client's progress and development plans (also to make sure that they remain aligned with the mission of the organization), yearly reassessments of the client's satisfaction and complaints, and a yearly re-evaluation of the client's training needs. **Regular internal evaluations** are conducted within the organisations, and **unannounced visits to local facilities** by staffers of the central offices are also envisaged to check the fulfilment of the national criteria, plus additional internal ones, among which to determine whether the communication done is suited for the target who need services, whether the facility is planning effectively and regularly together with the user, and whether recording and reporting requirements of planned activities are fulfilled.[85] Private providers employ similar procedures to monitor quality and key performance indicators, using **user satisfaction evaluation questionnaires** (which can also be anonymous), complaint management, interim and final evaluations of project-based work, and regular evaluation meetings between social service providers and municipalities.[86]

[79] Interview with high-ranking staffers of the Labour Market Department, MPSV, and interview with Romana Belova, Slezska Diakonie.
[80] Interviews with Jan Buba, Labor Office of the Czech Republic, General Directorate; interview with Petr Džambasov, Association of Vocational Rehabilitation of the Czech Republic; interview with high-ranking staffers of the Labour Market Department, MPSV;
[81] Follow-up exchange with high-ranking staffers of the Labour Market Department, MPSV (25 Nov 2020).
[82] Interview with high-ranking staffers of the Labour Market Department, MPSV.
[83] Interview with Jan Buba, Labor Office of the Czech Republic, General Directorate.
[84] Interview with Romana Belova, Slezska Diakonie.
[85] Interview with Romana Belova, Slezska Diakonie.
[86] Interview with Petr Džambasov, Association of Vocational Rehabilitation of the Czech Republic.

Key dimensions of quality for providers and regulators

Regulators and providers consider various criteria as important in ensuring VR quality:

- The Ministry sets timeliness, complexity of intervention, continuity, coordination, availability of services, individual-based and psychological approach, regular and final multidisciplinary assessment of intervention, and cooperation among providers as key areas of quality: these principles inform the Ministry's planning and its oversight and monitoring of the Labour Office's performance.[87]
- Labour Offices point at the very high **job application success rates** and **job retention** as key indicators of quality of services.[88] Evaluations of VR interventions against initial objectives follow a **goal-oriented approach** that sees **individual results** and success of **personalized rehabilitation paths** as key quality indicators.[89]
- Some private providers see the **participation of users** in the assessment of their own progress as a key step in ensuring quality, but this depends on the initiative of individual organisations. Representatives of a large national association of providers comment that the country needs to expand availability, improve timeliness, and strengthen cooperation between individual providers.[90]
- For NGOs, cooperation with authorities' work in the identification of needs and the planning of interventions is seen as key to guarantee quality. Authorities expect **providers to liaise with municipalities** and cooperate with local authorities to organise the social services necessary in their territory, contributing to **define local communities' needs**, relating them back to the authorities, and taking part in the community planning to address them.[91]

Current quality trends

A number of distinctive trends can be identified in VR services:

- Authorities (i.e. the Ministry and the Labour Office) see VR as an **individual-based process** aimed at functional evaluation of work potential of the PWD, requiring **personalised planning** of rehabilitation process and a **multidisciplinary approach** during planning and implementation. They seek to **professionalise services**, introduce a coordination system for rehabilitation services, strengthen counselling services and improve training of employees of organizations working on the integration of PWD in the labor market.[92]
- The Labour Office, in turn, seeks to address gaps in staff training in smaller, local sections, where staffers are not fully informed about VR services that the Offices and their contractors should offer.[93] **New certification strategies are being developed** for VR centres, in a collaboration initiative between the Labour Office and providers associations,[94] but this process is in its pilot phase.
- In terms of **users' needs**, personalised planning allows authorities to align individual PWD's hopes with what authorities can provide.[95] Authorities cannot generalize about PWDs' general perceptions and expectations,[96] but *private* providers point at emerging trends that see PWDs gaining **more consciousness of their rights** and expect **more professional, individual support** by social workers who can treat their needs more holistically, beyond the label of physical or mental disability.

[87] Interview with high-ranking staffers of the Labour Market Department, MPSV.
[88] In 2018, out of 620 vocational rehabilitation cases followed by the Offices, around 80-83% ended with PWD being hired; in 2019 around 440 cases, resulted in a success rate of around 75-80%. The Offices also follow up in 6 months and so far registered only a 15% dropout rate (Interview with Jan Buba, Labor Office of the Czech Republic, General Directorate).
[89] Interview with high-ranking staffers of the Labour Market Department, MPSV.
[90] Interview with Petr Džambasov, Association of Vocational Rehabilitation of the Czech Republic.
[91] Interview with Romana Belova, Slezska Diakonie.
[92] Interview with high-ranking staffers of the Labour Market Department, MPSV
[93] Interview with Jan Buba, Labor Office of the Czech Republic, General Directorate.
[94] Interview with Petr Džambasov, Association of Vocational Rehabilitation of the Czech Republic.
[95] Interview with Jan Buba, Labor Office of the Czech Republic, General Directorate.
[96] Interview with high-ranking staffers of the Labour Market Department, MPSV

- NGOs are shifting from providing any kind of help to PWDs to access the job market to addressing a **complexity of needs** to help integration, such as independent living and travel.[97] They seek to build new community-based services for PWDs with mental health issues to speed up deinstitutionalisation, and make the approach to VR more multidisciplinary, integrating healthcare, social services and social work in coordination with local authorities to better fulfil individual development plans.[98]

Role of voluntary quality systems

Providers' knowledge and use of voluntary quality frameworks

Knowledge of voluntary frameworks is limited: EQF (European Qualifications Framework) and EQUAVET (European Quality Assurance in Vocational Education and Training) criteria are used only in vocational *education,*[99] while mentions of EQUASS specific to VR are scarce in recent official documents.[100] Authorities do not monitor EQUASS compliance among providers and contractors.[101] **The Labour Office recently became interested in EQUASS**, which it feels it could be more relevant and tailored to VR providers than ISO certifications, but the COVID-19 crisis has put on hold work for new accreditations.[102] Even **large NGOs that know of EQUASS lack practical information** about it.[103] The main national association of providers is not aware of EQUASS.[104]

Some large NGOs use ISO certifications, as they help them assess their operations more objectively; other providers mention ISO 9001 and E-Qalin (a quality management system devised with EU funding and based on training of internal staff to use an organisational development approach in quality management to ensure involvement and participation of all relevant stakeholders),[105] but neither is required by law or internal regulations and thus depends on individual initiative.[106] Recommendations from authorities would be the main drive to acquire certifications, but at the moment such drive is absent: a Labour Office official notes that despite encouragement to do so, private contractors rarely use ISO, as they know that the Office will conduct periodic monitoring and consider it sufficient to ensure quality; in turn, favouring providers with ISO qualifications in public tender is not feasible for the Labour Office as doing so would exclude too many candidates.[107]

Voluntary quality controls include independent evaluation by the Association of Social Service Providers (APSS ČR, the country's largest professional organisation of social care providers).[108] In 2011 it introduced the "Quality mark in social services" (ZQ) system of assessment, a mechanism of external certification for providers of social services, based on the awarding of "stars" for quality of services.[109] ZQ evaluates provision of social services from the user's point of view. **Some providers ensure additional quality checks by having users participate** in evaluation of their

[97] Interview with Romana Belova, Slezska Diakonie.
[98] Interview with Romana Belova, Slezska Diakonie, and with Petr Džambasov, Association of Vocational Rehabilitation of the Czech Republic.
[99] European Commission (2016), Study on higher Vocational Education and Training in the EU, p. 43; https://cumulus.cedefop.europa.eu/files/vetelib/2019/Vocational_Education_Training_Europe_Czech_Republic_2018_Cedefop_ReferNet.pdf p 27 (p. 25 in internal page numbering of the document)
[100] https://www.mpsv.cz/documents/625317/625839/Anotace_Forum.pdf/c3356068-c720-a28e-7a63-bb539622febd; https://equass.be/index.php/activities/consultancy-proj/projects/past-projects/4quality
[101] Interview with high-ranking staffers of the Labour Market Department, MPSV.
[102] Interview with Jan Buba, Labor Office of the Czech Republic, General Directorate.
[103] Interview with Romana Belova, Slezska Diakonie.
[104] Interview with Petr Džambasov, Association of Vocational Rehabilitation of the Czech Republic.
[105] Interview with Petr Džambasov, Association of Vocational Rehabilitation of the Czech Republic; https://www.e-qalin.net/en/en-ueber-e-qalin/; http://interlinks.euro.centre.org/model/example/e-qalin
[106] Interview with Romana Belova, Slezska Diakonie.
[107] Interview with Jan Buba, Labor Office of the Czech Republic, General Directorate.
[108] https://hcn.eu/partner/association-of-social-care-providers-of-the-czech-republic-apss-cr/
[109] Follow-up exchange with Petr Džambasov, Association of Vocational Rehabilitation of the Czech Republic (22 Nov 2020).

own development and progress, but there is no methodological support and no clear criteria to do that.[110] Interviewees note that national or international voluntary frameworks are rarely used, but there is interest among providers in building a viable quality control framework in the absence of an official, VR-specific one.[111]

European quality systems impact on quality of VR

Providers are aware of European standards and principles, except for the Voluntary European Quality Framework for Social Services. European principles such as the European Pillar of Social Rights, as well as the UN Convention on the Rights of Persons with Disabilities (ratified in 2017) are **key in informing the national quality criteria**,[112] although their principles are not binding and are relevant for *social* rehabilitation rather than VR.[113] Some providers do not think European standards and principles help much beyond serving as **general orientation and inspiration for quality**, and as a negotiation tool when discussing funding with the government, lobby to improve the national legal framework, or in applications for EU funds.[114]

Interview List

Service Provider / Regulator	Interviewee	Organisation & Department	Designation	Date of Interview
Provider (non-profit)	Romana Belova	Slezka diakonie	Deputy Director for Social Work	29 Oct 2020
Institutional provider, local-level regulator, and monitoring authority.	Jan Buba	Labor Office of the Czech Republic, General Directorate	Mediation and Advisory Department Manager	12 Nov 2020
Association of private providers	Petr Džambasov	Association of Vocational Rehabilitation of the Czech Republic	Head of Social Services	30 Oct 2020
Regulator and monitoring authority	Staffers, Labour Market Department, Ministry of Labour and Social Affairs of the Czech Republic (Respondents asked to be kept anonymous)		Various decision-making roles	7 Nov 2020

[110] Interview with Romana Belova, Slezska Diakonie.
[111] Interview with Petr Džambasov, Association of Vocational Rehabilitation of the Czech Republic.
[112] https://www.cedefop.europa.eu/files/2207_en.pdf; Interview with Petr Džambasov, Association of Vocational Rehabilitation of the Czech Republic;
[113] Interview with Jan Buba, Labor Office of the Czech Republic, General Directorate, and interview with high-ranking staffers of the Labour Market Department, MPSV.
[114] Interview with Romana Belova, Slezska Diakonie.

Finland Case Study
Quality Regulations, Requirements and Trends in Vocational Rehabilitation

At a glance

- *Vocational rehabilitation in Finland is mainly organised by the Social Insurance Institution of Finland (Kela) and pension / insurance companies.*
- *Quality of VR services is ensured in every step of the VR process, from national legislation to standards set down by institutions like Kela, to service providers' quality management systems.*
- *Voluntary certifications such as EQUASS are not known and not used, but its principles already form part of the Finnish social security legislation and guidelines on good rehabilitation.*

Governance and provision of VR services

Vocational rehabilitation (VR) in Finland falls under the competence of multiple actors.[115] It is organised mainly in the following manner:

- Long-term unemployed persons are taken care of by the Social Insurance Institution of Finland (Kela),[116] since they do not belong to the earnings-related pension system. They are usually referred to Kela (one of the most important providers of VR) through the unemployment centre, social services or primary health care system;
- If the person is employed (the majority of VR clients), the obligation to provide VR falls on the earnings-related pension system, and – in the case of occupational accidents and diseases – on non-life insurance companies[117];
- If the person is involved in an accident (traffic / at work), the insurance company provides medical and vocational rehabilitation services.[118]

The **healthcare system** in Finland provides very little vocational rehabilitation: it mostly provides **medical rehabilitation**.

The majority of rehabilitation services are free of charge for the rehabilitee, although a client fee or a fixed non-reimbursable payment may be charged to the rehabilitee for some services such as therapies and care periods at rehabilitation facilities.[119] VR is provided to:

- support and enhance ability to work
- prevent rehabilitees' incapacity for work[120]
- prevent individuals' early retirement for disability pension and ensure that workers stay in the workforce as long as possible[121]
- improve their ability to work if their illness / disability poses a risk of incapacity for work
- persons whose ability to work or study has deteriorated
- persons who have an illness / impairment that makes it difficult to choose an occupation / cope with job demands
- young people if their functional capacity has deteriorated (they do not need to have a diagnosis.)[122]

[115] Sukula, S. and Harju-Kolkka, K. 2020. Interview with author.
[116] https://www.kela.fi
[117] Sukula, S. and Harju-Kolkka, K. 2020. Interview with author.
[118] Löfstedt, J. 2020. Interview with author.
[119] Ministry of Social Affairs and Health. n.d. *Rehabilitation*. Available: https://stm.fi/en/rehabilitation
[120] Sukula, S. and Harju-Kolkka, K. 2020. Interview with author.
[121] Reijonen, S. 2020. Interview with author.

VR is organised (i.e. arranged and supported) mainly by the following entities:

- Kela, the Social Insurance Institution of Finland
- earnings-related pension providers (e.g. Varma[123])
- non-life insurance companies[124] (occupational accidents and diseases)
- municipal social services.

The first two also pay rehabilitation allowances in the form of income support. If a person has an illness or a disability, they can apply with **Kela** (which is a government agency) to receive benefits to undergo training or study.[125] Some of the rehabilitation measures supported by Kela include VR supporting integration into work and VR courses.[126] Kela is an independent social security institution supervised by the Finnish Parliament. The Ministry of Social Affairs and Health[127] is responsible for developing legislation within its administrative sector (including VR) and does not have direct authority over Kela and its operations.[128]

Municipalities take care of the long term unemployed / youngsters unlikely to become employed. They organise **rehabilitative work**[129] (a municipal social welfare service for unemployed jobseekers[130]) which is part of **social rehabilitation** (i.e. only partly VR). After the clients have participated in the municipality activity, they can move on to a vocational rehabilitation course organised by Kela.[131]

Those who need multidisciplinary services to be able to be re-employed (most often the long-term unemployed who have both social issues and work capacity challenges due to health problems, and often alcohol abuse) are taken care of be the **LA FO S centres**, a joint service with Employment and Economic Development Office, Kela and the municipality social services.[132] The centres are autonomous public bodies (financed by central government but managed autonomously) and their services include rehabilitation.[133]

Pension institutions[134] are private (in this, Finland is different from other Nordic countries). However, they are strictly **regulated by the Ministry of Social Affairs and Health**. The **Finnish Centre for Pensions**[135] is the statutory liaison body of the earnings-related pensions[136] and its governance lies between the government and the private sector.[137] VR under the Finnish earnings-related pension include guidance, investigations, work try-outs, work training, education, subsidies for starting or carrying on a business and various tools to make working easier. The earnings-related insurers arrange and finance the rehabilitation. Rehabilitation is considered successful if

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[122] Ministry of Social Affairs and Health. n.d. *Rehabilitation*. Available: https://stm.fi/en/rehabilitation
[123] https://www.varma.fi/en
[124] Kela. 2018. *What is rehabilitation?* Available: https://www.kela.fi/web/en/what-is-rehabilitation
[125] Ministry of Social Affairs and Health. n.d. *Rehabilitation*. Available: https://stm.fi/en/rehabilitation
[126] Kela. 2018. *What is rehabilitation?* Available: https://www.kela.fi/web/en/what-is-rehabilitation
[127] https://stm.fi/en
[128] Sukula, S. and Harju-Kolkka, K. 2020. Interview with author.
[129] Also offered by NGOs, as detailed further on.
[130] Ala-Kauhaluoma, M. 2020. Interview with author.
[131] Löfstedt, J. 2020. Interview with author.
[132] Löfstedt, J. 2020. Interview with author.
[133] European Commission. 2015. *Literature review and identification of best practices on integrated social service delivery. Part II – Country case studies*. Available: https://ec.europa.eu/social/main.jsp?catId=1169&langId=en
[134] Every employee and employer pays a certain amount yearly to the pension system: https://www.etk.fi/en/finnish-pension-system/financing-and-investments/pension-contributions
[135] https://www.etk.fi/en
[136] Sukula, S. and Harju-Kolkka, K. 2020. Interview with author.
[137] Löfstedt, J. 2020. Interview with author.

the rehabilitee finds / continues to work / study, and retirement on a disability pension is prevented.[138]

VR is provided by:

- third sector (NGOs)
- companies specialising in rehabilitation
- rehabilitation institutions
- disability advocacy organisations
- educational institutions
- independent therapists.[139]

Examples of VR provider companies are: Verve;[140] Live[141] (part of Invalidisäätiö,[142] a foundation for invalids); Härmän Kuntokeskus;[143] and the Rehabilitation Foundation.[144] The third sector, with the help of the state and municipalities, has had a very large role in organising certain welfare services: third-sector operators historically offer a wide range of support and development work in the field of vocational and social rehabilitation. Furthermore, NGOs (including the Rehabilitation Foundation) are a big service provider of rehabilitative work activities, including advice, peer support and activities enhancing work ability and functional ability. A Finnish gaming company Veikkaus[145] is the main funding source for these activities.[146]

Regulation of VR quality

Vocational rehabilitation in Finland is regulated by a number of laws, including:

- The Act on the Social Insurance Institution of Finland's Rehabilitation Benefits and Rehabilitation Allowance Benefits (566/2005). This law sets provisions on providing vocational rehabilitation its content and conditions of issuance.[147]
- Provisions on vocational rehabilitation are laid down in the acts concerning earnings-related pensions[148] which regulate pension providers.[149]
- Vocational rehabilitation measures may also be compensated under the Occupational Accidents, Injuries and Diseases Act or the Act on Rehabilitation Compensable under the Third Party Motor Liability Insurance Act.[150]
- The Act on multisectoral joint services of 2014[151] establishes the joint service between the Employment and Economic Development Office, the municipalities and Kela.[152]
- The Act on Rehabilitative Work (189/2001)[153] provides the basis for rehabilitative work activities.[154]

[138] Finnish Centre for Pensions. n.d. *Rehabilitation.* Available: https://www.etk.fi/en/research-statistics-and-projections/statistics/rehabilitation
[139] Kela. 2018. *What is rehabilitation?* Available: https://www.kela.fi/web/en/what-is-rehabilitation
[140] https://www.verve.fi/in-english.html
[141] https://www.livepalvelut.fi/briefly-in-english
[142] https://www.invalidisaatio.fi/briefly-in-english
[143] https://www.harmankuntokeskus.fi/yhteystiedot
[144] https://kuntoutussaatio.fi
[145] https://www.veikkaus.fi/fi/yritys?lang=en
[146] Ala-Kauhaluoma, M. 2020. Interview with author.
[147] Sukula, S. and Harju-Kolkka, K. 2020. Interview with author.
[148] For example, the Employees Pensions Act, available in English: https://www.finlex.fi/en/laki/kaannokset/2006/en20060395.pdf
[149] Sukula, S. and Harju-Kolkka, K. 2020. Interview with author.
[150] Ministry of Social Affairs and Health. n.d. *Rehabilitation.* Available: https://stm.fi/en/rehabilitation
[151]https://www.finlex.fi/fi/laki/alkup/2014/20141369?search%5Btype%5D=pika&search%5Bpika%5D=Laki%20monialaisesta%20yhteispalvelusta
[152] Löfstedt, J. 2020. Interview with author.
[153] https://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=58927
[154] Ala-Kauhaluoma, M. 2020. Interview with author.

- The United Nations Convention on the Rights of Persons with Disabilities (CRDP)[155] and its optional protocol came into force in 2016 in Finland. In accordance with the CRDP, the rights of PWDs and the protection of these rights must be taken into account in the legislation on VR and its provision.[156]

Quality regulations and requirements for VR in Finland are built in every step (through legislation, Kela service descriptions, service provider quality management), as described below. As the representatives interviewed for this study confirm, this ensures a good level of quality[157] and external technical certifications as such are not required.[158]

Kela develops standards for VR services. These so-called **'service descriptions' are obligatory for VR service providers** to adhere to and encompass quality aspects such as the type of professionals providing VR services, the type of measurements they employ and the reports the service providers are obliged to submit to Kela.[159] Furthermore, Kela makes use of **standardised assessments such as the WHOQOL (World Health Organization Quality of Life)**[160] to assess whether VR is improving clients' quality of life. Evidence-based rehabilitation is ensured through **multiple questionnaire measurements** that service providers are obliged to fill in together with the service user in order to assess if and how the person's work capacity has improved. One example is the **Goal Attainment Scale,**[161] used by the client to see whether they have achieved their goals. Such standards enable Kela to improve their services. **Kela** is also obliged by law to carry out **research on rehabilitation**: it encompasses its own research department and also provides funds for other entities to carry out **research on Kela's services**. Currently, Kela is carrying out a longitudinal study on the outcome of VR in order to explore the **value added of VR for the client**.[162]

Service providers are also obliged to have their own quality management systems and documentation of quality; and most service providers of VR in Finland have some kind of certification in ISO[163] or good practice. Service providers such as the Rehabilitation Foundation emphasise the attention paid to such quality criteria as empowerment and client-centeredness. The effectiveness / quality of their services is measured by client's results of employability, satisfaction and participation, and other performance indicators including governance, access and timeliness. However, they have no international / European quality certifications in place for VR services.[164]

Keva[165] – a public sector pension provider administering the pensions of local government, state, Evangelical Lutheran Church and Kela employees – confirms that, in organising VR, cooperation with the employers is important. Nevertheless, the data privacy of individuals is always taken into account in the cooperation. The objectives of VR provided by Keva emerge from the relevant legislation and directives and they are well known by relevant stakeholders. Furthermore, while there is no precise standardisation for service procurements, service descriptions exist. [166]

[155] https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html
[156] Sukula, S. and Harju-Kolkka, K. 2020. Interview with author.
[157] Löfstedt, J. 2020. Interview with author.
[158] Ala-Kauhaluoma, M. 2020. Interview with author.
[159] Löfstedt, J. 2020. Interview with author.
[160] https://www.who.int/toolkits/whoqol
[161] https://www.sralab.org/rehabilitation-measures/goal-attainment-scale
[162] Löfstedt, J. 2020. Interview with author.
[163] https://www.iso.org
[164] Ala-Kauhaluoma, M. 2020. Interview with author.
[165] https://www.keva.fi/en
[166] Reijonen, S. 2020. Interview with author.

Quality Trends

As alluded to earlier, the **focus of VR** is increasingly on **the person** / individual, both by Kela[167] and by the service providers, who are including the client more and more in the VR process stages of planning, delivery and quality management, in line with clients' demands for better services and quality.[168] Keva, like other pension institutions, monitors the number of persons carrying on working after VR. They also rely on statistics provided by the Finnish Centre for Pensions, which are important as they reveal the trends in the success of VR.[169]

Kela also develops their services on **evidence-based rehabilitation** (e.g. through service provider/user questionnaires, see above) in order to provide services which make a difference. The Kela representative interviewed for this study also describes a value-based health care ('adding value' to the system, including VR), a system which Kela might apply in the future. In this system, quality management ensures that VR makes a *de facto* difference to the person. For example, if the goal of VR is that the client gets a paid job, Kela would pay the service provider the whole amount of costs incurred if the client becomes gainfully employed. Should the client, for example, only obtain a work tryout, then Kela would only pay the service provider a certain amount (e.g. 90% of costs). The Kela representative interviewed for this study confirms that such a value-based system would take quality up to a new level and ensure that the right service is given to the right person, i.e. the service is adjusted according to the individual's needs (as opposed to blanket services for all clients, as used to be the case five to ten years ago.). However, this system is still simply a vision, and is not currently being applied.[170]

Nonetheless, a **potential challenge to VR quality** in Finland – which has been going on for a number of years – is posed by the fact that **service providers are merging**, resulting in a **decrease in the number of providers participating in the competition** to provide services. Furthermore, since they are merging into bigger companies, service providers now have more 'power' in making their own rules (for example with regard to the acceptable timeframe within which to start VR for the client), rather than abiding by the ones Kela imposes on them. While Kela details **sanctions** in its service descriptions, these are almost becoming **impossible to impose** since such a large number of service providers are merging and essentially **monopolising the market** (with some service providers covering a whole region by themselves).[171]

Meanwhile, **health and social care** in Finland are currently **undergoing a huge reform** – already being piloted – at a governmental level. Currently, such services are provided and funded at a municipal level, while the reform aims at **moving this to the regional level**. Through the reform, the coordination of VR services would be improved as they would be provided by the new social- and health care district centres, in cooperation with Kela and with the unemployment system. The client can receive VR-related services (such as assessment) at these centres. VR-rehabilitation services will still be provided by Kela and produced by the different producers; however the integration of the assessment and planning will be taken care of by the new regional social- and health care centres (in cooperation with Kela and the unemployment system, whose officials will participate at the centers).[172]

Work to **harmonise and develop the measuring and assessment of functioning** in Finland is **among important future developments**. For example, the national expert network of measuring

[167] Löfstedt, J. 2020. Interview with author.
[168] Ala-Kauhaluoma, M. 2020. Interview with author.
[169] Reijonen, S. 2020. Interview with author.
[170] Löfstedt, J. 2020. Interview with author.
[171] Löfstedt, J. 2020. Interview with author.
[172] Löfstedt, J. 2020. Interview with author.

and assessing functioning (TOIMIA-network[173]) coordinated by the Finnish Institute for Health and Welfare produces data to the TOIMIA Functioning Measures Database that also includes recommendations on how to assess functioning. The aim of the recommendations is to harmonise different assessment practices in use. Recommendations include instruction on how functioning should be measured and assessed in different situations.[174]

Role of voluntary quality systems

There are no EQUASS certified organisations in Finland[175] and the interviewees are not aware of such standards. However, as the Kela representative confirms, the underlying notions of such frameworks and / or other guiding principles like the European Pillar of Social Rights (EPSR) – while not generally known to Finnish service providers[176] and regulators – are inherently part of the whole Finnish social security legislation and guidelines on good rehabilitation. Thus, while EQUASS, for example, is not referred to in any of the Finnish legislation / guidelines, its principles are automatically included, since the Nordic model for welfare – which has been around for a long time – takes these standards for granted.[177]

Interview List

Service Provider / Regulator	Interviewee	Organisation & Department	Designation	Date of Interview
Regulator	Mr Jan Löfstedt	Kela – Insurance Medicine Center / Benefit Services	Senior Medical Advisor	11.11.2020
Regulator	Ms Seija Sukula & Ms Kaisu Harju-Kolkka	Ministry of Social Affairs and Health	Senior Specialist & Specialist	18.12.2020
SP	Dr Mika Ala-Kauhaluoma	The Rehabilitation Foundation	Account Manager	13.11.2020
SP	Ms Sirpa Reijonen	Keva	Rehabilitation Manager	20.12.2020

[173] https://thl.fi/en/web/functioning/toimia-functioning-measures-database
[174] Sukula, S. and Harju-Kolkka, K. 2020. Interview with author.
[175] https://equass.be/index.php/certif-system/equass-certified
[176] Ala-Kauhaluoma, M. 2020. Interview with author.
[177] Löfstedt, J. 2020. Interview with author.

Malta Case Study
Quality Regulations, Requirements and Trends in Vocational Rehabilitation[178]

At a glance

- *Vocational rehabilitation for PWDs is regulated and mainly provided under health services, as part of occupational therapy.*
- *While there are no formal quality frameworks in place for VR, the quality of OT services in general is assured through:*
  - *OT Professional Lead*
  - *educational requirements and voluntary courses for OTs*
  - *standardised assessments used by OTs*
  - *quality standards employed by the entities where the OTs work.*

  Nonetheless, interviewees feel these are not enough to regulate the quality of VR, which is a relatively new area of OT in Malta.
- *VR service providers are unaware of related European quality frameworks and principles such as EQUASS and EPSR; however they feel such regulations would be beneficial in improving the structure and standards of VR services.*

Governance and provision of VR services

The Ministry for Health oversees the national OT (and thus VR) services.[179] However, the first two hospitals mentioned below are managed under a public-private partnership between the Ministry for Health[180] and the private company Steward Health Care. Due to its small size, Malta does not have an entity specifically dedicated to vocational rehabilitation (VR). **VR** for persons with disabilities (PWDs) is **generally provided as part of occupational therapy (OT) services under health auspices**, mainly in hospitals. The following are the major hospitals providing VR (as part of OT):

- Karin Grech Rehabilitation Hospital (KGRH)[181]: caters to PWDs with physical conditions such as neurological conditions, post-surgical or traumatic injuries.
- Gozo General Hospital[182]: caters to Gozitans[183] with physical and mental conditions.
- Mount Carmel Hospital (MCH)[184] and its community mental health day centres: caters to PWDs with mental health problems.

Besides these three hospitals, VR is also provided by Jobsplus[185], the national employment agency (under the Ministry for Employment and Education[186]) and is the only entity which has a small department (consisting of one full-time and two part-time staff) dedicated specifically to VR. It provides VR (mostly at assessment stage) for PWDs and vulnerable persons – with both physical and mental problems – who seek employment. Employers might request the assistance of the OT to conduct a workplace assessment. The assessment includes recommendations and adaptations.

[178] The responsibility for the opinions expressed in this publication rests solely on the author(s), and the publication does not constitute an endorsement by Jobsplus of the opinions expressed in it.
[179] Scerri, C. 2020. Interview with author.
[180] https://deputyprimeminister.gov.mt/en/Pages/health.aspx
[181] https://deputyprimeminister.gov.mt/en/kgrh
[182] https://www.stewardmalta.org/gozo-general
[183] The Maltese islands consist of Malta, Gozo and other largely uninhabited small islands.
[184] https://deputyprimeminister.gov.mt/en/ahcs/Pages/occupational-therapy-services/mch.aspx
[185] https://jobsplus.gov.mt
[186] https://education.gov.mt

After assessment by a medical doctor and an OT, the client with disability may also be referred to either KGRH / MCH for rehabilitation or to adult training centres, sheltered employment training, supported employment or open employment. Furthermore, the Lino Spiteri Foundation,[187] a public social partnership for inclusive employment, together with Jobsplus, assists PWDs through career guidance, job search activities, on-going job-related assessments, training/ work opportunities referrals and job coaching.

The VR trend at Jobsplus is moving towards working also with vulnerable persons (e.g. who need social housing; poor backgrounds; substance or alcohol abusers – who might also have mental or physical difficulties), rather than only PWDs. With vulnerable persons, the OT (or employment advisor) carries out motivational interviewing.[188] So far, in Malta, these groups are not much catered for in VR, since this is more medical-based rather than social. Thus, unless a person has a medical diagnosis or a psychological problem, the OT at Jobsplus cannot refer them anywhere.[189]

VR generally consists of:

- assessment of the capabilities and limitations of the individual through an activity analysis;
- assessment of the environment (e.g. ergonomics of the place of work) and the tools and adaptation of skills are required to perform the task;
- training on the job (or preparation for an alternative job);
- advice on job matching: the job most matched to the individual's capabilities.[190]

As the OT Professional Lead confirms, VR is a relatively new area of OT: it emerged out of general rehabilitation services because there was the requirement from the needs of the service users themselves. This is partly the reason for the lack of enough investment in VR. Indeed, at KGRH, the OT department is still in the process of obtaining the necessary equipment as well as more standardised assessment tools needed for VR services.[191]

Regulation of VR services and their quality

There is no regulation specifically on the quality of VR in Malta.[192] One of the reasons for this is, as mentioned above, is that VR is a relatively new area for OT.[193] However, there are a number of legal instruments which mention VR or rehabilitation related to employment:

- The Employment and Training Services Act of 1990[194] states that one of the functions of the National Employment Authority is to make rules providing for special consideration to be given to "applicants who are disabled, infirm or incapacitated or applicants requiring physical or social rehabilitation" (p.4).
- The Persons with Disability (Employment) Act of 1969[195] states that the Minister may either provide, or make arrangements for the provision, by any government department or Jobsplus, of vocational guidance and training services, and industrial rehabilitation courses.
- Rehabilitation is also part of the focus of one of the objectives of the National Disability Strategy (Consultation Document)[196] which states that rehabilitation centres should focus

[187] https://linospiterifoundation.org
[188] Motivational interviewing involves the interviewer rendering the client aware of their situation and to work on his/her problems in order to eventually change.
[189] Sciberras, H. 2020. Interview with author.
[190] Interviews with service providers and regulator.
[191] Interviews with service providers and regulator.
[192] Interviews with service providers and regulator.
[193] Scerri, C. 2020. Interview with author.
[194] Laws of Malta. 1990. *Chapter 343. Employment and Training Services Act.* Available: https://legislation.mt/eli/cap/343/eng/pdf
[195] Laws of Malta. 1969. *Chapter 210. Persons with Disability (Employment) Act.* Available: https://legislation.mt/eli/cap/210/eng/pdf

on person-centred approaches (rather than medical ones). The Strategy also states that *Aġenzija Sapport*[197] will set out a code of ethics / standards of practice for all staff working with persons with disability (including in rehabilitation centres). However, this Strategy is still a consultation document and thus has not yet been launched.

Thus, while legislation ensuring that PWDs receive VR has been in place for decades, legislation regulating its quality is generally lacking. The National Disability Strategy, should it materialise into an actual strategy, has the potential to improve the quality of rehabilitation centres in general (thus also VR ones). Nonetheless, none of the interviewees make reference to this strategy, potentially indicating the need for more awareness of disability-related strategies and policies among medically-oriented service providers.

Quality trends

Standards, Requirements and Certifications

No formal quality requirements or regulation frameworks for vocational rehabilitation exist in Malta; however VR quality is ensured through various standards, educational requirements and optional certifications.

The **professionals involved in vocational rehabilitation use international/ standardised tools and assessment tests.** For example, the medical doctor assessing PWDs at Jobsplus uses the International Classification of Functioning, Disability and Health (ICF)[198] issued by the World Health Organization (WHO), and the Montreal Cognitive Assessment (MoCA).[199] The Head OT at Jobsplus meanwhile states that the initial assessment used by the OT is home grown (while they tried to find standardised tests, they also needed something adaptable to the Maltese context). She then uses the Model of Human Occupation (MOHO)[200] and other assessment tools emerging from the MOHO: the Assessment of Work Performance (AWP) and the Work Environment Impact Scale (WEIS), in order to have a guide / a model of reference when she visits the client at the workplace. However, such standardised tools and assessments are bought and used on the professional's initiative, rather than being set nationally or by the service provider (in this case, Jobsplus).[201]

Quality of occupational therapy is also regulated with regard to education and professional training: occupational therapists in Malta need a 4-year University degree. The Head OT at Jobsplus has also read for a Master's Degree in Vocational Rehabilitation (available in the UK), for which another OT at KGRH is also reading. As the Head OT at KGRH confirms, this gives more opportunity for specialisation (in VR). Nonetheless, it is not obligatory, nor are the short courses on VR which OTs can attend as part of their professional training. It is up to the interest of the OT to do so.[202]

Regulators

While no entity regulates VR quality specifically, various entities regulate different quality aspects surrounding VR:

- The most pertinent one is the **OT Professional Lead, who is in charge of overseeing OT services in Malta and Gozo, including ensuring that standards are met**, that OTs are using the proper assessment tools and procedures, and that there are no waiting lists for

[196] Parliamentary Secretariat for Rights of Persons with Disability and Active Ageing, National Commission Persons with Disability and The Focal Point Office. 2015. *Consultation Document: The Malta National Disability Strategy.* Available at: https://activeageing.gov.mt/en/Pages/Malta-National-Disability-Strategy.aspx

[197] https://sapport.gov.mt

[198] https://www.who.int/classifications/icf/en

[199] https://www.mocatest.org

[200] https://www.moho.uic.edu/resources/about.aspx

[201] Sciberras, H. 2020. Interview with author.

[202] Hercegovac, S. 2020. Interview with author.

OT services; and of recruiting OTs and developing new services according to patients' needs. [203]

- The entity which employs the OT(s) also regulates quality of services according to its procedures. For example, Steward Health Care, the private company managing two of the hospitals in Malta, employs quality assurance and compliance in their services, although not specifically on VR.[204] Such quality standards however are not applicable to all hospitals providing VR services: for example, MCH has been the focus of an audit[205] exposing the hospital's multiple shortcomings, from lack of building safety and security arrangements to lack of staff and attention from management.
- **Client feedback** is also considered important: at Jobsplus, for example this resulted into the current trend towards vulnerable persons (mentioned above) and cooperation with other agencies.[206] OTs in such places as KGRH use a patient satisfaction questionnaire, which, while not specific to VR services, collects feedback on timeliness of services, quality, environment, etc.[207]
- Finally, the Malta Association of Occupational Therapists (MAOT)[208] is a non-profit organisation for local OTs, students and allied assistants. They are members of the Council of Occupational Therapists for European Countries (COTEC)[209] - which aims at improving the standards of the OT professional practice – and the World Federation of Occupational Therapists (WFOT)[210], which sets the standards for the practice of OT globally. However, the interviewees do not consider the MAOT as a regulatory body, nor does this association regulate or ensure the quality of OT / VR in Malta.

Other regulatory entities exist within health and social care which do not regulate the quality of OT or VR per se:

- OTs in Malta are regulated by the Council for the Professions Complementary to Medicine (CPCM).[211]
- The Healthcare Standards Directorate within the Ministry for Health is responsible to regulate, inspect and license establishments which provide services impacting public health and to issue standards to support excellence of services provided through these establishments.[212]
- The Social Care Standards Authority (SCSA)[213] - set up by Act XV of 2018[214] - aims at improving quality and standards in social welfare services. The SCSA licenses social welfare providers; establishes social regulation standards in the social welfare sector; and inspects services / takes action to protect service users.[215] It issues Social Regulatory Standards such as the National Standards Residential Services for Persons with Disability.[216] The SCSA also has a Quality Assurance Office through which people who

[203] Scerri, C. 2020. Interview with author.
[204] Steward Health Care Malta. 2020. *Quality Assurance & Patient Safety.* Available: https://www.stewardmalta.org/quality
[205] National Audit Office. 2018. *Performance Audit: A Strategic Overview of Mount Carmel Hospital.* Available at: http://nao.gov.mt/loadfile/b1adb86a-4ab4-49ac-95cf-534dc99c741c
[206] Sciberras, H. 2020. Interview with author.
[207] Interviews with service providers and regulator.
[208] https://www.facebook.com/MAOT1985
[209] https://www.coteceurope.eu
[210] https://www.wfot.org
[211] https://deputyprimeminister.gov.mt/en/regcounc/cpcm/Pages/cpcm.aspx
[212] Government of Malta. 2020. *Health Standards Directorate – About Us.* Available: https://deputyprimeminister.gov.mt/en/hcs/Pages/health-care-standards.aspx
[213] https://scsa.gov.mt
[214] Laws of Malta. 2018. *Act No. XV of 2018 – Social Care Standards Authority Act.* Available: https://parlament.mt/13th-leg/acts/act-xv-of-2018/#:~:text=The%20objects%20of%20this%20Bill,for%20the%20setting%20up%20of
[215] Government of Malta. n.d. *SCSA.gov.mt - About us.* Available: https://scsa.gov.mt/en/Pages/About-Us.aspx
[216] Social Care Standards Authority. 2018. *Social Regulatory Standards. Residential Services for Persons with Disability.* Available: https://meae.gov.mt/en/Public_Consultations/MFSS/Pages/Consultations/SocialRegulatoryStandardsResidentialServicesforPersonswithdisability.aspx

make use of social welfare services can provide feedback on such services.[217]

Interviewees are in agreement that current quality standards are not enough and that having frameworks regulating the quality of VR together with audits and quality assurance would be beneficial. The added value interviewees see include structure and standards aligned with EU ones and common and applicable to all service providers across the board. Interviewees are either not aware of the existence of such regulatory boards (e.g. the Healthcare Standards Directorate) or confirm that they do not regulate (the quality of) VR services. They are being mentioned here rather as an overview of potential sources of quality regulation. Furthermore, since VR falls under health auspices, regulatory boards within social services (e.g. the SCSA) potentially have no remit over VR services. OTs are thus currently obliged to employ their own 'quality' standards of choice, such as standardised assessments, which, however, are neither used across the board (i.e. not necessarily used by all OTs) nor are always at OTs' disposal (e.g. due to lack of funds). Furthermore, client feedback is only received on OT services in general – with the exception of Jobsplus – and thus does not feed back into the improvement of VR quality.[218]

Role of voluntary quality systems

VR providers and (OT) regulators in Malta do not use – and, based on the interviews carried out for this study, are not aware of – any voluntary quality frameworks applicable to vocational rehabilitation for PWDs such as the European Quality in Social Services (EQUASS) or European Foundation for Quality Management (EFQM). Likewise, regulation and practice based on feedback gathered is not at the moment guided by the principles of the European Pillar of Social Rights (EPSR).

Interview List

Service Provider / Regulator	Interviewee	Organisation & Department	Designation	Date of Interview
Service Provider	Ms Henriette Sciberras	Jobsplus - Inclusive Employment Services	Senior Occupational Therapist	1st October 2020
Service Provider	Ms Stephanie Hercegovac	Karin Grech Hospital – Rehabilitation Services	Occupational Therapy Focal Person	15th October 2020
Regulator	Ms Cynthia Scerri	Mater Dei Hospital – Occupational Therapy	Professional Lead	2nd November 2020

[217] Times of Malta. 2020. *We need feedback about social care standards – Matthew Vella.* January, 3. Available: https://timesofmalta.com/articles/view/we-need-feedback-about-social-care-standards-matthew-vella.760704

[218] Interviews with service providers.

Netherlands Case Study

Quality Regulations, Requirements and Trends in Vocational Rehabilitation

At a glance

- *Vocational rehabilitation for PWDs is delivered by private providers and paid by insurers or employers, as far as return to work / work retention services are concerned.*
- *Access to work services are delivered publicly as part of social services.*
- *Employers have an obligation to ensure effective rehabilitation processes; this is key to guarantee quality of outcomes in VR.*
- *There are no compulsory quality standards, but there is a vast range of voluntary regulations and auditing mechanisms that providers can abide by.*
- *Market dynamics ensure that private providers have an incentive to follow such standards, but public providers are not subject to the same pressure.*
- *Individual providers' initiative is a key driving factor in quality improvement, such as through additional specialised training of staff.*

Governance and provision of VR services

Vocational rehabilitation (VR) services in the Netherlands are defined to include both access to work services for PWDs and return to work / work retention services: The former are coordinated through public social services, while the latter are mostly organised around healthcare and generally delivered by - or in coordination with - clinics and medical rehabilitation centres. Services can include:

- **Medical rehabilitation** for employees who suffered brain injuries or other impairments;
- Help with **reintegration** to a previous place of employment after injury;
- Help for PWD in **finding a new job**;
- Assistance to employers in **accelerating return-to-work** when too many employees are on a sick leave;
- **Coaching employees** on health issues;
- **Short-term vocational education** for PWDs and assistance to their **integration into the labour market**.[219]

Some providers deliver specialised services, such as interdisciplinary **cognitive behavioural group** therapy - also part of VR - to help patients learn to coexist with medical conditions.[220]

It is important to note that VR is provided in **two key separate pathways**, one for return to work and work retention, and the other one for access to the job market. Access to work services are publicly-delivered; while return to work and work retention services are provided through a network of mainly **private providers** called *Arbodienst* (Health and safety service companies), or "**Arbos**", **rehabilitation centres** generally staffed by **occupational physicians and case managers**, and sometimes also by **psychologists, rehabilitation physicians and specialists, and physiotherapists**, who may be either employed directly or contracted.[221] Dutch law requires every company to have a company doctor, which they usually hire through Arbos, although some large companies do have their own Health and Safety Department including company doctors.[222]

[219] Interview with Kurt Schumacher, Labour Integration Manager, Heliomare (11 Nov 2020)

[220] Interview with Berry Trip, physiotherapist, member of the advisory team to the CEO, Winnock, and member of the Scientific Research Working Group, Zorg van de Zaak (12 Jan 2021)

[221] Interview with Dr Brigitte van Lierop, Senior Partner, Disworks (23 Dec 2020), and with Berry Trip, Winnock / Zorg van de Zaak.

[222] Interview with Kurt Schumacher, Heliomare.

The way in which return to work / work retention services are financed, as opposed to access to work ones, has a direct impact on quality monitoring mechanisms: The quality mechanisms for return to work / work retention are **more complex and more structured** than those for access to work. For this reason, the former will constitute the key focus on these sections, while the latter will be discussed in later ones.

In the Dutch system, **employers are obliged by law to ensure the return of the employee to work** following a sick leave: Regardless of the reasons for injury, employers have to pay up to 2 years of sick leave, and have an obligation to ensure that the employee is able to return to - or retain a - work place after this period.[223] In Dutch law, employers are forbidden from firing employees who have become disabled. Instead, employers are obliged to take all possible measures, including rearranging the workforce and re-allocating tasks, in order to **find, or create anew, a position that the employee with disability will be able to perform.**[224] The Employee Insurance Agency is responsible for monitoring employers' compliance. The costs are covered by insurance companies for the healthcare component of rehabilitation procedures, and by employers for all non-medical measures such as workplace adaptation, transportation assistance and the like, except for larger employers who generally pay for the whole rehabilitation process.[225] In turn, employees have to cooperate and participate in the rehabilitation plan supported by the employer, which is prepared and coordinated by the Arbo selected by the employer.[226]

In practice, the fact that employers and insurers are expected to carry the financial burden of the rehabilitation effort by funding the necessary rehabilitation procedures (within the limits of what is achievable given the severity of the disability), **creates a major market-based economic incentive for employers and insurers to maximise their investment by choosing providers who can ensure the best quality of rehabilitation**. Moreover, as the system does not require the identification of responsibilities for the injury before the employer and insurers have to start paying for rehabilitation, it can begin immediately after injury, without the delays that court actions and investigations would cause.[227]

Regulation of VR Services and their quality

There is no compulsory quality regulation specific to VR in the Netherlands: The quality of reintegration is guaranteed through **self-regulation of providers and non-compulsory adoption of certifications**, encouraged by the above-mentioned market mechanisms that reward providers who can build a stronger reputation and secure better results.[228] Key voluntary mechanisms to ensure quality of service include:

- The **Harmonization of Health Certification (HKZ)** certificate for medical rehabilitation, established in 1994;[229]
- The **Certificate for vocational rehabilitation** of the independent quality monitoring institute ***Blik op Werk***, which focuses on sustainable labour participation and integration;[230]
- Adherence to the standards of the **Central Register of Short Vocational Education**[231] **(CRKBO)**;[232]

[223] Interview with Dr Brigitte van Lierop, Disworks, and with Kurt Schumacher, Heliomare.
[224] Interview with Dr Brigitte van Lierop, Disworks, and with Berry Trip, Winnock / Zorg van de Zaak.
[225] Interview with Berry Trip, Winnock / Zorg van de Zaak.
[226] Interview with Dr Brigitte van Lierop, Disworks.
[227] Interview with Dr Brigitte van Lierop, Disworks.
[228] Interview with Kurt Schumacher, Heliomare, and with Dr Brigitte van Lierop, Disworks.
[229] WHO (2003), *Quality and accreditation in health care services. A global review*, p. 29
[230] https://www.blikopwerk.nl/over-blik-op-werk
[231] While vocational education is not strictly VR, providers consider this short-term vocational education as VR: it includes any course to teach PWDs skills that they may need to work.
[232] Interview with Kurt Schumacher, Heliomare; https://www.globalnlptraining.com/crkbo.html.

- Accreditation with the **Independent Clinics Netherlands (ZKN)**, the trade association for independent clinics in the country;[233]
- For non-healthcare services in work reintegration: Membership and abidance by the accreditation criteria of the **OVAL Network**.[234]
- Adherence to the standards of the **BOREA system**:[235] providers are not legally required to, but are *de facto* expected to follow if they want to be included in the list of reliable providers among which employers or insurers can choose.[236]

The key aspects monitored by these systems are detailed in the "Key dimensions of quality" section; at this stage, it is important to note that these standards are all **procedure-based** rather than outcome-oriented: They focus on assessing how fast providers work, on whether they have the necessary organisational processes in place, and whether the procedures are being followed, but they **do not focus on quality of outcome**. The same is also true of **public tender quality requirements**.[237] Technically, these standards can be followed both by public providers of access to work services, and by private ones working on work retention and return to work; in practice, however, market mechanisms only create an incentive to do so for private ones.

Providers are also subject to market pressure to ensure **high professional standards for individual staffers**, particularly medical ones, since they are heavily involved in VR in the Netherlands at a basic level, this is ensured through monitoring of occupational physicians' quality of work by the national Social Security Office,[238] and by the fact that official criteria required by medical graduates to start practicing in their respective fields are extremely tight. However, some providers **invest heavily in additional staffers' qualification and training to improve quality of service**, as they feel that this gives them a competitive edge and increases the likelihood that they will be commissioned by employers or insurers. When looking for new employees, they will therefore consider only medical rehabilitation specialists that can boast additional training, track records of professional achievements, membership in professional organisations with stringent qualification requirements for entry, and have passed psychological evaluations, before even beginning the hiring negotiation process. Once hired, they will groom their internal staff by organising interdisciplinary meetings to improve patient care, team coaching activities, training plans, guest lectures and seminars to keep up to date with the latest scientific processes, piloting new treatments and training staff accordingly before rolling out new programmes across the organisation. [239]

Quality monitoring and enforcement

Compliance with voluntary quality regulations and standards is monitored through **auditing by specialised companies** that manage the respective accreditation standards.[240] Internal procedures and quality of outcomes, on the other hand, are monitored through:

- **Satisfaction questionnaires**, used to gauge result satisfaction, quality of customer care received, and quality of infrastructures;
- **Internal auditing**, although this depends on the initiative of providers (and on whether dedicated quality monitoring staff exists);[241]

[233] Exchange with Pyt Hellinga, Employee Quality Care, Business Department, Winnock (5 Jan and 13 Jan 2021); https://www.zkn.nl/over-zkn.
[234] Interview with Berry Trip, Winnock / Zorg van de Zaak; https://www.oval.nl/over-oval/kwaliteit
[235] https://www.borea.nl
[236] Interview with Dr Brigitte van Lierop, Disworks.
[237] Interview with Kurt Schumacher, Heliomare.
[238] https://www.svb.nl/nl/; https://access-nl.org/relocating-to-netherlands/dutch-social-security-benefits/who-administers-dutch-social-security-schemes/#questions-1644
[239] Interview with Berry Trip, Winnock / Zorg van de Zaak.
[240] Interview with Kurt Schumacher, Heliomare.
[241] Interview with Kurt Schumacher, Heliomare.

- Use of **Safety Management Systems (VMS)**, employed by healthcare providers to continuously identify risks, make improvements and record, evaluate and adapt policies to meet the requirements of health insurers for safe service;[242]
- Monitoring of **changes in the number of patient referrals**, a proxy for changes in the reputation of the organisation;
- **Tracking of staffers' performance** to ensure the obtainment of daily targets.[243]

Mainly, however, it is **market dynamics** that are **expected to ensure the fulfilment of quality expectations**, as providers compete to secure contracts with employers and insurers, which, in turn, have a strong and pragmatic financial incentive to select only providers with a clear track record of successful rehabilitation to make sure that the resources they invest in employee's rehabilitation do not go wasted.[244] **There is lack of consensus about the ability of market dynamics to ensure quality of outcomes.** For some sector stakeholders, such mechanisms of competition are fully suitable to guarantee excellent quality.[245] For other providers, however, the reliance on market dynamics to guarantee quality of outcomes and the focus of voluntary certifications on procedures alone keeps the professional quality of service providers under-monitored: Instead, they argue that clearer quality standards for professionals, and a set of standards for quality of outcomes, rather than procedures alone, would be more useful in ensuring overall quality of service.[246]

The reliance on market mechanisms also generates major differences between the system of rehabilitation for work retention and return to work, on the one hand, and services designed to help PWDs *access* the workplace in the first place on the other hand. The provision of "access to work" services is organised around **regionally-based public organisations** that are not subject to the same mechanism of competition as the private ones delivering work retention/return to work services, and thus **lack incentives to ensure efficiency and quality of services**. Public providers can voluntarily abide by BOREA standards, but in the absence of market dynamics, they do not have sufficient incentive to do so.[247]

Key dimensions of quality for providers and regulators

The market mechanisms ensure that when commissioning providers, insurers and employers prioritise considerations of **quality of outcome** and **cost-effectiveness of intervention,** measured by looking at **success rate of rehabilitation intervention**. For some providers, the need to ensure successful rehabilitation outcomes has created an incentive to adopt **evidence-based medical approaches**,[248] a highly promising area that is yet to gain mainstream acceptance, and relies heavily on internal research to support them.[249] Providers' approaches in assessing success rates can vary: rehabilitation services can be considered of good quality if they succeed in *solving* the patient's issue, but some providers adopt a behavioural-centred approach, in which clients and healthcare staff discuss together what is realistic to achieve, which may not necessarily be "finding a solution *to*" a healthcare problem, but rather, finding solutions to *live with* a debilitating condition, in ways that do not impair daily life and work activities.[250]

[242] https://www.heliomare.nl/over-heliomare/kwaliteit-en-veiligheid/
[243] Interview with Berry Trip, Winnock / Zorg van de Zaak.
[244] Interview with Dr Brigitte van Lierop, Disworks, and with Kurt Schumacher, Heliomare.
[245] Interview with Dr Brigitte van Lierop, Disworks.
[246] Interview with Kurt Schumacher, Heliomare, and with Berry Trip, Winnock / Zorg van de Zaak.
[247] Interview with Dr Brigitte van Lierop, Disworks.
[248] Evidence-based practice is an approach that makes a systematic use of scientific research to assess the practical efficacy of practices in areas like healthcare, education, and public policies, rather than relying on traditional solutions or practitioners' intuition.
[249] Interview with Berry Trip, Winnock / Zorg van de Zaak; https://www.eboptometry.com/content/optometry/article/brief-history-evidence-based-practice-0
[250] Interview with Berry Trip, Winnock / Zorg van de Zaak

Interviewees also point to the **respect for clients' rights**, **inclusion requirements**, and **user satisfaction measurement procedures** as deeply ingrained features of VR service provision in the Netherlands, at least as far as return to work and work retention services are concerned.[251] **Protection of clients' privacy rights** has become a key concern and an important quality indicator in recent years, although the attention to client confidentiality also makes cooperation between providers and advocacy on behalf of patients more difficult.[252]

Procedures-based systems such as the above-mentioned ZKN, OVAL, HKZ, *Blik op Werk* and BOREA focus on aspects such as **waiting times, patient safety, treatment of patients' personal information**, and **communication with patients**.[253] ZKN, in particular, defines 31 highly detailed criteria that providers must follow;[254] these, however, pertain to the general management of clinics, and are not specific to VR. The OVAL system focuses on five key "guarantees" that providers must ensure:

- **Control of primary processes:** Providing clear agreements to clients about planned activities, expected results, and costs;
- **Customer satisfaction:** Keeping customer satisfaction as an objective in service provision and measuring it on a regular basis;
- **Education:** Investing in employees expertise and additional training;
- **Safeguarding privacy:** Ensuring strict data protection;
- **Complaint handling:** Organizing complaint management procedures and participating in dispute settlement schemes.[255]

The reason behind so many voluntary qualifications focusing primarily on procedures rather than results is the difficulty for lawmakers to agree on which metrics to use to measure quality of outcomes. When the VR sector was privatised in the early 2000s, national law-makers felt a clear need to establish criteria to "filter" underperforming providers and ensure they would leave a market that was rapidly becoming over-flooded. As they could not agree on criteria to properly measure quality of outcomes, they settled for procedural standards instead, leaving the assessment of quality of outcome to be determined by market dynamics alone.[256]

Providers that use HKZ and OVAL commit to adopting a client-centred approach.[257] However, there is lack of consensus as to whether an *employer*-centred approach would not be more suitable to ensure quality: a leading national expert notes that an employer-centred approach would ensure that job places for PWDs are organised not only around the needs of the PWD, but also on what is feasible and makes business sense for the employer, resulting in rehabilitation interventions that have a higher chance to remain **sustainable in the long term**.[258]

Current trends

Stakeholders expect that in the upcoming years smaller Arbos will slowly be pushed out of the market or consolidate into larger ones;[259] they also note that as healthcare costs grow due to the ageing of the population, insurers and employers will become increasingly focused on **cost efficiency and effectiveness of interventions**, and become much more selective in terms of which rehabilitation procedures they agree to finance, **prioritising evidence-based medicine**.[260]

[251] Interview with Kurt Schumacher, Heliomare, and with Dr Brigitte van Lierop, Disworks.
[252] Interview with Kurt Schumacher, Heliomare.
[253] Interview with Berry Trip, Winnock / Zorg van de Zaak, with Kurt Schumacher, Heliomare, and Dr Brigitte van Lierop, Disworks.
[254] ZKN (2021). *ZKN-keurmerk Toetsingscriteria & Toetsingsreglement. Versie januari 2021*. Internal document received from Pyt Hellinga, Employee Quality Care, Business Department, Winnock / Zorg van de Zaak.
[255] https://www.oval.nl/de-5-waarborgen-van-oval
[256] Interview with Dr Brigitte van Lierop, Disworks.
[257] https://www.heliomare.nl/over-heliomare/kwaliteit-en-veiligheid/
[258] Interview with Dr Brigitte van Lierop, Disworks.
[259] Interview with Dr Brigitte van Lierop, Disworks.
[260] Interview with Berry Trip, Winnock / Zorg van de Zaak.

This trend should not be confused with a mere cost-*saving* push, as employers and insurers are not interested in just saving money if they cannot achieve the desired results (In this regard, some stakeholders argue that the *long-term efficiency* of interventions also needs to be scientifically assessed, such as through follow up studies on patients after several years).

This shift will likely lead to a **rationalisation in the range of services** offered to patients, and the disappearance of expensive, unorthodox, non-evidence-based and inefficient ones which are currently still offered upon request by patients.[261] The growing reliance on insurers resulting from the increase in healthcare costs is also expected to reward providers that can guarantee **better quality of staff**: Providers that used to compete on cost of services alone by hiring staff with minimum professional qualifications to keep prices down already struggle to secure long-term contracts with insurers and are thus likely to be penalised further in the future push towards cost efficiency.[262]

Role of voluntary quality systems

Organisations providing vocational rehabilitation **often use ISO 9000 and ISO-based standards** to improve reputation and, thus, their position in the market.[263] Accreditations such as **HKZ, OVAL and *Blik op Werk* are themselves modelled on ISO principles**.[264] European principles such as the European Pillar for Social Rights are not known, or not seen as playing a noticeable role in orienting providers' work, and are mainly seen as a concern for policy-makers rather than day-to-day providers' activities.[265] The widespread usage of certifications of the ISO family, or based on the ISO model, leaves limited space for other mechanisms such as EQUASS, although some stakeholders recognise the advantage of its comprehensive approach and appreciate the fact that it focuses not only on processes, but also on aspects such as the impact on society (not only clients). Interviewees however comment that EQUASS, which is used by only few VR providers in the Netherlands, would be too expensive and difficult to mainstream in the Netherlands;[266] others believe that it would not add noticeable benefit, as the combination of market dynamics and ISO already ensure that providers perform at high standards of quality in the delivery of return to work and work retention services. EQUASS is seen as potentially more relevant for *access* to work services, which, being public services, do not have a market incentive to improve their quality, but there is strong resistance in the public sector against the introduction of any compulsory mechanism.[267]

Interview List

Service Provider / Regulator	Interviewee	Organisation & Department	Designation	Date of Interview
Service provider National expert, work retention, return to work, access to work	Dr Brigitte van Lierop	Disworks	Senior Partner	23 Dec 2020

[261] Interview with Berry Trip, Winnock / Zorg van de Zaak.
[262] Interview with Berry Trip, Winnock / Zorg van de Zaak
[263] Interview with Dr Brigitte van Lierop, Disworks.
[264] Interview with Kurt Schumacher, Heliomare.
[265] Interview with Kurt Schumacher, Heliomare, with Dr Brigitte van Lierop, Disworks, and with Berry Trip, Winnock / Zorg van de Zaak.
[266] Interview with Kurt Schumacher, Heliomare.
[267] Interview with Dr Brigitte van Lierop, Disworks.

Service provider, work retention, return to work	Kurt Schumacher	Labour Integration Manager	Heliomare	11 Nov 2020
Service provider, work retention, return to work Scientific expert	Berry Trip	Physiotherapist, member of the advisory team to the CEO	Winnock	12 Jan 2021
		Member of the Scientific Research Working Group	Zorg van de Zaak	
Service provider, work retention, return to work	Pyt Hellinga	Employee Quality Care, Business Department	Winnock	Email exchange, 5 and 13 Jan 2021

Sweden Case Study
Quality Regulations, Requirements and Trends in Vocational Rehabilitation

At a glance

- *Vocational rehabilitation in Sweden is the shared responsibility of employers, health care professionals, public employment services and other service providers.*
- *VR services and their quality are not subject to any national quality standards or regulations, but service providers use quality systems on a voluntary basis.*
- *Some of the professions who provide VR are regulated.*
- *All providers of VR services procured by public employment services are obliged to make their activities and premises accessible for people with disabilities.*
- *The EU level standards/frameworks have had little impact on the quality of VR services in Sweden so far.*

Governance and provision of VR services

In Sweden there are two terms used to define vocational rehabilitation (VR): *arbetslivsinriktad rehabilitering* and *yrkesinriktad rehabilitering*. The term *arbetslivsinriktad rehabilitering* literally translates into "working life-oriented rehabilitation", but it can also be translated as vocational, occupational or work-oriented rehabilitation. The term has a broad definition in Sweden and indicates all types of rehabilitating measures taken by health care professionals, employers, the public employment services, occupational health services, or other actors, usually when a person is on sick leave. The term *yrkesinriktad rehabilitering* is used for more specific purposes, such as rehabilitation within a specific profession.[268] In this study VR is used in a broader sense as a work-oriented rehabilitation.

The roles of the main actors involved in the provision of VR services are legally regulated under the Social Security Code[269], and are detailed below.

[268] The official term used by the main provider of VR services in Sweden, *Arbetsförmedlingen*, is *arbetslivsinriktad rehabilitering*. The word "arbetsliv" has a broader scope and encompasses all aspects of working life, which is why *Arbetsförmedlingen* officially uses this term. "Yrkesinriktad" has been more and more phased out in the "rehabilitation vocabulary"; now "yrkesinriktad" is used more when it comes to initiatives and measures within the education area, for example concerning vocational education, i.e. education that leads to a specific profession such as carpentry.

[269] *Chapter 30. Social Security Code (2010:110).* Available at: https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/socialforsakringsbalk-2010110_sfs-2010-110 .

The Swedish Social Insurance Agency (*Försäkringskassan*) is the main coordinating body of VR process, but it does not provide any rehabilitative measures itself. It has the responsibility to:

- Assess, in consultation with the insured person, the need for rehabilitation, and ensure that the necessary measures are taken as soon as possible;
- Cooperate, if the insured person agrees, with the person's employer, health care, social services, the employment service, and other bodies involved in the rehabilitation process;
- Ensure that the organisations involved, each within its field of activity, take the necessary measures for the effective rehabilitation of the insured person.[270]

Health care is not directly responsible for VR, but as part of the VR process, it has to propose measures to ensure that the patients retain or regain their physical and mental capacity as far as possible, and participate in a reconciliation meeting if the Swedish Social Insurance Agency calls for one.[271] If the person needs **medical rehabilitation**, as part of VR measures, it is provided by rehabilitation units within hospitals and primary healthcare.

If the person who needs VR is employed, then **employers** are legally obliged to ensure that their workers receive VR and can return to work with the employer.[272] They must:

- Keep in constant contact with their employee during sick leave;
- Adjust the work situation as far as possible so that the employee can work, for example, by customising tasks, working hours or the workplace;
- Examine whether there is any other appropriate work in the business that the employee can perform;
- Develop a return-to-work plan no later than day 30 from the start of the illness, for the employee who is assumed to have a reduced working capacity for at least 60 days;
- Participate in a reconciliation meeting if the Swedish Social Insurance Agency calls for it.[273]

If the person has no employer and needs VR measures, then they are provided by the **Swedish Public Employment Service (PES)** (*Arbetsförmedlingen*)[274]. PES is a Swedish government agency organised under the Ministry of Employment, and is the major provider of VR services in Sweden. The target group for VR is jobseekers with reduced work capacity due to disability or poor health. Characteristic of the Swedish PES support for individuals in this target group is to compensate for their reduced work capacity. In this context, rehabilitation entails individually adapted solutions that both build on, and further develop the individual's own resources.[275]

VR services provided to individuals with reduced work capacity by the Swedish PES include:

- Support to enter the labour market or to choose or change a profession, for example, individually tailored support for job search, sign language interpretation, guidance to make a transition from school to working life;
- Assistance in finding a job which is adapted to individual circumstances;
- Personal support in connection with the procured vocational training;
- A support person before and during an employment, a so-called SIUS consultant[276];

[270] Ibid.
[271] ibid
[272] The main legislation governing the role of employers are: *The Swedish Work Environment Act (AML), Swedish Work Environment Authority's regulations AFS 2001:1* and *AFS 1994:1,* and the *Discrimination Act SFS 2008:567*. Links are available at https://skr.se/arbetsgivarekollektivavtal/arbetsmiljo/rehabiliteringarbetsanpassning/lagarrehabilitering.718.html.
[273] https://www.forsakringskassan.se/sjukvard/sjukdom/arbetslivsinriktad-rehabilitering
[274] https://arbetsformedlingen.se/
[275] Based on the official response of the Swedish Public Employment Service to the study questions.
[276] SIUS consultants provide supported employment services. More information about supported employment is available on the European Union of Supported Employment (EUSE) webpage http://www.euse.org. More about support provided by a SUIS consultant is available at: https://arbetsformedlingen.se/for-arbetssokande/extra-stod/stod-a-o/sarskild-stodperson-for-introduktions--och-uppfoljningsstod---sius

- Grants for workplace adaption;
- Sheltered employment for example at Samhall[277], a state-owned company;
- Subsidies to the employer to set up extra individual support for the employee and wage subsidies.

The professionals who provide VR services in the local Swedish PES offices include employment officers and the following specialists in VR:

- SIUS consultant (a person with special competence in introductory and follow-up support);
- Occupational therapists;
- Physiotherapists,
- Psychologists,
- Social counsellors/supervisors,
- Audiologists,
- Vision specialists,
- Deaf consultants.[278]

There are also **smaller providers** of VR services, established by municipalities, counties or other bodies. For example, Actíva, involved in this study, is a small local foundation, which provides supported employment, individual placement and support (IPS) and some other VR services for people with disabilities and other disadvantaged groups. Actíva was established in 1988 by Örebro County Council to promote employment and education for people with disabilities.[279]

Regulation of VR Services and their quality

In Sweden **VR services and their quality are not subject to any national quality standards or regulation**s. **Each service provider decides, on their own, what quality measures should be applied.** The interviewed representative of a small service provider admits that they have never heard of any obligatory requirements related to the quality of VR services. Moreover, in Sweden, there are no national quality regulations which could be applied to municipal service providers or foundations. National authorities, such as the National Board of Health and Welfare,[280] can only give guidelines for the Association of Local Authorities and Regions of Sweden,[281] which in turn gives advice related to VR for employers and local government.

In general, **Sweden is characterised by a culture of guidance rather than that of regulation**. As mentioned by one of the interviewees, in Sweden, even mandatory requirements are implemented on a voluntary basis. For example, although all employers are legally obliged to draw up a vocational rehabilitation plan for their employees after 30 days of sick leave, there are no sanctions in case of non-compliance.

[277] https://samhall.se/

[278] Based on the official response of the Swedish Public Employment Service to the study questions.

[279] More about Actíva is available at: https://www.s-activa.se/

[280] The National Board of Health and Welfare (*Socialstyrelsen*) is a government agency under the Ministry of Health and Social Affairs. It collects, compiles, analyses and communicates data and official statistics in the field of social services, health and medical care, and communicable disease prevention. It also develops national guidelines for service providers on the allocation of resources. More information is available at: https://www.socialstyrelsen.se/

[281] The Association of Local Authorities and Regions of Sweden (*Sveriges Kommuner och Regioner, SKR)* is an employer's organization and an organization that represents and advocates for local government in Sweden. Its mission is to offer support and service to municipalities and regions. More information with regard to VR is available at: https://skr.se/arbetsgivarekollektivavtal/arbetsmiljo/rehabiliteringarbetsanpassning.132.html

Quality trends

Standards, Requirements and Certifications

The Swedish PES is currently moving towards using more procured services, also in the field of VR. It uses advice and guidelines from the Swedish Work Environment Authority[282] and The Swedish Agency for Participation[283] to assure that all providers of procured services are taking responsibility for **disability inclusion and accessibility**. All activities and premises must be accessible for all participants that PES refers to private providers. The responsibility is stated in mutual agreements between service providers and PES.

In addition, the Swedish PES plans to provide **competence-enhancing initiatives** to the providers of services in order to increase their knowledge about people with disabilities focusing on the individuals' competences and skills despite functional impairments. The effectiveness of these measures will be followed to ensure that the providers **maintain an inclusive "mind-set"** in their assignment to find suitable and sustainable work for persons with disability. [284]

Although it is not directly related to VR, the Swedish PES considers positive attitude of employers towards people with disabilities as important in increasing the employment rate of this target group. Therefore, it has implemented an **awareness-raising** campaign called *Make space* targeted at employers. The campaign has been presented on TV, in cinemas, on the internet (Youtube, Facebook, Instagram) and as posters in different places in public. The overall objective of this action is to render the employers aware of the capabilities of people with disabilities, rather than their functional impairments. A survey among employers during and after the campaign shows that employers have noticed the campaign and that the message in the videos has affected their attitudes towards people with disabilities. The result is that employers are more inclined to hire such people.[285]

There is also a mandatory requirement for employers to **adapt workplaces** for people with disabilities. It is based on the Work Environment Act.[286] Workplaces must be designed with reference to what suits different people. The employer has mandatory responsibilities that must be fulfilled before PES can agree on grants for workplace adaptations.

In Sweden a number of health care professionals who provide VR, including audiologists, occupational therapists, physiotherapists, psychologists and speech therapists, belong to the category of so-called **regulated professions**. [287] This means that they are regulated through Swedish legislation that defines the requirements for working within that profession, e.g. a particular qualification or authorisation, or other formal recognition. The other professionals who provide VR, such as supported employment counsellors, social counsellors and supervisors, are not subject to national quality standards.

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[282] One of the overall objectives of the Swedish Work Environment Agency is to, together with other authorities, realize the policy that deals with activity limitations so that persons with functional impairment may more easily be able to work. The agency is responsible for the Work Environment Act. More on https://www.av.se/

[283] The Swedish Agency for Participation is an expert agency that promotes work with the implementation of disability policy. They develop and spread information about obstacles to participation and support public sector bodies. More on https://www.mfd.se/

[284] Based on the reply from the Swedish PES to the author.

[285] Two of the videos of the campaign are available at: https://www.youtube.com/watch?v=b_OdqTS3KD0, https://www.youtube.com/watch?v=CKRrx6RevOQ

[286] The purpose of this Act is to prevent occupational illness and accidents and to otherwise ensure a good work environment.

[287] https://www.uhr.se/en/start/recognition-of-foreign-qualifications/before-you-apply/i-want-to-work-in-sweden/regulated-professions/

Regulated professions in Sweden are supervised by the **Swedish Health and Social Care Inspectorate** (IVO).[288] This is a government agency under the Ministry of Health and Social Affairs responsible for supervising health care, health professionals, social services and activities under the Act on Support and Services for Certain Disabled Persons (LSS). The supervision includes inspections of service providers, handling notifications and complaints, analysis and guidance, as well as licensing examinations. VR is not subject to IVO's supervision, but licensed healthcare professionals who provide VR services are. For example, a case might be opened if IVO becomes aware that any healthcare professional may pose a danger to patient safety.[289]

Some of the regulated professions, e.g. occupational therapists, have their own **competence descriptions**, the **code of ethics** and the **quality policy**,[290] all developed by the Swedish Association of Occupational Therapists.[291] The quality policy describes six quality areas that must be observed to ensure the quality of occupational therapy: 1) knowledge basis, 2) safety, 3) focus on client, 4) effectiveness, 5) equality and 6) timely provision.[292]

Role of voluntary quality systems

Since VR is not a single service in Sweden, but a combination of different measures, this section covers voluntary quality systems within some of the VR-related measures, specifically, medical rehabilitation and supported employment.

Voluntary quality systems used by medical rehabilitation units in Sweden include international accreditation, national quality registers and annual performance monitoring. About half of the units have internationally recognised **CARF accreditation** (Commission on the Accreditation of Rehabilitation Facilities)[293]. Two **national quality registers for rehabilitation** - the National Quality Registry for Pain Rehabilitation (NRS)[294] and the National Quality Register for Rehabilitation Medicine (WebRehab Sweden)[295] - collect patient data on different diseases/injuries, medical rehabilitation efforts and their outcomes, and produce annual public reports. The reports can be used by service providers to benchmark their performance. In addition, WebRehab Sweden carries out **annual performance monitoring** of rehabilitation units against a set of quality indicators such as the development of individual rehabilitation plans, patient satisfaction and the level of return to work after rehabilitation. As informed by the WebRehab Sweden registry holder, the traffic light assessment (in red, amber and green) works as a quick visual indicator of performance levels and a way of public shaming of the units which do not demonstrate good performance. In this way public monitoring makes the system change towards better performance. However, it is difficult to assess how exactly public monitoring affects the quality of rehabilitation services.

Different service providers have their own quality management systems, and below are some examples. Both providers of supported employment services (Swedish PES and Actíva) interviewed are familiar with the **Supported Employment Quality Framework (SEFQ)**[296]. It is a new self-assessment toolkit specifically developed for organisations working with supported employment. The framework was developed by organisations in Belgium, Norway, UK, Ireland,

[288] https://www.ivo.se/
[289] https://www.ivo.se/tillsyn/tillsyn-av-halso-och-sjukvardspersonal/
[290] Accessible at: https://www.arbetsterapeuterna.se/foerbundet/english/occupational-therapy-in-sweden/
[291] https://www.arbetsterapeuterna.se/foerbundet/english/
[292] *Swedish Association of Occupational Therapists. Quality Policy. 2011*. Available at: https://www.arbetsterapeuterna.se/media/1399/qualitypolicy.pdf
[293] CARF International, www.carf.org, Commission on the Accreditation of Rehabilitation Facilities
[294] National Quality Registry for Pain Rehabilitation (NRS) - Nationella Kvalitetsregister
[295] National Quality Registry for Rehabilitation Medicine (Webrehab Sweden) - Nationella Kvalitetsregister
[296] http://www.euse.org/index.php/resources/quality/seqf-se-quality-framework

Spain and the European Union of Supported Employment organisation (EUSE)[297] during an Erasmus+ funded project. Actíva has translated the framework from English into Swedish and will use it in 2021.

Actíva also consults a shared national knowledge base developed by the National Board of Health and Welfare while deciding which methods and services can deliver better outcomes for clients. For example, it introduced an Individual Placement and Support (IPS) model of supported employment, because it was proved to be 2-3 times more effective than traditional methods, such as sheltered employment. IPS supported employment helps people who have mental illness to get a regular job of their choice.

Other voluntary quality assurance measures used by Actíva include:

- Regular monitoring against quantitative performance indicators, such as the number of people with disabilities employed;
- Occasional user satisfaction questionnaires for both people with disabilities who are jobseekers and for employers;
- Internal trainings for employment consultants to enhance their professional competences;
- The Individual Placement and Support (IPS) Fidelity Scale. This is a self-assessment tool used only for supported employment services. It measures the extent to which IPS model is being implemented within the organisation.
- QUL (acronyms for Swedish words meaning Quality, Development and Leadership), which is part of the management model developed by the Swedish Institute for Quality (SIQ).[298] QUL is a national management assessment and certification model originally developed for health care providers. Actíva tried to adapt it to their own needs and services several years ago. Although QUL worked quite well, it was not exactly relevant to the type of services Actíva provides. Therefore, it stopped using this model.

One of the service providers considers methodological accuracy as an important dimension of quality. The commitment to the guidelines of the methods, e.g. the IPS model, is the way to ensure that their services produce the best outcomes for the clients. Finally, the commitment and motivation of staff to provide services of high standard is arguably the main element of quality.

According to a representative of a small service provider, **the quality assurance in practice is currently not sufficient in their organisation**. The respondent notes that there has been a decreasing focus on quality in their organisation because they used to have good outcomes and became too secure that they provided a very good service and, thus, lost the system of checking the quality. The focus on quality depends a lot on the leadership.

EU level standards/frameworks and guiding principles regarding social services (for example, European Pillar of Social Rights, European Voluntary Quality Framework) or certification system has so far not been implemented on VR in Sweden. According to one of the interviewees, Sweden is quite aware of the standards, frameworks and principles at a European level, but they have to be moved from the political to practical level in order to be integrated into the activities of service providers. Only one of the interviewees, a representative of Actíva, is aware of EQUASS, but their organisation does not plan to introduce it, as it is a small service provider. The other interviewees are not aware of EQUASS.

Interview List

Service	Interviewee	Organisation &	Designation	Date of

[297] http://www.euse.org/

[298] https://siq.se/en/SIQ - Institutet för Kvalitetsutveckling English page

Provider / Regulator		Department		Interview
Service provider	Karin Johansson	Swedish Public Employment Service (*Arbetsförmedlingen*)	Senior Desk Officer at the Head Office, Operational Area Jobseekers	November 12, 2020
Service provider	Bertil Johansson	Actíva, the foundation of supported employment	Head of Unit	November 17, 2020
Quality register[299]	Prof. Katharina Stibrant Sunnerhangen	WebRehab Sweden, the national quality register in rehabilitation	Registry holder	November 26, 2020

United Kingdom Case Study
Quality Regulations, Requirements and Trends in Vocational Rehabilitation

At a glance

- *Vocational rehabilitation for PWDs is provided by the NHS, by private providers (paid by insurers or users), and sometimes by charities.*
- *The reach and scope of NHS services suffers from vast regional inequalities.*
- *There are no quality standards specific to VR yet, although industry stakeholders are working to create relevant ones.*
- *Quality is ensured through informal mechanisms and non-VR-related general quality standards in service provision, which are not always compulsory.*
- *Lack of clear regulation leaves space for some providers to deliver services in absence of clear quality principles.*
- *Within the UK, Scotland is actively promoting the use of the international Certified Disability Management Professional (CDMP) qualification.*
- *European quality frameworks are scarcely known and almost never applied.*

Governance and provision of VR services

Vocational rehabilitation (VR) in the UK encompasses any services that can help people return to work or maintain employment when faced with capacity loss due to health conditions.[300] VR also refers to services for people with disabilities (PWDs) who are looking to enter the workforce, and now also includes wellbeing services and preventative activities to create healthy workplaces or reducing work-related stress.[301] Even though many VR services in the UK are well planned and evidence-based, interviews with stakeholders point to a **highly decentralised, deregulated, and uncoordinated quality monitoring** of services, and lack of knowledge among users of their rights and types of services they are entitled to. There can be, therefore, providers who do not work according to an evidence-based approach or to the standards of a professional body / those of the Vocational Rehabilitation Association (VRA), the only membership body in the UK specific to VR

[299] There are no regulators of VR quality in Sweden.
[300] Interview with Christine Parker, Senior Lecturer, University of Salford; Vice Chair and Trustee, Vocational Rehabilitation Association (VRA) (13 Nov 2020); https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5041047/.
[301] Exchange with Joy Reymond, VRA Trustee/Founding member, UK Rehabilitation Council/Board member, Council for Work & Health (10 Dec 2020)

practice.[302] Enforcement of quality standards is often based on customary practices (sometimes applied inconsistently), self-regulation, case-by-case checks on track record of providers, or indirectly, via membership requirements to professional organisations, rather than on a single, universally-applicable regulatory mechanism.

VR is provided either in connection with healthcare, through occupational health services or through NHS rehabilitation services, or in connection with social services and employability (detailed below).[303] VR services include "assessment, appraisal, programme evaluation and research; goal setting and intervention planning; provision of health advice and promotion, in support of returning to work; support for self-management of health conditions; making adjustments to the medical and psychological impact of a disability; case management,[304] referral, and service co-ordination; psychosocial interventions; career counselling, job analysis, job development, and placement services; functional and work capacity evaluations."[305] These can be delivered through three main channels:

- **Private providers**' (companies or individuals) services, with costs covered by **insurers** (and in rarer cases by users themselves): these, which are typically **case management** services, rely either on a "fault system" (users must prove that the injury is related to their work activity to claim compensation from employers) or income protection insurance (in which case no allocation of blame is required). The insurance system is largely non-litigious and relies on the Financial Ombudsman rather than courts. A growing number of employers now pay for VR or even have in-house VR specialists; most IP insurers also have in-house or outsources rehab teams.[306]
- Free services by **charities** and **NGOs** funded through grants or private donations; charities often provide services for Jobcentre Plus, and as such are expected to have staffers accredited with the Employment Related Services Association (ERSA).[307] These services are mostly targeted at long-term unemployed or never-employed users, not always PWDs, and are only partially related to VR.[308]
- Services delivered through the **healthcare system**, sometimes by Occupational Medicine and other healthcare professionals such as Primary Care Doctors, Physiotherapists and Occupational Therapists. These services are characterised by huge geographic inequalities: although rehabilitation is embedded in the NHS' planning and the early rehabilitative process is organised around medical treatment with an eye on vocational rehabilitation at a further stage,[309] provision depends on whether the local NHS trust invests in VR or not.[310] The NHS often provides VR services **only if civil society and providers' associations exert significant pressure**, taking it upon themselves to prepare VR curricula and procedures.[311] Users who cannot access NHS services have to pay for private occupational therapists or services from private hospitals, or go without.

Individual users can also apply for government grants to purchase services directly, either at the NHS or through private providers, in which case the NHS will advise about the best options

[302] Interview with Christine Parker, University of Salford/VRA.

[303] Interview with Gary Johnson, Trustee of the VRA, Director of Health and employment at Social Finance (10 Nov 2020).; with June F. Davies, Allied Health Professional Advisor, Macmillan Cancer Support (10 Nov 2020); and Lucy Robinson, Vocational Rehabilitation Coordinator, BackUp (11 Nov 2020).

[304] Case managers may not always be involved in VR and may simply focus on rehabilitation, including in cases when return to work is not possible at all. A VR case manager on the other hand focuses on all aspects related to work reintegration, including those in which a full recovery has not yet been achieved or is not possible.

[305] https://vrassociationuk.com/about/process-vr/

[306] Exchange with Joy Reymond, VRA/UK Rehabilitation Council/Council for Work & Health.

[307] Interview with Gary Johnson, VRA/Social Finance.

[308] Interview with Christine Parker, University of Salford/VRA.

[309] https://www.bsrm.org.uk/downloads/bsrm-core-standards-for-major-trauma-19.11.2018-clean-for-web.pdf; https://www.bsrm.org.uk/downloads/specialist-rehabilitation-prescription-for-acute-care-28-11-2014-ja--(ap1-redrawn).pdf; https://www.networks.nhs.uk/nhs-networks/vocational-rehabilitation/documents/FinalReport.pdf

[310] Interview with June F. Davies, Macmillan Cancer Support; Interview with Gary Johnson, VRA/Social Finance.

[311] Interview with Gary Johnson, VRA/Social Finance.

available.[312] **Government grants** provide support to PWD to continue doing their work by funding workplace adaptation (generally limited to equipment, as most buildings in the UK are now optimised for PWD access), work assistants, transportation costs, mental health and sign language support. Larger employers can be requested to co-fund such schemes for up to 30%.[313]

Services provided by charities include any non-health-related activities to help users return to work, such as CV writing and interviewing techniques training, competences and skills identification, emotional and motivational coaching, often delivered based on an action plan defined with the users.[314]

Regulation of VR Services and their quality

No clear VR-specific regulations exist. Instead, depending on the type of provision, mechanisms exist to vet providers and guarantee standards of quality. These include: non-compulsory international quality accreditations, whose use is being actively promoted by authorities at least in some parts of the UK; standards for professional membership associations such as the Vocational Rehabilitation Association (the only one specific to VR practice in the UK); non-VR-specific standards from the NHS and regulatory healthcare bodies such as the Health and Care Professions Council (HCPC), and monitoring processes, that do however set at least some general principles for all providers.

An important exception is Scotland, where the government encouraged the introduction of an international quality standard, the **Certified Disability Management Professional (CDMP)** accreditation developed by the Canadian National Institute of Disability Management and Research (NIDMAR). This acts as a basis for the accreditation process of staffers, to be able to work as case managers in VR.[315] CDMP is reserved to operators with some work or academic experience but there are plans to create a programme for sector newcomers.[316] This remains, however, a voluntary (albeit widely used) framework.[317] The Scottish government has however introduced a degree of compulsoriness as people trained in CDMP with government funding have an obligation to remain accredited. The objective of the adoption of CDMP in Scotland is to unify under one quality framework all standards for VR, employability and occupational health services provision, to cover all providers working in all areas of access to/retention of/return to work.[318] This would constitute a unique achievement for the UK. There is interest among some British universities outside of Scotland to adopt CDMP as an accredited teaching programme.[319]

In the rest of the UK, however, **the CDMP is not yet widespread**: England shows a regular, although slow uptake in the number of providers who opt to be CDMP-certified, and some large organizations have adopted it en bloc, but Wales and Northern Ireland are not registering any progress.[320] Quality regulation remains “patchy” and “piecemeal”:[321] Services provided by **private companies** have long suffered from quality deregulation: Until the late 2000s, VR services were not formalised; professional organisations started to emerge and have since pushed for the

[312] Interview with June F. Davies, Macmillan Cancer Support.
[313] Interview with Gary Johnson, VRA/Social Finance; interview with Lucy Robinson, Backup; exchange with Joy Reymond, VRA/UK Rehabilitation Council/Council for Work & Health.
[314] Interview with Lucy Robinson, BackUp; interview with Gary Johnson, VRA/Social Finance.
[315] https://www.cspdm.ca/certification/certified-disability-management-professional-cdmp/; interview with Gary Johnson, VRA/Social Finance; interview with Christine Parker, University of Salford/VRA; interview with Graham Halsey, Chairman of the International Disability Management Standard Council (IDMSC) UK and Ireland (13 Nov 2020).
[316] Interview with Graham Halsey, Chairman, IDMSC UK and Ireland.
[317] Interview with Gary Johnson, VRA/Social Finance; interview with Christine Parker, University of Salford/VRA; interview with Graham Halsey, Chairman, IDMSC UK and Ireland
[318] Interview with Graham Halsey, Chairman, IDMSC UK and Ireland.
[319] Interview with hristine Parker, University of Salford/VRA.
[320] Interview with Graham Halsey, Chairman, IDMSC UK and Ireland.
[321] Interview with Christine Parker, University of Salford/VRA.

adoption of industry-wide professional standards, although these remain **optional**. Three leading professional organisations; the **Vocational Rehabilitation Association (VRA)**, the **British Association of Brain Injury & Complex Case Management (BABICM)** and the **Case Management Society UK (CMSUK)**, are coordinating to build a register and standards of practice for case managers across the country, which will include those in the VR field, and accreditation requirements to be renewed yearly.[322] However, the registry is still in the planning stage, and will only cover case managers, which are not the entirety of VR professionals.[323] The VRA already established professional quality standards, first issued in 2007 and revised in 2013 and 2019,[324] but they are neither binding nor monitored.[325] Some universities and the VRA are working on training accreditation programmes; the VRA is also lobbying the government on the issue of lack of quality regulation.[326]

Public authorities such as the NHS who want to commission services issue a "services specification" with the details of the services they want to buy, calibrated based on the local needs: providers who compete to win a tender will have to demonstrate that their staff is qualified to provide the service.[327] Providers must register with and are subject to inspections from the **Care Quality Commission (CQC)**,[328] the national independent regulator of social and health care, which monitors critical areas of service provision through a multidisciplinary team whose composition depends on what the provider needs to be monitored for.[329] The **CQC does not have VR-specific requirements**, although it has criteria on rehabilitation in general.[330] In practice, however, most controls at the local level are conducted by the commissioning authority (such as the local NHS trust) in coordination with the provider. NHS England can also conduct inspections, and have the authority to shut down a VR provider's activity, but they tend to focus on aspects such as accessibility and waiting lists.[331] As long as they register with the CQC, providers do not in fact need to have quality certifications to access public tenders: instead, authorities will choose based on **companies' experience in the sector** assessing the references, testimonials, track record and CV of staffers.[332]

Occupational healthcare practitioners, such as occupational therapists, nurses, psychologists, and physiotherapists, who sometimes provide VR services, can practice upon registration with the **Health and Care Professions Council (HCPC)**, which guarantees the professionality of its members,[333] but not their skills in delivering VR, as none of the HCPC professions has specialist training in VR within their curriculum.[334] **VR does not have a specific professional regulating body**, and in fact does not as yet have a clear career pathway with defined professionality requirements needed to become a VR provider.[335] Most VR providers are occupational therapists, physiotherapists, psychologists or nurses, but many, especially those who work for charities, come

[322] Interview with Gary Johnson, VRA/Social Finance.
[323] Interview with Joy Reymond, VRA /UK Rehabilitation Council/Council for Work & Health (13 Nov 2020)
[324] https://vrassociationuk.com/resources/vra-standards-practice/; https://www.networks.nhs.uk/nhs-networks/vocational-rehabilitation/documents/VRA-Standards-2008-02-04.pdf
[325] Interview with Christine Parker, University of Salford/VRA.
[326] Interview with Christine Parker, University of Salford/VRA, and with Joy Reymond, VRA/UK Rehabilitation Council/Council for Work & Health. The VRA is also looking at the regulatory and training practices of the Institute of Employability Professionals (IEP) as a source of best practices: even though the IEP focuses on social services for unemployed people, overlap between VR and the field of employability exists in ethos and practices.
[327] Interview with June F. Davies, Macmillan Cancer Support.
[328] https://www.cqc.org.uk/
[329] Interview with June F. Davies, Macmillan Cancer Support.
[330] https://www.cqc.org.uk/sites/default/files/201608_briefguide-rehabilitation.pdf.
[331] Interview with June F. Davies, Macmillan Cancer Support.
[332] Interview with Christine Parker, University of Salford/VRA, and June F. Davies, Macmillan Cancer Support.
[333] Interview with Gary Johnson, VRA/Social Finance.
[334] Exchange with Joy Reymond, VRA/UK Rehabilitation Council/Council for Work & Health.
[335] Interview with Christine Parker, University of Salford/VRA.

from a social services, insurance, or employment industry background.[336] SEQOSH standards are scarcely relevant to VR, and focus on general management aspects and minimum safety criteria rather than on quality.[337]

There is a large number of **professional guidelines produced by VR-related associations** or **sector-specific guidelines produced by health authorities**, the latter being only partially related to VR, such as the **National Institute for Clinical Excellence's (NICE)** guidelines on rehabilitation after clinical illness in adults,[338] or the **Certificate in OH** [Occupational Health] **Case Management**, but **these are only optional.**[339] Assessment of the application and impact of these guidelines varies: some interviewees comment that the UK's system is based on the idea that guidelines compliance is "something nice to help", but point at a general deregulation in the sector as sign of their ineffectiveness;[340] others comment that they genuinely help providers guide their work, orient their provision, and strengthen their argument in their efforts to convince local healthcare authorities about the need to start providing specific services.[341] In practice, VR professionals who are also healthcare practitioners follow professional standards common to healthcare in general, but are not subject to comparable requirements for their VR work. Charities that provide VR services **outside of insurance or NHS channels** do not have any formal quality requirements or accreditation mechanisms.[342]

Quality monitoring and enforcement

Since the quality framework for VR services in the UK relies heavily on non-compulsory guidelines and principles, it is necessary to focus on the monitoring processes to determine whether these instruments have any practical impact.

Much of the quality monitoring of VR in the UK still depends on the personal initiative of users or of professional organizations, and on un-written customary practices. Authorities, for example, encourage users' engagement in the development of services, including VR: this is done by relying on networks of community-driven civil society organizations and charities that relate back the needs of users. They also rely heavily on **satisfaction questionnaires** to gauge services' quality: the NHS, in particular, employs "**Friends and Family Tests**", which asks if users would recommend their service to friends and relatives, as a proxy to evaluate the quality of services provided.[343]

When commissioning large VR programmes, **central government** departments tend to assign tenders to large 'preferred providers', based on long-standing track records of service provision. These providers subcontract elements of their delivery, taking responsibility for the quality of provision by their sub-contractors. **Local authorities** generally assign projects through competitive tenders in which they take more direct responsibility for assessing the applicants' declared ability to deliver outcomes within a budget. They (partly) judge applicants on financial viability, professional affiliations (membership of a professional regulatory body) and reputation or track record, including testimonials. Overall, **quality monitoring and enforcement in public tenders suffers from a degree of unreliability** as there are no compulsory and universal qualifications required for a VR provider (unless the target population needs a specialist such as a neurological therapist).

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[336] Interview with Christine Parker, University of Salford/VRA; interview with Lucy Robinson, BackUp.
[337] Interview with Joy Reymond, VRA/UK Rehabilitation Council/Council for Work & Health.
[338] https://www.nice.org.uk/guidance/qs158
[339] https://www.nice.org.uk/standards-and-indicators; interview with Christine Parker, VRA/University of Salford; June F. Davies, Macmillan Cancer Support; and Gary Johnson, VRA/Social Finance.
[340] Interview with Christine Parker, University of Salford/VRA, and Graham Halsey, Chairman, IDMSC UK and Ireland.
[341] Interview with June F. Davies, Macmillan Cancer Support.
[342] Interview with Lucy Robinson, BackUp.
[343] Interview with June F. Davies, Macmillan Cancer Support.

In addition, whilst some practitioners delivering VR in the UK are regulated through their professional bodies (e.g. General Medical Practitioners; Physiotherapists; Occupational Therapists; Nurses; Psychologists), their professional training programmes focus primarily on health and rehabilitation. While some of these bodies cover VR principles and a VR approach, this is not specifically identified as such, and they do not necessarily cover the specialist skills and knowledge for all aspects of VR practice. The above-mentioned coordination by the VRA and other VR-related groups to build a register and standards of practice for case managers seeks to address this gap.[344] The VRA is also considering the development of an evaluation framework for currently available training and education in VR-related areas, with a view to creating an educational route into VR practice. This would then provide some degree of quality assurance to support commissioners and purchasers of VR services in making more informed choices.[345]

The quality of work of providers **commissioned to deliver VR services by insurers** is judged through informal mechanisms such as checking their track record, reputation and testimonials for similar work done previously. These determine the **likelihood of commissioning and referral:** insurers will not re-commission the same provider or recommend them to future users unless previous insured users are satisfied with the result. Likelihood of commissioning and referral increases if providers are members of professional organizations,[346] or, to a lesser extent, if staffers are CDMP-certified:[347] in *theory*, a company could still provide VR without any kind of professional association membership, and still be commissioned work by insurers and other commissioners, but there is growing pressure from the industry to encourage commissioners to only choose companies that abide by some standards such as the VRA standards or the CDMP qualification and are members of professional associations; and insurers in turn consider membership of associations to be an assurance of quality.[348] Many insurers tend to commission work only to providers whose staff has a healthcare background as they will be professionally regulated.[349] The VRA also expects vocational rehabilitation providers to perform regular self-audit, but this is a non-enforceable requirement, and there are currently no mechanisms to audit providers for standards compliance.[350]

Charities that do not depend on institutional or insurance company funding monitor quality primarily via **user satisfaction**, **success rate statistics** in job applications (monitored also by checking in with users several months from the conclusion of a programme), and through mechanisms such as **testimonials and users' recommendation**, which are crucial in ensuring **continuity of volunteers' support and of private donations** – these, in turn, acts as crucial metrics for many providers of this type to confirm that the service being delivered is of good quality. Employees are also subject to performance reviews checks based on key performance indicators.[351]

Key dimensions of quality for providers and regulators

Identifying the key quality dimensions in the UK is difficult due to the informal nature of regulations. As existing guidelines are generally optional and rely on the individual initiative of providers and staffers to be put to practice,[352] determining their actual implementation and adherence is arduous. The creation of a national register for case managers might make quality criteria clearer: its

[344] Interview with Christine Parker, University of Salford/VRA, and follow-up exchange with Joy Reymond and Christine Parker, 11 Dec 2020.
[345] Exchange with Christine Parker, University of Salford/VRA, 11 Dec 2020.
[346] Interview with Gary Johnson, VRA/Social Finance.
[347] Interview with Christine Parker, University of Salford/VRA.
[348] Interview with Gary Johnson, VRA/Social Finance, and with Christine Parker, University of Salford/VRA.
[349] Interview with Christine Parker, University of Salford/VRA.
[350] Interview with Christine Parker, University of Salford/VRA, and Gary Johnson, VRA/Social Finance.
[351] Interview with Lucy Robinson, BackUp.
[352] Interview with Gary Johnson, VRA/Social Finance.

proponents hope that it will create a more structured approach towards defining what constitutes acceptable case management, and that commissioners will only employ registered practitioners, but it is not yet clear which (if any) quality standards will emerge as the dominant ones, what the registry of case managers will entail in practice, what will be assessed in terms of quality, and how.[353]

The CDMP, which to this date remains the closest thing to a unified, semi-officially adopted qualification for VR in the UK, secures quality in service provision by focusing on the importance of **securing employment within the PWD's former area of practice**; **not forcing users to work beyond their set of skills**; guarantee a return-to-work that is **both safe for the PWD and sustainable in the long term**; provide services **in coordination with work place unions** to ensure that PWDs **return to a workplace that is good for people**. A recognized advantage of CDMP is that it provides both users and employers with more certainty about the competence of operators, and makes it easier to establish trust between operators and employers and engage with them from the start of the VR process, facilitating the re-entering of PWDs in the workplace.[354] This is possible thanks to its focus on **employee-employer relationship**: employers are already involved in paying for rehabilitative treatment, and to some degree in the process of recovering work potential, but the CDMP makes this collaborative relationship one of its core tenets: CDPM-trained VR providers train PWDs on workplace-relationship and navigating the reality of working with managers who may not understand PWDs' needs in return-to-work.[355]

When users access government grants for the purchase of VR services, **cost-effectiveness** rather than quality is the dominating criterion: PWDs have their needs assessed by a commission that will determine what equipment or services the PWD needs to carry out work; PWDs have to produce three quotes, and the government will approve the cheapest one. For **work assistant services**, users can find assistants that will work for the cheapest amount per hour, generally in line with the minimum salary; the government reimburses the cost. Theoretically, anyone can be hired as assistant as long as they are able to help the PWD perform the tasks requested by employers.[356] **Cost-effectiveness, fulfilment of cost and timely delivery agreements**, and **planning requirements** are the dominating criteria to monitor contractors work, too: this is seen as sufficient to ensure quality, but these criteria pertain more to the fulfilment of general quality standards in *management,* rather than in VR itself.[357]

Current trends

The current quality guarantee system in the UK is slowly moving towards clearer regulation and better-defined principles, which all interviewed stakeholders consider to be long overdue. The work of the VRA in defining standards and establishing accredited training programmes, the existing plans of BABICM, CMSUK and VRA to create a registry of case managers and standardize their training, and the slow expansion of the CDMP accreditation should reduce the existing uncertainty in the industry. There are hopes that the CDMP will become a base-level qualification for all professionals in VR, employability, and occupational health, helping social and healthcare services coordinate better.[358] CDMP proponents however recognize that for this to happen, collaborations have to be established with universities to make CDMP a recognised preferential condition for admission to Masters level courses, and changes in government practices in England, Wales and

[353] Interview with Joy Reymond, VRA/UK Rehabilitation Council/Council for Work & Health.
[354] Interview with Graham Halsey, Chairman, IDMSC UK and Ireland.
[355] Interview with Joy Reymond, VRA/UK Rehabilitation Council/Council for Work & Health.
[356] Interview with Lucy Robinson, BackUp.
[357] Interview with Gary Johnson, VRA/Social Finance.
[358] Interview with Graham Halsey, Chairman, IDMSC UK and Ireland.

Northern Ireland are needed.[359] The IDMSC-UK & Ireland, the VRA and the University of Salford are already working together to address these issues.

VR is expected to become more important in the next years due to prolonged life expectancy and survival rates for patients of previously deadly diseases; such patients will be more likely to need help re-entering the job market.[360] Some providers also feel that the shift to remote working as a result of the COVID-19 pandemic may help make re-integration of PWDs in the work market easier, as many job places will shift to home working, thereby removing the burden of workplace adaptation and related costs.[361] There are hopes that the government will expand subsidies to employers who offer support to employees who struggle to retain work due to health, and that this will cover not just occupational medicine, but also VR services.[362]

Role of voluntary quality systems

As illustrated, the UK quality system relies almost entirely on voluntary frameworks. Besides the CDMP, which was discussed in previous sections and is slowly becoming a semi-official standard rather than a purely voluntary one, international standards play a small role. Standards such as ISO are not widely used, while others, such as EQUASS, are virtually unknown. Some providers use voluntary quality frameworks in non-VR-related parts of their work as it increases their chance of being referred to by the NHS and gives users more confidence about the quality of services, and may consider doing this also for their VR services in the future.[363]

Private providers often use **ISO standards**, the **Merlin Standard** for delivering excellence in supply chain management,[364] or seek to obtain the UK's government certification as **Disability confident employer**;[365] none of these are mandatory, nor specific to VR, since they merely certify good quality internal management, but are seen as useful to win contracts.[366]

European standards and principles, including the EPSR, are virtually unknown of in the UK (except for some providers who work in VR for PWDs with learning disabilities and rely on EU regulations).[367] Interviewees comment that British cultural habits and deeply different regulatory practices, which set the UK apart from Europe, has made **learning about possible best practices unfeasible or uninteresting,** and created **reluctance to adopt standards and principles from the Continent**, a tendency that will probably exacerbate after Brexit.[368]

Interview List

Service Provider / Regulator	Interviewee	Organisation & Department	Designation	Date of Interview
Provider, national expert, and regulator	Christine Parker	University of Salford	Senior Lecturer	13 Nov 2020
		Vocational Rehabilitation Association (VRA)	Vice Chair and Trustee	

[359] Interview with Graham Halsey, Chairman, IDMSC UK and Ireland, and with Joy Reymond, VRA/UK Rehabilitation Council/Council for Work & Health.
[360] Interview with June F. Davies, Macmillan Cancer Support.
[361] Interview with Lucy Robinson, BackUp.
[362] Interview with Joy Reymond, VRA/UK Rehabilitation Council/Council for Work & Health.
[363] Interview with Lucy Robinson, BackUp.
[364] https://merlinstandard.co.uk/
[365] https://www.gov.uk/government/collections/disability-confident-campaign
[366] Interview with Gary Johnson, VRA/Social Finance.
[367] Interview with Gary Johnson, VRA/Social Finance.
[368] Interview with Joy Reymond, VRA/UK Rehabilitation Council/Council for Work & Health, and with Graham Halsey, Chairman, IDMSC UK and Ireland.

Provider and regulator	Gary Johnson	VRA	Trustee	10 Nov 2020
		Social Finance	Director of Health and Employment	
Regulator	Graham Halsey	International Disability Management Standard Council (IDMSC) UK and Ireland	Chairman	13 Nov 2020
Provider	June F. Davies	Allied Health Professional Advisor	Macmillan Cancer Support	10 Nov 2020
Provider	Lucy Robinson	BackUp	Vocation rehabilitation coordinator	11 Nov 2020
Provider, national expert, and regulator	Joy Reymond	VRA	Trustee	13 Nov 2020
		UK Rehabilitation Council	Founding member	
		Council for Work & Health	Board member	

G. Annex - Questionnaires

Questionnaire for Service Providers

General situation in the country

1. What are they key quality trends for vocational rehabilitation services in the past few years? (*prompt interviewees to answer each of the below)*
   - Certification requirements for providers
   - Expectations from authorities (beyond certification requirements – quality criteria that apply for e.g. public procurement or reserved markets)
   - Expectations from clients
2. How well do you feel the current regulations and requirements for quality standards in your country support quality service provision in the vocational rehabilitation sector?
3. Are you familiar with the European Pillar of Social Rights (EPSR)? If so, do you find it has an impact on development of quality regulations in this sector in your country and what is it?
4. Do EU level standards/frameworks on social services impact quality of social services (or vocational rehabilitation and training) in your country? *(prompt about each of the below)*
   - European Pillar of Social Rights
   - European Voluntary Quality Framework
5. What do you expect to be the trends in the coming few years? (*prompt to address internal – practice-related changes in the way they work but also the policy level in case they know of any foreseen changes to be implemented)*

Your organisation

6. What kind of vocational rehabilitation services do you provide?
7. What key performance indicators due you use to measure the effectiveness/quality of your service? *(prompt if needed: user satisfaction, user participation, employee satisfaction, governance, access, timeliness….)*
8. What quality certifications (any local, ISO, EQUASS etc.) do you have in place for vocational rehabilitation services?
9. What is your motivation for having or not having voluntary certifications (*depending on answer to the above)*

10. Are you aware of EQUASS certification system? (*if not mentioned already when answering the above questions)*

If the answer is "yes":

11. What in your view is the value of EQUASS compared to other certifications? (*prompt: ISO, EFQM, others)*
12. Any aspects in which other certification systems are more useful in your view compared to EQUASS?
13. Do you believe there is a market for EQUASS certification in the coming years among providers of vocational rehabilitation services?

Questionnaire for Regulators

General situation in the country

1. What are they key quality trends for vocational rehabilitation services in the past few years? (*prompt interviewees to answer each of the below)*
   - Certification requirements for providers
   - Expectations from authorities (beyond certification requirements – quality criteria that apply for e.g. public procurement or reserved markets)
   - Expectations from clients
2. How well do you feel the current regulations and requirements for quality standards in your country support quality service provision in the vocational rehabilitation sector?
3. Are you familiar with the European Pillar of Social Rights (EPSR)? If so, do you find it has an impact on development of quality regulations in this sector in your country and what is it?
4. Do EU level standards/frameworks on social services impact quality of social services (or vocational rehabilitation and training) in your country? *(prompt about each of the below)*
   - European Pillar of Social Rights
   - European Voluntary Quality Framework
5. What do you expect to be the trends in the coming few years? (*prompt to address internal – practice-related changes in the way they work but also the policy level in case they know of any foreseen changes to be implemented)*

Quality certifications

6. What quality certifications, including regulatory (national systems) and voluntary (e.g. EQUASS, ISO, EFQM) exist/are common among vocational rehabilitation (or social service) providers?
7. Are any of the certifications obligatory in order to participate in public tenders/provide vocational rehabilitation or other social services?
8. What do you think is the primary motivation for organisations that do opt for voluntary certifications?
9. Are you aware of EQUASS certification? *(if not mentioned already when answering the above questions)*

If the answer is "yes":

10. What in your view is the value of EQUASS compared to other certifications? (*prompt: ISO, EFQM, others)*
11. Any aspects in which other certification systems are more useful in your view compared to EQUASS?
12. Do you believe there is a market for EQUASS certification in the coming years among providers of vocational rehabilitation services?

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