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The assessment of person-related criteria for allowances and personal assistance for people with disabilities.

A comparative study.

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Good morning, ladies and gentlemen. First of all I wish to thank our President and our Secretary for the opportunity they gave me to offer a contribution to this Congress. I wish to thank also Madame Podestà Le Poittevein, Head of the Partial Agreement in the Social and Public Health Field, to let me represent a piece of work of the Council of Europe (COE) and last but not the least, I thank you, friends and colleagues for the patience you will pay in listening another foreign speaker in this international reunion.

The present contribution aims to offer some preliminary results of my activity as an Expert Consultant of a Working Group of the Partial Agreement in the Social and Public Health Field on the assessment of criteria for granting allowances and personal assistance for people with disabilities.

The Council of Europe, founded in 1949, aims to work for greater European unity, to improve living conditions and develop human values in Europe and to uphold principles of parliamentary democracy and human rights. At the present the COE counts 41 member States[1]. When a lesser number of States wish to engage some action in which not all other European partners desire to join, they can conclude a Partial Agreement.

The partial Agreement in the Social and Public Health Field [2]was concluded in 1959 with the aim of continuing the work previously undertaken under the Brussels Treaty and then by the Western European Union.

The areas of activity include protection of public health, particularly consumer health and rehabilitation and integration of people with disabilities.

In 1996 the Committee on Rehabilitation and Integration of People with Disabilities considered a priority to examine the assessment of disability over the 1997-2000 period. For this reason a Working Group was given responsibility, among others, for carrying out a comparative analysis on the criteria governing the granting of allowances and personal assistance and for studying the role of multidisciplinary teams.

Sources of data were the replies to a Questionnaire set up by the Working Group and circulated among all Member and Observer States and other official publications of the Council of Europe. In

[1] COUNCIL OF EUROPE 41 MEMBER STATES: Albania, Andorra, Austria, Belgium, Bulgaria, Croatia, Cyprus Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Moldova, the Netherlands, Norway, Poland, Portugal, Romania, Russian Federation, San Marino, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, "the former Yugoslav Republic of Macedonia", Turkey, Ukraine, United Kingdom of Great Britain and Northern Ireland.

[2] PARTIAL AGREEMENT IN THE SOCIAL AND PUBLIC HEALTH FIELD 17 MEMBER STATES: 17 MEMBER STATES: Austria, Belgium, Cyprus, Denmark, Finland, France, Germany, Ireland, Italy, Luxembourg, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, United Kingdom of Great Britain and Northern Ireland. 8 OBSERVER STATES: Canada, Estonia, Hungary, Iceland, Latvia, Lithuania, Poland, Slovenia.

1998 I was appointed as an external Consultant to analyse the data resulting from the completion of the questionnaires.

All the member and observer states of the Partial Agreement but Canada sent a contribution although it was not possible to compare data from Poland as structural changes in Social Security System were under discussion during the phase of data collection and from Estonia as this country sent only a brief description of its Social Security System and data were not comparable. With respect to EU partners[3], Greece is the only country not included in the analysis as it is not part of the Partial Agreement.

In total 22 countries were analysed: 17 Member States and 5 Observer States.

Three main areas were investigated:

1. Legislative principles
2. Criteria governing benefits in cash and in kind common to each country
3. Role of Multidisciplinary Teams.

1. Legislative principles

Two legislative aspects were analysed.

1. The first one was whether rehabilitation is a pre-requisite for granting allowances in each country.

2. The second and more general aspect was on the regulation of allowances and personal assistance at national, regional or local level.

1. Before giving a synthesis on the first aspect, it is necessary to recall the definition of rehabilitation according to the Council of Europe Recommendation No. R (92)6 on a coherent policy for people with disabilities. Rehabilitation is a duty of society and covers more fields of intervention from prevention to vocational integration. Regarding social, economic and legal protection the text states that people with disabilities should have a minimum livelihood, specific allowances and a system of social protection. Economic and social security should grant cash benefits, benefits for families with children with disabilities, long-term care, benefits to people unable to seek employment because of care provided to a person with a disability, benefits to people with disabilities who are able to work only part-time.

Going back to the analysis on the principle **rehabilitation before the allowance** two main types of approach have been identified.

[3] EUROPEAN UNION 15 MEMBER STATES: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden, United Kingdom of Great Britain and Northern Ireland.

In some countries rehabilitation always precedes the granting of allowances (Austria, Denmark, Germany, Hungary, Iceland, Lithuania, Luxembourg, Norway, Slovenia, Spain, Switzerland), in other countries, however, rehabilitation is a right of the individual but not necessarily a pre-condition for an economic benefit (Belgium, Cyprus, France, Ireland, Italy, Latvia, Portugal, Sweden and United Kingdom). In Iceland, Finland, Germany and Switzerland persons undergoing a rehabilitation programme receive a temporary allowance. In the Netherlands a citizen is permanently required to undergo rehabilitation programmes and receives a temporary allowance.

The link between clinical and social rehabilitation is not clear in some countries and clinical and social rehabilitation seem to be two different procedures managed in different structures.

2. With regard to the second aspect of legislative principles data show that there is a high prevalence of countries where the management of allowances and personal assistance is regulated at national or federal level. Regions and municipalities are mainly involved in implementing or in delivering services. There are a few exceptions. Germany has some regional provisions for blind and deaf people and some local provisions for transport. Spain, Finland, Belgium, Norway and Iceland have provisions at regional and/or local level mainly concerning technical aids housing and transport.

2. Criteria governing benefits in cash and in kind common to each country

Regarding the core of the analysis, benefits in cash or in kind have been grouped as follows according to the structure of the Questionnaire and the guidelines of the Working Group.

Regarding **Long term benefits for people who become disabled during working life** which are the best known and widely represented type of benefit, it Italy, is possible to draw the following - partial - conclusions.

In Austria, Belgium, Cyprus, France, Germany, Iceland, Italy Latvia, Luxembourg, Norway, Portugal, Slovenia, Switzerland, and United Kingdom there is a special management for industrial injury and occupational diseases.

The most common legal criterion to grant cash benefits for industrial injuries and occupational diseases is the *loss of capacity for work,* measured with barémas which are in general impairment based (with reference to ICIDH definition). In Slovenia, Iceland and Cyprus the legal reference is *impairment* (respectively > 30%, > 10% and over 10% with the exception of pneumoconiosis which are compensated from >1%). In Austria, instead, the legal reference is *disability* (> 20%) although the method of assessment is baréma which probably reflects an impairment based method of assessment. As above anticipated *baréma* seems to be the most common tool of assessment for this group of countries although Cyprus uses a *functional capacity* based method. Iceland has a

baréma based on AMA IV Edition[4] that is impairment based. In Latvia according to severity of impairments there are three groups of disability (I to III for descending severity). In Lithuania method of assessment includes impairments, functional capacity and non medical factors (loss of income).

Regarding **other long term-benefits for people who become disabled during working life** the most common legal criterion is again *loss of work capacity* due to a medical condition as in Cyprus, Denmark, France, Germany, Hungary, Iceland, Italy, Latvia, Lithuania, the Netherlands, Norway, Slovenia, Spain and United Kingdom. Threshold differs in different countries: 15% for employees and 25% for self employed in the Netherlands, from 30% in Germany, >50% in Norway and Denmark, > 67% in Hungary in France and Italy. In Slovenia threshold for partial loss of capacity for work is not specified.

Capacity of earning is the legal reference also in Belgium and Switzerland with threshold of 1/3 and 40% respectively.

In Finland the legal criterion is *disability.*

Austria stated to have different and defined "complex" *criteria depending on category* of applicants.

Sweden has *non medical* criteria based on extra costs due to disability.

Ireland and Luxembourg did not specify the legal criteria.

Criteria common to all countries are the *contributory* nature of benefits and qualifying age. This is peculiar for each country but clearly reflects the *working age* period.

Although it is relatively simple to group criteria governing the granting of this type of benefits when we come to the ground of method of assessment the approach is less homogeneous.

Barema method is in use in Austria (in combination with assessment of care needs), Hungary, Germany (Social compensation Funds), Cyprus (which uses, instead, a so called functional capacity based method for workmen's compensation scheme, field of intervention traditionally based on impairment), Lithuania and Latvia.

Comparison between real and hypothetical (average) *income* is the method in use in Denmark and Switzerland.

The most represented method is *Functional capacity* as it is used in the Netherlands, Slovenia (in both countries in combination with the analysis of *job requirements)*, Spain (see also page 20), Finland (in combination with assessment of *extra costs* and *care needs*), Belgium (in combination with assessment of care needs), the United Kingdom, Iceland (since last September) and it is under consideration in Denmark. The method is based on the concept of disability of ICIDH .

[4] AMA: American Medical Association Guides to the Evaluation of Permanent Impairment, Fourth Edition. Chicago:

A *mixed method* based on social, work, clinical history and medical examination is used in Italy.

France has in place a *socio-vocational method.*

Assessment of extra costs is the only method described for Sweden.

In Portugal the legal reference is the loss of capacity of earning and the threshold is 50%.

Incapacity long term benefits for people who have never entered the labour market are broadly represented although less details were offered in the reply of the Questionnaire on criteria and method of assessment in comparison to contributory benefits. They are disability or invalidity allowances or pensions. These non-contributory benefits are granted in the context of the Social Assistance of each State.

Short-term benefits seem more common for people who become disabled during working life than for people who did non enter the labour market due to their disability. This result is based on the replies of 13 countries, for people who become disabled during working life and on the replies of 8 countries, for people who did not enter the labour market (Belgium, Germany, Iceland, Ireland, Italy, the Netherlands, Slovenia, UK). Among these countries only Belgium, Ireland, Slovenia and United Kingdom have this provision. In Iceland, however, a short-term allowance for parents of children with special needs is granted. In Slovenia, remarkably, supplementary allowance and assistance on the basis of involvement in vocational guidance and training programme are foreseen.

Criteria governing granting of **benefits in cash or in kind to special target groups**, especially children and relative methods of assessment are more homogeneous. They are mainly represented by a *medical condition* with *need of home care* and *extra costs.* Methods of assessments are generally based on *functional capacity*, which is the way the disabled child performs a task in comparison to a non disabled child of the same age. The assessment method takes into account also care needs and extra costs according to national legislation. Possible explanations for this aspect is that these benefits are obviously not linked to capacity for work or gain, are relatively newer in comparison with pension and workmen's compensation schemes and therefore they have been set in most countries according to international recommendations and regulations taking into account the global functioning of the individual rather than a single function.

Similar considerations are applicable to **long term care allowances.** The most common criterion, where clearly stated, is represented by a medical condition that causes *difficulties in daily life* and *need of a third person.* Method of assessment is based on *functional capacity* which is the way the person can cope with basic everyday needs and tasks to be independent. Method of assessment includes also *need of another person* and *extra costs.* In several countries the concept of dependence is a “all or nothing” one. However it should be considered that there are different levels

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American Medical Association, 1993.

of dependence as, in example, between a paraplegic on a wheel chair and a person bound in bed. In Italy these two subjects would be recognised not self-sufficient and would receive an equivalent attendance allowance. This approach needs to be reviewed bearing in mind the concept of the individual dimension and regulating the economical and non economical interventions. Denmark, in this respect, offers an interesting range of benefits according to the level of dependence and the type of needs.

Slovenia has two levels of long term care benefits based on the number and the level of performance of a list of activities of daily life stated by law.

CONCLUSIONS

The present analysis offers a picture of criteria governing the granting of allowances and personal assistance in 22 countries of the Council of Europe. The study was based mainly on data derived from the replies of Questionnaires filled in by generous as much as heterogeneous professionals so that the problem of the language was a major one in trying to group the answers into clusters. However some partial conclusions can be drawn.

With regard to the application of the principle "rehabilitation before the allowance", that was the starting point of the Working Group, about a half of the countries stated that the principle is in force and/or foreseen by law. As the Working Group decided, relatively to rehabilitation, to make reference to the Council of Europe Recommendation No. R (92)6 on a coherent policy for people with disabilities, it is advisable to reinforce in all members and observers states that rehabilitation is the key to ensure participation and consequently integration of people with disability.

Regarding common benefits, particularly long term-benefits under contributory or non-contributory schemes, provisions seem to be homogeneously represented. Benefits have more or less the same names cross countries, however legal definitions like invalidity or incapacity not necessarily hide the same concepts. The same happens when we try to understand how to measure invalidity or incapacity, as terms like impairment or disability are often used alternatively and not always with reference to the meaning of ICIDH definitions. However at the moment 7 countries (plus one in the nearest future) have adopted a functional capacity assessment method that clearly recalls the ICIDH concept of disability to grant long term contributory benefits (this statement does not include workmen's compensation schemes). Two of these countries introduced the system quite recently (UK in 1995 and Iceland in 1999) and Denmark is considering doing so. This trend shows a strong interest in finding a common ground for assessing methods.

In this respect it could be interesting to explore once more the use of ICIDH concepts in legislation across countries to understand whether legal definitions in the field of disability and related

assessment procedures, beyond legal terms, are homogeneous or not. We believe that a common language may help to ensure common interventions to people with disabilities.