

ASSESSING DISABILITY IN EUROPE – SIMILARITIES AND DIFFERENCES

Report drawn up by the
Working Group on the assessment
of person-related criteria for allowances
and personal assistance for people with disabilities
(Partial Agreement) (P-RR-ECA)

Integration of people with disabilities

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Preface

1. The Council of Europe

The Council of Europe is a political organisation which was founded on 5 May 1949 by ten European countries in order to promote greater unity between its members. It now numbers 43 member States¹.

The main aims of the Organisation are to reinforce democracy, human rights and the rule of law and to develop common responses to political, social, cultural and legal challenges in its member States. Since 1989 the Council of Europe has integrated most of the countries of central and eastern Europe into its structures and supported them in their efforts to implement and consolidate their political, legal and administrative reforms.

The work of the Council of Europe has led, to date, to the adoption of over 170 European conventions and agreements, which create the basis for a “common legal space “in Europe. They include the European Convention on Human Rights (1950), the European Cultural Convention (1954), the European Social Charter (1961), the European Convention on the Prevention of Torture (1987) and the Convention on Human Rights and Bioethics (1997). Numerous recommendations and resolutions of the Committee of Ministers propose policy guidelines for national governments.

2. The Partial Agreement in the Social and Public Health Field

The scope of the Council of Europe's activities is vast, since only defence questions are excluded from its competence. Where, however, a lesser number of states wish to engage in some action in which not all their European partners desire to join, they can conclude a 'Partial Agreement' which is binding on themselves alone.

¹ Albania, Andorra, Armenia, Austria, Azerbaijan, 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.

The Partial Agreement in the Social and Public Health field was concluded on this basis in 1959 by seven member states with the aim of continuing the work in this field previously undertaken under the Brussels Treaty and then by the Western European Union (WEU). At present, the Partial Agreement has 18 member States; 7 States are observers in the field of integration of people with disabilities.¹

The areas of activity include:

- a. protection of public health, particularly consumer health,
- b. rehabilitation and integration of people with disabilities;

The activities are entrusted to a number of committees of experts or working groups, which are in turn responsible to the steering committee for each area.

The work of these Partial Agreement committees occasionally results in the elaboration of conventions or agreements, but the more usual outcome is the drawing-up of recommendations to member governments in the form of resolutions adopted by the Committee of Ministers (composed of the representatives of the states participating in the particular activity). These recommendations/resolutions may be considered as statements of policy or common guidelines for national policy-makers. Governments have actively participated in their formulation: the delegates to the Partial Agreement committees are both experts in the field in question and responsible for the implementation of government policy in their national ministries.

This procedure provides for considerable flexibility in that any state may reserve its position on a given point without thereby preventing the others from going ahead with what they consider appropriate. Another advantage is that the recommendations are readily susceptible to amendment should the need arise. Governments are furthermore called upon periodically to report on the implementation of the recommended measures.

A less formal procedure is the publication of general guidelines intended to serve as a model for member states. Each government can interpret these guidelines in accordance with its own law and practice in the matter.

Bodies of the Partial Agreement in the Social and Public Health field enjoy close co-operation with equivalent bodies in other international institutions. Contact is also maintained with international non-governmental organisations (INGOs) working in related fields.

¹ Member States: Austria, Belgium, Cyprus, Denmark, Finland, France, Germany, Ireland, Italy, Luxembourg, the Netherlands, Norway, Portugal, Slovenia, Spain, Sweden, Switzerland, United Kingdom.
Observers: Canada, Estonia, Hungary, Iceland, Latvia, Lithuania, Poland.

1. INTRODUCTION

**Dr. Peter WRIGHT (United Kingdom) and
Dr. Wout DE BOER (The Netherlands)**

I. BACKGROUND

At its 19th session (Strasbourg, 11-14 June 1996), the Committee on the Rehabilitation and Integration of People with Disabilities (CD-P-RR) examined nine proposals for further work which had been submitted to it by the Committee of Experts for the application of the WHO International Classification of Impairments, Disabilities and Handicaps (ICIDH). It assigned first priority to a proposal to examine the assessment of disability. The terms of reference were adopted at the 20th session (Bled, Slovenia, 10-13 June 1997), with a duration from 30 June 1997 to 30 June 2000 allowing for six meetings.

Under the terms of reference, the Working Group on the Assessment of Person-Related Criteria for Allowances and Personal Assistance for People with Disabilities (P-RR-ECA) was given responsibility for carrying out:

- a. a comparative analysis of criteria governing the granting of allowances and personal assistance in each country;
 - b. within this framework, a study of the roles and responsibilities of multidisciplinary teams, including medical doctors, in determining allowances and personal assistance;
 - c. a study of possibilities and modalities of communication and exchange of information contained in administrative and medical files concerning people with disabilities to and between various competent authorities of their country or of the country to which a person intends to move;
- and
- d. submitting concrete recommendations to the CD-P-RR.

II. WORKING METHODS

The Working Group decided to issue a questionnaire to member and observer states of the Partial Agreement in the Social and Public Health Field, and to use the answers as the basis for the fact-finding parts of its remit. It appreciated the difficulty of creating a questionnaire which would be readily understood by all its recipients when there has been little international comparative analysis in the field it was asked to explore. It adopted three methods to help those completing the form:

- Defining the terms it used wherever possible, and
- Giving examples to show how the definitions might be used;

- Individual members of the Working Group offered to help with questions from those filling in the questionnaire, and were chosen because of their ability to speak the language of the country completing the questionnaire.

All member and European observer States of the Partial Agreement in the Social and Public Health Field replied to the questionnaire. The Working Group engaged a Consultant, Dr. Cristina Dal Pozzo to analyse the answers, which contained considerable amounts of information, thus allowing for analyses beyond and outside her remit. Individual members of the Working Group, Dr. Hartmut Haines (Germany), Dr. Yves Laroche (Belgium), Dr. Francesca Fratello and Professor Carlo Scorretti (both Italy) offered to analyse specific aspects of the data and contribute their findings to the overall work. These generous offers were accepted, but meant that the Working Group was faced with four final contributions. Moreover, they were different in their approach, particularly in the balance between factual information presented and analysis. Each contribution could stand alone on its merits, particularly that of Dr. Dal Pozzo. The Working Group therefore decided that all four should be published together, with a short introduction and analysis, and general conclusions. These would seek to draw them together whilst respecting that the individual contributions have (and should have) independent existences. They complement and supplement each other in contributing to a wider analysis than each can achieve alone.

The Working Group also arranged for a written consultation process and a hearing with international non-governmental organisations. Written submissions were received from seven organisations, six were invited to attend to supplement their views orally; three accepted the invitation, and representatives of two came. The Working Group was most grateful for this help, which raised a number of valuable points. Two organisations said that they regarded the task of helping people with disabilities to move more easily by improving the flow of information about them as of great significance.

III. POINTS OF TERMINOLOGY

The task of the Working Group was to look at the methods of assessment used in the different countries whenever they do "something" for people with disabilities which is allocated or given after some test of the disability. The Group recognised that it would have to use terms very precisely in its questionnaire if it was to get useful answers, and spent some time debating the definitions of the terms in this statement. It is simplest to call the 'something' in the first sentence a 'benefit', but it may be money (which the Working Group termed an 'allowance' with a wide definition¹), or goods, or services (including 'personal

¹ For the purpose of this Working Group, for the time being and subject to further discussion, the term "allowance" should mean any disability/invalidity-related allocation of payments on a regular basis, which replace and/or supplement income and to which the entitlement is enshrined in law.

assistance' which the Working Group defined with examples¹). The form of the 'test' may also vary widely, and may require:

- a simple declaration by an individual that s/he qualifies for the benefit,
- some supporting evidence from a neighbour or trustworthy acquaintance who knows the applicant's problems,
- some evidence from a health care professional who has treated the applicant,
- a specific assessment, traditionally by a doctor but increasingly (and especially when social factors are being considered) by consultation within a multi-disciplinary team.

The Working Group decided to use the terms 'benefit' and 'test' in these very wide meanings.

Some benefits have the condition that the person should be incapable of work. This, in the terms of the WHO 'International Classification of Impairments, Disabilities and Handicaps' (ICIDH), corresponds to a handicap². A major question where work is being considered is the standard against which capability is compared. Alternatives include:

- The person's own job (i.e. the one they have recently been doing). This test is only really used for those who have worked recently, and whose period off work is relatively short.
- Any job which may be defined as:
 - One which could be done by anyone;
 - One suitable for the person taking account of their age and skills as well as their disability (i.e. some 'non-medical' factors);
 - One which is reasonable considering its location, type and the earnings it will give compared to those from the previous occupation (even more 'non-medical' factors);
 - One which is theoretically available in the economy (e.g. not a lighter of gas lamps);

¹ For the purpose of this Working Group, for the time being and subject to further discussion, the term "personal assistance" should include all forms of aid and assistance in the broadest possible sense and where disability/invalidity is one of the criteria for the allocation; eg. education: mainstream education, special education, adult education, vocational guidance, vocational training, employment: quota systems, compensation to employers, job coaches, sheltered work institutions, work at home, tax allowances, accessibility, transport, housing, technical aids, communication, sport, leisure, culture; cf. Council of Europe Recommendation No. R (92) 6 on a coherent policy for people with disabilities.

² "In the context of health experience, a handicap is a disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual." International Classification of Impairments, Disabilities, and Handicaps. A manual of classification relating to the consequences of disease, World Health Organization, Geneva 1980, p.183. Cf. P. Fougeyrollas, Applications of the concept of handicap of the ICIDH and its nomenclature, Council of Europe Press, Strasbourg 1993.

- One which is actually available in the economy (i.e. there is that type of job available in the locality of the individual right now);
- A real job (here is a job, tell me why you could not do it).

These are not exclusive; some systems (such as that of the Netherlands) incorporate several of these possibilities. Obviously, the tighter the specification, the fewer people will qualify for benefit. Changing the criteria in apparently technical ways will allow the entry to benefit, and so the benefit cost, to be controlled. Despite these complexities, the Working Group decided to refer to this question of the ability to work for a particular benefit as one of 'incapacity', recognising that this then needed to be qualified in a number of ways to give a clear picture of the test involved.

Thus, the words 'benefit', 'test' and 'incapacity' have special technical meanings when used in this report.

Nevertheless, it became clear that different respondents to the questionnaire had interpreted terms in different ways. The Working Group increasingly found the concepts of the WHO 'International Classification of Impairments, Disabilities and Handicaps' (ICIDH) of 1980 useful in its work¹ although aware that WHO is currently revising this classification. It recognised that it would have given different instructions and definitions for some of the words in the questionnaire in the light of the replies it received. If this report can clarify some of these words and concepts for future researchers, it will have served an important purpose in addition to answering the formal questions the Working Group was asked to consider.

IV. ASSESSING ASSESSMENT METHODS

A test can be analysed by considering the questions which have to be answered before benefit is awarded.

The conditions for a particular benefit are often very complex. Many have criteria related to age, criteria about having paid taxes (or contributions), or conversely being poor (means testing). These can be grouped as 'personal and demographic factors'. Some have what might first be called social conditions. Claimants may have to show that they have taken all reasonable steps to get themselves treated and rehabilitated. Unemployed people may be required to show that they are available for work and are actively seeking it; that they are looking for vacancies, applying for them, attending for interview and so on. The idea of these conditions is very similar to a legal principle affecting those who want to sue for damages in the courts in many countries; they have an obligation to do all they can to

¹ Cf. F. Chapiro, *The conceptual framework of the International Classification of Impairments, Disabilities and Handicaps (ICIDH)*, Council of Europe Press, Strasbourg, 1994. W.J. van Minnen, *Use and usefulness of the ICIDH for policy and planning of public authorities*, Council of Europe Publishing, Strasbourg, 1995.

recover from their injuries so as not to reduce their need for compensation. The principle is that they must 'mitigate the loss'. If they fail to do so, the court may cut their award if they win any case for damages. These social conditions can therefore be seen as 'evidence of mitigation of loss', which is rather technical but actually explains the principle they seem to share more precisely. In general, these preliminary factors in benefit conditions are either personal and demographic factors, or such that involve evidence of mitigation of loss.

Then, there is the requirement to be disabled. It may involve considering all or some of five questions covering whether:

- disability is present (disablement question),
- it is of a particular type which qualifies for benefit (the quality of the disability);
- it is sufficiently severe to qualify for the benefit (the quantity of disability);
- it results from an appropriate cause for the benefit (e.g. industrial injury) (causation);
- it will persist long enough for benefit to be worth allocating (the prognosis).

The questionnaire gave three examples of tests, though it allowed respondents to set down any other form of test which they had devised. The three types quoted were set out and defined as follows:

1. Barema method: An arbitrary ordinal scale which attaches progressive percentage values to define disabilities. The disabilities of the claimant are compared to those for which there are scale values and a percentage is thereby obtained.
2. Assessing care needs: An evaluation of the time periods during the day or night for which a claimant needs help from another person. The needs to be included in the assessment may be more or less clearly defined.
3. Functional capacity method: The assessor is given a list of abilities or disabilities. There may be a series of statements (descriptors) for each describing levels of ability/disability. The abilities/disabilities of the claimant are described or the closest descriptor to the situation of the claimant is accepted.

V. RESULTS

Comments on the assessment methods

An important question was whether the initial list used for the questionnaire omitted any further type of assessment method which was used sufficiently frequently that it should be included. It was this question that Dr. Fratello and Professor Scorretti agreed to investigate by a cluster analysis of the methods in the responses to the questionnaire, which is one of

the four studies in this report. It revealed a fourth method, which may be described as follows:

4. Economic loss: The loss of income of the claimant due to disability is calculated, either directly from his/her income or tax returns, or by some technique which determines what he could have earned if he/she were fit and well, and/or what he/she is thought to be capable of earning given his/her disablement, taking other factors into account to a greater or lesser extent as prescribed. These notional figures are then compared with each other, or with actual figures the claimant produces.

An important finding of our work is that these four possibilities appeared to cover the tests described in the questionnaires. Sometimes tests seemed to use part of one approach and part of another, and some were extremely complex. It often proved quite difficult to get a picture of how a benefit worked. Even absolutely clear explanations of benefits given by members of the Working Group to each other sometimes left colleagues asking questions showing that the explanations were not so simple for someone dealing with a translation. Nevertheless, this basic similarity of methods could be seen in the results.

Baremas

Dr. Fratello and Professor Scorretti pointed out that scales of compensation for injuries date back at least to mediaeval times in Europe. They related sums for loss of body parts to the 'wergeld' or 'mangeld' (sum payable as a compensation for the killing of a free man) found in Germanic law. The method of transposing such scales to percentages was introduced by the French mathematician François Bareme. They have therefore become known as Baremas. Dr. Laroche (Belgium) agreed to do a special study of Baremas, and produced a report comparing typical ones from each country which had sent him information.

Examining the results showed that the oldest Baremas were set up to assess impairment as defined by the ICIDH¹. Later ones were set up to assess disability², or disablement (which can be defined as the sum total of all of a number of disabilities in whatever method is

¹ "In the context of health experience, an impairment is any loss or abnormality of psychological, physiological, or anatomical structure or function." International Classification of Impairments, Disabilities, and Handicaps. A manual of classification relating to the consequences of disease, World Health Organization, Geneva 1980, p.47.

² Defined by ICIDH as "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being". International Classification of Impairments, Disabilities, and Handicaps. A manual of classification relating to the consequences of disease, World Health Organization, Geneva 1980, p.143.

appropriate in the circumstances). We had no information on the reasons for choosing the levels set out in the Baremas. It seemed that both social and medical factors had been considered. In at least some cases, there seemed to be no mechanism for reviewing and updating Baremas in the light of changes in epidemiology and medical progress affecting the management and prognosis of conditions, let alone social pressures on the benefit system. For example, the Netherlands has considered excluding some mental health problems from benefit entitlement, as has been tried by some US states. In Germany, on the other hand, the possible grade of vocational qualification is taken as a criterion for the classification of mentally retarded persons for the Barema.

The most complex impairment-based system is the AMA 'Guidelines'¹. A number of countries base tests upon it, but it was not used by any of those responding to our questionnaire. A major problem is that when Baremas suggest awards for impairments, there may often be a wide variety of effects associated with a particular impairment; for example, possible awards for problems of the upper digestive tract in the AMA 'Guidelines' range from 0% to 75% in four classes described by a range of symptoms and signs, and wide percentage bands which therefore leave the clinician applying the 'Guidelines' considerable latitude:

- Class 1: 0% to 9%;
- Class 2: 10% - 24%
- Class 3: 25% - 49%
- Class 4: 50% - 75%

There was no clear evidence to us of how clinicians applying such scales make their decisions, and so how it would be possible to reduce the international variation amongst awards which must presumably exist. Moreover, it became clear that even though the 'AMA Guidelines' set out to assess impairment, at least some of the requirements set out to narrow the initially wide percentage bands related to disability rather than impairment.

The most difficult area for impairment-based systems is that of mental health problems. Arguably, all the manifestations of mental health problems are disabilities, though it may be possible to infer an impairment of brain function as an underlying cause of a number of different disabilities manifested by a person, as claimed by biological psychiatrists.

For example, the United Kingdom Barema for the Industrial Injuries Benefits Scheme measures disabilities and so disablement in law, with two exceptions. First, awards may be made for severe facial disfigurement where there is no disability except in a social sense, and arguably this is a handicap rather than a disability. Secondly for the presence of

¹ American Medical Association. Guides to the Evaluation of Permanent Impairment, Fourth Edition. Chicago: American Medical Association, 1993.

pneumoconiosis where there are no symptoms and so disability. Both these exceptional circumstances were specified in the law for political rather than scientific reasons. Thus, careful analysis shows that Baremas may mix values for impairments and disabilities which complicates comparisons of values from different systems, though Dr. LAROCHE tried to do this for a number of situations. His results suggested that it would be possible to consider some General European Barema which could be applied by a number of countries in an attempt to harmonise awards.

There are a number of inherent problems in deriving a single summary figure for awards based on Baremas, which may be summarised as:

- The Set Points; how do you compare a fractured leg with schizophrenia, without giving ranges of values for one or the other which are really little guide to the user;
- The Paired Organs Problem; what do you do about the one-eyed man who loses his remaining eye;
- The Whole Body Problem; if loss of a finger is 10%, and back pain is 20%, and depression is 40%, what is the total award for an individual with all three conditions;
- The Threshold Problem; if benefit is awarded at a threshold (such as 30% for a partial disability pension, and 80% for a full one), how do you decide whether someone falls at 29%, 30% or 31%?

Dr. Laroche was able to show a number of ways of dealing with these points in the different schemes, but without any logical framework for choosing one approach over another. This means that even using a General European Barema would not necessarily harmonise benefit awards unless either these rules were also harmonised, or only the percentages and their determination were harmonised, leaving countries free to adopt different approaches to the questions set out above. The latter approach would still leave people with disabilities in considerable doubt about how their case would be considered in different countries with different rules.

One of the NGOs spontaneously mentioned the most severe example of the threshold problem. Given the latitude inherent in impairment-based Baremas, they suggested that doctors faced with a cut-off level for a benefit (for example 60%), simply decide whether or not the claimant seems above or below that threshold. They then set their results accordingly, as opposed to building up a series of quite complex decisions to a final figure. The doctors using Baremas are in fact using methods and criteria which are not inherent in the scales at all, but are developed from some health and social model of what a typical benefit recipient should be like. If this is indeed so, we can only assume that good results of using the Barema in such a way could only result if that view of who should qualify for benefit was shared by all doctors by the appeal system and by whatever judicial arrangements oversee it. Such a process is not, as far as we could discover, part of the official instructions that accompany any of the Baremas we found. If it is what is

happening, it adds a further reason why a simple General European Barema would not necessarily harmonise standards. It could, however, lead to a unifying language, greater transparency of systems, and so help clarify the reasons for different outcomes.

Finding such problems with Baremas, one response could be to wonder that they survive so widely. In fact, they seemed to work well for awards of compensation, usually for injuries sustained from military service, or in civilian work, or from acts of violence and in civil disorders where no perpetrator could be identified to recompense the victim. The fact that Baremas allow awards to be made for impairment, or disability, or a mixture of the two is an advantage in this situation. It allows the lawmakers to decide whether to compensate for having been injured, or only for disablement arising from the injuries, again allowing a sensitive control of benefit costs which can be wrapped up in apparently technical details. Problems seem to arise when Barema percentages are applied to other benefits, for example when a part pension is awarded at 30%, and a whole one at 70% of some scale. It then becomes extremely difficult to issue clear instructions to those applying the Barema. This is what is called the 'threshold problem' in the list above.

In most cases, it is doctors who apply Baremas, because:

- It was the custom when these early systems were evolved.
- They are generally seen as difficult to apply, so a highly qualified examiner is needed.
- Their application is very reliant upon the results of examinations and tests of which doctors have thorough knowledge.

Dr. Laroche's report concluded that some form of indicative General European Barema would help harmonise standards and so ease cross-cultural and cross-border problems, and this seems a real possibility for awards where there is no threshold. But if local and unwritten custom is important when Baremas are used with thresholds, it is unlikely that a General European Barema would help harmonise standards for this group of benefit claimants. The Working Group had the impression that the problems of Barema thresholds were recognised as a serious problem in most countries using such thresholds, which might imply that this use of Baremas would gradually disappear.

Assessing care needs

The method seems to have been first used for war pensioners with very severe injuries. It was developed at a time when social security systems did not supply home nursing services, so that people with disabilities (or their families) had to pay for such help. The benefit was often restricted to those with severe impairments, for example to ones with war pension or industrial injuries awards of at least 80%. Later, the assessment method was extended to other people with disabilities, but without such severe impairment. This

produced considerable problems with defining what such people might reasonably require. First, some systems distinguish between 'care' and 'supervision', presumably on the basis that the first requires a carer with some skill, but the latter only the ability to observe and raise the alarm. Secondly care or supervision may be held to be required for a range of functions, from such basic ones as eating and drinking, to going out to the theatre. Finally, the need for supervision may only be held necessary for serious eventualities that are highly unlikely to occur, or for minor disturbances of life occurring only infrequently. The exact details differed between schemes, and were usually not clearly set out in law or regulations. As a result, comparing awards between schemes was difficult or impossible, and it was hard to see that any general European scheme could be drawn up easily. It should, however, be possible to define the assessment questions, methods and results of assessments in a way that might allow them to be used in different schemes for assessing care needs.

Functional capacity assessment

Dr. Dal Pozzo found that this method is increasingly being introduced to assess incapacity for work. It relies upon assessing the level of ability for a number of different activities, which together yield a form of 'ability profile' of the individual. This profile is then compared with some template, which may be actual job requirements (as in the Netherlands), or requirements defined for 'any form of work' (as in the United Kingdom, where the requirements are set out as a numerical formula).

The profiles differ between countries, both in the selection of the abilities thought to be relevant, and in the methods of assessment and evaluation. In general, the abilities seem to reflect local notions of the requirements for jobs available in the country concerned. The Working Group referred to work on the assessment of vocational aptitudes previously done by the Council of Europe¹ and although it did not have the time to study differences in the abilities selected and defined in detail, clear overall similarities emerged from the comparison. The differences appeared to be in detail. As previously pointed out, the difference between impairment and disability may be quite blurred especially when mental health problems are considered. The border between disability and handicaps of environmental tolerance (e.g. allergies or temperature) are also indistinct.

The 1995 Council of Europe Charter on the vocational assessment of people with disabilities² calls for a shift in focus: away from disabilities towards abilities. The assessment should concentrate on the vocational capacities of the individuals and relate them to the specific job requirements. Comparison and matching of vocational aptitudes

¹ P. Charpentier, H.M. Schian, Use of the International Classification of Impairments, Disabilities and Handicaps (ICIDH) in the assessment of vocational aptitudes of people with disabilities, Part I: General Report, Part II: Methods of assessment and the index of occupational characteristics, Council of Europe Press, Strasbourg, 1993.

² Council of Europe Resolution AP (95) 3 on a Charter on the vocational assessment of people with disabilities, and glossary. Council of Europe Publishing, Strasbourg 1997.

and specific job requirements should facilitate employment. As long as vocational assessment still concentrates on deficiencies and weak points it will lead to exclusion. But since performing a task of a particular job may require only a limited number of abilities, there is no justification for putting at a disadvantage people whose disabilities would have no effect on their performance in that job. Furthermore, the Charter promotes the right of persons with disabilities to access to vocational assessment and to take an active part in it and thus in their own rehabilitation process. It also includes recommendations on data protection and calls upon member states to harmonise the principles pertaining to vocational assessment of people with disabilities.

Also the European Community EC forms try to help transfer information about this type of assessment. As more and more countries adopt this type of assessment, it should be possible to improve the transfer of information about the ability profile, if not the results of the test. So, it may be possible to develop a General European Functional Capacity Assessment.

Economic loss

The rules for calculating economic loss are essentially locally based. The method is extremely old, dating back at least to the Roman Empire, where slaves with disabilities were evaluated by their economic value. Today, the approach exists in many countries. Economic loss refers to jobs currently existing, be they specific ones for the individual (for instance the previous job held), or jobs in general, or anything in between. Systems are characterised by the detailed rules of what jobs to consider and how to consider them, which may be changed relatively frequently to regulate overall costs. The interaction of disability and age is another major problem. The basic assessment is essentially that of a handicap. The actual assessment needs both a medical examination (on impairments and incapacity), and a vocational investigation. Ideally, a database of relevant jobs and their demands should be available. There would seem to be limited scope for improving the cross-border flow of data on the process, as opposed to the criteria which indicate that the formula should be applied.

Multidisciplinary teams

The benefits of multidisciplinary or multiprofessional approaches in the health field in the interest of gaining a holistic view have long been recognised.¹

In disability assessment, however, the use of multidisciplinary teams seemed, in general, to be a recent development so that experience of them is relatively limited. Generally, they are

¹ Council of Europe Recommendation No. R (89) 13 on the organisation of multidisciplinary care for cancer patients. Recommendation No. R (93) 8 on the organisation of multiprofessional education of health personnel.

introduced as part of radical reviews of schemes. They seemed to be being used for allocating services rather than monetary benefits, so that teams consider handicaps rather than impairments or disabilities, and take account of wider social aspects. The usual questions being considered related to the details and extent of the services, rather than whether anything should be done at all. The output tended to be a programme to promote social participation, rather than a number, or allocation of the individual to a category. This meant that the number of appeals against team findings were relatively restricted, and this in turn meant that the way teams operate and reach decisions had not been subjected to much scrutiny. Normally, there seemed to be few rules to guide the teams on how they should reach decisions, and of the relative contributions of specialist members to the overall decision of the group. For example, there could be a marked difference between teams which decide what services each of its members would supply to an individual and fund, as opposed to ones whose decisions would go to other organisations responsible for allocating and delivering services.

This flexibility can be seen as one advantage of the system. The usual members appeared to be a physician (drawn from a number of possible medical specialties), a psychologist, and a social worker. Physiotherapists and occupational therapists were other possible disciplines.

Most respondents felt that multidisciplinary teams were more in keeping with modern views on people with disabilities and what society should do for them. Considering participation in the widest sense, in a group where no single professional group was dominant, and which could involve the person being considered in the decision-making process, seemed a good model for both people with disabilities and those who try to help them.

Cross-border flows of information

Medical information is naturally regarded as highly confidential personal information. There are strict international rules and conventions regulating the transmission of such information across national borders, essentially devised by the Council of Europe. Nevertheless, the Convention for the Protection of Individuals with Regard to the Automatic Processing of Personal Data (No. 108) provides that, in general, issues of confidentiality should not be used to impede the flow of data without good cause when the recipient country is likely to handle it in an acceptable way, saying:

"A party shall not, for the sole purpose of protection of privacy, prohibit or subject to special authorisation transborder flows of personal data going to the territory of another Party"¹.

¹ Council of Europe Convention No. 108: For the Protection of Individuals with Regard to the Automatic Processing of Personal Data; Article 12 2.

Two cases before the Court of Human Rights confirm this approach, the second being of particular interest to this study. They have been described as follows:

"in the cases of *Anne-Marie Andersson v. Sweden* (72/1996/691/883) and *M.S. v. Sweden* (74/1996/693/885). The applicants had complained of the absence of a prior possibility to oppose communication of medical data by one public authority to another. The Court found that communication constituted indeed an interference but it was justified (in the former case to protect the interests of a child and in the latter case in order to enable deciding a claim for compensation). Moreover the data thus communicated had remained confidential¹".

There are additional important differences between the health data used for benefit purposes and other health data.² First, benefits are claimed or requested, so that the claimant can be held to have given consent for the release and use of that health information which is required to process the claim. Secondly it is generally true that the claim can only result in benefit being awarded or not; so that the claimant cannot be worse off, only better off. This does, however, assume that the information:

- is only used for benefit purposes, and not for other reasons;
- does not suggest benefit fraud.

This implies that the recipient country treats the information with some circumspection. As set out in Recommendation No. R (97) 5 on the Protection of Medical Data, if a recipient country has adopted and implemented Convention 108, no problems should arise and transmitting information there 'should not be subject to special conditions concerning the protection of privacy'³. Where the country either has not done so, or is outside the Council, a non-member of Europe either:

- 'necessary measures, including those of a contractual nature, to respect the principles of the convention and this recommendation, have been taken, and the subject has the possibility to object to the transfer' or
- 'the data subject has given his/her consent'.

¹ Hondius FW. Protecting Medical and Genetic Data. *European Journal of Health Law* 1997;4:361-388.

² Ripol Carulla, S. The protection of medical and genetic data in the Council of Europe's normative texts, *Law and the Human Genome Review* 5/1996: 109-120.

³ Council of Europe Recommendation No. R (97) 5 on the Protection of Medical Data, Para 11.2.

Given that questions of benefit will only be considered at the behest of the potential recipient, there will always be consent to disclose. The only action required may be on in relation to countries outside the Council of Europe, or who have not accepted and implemented Recommendation (97) 5. Council of Europe countries who make agreements with each other are recommended to ensure that the provisions of Convention 108 are in the agreement¹, but the title of this Recommendation implies that it does not extend to agreements with countries which are not member states.

Views of the NGOs

The NGOs recalled that they oppose assessment processes which focus on impairment and disability and so the individual. They saw people with disabilities as having needs which reflect the social situation they find themselves in at least as much as the nature of their health or personal problems. If this were accepted, any assessment process would become very specific to the culture and locality of the person being assessed, making data transmission if anything more difficult. Nevertheless, the NGOs felt that mobility across borders should be encouraged, and ideally wanted some form of card which would give people with disabilities entitlement to benefits throughout Europe. Rehabilitation International told us that, in the longer term:

"It is, on a European level, a central claim of NGOs to adjust legal regulations within handicapped politics throughout Europe, and to standardise new regulations to the effect that identical rights are granted to disabled persons throughout Europe, and that the same aids are available to all of them. This could, for example, be achieved by introducing a genuine European Disability Pass."

Final comments of the Working Group

A number of extremely positive points emerged from the discussions and the work:

- Whilst the details of systems differ between countries, in ways which reflect history and national development, underlying principles are remarkably similar.
- Terminology as opposed to mere translation, remains a major problem. It takes time to share concepts, and then attach clear definitions and finally names to them. The concepts of the WHO 'International Classification of Impairments, Disabilities and Handicaps' (ICIDH) are an extremely valuable resource in this regard.

¹ Council of Europe Recommendation No R (99) 17 on the Improvement of Co-operation Among Member States in the Social Security Field.

- There has been remarkably little international investigation in this field, and there are few academic institutions which have covered this area, and few individuals have been involved.
- Much of the detail of implementing assessment methods is not in law, but in attitudes and practices which are themselves a reflection of local culture.
- Harmonisation of such culturally specific and diverse things as social security benefits would be extremely difficult politically, even though actual differences are in detail rather than substance; this should, however, be possible in the longer term.
- Increasing communication between the experts involved in each country, and continually reviewing the possibilities of improving cross-border communications, are important in moving towards greater homogeneity of systems which will, in the long run, benefit people with disabilities in Europe.

On the whole a shift was recognised in social policy regarding persons with disabilities. It was noted that, although for benefit purposes and for instruments to overcome obstacles peoples' restrictions have to be investigated, the accent lies more and more on evaluations that help discover possibilities for social integration. So rehabilitation possibilities, social and environmental barriers and the perspective of the individual are becoming a part of the assessment methods. In line with that multidisciplinary teams tend to gain importance.

**2. COMPARATIVE ANALYSIS OF CRITERIA GOVERNING
THE GRANTING OF ALLOWANCES AND PERSONAL
ASSISTANCE**

Dr. Cristina DAL POZZO (Italy)

I. INTRODUCTION

At the 1st session of the Working Group on the assessment of person-related criteria for allowances and personal assistance for people with disabilities (P-RR-ECA) (12-14 November 1997), the Working Group decided to draft and circulate to all member and observer States of the Partial Agreement in the Social and Public Health field, a questionnaire on the assessment of person-related criteria for allowances and personal assistance for people with disabilities. All States were asked to reply to this questionnaire by 28 February 1998. At the 2nd session (27-29 April 1998) the Working Group decided to appoint an external consultant to analyse the data resulting from the completion of the questionnaires.

The following countries have answered the questionnaire: Member states: Austria, Belgium, Cyprus, Denmark, Finland, France, Germany, Ireland, Italy, Luxembourg, the Netherlands, Norway, Portugal, Slovenia, Spain, Sweden, Switzerland, United Kingdom. Observer states: Estonia, Hungary, Iceland, Latvia, Lithuania, Poland.

When considering rehabilitation, the Working Group suggested making reference to the Council of Europe Recommendation No. R (92) 6 on a coherent policy for people with disabilities. This text states that offers for rehabilitation are a duty of society and should cover fields of intervention from prevention to vocational integration. Regarding social, economic and legal protection the recommendation states that people with disabilities should have a minimum livelihood, specific allowances and a system of social protection. Economic and social security involves cash benefits, benefits for families with children with disabilities, long-term care, benefits for people unable to seek employment because they are caring for a person with a disability, and benefits for people with disabilities who are able to work only part-time. As the concept of rehabilitation is so broad, no guidelines are given as to whether rehabilitation should be a pre-requisite for the granting of allowances.

II. REPORT

The following report will focus on the criteria governing the granting of allowances and personal assistance in each country, as far as information was available, with particular attention to:

- significant provisions common to each country,
- the role of multidisciplinary teams.

II.1 General principles

According to the structure of the questionnaire and the Decisions of the 2nd session, a synoptic form has been chosen to present the data. An introductory table shows the results of the answers to the first chapter of the questionnaire as a baseline for further analysis. Missing results are marked by N/A (not available).

Table 1. Rehabilitation before allowance

Country	Does the principle "rehabilitation before allowance" apply in your country?	Do legal provisions regarding this principle exist?
Austria	Yes	Yes
Belgium	No	No
Cyprus	No	No
Denmark	Yes	In force in practice
Finland	N/A	Yes
France	No	No
Germany	Yes	Yes
Hungary	Yes	Yes
Iceland	Yes	Yes
Ireland	No	No
Italy	No	No
Lithuania	Yes/No	Yes
Luxembourg	Yes	No
The Netherlands	Rehabilitation is permanently demanded by the clients	-
Norway	Yes	Yes
Portugal	No	No
Slovenia	Yes	Yes
Spain	Yes	Yes
Sweden	N/A	Yes
Switzerland	Yes	Yes
United Kingdom	No	No

Comment on table 1: There are two main types of approach regarding rehabilitation and the granting of allowances. In some countries rehabilitation (as far as it is practicable) always precedes the granting of allowances (Austria, Denmark, Germany, Hungary, Iceland, Lithuania, Luxembourg, Norway, Slovenia, Spain, and 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, the Netherlands, Portugal, Sweden, the United Kingdom). In Finland, Germany, and Switzerland persons undergoing a rehabilitation programme receive a temporary allowance.

In the Netherlands no distinction is made between clinical and social rehabilitation. The individual is asked to undergo a rehabilitation programme with the intent to go back to suitable work (reintegration). A refusal can be a reason to suspend the allowance. The allowance (short-term benefit) is granted from the onset of the wage loss and covers the waiting period for the long-term benefit (in case return to work failed). Theoretically a client is always required to undergo rehabilitation.

In Iceland the principle “rehabilitation before allowance” has recently been enacted in legal provisions. Vocational rehabilitation falls under the responsibility of the Ministry of Social Affairs, whereas medical rehabilitation falls under the responsibility of the Ministry of Health and Social Security. However the Ministry of Health and Social Security is now promoting a vocational rehabilitation programme for persons unable to work due to a disease or disability as attested by their physician (New Methods for Disability Assessment and Vocational Rehabilitation by the State Social Security).

Norway has published a White Paper on rehabilitation 1998-1999. This document defines rehabilitation as “a process or a set of processes which is planned, has well-defined goals and means, is limited in time and where several professions or services co-operate in assisting the individual in his or her own effort to achieve capability to function and cope with problems due to disability, promote independence and social participation.”

Although it is not clear from the replies to the questionnaire whether rehabilitation is considered to be clinical or social, some of those countries where rehabilitation is not a pre-condition for allowances pointed out that there are special acts to promote returning to work (France, the Netherlands, Sweden). In this respect it can be said that rehabilitation, intended as promotion of return to work, is the core of legislation of most of the countries that replied to the questionnaire. However, as indicated in the introduction, the field of rehabilitation which is a pre-condition for benefits is not specified.

II.2 Legislation, allowances and personal assistance

According to Chapter II.1 of the questionnaire on the existing forms of allowances and personal assistance for people with disabilities as well as the legislation regulating them a) at federal/national level; b) at regional level; c) at local level, an introductory table shows the distribution of legislative tasks at different levels.

Table 2. Legislation at federal, regional and local level

Country	Legislation regulating existing forms of allowances and personal assistance for people with disabilities at		
	Federal/National level	Regional level	Local level
Austria	Yes	Yes	No
Belgium	Yes	Yes	Yes
Cyprus	Yes	No	No
Denmark	Yes	No	No
Finland	Yes	Yes	Yes
France	Yes	No	No
Germany	Yes	Yes	Yes
Hungary	Yes	Yes	Yes
Iceland	Yes	No	Yes (home assistance, nursing at home, housing, social allowance)
Ireland	Yes	Yes	Yes + Mobility and housing
Italy	Yes	No	No
Latvia	Yes	N/A	Social services
Lithuania	Yes (legislation and implementation)	N/A	Implementation
Luxembourg	Yes	No	No
The Netherlands	Yes	No	No
Norway	Yes	No	Yes
Portugal	Yes	Implementation	No
Slovenia	Yes	Implementation	No
Spain	Yes	Yes	Yes
Sweden	Yes	Implementation	No
Switzerland	Yes	Yes	
United Kingdom	No	Yes	Implementation of social services and education

Comment on table 2: 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 delivering services.

There are a few exceptions. In the United Kingdom social security is administered separately in Great Britain (England, Scotland and Wales) and in Northern Ireland. Health, education and personal social services are administered separately in England, Scotland, Wales and in Northern Ireland. Germany has some regional provisions for blind and deaf people and some local provisions for transport. Spain, Finland, Belgium, Norway, Iceland and Ireland have provisions at regional and/or local level mainly concerning technical aids housing and transport. Spain has regional and local provisions for home assistance, urban design measures, housing reservations, transport vouchers and adaptation of public areas. Finland has regional provisions for rehabilitation and technical aids and local provisions for school, transport, housing, rehabilitation counselling and compensation for extra costs. Belgium has regional provisions on technical aids, housing, transport, vocational training and work reintegration and local provisions and work integration on housing and family help. Norway has local provisions for home-based services and transportation. In Latvia self-governments may decide about additional support (social services) based on the financial possibility of local-government.

II. 3 Significant provisions common to all countries

Data are presented in synoptic form taking into account the structure of the questionnaire and the answers given as well as the priorities set by the Working Group.

Table 3. shows all the provisions (allowances and personal assistance) listed in the questionnaires for each country.¹

Table 4. shows the criteria governing the granting of some benefits common to all countries (long-term benefits for people who become disabled during working life).

¹ For Table 3, please see end of document.

Table 4. Criteria governing the granting of long-term benefits for people who become disabled during working life

Country	Name	Contributory	Age	Criteria	Method	Who uses it	ICIDH
Austria	Accident pension	Yes	N/A	20% disability	Barema	N/A	N/A
	Invalidity pension	Yes	N/A	Complex related to category	Barema Care needs	N/A	N/A
Belgium	Benefit for permanent disability by: - common diseases - industrial injuries - occupation-related diseases	Yes	18-65	Permanent functional impairments by common disease etc. Total incapacity = capacity of gain is equal to or is less than 1/3	Barema (in case of industrial injuries) Medico-social assessment by doctors	Medical services	No
Cyprus	Invalidity pension	Yes	63	Incapacity for work/earn	Barema	Ministry of Labour and Social Insurance Doctors (2 chairmen)	No
	Disablement benefit (Employment injuries or occupational diseases)	No contribution conditions		Loss of physical or mental faculty not less than 10% (Pneumoconiosis >1%)	Functional capacity	Ministry of Labour and Social Insurance Doctors (2 chairmen)	No
Denmark	Early retirement pension Highest Intermediate Increased Ordinary	Yes	18-60	Permanent reduction of >½, 2/3 or total loss of working capacity Special criteria for over 50% and over 60% Functional capacity is under consideration	Comparison between level of income of the person and average income	Local authorities	No
Finland	Disability allowance	N/A	16-64	Sickness, injury or disability	Care needs, functional capacity and extra costs	Officials of social insurance institution	N/A
France	Industrial injury pension	Yes	N/A	N/A	N/A	N/A	N/A
	Invalidity pension	Yes	N/A	67% reduction capacity for work	Socio-vocational	Medical officers	N/A
Germany	Disability/invalidity pension Accident insurance funds	No	Not relevant	Useful medical or vocational rehabilitation Disability/invalidity 30% or more	Barema	Funds' medical services	Yes (concepts)
	Disability/invalidity pension Pension insurance funds	Yes	Not relevant	Useful medical or vocational rehabilitation Incapacity to do paid work	Needs	Funds' medical services	Yes (concepts)
Hungary	Invalidity pension	Yes	N/A	67%-100% loss ability to work + attendance	Barema	Medical boards	Uncertain
Iceland	Compensation for permanent medical impairment due to accidents at work	Yes	16-66	Permanent medical impairment. 10-49% capital 50% or > monthly allowance	Barema (AMA IV Ed)	State Social Security Institute doctors	No
	Disability pension	Yes	16-66	Capacity to do specified activities List of specified conditions and exceptional circumstances	Functional capacity	State Social Security Institute doctors	No
Ireland	Disablement benefit Invalidity pension	Yes	18-66	Loss of faculty (no threshold apart for deafness from 20%) Specified conditions Work capacity	Barema	Medical assessors Department of Social Community and Family Affairs	No
Italy	Benefit for permanent disability	Yes	No limits	Old cases. Loss of all work capacity >11% New cases from 2000 Biological damage 6-15% capital >16% monthly allowance	Barema (impairment) Barema (biological damage = loss of psychophysical integrity)	INAIL Doctors	No
	Ordinary invalidity allowance/inability pension	Yes	No limits	>2/3 total loss of work capacity (all work)	Social/work/clinical history/examination	INPS Doctors	No

Table 4 (contd) Criteria governing the granting of long-term benefits for people who become disabled during working life

Country	Name	Contributory	Age	Criteria	Method	Who uses it	ICIDH
Latvia	Insurance indemnity	Yes		Loss of work capacity	List of impairments = Disability, three levels of severity I, II, III	State Medical Examination Commission of health and capacity for work	Unspecified
	Disability pension	Yes	16-60	Loss of work capacity	List of impairments = Disability, three levels of severity I, II, III	State Medical Examination Commission of health and capacity for work	Unspecified
Lithuania	Invalidity pension		>16	Loss of work capacity and social factors	List of impairments Level of severity I, II, III Functional capacity Work capacity Loss of income	State medical social expertise commissions (MSEC)	Yes (partially)
Luxembourg	Invalidity pension	Yes		Not mentioned	Not mentioned	Not mentioned	No
	Industrial injury pension	Yes		Capacity for work	Not mentioned	Not mentioned	No
The Netherlands	WAO employee	Yes	15-65	Incapacity to gain >15%	Medical assessment of functional capacity professional final selection	LISV	Yes
	WAZ self-employed	Yes	15-65	Incapacity to gain >25%	Medical assessment of functional capacity professional final selection	LISV	Yes
Norway	Disability pension	Yes	18-67	Permanent reduction of work capacity by minimum 30% for accident at work and minimum 50% for other causes	Functional capacity	Social security office	No
Portugal	Disability pension	Contributory and non-contributory scheme	>18	Complex (see comment)	Complex (see comment)	Doctors and verification commission	No
	Disablement benefit (occupational disease)	Yes	Not mentioned	Not mentioned	Not mentioned	Not mentioned	Not mentioned
Slovenia	Disability pension Cash replacement allowance	Yes	>15	Complete loss and partial loss of working capacity	Conformity between the person's capacity and the requirement of the work	Disability Committee	No
	Disability benefit	Yes	>15	At least 30% physical impairment for injury at work or occupational illness and 50% for illness or injury outside work	Barema	Disability Committee	No
Spain	Incapacity pension	Yes	18-65	Incapacity to work in the habitual profession Three degrees for different levels of pension	Diagnosis and opinion on medical and functional condition Rating scale	Medical advisers	No
Sweden	Disability allowance	Yes	16-65	Non-medical	Assessment of extra costs	Administrative officials	No
Switzerland	Invalidity pension		Until statutory age of retirement	Reduction of earning capacity at least 40% Incapacity to work of at least 40% without a major interruption combined with an incapacity to earn of at least 40%	Comparison between real income and potential income	Cantonal Office of Invalidity Insurance	No
United Kingdom	Industrial injuries/diseases disablement benefit	Yes	>16	Injuries \geq 14% disablement Deafness \geq 20%	Barema	BAMS doctors	No
	Incapacity benefit	Yes	>16	Specified conditions and exceptional circumstances (listed) Capacity to do some activities	Functional capacity	BAMS doctors	Yes (concepts)

Comment on table 4: All countries have long-term benefits for people who become disabled during working life. The name of the benefits often uses terms such as “invalidity” or “disability” and “pension” or “allowance”. They are contributory benefits. In some countries there is a strict partition between disabilities causally related to work (Austria, Belgium, Cyprus, France, Germany, Iceland, Italy, Latvia, Luxembourg, Norway, Portugal, Slovenia, Switzerland, and the United Kingdom,) and disabilities due to common diseases. Hungary is planning to have this dual system in the future. In Sweden disability is a term of reference referred not only to an occupational or non-occupational cause, but also to a social cause.

In Spain new criteria for incapacity pension (contributory) are under discussion. Incapacity for work will be assessed using a list of illnesses and their consequences on work capacity.

Germany grants long-term benefits (Disability/Invalidity pension) through different funds. In Italy new criteria for a working compensation scheme were adopted in February 2000. The economic benefit will be a lump sum for bodily damage between 6% and 15% and a monthly allowance from 16%. The Barema will be thoroughly renewed and will be based on the existing criteria for compensation in third party liability. The benefit, in fact, will be granted on the basis of permanent damage to complex functions that allow a person to perform everyday tasks related and not related to work. The older system (see Table 4.) will still be in use for the transitional period set out in law.

All countries have benefits for disabled children. They are mainly family benefits to cover home care, assistance, extra costs and education. Also long-term care is broadly guaranteed.

All countries have some sort of assistance for the costs of housing and transport and tax relief and special policies to promote work reintegration.

The following countries stated that they have specific benefits for people who have never entered the labour market due to disability: Hungary, the Netherlands, Slovenia, Sweden, (only if disability occurred < the age of 25), Belgium, Cyprus, France, Germany, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Norway, Portugal, Spain, and the United Kingdom. Finland provides this target group with services.

In Portugal disability pensions are granted under contributory and non-contributory schemes. Incapacity for work is relevant if its duration is at least five years prior to the assessment and it is considered permanent when the beneficiary will presumably not regain more than 50% of earning capacity for the following 3 years. In the non-contributory scheme, however, the disability social pension is a means test and it is granted when monthly gross income is no higher than 30% of the highest national minimum wage. The panel of assessing doctors have a technical assistant in the employment area. Short-term benefits are more common in contributory schemes. (See also chapter II. 6 Cluster analysis on common methods of assessment.)

II.4 Role of multidisciplinary teams
Table 5. Role of multidisciplinary teams

Country	Benefit	Multidisciplinary team	Purpose	Membership	Working methods	Impact
Belgium	1. Federal provisions (cash benefits) 2. Regional provisions on social integration: technical aids, housing and ambulatory services, vocational training, work reintegration	1. No 2. Yes	Individual examination and guidance Assessment of the handicap and decision on an "integration protocol"	In all teams: doctor(s), social workers, psychologists In most teams: other experts: paramedics (speech therapists, occupational therapists, physiotherapists), lawyers, experts in vocational assessment, remedial educationalists	Multidisciplinary synthesis of the case, after individual examination by the expert (in Flemish Community) Presentation and discussion of the case by multidisciplinary (assessing) commission (in all regional entities)	Person with disability is seen by each expert Person is invited and must be heard before any decision is taken
Finland	1. Cash benefits 2. Personal assistance	1. Not officially 2. Yes	2.a Municipal services 2.b Technical aids and rehabilitation	2.a Municipal services: social workers, psychologists, medical doctors, etc 2.b Physicians, psychologists, social workers	2.a Assess person's capacity and needs 2.b Assess the whole situation and plan suitable service and rehabilitation	2.a No 2.b Yes
Hungary	Invalidity pension	Yes	NA	Two social insurance physicians (internal medicine, surgery, neurology)	N/A	N/A
Iceland	Disability pension	Yes	To assess rehabilitation potential of the applicant	Physician, social worker, physiotherapist, psychologist and representatives of other disciplines if needed	Interview/examination of the applicant by each member + separate discussion to assess rehabilitation potential + setting of individual plan	Yes
Italy	Non-contributory benefits	Yes	Assessment of degree of reduction of incapacity for work and status of disability	Social insurance, occupational and clinical specialists (neurologists) For disability status also a social operator	Interview, medical assessment, decision	Yes
Lithuania	Invalidity pension	MSEC	To assess impairment, work capacity and loss of income	Three physicians, social workers, labour market specialist, employer representative and psychologist	Medical evidence, medical assessment of functional capacity work and social data, expert examination	Yes
Luxembourg	<i>Assurance dépendance</i>	Yes	To assess the state of dependence, care and aids needed, home or institutional care, rehabilitation plan	Doctors, psychologists, ergotherapists, social assistants, nurses	Medical assessment (cause and term of dependence) and assessment on the state of dependence based on 4 questions	Yes
The Netherlands	WAO, WAZ, Wajong	Yes	Assess ability to work	Medical insurance doctors and labour expert	Medical, functional, vocational J.I.S (Job Information System)	Yes
Norway	1. Most benefits 2. Municipal level: practical assistance at home	1. No 2. Yes (where foreseen)	2. Freedom in organising the services	2. Unspecified by law	N/A	2. Depends on practice of each municipality
Portugal	Supplementary benefit (higher rate of family allowance) and education allowance	Yes	To assess the existence of a medical condition as requisite to personal support, care or special school	Physician, pedagogical and expert of the case	Clinical assessment	Yes
Slovenia	All benefits for working people with disabilities	Yes	Assess disability, remaining work capacity, needs, etc.	Two specialist doctors and one expert in work safety	Medical evidence, documentation on the work and social data of the insuree, medical examination, expert opinion to return to work in co-operation with employer	Yes
Spain	1. Disability pension, other benefits and services 2. Education	Yes	1. Diagnosis, causes of disability, personality/intelligence/abilities/ personal and social situation, guidance on rehabilitation 2. To assess special educational needs	1. Doctor, psychologist, social worker (educator, job counsel, employment expert) 2. Psychologists, psychopedagogists and social workers	1. Integration of expert opinions decision based on Barema 2. Integration of expert opinions	1. and 2. Yes
Switzerland		Cantonal Offices of Invalidity Insurance may choose their model of organisation				
United Kingdom	Special education	Occasionally	Child's needs, support and provisions	Variable + educational psychologist	Variable	No but relevant

Comment on table 5: The following countries have multidisciplinary commissions: Belgium, Finland, Hungary, Iceland, Italy, Lithuania, Luxembourg, the Netherlands, Norway Portugal, Slovenia, Spain, Switzerland, and the United Kingdom. However, apart from Switzerland which leaves freedom of organisation to Cantonal offices of invalidity insurance, among the other countries, only Hungary, Iceland, Lithuania, the Netherlands, Slovenia, and Spain use MT in the assessment process to grant contributory **long-term benefits in cash** other than services. In the other countries MT is applicable in the assessment for granting personal assistance (services) or non-contributory benefits (Italy). It could be said that in some countries multidisciplinary teams are used to deliver services, not benefits. An important exception is Slovenia where MT are used for all benefits apart from war pensions for which the assessment is done by competent committees of specialists and medical practitioners.

Regarding the **composition** of MT, one or more physicians are always represented and in so doing reflect that benefits are granted on the basis of a medical condition. They may be social insurance doctors and or specialists in several disciplines (internal medicine, neurology, surgery, occupational medicine). Other specialists relevant for specific cases may be involved.

In Lithuania, the Netherlands, Slovenia and Spain a labour expert takes part in the team. In Lithuania there is also a representative of the employers in the assessment process. Other members broadly represented are psychologists, speech therapists, social assistants, social workers, physiotherapists, ergotherapists and nurses. When children are under assessment an expert in pedagogy may be part of the team.

Some examples are given as follows. Slovenia has two different systems of disability assessment especially designed for vocational aptitude: one of them is carried out by a professional commission of the National Employment Office, the other one, described in Table 5, is carried out by the Institute for Retirement and Disability Insurance. In Finland, Iceland, Norway, Slovenia and Spain the applicants for disability pension are assessed for their rehabilitation potential.

In Switzerland all cantons have a Cantonal Office of Invalidity Insurance and each Office may choose a multidisciplinary team as part of its model of management.

Luxembourg offers a detailed description of the methodology of the multidisciplinary team involved in the assessment of dependence for granting the allowance of *assurance dépendence* (issued in 1998). The team has medical and non-medical members. The first assessment is medical and it aims to define the cause and duration of the condition of dependence. The second assessment describes the state of dependence based on four related questions regarding the appreciation of the state of dependence by the observer, the person with a disability and the person who takes care of him/her.

Portugal adopted multidisciplinary assessment for children with disabilities related benefits.

The Lithuanian model of a multidisciplinary team includes physicians, psychologists, labour market experts and a representative of the employers. It is close to the Italian modernised model of work integration described in the Law 68/1999 that redefines the quota system and the so-called “targeted work integration”.

In Latvia there is a State Commission of Doctors for assessment of disability for disability pension but it is not clearly stated whether it is a multidisciplinary team.

Regarding the **impact** of multidisciplinary assessment the answer is positive for Finland, Iceland, Italy Luxembourg, Lithuania, the Netherlands, Portugal, Slovenia, and Spain. It is also relevant to Belgium and the United Kingdom. In Norway the impact depends on each municipality.

With regard to **advantages, disadvantages and constraints** most countries consider there are advantages in using MT especially where delivering services is the object of the assessment and generally the global functional capacity of the person with a disability and therefore more areas of interests are to be investigated. In this respect MT assessment ensures a wider assessment of the applicant and his/her needs. As the person is examined from different points of view (holistic approach), different questions such as rehabilitation potential, residual capacity for work, needs of support, re-qualification and adaptation of the work place, may be answered with the active participation of the applicant. The down side of MT consists in the fact that members have to reach a common decision going through different languages and objectives. These differences may lead to “never-ending” discussions on single cases and uncertain conclusions. In this respect a specific training on a multidisciplinary approach to disability could be of interest in the view of good practice for MT operators.

II. 5 Special groups/issues

According to decisions of the 3rd session of the Working Group it was decided to break down the analysis to focus on specific benefits for special groups and issues:

- Benefits for families with children with disabilities are shown in Table 6.
- Initial vocational integration of school leavers/young people is shown in Table 7.
- Long-term care allowance is shown in Table 8.

The analysis of the questionnaires has shown that in the area of family benefits, work integration or reintegration and personal assistance, all countries have some provisions (see paragraph II.3 and Table 3).

Benefits for children with disabilities are mainly family benefits to cover home care, assistance, extra costs and education. Although all countries foresee some sort of personal assistance mainly related to housing, transport and tax relief, the situation for long-term care is less clear.

Table 6. Benefits for families with children with disabilities

Countries	Legislation	Benefits	Criteria	Method
Austria	Family Burden Compensation Act	Increased family allowance	To cover additional expenses resulting from disability	Medical (disability >50%) and young person income threshold
Belgium	Federal level	1. Supplementary family allowance 2. Increased family allowance	1. Children with 66% invalidity or more and decreased (age related) autonomy 2. Children of parents with 2/3 work incapacity or more	1. Barema (Belgian scale and special Barema for children) and a specific scale for assessment of autonomy of children (six functional categories) 2. Barema (industrial injuries)/ medico-social assessment/ evaluation of socio-professional parameters
Cyprus	Several	Dowry allowance	Disability >16% as a result of emergency situation	Disability Chart used in the UK
Denmark	Act on Social Services 454/97 (Ministry of Social Affairs)	Loss of earnings (for an adult looking after a child <18 yrs)	Care is a consequence of the child's reduced functional capacity Parents are more appropriate The provider has suffered loss of income The provider has ceased in part or in full his/her employment	Medical and non-medical
Finland	Several	Child care allowance School assistants	Diagnosis, functional ability, possibility to avoid institutionalisation Learning difficulties	Assessing care, rehabilitation needs, extra costs Pupil's needs and psychosocial factors
France	Act No. 75-534 1975	Special education allowance	Child <20 yrs at least 80% incapacitated or 50-80% incapacitated attending special education centres	Medical
Germany	Book 8 of Social Code for Youth Assistance	Medical and dental treatment, special benefits, help to get and adequate participation in working life and for general integration into society	Children with or in danger of psychological disability	Medical (assessing necessity of treatment/special benefit/help/ assistance)
Hungary	1990 Act XXV on Family Allowance and others	Higher rate family allowance	Child permanently ill, physically or mentally disabled (for <18 yrs there is a list of diseases and impairments; for >18 yrs disability >67%)	Medical
Iceland	National Social Security Act and Law on Special Assistance	Allowance for care of children with special needs	Special needs	Medical and assessment of needs for special care
Ireland	Social Welfare Acts	Home care allowance	Children between ages 2-16 yrs who require more than average care/attention due to their disability	Assessment of needs of extra care and attention
Italy	Several	Monthly allowance <18 yrs (attending centres) <18 yrs Communication allowance Three years extension maternity leave + three days leave a month	Difficulties in performing tasks typical of that age Deaf/mute Parent with disabled child	Functional capacity
Latvia	Law on Social Assistance	State family benefit for children with disabilities <16 yrs	N/A	Medical
Lithuania	National	Care allowance for parents with disabled children 0-16 yrs	N/A	Medical
Luxembourg		Family allowance Orphan allowance	N/A	N/A
The Netherlands	TOG 1997	Financial allowance	Caring for physically disabled at home or mentally disabled in a residential home	Mainly medical
Norway	Several	Basic benefit Attendance benefit	Extra costs Need of special attention and nursing	Assessment of extra costs Assessment of care needs
Portugal	National legislation	1. Supplementary benefit (higher rate of family allowance) Life monthly allowance >24 yrs. Education allowance to attend a special school <24 yrs. Constant attendance allowance 2. Attendance allowance in sickness for descendants with disability and for under-aged children 30 days/year 3. Attendance allowance in sickness for long-term patients and for people with severe disabilities 6 months to 4 years for aged <12 yrs	Mainly status of dependence	Medical and non-medical
Slovenia	Special and general	Child care supplementary allowance Institutional care Mobile assistance – treatment and assistance to families at home Medical and dental treatment Special education	List of anomalies defined in the regulations on classification and survey of children, young people and younger people of age with mental and physical disabilities	Medical-defectological
Spain	Royal Decree 1/1994 on Social Security Law	Family benefits for each disabled child	<18 yrs disability degree from 33% (lower rate) >18 yrs disability degree 65% (Basic family allowance) >18 yrs disability degree >75% depending on someone else for everyday activity (supplementary daily allowance)	Barema method and rating scale related to ICIDH for dependence
Sweden	N/A	Care allowance Care financing	Children <16 yrs in need of special attention and care for at least 6 months Parent with a disabled child	N/A Non-medical
United Kingdom	Several	Disabled child premium Disability living allowance care component Attendance allowance special education	Child registered as blind or awarded a disability living allowance Need of attention/frequent attention/ Constant supervision Learning difficulties	Mainly non-medical assessment of needs of care/supervision Psychosocial and educational factors

Table 7. Initial vocational integration of school leavers/young people

Country	Legislation	Benefits (financial and non-financial)	Criteria	Method
Belgium	Special services Regional level	No special financial benefits Special services for vocational assessment and training: in Flanders special services for guidance on the way to work	Less able to perform a job because of disability; for use of special services: positive advice of multidisciplinary commission	Special services: information on impairments and disabilities and specific assessment of work abilities
Cyprus	1969 Centre for Vocational Rehabilitation	Assessment, training, placement Self-employment scheme Supported employment scheme	Different for different schemes	N/A
Germany	Different funds	Service or cash	Priority to rehabilitation – benefits necessary to vocational integration – details depending on funds	Barema/needs/functional capacity depending on funds
Iceland	National Social Security Act	Vocational training programme	Unfit for work	Medical assessment
Ireland	Health and Education Acts	Vocational rehabilitation (courses, part-time jobs)	Inability to work (at least one year) in receipt of disability allowance	Notification to National Rehabilitation Board
Italy	Law 104/1992	Special education General provisions for vocational and occupational training	Civil invalidity/disability	Functional assessment/ learning capacity/individual plan
The Netherlands	Reintegration Act (July 1998)	Subsidies, work adjustments, burnout training, lowback school to employees and employers	The individual is less able to perform a job because of disability	Functional capacity and J.I.S (Jobs Information System)
Norway	National Social Security Scheme	Yes	Reduced work capacity	N/A
Slovenia	General and Special (Law on the Training and Employment of Persons with Disabilities and Regulation relating to the Active Employment Policy)	Financial and non-financial supplementary allowances and assistance on the basis of the involvement of a disabled person in vocational guidance, training and employment programmes and different reimbursement to the employer who employs disabled people	Abilities and interests of the individual, funds available to the employment institute from the adopted budget, in some cases disabled status	Assessment of work capacity (matching persons capacity and requirements of the work – individual plan)
Spain	Law 13/1982 on Social Integration of People with disabilities	Training Vocational guidance	Status of disability	Barema and assessment of job requirements
Switzerland	Invalidity Insurance Scheme	Careers advice Initial professional training Recycling in a new or old job Employment Agency Capital grant for self-employed job Contributions for working clothes/tools/moving house	Invalidity (no minimum degree is required)	Medical (damage to health of disabling nature causing incapacity)
United Kingdom	Permissive legislation	Rehabilitation allowance paid by employment services	Unemployment	Crude functional capacity

Table 8. Long-term care allowance

Country	Legislation	Benefits	Criteria	Method
Austria	Federal Act	Economic	Difficulties in daily life	Assessing care needs
Belgium	Several	Financial allowance for help by other persons Services for help at home In Flanders: "assistance budget"	Difficulties in daily life/need of another person	Assessing care needs Assistance budget: positive advice multidisciplinary commission
Denmark	Act on Social Services 454/97	Personal assistance, care and nursing (home help) Subsidy for personal assistance, care and everyday tasks at home Assistance scheme Attendance scheme	Lack of autonomy	Functional capacity
Finland	Several	Municipal services (non-economic)	Severely disabled	Functional capacity/care needs and avoiding institutionalisation
Germany	Different funds	Service or cash	Priority to rehabilitation Long-term care necessary – details depending on funds	Barema/care needs/functional capacity depending on funds
Hungary	Decree No. 83/1987	Economic	100% loss of work capacity	Barema
Iceland	National Social Security Act	Supplementary pension Home care paid by the community	Incapacity of looking after themselves	Medical certificate of treating physician
Ireland	Social Welfare Acts	Carer's allowance	Old age or sickness pension medically certified to need long term care in the area of safety and the ADL	Medical certificate (family doctor)
Italy	Several	Economic	Lack of autonomy/need of another person	Functional capacity
Latvia	National	Home care	Not able to provide for themselves	N/A
Lithuania	National	Nursing benefit	Total disability (in receipt of invalidity pension)	Medical
Luxembourg	Law of 19 June 1998 Ministry of Social Security	<i>Assurance Dépendance</i> (contributory) <i>Allocation de soins</i> (non-contributory) Special allowance for severely disabled people Industrial injury pension higher rate	<i>Assurance Dépendance</i> : State of dependence type of care and aids needed For the others: need of a third person	Medical and non-medical
The Netherlands	Several	Economic and non-economic	Difficulties in daily life	Mainly medical (ICIDH)
Norway	Social Services Act	Non-economic	Difficulties in daily life	Functional capacity and care needs
Portugal	National legislation (Ministry of Labour and Solidarity)	Constant attendance allowance (children and all pensioners with dependant status)	Status of dependence	Medical
Slovenia	Special and general	Economic	Difficulties in daily life	Assessing care needs
Spain	1/1994	Economic and non-economic	>75% and difficulties in daily life	Barema and rating scale (See also Table 6)
Sweden	Compensation for Assistance Act LASS	Economic and non-economic	Difficulties in daily life	Assessment of the cost
Switzerland	Incapacity Insurance Scheme or Old-age Insurance Scheme	Incapacity allowance	Need of another person to carry out ordinary activities	Medical and non-medical
United Kingdom	Several	Economic	Need of care or supervision from another person	Care needs

Comments on tables 6, 7 and 8: Benefits for children with disabilities are mainly family allowances to cover home care, assistance, extra costs and education. The methods of assessment are generally medical to have access to benefits in cash and non-medical to have access to services.

In the United Kingdom, by virtue of the Family Fund, a social worker visits families that care for a very severely disabled child. On the basis of the report the fund can pay for identified needs (cleaning, clothing, recreation and transport).

Regarding long-term allowance it is possible to state that the common ground is lack of independence or at least difficulties in performing daily life activities.

Denmark shows different levels for long-term care according to the level of dependence and also Slovenia has two levels of long-term care benefits.

Several countries have vocational training programmes and sometimes they apply to people with disabilities as well as to the general public. However the Working Group felt that more interest should be put on school-leavers and young people because the integration process has a better chance to succeed the earlier it starts.

With regard to this point in Italy, the current trend is to bridge education with the open labour market via the NHS Work Integration Services. In practice once students with disabilities have completed their compulsory education period they are offered specific training programmes in cooperation with the local labour market. The Work Integration Services have the duty to find companies willing to host traineeships and eventually to offer jobs to young people with disabilities.

II.6 Cluster analysis on common methods of assessment

After the presentation of the data in a synoptic form it was considered appropriate to identify groups of common criteria and assessment methods.

Regarding **long-term benefits for people who become disabled during working life** which are the best known and widely represented type of benefit (Table 4.), it is possible to draw the following - partial - conclusions.

The first important observation is that there is special management for industrial injury and occupational diseases in Austria, Belgium, Cyprus, France, Germany, Hungary, Iceland, Italy, Latvia, Luxembourg, Norway, Portugal, Slovenia, Switzerland and the United Kingdom.

The most common legal criterion for granting cash benefits for industrial injuries and occupational diseases is the *loss of capacity for work* measured with Baremas which are in

general impairment-based (with reference to the ICIDH definition). Thresholds are different as shown in Table 4.

In Slovenia (only for disability benefits), 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 *Barema* which probably reflects an impairment-based method of assessment. As anticipated above, *Barema* 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 *Barema* based on AMA IV Edition¹ 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 the 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 the United Kingdom. The 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.

Capacity of earning is the legal reference also in Belgium and Switzerland with thresholds 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.

Criteria common to all countries are the *contributory* nature of benefits and qualifying age. This is peculiar to each country but generally 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 area of method of assessment the approach is less homogeneous.

¹ AMA: American Medical Association Guides to the Evaluation of Permanent Impairment, Fourth Edition. Chicago: American Medical Association, 1993.

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

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

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

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

France has indicated 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 replies to 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 not 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, and the United Kingdom).

Among these countries only Belgium, Ireland, Slovenia, and the 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 the granting of **benefits in cash or in kind to special target groups**, especially children and relative methods of assessment are more homogeneous (**Table 6.**). 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 child with a disability performs a task in comparison to a non-disabled child of the same age. The assessment method also takes into account 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** (Table 7.). 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*. The 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. The method of assessment includes also *need of another person* and *extra costs*. In several countries the concept of dependence is a question of “all or nothing”. However it should be considered that there are different levels of dependence for example, between a paraplegic in a wheelchair and a bedbound person. In Italy these two subjects would be recognised as 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 financial and non-financial 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 from a list of activities of daily life stated by law.

III. CONCLUSIONS AND RECOMMENDATIONS FOR FUTURE WORK

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 to questionnaires filled in by homogenous 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”, which was the starting point of the Working Group, about half of the countries stated that the principle is in force and/or foreseen by law. With 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 member and observer 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 across countries, however legal definitions like invalidity or

incapacity do not necessarily refer to 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 the ICIDH definitions. However at the moment 7 countries (plus one in the near 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 workers' compensation schemes). Two of these countries introduced the system quite recently (United Kingdom in 1995 and Iceland in 1999) and Denmark is considering doing so. This trend shows a strong interest in finding a common ground for assessment methods.

In this respect it could be interesting to explore once more the use of the 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, in fact, that a common language may help to ensure common interventions to people with disabilities.

**3. COMPARATIVE ANALYSIS OF CRITERIA GOVERNING THE
GRANTING OF DISABILITY/INVALIDITY PENSIONS**

Dr. Hartmut HAINES (Germany)

Criteria governing the granting of disability/invalidity pensions

Austria	Does the principle "rehabilitation before allowance" apply in your country? Yes		
disability/invalidity pensions	accident pensions	pensions for war veterans and other specific groups	invalidity pension
Which are the disability/invalidity related questions that govern the granting of this particular pension?	- is the disability/invalidity the result of a work accident or of a work related illness? - degree of disability 20 or more?	is the disability/invalidity the result of a war injury or of an event of equal status	
Method of assessment regarding :	Barema method	Barema method	Barema method + assessing needs
- physical/psychical conditions	X	X	X
- ability to work	X	X	X
- loss of income			
- remaining (chance of) income	X	X	X
Who uses it?	AUVA	Ministry of Health and Labour	Social Insurance
In which environment: public or private?	Public	public	public
Other criteria not related to disability/invalidity	No	no	contributions to pension insurance
Are multidisciplinary teams involved in the above-mentioned assessment(s)?	Yes	no	yes

Criteria governing the granting of disability/invalidity pensions

Belgium	Does the principle "rehabilitation before allowance" apply in your country? No					
disability/invalidity pensions	compensation for war victims	compensation for punishable acts	for industrial accidents	for occupation-related diseases	invalidity pension	adult disability allowance
Which are the disability/invalidity related questions that govern the granting of this particular pension?	is the disability/ invalidity the result of a war injury or of an event of equal status?	is the disability/ invalidity the result of an act of violence?	is the disability/invalidity the result of an accident at work?	is the disability/invalidity the result of an occupation-related disease?	is the health status of an employed person restricted to less than 2/3 of his/ her working capacity? must a self-employed person end his/her professional activity and do it for 12 connected months?	does the health status diminish the earning capacity to 1/3 or less?
Method of assessment regarding:	Barema method	Barema method	evaluation of economic invalidity resulting from the event	evaluation of economic invalidity resulting from the event	evaluation of sociomedical factors: impairments, age, qualification, work experience	evaluation of sociomedical factors: impairments, age, qualification, work experience
- physical/psychical conditions	X	X	X	X	X	X
- ability to work			X	X	X	
- loss of income						
- remaining (chance of) income						
Who uses it?	the ministry's medical-legal service	the ministry's medical-legal service	the fund's medical service	a medical commission	the fund's medical service	doctors of the ministry
In which environment: public or private?	public	public	public (private in private insurances)	public	public	public
Other criteria not related to disability/invalidity	no	no	employment	employment	insurance since at least 6 months a total of 120 working days in this period younger than normal pension age	age 21 to 65 EU citizenship or comp. living in Belgium insufficient personal income
Are multidisciplinary teams involved in the above-mentioned assessment(s)?	no	no	no (exceptionally ergologic counselling)	no	no	no

Criteria governing the granting of disability/invalidity pensions

Cyprus	Does the principle "rehabilitation before allowance" apply in your country? No		
disability/invalidity pensions	employment injury benefit: injury benefit	employment injury benefit: disablement benefit (grant or pension)	invalidity pension
Which are the disability/invalidity related questions that govern the granting of this particular pension?	is the injury the result of industrial accident or occupational disease?	is the injury the result of industrial accident or occupational disease? loss of physical or mental faculty of a degree of not less than 10 %? disability of 10 to 19 % for grant disability of 20 % or above for pension	has the claimant been incapable for work for at least 156 days? is the claimant expected to remain permanently incapable for work? in cases where the invalidity is not 100 %: what percentage (of full pension)?
Method of assessment regarding:	medical certificate	functional capacity method	Barema method
- physical/psychical conditions	X	X	X
- ability to work	X	X	X
- loss of income			
- remaining (chance of) income			
Who uses it?	responsible officers	responsible officers	responsible officers
In which environment: public or private?	public	public	public
Other criteria not related to disability/invalidity	is the claimant an employed person?	is the claimant an employed person?	satisfying qualifying conditions (contributions, age etc.)
Are multidisciplinary teams involved in the above-mentioned assessment(s)?	no	no	no

Criteria governing the granting of disability/invalidity pensions

Denmark	Does the principle "rehabilitation before allowance" apply in your country? Yes	
Disability/invalidity pensions	early retirement pension	consumables
Which are the disability/invalidity related questions that govern the granting of this particular pension?	is the work capacity reduced by at least 50 % for health and social reasons or for people between 50 and 67 years: when the social and health conditions warrant an award of a pension (different conditions for different amounts)	permanently reduced physical or mental functional capacity
Method of assessment regarding:	(under revision)	
- physical/psychical conditions	X	X
- ability to work		
- loss of income		
- remaining (chance of) income		
Who uses it?		
In which environment: public or private?		
Other criteria not related to disability/invalidity	period of permanent residence in Denmark partly earnings-related	the consumable can substantially alleviate the permanent consequences of the reduced capacity everyday life in the home or is necessary to practise an occupation
Are multidisciplinary teams involved in the above-mentioned assessment(s)?		

Criteria governing the granting of disability/invalidity pensions

France	Does the principle "rehabilitation before allowance" apply in your country? No			
disability/invalidity pensions	war pensions	industrial injuries pensions	invalidity pensions	adult disabled person's allowance
Which are the disability/invalidity related questions that govern the granting of this particular pension?		is the disablement the result of an industrial accident or disease?	does the state of health reduce the applicant's capacity to work or to earn a living by at least two thirds?	are claimants at least 80 % incapacitated, or are claimants between 50% and 80 % incapacitated, and are they also unable, for medical reasons, to obtain employment?
Method of assessment regarding :	Barema method	Barema method	assessment of social-vocational parameters: impairment, age, social background, education, vocational experience, physical and mental capacities	Barema method
- physical/psychical conditions	X	X	X	X
- ability to work			X	
- loss of income			X	
- remaining (chance of) income				
Who uses it?			state health insurance scheme's medical officers	Technical Commissions for Vocational Guidance and Resettlement
In which environment: public or private?	public	public	public	public
Other criteria not related to disability/invalidity			insurance for at least 12 months before stopping work at least 800 working hours during that period, including 200 hours in the first three months	other payments may reduce the award
Are multidisciplinary teams involved in the above-mentioned assessment(s)?		no	no	

Criteria governing the granting of disability/invalidity pensions

Germany	Does the principle "rehabilitation before allowance" apply in your country? Yes			
disability/invalidity pensions	by occupational accident insurance funds	by social compensation funds	by pension insurance funds	old-age pension for severely disabled persons by pension insurance funds
Which are the disability/invalidity related questions that govern the granting of this particular pension?	is the disability/invalidity the result of an occupational accident, of an occupational disease or of an event of equal status? could medical or vocational rehabilitation be useful? grade of disability/invalidity 20 or more?	is the disability/invalidity the result of a war injury or of an event of equal status? could medical or vocational rehabilitation be useful? grade of disability/invalidity 30 or more?	could medical or vocational rehabilitation be useful? is the claimant able to do normal, paid work?	is the claimant severely disabled (grade of disability/invalidity 50 or more)?
Method of assessment regarding :	Barema method	Barema method	assessing needs	Barema method for the classification as "severely disabled"
- physical/psychical conditions	X	X	X	X
- ability to work			X	
- loss of income	(only for supplements)	(only for supplements)		
- remaining (chance of) income			X	
Who uses it?	the funds' medical service	the funds' medical service	the funds' medical service as far as the deciding administration deems it necessary	the medical service of the social compensation fund
In which environment: public or private?	public (or private on demand by public) environment	public (or private on demand by public) environment	public (or private on demand by public) environment	public (or private on demand by public) environment
Other criteria not related to disability/invalidity	no (but for additional benefits e.g. because of unemployment)	no (but for additional benefits e.g. because of low income)	contributions to pension insurance for 5 (3 of them in the last 5) years no relevant earnings	age 60 or more contributions to pension insurance for 35 years no relevant earnings
Are multidisciplinary teams involved in the above-mentioned assessment(s)?	no, but close co-operation between administration and medical service	no, but close co-operation between administration and medical service as far as necessary	no, but close co-operation between administration and medical service	no

Criteria governing the granting of disability/invalidity pensions

Hungary (1)	Does the principle "rehabilitation before allowance" apply in your country? Yes				
disability/invalidity pensions	industrial injuries invalidity pension	industrial injuries disablement allowance	veterans allowance (war-disability)	invalidity pension	provisional allowance
Which are the disability/invalidity related questions that govern the granting of this particular pension?	the disability results from an injury on the job or an occupational disease? has the claimant lost at least 67 % of his ability to work for a continuous period of 12 months?	the disability results from an injury on the job or an occupational disease? disability exceeds 15 %?	is the disability/invalidity the result of a war injury or of an event of equal status? grade of impairment of 25 or more?	has the claimant lost at least 67 % of his ability to work for a continuous period of 12 months?	grade of disability of 50 or more? lack of suitable rehabilitation employment?
Method of assessment regarding :	similar to Barema method	similar to Barema method	Barema method	similar to Barema method	similar to Barema method
- physical/psychical conditions	X	X	X	X	X
- ability to work	X				X
- loss of income					
- remaining (chance of) income					
Who uses it?	medical boards	medical boards	medical boards	medical boards	medical boards
In which environment: public or private?	public	public	public	public	public
Other criteria not related to disability/invalidity	former income termination of office/work	former income	no	former income termination of office/work	within a 5 year period before retirement age former income termination of office/work
Are multidisciplinary teams involved in the above-mentioned assessment(s)?	no	no	no	no	no

Criteria governing the granting of disability/invalidity pensions

Hungary (2)	1. Does the principle "rehabilitation before allowance" apply in your country? Yes			
disability/invalidity pensions	social allowance	social support	severe disablement allowance	personal allowance for the blind
Which are the disability/invalidity related questions that govern the granting of this particular pension?	loss of 50 % ability to work? lack of suitable rehabilitation employment?	loss of 67 % ability to work?	becoming incapable of work before 25th birthday? 100 % disabled?	blindness?
Method of assessment regarding ...	similar to Barema method	similar to Barema method	similar to Barema method	similar to Barema method
- physical/psychical conditions	X	X	X	X
- ability to work	X	X	X	
- loss of income				
- remaining (chance of) income				
Who uses it?	medical boards	medical boards	medical boards	the county chief ophthalmologist
In which environment: public or private?	public	public	public	public
Other criteria not related to disability/invalidity	former income termination of office/work	means test taken into consideration	no	means test taken into consideration
Are multidisciplinary teams involved in the above-mentioned assessment(s)?	no	no	no	no

Criteria governing the granting of disability/invalidity pensions

Iceland	Does the principle "rehabilitation before allowance" apply in your country? Yes	
disability/invalidity pensions	compensation for permanent medical impairment due to accidents at work	disability pension
Which are the disability/invalidity related questions that govern the granting of this particular pension?	permanent medical impairment?	invalidity grade of 75 % or more (as reflected by a score of 15 points covering physical activities or 10 points covering mental condition) if no exempting conditions or exceptional circumstances?
Method of assessment regarding :	Barema	functional capacity method (except specified groups)
- physical/psychical conditions	X	X
- ability to work		X
- loss of income		if working and earning: no payments
- remaining (chance of) income		
Who uses it?	medical officers of the State Social Security Office	medical officers of the State Social Security Office
In which environment: public or private?	public	public
Other criteria not related to disability/invalidity	number of years of potential wage earning (until usual retirement age)	age 16-66 years pension insurance at the State Social Security Institute having received short-term sick benefit or statutory sick pay
Are multidisciplinary teams involved in the above-mentioned assessment(s)?	no	no

Criteria governing the granting of disability/invalidity pensions

Ireland	Does the principle "rehabilitation before allowance" apply in your country? No			
disability/invalidity pensions	disablement benefit (+ unemployability supplement)	invalidity pension	disability allowance	blind pension
Which are the disability/invalidity related questions that govern the granting of this particular pension?	full or partial inability to work due to occupational illness or injury?	inability to work due to illness or injury (expected at least 1 year)?	is the person substantially handicapped from doing "normal" work? (expected at least 1 year)	loss or serious impairment of vision?
Method of assessment regarding :	Barema	clinical/functional assessment	clinical/functional assessment	ophthalmological assessment
- physical/psychical conditions	X	X	X	X
- ability to work	X	X	X	
- loss of income			means check	
- remaining (chance of) income				
Who uses it?	medical assessors of DSCFA	medical assessors of DSCFA	medical assessors of DSCFA	medical assessors of DSCFA
In which environment: public or private?	public	public	public	public
Other criteria not related to disability/invalidity			means check	
Are multidisciplinary teams involved in the above-mentioned assessment(s)?	no	no	no	no

Criteria governing the granting of disability/invalidity pensions

Italy	Does the principle "rehabilitation before allowance" apply in your country? No						
disability/invalidity pensions	war allowances	occupational injuries benefit	ordinary invalidity allowance (INPS)	ordinary pension of inability (INPS)	pension of inability and invalidity	pension/allowance for blind persons	allowance for deaf mute persons
Which are the disability/invalidity related questions that govern the granting of this particular pension?	loss of generic capacity of work?	loss of generic capacity of work over 11 % resulting from working accident or working disease?	reduction of 2/3 of total capacity for work in "suitable activities"?	total loss of capacity for all work?	partial (75 % or more) or total loss of capacity for work?	total or partial blindness?	deafness whose cause is not psychological or from war or work?
Method of assessment regarding :	Barema	Barema	clinical, social and working history, clinical examination	clinical, social and working history, clinical examination	Barema and evaluation of functional deficit	assessment based upon clinical evidence and history	assessment based upon clinical evidence and history
- physical/psychical conditions	X	X	X	X	X	X	X
- ability to work	X	X	X	X	X		
- loss of income							
- remaining (chance of) income							
Who uses it?	Ministry of Treasure medical doctors	INAIL medical doctors	INPS medical doctors	INPS medical doctors	Local commissions of public health doctors	Local commissions of public health doctors	Local commissions of public health doctors
In which environment: public or private?	public	public	public	public	public	public	public
Other criteria not related to disability/invalidity	no	no	insurance by INPS education and "career" are important to analyse "suitable activities"	insurance by INPS education and "career" are important to analyse "suitable activities"	education and "career" are important to analyse "suitable activities"	no	no
Are multidisciplinary teams involved in the above-mentioned assessment(s)?	no	no	no	no	no	no	no

Criteria governing the granting of disability/invalidity pensions

Latvia	Does the principle "rehabilitation before allowance" apply in your country? When possible		
disability/invalidity pensions	insurance indemnity for the loss of capacity for work	disability pension	State social security benefit
Which are the disability/invalidity related questions that govern the granting of this particular pension?	is the loss of capacity for work the result of an occupational accident or an occupational disease?	permanent or chronic physical or psychological restraints?	
Method of assessment regarding :		medical and social (list of impairments; 3 groups)	
- physical/psychical conditions	X		
- ability to work	X		
- loss of income			
- remaining (chance of) income			
Who uses it?		State Doctors' Commission	
In which environment: public or private?			
Other criteria not related to disability/invalidity			
Are multidisciplinary teams involved in the above-mentioned assessment(s)?			

Criteria governing the granting of disability/invalidity pensions

Lithuania	Does the principle "rehabilitation before allowance" apply in your country? When possible	
Disability/invalidity pensions	invalidity pension 16 years and older	invalidity pension up to 16 years
Which are the disability/invalidity related questions that govern the granting of this particular pension?		
Method of assessment regarding :	medical and social (list of impairments; 3 groups)	medical (list of impairments)
- physical/psychical conditions	X	X
- ability to work	X	
- loss of income	X	
- remaining (chance of) income		
Who uses it?	State medical social expertise commissions	State medical social expertise commissions
In which environment: public or private?	public	public
Other criteria not related to disability/invalidity		
Are multidisciplinary teams involved in the above-mentioned assessment(s)?	yes	yes

Criteria governing the granting of disability/invalidity pensions - answers on the questionnaire for disability

The Netherlands	Does the principle "rehabilitation before allowance" apply in your country? Yes and No		
disability/invalidity pensions	disablement benefits (WAO)	disablement benefits (WAZ)	disablement benefit (WAJONG)
Which are the disability/invalidity related questions that govern the granting of this particular pension?	has a sick employee been unable to work for 52 consecutive weeks? age 15 years or more? rate of disability 15 % or more? (partially or wholly) unable to derive income from usual employment?	has a self-employed persons been unable to work for 52 consecutive weeks? rate of disability 25 % or more?	has a person, not entered in the labour market, been unable to work for 52 consecutive weeks? age: 17 or more? rate of disability 25 % or more?
Method of assessment regarding :	functional capacity method	functional capacity method	functional capacity method
- physical/psychical conditions	X (medical + psychological)	X (medical + psychological)	X (medical + psychological)
- ability to work	X (medical)	X (medical)	X (medical)
- loss of income	X (labour expert)	X (labour expert)	X (labour expert)
- remaining (chance of) income	X (labour expert)	X (labour expert)	X (labour expert)
Who uses it?	the insurance doctor + labour expert	the insurance doctor + labour expert	the insurance doctor + labour expert
In which environment: public or private?	public	public	public
Other criteria not related to disability/invalidity	no	no	no
Are multidisciplinary teams involved in the above-mentioned assessment(s)?	yes	yes	yes

Criteria governing the granting of disability/invalidity pensions

Norway	Does the principle "rehabilitation before allowance" apply in your country? Yes	
disability/invalidity pensions	occupational injury benefits	disability pension
Which are the disability/invalidity related questions that govern the granting of this particular pension?	is the work capacity reduced by at least 30 % due to (physical) injury at the workplace?	is the working capacity of an insured person between 18 and 67 by at least 50 % due to illness, injury or defect?
Method of assessment regarding :	percentage reduction in working capacity due to injury	percentage reduction in working capacity due to illness, injury or defect
- physical/psychical conditions	X (physical condition)	X
- ability to work	X	X
- loss of income		
- remaining (chance of) income	X	X
Who uses it?	civil servants at Regional Social Security Office	civil servants at Regional Social Security Office
In which environment: public or private?	public	public
Other criteria not related to disability/invalidity	less restrictions (than ordinary disability pension) on age and (time) membership requirements in the National Insurance Scheme	age restrictions (time) membership requirements in the National Insurance Scheme former income influences the amount granted
Are multidisciplinary teams involved in the above-mentioned assessment(s)?	no	no

Criteria governing the granting of disability/invalidity pensions

Poland	Does the principle "rehabilitation before allowance" apply in your country? Yes
disability/invalidity pensions	social pension
Which are the disability/invalidity related questions that govern the granting of this particular pension?	is an adult fully unable to work because of a disability which occurred before reaching the age of 18 or during studying?
Method of assessment regarding:	
- physical/psychical conditions	X
- ability to work	
- loss of income	
- remaining (chance of) income	
Who uses it?	
In which environment: public or private?	
Other criteria not related to disability/invalidity	
Are multidisciplinary teams involved in the above-mentioned assessment(s)?	

Criteria governing the granting of disability/invalidity pensions

Portugal	Does the principle "rehabilitation before allowance" apply in your country?	
disability/invalidity pensions	life monthly allowance	disability/invalidity pension
Which are the disability/invalidity related questions that govern the granting of this particular pension?	inability to perform a professional activity in order to provide the own subsistence?	inability to perform due to physical or mental permanent disability a gainful occupation (=more than a third of the earnings gained whilst working normally)?
Method of assessment regarding:	medical diagnosis	medical diagnosis
- physical/psychical conditions	X	X
- ability to work	X	X
- loss of income		
- remaining (chance of) income	X	X
Who uses it?	medical doctor appointed by regional social security centre	medical doctor appointed by regional social security centre
In which environment: public or private?	public	public
Other criteria not related to disability/invalidity	24 years or more under the responsibility of the beneficiary	over 18 years old 5 years with registered earnings not covered by social security general scheme income limits
Are multidisciplinary teams involved in the above-mentioned assessment(s)?	yes	yes

Criteria governing the granting of disability/invalidity pensions

Slovenia	Does the principle "rehabilitation before allowance" apply in your country? Yes				
disability/invalidity pensions	disability pension *	cash replacement allowance*	disability benefit (military activities)	disability benefit (insurance) *	disability replacement allowance
Which are the disability/invalidity related questions that govern the granting of this particular pension?	loss of working capacity (ability to perform organised gainful work in the relevant job)? disability arose at a time when the person was in employment?	reduced working capacity? disability arose at a time when the person was in employment?	is the disability/invalidity the result of a war injury or of an event of equal status? grade of disability/invalidity 20 or more?	physical disability of at least 30 % (injury at work or occupational illness) 50 % (illness or injury outside work)?	person with serious congenital anomalies or other specified disabilities who cannot train for independent living and work?
Method of assessment regarding:	determination of counter-indications in comparison to the requirements of the work		similar to Barema method	similar to Barema method (loss or incapacity of organs or parts of the body)	individual examination
- physical/psychical conditions	X	X	X	X (physical)	X
- ability to work	X	X			X
- loss of income		X			
- remaining (chance of) income		X			
Who uses it?	the expert body of the Retirement and Disability Insurance Institute		medical committee	the expert body of the Retirement and Disability Insurance Institute	classifying committee
In which environment: public or private?	public	public	public	public	public
Other criteria not related to disability/invalidity	satisfying the relevant qualifying conditions defined under the law	satisfying the relevant qualifying conditions defined under the law	no	satisfying the relevant qualifying conditions defined under the law	age of 18-26 years when disability arises
Are multidisciplinary teams involved in the above-mentioned assessment(s)?	yes	yes	no	yes	yes

* will be formed in a different way in 2003, due to changed legislation

Criteria governing the granting of disability/invalidity pensions

Spain	Does the principle "rehabilitation before allowance" apply in your country? Yes	
disability/invalidity pensions	incapacity pension	disability pension not contributive
Which are the disability/invalidity related questions that govern the granting of this particular pension?	permanent loss of at least 33 % of the individual's normal capacity for the individual's usual occupation, or permanent total disability for the individual's usual occupation, or permanent total disability for any occupation, or need of assistance, as a result of bodily or functional losses, to perform essential everyday activities?	handicap degree of 65 % or higher?
Method of assessment regarding :	medical diagnosis	Barema method
- physical/psychical conditions	X	X
- ability to work	X	
- loss of income		maximum income amount
- remaining (chance of) income		
Who uses it?	INSS doctors	assessment and guidance teams
In which environment: public or private?	public	public
Other criteria not related to disability/invalidity	age 18 to 65 contributions to the social security system	age 18 to 65 EU nationals etc.; residence in Spain lack of sufficient income
Are multidisciplinary teams involved in the above-mentioned assessment(s)?	no	yes

Criteria governing the granting of disability/invalidity pensions

Sweden	Does the principle "rehabilitation before allowance" apply in your country? Yes	
disability/invalidity pensions	occupational injury benefits	disability pension
Which are the disability/invalidity related questions that govern the granting of this particular pension?	accident or illness related to the working situation?	is the working capacity of a person between 16 and 64 reduced by at least 25% due to illness, injury or impairment?
Method of assessment regarding :	percentage reduction in working capacity due to injury	percentage reduction in working capacity due to illness, injury or impairment
- physical/psychical conditions	X (medical)	X (medical)
- ability to work	X (medical)	X (medical)
- loss of income		
- remaining (chance of) income		
Who uses it?	civil servants at the regional social security office	civil servants at the regional social security office
In which environment: public or private?	public	public
Other criteria not related to disability/invalidity	age restrictions former income influences the amount granted	age restrictions membership requirements in the national insurance scheme former income influences the amount granted
Are multidisciplinary teams involved in the above-mentioned assessment(s)?	no	no

Criteria governing the granting of disability/invalidity pensions

Switzerland	Does the principle "rehabilitation before allowance" apply in your country? Yes
disability/invalidity pensions	invalidity pensions
Which are the disability/invalidity related questions that govern the granting of this particular pension?	does a damage to health reduce the capacity to earn permanently by at least 40 %? could rehabilitation be useful?
Method of assessment regarding :	percentage reduction in capacity to earn (or to do normal work)
- physical/psychical conditions	X
- ability to work	X
- loss of income	
- remaining (chance of) income	X
Who uses it?	Cantonal Office of invalidity insurance
In which environment: public or private?	public
Other criteria not related to disability/invalidity	one year of contributions domicile and normal residence in Switzerland no entitlement to old age pension
Are multidisciplinary teams involved in the above-mentioned assessment(s)?	in principle yes, depending on the Cantons

Criteria governing the granting of disability/invalidity pensions

United Kingdom	Does the principle "rehabilitation before allowance" apply in your country? No					
disability/invalidity pensions	war pensions / disablement benefit	industrial injuries disablement benefit	criminal injuries compensation	vaccine damage payment	long-term incapacity benefit	severe disablement allowance
Which are the disability/invalidity related questions that govern the granting of this particular pension?	is the disablement the result of an injury related to service? percentage of disablement 20 or more?	is the disablement the result of an industrial accident or disease? percentage of disablement 20 or more?	is the disablement the result from a crime of violence?	is the disablement the result of specified vaccine? percentage of disablement 80 or more?	is the claimant unable to do any form of work since 28 weeks or more? a score of 15 points covering physical activities (10/15 points if mental problems are involved) if no exempting conditions or exceptional circumstances?	is the claimant unable to do any form of work? percentage of disablement 80 or more?
Method of assessment regarding :	Barema method	Barema method	Barema method (level in a scale of compensation)	Barema method	functional capacity method (except specified groups)	functional capacity method + Barema method
- physical/psychical conditions	X	X	X	X	X	X
- ability to work					X	X
- loss of income		(only for supplement: Reduced Earnings Allowance)			if working and earning: no payments	
- remaining (chance of) income						
Who uses it?	administrative and medical staff of War Pensions Agency	benefits agency medical services	Criminal Injuries Compensation Authority	Secretary of State for Social Security	benefits agency medical services, reporting to adjudication officers	benefits agency medical services
In which environment: public or private?	public	public	public	public	public	public
Other criteria not related to disability/invalidity	no (but additional age allowance where the degree of disablement reaches a certain value)	is the claimant an employee?	other payments may reduce the award	no	sufficient National Insurance contributions under retirement age incapacitated for a year evidence of sickness	age over 16 years and under retirement age incapacity must have been present for at least 28 weeks
Are multidisciplinary teams involved in the above-mentioned assessment(s)?	no	no	no, but legal input in some cases	no	no	no

4. EUROPEAN DISABILITY BAREMAS

Dr. Yves LAROCHE (Belgium)

I. ENGLISH BAREMA

1. HEAD

- Severe disfigurement 100%

2. VERTEBRAL COLUMN

3. UPPER LIMBS

- Amputation at the level of the shoulder joint 90%
- Amputation under the shoulder with a stump less than 20.5 cm in length 80%
- Loss of both hands or amputation located higher up the arm 100%
- Loss of a foot and a hand 100%
- Loss of a hand or a thumb and four fingers of one hand 60%
- Loss of the thumb and its metacarpal 40%

4. PELVIS

5. LOWER LIMBS

- Amputation at the level of the hip 90%
- Amputation at the level of the knee or under the knee with a stump less than 9 cm in length 60%
- Amputation of a foot with a functional stump 30%
- Loss of a foot and a hand 100%

6. HEART

7. VESSELS

8. RESPIRATORY SYSTEM

9. DIGESTIVE SYSTEM AND ADNEXA

10. **DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS**

11. **DISORDERS OF THE GENITO-URINARY SYSTEM**

12. **NEURO-PSYCHIATRIC DISORDERS**

13. **DIABETES**

14. **EYE DISORDERS**

- Loss of sight to the point where the person is incapable of carrying out any work in which vision is vital 100%
- Loss of one eye without complications, the other being normal 40%

15. **AUDITORY SYSTEM**

- Complete deafness 100%

II. BELGIAN OFFICIAL DISABILITY RATING SCALE (BOBI)

A. Use of the BOBI

1. Supplementary family benefits for disabled children

Any child with a disability aged between 0 and 21 years may receive in addition to the usual family benefit, a supplementary family benefit if he or she is affected by physical and/or mental disability of at least 66%.

Physical or mental disability of at least 66% is evaluated using:

- a) the BOBI
- b) a list of specific childhood illnesses not included in the above-mentioned scale.

2. Pension for war veterans and certain other groups

Benefits are linked to a "permanent reduction in physical or mental functional capacity".

In accordance with the BOBI, pensions are set:

- a) by the Medico-legal Department for:
 - disabled war veterans and military personnel injured in peacetime;
 - political prisoners;
 - civilian victims of war;
 - victims of intentional acts of violence.
- b) by the Public Health Service for federal state employees.

3. Pensions for occupational disablement

a. Occupational accidents

The law on occupational accidents provides for compensation for losses resulting from occupational disablement.

Occupational disablement is determined by the loss of the victim's capacity to compete on the general labour market, account being taken of the social and economic circumstances. In addition to the loss of faculty, the socio-economic factors taken into account are:

- age;
- vocational training;

- the possibility of adjustment;
- the possibility of re-training.

In practice, the degree of physiological disability is calculated by referring to the applicable articles of the BOBI, then deciding on an "adjustment" known as the "vocational coefficient": finally, the two figures are added together.

b. *Accidents covered by ordinary law*

The requirement under ordinary law of complete compensation means that the expert must study the injury from every point of view, i.e., not only the purely physiological injury but also the pecuniary and occupational loss and the social implications.

The expert must determine the final percentage of the permanent disability with the greatest of care, since this will determine the final compensation rate. In this case, it is preferable but not compulsory for the expert to refer to the BOBI whenever possible.

c. *Accidents covered by personal insurance*

In many cases, the BOBI is applicable, but this is not necessarily so in every case. Indeed, in certain cases, the insurance company has its own disability scale.

4. The Walloon Agency for the Integration of Disabled Persons

Within the terms of this law, a person is disabled if his or her possibilities of employment are decreased as the result of a impairment or further to a reduction of at least 30% in his or her physical capacity or at least 20% in his or her mental capacity.

Here again, to determine the percentage the medical referee was the BOBI.

B. The evaluation procedure

The doctor will apply the following procedure:

1. medical diagnosis;
2. identification of impairments;
3. evaluation of disability.

In assessing disabilities, the doctor will take account not only of those directly related to the impairment, but also of those inherent in the therapeutic constraints: poorly tolerated drug treatment, repeated hospitalisation and repercussions on the individual's general state of health.

The disabilities should be sufficiently long-term in nature to justify a decision valid for one year. This does not mean that they must necessarily be permanent. However, potential developments will be taken into account in deciding on the degree of disability and setting a reasonable time period.

C. Determining rates

Evaluation of loss of faculty is carried out separately for each organ or physiological function.

For multiple disabilities, where the most serious disability is not as high as 100%, the disabilities are ranked in decreasing order of severity.

Examples:

An impairment A results in 40% disability, the remaining capacity being 60%.

An impairment B results in a disability calculable, according to the rating scale, at 20%.

The disability resulting from this second impairment will be 20% of the 60% remaining capacity, i.e. 12%.

The overall disability will thus be: $40\% + 12\% = 52\%$.

Conclusion

All Belgian physicians who evaluate physical injury know of the existence of the BOBI and refer to it on many occasions. It may be said that the current trend is to make less use of this scale, and yet at present there is no rating scale that can replace it.

Its main advantage resides in the fact that it is widely available and permits widespread communication between medical referees; its dissemination and practicality and the power of communicability that they confer constitute its sole authority.

III. OFFICIAL BELGIAN BAREMA

1. HEAD

- Loss of the upper jawbones and loss of the entire mandible 100%
- Disfigurement 10 to 100%

2. VERTEBRAL COLUMN

- Congenital and growth conditions resulting in severe functional disorders 30 to 100%
- Traumatic sequelae of major importance at the level of the cervical spine 20 to 40%
- Sequelae of major importance at the level of the lumbar spine 20 to 30%
- Inflammatory and degenerative phenomena 5 to 100%

3. UPPER LIMBS

- Disarticulation of the shoulder at gleno-humeral level 85%
- Loss of the forearm as a result of disarticulation of the elbow 75%
- Loss of the hand by disarticulation or amputation of the wrist immediately above the wrist-joint 65%

4. PELVIS

- Congenital dislocation of both hips 35 to 65%
- Ankylosis in an aberrant position 40 to 70%
- Ankylosis of both hips 100%

5. LOWER LIMBS

- Ankylosis of the knee bent more than 45° 45 to 55%
- Total loss of a lower limb 90%
- Total loss of a foot 50%
- Sequelae of simultaneous fractures of ankle and thigh bones 5 to 45%
- Traumatic clubfoot with major, fixed deviation 30 to 50%

6. HEART

- Lesions involving the valvular system of traumatic origin 20 to 70%
- Coronary failure without infarction 10 to 40%
- Myocardial infarction with parietal ectasia 30 to 60%
- Decompensated coronary artery disease 50 to 100%

7. VESSELS

- Physical or mechanical traumatism of an artery 0 to 30%
- High blood pressure caused by atherosclerotic damage 5 to 20%
- Arterial lesions resulting in tissual necrosis or amputation 20 to 50%

8. RESPIRATORY SYSTEM

- Very severe chronic bronchitis 70 to 100%
- Asthma with damage to the general condition and cardiac repercussions 60 to 100%
- Bronchiectasis 20 to 100%
- Pyothorax and pyopneumothorax fistulized on the skin or in the bronchi 60 to 100%
- Foreign body in the lung 5 to 100%
- Inactive parenchymatous sequelae of a more extensive phthisis (at least one third of the pulmonary area) 15 to 100%
- Chronic active pulmonary tuberculosis 50 to 100%
- Pneumonectomy 30 to 100%

9. DIGESTIVE SYSTEM AND ADNEXA

- Total amputation of the tongue 80%
- Cicatricial stenosis of the oropharynx requiring the definitive or complicated gastrostomy of a fistula 50 to 100%
- Acute oesophageal stenosis requiring definitive gastrostomy or an oesophageal derivation 50 to 100%
- Diaphragmatic lesions resulting in the displacement of abdominal organs 10 to 80%
- Complicated gastric or duodenal ulcer 30 to 100%
- Total gastrectomy 60 to 100%
- Intestinal resection (calculi) with major repercussions on the general condition and major disorders of nutrition and absorption 80 to 100%
- Colectomy 40 to 100%
- Sphincterial lesions of the rectum with incontinence 30 to 100%

- Post-traumatic or postoperative sequelae to lesions of the liver with repercussions on the general condition 60 to 100%
- Chronic pancreatitis with major repercussions on digestion and the general condition 30 to 100%
- Splenectomy 5 to 30%

10. DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS

- Myelofibrosis of infectious, toxic, physical or medicated origin 100%
- Thrombocytopenia or thrombocytopathy or infectious, toxic, physical or medicated origin 20 to 100%

11. DISORDERS OF THE GENITO-URINARY SYSTEM

- Nephropathy 0 to 100%
- Nephrectomy 5 to 100%
- Total urinary incontinence 60 to 100%
- Perineal uro-cutaneous fistula 10 to 100%
- Recto-vaginal fistula 10 to 100%
- Malignant neoplasia 100%
- Renal lithiasis 5 to 100%

12. NEURO-PSYCHIATRIC DISORDERS

- Severe postconcussional syndrome, with or without fracture, further to a craniocerebral traumatism, with coma and/or very prolonged state of confusion 40 to 60%
- Hemiplegia requiring permanent confinement to a bed or wheelchair; sphincterial disorders 100%
- Paraplegia requiring permanent confinement to a bed or wheelchair 100%
- Aphasia with alteration of interior speech 40 to 100%
- Complete medullar quadriplegia with anaesthesia below the lesion accompanied by an inability to control the sphincter muscles 80 to 100%
- Bilateral cerebellar syndrome 30 to 100%
- Marked parkinsonian syndrome with speech and/or mental disorders 60 to 100%
- Spasmodic torsional dyskinesia 20 to 100%
- Severe intracranial hypertension, complicated by signs of localisation 75 to 100%
- Tonic-clonic epileptic seizures occurring almost daily or even more frequently 75 to 100%
- Complete impairment of medullar origin with physical infirmity of the two upper limbs 100%
- Continuous urinary incontinence 75%
- Severe forms of multiple sclerosis with considerable disorders or severe bulbar or ocular phenomena 60 to 100%

- Partial or total lesion of the brachial plexus 10 to 75%
- Severe impairment of the sciatic nerves 40 to 80%
- Severe anxiety neurosis with major psychomotor and neurovegetative disorder 50 to 80%
- Malignant obsession 50 to 80%
- Schizophrenia marked by discordant behavioural patterns, major occurrences of delirium, autism, apragmatism and a deep disruption of social relations 65 to 100%
- Acute manic, melancholic or thymic psychosis combined with disruption of social life 40 to 100%
- Persistent thymic disorders with subintractant circular access or severe chronic forms, requiring permanent surveillance and treatment 100%
- Chronic delirium with antisocial behavioural patterns requiring permanent surveillance and medical treatment 65 to 100%

13. DIABETES

- Insulin-dependent diabetes mellitus without complications and not hindering normal activity 20 to 40%
- Unstable insulin-dependent diabetes mellitus or with repeated occurrences of diabetic acidosis or complications seriously impairing the activity of the patient 60 to 100%

14. EYE DISORDERS

- Total loss of vision in one eye (absence of any perception of light) 30%
- Total blindness (loss of the perception of light) 100%

15. AUDITORY SYSTEM

- Bilateral loss of hearing greater than 90 decibels in both ears 80%

IV. BAREMA GUIDE FOR THE ASSESSMENT OF THE IMPAIRMENTS AND INCAPACITIES OF PERSONS WITH DISABILITIES

(FRANCE)

1. The Barema guide is methodological

a) Input mode: impairments and disabilities

The guide is based on the concepts of impairment, disability and handicap put forward by the World Health Organization.

The methodology of P.H.N. WOOD⁽¹⁾ used by the WHO defines a handicap as a process involving four experimental designs:

- the diagnostic design is that of the morbid process;
- the impairment design is that of the impairments to organs and functions;
- the disability design characterises the limitation of the capacities in the basic gestures and acts of everyday living;
- the social handicap design characterises the limit or inability to accomplish a role considered as normal given the age and sex of the patient, and socio-cultural factors.

The phenomena of each design have effects on the neighbouring design(s), but their intensity can vary considerably from one design to another. In each of the designs, there is interaction between the patient's health and environment. The last three designs concern the consequences of the diseases. The international classification of the consequences of disease is proposed as a descriptive supplement to the diagnostic classifications.

As a result, it can be seen that diagnosis by itself does not permit the assessment of the handicap; the latter changes with the level of progression of the disease, the therapeutic possibilities and the environment.

The input mode for the Barema is via the type of impairment, corresponding to "any loss of substance or alteration to a function or a psychological, physiological or anatomical structure. The impairment is characterised by the losses of substance or alterations, which may be temporary or permanent. It represents the exteriorisation of a pathological state, and reflects disorders manifested at the organ level. It can be congenital or acquired."

The purpose is not to strictly apply the classification, which would mean applying a rate to each lesion, but to take into account the difficulties caused by the impairment in daily or vocational life.

¹ Cf. "International classification of impairments, disabilities and handicaps (ICIDH). A manual of the classification relating to the consequences of disease". WHO Geneva, 1980

This directly leads to the concept of disability developed in the International Classification of Impairments, Disabilities and Handicaps, corresponding to "any partial or total reduction in the capacity to accomplish an activity in a way or within the limits considered normal for a human being."

Disability, unlike impairment, involves composite and integrated activities: it involves the person as a whole, in carrying out a task, skill or behaviour. The assessment is essentially based, except with regard to visual and auditory impairments, on the appraisal of the disabilities. The medical diagnoses are used as guidelines but do not in themselves permit a disability rate to be allocated, other than in exceptional circumstances, such as the case of chromosomal aberrations.

With regard to sensory impairments, the assessment of the rate is based on measuring the impairments; it may, however, be weighted by an assessment of the disabilities.

b) Determining the disability rate

The Barema guide has been drafted also taking into account a certain number of guidelines concerning the ultimate purpose of determining the disability rate and the advantages resulting from it.

Determining the disability rate is particularly decisive when it lies close to the thresholds provided for by the regulations:

- 80% threshold which provides full entitlement to the health insurance card for persons with disabilities the adult disabled person's allowance, the special education allowance, complementary old-age insurance benefits for relatives with a person with a disability under their charge, and conditions entitlement to the compensation allowance;
- the 50% threshold which provides entitlement, under certain conditions, to the special education allowance.

The disability rate must therefore be most carefully determined when it neighbours 50% or 80%.

The disability rate does not, however, need to be systematically indicated on the disabled person's health insurance card.

The Barema determines for each category of impairment degrees of severity (usually four, exceptionally three or five) to guide the expert in assessing the disability rate. The Working Group also sought to harmonise the various chapters in the Barema, despite the normalisation that may result for disabilities of widely ranging types.

c) *Disability rate allocated to persons infected with HIV*

Section 6 of chapter VI on hematopoietic impairments and impairments of the immune system requires further discussion.

While the assessment of light and severe impairments (1 and 4) poses no problem, the assessment of moderate and major impairments (2 and 3) can only be medical in its basis; it must take into account – even in the absence of any clinical evidence – the decrease in the level of immunity which can result in severe fragility, limiting and sometimes preventing any movement or work which, in itself, may justify a disability rate of 50%.

It should be recalled that doctors must also take into account in their assessment of the overall disability rate the disorders of behaviour, mood, emotional and affective life described in chapter II section 2, with the possibility of using Balthazar's rule (Cf. paragraph I-f of the present circular). In the presence of these related handicaps, the disability rate will automatically be higher than 50%.

CDES and COTEREP¹ physicians may usefully refer to the Weekly Epidemiology Newsletter² no. 51 (1987) on the definition of declared AIDS (1987 revision) and no. 11/1993 on the revision of the definition of AIDS in France; in appendix II the same issue also includes the 1993 revision of the classification systems of HIV infection for adults and adolescents.

Furthermore, attention is drawn to the need to comply with the provisions of the ministerial circular dated 22 October 1990 as well as DGS memo no. 44 dated 17 June 1991 with regard to accelerating the COTOREP examination procedure for claims for allowances for adult disabled persons and the medical files for persons infected by HIV.

d) *Disability rate allocated to persons affected by blindness*

In the Barema for war veterans, a rate of 100% is allocated in the case of blindness. Application of the Barema guide for the assessment of the impairments and incapacities of disabled persons results in a disability rate of 95% being applied to persons whose central vision is null or less than a twentieth of normal sight.

¹ Commission Technique d'Orientation et de Reclassement Professionnel

² Bulletin Epidémiologique Hebdomadaire

e) *A disability rate of 100%* is very exceptionally allocated, it being considered in the past that it should be reserved for total invalidity, such as vegetative states or coma. Inversely, 0% does not mean the absence of any impairment, simply its non-recognition under the system established by the 1975 Act.

In consequence, when a single impairment results in a situation justifying the allocation of a rate equal to, or higher than 80%, seeking other related impairments which might increase the rate offers no added advantage.

f) *Case of multiple disabilities – the evaluative approach*

The evaluative approach, although requiring a stage during which the various impairments are individually identified, must, as far as possible, remain global in its appraisal. In the present case, this involves assessing the degree of importance of the disabilities linked to the main body functions, and, where children are concerned, the increased schooling costs this entails, at the precise time when the assessment is carried out.

The disabilities which result from the impairments are assessed in relation to a person of the same age, in good health, and in relation to everyday acts, as defined in the various chapters of the Barema.

It has not been possible to systematically evaluate all of the items retained in order to construct the disability rate. The overall rate is distributed according to 3 or 5 different classes as the case may be:

- 0 to 50%: mild disability
- 50 to 80%: moderate disability
- 80% or higher: severe disablement

If the disabled person has several disabilities which fall under different chapters resulting in a limitation of the person's capacities, the expert, once the non-evaluated analytical review has been carried out, will allocate a total incapacity rate.

In certain chapters and for certain impairments, low-value rates have been indicated (5% or 10%). It is clearly stipulated how these rates are to be added (Cf. speech disorders, for instance). They can only be used in the case of small cumulative impairments, or a major principal impairment.

In the event of doubt or difficulties in assessment, it is possible to use Balthazar's rule, the principle of which is recalled here for guidance. The method, known as the residual capacities method, is only used in the case of multiple disabilities indicated in different chapters or sub-chapters when overall assessment may be difficult.

One of the impairments is assessed first of all. The disability rate, thus determined, is subtracted from 100, which represents the total capacity; the result is the residual capacity.

The following disability, resulting from another impairment, is also assessed, and then related to the residual capacity. We thus obtain the rate corresponding to the second impairment. The total incapacity is the result of the sum of the two rates calculated in this manner. The total incapacity is the same, no matter what order in which the impairments are taken into account.

Examples:

- impairment A results in a disability of 40%, the residual capacity is therefore 60%.
- impairment B results in a disability assessed, according to the Barema, at 20%. The disability resulting from this second impairment is 20% of the 60% residual capacity ie 12%. The total disability is therefore: $40\% + 12\% = 52\%$.
- in the case of a third impairment, based on the same example, the residual capacity will be 48%.

This method of calculating total incapacity, based on multiple disabilities and the use of the Balthazar formula, is only indicative in nature, but nonetheless may be used to verify the pertinence of a proposed disability rate.

2. The assessment approach

In practise, the physician will adapt the following approach:

- 1) medical diagnosis, analysis of the eventual treatment, its stringency, and repercussions on daily life,
- 2) identification of impairments,
- 3) assessment of disabilities.

The latter part of the clinical examination must be supplemented by the observations of the other members of the medical team and by reading the other documents in the case file when these provide information about functional limitations.

With particular regard to children, it is vital that the reports drafted by teachers, psychologists, educators, therapists etc. also be taken into account in order to assess disabilities.

As a result, when assessing disabilities, the medical team will take into account not only those directly inherent to the impairment, but also those inherent to the therapeutic constraints, such as poorly tolerated medicated treatment, repeated hospitalisation, and repercussions on the patient's general condition.

The rate is difficult to assess in the case of certain diseases which progress in outbreaks, such as multiple sclerosis, rheumatoid polyarthritis or certain psychiatric conditions. While in no case may the state of the patient at the time of the attack be taken into account, on the other hand the disability rate must be weighted not only by the frequency and severity of the relapses, but also by their effect on the social and vocational life of the patient.

Orthotics and prosthetics

The rates have taken into account the progress made in the medical and surgical fields and in that of orthotics and prosthetics. The assessments on which they are based must, however, demonstrate the latitude required to discern genuine compensation for the handicap: for example, a below-knee prosthesis which fits perfectly and causes no pain is still only a palliative; a wheelchair is still vital for all paraplegics, even if some can walk over limited distances.

Other than for auditory impairments, the disability assessment is done taking into account the orthotic and prosthetic possibilities. The latter must be accepted by the person with a disability properly tolerated, and effectively used. Finally, medical boards must also ensure that there is complete acceptance of liability for the costs of the orthotics and prosthetics in order to take this factor into account.

Permanence of disorders – term of decisions

The disabilities must be sufficiently permanent to justify a decision within a time limit of one year. This does not mean such decisions must be definitive; consolidation, in particular, need not be reached in order to determine the disability rate. Account will, however, be taken of the potential progression of the condition in order to decide and determine a coherent duration. The etiological diagnosis, whenever known, is an important source of information about the progression of the condition and hence with regard to the requisite frequency of further examinations. The diagnosis provides information about the possibilities of improvement or deterioration in continuous or discontinuous modes, even though it does not, by itself, always permit determination of either the presence or absence of impairments, or assessment of the scale of disability.

It is recalled in this respect that the medical secret must be upheld. The medical referee must not communicate the diagnosis to the other members of the medical team. The referee must simply describe the foreseeable consequences of the diagnosis in terms of impairments and disabilities, in the short, middle and long terms. Finally, the medical secret must be upheld beyond the confines of the medical board, and the medical certificates kept under sealed letter in the case files.

Regular examinations are to be provided for; their frequency is left to the appreciation of the referee, depending on the condition of the patient in question and the progression of same. Care should, however, be taken that there no useless measures are taken or examinations made when the state of the patient is stable and has been properly assessed, and there is little likelihood of change.

Children

Finally, while common rules of assessment can be found for children and for adults, the experts wished to recall the guidelines which help in assessing the disability rate of child patients.

The disability of a child must be assessed in relation to a child of the same age and in good health, and in relation to the acts of everyday life and "normal" schooling.

The provisions of the Barema specific to childhood apply a rate ranging between 50% and 80% to the circumstances and disabilities resulting in noteworthy restraints in the daily life of the child and the child's family.

The assessment of children with disabilities is progressive and in most cases takes into account the on-going educational assistance required to maintain or develop the autonomy of the child.

Medical boards will be attentive to the most sensitive periods:

- when the child is very young, diagnosis is sometimes uncertain, for example in cases of suspected deafness, or psychomotor retardation indicating severe mental retardation. The medical board is not held to wait for a precise etiological diagnosis in order to decide the case: the information is found to be lacking in nearly one third of all cases. Regular reassessments will permit the diagnosis to be refined. Furthermore, where very young children are concerned, the impossibility of finding proper childcare because of the handicap is, in itself, a restraint on the daily life of the child and the child's family.
- adolescence is also a period which can be marked by a deterioration or a reactivation of disorders. Account must be taken of this not only in order to determine the rate of disability but also that of the review interval.

The capacities of every child for social and scholastic adaptation must be assessed. Confining the child to a special educational institution is an indicator but in no way should it lead by itself to the automatic allocation of a 50% or 80% disability rate.

3. Deterioration renewals and claims

The French government, in accordance with the claim of national associations for persons with disabilities, has wished to maintain the vested rights of disabled persons whose disability rate was determined on the basis of the Barema for war veterans. Articles 3 and 5 of decrees 93-1216 and 93-1217 stipulate the methods of application.

First of all, if the state of the person has not changed, the disability rate is maintained.

If that is not the case, and there has been either improvement or deterioration in the patient's condition, assessment of a new rate will be exclusively based on the new Barema guide.

In the event of deterioration, the rate must be proposed by the referee and determined by the medical board with reference to the new Barema guide; the board will adopt the highest rate.

Should there have been an overt error in assessment during the previous examination made before December 1993, the board shall refer to the Barema for war veterans to provide evidence of the error.

4. Review of main provisions

It is recalled that the medical boards must examine all claims, and decide each case without taking into account the financial resources of the applicants. The new Barema guide is applicable to all claims, first claims or renewals, registered after 30 November 1993.

Furthermore, the reasons for all decisions must be given, particularly in cases of refusal. The grounds must stipulate the nature of the claim: first claim, renewal or claim for deterioration.

The time limits and appeal procedure have not changed.

Conclusion

The Barema is a methodological guide designed to harmonise CDES and COTEREP practices. A simple work tool, it permits assessment of the difficulties of persons with disabilities, taking into account the diversity of their personal situations. The various degrees of severity are precise, but medical boards retain a certain degree of latitude of assessment, particularly within each of the disability rate brackets.

The medical certificates are to be changed in the near future in order to facilitate the work of the medical referees, teams and boards.

V. FRENCH BAREMA

1. HEAD

- Major impairment; disorders seriously hindering or preventing feeding, head carriage, and saliva retention 50 to 70%
- Dependence on a third party 80%

2. VERTEBRAL COLUMN

- Major impairment with major repercussions on social, vocational or family life or limiting the performance of certain acts basic to daily living 50 to 75%
- Severe impairment rendering movement extremely difficult or impossible, or preventing the performance of one or several basic acts 80 to 85%

3. UPPER LIMBS

- Amputation of the forearm 50 to 75%
- Disarticulation of the shoulder 80 to 90%

4. PELVIS

5. LOWER LIMBS

- Amputation of the ball of the foot 20 to 40%
- Amputation of the leg or thigh with prosthetics 50 to 75%
- Amputation rendering movement extremely difficult or impossible 80 to 90%

6. HEART

- Continuous or semi-continuous angina pectoris which resists treatment 80 to 90%
- Cyanogen congenital heart condition 50 to 100%
- Decompensated congestive heart failure or therapeutically compensated in precarious and unstable fashion 80 to 90%

7. VESSELS

- Unstable, persistent high arterial blood pressure despite continuous medical treatment with major subjective disorders (cephalgia, discomfort) 15 to 30%
- Intermittent claudication 50 to 75%
- Massive, general damage resulting in repeated lesions causing a state of dependence for most acts of daily life 80 to 90%

8. RESPIRATORY SYSTEM

- Repeated bronchial infections but without major repercussions on social or vocational life 20 to 45%
- Acute respiratory failure with continuous congestive failure of the right ventricle 85 to 90%
- Cystic fibrosis 80%
- Chronic asthma despite treatment or with severe attacks (such as more than ten per month) 50 to 75%

9. DIGESTIVE SYSTEM AND ADNEXA

- Sphincter disorders with fistula 20 to 40%
- Total gastrectomy (by analogy) 50 to 75%
- Total faecal incontinence 80 to 90%
- Oesophagectomy 80%
- Gastrostomy 80%
- Colostomy 70%
- Acute hepatic failure greater than 80%
- Exocrine pancreas failure 70%

10. DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS

- Leukaemia in the progressive stage, or haematological or immunity condition requiring constant medical supervision with complete or partial hospitalisation 80 to 95%
- Declared AIDS 80 to 95%
- Leukaemia and reticulocytoses considered clinically cured 1 to 10%

11. DISORDERS OF THE GENITO-URINARY SYSTEM

- Renal lithiasis 15 to 45%
- Acute renal failure 80 to 95%
- Urinary incontinence 50 to 60%
- Cystostomy 70 to 80%
- Nephrotic syndrome 50 to 75%
- Transplanted renal failure 30% (at least)

12. NEURO-PSYCHIATRIC DISORDERS

- Tonic-clonic epileptic seizures with falls and/or fainting (at least once per day) greater than 80%
- Massive hemiplegia 80 to 90%
- Complete quadriplegia at motor level 80 to 90%
- Complete paraplegia at motor level 80 to 90%
- Acute athetosis 80 to 90%
- Severe cerebellar syndromes of all four limbs 80 to 90%
- Invalidating phobias 50 to 75%
- Acute depression without severe signs of melancholia 50 to 75%
- Obsessional rites affecting behaviour 80 to 95%
- Invasive delirium or restricted to isolation 80 to 95%
- Perturbative maniacal state or restricting socio-vocational life 75 to 95%
- Severe or acute mental retardation greater than 95%
- Total autistic withdrawal 80 to 95%
- Total mutism 80 to 95%

13. DIABETES

- Non-insulin-dependent diabetes mellitus 5 to 20%
- Balanced insulin-dependent diabetes mellitus 25 to 35%
- Unstable insulin-dependent diabetes mellitus with frequent or severe hypoglycaemic and/or diabetic acidotic incidents and/or with repeated hospitalisation, difficult to balance with frequent comas 50 to 75%

14. EYE DISORDERS

- Unilateral blindness 25%
- Total blindness 95%
- Complete hemianopia 42%
- Complete lateral double hemianopia 85% (maximum)

15. AUDITORY SYSTEM

- Bilateral deafness (80 decibels and more) 80%

VI. ITALIAN BAREMA

Preliminary comment

The “Barema” (or table) method is used in Italy for assessing civilian disabilities, occupational disabilities and disabilities sustained in war or military service or by public employees.

In each case, a different “Barema” is used, the most recent being that for civilian disability (introduced in 1992), in which the given percentages have been aligned with those of the other “Baremas”.

The following relates only to the civilian disability table.

Part 1 METHOD FOR USING THE NEW BAREMA

The new table is concerned with the impact of disabilities that impair people’s capacity to work, according to the criteria laid down in current regulations.

It therefore requires the analysis and percentage measurement of each anatomic-functional disability and the resulting loss of capacity to work.

The table includes both specific disabilities to which a “fixed” percentage loss is attributed and disabilities in relation to which the extent of permanent functional impairment must be expressed as a 10% loss of capacity to work - this formula being applied essentially in cases that are difficult to classify.

Many other disabilities are omitted but, according to their nature and seriousness, the impairment they cause can be evaluated using techniques similar to those listed.

1. Permanent functional damage is calculated in relation to capacity to work (Article 1(3) and Article 2, DL 509/1988, of 23 November), i.e. capacity to do work of a general nature, with the possibility of increasing the base value by not more than five percentage points in cases where the disability also has an incidence on the person’s capacity for occupations suited to his or her abilities and preferences (so-called semi-specific capacity) and on capacity for specific jobs.

The base value may also be decreased by not more than five percentage points in cases where a disability appears to have no impact on semi-specific or specific capacity for work.

2. In cases of a single disability that is included in the table, the basic percentage of permanent disablement must be expressed using one of the following:

- a. the fixed percentage of disablement, in cases where the nature and extent of the disability exactly match one of the entries in the table (in the “fixed” column);
 - b. a percentage measure of disablement within the relevant range, in respect of disabilities for which a range is indicated (in the “min-max” column);
 - c. if the disability is not included in the table, it must be evaluated in percentage terms using criteria similar to those indicated for comparable disabilities of similar gravity (see (a) and (b)).
3. In the case of multiple disabilities, the criteria used for the final assessment are the following: calculation is made of the percentages for a disability, based exclusively on the criteria described in section 2, sub-sections a, b and c.

Thereafter, account must be taken of the fact that the disablement due to multiple disabilities present and/or not present in the table can result from the functional interaction of the disabilities in question or simply from their coexistence.

The disabilities involving a single organ or system are, in functional terms, in competition with each other.

In all other cases, each disability is assessed separately: an overall assessment is thus reached which must not, in principle, consist in the arithmetic sum of each percentage, but comprise a percentage value proportional to that quoted for the total anatomo-functional loss of the organ or system in question.

With regard to the overall assessment of the disablement, according to article 5, DL. 509/1998, the disabilities entered between 0 and 10% are only taken into consideration subject to the condition that they are not in competition with each other or with other disabilities included in higher brackets.

In addition, equally under the specific terms of article 5, no other disabilities have been characterised in the table.

Disabilities involving functionally distinct organs and systems coexist. In this case, after assessing each disability in percentage terms, a reduction calculation is made, using the following formula expressed in decimals:

$$IT = IP1 + IP2 - (IP1 \times IP2)$$

in which the final overall disability IT (total invalidity) is equal to the sum of the partial individual disability factors IP1, IP2, minus the product of same.

For example, if the first disability (IP1) is assessed at 20% and the second (IP2) at 15%, the final result (IT) will be $(0.20 + 0.15) - (0.20 \times 0.15) = 0.32$, ie 32%.

In cases where there are more than two disabilities, the process is repeated and continued in the same way. For practical reasons, it would be expedient to use a special combined calculation table which will be available to each Committee.

4. The appropriate Committees will examine the possibility or not of using prosthetic devices.

The prostheses are to be considered as a functionally effective factor for attenuating the gravity of the impairment, and as a means of permitting a capacity for work of a general, semi-specific (occupations compatible with the predilections of the subject) or specific nature.

Each examination must be verbalised in such a way that the following items are determined: the anagraphic data, the occupational status, present work activities and those having occurred in the past, the physiological and pathological family case history (past and future), a complete clinical examination, laboratory and instrumental tests, clinical diagnosis for those features covered by art. 1, section 3, DL. 509, the prognosis with particular regard to the eventual permanence of the disability and the functional damage, the percentage allocated to each disability on the basis of the table, and in the case of multiple disabilities the overall assessment if applied to competing disabilities or the assessment obtained using the reduction calculation carried out with the formula and the combined calculation table (cf. 3 above) and if the overall assessment concerned coexisting disabilities, the possibility of using prostheses and any variation in percentage related to same.

The Committee should indicate the reference code corresponding to the disability diagnosed in order to characterise the correlated disablement (art. 2, section 1, DL. 509) on the basis of the WHO classification.

The relation also provides for the reasons for the Committee's decision based on the repetition of the requisite qualities, for the allocation of support compensation for subjects entitled to same on the grounds of art. 1, L 508/1988, and the determination of the subject's capacity to work, pursuant to art. 3, DL 509, taking into account art. 1, section 3, L 508/1988.

Based on the above example, the Committee should fill in the following headings:

1. *Diagnosis*

Disablement no. 1..... reference code
Disablement no. 2..... reference code

2. *Percentage assessment of disabilities*

Disablement no. 1..... %
Disablement no. 2..... %

Prostheses see 4 below

3. *Final percentage of disability*

- a. Single disability (carry forward without changing the percentage calculated in section 2 above);
- b. Multiple disabilities:
 - Disabilities competing between each other to cause the damage

Disablement no.....
Disablement no.....

- c. Overall assessment of competing disabilities
 - assessment of reduction applicable to coexisting disabilities

For practical reasons, it is preferable to use the combined calculation table available to each Committee.

- d. Competing disabilities combined with coexisting disabilities (on the hypothesis of the existence of a group of competing disabilities and a group of coexisting disabilities, the partial results of a. and b. above are to be included in the overall final assessment).

To the percentages expressed for a. and b., should be applied a percentage increase to take into account the incidence on the semi-specific and specific capacity [for work] (maximum increase 5%), or should be applied a percentage decrease for no incidence on the semi-specific and specific capacity [for work]. The disability rate (percentage) can then be stated.

Support compensation

L. 508/1988

YES..... NO

Grounds:

Communication compensation L. 508/1988

YES NO

Grounds:

Frequency compensation L. 298/1990

YES NO

Grounds:

Determination of the capacity for work pursuant to the terms of article 3, DL 509/88.

Part 2 Indications for the assessment of functional deficiencies

CARDIO-CIRCULATORY SYSTEM

Congestive heart problems have been assessed with reference to the functional classification of the New York Association of 1964. They comprise 4 types of subject:

CLASS I – person with a cardiac deficiency which has no effect on the subject's ordinary physical activity;

CLASS II – the deficiency determines a mild limitation on the ordinary physical activity of the subject, but the latter can nonetheless have a mild physical activity;

CLASS III – the deficiency determines a marked limitation on each physical activity of the subject, and the latter can only have sedentary physical activity;

CLASS IV – even when at rest the subject can experience fatigue, dyspnea, palpitations, cyanosis, and pains of anginal type.

RESPIRATORY SYSTEM

① *mild respiratory failure*: dyspnea which appears after each effort that any subject of the same age and size succeeds in performing, functional breathing test:

- VC/FEV¹ % min. 85 max. 75%
- Consumption O₂ (ml O₂ x kg min.) min. 25 max. 22
- No cardiac complications

② *moderate respiratory failure*: dyspnea often appears with effort of moderate importance, functional breathing test:

- VC/FEV % min. 65 max. 55%
- Consumption O₂ (ml O₂ x kg min.) min. 20 max. 18
- No cardiac complications

③ *severe respiratory failure*: dyspnea at rest has not been taken into consideration as long as it has no serious consequences, such as making everyday acts impossible

¹ CV/VEMS : capacité vitale / volume expiratoire maximale en 1 seconde [vital capacity/maximal expiratory volume in 1 second]

DIGESTIVE SYSTEM

Four levels of functional impairment are identified, corresponding to the classes indicated below.

For the assessment of disablements stemming from complex pathological situations, which do not always correspond to a clearly defined pathology of organs or system, reference is made to the impairment of the general condition of the patient, in addition to the functional impairment.

CLASS I – The disablement determines the mild alterations to the function which can provoke dysfunctions, irregular pains, medication is not continuous and there is stabilisation of the standard body weight (indicated in the tables referring to sex and stature) on optimum values. In the event of surgical treatment, there must be no functional disturbance or gastro-intestinal disorder.

CLASS II – The disablement determines the functional alterations due to discontinuous painful discomfort, medication is not continuous, there is a loss of body weight of up to 10% in relation to the standard value, there may be anaemia and irregular disorders of the gastro-intestinal transit.

CLASS III – There is severe alteration of the digestive function, with very frequent painful constraints, medication is continuous and a diet constant, loss of body weight is between 10% and 20% in relation to the standard value, there may be anaemia and irregular disorders of the gastro-intestinal transit. The socio-vocational repercussions are considerable.

CLASS IV – There are very severe alterations to the digestive function with pain, medication is continuous but effective, loss of body weight is greater than 20% in relation to the standard value, there is anaemia and constant, severe disorders of the gastro-intestinal transit. There are significant limits in the socio-vocational field.

URINARY SYSTEM

- mild renal failure (clearance of creatinine less than 80ml greater than 40ml/m);
- moderate renal failure (clearance of creatinine less than 40ml greater than 20ml/m);
- severe renal failure (clearance of creatinine less than 20ml/m);
- very severe renal failure (clearance of creatinine less than 20ml/m with metabolic and tensional complications).

ENDOCRINE SYSTEM

CLASS I – Type 2 pancreatic diabetes mellitus (non-insulin-dependent) with satisfactory metabolic control (fasting blood glucose rate mg 150/dl and blood glucose rate after eating mg 180-200/dl)

CLASS II – Type 1 pancreatic diabetes mellitus (insulin-dependent) with satisfactory metabolic control (fasting blood glucose rate mg 150/dl and blood glucose rate after eating mg 180-200/dl)

Type 1 and 2 pancreatic diabetes mellitus with diabetic micro- and macroangiopathic symptoms verified only with instrumental tests.

CLASS III – Pancreatic diabetes mellitus (insulin-dependent) with mediocre metabolic control (fasting blood glucose rate mg 150/dl and blood glucose rate after eating mg 180-200/dl) with hyperlipidemia or frequent hypoglycaemic relapses (despite satisfactory treatment and regular observation of the patient). Type 1 and 2 pancreatic diabetes mellitus with diabetic micro- and/or macroangiopathic complications and clinical symptomatology of moderate level, e.g. non proliferative retinopathy with no maculopathy, presence of pathological micro-albuminuria with normal creatininaemia and azotaemia, obstructive arteriopathy without severe ischaemic pains etc.

CLASS IV – pancreatic diabetes complicated by:

- nephropathy with chronic renal failure and/or
- proliferative retinopathy, maculopathy, vitreous haemorrhage and/or
- obstructive arteriopathy with severe claudication or amputation of a limb.

The body mass index is expressed by the formula: $BMI = w/h^1$
where "w" = weight expressed in kilograms
and "h" = height in metres.

MUSCULOSKELETAL SYSTEM

With regard to the other upper limbs, the damage evaluated in the table refers to the dominant limb. In cases where the damage involves the non-dominant limb, the flat value indicated should be decreased from 1 to 5 per cent.

¹ IMC = p/h^2 : indice de masse corporelle, p/poids, h/hauteur

NERVOUS AND CEREBRAL SYSTEMS

Loss of strength (pyramidal disability, peripheral nerves, muscular handicaps)

- a) **Mild** loss of strength: overcomes the force of gravity, walks without support; demonstrates a reduction in strength against resistance, sensitive movements of the fingers maintained with a moderate functional reduction;
- b) **Moderate** loss of strength: overcomes the force of gravity, walks with support; does not overcome resistance in movement, finger movement maintained but no considerable functional reduction, such as not succeeding in carrying out precise movements;
- c) **Severe** loss of strength: cannot overcome the force of gravity, finger movement is impossible.

The same assessment must be used for loss of strength demonstrated in cases of hemiparesia, with particular reference to the upper limb, in cases of paraparesis and paresis of a single lower limb, and in cases of quadriparesis with reference to all four limbs.

Mild cerebral loss: intention tremor, impairment of all four limbs with prehension maintained, ataxia of the trunk and of the limbs still compatible with walking unaided.

Moderate cerebral loss: intention tremor enabling the function only with difficulty, ataxia of the trunk and of the limbs still compatible with walking unaided, occasional falls.

Severe cerebral loss: intention tremor with prehension maintained, ataxia of the trunk and of the limbs incompatible with walking.

Mild extrapyramidal loss: good compensation with regular therapy

Moderate extrapyramidal loss: partial compensation under regular therapy, postural tremor interfering with prehension, extrapyramidal hypertonia and/or bradykinesia interfering with prehension and walking, involuntary movements interfering with prehension and walking.

Severe extrapyramidal loss: severe decompensation under regular therapy, postural tremor, extrapyramidal hypertonia, bradykinesia, involuntary movements preventing normal activity.

- **Sensorial disorders:** while these may be isolated they are important given they involve a delimited distal portion, they limit daily activities, they interfere with movement and are verified by means of neuroradiological and/or neurophysiopathological examinations.

➤ **Loss of cognitive functions:**

a) Speech disorders:

- **Mild:** oral and/or written production conveys a reduced quantity of information, due to the presence of grammatical disorders or frequent errors, the production of a high number of speech sequences unsuitable for the communicative context, in terms of meaning, or by the production of frequent phonetic distortions or neologisms, gestural communication is maintained, the comprehension of phrases in the oral and/or written mode is compromised, the comprehension of isolated utterances is normal and only slightly compromised.
- **Moderate:** linguistic communication is considerably reduced, but still possible through the production of fragmentary oral and written language, thanks to a sufficient quantity of speech sequences suitable for the communicative context in the register of everyday language, but containing numerous vague or incomprehensible generic terms (neologisms), difficulties in gestural communication, the comprehension of utterances or phrases in the oral and/or written mode is compromised.
- **Severe:** linguistic communication consists of short, stereotyped words or phrases containing only a few terms suitable for the communicative context, or of a sequence of incompatible terms (neologisms), the comprehension of words or phrases is seriously compromised or is fundamentally null.

b) Spatio-visual analysis disorders:

- **Mild:** the patient demonstrates a tendency to forget a part of the body and the space contralateral to the side of the lesion.
- **Severe:** the patient almost systematically disregards the part of the body and the space contralateral to the side of the lesion.

c) Memory loss:

- **Mild:** presence of the loss of recording memory which interferes only occasionally with the acts of everyday life.
- **Moderate:** marked loss of recording memory which interferes very frequently with the acts of everyday life.
- **Severe:** severe loss of recording memory and autobiographical memory, presence of spatiotemporal disorientation.

For memory loss to be considered it must bear a relation with demonstrable cerebral organic damage evidenced by neuropsychological, neuroradiological and/or neurophysiopathological examinations.

d) Behavioural disorders:

- **Mild:** inconstant reductions in initiative at the psychomotor and communicative levels and/or a minor increase in irritation and/or occasional fits of violent behaviour, not interpretable as reactions to stimuli, disorders interfering to a significant degree with the possibility of a normal relational life.
- **Moderate:** frequent reductions in initiative, irritability and/or frequent fits of violent behaviour, not interpretable as reactions to ambient stimuli, disorders interfering to a significant degree with the possibility of a normal relational life.
- **Severe:** stable reduction in initiative on the psychomotor and communicative levels, systematic instability of mood, frequent fits of violent behaviour, not interpretable as reactions to ambient stimuli, severe interferences with normal relational life.

For behavioural disorders to be considered they must be combined with demonstrable cerebral organic lesions evidenced by neuropsychological, neuroradiological and/or neurophysiopathological examinations.

e) Loss of intellectual functions:

- **Mild deterioration or mental retardation:** mild loss of memory combined with at least two of the following symptoms:
 - * temporal disorientation
 - * mild aphasia
 - * mild behavioural disorders occurring approximately at the same time as the other symptoms.
- **Moderate deterioration or mental retardation:** serious loss of memory, temporal disorientation, mild and moderate aphasia, self-sufficiency in personal needs for everyday living.
- **Severe deterioration or mental retardation:** serious loss of memory, temporal and spatial disorientation, moderate and severe aphasia, behavioural disorders, dependence on others for personal needs for everyday living, sphincterial disorders.

f) Disorders of the mental function:

- **Mild:** I.Q. verified with the WAIS test to be between 60 and 70%, considerable emotional distress further to mental stress, capacity for work maintained, no need for supervision, capacity to face the economic and assistance problems of everyday life.
- **Moderate:** I.Q. verified with the WAIS test to be between 50 and 60%, considerable emotional distress depending on mild mental stress, useful capacity for work maintained, capacity to have a gainful job maintained with need for supervision, capacity to face the milder economic and assistance problems of everyday life; need of a tutor or the appropriate social worker for complex problems.

- **Severe:** I.Q. verified with the WAIS test to be between 40 and 50%, serious and frequent emotional distress, pharmacotherapy with need for frequent checks and supporting psychological therapy, loss of the capacity to have a gainful job; need of a tutor or the appropriate social worker for all economic and assistance problems.

AUDITORY SYSTEM

Hypoacusia:

Unilateral and bilateral losses of hearing equal to, or less than 245 dB are to be assessed using the table scheduled hereto, the percentage values of which are derived from a simplified, re-drafted version (with rounding up or down) of the table for unilateral and bilateral hearing losses proposed by the Committee on the Conservation of Hearing, based on the A.M.A. method of 1961.

Total unilateral deafness is allocated a disability rate of 15%, and to total bilateral deafness, a handicap degree of 58.5%. Wherever the percentage values in the table are expressed in decimal figures with half-point fractions, the assessment is left to the discretion of the Committee; case by case, half points in the final score should be rounded up or down (i.e. the score of 58.5% should be rounded off to 59 or 58).

1. The disability rate for a fluctuating form of hypoacusia which is highly discontinuous over time (transmission hypoacusia, hypoacusia of mixed type, neurosensory hypoacusia with pathological tympanogram, Ménière's syndrome etc) should be determined after a period of observation of at least one year, based on at least 3 otofunctional examinations carried out every 3-4 months. The handicap degree will be based on the average loss between the 3 examinations. A review is also recommended every 3 years.
2. The assessment of the degree of hypoacusia and the calculation of the disability rate are to be carried with the ear bare, i.e. with no prosthesis, for a number of reasons:
 - * it is not possible to assess the efficiency and the benefit of the prosthesis until after a suitable period of training and variable adaptation, on a case by case basis;
 - * the conventional assessment of the benefit of the prosthesis based on the audiometric examination of tonality in an acoustical-free field is not appropriate; furthermore it is not correct in acoustic terms to compare responses in an acoustical free field with responses using earphones;
 - * the only valid test for checking the benefit of the prosthesis is vocal audiometry, carried out in a few specialised centres; furthermore, certain methods use dB SPL as their unit of measure, but the results are difficult to

convert into dB HTL, and introduce the same problems of assessment linked to the use of acoustical-free fields mentioned above;

- * verifying the gain produced by the prosthesis supposes a contextual verification by the Committee, with regard to the exactitude of either the prescription or use of the prosthesis;
 - * the assessment in medico-legal terms of the advantage created by the use of acoustic prostheses is both difficult and indiscriminate; consideration should be given to the disadvantages and aesthetic impairment the prostheses imply, the impossibility of using them in noisy environments, the difficulties of using them during work time, auditory fatigue etc.
 - * it is worthwhile carrying out a theoretical assessment of the possibility of applying prostheses for each degree of hypoacusia, and, wherever any such theoretical possibility exists, to apply a limited reduction to the disability rate;
 - * the reduction in the disability rate in the case of hypoacusia (with prosthesis) has been stipulated in our table and concerns all forms of hypoacusia equal to, or less than 245 dB on the better ear; to do so, from difficult cases of bilateral hypoacusia greater than 245 dB with prostheses, for which a disability rate of 65% is recognised, we pass to bilateral hypoacusia equal to, or greater than 245 dB on the better ear, in which the use of prostheses is possible, and for which a maximum handicap degree of 59% is recognised; the critical level for passing from a properly corrected hypoacusia with prosthesis to a difficultly corrected hypoacusia with prosthesis has been set at 245 dB; under this level of loss a reduction of 9% is automatically applied, based on the possibility of using a prosthetic device, which is capable of ensuring either totally or partially the functional recovery of the auditory system.
3. In cases where it is not possible to use subjective audiometry, and hence values expressed in dB HTL, but only objective tests such as the hearing evoked potentials mentioned above, and therefore values expressed in dB SPL, the table can be used in the following fashion:
- * conversion of dB SPL (acoustic pressure) into dB HTL (subjective threshold) in cases where the threshold produced has been expressed in dB SPL;
 - * sum the loss in dB HTL over 3 frequencies (500, 1,000 and 2,000 Hz) in cases where pure tonalities or stimuli characterised in frequencies have been used;
 - * multiply by 3 the loss value compared and converted into dB HTL in cases where threshold types of stimuli (such as clicks) not characterised in frequencies have been used.

With regard to the communication compensation allowance, the expression "*prelingual deaf person*" in art. 4 of the Law dated 21 November 1988 no. 508, is to be considered the equivalent of the expression "*deaf mute*" in art. 1 of the Law

dated 26 May 1970 no. 381: "[...] are considered as deaf mutes, persons with a sensory hearing disablement afflicted by congenital deafness or which has been acquired during early development and which has prevented the normal acquisition of spoken language, given that the deafness is not exclusively psychical in nature or caused by war, work or use".

- a. Under the terms of application of the norms cited above, the expression "early development" is identified as being up to and including 12 years of age.
- b. The expression "which has prevented the normal acquisition of spoken language" is to be understood in the sense that *hypoacusia* renders or can have rendered the acquisition of spoken language difficult. The factors which in *hypoacusia* can render the acquisition of spoken language difficult are varied and complex: the first are, above all, the age at which the hypoacusia initially appears in relation to the age of development [see (a)], and the level of auditory loss [see (c)]. Other important factors, but which are indiscriminate and therefore neither quantifiable nor assessable in normative terms, are the earliness and exactitude of both diagnosis and treatment, the socio-cultural level of the family and others etc.
- c. Exclusively with regard to the granting of the communication compensation allowance, the hypoacusia which entitles persons with disabilities such compensation must be:
 - equal to, or greater than 60 dB* on average between the frequencies of 500, 1,000 and 2,000 Hz in the better ear, if the claimant has not fully reached the age of 12;
 - equal to, or greater than 75 dB* if the claimant has fully reached the age of 12, subject to the condition that the onset of the hypoacusia before the age of 12 is demonstrable. To do so, shall be accepted as evidence those clinical documents "issued" by public bodies lacking certain chronological data, [as well as] the assessment of the qualitative and quantitative features of spoken language and overall communicative capacity, (from which can be deduced their endogenous origin), and the phono-linguistic impairments found present;
 - the audiometric examination(s) to be assessed with regard to the compensation allowance must be carried out after the first year of age;
 - the examination(s) concerning patients under the age of 12 must clearly certify the exactitude of the examination in question (ie whether it is reliable or not) and be signed by the medical examiner;
 - hypoacusia of transmission type, or supported by tympanograms demonstrating tubo-tympanic pathologies are to be assessed in accordance with the criteria previously discussed for civil disablement;

- to permit an assessment as in the previous point, each audiometric examination must be accompanied by an impedancometric examination, unless there are any contraindications (chronic otitis with open tympan, stenosis or lesions of the antrum auris).
- d. The beneficiaries of the communication allowance granted before the age of 12 due to a loss of hearing of less than 75 dB on average between the frequencies of 500, 1,000 and 2,000 Hz in the better ear, are no longer entitled to the allowance after that age.

In cases where the levels of hearing loss are less than those indicated above, or are not demonstrable at the time of the onset of hypoacusia within the period of early development, an assessment is carried out based on the criteria of civil disablement. Under the terms of the allowance, art. 1 of the act dated 26 May 1970, no. 381 and amendments thereto, the auditory threshold level to be considered corresponds to a hypoacusia equal to, or greater than 75 dB HTL on average between the frequencies of 500, 1,000 and 2,000 Hz in the better ear, the other characteristics are those provided for by the above-mentioned act.

The medical inspections for prelingual deafness are to be carried out by ear, nose and throat specialists, or physicians specialised in audiology or phoniatics. The auditory threshold values indicated above refer to dB HTL; in cases where the clinical examinations give values expressed in dB SPL (as in the case of evoked potentials), the values are to be converted into dB HTL.

INTERNAL EAR

Unilateral vestibular loss is correctly compensated for if the following are present:

- mild vertigo in darkness, normal clinical examination or mild instability, unilateral caloric anareflexia, symmetric pendular or rotatory examination.
- Unilateral vestibular loss is incorrectly compensated for if there are persistent vertigo- postural disorders when changing position in darkness, clinical examination with one or several positive results (nystagmus, technical tests), caloric examination with anareflexia or marked hyporeflexia, pendular or rotatory examination without compensation, disorganised.

The vestibular loss is bilateral if there are objective balance disorders, latent nystagmus, positive Romberg, severely disturbed gait, highly altered pendular or rotatory examination, disorganised or with ENG trace virtually absent.

Severe attacks of paroxysmic vertigo can be confirmed in the acute stage. Walking and working are perturbed. Ménière's syndrome type of case or labyrinth fistula. Instrumental tests are varied over time, depending on the onset of the attack.

Elements similar to poorly compensated unilateral loss syndromes may be found. Severe irritative elements are evident (monolateral vestibular hyperreflexia, vertigo, nausea, vomiting and other neuro-vegetative symptoms). Association with a hypoacusia of mixed or neurosensory type is frequent. Ménière's syndrome and diseases also fit into this category.

The possibility of remote compensation, variable over time, which has determined the damage is included, as well as the possibility of progression in time of the pathological structure. It is recommended to:

- ☞ carry out two clinical examinations and instrumental tests within an interval of at least 12 months, the first of which will provide the initial basic or comparative documentation, the second forming the definitive documentation on which the disablement shall be assessed;
- ☞ carry out a review every three years.

The terms of assessment require that in addition to the traditional spontaneous examinations, caloric, pendular or rotatory tests should also be taken into consideration. If a pendular or rotatory examination with ENG traces is carried out, a caloric test is not indispensable, and not vice versa. In all cases, it is always recommended to carry out both types of examination, unless there are clear contraindications for the heat test (such as open tympanitis).

VISUAL SYSTEM

Decreases in visual acuity must be assessed after correction, unless the anisometropia is such that the requisite lens has too high a degree of correction; in such cases, 5 per cent are to be added to the disability rate. Any campimetric losses which may be detected in cases of congenital and acquired glaucoma are to be assessed apart.

The assessment of binocular vision loss is to be performed based on the special table indicated below, in which central visual acuity is indicated in the first horizontal column for one eye and the vertical column for the other. The intersection of the two columns indicates the percentage of the disability rate.

It is very important to remember that the central visual acuity indicated is that of residual sight.

Assessment table for binocular vision loss

Sight	9/10 8/10	7/10 6/10	5/10 4/10	3/10	2/10	1/10	1/20	Less than 1/20
9/10 to 8/10	0	2	3	5	7	10	15	20
7/10 to 6/10	2	3	5	7	10	15	20	30
5/10 to 4/10	3	5	7	10	15	20	30	40
3/10	5	7	10	15	20	30	40	60
2/10	7	10	15	20	30	40	60	70
1/10	10	15	20	30	40	60	70	80
1/20	15	20	30	40	60	70	80	100
Less than 1/20	20	30	40	60	70	80	100	100

Immunitary and systematic pathology

For disablements with a visceral factor, the percentage of the disability rate increases in proportion to the degree and type of the factor in question.

VII. ITALIAN BAREMA: NEW DISABILITY TABLE

(Examples taken from the Barema)

1. HEAD

- Wolf-mouth 80%
- Congenital maxillo-nasal dysostosis or BINDER's syndrome 100%

2. VERTEBRAL COLUMN

- Scoliosis with curvature greater than 60° 31 to 40%
- Ankylosis of the lumbar vertebrae 31 to 40%
- Ankylosis or complete rigidity of the head 61 to 70%

3. UPPER LIMBS

- Amputation of the shoulder 80%
- Anatomical or functional loss of both hands 100%

4. PELVIS

- Hemipelvectomy 100%

5. LOWER LIMBS

- Disarticulation of the hip 85%
- Amputation of the thigh 65%
- Disarticulation of the knee 65%
- Loss of both feet 70%

6. HEART

- Aortic valvular cardiopathy with use of a prosthesis 25%
- Stenosis or coarctation of congenitally closed aorta 75%
- Severe coronary artery disease 100%
- Myocardopathy or valvulopathy with severe cardiac failure 100%

7. VESSELS

8. RESPIRATORY SYSTEM

- Chronic obstructive lung disease (on bronchitis) 75%
- Chronic asthmatic bronchitis 45%
- Acquired bronchiectasis 35%
- Pulmonary tuberculosis with severe respiratory failure 100%
- Pneumonectomy (depending on the degree of respiratory failure) 45 to 100%

9. DIGESTIVE SYSTEM AND ADNEXA

- Cervical oesophagostomy and gastrostomy 80%
- Result of the surgical treatment for a congenital diaphragmatic hernia 10 to 30%
- Gastric or duodenal ulcer 10 to 30%
- Postprandial gastrectomy syndrome 10 to 20%
- Cirrhosis of the liver with portal hypertension 71 to 80%
- Hepatic lobectomy (right) 35%
- Chronic pancreatitis 10 to 70%

10. DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS

- Autoimmune haemolytic anaemia 41%
- Cooley's anaemia 90%

11. DISORDERS OF THE GENITO-URINARY SYSTEM

- Hereditary glomerulonephritis 100%
- Nephropathy under treatment with continuous dialysis 100%
- Nephrectomy with one kidney remaining intact 25%
- Wilms' tumour 95%
- Urethral fistula 15%
- Kidney transplant 60%

12. NEURO-PSYCHIATRIC DISORDERS

- Severe hemiparesia or hemiplegia combined with sphincterial disorders 100%
- Quadriparesis with severe loss of strength
or quadriplegia combined or not with sphincterial incontinence 100%
- Alzheimer's disease with deliria or depression and the onset of senility 100%
- Paraparesis with moderate loss of strength 51 to 60%
- Severe aphasia 91 to 100%
- Severe cerebellar syndrome 91 to 100%
- Parkinsonian extrapyramidal syndrome or
choreiform or severe chore-athetosis 91 to 100%
- Parietal syndrome with bilateral apraxia of the hands 50%

- Generalised epileptic seizures occurring daily under treatment 100%
- Lesion of the median nerve of the dominant arm 31 to 40%
- Lesion of the sciatic nerve (common section) 21 to 30%
- Paresis of the dominant upper limb with severe loss of strength or plegia 61 to 70%
- Mental deficiency 41 to 100%
- Severe endogenous depression 80%
- Severe obsessional phobic neurosis 41 to 50%
- Chronic severe delirium requiring continuous treatment 100%
- Severe schizophrenia with autism, delirium or profound disorganisation of social life 100%
- Cyclothymic disorders with attacks or in severe chronic form requiring continuous treatment 100%

13. DIABETES

- Insulin-dependent diabetes mellitus with mediocre metabolic control and hyperlipemia with frequent hypoglycaemic relapses despite treatment 51 to 60%
- Diabetes mellitus complicated by a severe nephropathy and/or proliferative retinopathy, maculopathy, vitreous haemorrhage and/or obstructive arteriopathy 91 to 100%

14. EYE DISORDERS

- Monocular blindness, vision of the controlateral eye less than 1/20 91 to 100%
- Binocular blindness 100%

15. AUDITORY SYSTEM

- Bilateral auditory loss greater than 275 decibels with the better ear 65%

VIII. GERMAN BAREMA

1. Development of the assessment criteria up to the new 1996 edition

The criteria have a long tradition, as the earliest assessment criteria were devised during the First World War by the scientific section of the Kaiser Wilhelm Academy in 1916.

They were reproduced in a 19-page schedule headed criteria to be used by army medical officers for assessing the effects of impairments sustained during military service or wartime in the category of mental or neurological disorders.

In the early 1920s there appeared a list of criteria for assessing occupational incapacity, which was governed by the German Social Security Act of 12 May 1920; the list was published by authority of the Labour Ministry. It was only a 35-page document but constituted a basis for the current schedule of criteria without major alterations.

In 1952, after the Federal Social Security Act of 20/12/50 took effect, the Labour Ministry issued the first criteria for expert medical appraisal in this area; they were reviewed so as to cover disabled war veterans and then, pursuant to new social security legislation, adapted to the field in question (currently referred to as welfare law concerning compensatory benefits); the new legislation derives from the old invalidity laws.

Expert medical appraisal criteria for social security purposes were issued in 1954, 1958 and 1965.

In 1977 the authorities issued criteria for the medical assessment of people with disabilities, defined according to disability legislation as before. Though principally intended for the assessments prescribed under the 1974 Disabilities Act, they were also applicable to persons eligible for social security benefits.

In 1983 a further edition, followed by the 1996 edition, incorporated the criteria for expert medical appraisal within the ambit of the welfare law provisions on compensation deriving from the disability legislation. This edition included assessment criteria in respect of all classes of persons requiring an expert medical opinion for the purposes of the social security administration. The publisher of the 1996 table and its predecessors is the Federal Ministry of Labour and Social Security; the scales of disability were compiled in the departments of the organisation for disabled veterans' affairs.

2. Purpose of the criteria

Many decisions relating to the above legislative areas stipulate prior medical assessment, and therefore depend on its quality.

They have at all times been meant to provide assessors with clear and well-structured references enabling medical experts to deliver unimpeachable objective appraisals that give consistent results in identical situations.

To meet this aim, on the one hand they inform medical experts of their obligations, the phraseology used in assessment, and of the relevant legislation, administrative instructions and circulars from the Ministry of Labour and Social Security which the expert needs to know in order to fulfil the assignment.

On the other hand the criteria, based on the latest medically reliable data, provide guidelines in all matters of importance for proper assessment of the different sequelae as evidenced by varied forms of health damage.

These criteria cannot take account of every situation which may arise, but those most frequently encountered in assessment are analysed so as to enable the expert to deliver reliable conclusions even in less common situations.

It is neither possible nor expedient for a medical handbook to replace the compendium of criteria; nor should this be directly used as a guide by beneficiaries of social security or government assistance to formulate their compensation claims. The criteria are intended purely for the guidance of medical experts.

3. Reasons for revising the criteria

There have been three reasons for revising the criteria over the last decade:

- A. New knowledge and progress in medical science**
- B. Alteration of the statutory framework**
- C. Experience gained in applying the criteria**

A. New knowledge and progress in medical science is relevant to all areas of assessment where it concerns the lasting effects of health damage.

Example:

In 1973, according to the criteria then applicable, implanting pacemakers involved disability of at least 50%; they were adjusted to a fixed compulsory frequency irrespective of the effort level.

Since then, as a result of technical development, they come into operation only under special conditions and are implanted even in cases of slight heart trouble or preventively (eg for occasional rhythmic disorders).

According to the 1983 criteria, it was no longer possible to certify major disability on the sole ground of pacemaker implantation.

In fact the assessment depends on the heart's residual ability.

According to the 1996 criteria, the base rate for disability and occupational incapacity alike is 10%. Especially in the sphere of social security law, new scientific knowledge is of great relevance - in particular where it concerns aetiology and pathogenesis - and affords new approaches for investigating the causality of complaints.

Diabetes has more and more recognised forms due to different aetiopathogenic factors, in the light of which it has become necessary to adapt the assessment scale.

B. Alteration of the statutory framework

The criteria for the 1996 assessment scale have been altered mainly to allow for the introduction of the term disability rate, acknowledged by the first law (1986) dealing with serious disability.

It has also been necessary to take account of the 1992 Criminal Rehabilitation Act, the 1994 Administrative Rehabilitation Act and the new terminology of section 35 (1) of the Federal Administrative Act on dependence.

C. Experience gained in applying the criteria

As the criteria are meant to provide all possible references to guide practice, this may lead to disparity or insufficient objectivity of assessment; experience acquired in this respect must be considered when revising the criteria.

Example:

For assessments under the law on serious disabilities, expert opinions have often been necessary in recent years for cases of diseases hitherto not included in the incapacity or disability tables; it has consequently proved difficult to carry out assessments matching the conditions listed in the table. That is why a new list of complaints had to be included in the 1996 assessment scale (e.g. cerebral tumours, Parkinson's syndrome and immunodeficiency).

4. Procedure applied in revising the criteria

In the light of the specified grounds for updating the criteria, revision was proceeded with as follows.

Firstly, the Ministry of Labour and Social Affairs issued a request to the Ministers and Senators responsible for the labour and social affairs departments and to the social security authorities (medical department) in the various *Länder* to submit their proposals regarding the revision; opinions were also requested from the Federal Defence Ministry (health inspectorate) and the associations of disabled war veterans and civilians. In the light of these proposals, it was possible to determine the areas where revision of the references was essential. The Labour Ministry, in consultation with the social medicine section of its board of medical experts, set up specialised working parties (ophthalmology, ear, nose and throat, neurology, psychiatry, paediatrics, orthopaedics, surgery, internal medicine, gynaecology, dermatology).

The members were doctors with clinical and scientific experience, and doctors specially qualified in the welfare field (*Land* and military authorities); a few doctors designated by associations of and for people with disabilities also took part. The proposed amendments were then put to the members of the social medicine section of the board of medical experts of the Federal Ministry of Labour and Social Affairs; this section discussed and finalised the new version.

Revision of the criteria in the 1996 version involved over 160 experts, two-thirds of them doctors in the clinical and scientific fields.

The criteria are thus founded on a broad spectrum of experience and knowledge in the realm of science and expert medical reporting.

1. HEAD

- Loss of the upper jawbones causing degeneration of the nose and sinuses 20 to 40%
- Loss of the lower jawbone affecting mastication 20 to 50%
- Visually repulsive disfigurement 50%

2. VERTEBRAL COLUMN

- Mild functional disorders 10%
- Moderate functional disorders in a demarcated region 20%
- Severe functional disorders in a demarcated region 30%
- Moderate or severe functional disorders in two demarcated regions 40%
- Functional disorders with serious consequences such as immobilisation or corset worn over three sections 50 to 70%
- Severe scoliosis 50 to 70%
- Inability to stand upright or walk 80 to 100%

3. UPPER LIMBS

- Loss of both arms or hands 100%
- Loss of an arm and a leg 100%
- Loss of shoulder joints leaving a small stump 80%
- Loss of forearm by disarticulation of the elbow 70%
- Amputation at the forearm 50%
- Complete loss of a hand 50%

4. PELVIS

- Total prosthesis of one hip 20%
- Total prosthesis of both hips 40%
- Total prosthesis of one knee 30%
- Total prosthesis of both knees 50%

5. LOWER LIMBS

- Amputation of both legs at the upper thigh 100%
- Amputation of one leg at the hip or leaving a very short stump 80%
- Partial loss of one foot (at the transverse tarsal joint) 30%
- Ankylosis of one knee in a favourable position (bent 10-15°) 30%
- Ankylosis of one knee in an unfavourable position 40 to 60%
 - Clubfoot with unilateral functional impairment 20 to 40%
- Clubfoot with bilateral functional impairment 30 to 60%
- Pseudarthrosis of the tibia 20 to 50%

6. HEART

- Disorders of cardiac rhythm not causing permanent deficiency 10 to 30%
- Valvular lesions, coronary conditions, cardiomyopathies, congenital conditions causing dyspnea at rest and pulmonary hypertension 90 to 100%

7. VESSELS

- Arterial lesions with intermittent claudication:
 - If able to walk painlessly on a level for at least 500m 20%
 - If able to walk painlessly on a level for up to 50m (without pain at rest) 70 to 80%
 - Articular hypertension affecting the fundus oculi and/or causing hypertrophy of the left ventricle and/or proteinuria with diastolic tension consistently above 100 mm of Hg despite properly applied treatment 20 to 40%

8. RESPIRATORY SYSTEM

- Severe chronic bronchitis (with normal pulmonary function) 20 to 30%
- Pneumoconiosis and asthmatic or emphysematous bronchitis causing severe respiratory failure 80 to 100%
- Pneumoectomy for minimum tumour 80%
- Parvicellular and undefined bronchial tumours 100%
- Pulmonary tuberculosis active for over 6 months 100%

9. DIGESTIVE TRACT AND ADNEXA

- Functional oesophageal stenosis impairing general condition and increasing inhalation rate 50 to 70%
- Organic oesophageal stenosis severely impairing general condition 50 to 70%
- Gastric tumour with stenosis severely impairing general condition 40 to 50%
- Partial gastrectomy with gastroenterostomy and complication such as DUMPING SYNDROME 20 to 40%
- Total gastrectomy impairing general condition 40 to 50%
- Gastrectomy due to malignant tumour not diagnosed early, according to stage and impairment of general condition (over a 5 year remission period) 80 to 100%
- Colicky diverticulitis impairing general condition 40 to 50%
- CROHN's disease with severe permanent or recurrent disorders, deterioration of general condition, nocturnal or diurnal diarrhoea 50 to 60%
- Sphincterial lesions of the rectum with incontinence minimum 50%
- Artificial anus without complications 50%
- Liver cirrhosis with ascites 60 to 100%
- Chronic pancreatic disorder (exocrine function) causing serious interference with digestion of fats and significant deterioration of general condition 50 to 80%

10. DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS

- Splenectomy (before 8 years of age) 20%
- Hodgkin's at the most advanced stage:
 - a. until completion of therapy 100%
 - b. first three years after total remission 60%
- Stabilised chronic myeloid leukaemia 50 to 80%
- Myelodysplastic syndrome displaying its severest effects 100%

11. DISORDERS OF THE GENITO-URINARY SYSTEM

- Nephrectomy, congenital absence of a kidney, total unilateral renal failure 25%
- Renal lithiasis with frequent colic and recurrent infection of the urinary tract 20 to 30%
- Severe renal failure requiring haemodialysis 100%
- Transplanted renal failure 50% (minimum)
- Decompensated nephrotic syndrome (oedemas) 40 to 50%
- Chronic bladder infection with contracted bladder 50 to 70%
- Defective voiding of bladder, requiring cystostomy 50%
- Complex urinary incontinence 50-70%

12. NEURO-PSYCHIATRIC DISORDERS

- Cerebral disorders irrespective of origin with serious mental effects 70 to 100%
- Defects in co-ordination and balance of spino-cerebral origin 30 to 100%
- Cerebral disorders with cognitive deficiencies (aphasia, apraxia, agnosia) 30 to 100%
- Hemiplegia 100%
- Parkinson's disease with severe functional infirmity 80 to 100%
- Epilepsy (generalised seizures occurring at least weekly or in bursts) 90 to 100%
- Cerebral tumour seriously impeding adaptation or learning 100%
- Acute autistic syndrome 100%
- Schizophrenia according to impairment of occupational and social adaptability 50 to 100%
- Residual schizophrenia seriously impeding social adaptation 80 to 100%
- Compulsive disorders seriously impeding social adaptation 80 to 100%
- Partial lesion of cervical medulla with severe paralysis of both arms and legs and vesical or intestinal disorders 100%
- Multiple sclerosis (peaks excepted) threshold of 50%

13. DIABETES

- Non-insulin dependent diabetes:
 - a) in case of biguanide treatment 10%
 - b) in case of hypoglycemic sulphonamide treatment 20%
- Well-balanced insulin-dependent diabetes 40%
- Confirmed insulin-dependent diabetes with intermittent hypoglycemic incidents 50%

14. EYE DISORDERS

- Total loss of vision in one eye 30%
- Total blindness 100%

15. AUDITORY SYSTEM

- Bilateral hearing loss between 80 and 90% in both ears 70%

IX. ICELANDIC BAREMA

1. HEAD

- Total loss of teeth 5 to 8%
- Loss of outer ear 5 to 8%
- Loss of hair 5 to 10%
- Paralysis of the facial nerve 5 to 15%

2. VERTEBRAL COLUMN

- a. fractures without neurological complications:
 - Sensory disturbances and marked loss of movement 19 to 25%
 - Total loss of movement in spinal column 20 to 25%
- b. Severe damage to the spinal cord max.100%

3. UPPER LIMBS

- Amputation of the entire arm Right: 70% - Left: 65%
- Amputation at the elbow Right: 60% - Left: 55%
- Loss of hand at the wrist Right: 50% - Left: 45%
- Loss of thumb Right: 20% - Left: 17%

4. PELVIS

- Mild symptoms Max. 5%
- Moderate symptoms 6 to 10%
- Pronounced symptoms 11 to 20%
- Abnormal consequences of a fracture or dislocation +1 to 10%
- Ankylosis of the hip in a favourable position 20%

5. LOWER LIMBS

- Total loss of a lower limb Right: 50% - Left: 40%
- Amputation at the knee with satisfactory adaptation to prosthesis Right: 35% - Left: 35%
- Ankylosis of the knee in a favourable position Right: 20% - Left: 20%
- Amputation of foot at the ankle with poor adaptation to prosthesis Right: max. 35% - Left: 35%

6. RESPIRATORY SYSTEM

- Loss of one lung 30%

7. **DIGESTIVE TRACT AND ADNEXA**

- Splenectomy (according to age) Max: 5%

8. **DISORDERS OF THE GENITO-URINARY SYSTEM**

- Unilateral nephrectomy Max: 10%

9. **NEURO-PSYCHIATRIC DISORDERS**

- Postconcussional syndrome 5-8%
- Serious damage to the spinal cord (NB: the severest traumatism must be individually assessed) Max: 100%
- Lesions of the brachial plexus Right: 70% - Left: 65%
- Total lesion of the median nerve Right: 35% - Left: 30%
- Lesions of the sacral plexus Right: 50% - Left: 50%
- Total destruction of the sciatic nerve Right: max. 40% - Left: 50%

10. **EYE DISORDERS**

- Total loss of vision in one eye 20%
- Total loss of vision in both eyes 100%
- Hemianopsia due to a cerebral trauma 50%

11. **AUDITORY SYSTEM**

- Total unilateral hearing loss 10%
- Total bilateral hearing loss 75%

X. PERCENTAGE OF DISABILITY IN CERTAIN PATHOLOGIES

1. ESTONIA

In Estonia, diagnoses are not the sole basis for determining disability. The subject's occupational status (education, qualification) is also taken into account.

Three groups of disability are defined:

Group III: 50-60%
Group II: 60-80%
Group I: above 80%.

As a result, the same diagnoses may produce differing results depending on the person.

Result for diagnoses requested:

1. Total gastrectomy: Group III.
2. Total nephrectomy (unilateral): not provided for in the disability groups.
3. Unstable insulin-dependent diabetes mellitus with repeated occurrences of diabetic acidosis and/or complications: Group II or III.
4. Hearing loss of 80 dB in the right ear and 60 dB in the left ear: Group III or not included in any of the groups.
5. 1/10 vision in the right eye and 0.15/10 in the left eye: Group III.

2. GERMANY

Federal Ministry of Labour and Social Affairs

1. Total gastrectomy: 20-50%
2. Total nephrectomy (unilateral): 25%
3. Unstable insulin-dependent diabetes mellitus with repeated occurrences of diabetic acidosis and/or complications: 50% minimum
4. Hearing loss of 80 dB in the right ear and 60 dB in the left ear: 30%
5. 1/10 vision in the right eye and 0.15/10 in the left eye: 90%

3. ICELAND

1. Total gastrectomy
 - a. with symptoms of complications: 15%
 - b. without symptoms of complications: up to 50%
2. Total nephrectomy (unilateral): 10%
3. Unstable insulin-dependent diabetes mellitus with repeated occurrences of diabetic acidosis and/or complications: up to 40%
4. Hearing loss of 80 dB in the right ear and 60 dB in the left ear: 58%
5. 1/10 of normal vision in the right eye and 0.15/10 in the left eye: 80%

4. IRELAND

The figures below are only valid in the event of occupational injury or disease.

1. Total gastrectomy: 45 to 80%.

Disability depends on the state of nutrition and the extent of weight loss and anaemia.
2. Total nephrectomy (unilateral):

5% in most cases;

5 to 10% in case of persistent pain or distress in the region where surgery was performed.
3. Unstable insulin-dependent diabetes mellitus with repeated occurrences of diabetic acidosis and/or complications: 75 to 100%. The percentage depends on the degree of instability and the severity of the complications.
4. Hearing loss of 80 dB in the right ear and 60 dB in the left ear: 38%, in so far as hearing loss is work-related.
5. 1/10 vision in the right eye and 0.15/10 in the left eye: 16%.

5. ITALY

1. Total gastrectomy: No percentage for civilian disablement. In terms of liability in tort (biological damage): 36 to 60%; over 60% for severe impairment of general condition.
2. Total nephrectomy (unilateral): 25% for civilian disablement, 15% in terms of liability in tort.
3. Diabetes: 51-60% for civilian disablement, 35-60% in terms of liability in tort.
4. Hearing loss of 80 dB in both ears: 60%
5. 1/10 vision in the right eye and 0.15/10 in the left eye: 80% (civilian disablement), same percentage for liability in tort

6. LITHUANIA

In Lithuania, diagnosis is not the only basis for determining capacity for work: other social factors are also taken into consideration.

There are three groups of disabilities: I (the most severe), II, III.

AVERAGE	
GROUP I	100%
GROUP II	60-100%
GROUP III	30-60%

Results for the requested diagnoses:

1. Total gastrectomy: group III.
2. Total unilateral nephrectomy: not provided for in the disability groups.
3. Unstable insulin-dependent diabetes with repeated occurrences of acidosis and/or complications: group II or III.
4. Loss of hearing of 80 DB in the right ear and 60 DB in the left ear: group III, or not provided for in the other groups.
5. Vision of 1/10 in the right eye and 0.15/10 in the left eye: group III.

7. SLOVENIA

1. Total gastrectomy
After-effects of a total gastrectomy 80%
2. Total unilateral nephrectomy
 - loss of a kidney after an adaptation period
 - or
 - complete loss of a kidney's functions
second kidney functioning normally 30%
3. Unstable insulin-dependent diabetes with
repeated occurrences of diabetic acidosis and/or
complications no list
4. Hearing:

In order to define a percentage of physical disability, an audiogram and
calculation of hearing loss using the FOWLER method are essential. According to
Fowler, complete loss of hearing is a loss greater than 95%.
5. Sight

1/10 vision in the right eye and 0.15/10 in the left eye 90%

8. SPAIN

1. Total gastrectomy: No exact percentage is assigned to gastrectomy.

Anatomical and/or functional disorders of the digestive tract are assessed having regard to their possible effects on the patient's nutritional condition, weight loss, need for specific diet and medication, etc. These combined factors determine a greater or lesser degree of disability according to the restriction of day-to-day activities. The degree is ascertained as specified in the appendix.

2. Total unilateral nephrectomy:

All nephrological disorders are assessed with reference to residual kidney function measured by clearance of creatinine, and the resultant degree of disability (see appendix).

3. Insulin-dependent diabetes with acidosis relapses and/or complications:

A maximum rating of 24% disability is assigned to patients unable to achieve adequate metabolic control despite satisfactory treatment, or where there is objective evidence of micro-angiopathy through retinopathy or persistent albuminuria.

When hospitalisation for more than 48 hours is necessitated by acute decompensation, the assessment is 49% or may even attain 70% depending on the frequency of decompensations over the year.

4. Hearing loss of 80 dB in one ear and 60 dB in the other: Percentage of disability or overall personal impairment = 30%.
5. 1/10 visual acuity one eye and 0.15/10 in the other: Disability percentage 69%.

APPENDIX TO THE SPANISH CONTRIBUTION

Degrees of disability according to the repercussions of a deficiency on the activities of day-to-day life.

Zero disability (rating 0%)

"Such symptoms, signs or sequelae as may be present do not vouch for any impairment of ability to carry on the activities of day-to-day life".

Slight disability (rating 1% to 24%)

"The symptoms, signs or sequelae are present and vouch for some degree of difficulty in carrying on the activities of day-to-day life, but are compatible with virtually all these activities".

Moderate disability (rating 25% to 49%)

"The symptoms, signs or sequelae cause significantly reduced ability or inability to carry on most activities of day-to-day life, although patients remain independent as regards self-care".

Severe disability (rating 50% to 70%)

"The symptoms, signs or sequelae cause significantly reduced ability or inability to carry on most activities of day-to-day life, and certain self-care activities may be affected."

Very severe disability (rating above 70%)

"The symptoms, signs or sequelae render it impossible to carry on any activities of day-to-day life".

Activities of day-to-day life are understood to mean those common to all citizens, and are divided into:

1. Self-care activities (e.g. eating, avoiding hazards, personal care and hygiene, etc.);
2. Other activities of day-to-day life:
 - communication
 - physical activity
 - sensorial function
 - dexterity functions
 - ability to use means of transport
 - sexual function
 - sleep
 - social and leisure activities.

**XI. COMPARISON OF DISABILITY BAREMAS IN DENMARK,
NORWAY AND SWEDEN**

HEAD	DENMARK	NORWAY	SWEDEN
FACE			
Total loss of teeth	10	0-20	-
Loss of 1 outer ear	8	15	
Loss of 2 outer ears	-	25	-
Loss of scalp	10	15-35	
Total paralysis of facial nerve	8-10	15	
Bilateral paralysis of facial nerve	Max. 30	30	-
Loss of sense of smell	10	5	4
Loss of sense of taste	-	5	7
Loss of sense of smell and taste	-	15	10
Serious lesion of trigeminal nerve	Max. 10	Max. 10	10

EYES			
Loss of 1 eye	20	25	17
Loss of 2 eyes	100	-	-
Total loss of vision in 1 eye	20	20	14
Total loss of vision in 2 eyes	100	100	68
Diplopia	5-10	Max. 20	-
Ptosis	18	15	-
Problems with lacrimal secretion	Max. 10	0-10	-

EARS			
Loss of an outer ear	8	15	-
Loss of 2 outer ears	-	25	-
Total loss of hearing in 1 ear	10	15	15
Total loss of hearing in 2 ears	75	65-100*	60

* if it appears later and language is incomprehensible: 65%, if congenital: 100%.

Comparison of disability Baremas in Demark, Norway and Sweden
(Continued)

HEAD (continued)	DENMARK	NORWAY	SWEDEN
BRAIN			
Post-traumatic encephalopathy	8-10	Max. 14	13
Dementia	15-100	15-100	25-99

THORAX, ABDOMEN and PELVIS			
Loss of a lung	-	35	25
Loss of the spleen (depends on age)	5	5	5
Loss of a kidney	10	15	5
Loss of 2 testicles/ovaries	Max. 15	Max. 44	-
Loss of 1 testicle	-	-	5

VERTEBRAL COLUMN			
Fractures/traumas without neurological consequences			
Minor fractures	5-10	Max. 9	5
Moderate fractures	8-15	10-19	15
Serious fractures	15-25	20-30	30
Fractures/traumas with neurological consequences	20-100	25-100	23-97

Comparison of disability Baremas in Demark, Norway and Sweden
(Continued)

UPPER LIMBS	DENMARK		NORWAY		SWEDEN	
	Right	Left	Right	Left	Right	Left
Loss of an arm	70	65	60	55	51	45
Recurrent dislocation of shoulder joint	10	10	5-12	5-12	6	6
Amputation at elbow level	65	60	55	50	42	38
Amputation at lower forearm level, good elbow mobility	60	55	50	46	37	35
Loss of the hand at wrist level	60	55	45	41	37	35
Ankylosis of the wrist in a favourable position	10	10	15	15	7	7
Loss of a thumb	25	25	20	19	17	16
Loss of index finger	10	10	10	10	7	7
Loss of middle finger	10	10	10	10	7	7
Loss of third finger	8	8	7	7	4	4
Loss of little finger	8	8	7	7	4	4
Total lesion of the brachial plexus	70	65	60	55	51	45
Total lesion of the radial nerve	25	20	20	19	17	16
Total lesion of the ulnar nerve	30	25	25	23	16	15
Total lesion of median nerve	35	30	30	28	23	21
LOWER LIMBS						
Loss of lower limb	65	65	45	45	38	38
Amputation at knee level	50	50	35	35	19	19
Amputation at ankle level	30	30	20	20	9	9
Total lesion of the sciatic nerve	50	50	25	25	21	21
Total lesion of the femoral nerve	12-30	12-30	15	15	14	14
Total lesion of the fibular nerve	15	15	10	10	7	7

XII. COMPARISON OF DISABILITY BAREMAS IN BELGIUM, ENGLAND, FRANCE, GERMANY, ICELAND AND ITALY

	Belgium	England	France	Germany	Iceland	Italy
Amputation at shoulder level	85%	90%	80-90%	80%	70% right arm	80%
Loss of a hand	65%	60%		50%	50% right hand	100% (2 hands)
Amputation at hip level	90%	90%	50-70% (fitted with artificial limb)	80%	35% R	85%
Amputation at knee level	70%	60%			35%	65%
Amputation of one foot	50%	100%	20-40% (forefoot)	30% partial loss	35% R	70% (2 feet)
Infarct or coronary heart disease	30-60% (ectasia)		80-90% (near permanent angina)	90-100%		100%
Very severe chronic bronchitis	70-100%		85-90% (permanent right cardiac insufficiency)	80-100%		75%

XIII. CONCLUSIONS

A number of countries use rating scales according to specific legislation (on disabled war veterans, civilian disabled persons, accidents incurred at work and those covered by ordinary law, occupational diseases, people with disabilities, etc.).

It is necessary to emphasise the importance of **terminology** and of clarifying certain definitions, such as those concerning bodily injury, the general employment market, impairment, invalidity and disability. In this area, the **ICIDH** would be very useful.

The need for a rating scale should also be questioned: if its purpose is to determine whether there is a loss of at least two-thirds of earning capacity, it serves no purpose. On the other hand, if it is necessary to indemnify on the basis of a precise percentage (35%, for example), then the situation would appear different.

Providing compensation for the after-effects of an accident or illness implies taking into account not only earning capacity, but also leisure activities, technical aids and social integration. Indemnification should be dealt with differently for children and elderly people.

Most Baremas define the degree of invalidity, while others define the degree of disability; at the same time, some evaluations are comparable and others are contradictory. The latter are due to different historic and cultural situations.

Certain evaluations are not precise (for some ailments of the vertebral column, the BOBI provides for a percentage ranging from 0 to 100%).

For ailments not covered by the rating scale, it is sometimes necessary to proceed by analogy and, for multiple ailments, it would be appropriate to use a formula such as that provided for in the Balthazar rule.

In the case of certain ailments for which treatment has been greatly improved (such as coronary heart disease), certain evaluations are out of date.

The **elaboration of a European rating scale** would be **useful and indeed possible**, but would require considerable work to be carried out with the assistance of experts in the various fields of medicine (ear, nose and throat, ophthalmology, surgery, nephrology, etc). This work would also call for collaboration with, *inter alia*, psychologists, neuropsychologists, legal experts and occupational therapists.

This new Barema should take more account of disabilities due to diseases or injuries following the ICIDH concepts.

**5. COMPARATIVE ANALYSIS OF THE TYPOLOGY OF
ASSESSMENT CRITERIA USED FOR THE ALLOCATION OF
BENEFITS IN CASH AND IN KIND TO PERSONS WITH
DISABILITIES**

Dr. Francesca FRATELLO, Prof. Carlo SCORRETTI (Italy)

I. FOREWORD

Historical background: The assessment of invalidity in Europe as a cultural pattern

The first recorded assessment protocol for bodily damage compensation is in the Sumerian Codex of the King Ur-Nammu (tables by Nippur, 2050 BC), which correlated impairments (bodily damages) with the due amount in old Sumerian currency. Hammurabi's Codex (1750 BC) set out a more comprehensive scheme. In the ancient world (Greeks and Romans) disability assessment tools were used to evaluate the loss of economic value for disabled slaves.

The first written European Scheme (in old shillings) after the fall of the Roman Empire is to be found in the tables of the "Salii", a Frankish tribe from the north of the Merovingian Empire. It spread to England with the Anglo-Saxons and was cited by Adalberte of Kent (+AD 616) and by Alfred the Great of Wessex (AD 848-900). It seems to have been used until Canute the Great (Knut Sveinsson), King of Denmark, England and Norway, who died in AD 1035. The scheme provided that the loss of a thumb, index and middle finger merited awards of 30, 15 and 12 old shillings respectively. The current percentage values for UK Industrial Injuries Disablement Benefits for the same fingers are 30, 14 and 12 %.

An edict of the King Rothair of the Longbards of Northern Italy (636 – 652 AD) was the first written Longbard law. Articles 41 to 138 deal with injury compensation, and set out a value for each kind of wound or amputation. Awards were calculated as a part of the "wergelt", which was the money amount to be paid for the death of a free man.

The word "barème" comes from the 17th century French mathematician François Barème. He first set out a table of ordered percentage values for bodily damage. In the 19th century, when the modern European nations developed and introduced the social insurance systems, Baremas were first used for war pensions and later for workmen's compensation. Between 1883 and 1889, Otto von Bismarck quickly built up his innovative German social insurance system, introducing benefits for children, for health care, for workmen's compensation, for invalidity and for old age retirement. The Bismarck pattern was soon adopted in almost all European countries and still operates in many of them, despite substantial changes in the 20th century. The Bismarck schemes used Baremas to ensure the equity of compensation by separating the quantum of an award from previous pay level, but it was later used for evaluating working capacity. For the invalidity pensions the Bismarck pattern introduced the concept that benefit should reflect the loss of income. The need to evaluate the capacity to earn forced governments to consider not only the bodily changes of a person from a strictly medical point of view, but also the environmental and social conditions in which the invalidity pension claimant was living (the labour market).

A new pattern was adopted in many assistance and insurance laws after the Second World War, based on Lord Beveridge's social welfare approach. Workers were no longer targeted, but provision was open to all citizens. This meant evolving new assessment tools, not only for the capacity of work, but also for the activities of daily living. Baremas are now generally used in every field related to compensation following bodily damage, both in the public and in the private fields (civil liability, private insurance, and so on). Barema assessment systems were designed to meet the operational requirements of the organisations which used them (quick management of the files, easy quantification, reproducibility and so on) and always to achieve the aim of strictly dealing with the existing bodily damage.

There is a general consensus about the reliability of the Barema percentage values for body parts (i.e. for one eye, one kidney, limb amputations and so on), but the problems with quantifying impairments with a Barema are also well known. In fact their use:

- impedes the evaluation of personal and environmental factors;
- pushes award towards the threshold values employed for eligibility purposes defined by the specific laws which requires the use of a Barema (10%, 15%, 33%, 66%, 75%) etc.
- is poorly reproducible in the majority of psychical impairments, and, generally, in all the impairments regarding vital bodily functions as opposed to structures.

Reproducibility becomes progressively harder to achieve. Today long-term diseases with related impairments or stable diseases with a consistent impairment affecting vital bodily functions are far more common than in past times, when medicine was unable to halt or to slow the lethal evolution of the diseases regarding vital functions. In such cases applying a well-defined percentage value often appears less reproducible than with amputations. This is the reason for the growing trend to evaluate impairment of vital bodily functions as a range value (10-20%; 20-40%; 40-60% and so on) instead of one number.

Another question now arises among people working inside the health and social care fields, when long-term disease disabilities are considered or when the chances of rehabilitation fail to be analysed. They have the concept that disability is not simply an attribute of a person but a complex collection of conditions, activities and relationships.

In 1976 the WHO approved the publication (Geneva, 1980) for trial purposes of the International Classification of Impairments, Disabilities and Handicaps (ICIDH), a classification of disablement, suitable for research and for many other uses. It has three dimensions (impairment, disability and handicap) linked to three different views: looking at the physiological functioning of the body (impairment); looking at the ability to perform the normal human activities (disability) and looking at the interaction with the environment of the disabled person (handicap). The aim was to furnish a pattern of analysis of disablement, which was not only medically oriented, as it had been before. This goal was

not satisfactorily achieved, basically because the classification was still considered too medically oriented, particularly by people with disabilities and the NGOs representing them.

WHO is now developing a new ICIDH (ICIDH-2) based on the same multidimensional architecture, but with some important conceptual changes.

ICIDH-1980 (and ICIDH-2) has already deeply affected many national laws regarding social insurance and social assistance, strongly impelling them toward a multidisciplinary not only medical or not medical at all - approach to disability assessment.

Methods

Following the approach adopted by the Working Group on the assessment of person-related criteria for allowances and personal assistance for people with disabilities in the member and observer states of the Partial Agreement in the Social and Public Health Field, we followed the division of the different allowances of each country in three main areas:

- Workmen's compensation scheme
- Pensions for target groups (including war veterans, civil invalidity, and others inside the non contributory system)
- Disability allowances (contributory system)

When possible, for each area, a reference term for the assessment methods employed was written in **bold characters** at the right margin of the page.

We were well aware that to better understand the real meaning of the assessment criteria used for the allocation of benefits in cash and in kind to persons with disabilities quoted in the "questionnaires", they should be studied in their original language and the text of the specific law in which the assessment criteria is mentioned should be followed strictly. Nevertheless we tried to analyse the text in the two official languages of the Council of Europe, English and French, well conscious of the limits of this overview, and following, whenever possible, answers given in the national replies to the questionnaire. If necessary for better explanation, other sources or publications, if available, were employed.

II. COUNTRY BY COUNTRY ANALYSIS

Austria

Disability

Workmen's compensation scheme

“Accident pension is granted in case of disability of at least 20%.”

NB: *the reference term is “disability”. This condition should be evaluated, according to the similar benefit existing in the other European countries, with a “Barema”, in order to reach at least a percentage value threshold of 20%.*

Care needs

Pensions for other target groups

The other kind of benefits – increased family allowance, pensions for war veterans, tax allowances, fare reductions, preferential treatment when parking and stopping, income maintenance benefits - are mainly “Barema”-based, without other explanations. For the social services and for the long-term care allowances the assessment method is type 2 (assessing care needs).

Capacity for work

Earning capacity

Disability allowances

In the reply to the questionnaire there is a short explanation: “The criteria are complex and related to the category of employment”. At the section: “assessment methods” there is only the reference to the assessment method 1 (Barema) and assessment method 2 (assessing care needs).

We obtain from other sources¹ that in Austria there is an invalidity pension based, for clerks and for skilled workers, on their job (*Berufsunfähigkeit*). The condition for eligibility is a reduction of at least 50% of the capacity for work reasonably expected by a healthy person of the same occupation or category and education.

NB: *the reference term is “capacity for work”. The work taken into account is the specific work, or almost specific. It is not clear how the Barema assessment can be employed, in fact the same impairment can give different consequences, according to the specific job.*

¹ Doronzio I: L'invalidità pensionabile in Italia ed in ambito internazionale. MP, 61, 2, 1997.

In Austria there is another kind of pension for non-skilled workers (*Erwerbsunfähigkeit*): the condition for eligibility is a reduction of at least 50% of the earning capacity reasonably expected by a healthy person.

NB: *the reference term is “earning capacity”. As usual two main criteria are involved: the first is psychophysical and the second is related to the labour market.*

Belgium

The answers in the questionnaires come from three areas:

- Flemish Region,
- Walloon Region,
- Belgium Federal Level

Capacity for work

Workmen's compensation scheme

In Belgium the Insurance regards accident injuries only. The evaluation must consider the loss of working capacity. The evaluation tool is BOBI Barema, which contains the following general definition of invalidity: “General concepts A. Invalidity: definition

Invalidity is understood as a state implying a partial or total loss of integrity, - physical or mental. Any valid individual can coordinate and use completely his/her abilities, energy and movements in view of an activity. It is the importance of the prejudice that can occur through accident, illness or infirmity. Total or partial loss constitutes a 100% or x-100% loss of physical capacity in general”.

NB: *The reference term is not only the working activity, but any activity (“en vue d’une activité”). Under this perspective it is possible to consider the BOBI Barema as an impairment-based Barema. On the other hand the general approach is still related to the definition of the diseases more than to the appreciation of its consequences at a functional apparatus level (impairment).*

The evaluation of the reduction of work capacity is based on the loss of competitive capacity of the person with a disability on the job market, taking into account the socio-economical context.

Capacity for work

Pensions for other target groups

For children there is a special benefit (Allocations Familiales Supplémentaires) BOBI Barema based, according with other criteria too.

The BOBI Barema is specific for war veterans.

The evaluation for “support measures for social and vocational integration” is BOBI related too, although there is a significant distinction (only in the Walloon area) between the required threshold reduction in physical abilities (30%) and mental abilities (20%).

Earning capacity

Disability allowances (contributory system)

Replacement allowance is granted to persons whose earning capacity, owing to their physical or mental state, has been reduced to one third or less of what able-bodied persons are able to earn in employment on the general labour market.

NB: *Two main parameters must be taken into account:*

- *the claimant's psychophysical condition;*
- *work (age, sex, occupational training, regional labour market, economic situation).*

Cyprus

Capacity for work

Disablement

Workmen's compensation scheme

The evaluation tool is a Barema quite similar to the UK corresponding accident pension Barema. The reference term is “Disablement”.

Impairment/Disability

Pensions for other target groups

Many benefits are percentage-related (percentage of disability) “bearing in mind the Disability Chart used in the United Kingdom, as well as the disease Chart of the ILO”. For other benefits there is a list of prescribed diseases.

NB: *It is not clear if the reference term is impairment, or disability, or both.*

Earning capacity

Invalidity

Disability allowances

Disability allowance is granted to persons unable to earn from work which they are reasonably expected to perform, more than 1/3 of the sum earned usually by a healthy person on the same area, or, in the case of persons between the ages of 60 and 63, more than 1/2 of the aforesaid sum.

NB: *it corresponds to the traditional earnings-based German pattern.*

Denmark

In the Danish reply to the questionnaire there is clear evidence of a prevailing importance of the municipal assistance level compared to the national level.

Disablement

Workmen's compensation scheme

The "Act of Compensation to Disabled Persons in Employment" 293/1998 does not clearly refer to Barema.

Capacity for work

Pensions for other target groups

Many benefits are related to a "permanently reduced physical or mental functional capacity" assessed without a Barema. Another important term is "limited capacity for work", for Rehabilitation and Flexiwork (The Act of Active Social Policy). For this benefit a threshold is not specified in the reply to the questionnaire. "The assessment of the capacity for work is aimed at the future, i.e. it must look at the possibility of maintaining employment or obtaining employment".

N.B.: *It seems to be an assessment based on two main parameters: the psychophysical and the social one.*

Capacity for work / Earning capacity

Disability allowances

Disability allowances are granted to persons whose working capacity has become negligible (highest amount of the early retirement pension) or whose working capacity has been reduced by approximately 2/3, due to physical or mental disability (intermediate amount of early retirement pension) or whose working capacity has been reduced by at least one half, due to physical or mental disability (increased ordinary early retirement pension). To assess the reduction of working capacity, a comparison is made between the level of income the applicant would be able to obtain taking the disability in account and the average earnings for others with a similar educational background.

NB: *This approach is based on the assessment of the earning capacity. The target of the on-going Danish social assistance scheme is to keep the pension claimant in some kind of activity or occupation. In the reply to the questionnaire mention is made of new criteria (function – capacity criterion) under which it will be assessed to what degree the applicant is able to undertake any occupation, now or in the future, keeping well in mind all the possible opportunities for medical and social rehabilitation.*

Estonia

Workmen's compensation scheme

There is no reference to working compensation or to a "Barema".

Capacity for work / Degree of impairment

Pensions for other target groups

Many benefits are related to "incapacity for work". This concept is determined by medical criteria (degree of impairment) and not from economic or social criteria (earning capacity and income).

Degree of impairment

Disability allowances

Disability allowances are granted on the basis of medical criteria to assess the degree of impairment.

Finland

Workmen's compensation scheme

In the reply to the questionnaire there is no clear reference to an assessment for working compensation, but a specific law is mentioned (Employment Accident Insurance Act 625/1991).

Person capacity/Care needs

Pensions for other target groups

Many benefits at local level are related to the "assessment of the person's capacity", taking into account the social environment and the rehabilitation needs.

A group of cash benefits is assessed with a combination of assessing care needs and estimating the functional capacity and calculating the extra costs caused by incapacity.

These are:

- Pensioner care allowance
- Disability allowance
- Child care allowance

There is no mention of a Barema.

Disability allowances

There is a law, but specific indication about assessment criteria is missing in the reply to the questionnaire.

France

N.B. data were obtained from the reply to the questionnaire, but also from available French laws and from Tavet: "les barèmes, à chaque barème, sa philosophie" réf. *Echanges santé-social, Dossier, 78, 1995.*

Incapacity

Workmen's compensation scheme

The assessment is based on a « Barème indicatif » (1939) updated in 1982.¹ "The rate of permanent incapacity is determined by the type of infirmity, general state of health, age, physical and mental faculties of the claimant, as well as his/her capacities and professional qualifications, taking into account an indicative Barema established in 1939, updated in 1982."

NB: *There are several parameters to be considered. The same barème for the percentage of "incapacité" is "indicatif", which means that the same impairment can give different results in the final value in different workers.*

Physical condition / Incapacity

Pensions for other target groups

Pensions for war veterans (ACVG): based on a particular Barema in which the only reference is to the physical condition.

The Technical Commission for Vocational Guidance and Resettlement (COTOREP) evaluates incapacity with a Scale Rate for the Adult Disabled Person Allowance ("Guide-barème pour l'évaluation des déficiences et incapacités des personnes handicapées" 1993), based on the concept of impairment. i.e. loss or deficiencies affecting psychological, physiological or anatomical structures or functions.

A particular allowance, "Special education allowance" is based on a Barema. In the reply to the questionnaire it is explained that it is based "on the concept of disability..." We have no more indications, but probably it is the same "Guide-barème pour l'évaluation des déficiences et incapacités des personnes handicapées".

Disability allowances

Disability allowance is granted to persons unable to earn less than 1/3 of what is reasonably expected by a healthy person of the same occupation or category and education in the same region, due to their health conditions. The evaluation is made without Barema.

¹ Tavet: "les barèmes, à chaque barème, sa philosophie" réf. *Echanges santé-social, Dossier, 78, 1995*

Germany

Disability/Invalidity

Workmen's compensation scheme

The assessment is based on a Barema, with a threshold of 20% of reduction of "disability/invalidity".

Care needs

Pensions for other target groups

War pensions are based on a Barema.

Several other benefits, mainly related to health care benefits, are given following the assessment criteria 2 (Assessing care needs). For special target groups (work or war disabled people) there is a threshold of 20% of invalidity.

If the law requires the title of severely disabled person, for a particular benefit, the threshold required is 50%.

Earning capacity

Disability allowances

Invalidity pension related to the specific job [*Berufsunfähigkeit*] when the insured person on account of disease, accident or other ailment is capable neither in his training profession nor any other suitable occupation, to perform and earn half of what other employees with similar training and equal knowledge and capabilities would.

Invalidity pension related to the labour market [*Erwerbsunfähigkeit*] when the insured person due to illness or other ailment or on account of physical and mental functioning can engage only irregularly in gainful activity, or though following such activity on a regular basis, can only achieve insubstantial income from it.

Hungary

Disability

Workmen's compensation scheme

The assessment is founded on a disability-based Barema.

Impairment Disability

Pensions for other target groups

War veterans are assessed with a particular Barema, with 5 classes of "impairment" percentage (25-49%; 50-64%; 65-74%; 75-100%).

All main benefits for adults are linked to an assessment based on a special Barema: "An arbitrary scale with percentage limits attaches progressive percentage values to define disabilities. The disabilities of the claimant are compared to those for which there are scale values and a percentage is thereby obtained". According to the reply to the questionnaire this method of assessment evaluates the "disability".

For children the benefit assignment is related to the correspondence with a list of serious diseases.

Disability

Disability allowances

The assessment is founded on a disability-based Barema.

Iceland

Permanent impairment

Workmen's compensation scheme

The assessment is based on a specific Barema, based on the "Guides to the evaluation of permanent impairment, AMA, Fourth edition 1993", but if necessary other Baremas are employed, particularly Scandinavian Baremas.

Need of special parental care

Pensions for other target groups

For children with disabilities or chronic diseases the assessment of the need of special parental care is required.

Earning capacity

Capacity for work through rehabilitation

Disability allowances

Disability pension used to be granted when the person could not earn a quarter of what persons with full mental and physical health were able to earn in the same area, by work appropriate to their strength and skill, and such as might reasonably be expected of them in the light of their upbringing and previous employment.

From September 1999 a new disability allowance law took effect, with a new evaluation approach, based on the British "all work test".

In cases where prognosis regarding disability is uncertain and there is rehabilitation potential (when it is considered likely that the person will regain capacity to work through rehabilitation) a special rehabilitation pension is granted.

Ireland

Disablement

Workmen's compensation scheme

The evaluation tool is a Barema quite similar to the corresponding UK accident pension Barema. The reference term is "Disablement".

Requirement of more than average care/attention due to handicap (for children)

Pensions for other target groups

Domiciliary care allowance is granted to children between ages 2 - 16 who require more than average care/attention due to their disability.

Capacity for work

Disability allowance is granted when the person is substantially hampered from doing work of a kind which would be suited to a normal person of similar age, education and experience.

Italy

Capacity for work

Workmen's compensation scheme

The assessment is based on a Barema. Its criteria relate to the capacity to work in any job (mainly physical work).

Capacity for work in suitable activities / Disability and Serious disability

Pensions for other target groups

Pensions for war veterans are based on generic capacity for work, evaluated with a particular Barema.

Pensions for civil disabled are based on a capacity for work Barema, which takes into account ICIDH 1980. It is basically an impairment Barema. Inside this evaluation it is possible to keep in account ($\pm 5\%$) the "suitable" activities.

Many benefits, particularly at local level, are granted if the person has a disability or a serious disability.

Capacity for work in suitable activities

Care needs

Disability allowances

Disability pension is granted when the person has a reduction of his capacity for work (in suitable activities) of 2/3 of total working capability. The personal and continuous care monthly allowance is based on care needs.

NB: The leading criteria are based on the psycho-physical impairment of the person. Special care is required for the clinical study of each apparatus. The grounds of education and a "normal" career are important to analyse the "suitable activities".

The Netherlands

Disablement

Workmen's compensation scheme

The disability caused by work pathology has the same status as any disability caused by other conditions (congenital, common diseases, etc.).

Earning capacity

Pensions for other target groups /Disability allowances

A disability allowance is payable when an employee, as a direct result of an "objective medical examination", is pronounced partially or wholly unable to derive income from employment that a healthy person with similar training and experience can usually earn in his/her workplace, or last workplace, or its vicinity (usual employment).

A particular aspect of the allowances for disability in the Netherlands is the narrow linkage (it seems compulsory) with provisions to promote, maintain or recover the ability to work.

The fitness of a person with a disability for an actual or new job is assessed with FIS, which is a functional working ability based evaluation tool, strictly connected with job requirements.

Norway

Workmen's compensation scheme

In Norway there is compensation based on a Barema for people who suffered an accident at work. The compensation is a lump sum. Disability pension can also be granted if the work capacity is reduced at least by 30% due to the accident.

Capacity for work / General functional capacity / Care needs

Pensions for other target groups

An important benefit is the "Basic benefit", that is granted if the disability involves significant extra expenses (for technical aids and prosthesis, telephone, transportation, extra food, and so on). Attendance benefit is granted if the person with a disability needs special attention or nursing. Rehabilitation benefits are granted if the person has a permanently reduced working capacity, and technical aids and cars are granted if the person has a substantially and permanently reduced general functional capacity.

Capacity for work

Disability allowances

Disability allowances are granted to persons whose working capacity has been reduced by at least one half, due to illness, injury or defect.

Poland

Workmen's compensation scheme
It is not specified.

Pensions for other target groups
It is not specified.

Disability allowances
"it is taken into account whether the person is an invalid without own income"

Slovenia

Physical impairment

Workmen's compensation scheme

The most similar benefit is a "Disability Benefit", which is granted if the worker suffers from significant damage or a marked incapacity of individual organs or parts of the body, thereby rendering activity more difficult and requiring greater effort to satisfy living needs, whether they cause disability or not.

The assessment is based on a specific Barema, which has 11 chapters regarding only physical impairment, determined in percentage. The threshold level is at least 30%.

Care needs

Individual performance for independent living

Other target groups

For children with disabilities or chronic diseases prescribed by law in a list, a special care supplementary allowance is granted. The same list is also employed for institutional care, outside care and assistance supplementary allowance, for disability replacement allowance and for other kinds of benefits.

The replacement for assistance and services is the "cash allowance" which is granted to the beneficiary when he/she is not able to perform independently all or most of the basic life activities. These allowances are for children, war veterans and people assisted according to the Law on Retirement and Disability Insurance (especially blind persons and people with severe mobility impairment).

Capacity for work

Capacity for work in his/her specific job

Disability allowances (contributory scheme)

Disability is recognised when the person has a complete loss of his/her capacity to work or a reduction in the working capacity for work in the job which he/she was doing prior to the onset of disability. In this case the evaluation process takes account of the remaining working capacity, the counter-indications which may threaten his/her state of health, and an opinion on the scope and form of the professional rehabilitation.

Spain

Workmen's compensation scheme

In the reply to the questionnaire an "Occupational recovery programme" is mentioned. According to the Spanish law (Ordre 5/4/74)¹ a special compensation Barema is employed, in which a specific amount of money is linked to each loss or amputation.

Degree of disability

Other target groups

Disability Pension in the non-contributory scheme requires a disability degree of at least 65%. For other social interventions and for many other benefits the recognition of disabled status by law is required. A person is disabled when his/her disability degree is 33% or above. The rating scale is basically a translation of the AMA scale. Quite a large amount of assessment tools have been developed in Spain to assess care and assistance needs. This approach changed in 1999, when the disability status was removed and a tighter correlation between benefits and the percentage evaluation of disability was introduced. A new Barema has been enacted, basically based on disability assessment.

War pensions follow a Barema evaluation system. In many cases a wide range of percentage is given for each loss or amputation.

Individual's normal capacity for his/her usual occupation

Disability allowances (incapacity allowances).

Following the reply to the questionnaire there are various degree of permanent disability, for each of which different criteria apply. They start from loss of at least 33% of the individual's normal capacity for his/her usual occupation. Permanent total disability is also considered for any occupation. The higher level is "great disability", when a person needs assistance from another person to perform essential everyday activities.

¹ Viso M.G., Diagnostico y valorizacion des discapacidades, 1989

Sweden

The Swedish system is characterised by the importance of the municipal assistance level (communities). The Swedish social system benefits and allowances are strictly handicap oriented; attention is not only paid to the psychophysical medical objectivity, but also to the environmental conditions.

In the reply to the questionnaire there are no indications for workmen's compensation, or for other target groups.

Personal assistance for his/her basic needs more than 20 h/week

A good example of the Swedish interventions for people with disabilities is defined in the reply to the questionnaire as "Support and Service". This benefit is granted to persons with severe disabilities (mainly intellectual function related) and also to persons in need of personal assistance of more than 20h/week for their basic needs.

Disability allowances

Viso¹, examining the Swedish System (1989), presents a "Disability pension", which is granted when the person, for medical reasons, cannot earn or if the person has at least a 50% reduction of his/her capacity to work.

Switzerland

Workmen's compensation scheme

There are no specifications

Invalidity / Earning capacity

Pensions for other target groups / Disability allowances

General overview:

The basic parameter in Switzerland is the capacity to earn: "It is a question only of invalidity insurance benefits". Different branches of social security provide benefits intended for persons suffering of invalidity. The assessment is basically a comparison of incomes. It is obtained comparing the income the claimant can actually/or after a possible rehabilitation intervention /gain and the income which he/she would have been able to earn if he/she had not been disabled. The threshold degree is 40%.

Another benefit is the Incapacity Allowance, which is based on care and assistance needs for serious, medium and slight invalidity.

¹ Viso , see note 378, 1995

¹ Viso M.G., Diagnostico y valorizacion des discapacidades, 1989

¹ Viso , see note 3

United Kingdom

Capacity for work

Workmen's compensation scheme

The assessment is based on a Barema. Criteria relate to the capacity to work: "...the degree of disablement shall be assessed by making a comparison between the condition of a normal healthy person of the same age and sex, without taking into account the earning capacity of the member in his/her disabled condition in his or any other specific trade or occupation, and without taking into account the effect of any individual factors or extraneous circumstances".

Capacity for work

Pensions for other target groups

Pensions for war veterans are based on the generic capacity for work, evaluated with a special Barema. Many other benefits for other groups are granted on the claimant's declaration, with medical certification about the claimant's clinical condition, or checking whether there are specific diseases or particular conditions (prescribed diseases or exemption diseases).

Attendance allowance is granted after evaluating the care and attendance needs.

Capacity for work ("all work")

Disability allowances

From 1995, Disability pension is granted when, the person reaches a high level of loss of capacity using a detailed score scale, close to the ICIDH concept of abilities and also related to well-known functional working ability scales.

NB: the name of the assessment system is clear: "all work" test. The functional evaluation is intended to reflect the applicant's ability to perform all types of work.

III. CONCLUSIONS

The Questionnaire on the criteria governing the granting of allowances and personal assistance for people with disabilities in the member and observer states of the Partial Agreement in the Social and Public Health Field can be considered as an important first step for a comparative analysis of the typology of assessment criteria used for the allocation of benefits in cash and in kind to persons with disabilities in Europe.

Many reasons prove the significance of this kind of comparative evaluation: economic (in all European countries the costs of social welfare are being reviewed and assessment methods discussed for their consistency and for their effectiveness), cultural (the world is changing quickly and the way of living and of working is changing too), technical (today we have very strong tools against the consequences of disabilities and probably tomorrow they will be ever more powerful and effective).

Workmen's compensation scheme

The old system (with few exceptions) still works and it is generally Barema-based. These Baremas are usually related to the capacity to work in all occupations (they are still strongly oriented towards physical rather than psychological damage). In our opinion, the tendency to increase prevention and consequently to reduce to a very low figure the number of accidents at work should be taken into account, as well as the tendency that chronic work-related pathology is increasingly indistinguishable from common pathology. In the Netherlands the historical privileged approach to work-caused disablement has already changed.

Other target groups

Throughout Europe the concept that disability is not simply an attribute of a person but a complex collection of conditions, activities and relationships is increasingly being adopted by the governmental institutions and by public opinion.

This has led in many cases to adaptations of the old technical evaluation tools (the Baremas) to the new parameters of Impairment, Disability and Handicap. Until now, real handicap-based Barema has not been observed, but in many countries the capacity to work Barema has become "impairment-based" and sometimes "disability-based".

Disability allowances

In almost all European countries the aim is to restore impaired capacity to earn.

The assessment is generally based on two points: a medical objectivity and an evaluation of social factors, with particular regard to the job market.

Interesting differences are developing in assessment, through functional ability evaluations, giving more importance to what the person can do instead of what the person has lost.

The trend is evident, considering the changes that have already occurred in Europe, as, for example:

- The new Baremas developed in Europe in recent years are taking into account more the disabilities than the impairments, and in this way they compel the evaluators to focus increasingly on the consequences of the diseases for the person, together with the clinical aspects thereof.
- The assessment for many non-economic benefits, and in many countries also for economic ones, is performed by multidisciplinary teams, including social experts, psychologists, labour market experts, and so on.

The final goal in this trend is to obtain a positive evaluation of what the person with a disability can do, instead of a negative balance linked to a number related to what the person has lost.

To reach it, it is necessary to achieve two intermediate goals:

1. a real knowledge of the existing capacities and a realistic forecast of the potential capacities. This means that new assessment tools must be developed and validated.
2. an evaluation of the person integrated with the evaluation of her/his social environment. This means that the social conditions which let a person with a disability interact with her/his environment must be well-known, taking sufficiently into account the differences linked to sex, age and so on.

This cannot be performed without the development of an appropriate background in the media and in the cultural field, in order also to improve the exchange of information between European countries for a better knowledge of people with disabilities.

The “life project”, which is the project for the social integration of a person with a disability, is strictly linked to a holistic assessment of the person.

The trend we highlighted has a clear finality to remove the obstacles for true equality of opportunity for people with disabilities. This is what is written in European conventions, charters and recommendations.

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