

# Disability assessment, mutual recognition and the EU Disability Card

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Progress and opportunities





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## Progress and opportunities

### **Abstract**

This study, commissioned by the European Parliament's Policy Department for Citizens' Rights and Constitutional Affairs at the request of the Committee on Petitions (PETI), examines the progress made on mutual recognition of disability status, and the challenges this presents. There are different definitions and practices of disability assessment, among the Member States and in different policy fields. Citizens' petitions raise concerns about this, and about the need for mutual recognition. Harmonising assessment is difficult but common entry points are possible. The EU Disability Card provides an administrative model for mutual recognition.

This document was requested by the European Parliament's Committee on Petitions.

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## LIST OF ABBREVIATIONS

<b>ADL</b>	Activities of Daily Living
<b>ANED</b>	Academic Network of European Disability experts
<b>CoE</b>	Council of Europe
<b>CRPD</b>	United Nations Convention on the Rights of Persons with Disabilities
<b>DG REFORM</b>	Directorate-General for Structural Reform Support
<b>EDE</b>	European Disability Expertise
<b>EDF</b>	European Disability Forum
<b>EESC</b>	European Economic and Social Committee
<b>ESSPROSS</b>	The European System of Integrated Social Protection Statistics
<b>GDP</b>	Gross Domestic Product
<b>ICF</b>	International Classification of Functioning, Disability and Health
<b>IDA</b>	International Disability Alliance
<b>ILO</b>	International Labour Organisation
<b>MISSOC</b>	Mutual Information System on Social Protection in the European Union
<b>PETI</b>	Petitions Committee
<b>SPC</b>	Social Protection Committee
<b>TFEU</b>	Treaty on the Functioning of the European Union
<b>WHO</b>	World Health Organisation
<b>WHODAS</b>	WHO Disability Assessment Schedule

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## EXECUTIVE SUMMARY

This study was commissioned by the European Parliament's Policy Department for Citizens' Rights and Constitutional Affairs at the request of the PETI Committee. It examines progress on mutual recognition of disability status in the EU, and the challenges this presents. It is based on existing available data and published studies, including national, European and international studies. The emphasis is on recent and current developments, including ongoing reforms in the Member States relevant to implementation of the United Nations Convention on the Rights of Persons with Disabilities (CRPD), the EU Disability Strategy 2021-2030, and the European Semester. The study:

- identifies the **barriers to free movement** that persons with disabilities experience, due to lack of mutual recognition, and notably as expressed in petitions;
- describes the **main types of disability assessment** methods in the EU Member States, the types of criteria applied, recent policy reforms, and their compliance with the CRPD
- determines how **common European principles** of CRPD-compliant disability assessment can be promoted with Member States
- examines how the principle of **mutual recognition** could be applied to determinations of disability status, between Member States and across the EU, and the barriers to this
- analyses the pilot implementation of a **European Disability Card** and the potential for its expansion, to facilitate the portability of disability rights and benefits across borders.

**Petitions** show that citizens face barriers to their freedom of movement in the EU due to a **lack of mutual recognition for disability status** between Member States, and differences in **methods and outcomes** of national disability assessment systems. This impacts on people's lives and life choices.

The mutual recognition of disability status between Member States is an important goal. It also poses challenges. The Charter conveys **social rights** to everyone who moves legally within the EU but Member States retain competence over **national rules** of entitlement to social protection benefits. Nevertheless, there are well-established EU mechanisms for the **portability of some social security benefits**, including some disability benefits, and EU competence to support and complement the Member States in the field of **social protection**. To this end, the Parliament and the Council may adopt **directives** for the implementation of minimum requirements, as well as measures to encourage co-operation.

**There is a substantial and well-researched evidence base upon which to make policy decisions.** Studies have been carried out on disability assessments, disability definitions and mutual recognition, in Europe and internationally. These include studies by the European Commission, the World Bank, the OECD and the WHO. There are case studies of **assessment reform** in Member States. The EU Disability Card pilot scheme has been thoroughly evaluated. Civil society has reflected on these issues, conducted additional investigations and arrived at considered opinions. There is a **high degree of consensus** across these various studies, reforms and opinions for adoption of shared principles and greater harmonisation.

A shared understanding of disability is already evident, framed by a **social model of disability** and aligned with a **rights-based approach** to disability equality. The EU and all Member States are parties to the **CRPD**, which presents disability as a situation arising from interactions between **people with impairments and barriers in society** that limit their full participation. Existing assessment systems have focused more on individual characteristics than environmental ones. They have also relied heavily on **medical** knowledge, or tests of individual **functioning** out of context. A more **holistic** approach to disability assessment requires consideration of people's **actual life situations**.

**There is much variation in disability assessment and determination in the Member States.** The study reviews the main types of assessment and illustrates these in two key policy functions – assessments of **work capacity** (used to determine eligibility for 'invalidity' pensions), and assessments of **needs for support** (for 'long-term care'). Disability assessments for social security benefits are more likely to use fixed measurement scales and categorical determinations of disability status. Disability assessments for social assistance are more likely to be needs-based and discretionary, prescribing the type of support required to live independently in the community. A **general determination of disability status** may sometimes act as a passport to either policy function.

Disability assessments have high policy relevance when they are sensitive to people's needs and capacities in context, such as in their workplace or their community. Conversely, **categorical determinations** of disability status have high administrative efficiency. A fixed disability status, based on validated scales, is more easily transposed to a disability register or card recognition system than a flexible, nuanced and dynamic assessment (valid for a specific life situation). This suggests that a **hybrid** approach is needed – involving **mutual recognition of some core transferable components** of disability assessment but backed by commitments to **shared principles** of disability assessment that are rights-based, needs-based, and sensitive to life changes.

**People who move between Member States find themselves in a new disability situation.** They will clearly benefit from rapid 'mutual recognition' of their existing capacities, the kinds of barriers they may face, and the type of help they may need. This would be greatly assisted by a **passport mechanism**, like the European Disability Card, backed by a verifiable digital record of mutually recognisable assessment information. However, people who move also have the **right to a comprehensive and holistic rights-based assessment of needs in their new environment**, particularly if they will be living, working or studying there for any length of time.

**The participation of organisations of persons with disabilities** in all significant policy reforms is an obligation under the CRPD, both for the EU and the Member States. The views of civil society, such as the position statement of the European Disability Forum (EDF) on disability assessment procedures, and the Opinion of the EESC on shaping the EU disability agenda should be considered, as well as the views of the European Parliament.

**There are many examples of assessment reforms in the Member States**, supported by technical assistance from the EU and international organisations, such as the **World Bank and the OECD**. Ten case studies reinforce the themes of the study. They evidence the **trend** from medically based determinations of disability status, and functional assessments, towards a more contextual disability approach. They also point to convergence on the adaptation of internationally standardised frameworks and tools, like the **WHO Disability Assessment Schedule based on the International Classification of Functioning (ICF)**.

**The case studies highlight points of good practice.** There is a need for more holistic assessments, with more attention to environmental factors. There is a need to consider efficiency gains from reform, as well as the validity of the methods used. A more unified assessment system could help to streamline disability recognition systems, while ensuring greater transparency and facilitating greater access to social rights across the EU. **Greater harmonisation of assessment principles and tools** could address the inconsistencies perceived by citizens and reduce administrative burden for national authorities.

**The concept of mutual recognition is already familiar to the Member States.** National disability assessments are often recognised by various administrative authorities, or between sub-national jurisdictions. Many, but not all, Member States maintain a **national disability register, or card**

**scheme**, that accredits a person's general disability status administratively. There are also examples of mutual recognition between Member States, notably the **European Parking Card**, which has operated successfully for two decades.

**The UN CRPD Committee recommended introduction of a 'European Mobility Card' in 2015** to assist travellers with disabilities in their right to personal mobility throughout the EU. This idea was proposed originally by civil society. It was **piloted in eight Member States from 2016**, and positively evaluated in 2021. The concept was tested in a voluntary recognition scheme, involving mainly private providers of culture, leisure, sport and transport services. **The Commission proposes to create a European Disability Card by end of 2023, to be recognised in all Member States.** This should be endorsed and exploited to the greatest extent possible among the Member States.

**The policy scope of the European Disability Card could be extended.** The Card scheme provides a proven mechanism for identity recognition, particularly if enhanced by an appropriate digital security protocol. The **extension of the scheme to wider policy functions**, such as entitlement to public support in cash or kind requires a high level of legitimacy. There is a tension between the divergent assessment criteria used to establish disability status in the Member States, and the convergent mechanism of an EU Disability Card to establish mutual recognition between them.

**The study recommends that the EU and Member States commit their support** - to the adoption of shared principles for rights-based disability assessment, to a process of knowledge sharing and lesson learning informed by international best practice, to the full implementation of a **European Disability Card**, and to the development of a **common core standard for disability assessment**.

### Recommendations to the PETI Committee

- review and respond to the **petitions** received concerning barriers to the mobility of persons with disabilities arising from problems of disability assessment and recognition.
- report on its findings and opinions to **other relevant Committees and to the Parliament** for their consideration
- reaffirm its commitment to promote and protect the rights assured to persons with disabilities under the **CRPD**, and state its commitment to the general principles of disability assessment arising from these rights
- when responding to relevant petitions, encourage national authorities to adopt **internationally validated tools of assessment**, and to collaborate with relevant authorities in other Member States to **mutually recognise assessments** conducted using such tools
- promote adoption of the **European Disability Card** in all Member States, to the widest extent possible as means of recognition for access to benefits and services, both public and private.

### Recommendations to the Commission

- renew the Flagship commitment in the EU disability Strategy to launch a **European Disability Card** before the end of **2023**
- frame its work on disability assessment and recognition in context of an **interactive, social and rights-based model of disability, consistent with the CRPD**

- develop and endorse a **statement of general principles** for rights-based disability assessment, in close consultation with organisations of persons with disabilities and promote this to the Member States
- draw on the findings of EU-funded technical assistance projects and evaluations to assist the Member States in establishing and sharing **good practice** in disability assessment
- facilitate agreements among the Member States on mutual recognition of a **common core evidence standard for selected disability assessment components**, based on internationally validated assessment tools, and protocols for data sharing
- enhance the functionality of the existing Card format to include facility for a **secure but mutually recognisable digital record, or parallel register**
- collaborate with the Member States in creating an **online resource**, detailing information on how to obtain the Card, the benefits it provides, and contact details for support in each country

### Recommendations to the Member States

- reaffirm their commitment to the rights assured to persons with disabilities under the **CRPD**, in a **joint statement of general principles on disability assessment** arising from these rights
- accelerate and deepen their efforts to **reform** national disability assessment systems in line with CRPD recommendations, international best practice and mutual lesson learning, and in consultation with representatives of organisations of persons with disabilities
- adopt and promote the implementation of a **European Disability Card** to the fullest extent possible, collaborating **with public and private stakeholders** to ensure that it ensures access to a wide and increasing range of relevant disability **benefits and entitlements**
- participate in developing shared agreements on a **common core or equivalence framework for disability assessment**, based on internationally validated tools, that could be **mutually recognised as evidence** in national disability assessments, or as a shared baseline of eligibility for a European Disability Card, and appropriate protocols for data sharing.

## 1. BACKGROUND AND KEY CONSIDERATIONS

### KEY FINDINGS

The lives of persons with disabilities are changed when their disability status is recognised and responded to. **Disability recognition**, resulting from appropriate **assessment**, provides people with a **gateway to the help and support** they need. This includes entitlement to public benefits in cash (such as disability pensions and allowances) or in kind (such as social services or personal assistance). The rules and processes for disability assessment are also used by governments as a policy mechanism to manage public spending. Public recognition of disability status also acts as a passport to everyday concessions from private providers (such as discounted bus travel, preferential seating at sporting events, or entry to leisure facilities). However, Member States use **different methods of assessment** for similar purposes, and **assessments from one Member State are rarely recognised in another**. This lack of recognition, and the need for comprehensive reassessment of disability status when moving between Member States presents a barrier to freedom of movement. Citizens' **petitions** raise concerns about these inconsistencies and about the problems they creates.

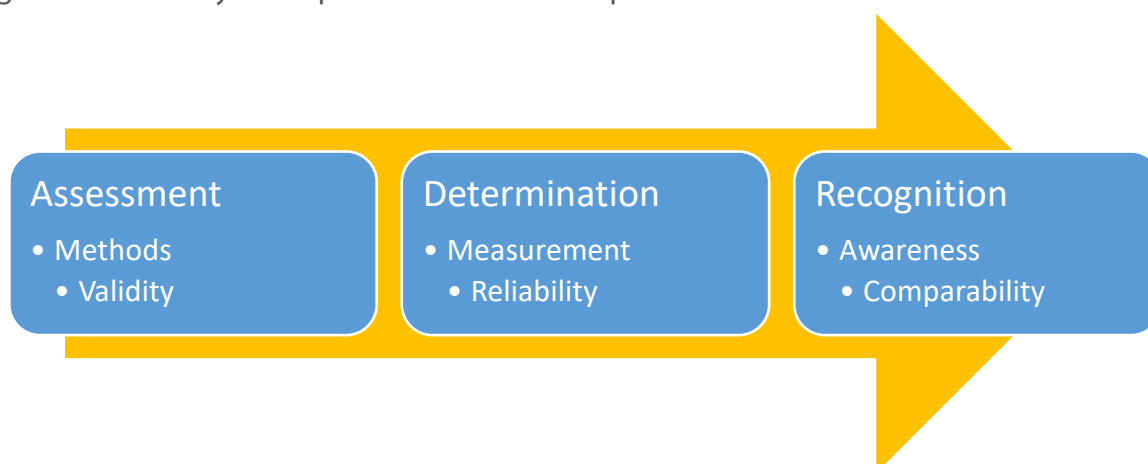
It is useful at the outset to distinguish between three different concepts or stages – **assessment, determination and recognition** (as shown in Figure 1).

These three stages may be administratively co-ordinated or separated. For example, a disability assessment might be conducted by a local social worker or health professional, a determination of disability status made in a letter from a national social security agency, and a disability card issued by a transport authority for the purpose of booking concessionary rail fares. Alternatively, a single agency might conduct assessments, determine the outcome and issue national disability cards that are widely recognised by other agencies (both public and private). The proposal for **an EU Disability Card** aims to make widespread recognition easier.

A **disability assessment** may be carried out for a specific **policy purpose**, such as determining the number of hours of personal assistance that a person needs to live at home, or it may be more general. For example, it may result in a general disability **score or classification** that can be used for a variety of policy purposes (e.g. determining entitlement to social security benefits or a parking badge). To achieve **recognition** for this determined disability status, resulting from an assessment, the person may be issued with a **card, letter or certificate, or their identity may be entered in a register** to which relevant authorities can refer.

**Each stage raises different challenges for policy and practice.** Disability assessment raises questions about methods and validity. Disability determination raises questions about measurement and reliability. Disability recognition raises questions about awareness and comparability. These are all relevant when considering mutual recognition and freedom of movement for persons with disabilities. Are disability assessment methods fit for purpose? Are determinations of disability status reliable? Can evidence of this be easily recognised?

Figure 1: Three key concepts in the assessment process



### 1.1. Why do we assess disability?

In EU Member States, as in other established welfare states, disability assessments exist mainly to **confer eligibility and entitlement to various forms of help and support** (either from the state or from other providers of goods and services of general interest). This might include medical assessments that determine a person's entitlement to a particular health treatment, functional assessments that determine whether someone is entitled to an additional cash allowance, or needs-based assessments that determine whether they are eligible for practical assistance at home, at work or in education. Disability assessments are used to determine whether people are entitled to financial support, whether they are expected to search for work in the open labour market, and so on.

Ease of recognition of disability status (based on determination resulting from an assessment) is relevant to a wide range of policy functions and to a wide range of public authorities or service providers, both public and private. Table 1 illustrates the **range of actors who stand to benefit** from improved disability status recognition, across this range of policy functions.

In short:

Disability assessment affects labor supply, government spending and individual welfare. Through the power vested in them, disability assessors make decisions that affect tens of millions of working age adults (on average 6 percent of working age population in OECD countries in the early 2000s) and influence the allocation of national resources that often surpass 1 percent of GDP in any given year (on average 1.8-1.9 percent of GDP in the OECD countries).<sup>1</sup>

<sup>1</sup> Bickenbach, J., Posarac, A., Cieza, A., & Kostanjsek, N., *Assessing disability in working age population : a paradigm shift from impairment and functional limitation to the disability approach*, World Bank Group, 2015, pp. ix-x <https://documents1.worldbank.org/curated/en/272851468164970738/pdf/Disability-Assessment-Report-June-18-2015.pdf>

Table 1: Policy functions and actors benefiting from easy recognition of disability status

Policy functions	CRPD	Public	Voluntary/private
General disability recognition	Article 1	Disability registration authorities	Any service of general interest
Social security payments	Article 28	Disability pension authorities	Advocacy and advice services
Tax concessions	Article 28	National or local revenue authorities	Advocacy and advice services
Additional cost of living benefits	Article 28	National or local benefit authorities	NGOs
Reasonable accommodation in education and training	Article 24	National or local educational authorities	Schools, colleges, universities, businesses
Reasonable accommodation in the workplace	Article 27	National or local employment services	Employers, NGOs
Access to transport	Article 9	National or local transport authorities	Bus, train and ferry companies
Access to culture, recreation, leisure and sports	Article 30	National or local leisure authorities	Leisure service providers, cultural and sports venues
Access to housing and adaptations	Article 19	National or local housing authorities	NGOs and private housing providers
Access to health services	Article 25	National or local health authorities	Health service providers
Access to rehabilitation services	Article 26	National or local rehabilitation authorities	Rehabilitation service providers, assistive technology providers
Personal assistance	Article 19	National or local funding authorities	NGOs, assistance providers
Other long-term care	Article 19	National or local social care authorities	NGOs, service providers

Disability assessment is big business. Up to **one quarter of the European population, and almost half of the elderly population**, now report some level of **limitation** in their everyday activities that



they associate with an impairment or health condition.<sup>2</sup> Of these, many also report a lack of assistance.<sup>3</sup> Tens of millions of citizens stand to benefit, or to be denied benefits, as a result of disability assessments carried out by hundreds of thousands of specialist professionals and technical administrators, utilizing often complex and costly procedures and record systems. The demand for disability assessment is growing,<sup>4</sup> increasing the incentives for Member States to avoid duplications of cost and effort, and to rationalise their systems and processes. For example, it has been shown that:

European social security organisations experience shortages of insurance physicians and they attempt to streamline procedures in the disability assessment services in order to save costs, while safeguarding the quality of the assessments.<sup>5</sup>

Or, as the OECD found:

The recently tightened way in which disability is assessed – in some cases more stringent medical, in others tighter vocational assessment – appears to be correlated with an increasing beneficiary caseload.<sup>6</sup>

These kinds of pressures suggest the **potential for added European value** in sharing knowledge and good practice among the Member States, in **mutually recognising assessment outcomes, or/and in harmonising the core principles and tools of assessment**.

## 1.2. Concerns expressed in petitions

Disability classifications, resulting from assessment and determination processes, often give the impression of objective measurement but citizens complain that disability assessments in different Member States result in the determination of different results. This might be because of differences in judgement or differences in measurement (i.e. Member States use different assessment criteria or different measurement scales).

For example, in **Petition No 1262/2019 (German) on the recognition of a degree of disability in other Member States**

The petitioner has been a single mother, with financial responsibility for her daughter (born in 1988), since 2005. Economically independent, her daughter has since 2009 a German card indicating that she is 50% disabled. The petitioner is currently resident in Austria, where, however, her daughter is only recognised as 40% disabled. She considers this discriminatory, since the German authorities accept Austrian disability assessments. She would also like an increased allowance for 2014 and 2015 for her German-resident daughter.

In this example, the person's disability status has been recognised in one Member State by the issue of a national 'card', based on a percentage resulting from a disability assessment according to national rules. A confusion arises in movement between two Member States. The petitioner claims that while the first Member State accepts the outcome of disability assessments conducted in the other, this

<sup>2</sup> Eurostat, *Functional and activity limitations statistics*, 2022. [https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Functional\\_and\\_activity\\_limitations\\_statistics](https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Functional_and_activity_limitations_statistics)

<sup>3</sup> Eurostat, *Disability statistics - elderly needs for help or assistance*, 2022. [https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Disability\\_statistics\\_-\\_elderly\\_needs\\_for\\_help\\_or\\_assistance](https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Disability_statistics_-_elderly_needs_for_help_or_assistance)

<sup>4</sup> Beller, J., & Epping, J., Disability trends in Europe by age-period-cohort analysis: Increasing disability in younger cohorts, *Disability and Health Journal*, 2021, 14(1), 100948.

<sup>5</sup> de Wind, A., Brage, S., Latil, F., & Williams, N., Transfer of tasks in work disability assessments in European social security, *European Journal of Social Security*, 2020, 22(1), 24-38.

<sup>6</sup> OECD, *Sickness, Disability and Work: Breaking the Barriers: A Synthesis of Findings across OECD Countries*, 2010, p. 92. <https://www.oecd.org/publications/sickness-disability-and-work-breaking-the-barriers-9789264088856-en.htm>



recognition is not reciprocated. In addition, disability assessment in the second Member States produces a different result. This example illustrates two separate but related challenges, as perceived by citizens: (a) inconsistency between national disability assessments, and (b) lack of mutual recognition of assessment outcomes.

A similar example is evident in **Petition No 0086/2021 (German) on alleged discrimination in connection with the payment of a disability pension**, where:

The petitioner states that she lives in Spain with her husband, who receives a disability pension. She further states that the 100% rating applicable to the disability pension from Germany has been downgraded to 33-65% in Spain and that that makes her husband liable for tax in Spain. For that reason, the petitioner and her husband have been requested to resubmit their tax records for 2015 and to make payment. The petition asks whether the Spanish authorities' grading is lawful.

The assessment protocols and benefit eligibility rules in Member States are often complex. They involve not only guidance for disability assessors, but also national rules on social security and taxation. Without a detailed technical knowledge, it is difficult for people with disabilities and their families to determine whether the differences they experience in recognition of assessment outcomes between Member States result from local/individual factors, such as the professional judgement of an assessor, or from the use of different assessment criteria, or from the use of a different measurement scales to report the results.

A similar level of impairment or functioning may be expressed differently in different Member States. Disability determination on a fixed scale – such as a percentage, a point score or a grade classification – is always an oversimplification because 'disability' is a dynamic and relational situation, rather than a fixed state. Nevertheless, it is a convenient administrative device. It is used by public authorities, in several Member States, to determine eligibility rules for various benefits and concessions with reference to a shared and commonly understood scale.

These situations can be quite complex and difficult to interpret, however, and notably between different Member States. For example, in **Petition 1051/2013 (Slovenian), on Cross-border pension rights**:

The petitioner is asking the European Parliament to help him to get his pension rights transferred from Italy to Slovenia. He claims to have worked in Italy for nearly 27 years. Following his illness (a skin disease) he was dismissed by his employer. He was declared as unfit to work but a right to a disability pension was refused to him. In Slovenia, he has a status of a pensioner with disability and he receives 89, 23 Euro pension which is in accordance with his years of employment in Slovenia (something over 7 years). Given that his status (pensioner with disability) is not recognised in Italy he finds himself in a very serious financial and social distress. He feels discriminated against on a basis of his nationality. He believes that if he was an Italian citizen his status would be recognised.

In this example, the petitioner has the status of a disability pensioner in his current Member State of residence but was not awarded similar pension rights in the Member State where he previously worked, and where he accumulated past contributions. This is a complex situation that relies on interpretations of social security rights as well as disability determination. Nevertheless, the component of disability recognition is experienced by the petitioner as contradictory and confusing.

A similarly complex example is presented in **Petition No 0709/2020 (Belgian) on pension calculations in the context of cross border employment**, where:

The petitioner worked for many years as a self-employed person in Belgium and in the Grand Duchy of Luxembourg. In 1980, he was victim of an accident at work, after which he received a medical certificate of disability of more than 66%. The petitioner claims that, in the calculations for his retirement rights, the competent Belgian authorities (INASTI) did not take into account some of the periods the petitioner was under the more than 66% disability status in Luxembourg, in breach of Regulation (EEC) No 1408/71 of the Council of 14 June 1971 on the application of social security schemes to employed persons and their families moving within the Community. The petitioner went to court but his appeal was denied.

Again, the complexity of the claim is associated primarily with the transferability of social security benefits between Member States, but the mutual recognition of disability status also plays a part in the petitioner's concerns. Irrespective of the substantive claim to an increased pension, the petition also conveys the perception of citizens that '66%' disability in Luxembourg should be recognisable also in Belgium.

This is a common theme in petitions, where mutual recognition of disability status is often conflated with equivalence of disability benefit payment levels. For example, in **Petition No 0278/2021 (Spanish) on the recognition of disability status and degree across the EU:**

The petitioner complains that the level and nomenclature of invalidity pensions of other EU countries are not officially recognised by the Spanish Government. To remedy this problem, he calls for harmonisation of invalidity pensions and the degree of disability recognised by each of the Member States so that the rights of affected persons are recognised in their country of residence. In support of this, the petitioner points out that this lack of harmonisation results in financial losses for migrant workers who return to Spain after retiring.

In this case, the petition calls for both the harmonisation of 'the degree of disability' recognised by the Member States and for the harmonisation of disability pensions. These are two different types of problem. It is unlikely that EU action could, or should, determine national benefit levels and rules (beyond helping to establish common social protection floors) but there is potential for the EU to assist citizens, and support the Member States, in easing the mutual recognition or harmonisation of disability assessment methods and standards.

A related, and equally complex example, was presented in **Petition No 2505/2014 (Bulgarian) on problems related to the transfer of disability pension rights**, in which:

The petitioner is a Bulgarian citizen who worked in Spain for 2,5 years on a contract. The petitioner appeals to the European Parliament on the decision of Spanish (Madrid) INSS (the Spanish National Social Security Institute), according to which he was denied Spanish disability pension benefits. The petitioner explains that he has multiple severe health conditions qualifying him for the disability benefits. In July 2011 he applied for a disability pension to the Bulgarian National Social Security Institute (NSSI). The NSSI accorded to him 85 % of disability which later was reduced to 75 % due to the changes in national regulations. The NSSI also demanded information from Spanish INSS, but the petitioner did not receive a reply and turned to SOLVIT. SOLVIT investigated his case and in May 2014 delivered to the petitioner a negative reply stating that according to the information received by SOLVIT the petitioner does not qualify for Spanish disability benefits. The petitioner also applied to the Spanish Ombudsman and received a negative reply. The petitioner asks the European Parliament for help to get Spanish disability benefits.

In this case the petitioner qualified for disability benefits in one Member State but not in another, which might be due to differences in assessment method or differences in benefit eligibility rules. In addition,

the percentage level of disability determined by the national authorities in one Member State was altered 'due to the changes in national regulations' (i.e. the scale of measurement or the assessment criteria were changed). The experience for citizens is again confused by inconsistency in both assessment methods and benefit rules.

It is worth noting that this is by no means just a European problem. Inconsistencies in disability assessment also affect citizens coming from third countries. For example, in [Petition No 0557/2020 \(Spanish\) on the recognition of the degree of disability granted in Venezuela](#):

The petitioner is seeking the assistance of the European Parliament in obtaining recognition from the Spanish health authorities of the degree of disability granted to her by the Venezuelan authorities. It appears that the Spanish authorities conducted a different assessment.

Disaggregating the problems of disability assessment, determination and recognition from differences in national benefit rules is important, not least on grounds of subsidiarity. **Disability benefits present a large and complex area of social policy over which the Member States have widespread historic competence, and which form a significant part of their national welfare state budgets.** It is not within the scope this study to propose mechanisms for harmonising social protection benefit levels, or eligibility rules within the competence of each Member State.

EU nationals from any Member State must be treated equally to nationals of the state in which they reside, but **rules of domestic eligibility to entitlement vary between Member States.** There are some exceptions to this, as discussed below and these are relevant to some of the concerns outlined in petitions. In addition, when addressing the EU in 2015, the **UN CRPD Committee** recommended 'setting a **social protection floor** that respects the core content of the right to an adequate standard of living and to social protection'.<sup>7</sup> Greater mutual recognition of disability assessment or/and determination would go some way towards this.

### 1.3. Considerations and challenges to mutual recognition

The observations outlined so far raise important considerations. They underline the need for mutual recognition of disability assessments between Member States, or the portability of administrative disability status. They also suggest some of the challenges to mutual recognition or harmonisation in the disability field. These can be summarised as follows.

**The general policy function of disability assessments, as a gateway to public resources, raises considerations of subsidiarity and proportionality.** Most of the services and benefits to which disability assessment determines access fall within areas of social policy that are exclusively or mainly within the competence of the Member States (such as the provision of social security benefits, social assistance, housing services, educational support, housing support, employment support and so on). Nevertheless, Article 151 of the Treaty on the Functioning of the European Union (TFEU), in recognising the Social Charter, also promotes the harmonisation of living and working conditions and the implementation of 'measures which take account of the diverse forms of national practices ... which will favour the harmonisation of social systems'. For example, the European Parliament and the Council may adopt supportive and complementary actions with Member States in some areas, and adopt minimum requirements for the social security and social protection of workers.

<sup>7</sup> Committee on the Rights of Persons with Disabilities, *Concluding observations on the initial report of the European Union*, 2015, [https://tbinternet.ohchr.org/\\_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRPD%252FCO%252F2015%252F1](https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRPD%252FCO%252F2015%252F1)

**The assessment criteria used to determine disability status are among the main mechanisms for rationing public spending in the Member States.** Disability is a significant category of public spending on social protection and social assistance, and disability assessments determine access to important benefits in cash and in kind, such as entitlement to disability pensions or long-term care (these examples are explored in more detail later).

For example, Eurostat reports that in 2020, 'disability' accounted for 7.3% of total expenditure on social protection benefits in the EU, considerably more than expenditure on unemployment benefits (although much smaller than overall expenditure on old age pensions or health care). It varies greatly among the Member States, ranging from more than 10% in Denmark, Estonia and Luxembourg to less than 5% in Malta, Cyprus, Greece and Slovenia.<sup>8</sup> Disability benefits in this context refer to spending on designated disability pensions and early retirement benefits due to reduced capacity to work (historically referred to as 'invalidity' benefits). These types of entitlement have been strongly associated with formal assessments of disability and functioning. Tightening the eligibility rules for disability assessments has often been viewed by governments as a mechanism to limit growth in the welfare benefits bill.<sup>9</sup>

Public spending on 'long-term care' is another significant example. The Social Protection Committee's (SPC) *Long-Term Care Report* projects public spending in this area to rise faster than either pensions or healthcare, and positions this as a major challenge to sustainability in an ageing society.<sup>10</sup> The Member States do not report spending on the social component of long-term care in a consistent way and a wide variation in reported spending reflects this. Nevertheless, it is evident that increasing demand for long-term social care arises primarily from the increasing number of claims for assistance due to disability and chronic illness. All these kinds of claims (i.e. for long-term support from services, and personal assistance in everyday living) are premised on disability assessments of need and/or functioning.

**Disability assessments have a range of different policy functions** – different policy functions may require different approaches to disability assessment. For example, at the most general level, Member States and the EU benefit from knowledge about the population of persons with impairments so they can plan public policies and tackle systematic discrimination. To this end, simple screening questions (a basic form of self-assessment) are often inserted into social surveys and census questionnaires. Most disability assessments do not rely on self-assessment alone, and engage professional expertise, which may vary according to the policy function. Determinations of general disability status - defining who is or is not classified as disabled – often draw on the opinion of medical or health professionals. An assessment for employment support might be conducted by an employment specialist in context of actual workplaces and job opportunities. An assessment of need for assistance with daily living at home, carried out by a local social worker or occupational therapist, might differ from an assessment of need for education support in the classroom, carried out by an advisory teacher or educational psychologist.

Disability is contextual and it would be impossible to harmonise all forms of disability assessments, for all policy functions, even within a single Member State. The assessment processes and criteria used to determine eligibility for public support may also vary between sub-national regions, and local or

<sup>8</sup> Eurostat, *Expenditure on social protection benefits by function*, 2022 [https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Social\\_protection\\_statistics\\_-\\_social\\_benefits](https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Social_protection_statistics_-_social_benefits)

<sup>9</sup> Haller, A., Staubli, S., & Zweimüller, J., *Designing disability insurance reforms: Tightening eligibility rules or reducing benefits* (No. w27602), National Bureau of Economic Research, 2020

<sup>10</sup> Social Protection Committee (SPC) and the European Commission (DG EMPL), *Long-Term Care Report: Trends, challenges and opportunities in an ageing society*, 2021, <https://ec.europa.eu/social/BlobServlet?docId=24079>

municipal authorities (as illustrated later in chapter 3.2). However, there are opportunities to harmonise some core components or principles of assessment across policy functions and between Member States (as shown in chapter 2).

**The cost of re-designing and implementing new disability assessment systems is high.** Disability assessments involve millions of citizens in often complex administrative procedures. Design and implementation changes can be costly where they require new systems, widespread training, or intensive input from senior professionals (such as doctors). Inconsistencies in design and decision making also result in a high level of disagreement and appeals. Indeed:

...the overall accuracy of disability assessment is crucial for the political sustainability, and perceived fairness of social security and other policies that rely on disability assessment. If expert disability assessors, following the rules they have been set down, often came to different judgments about the same applicant, then the process might be viewed as arbitrary and unjust.

<sup>11</sup>

The cost of complexity, ambiguity or low reliability in disability assessments is borne both by public authorities and by persons with disabilities themselves. For example, the additional labour, time and expense of form filling, gathering evidence, travelling to assessment meetings, correspondence, and the loss of income or access to support while waiting for decisions, is commonly reported and has a major effect on people's lives.<sup>12</sup> As noted earlier, there may be considerable **cost-benefit potential and added European value** in sharing assessment principles and practice among the Member States, and mutually recognising the outcomes.

#### 1.4. Portability of social protection benefits

As shown earlier, the main policy function of disability assessment within each Member States is to determine entitlement to publicly funded support, including disability benefits. The **portability** of benefits is a **complex** area, due to the mixed competences involved and the diversity of benefit systems and rules in the Member States. At a basic level, the Parliament and the Council should 'adopt such measures in the field of **social security** as are necessary to provide freedom of movement for workers'.<sup>13</sup> and different social security systems in the Member States should not adversely affect the **free movement of workers** and their families.<sup>14</sup> There has been provision for the co-ordination of these systems since the 1970s, for the main types of statutory scheme (i.e. **sickness, maternity, invalidity, old age, survivors, family, and death benefits**).<sup>15</sup> For example, citizens insured in one Member State may receive certain health care (sickness benefits in kind) in another Member State as if they were insured there. Citizens may continue to claim unemployment benefits while moving between Member States, under certain conditions. Certain kinds of social contributions accrued in different Member States may be combined when claiming social benefits at a later date.

<sup>11</sup> Bickenbach, J., Posarac, A., Cieza, A., & Kostanjsek, N., *Assessing disability in working age population: a paradigm shift from impairment and functional limitation to the disability approach*, World Bank Group, 2015, p. 7. <https://documents1.worldbank.org/curated/en/272851468164970738/pdf/Disability-Assessment-Report-June-18-2015.pdf>

<sup>12</sup> For example, see: P. Gray, *The Second Independent Review of the Personal Independence Payment Assessment*, 2017 [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/604097/pip-assessment-second-independent-review.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/604097/pip-assessment-second-independent-review.pdf)

<sup>13</sup> Article 48 TFEU

<sup>14</sup> Council Regulation 1612/68 of 15 October 1968 on freedom of movement for workers within the Community

<sup>15</sup> Council Regulation 1408/71 of 14 June 1971 on the application of social security schemes to employed persons, to self-employed persons and to members of their families moving within the Community



In general, **'social security'** refers to **benefits that are provided, 'to the working population... whose activity is interrupted** by illness, accident or involuntary unemployment and persons seeking employment – and to retired or invalided workers and self-employed persons'.<sup>16</sup> Social security is clearly **relevant to disabled people** in this population (e.g. the outdated term 'invalided' refers to persons assessed as unable to work due to reasons of disability, around half of all disabled people in Europe are 'retired', and others may be disproportionately at risk of 'illness, accident or involuntary unemployment'). An improved EU system of mutual recognition for determining 'invalidity' or 'sickness' or 'involuntary unemployment' due to disability could help **facilitate existing entitlements** to portability.

There are some exceptions to the general rules on **transferability** of social security benefits that affect disabled people. For most **social security benefits**, contributions are paid in the Member State where the person is resident at the time but the benefit **may be exported** (such as contributions to unemployment benefit made in one country but claimed in another). By contrast, **social assistance benefits** are funded in the country where the support is provided (such as social services support with daily living). There are also **'special non-contributory benefits'**, including some aspects of care for disabled people, which are payable in the country that provides them but which are not exportable.

The **Charter of Fundamental Rights** conveys rights to 'social security benefits and social services' to everyone who resides and moves legally within the EU.<sup>17</sup> but this is also limited by 'the right of Member States to define the fundamental principles of their social security systems'.<sup>18</sup> The **Maastricht Treaty's Protocol on Social Policy** extended EU competence to 'support and complement the activities of the Member States' in the fields of 'social security and social protection of workers'.<sup>19</sup> To this end, the Parliament and the Council may adopt **directives** for the implementation of minimum requirements, as well as measures to encourage co-operation.

The scope for EU intervention is therefore broad. In practice, it has been **confined** mainly to ensuring the equal treatment of women and men, and the free movement of workers. There is scope to develop such requirements and co-operation in relation to equal treatment of persons with disabilities. The concerns of **Member States to retain regulatory and budgetary control over their national systems** remain significant considerations in this regard. Nevertheless, the Commission has identified several barriers to portability, including those associated with the recognition of disability status that could be addressed.

## 1.5. Existing research and evidence

The following studies inform this study and provide a baseline of existing knowledge for thinking about disability assessments in European countries. The findings from these and related reports are elaborated in more detail, with examples, in the following chapters.

**In 2002 the Council of Europe (CoE) produced a report on similarities and differences in assessing disability in Europe.**<sup>20</sup> This was conducted on behalf of a 'Working Group on the assessment of

<sup>16</sup> Council Directive 79/7/EEC of 19 December 1978, on the progressive implementation of the principle of equal treatment for women and men in matters of social security

<sup>17</sup> Article 34 Charter of Fundamental Rights of the European Union

<sup>18</sup> Article 153(4) TFEU

<sup>19</sup> Article 153(1c) TFEU

<sup>20</sup> Council of Europe, *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), 2002, <https://rm.coe.int/16805a2a27>.

person-related criteria for allowances and personal assistance for people with disabilities', based on voluntary collaboration within the CoE's Partial Agreement in the Social and Public Health Field. As the Group's remit suggests, the scope of the review covered the methods and criteria for assessments as a gateway to disability entitlements in cash or in kind (i.e. disability pensions or provision of personal assistance). It was based on responses to a questionnaire concerning different 'tests' used to access 'benefits' in 21 countries.

This study was important in highlighting the wide variety of tests used at the time, and the complexity of their definition and application in different policy systems (e.g. in assessing capacity for work, additional costs of living with disability, or needs for help with daily living). Disability assessments vary not only between different countries, with different welfare state traditions, but also between different policy functions or fields within each country. In addition, assessments for access to benefits may include a range of criteria other than disability-related criteria, such as age or household criteria, past social insurance contributions, employment status, and so on. The focus of the CoE was on methods and criteria for assessing the 'disability' component within such assessments and dividing these into types (which are outlined in more detail later). It also observed the strong claims of NGOs to equality of rights throughout Europe, for example 'by introducing a genuine European Disability Pass' (p. 27).

**Another study, funded by the European Commission and also published in 2002, reported on definitions of disability found in the social policies and anti-discrimination laws of the EU Member States and Norway.**<sup>21</sup> This focused mainly on the determination of entitlements to social protection benefits and included an analysis of disability assessment processes. Adopting a different framework to the CoE study above, the analysis focused on the extent to which disability assessments relied on medical evidence in the process, and the extent to which assessors exercised discretion in the determination.

**In the same year, De Boer et al. compared the organization of 'work disability' assessment with legal criteria for work capacity and entitlement to support, in 15 countries.**<sup>22</sup> They determined that differences in assessments methods, procedure and expertise between countries was not closely related to differences in the criteria used for evaluation/determination of the outcomes. Indeed, they established that the legal criteria for work capability were rather similar while the methods of assessment varied considerably. This finding is significant as it highlights a common theme – EU Member States are often using very different methods to assess the same phenomenon for the same purpose. This insight raises the question of whether lesson learning and mutual recognition might assist the EU in harmonising best practices of assessment design (which is a central theme for the current study).

**In 2007-2009 the Organisation for Economic Cooperation and Development (OECD) examined welfare state responses to addressing sickness and disability in relation to work, and the specific challenge of 'partial work capacity'.** While the focus was on active labour market policies and integration assistance to workers but it drew attention to significant changes in benefit eligibility rules and assessments. These reviews indicated that the way countries deal with sick and disabled workers was changing. On the one hand, eligibility criteria were becoming tighter in response to economic and demographic pressures (rising claims for disability benefits and ageing populations). On the other hand, attention was shifting towards a more functional approach (with an increasing emphasis on

<sup>21</sup> Brunel University, *Definitions of Disability in Europe, A Comparative Analysis*, European Commission, 2002, [www.ec.europa.eu/social/BlobServlet?docId=2088&langId=en](http://www.ec.europa.eu/social/BlobServlet?docId=2088&langId=en)

<sup>22</sup> De Boer, W., Besseling, J., Willems, J., 'Organisation of disability evaluation in 15 countries', *Pratiques et Organisation des Soins*, 2007, vol. 38, no. 3, p. 205.

assessing people's capabilities for work). A key policy concern was to reduce the use of disability assessments to divide people, categorically, into work able and not able groups, thereby pushing the latter group into permanent exit from the labour market. Thus:

To ensure that people with partial work capacity remain in or enter the labour market, it has proven necessary to reform assessment procedures and to change the benefit structure.<sup>23</sup>

It is relevant then to observe that national choices about disability assessment criteria have been driven by economic and political concerns as well as scientific ones, notably so in the period following the 2007-2008 financial crisis.

Nevertheless, during the same period there has been considerable work to advance the objective measurement and identification of functional disability/impairment. **The World Health Organisation (WHO)** supported to projects over many years to standardise question items that could be used in national surveys and screening to identify people with functional impairments. For example, based on the **International Classification of Functioning, Disability, and Health (ICF)** the **UN Washington Group** developed and tested question sets that could be used in national censuses and surveys.<sup>24</sup> In addition, the WHO developed a standardized **Disability Assessment Schedule (WHODAS)** 'a standardized method for measuring health and disability across cultures'.<sup>25</sup> Such tools were not developed principally for application in social policy contexts, such as administrative recognition of disability status or eligibility to benefits and entitlements but may have some relevance in these contexts (they are examined in more detail later).

**In 2015, the World Bank and WHO collaborated in a study on Assessing Disability in Working Age Population**, which envisaged a 'paradigm shift' in disability assessment from a focus on impairment and functional limitation to an approach based on the ICF.<sup>26</sup> This report situated methods of disability assessment within the context and public credibility of wider policy systems, acknowledging that states require strong arguments to undertake any substantial reform of disability assessment procedures. It made a case for applying ICF concepts to develop new tools for disability assessment (which have been subsequently piloted in some EU Member States, see section 0). Hence, it argues that:

...while acknowledging limitations, both in conception and implementation, it makes a case for why adopting the ICF approach to disability assessment may be smart policy that corresponds well with the aims of modern disability policy that focuses on social and economic inclusion for individuals with disabilities, in the context of a recognition of their fundamental human rights. (p. xvii)

**From 2016, a European or EU Disability Card was piloted in eight Member States, on a voluntary cooperation basis.** This did not involve any standardised approach to disability assessment but provided an administrative mechanism (the Card) to allow disability status resulting from assessment in one country to be easily recognised in another country. An assessment of this pilot scheme was

<sup>23</sup> OECD, *New Ways of Addressing Partial Work Capacity*, 2007, <http://www.oecd.org/social/soc/38509814.pdf> p. 4.

<sup>24</sup> Washington Group on Disability Statistics, *Question Sets*, undated <https://www.washingtongroup-disability.com/question-sets/>

<sup>25</sup> WHO, *Measuring health and disability : manual for WHO Disability Assessment Schedule (WHODAS 2.0)*, 2012 [https://www.who.int/publications/i/item/measuring-health-and-disability-manual-for-who-disability-assessment-schedule-\(whodas-2.0\)](https://www.who.int/publications/i/item/measuring-health-and-disability-manual-for-who-disability-assessment-schedule-(whodas-2.0)) p. v.

<sup>26</sup> Bickenbach, J., Posarac, A., Cieza, A., & Kostanjsek, N., *Assessing disability in working age population: a paradigm shift from impairment and functional limitation to the disability approach*, World Bank Group, 2015, <https://documents1.worldbank.org/curated/en/272851468164970738/pdf/Disability-Assessment-Report-June-18-2015.pdf>



published in 2021.<sup>27</sup> Unlike the examples noted so far, this scheme targeted mainly recognition by service providers in the market (such as leisure, retail or transport services) rather than statutory entitlements provided by the state (such as social protection benefits).<sup>28</sup> It is important, therefore, to distinguish the challenge of disability assessment methods from the challenge of mutual recognition. They are related, however, and it is likely that mutual recognition, and therefore freedom of movement for disabled people, would be assisted in areas where a shared approach or partial harmonisation of disability assessments could be achieved.

**In 2017 the European Commission commissioned research by its Academic Network of European Disability experts (ANED) to map the state of the art in disability assessment methods in use among the EU Member States and associated countries.**<sup>29</sup> This is the most comprehensive study of relevance to date. The network collected examples from national experts in 34 European countries, including diverse examples of assessments to determine disability registration, access to out-of-work disability benefits, or access to long-term care services supporting independent living. The different types of approach were subsequently compared, in light of the UNCRPD, to develop new principles and recommendations for the design and implementation more rights-based approaches to disability assessment.<sup>30</sup>

**In 2021, the European Disability Forum (EDF) produced a position paper on Improving Disability Assessment Procedures in the EU.**<sup>31</sup> This drew on similar examples and updated examples, across the Member States and the UK. It also reported on the experience of persons with disabilities undergoing disability assessments, for example in relation to shortcomings in administration or the expertise of assessors. It focuses on the fragmentation and inconsistency of different assessment systems and the impediments this creates for freedom of movement. It calls for EU agreement on the mutual recognition of disability assessment and adoption of the EU Disability Card as a common format for 'proving disability assessment when in another EU country' (p. 13).

**The present study** draws extensively on the findings of these previous studies, including from country reports contributing to them or subsequent pilots and evaluations. It also draws on publicly available information from policy databases summarising information about benefit assessment criteria, such as those provided by the Mutual Information System on Social Protection (MISSOC) in the EU Member States<sup>32</sup> or the Disability Online Tool of the Commission (DOTCOM), maintained by its European Disability Expertise network (EDE).<sup>33</sup> The *2021 Long-Term Care Report*, produced by the Social Protection

<sup>27</sup> European Commission, *Study assessing the implementation of the pilot action on the EU Disability Card and associated benefits*, 2021 <https://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=8407&furtherPubs=yes>

<sup>28</sup> See also EDF summary of discussions on the future of the European Disability Card: <https://www.edf-feph.org/summary-report-of-the-discussion-on-the-future-of-the-disability-card-on-16-september-2021/>

<sup>29</sup> Waddington, L., Priestley, M & Sainsbury, R., *Disability assessment in the European States*, on behalf of the Academic network of European disability experts (ANED), with contributions from the ANED country experts, 2018. <https://www.disability-europe.net/downloads/899-aned-year-3-policy-theme-synthesis-report-2017-18>

<sup>30</sup> Waddington, L., & Priestley, M., 'A human rights approach to disability assessment', *Journal of International and Comparative Social Policy*, 2021, 37(1), 1-15. <https://doi.org/10.1017/ics.2020.21>

<sup>31</sup> European Disability Forum (EDF), *Improving Disability Assessment Procedures in the EU*, 2021, <https://www.edf-feph.org/content/uploads/2021/09/Disability-Assessment-Position-Paper.docx>

<sup>32</sup> MISSOC (2022) *Comparative tables* <https://www.missoc.org/missoc-database/comparative-tables/>

<sup>33</sup> European Commission, *DOTCOM: The Disability Online Tool of the Commission*, 2022, <https://ec.europa.eu/social/main.jsp?catId=1541>

Committee and the Commission also included a review of relevant assessment processes, with examples.<sup>34</sup>

As indicated by the sources outlined above, there is now an extensive and long-standing evidence base on which to develop policy on disability assessment and recognition in Europe.

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<sup>34</sup> Social Protection Committee (SPC) & European Commission (DG EMPL), *Long-Term Care Report: Trends, challenges and opportunities in an ageing society*, 2021, <https://ec.europa.eu/social/BlobServlet?docId=24079>

## 2. TYPES AND PRINCIPLES OF DISABILITY ASSESSMENT

### KEY FINDINGS

Contemporary disability policy, including that of the EU, is informed by a **social interpretation of disability and a rights-based approach**. The **UN CRPD Committee** has recommended **reform of disability assessment and recognition systems in the EU and Member States**. New innovations should reflect this and adopt common principles in their implementation. Disability arises from **interactions between people with impairments and barriers in society** that hinder their full participation and equality. The **International Classification of Functioning, Disability and Health (ICF)** is widely used to frame disability assessment in this context, leading to development of some mutually recognisable components of disability assessment. Existing approaches to disability assessment can be divided into several types. **Holistic and direct assessments of real-life situations** are often most useful to people in context of their lives and may draw on different assessment types.

### 2.1. Models of disability

**The concept of disability has been widely interpreted, and contested, in academic, political and policy debates.**<sup>35</sup> The design of any disability assessment system needs to be grounded in an understanding of what 'disability' is, or which of its causes and consequences are relevant to the task.<sup>36</sup> There are various ways of representing these debates but it is useful, at the outset, to distinguish between individual and social dimensions of disability, and the interactions between them. **Individual models of disability** focus attention on the person and their impairment characteristics (such as a health condition or their bodily characteristics). **Social models of disability** focus on the environment and societal characteristics (such as accessibility or inclusiveness). The implication of an individual model of disability is that the person has the problem and that solutions require the person to change, through treatment or adjustment to their circumstances. The implication of a social model of disability is that society has the problem and that the solutions lie in social change, through the removal of barriers in society. From this perspective:

Disability is something imposed on top of our impairments, by the way we are unnecessarily isolated and excluded from full participation in society.<sup>37</sup>

**A rights-based approach to disability**, as embodied in the CRPD, is inspired by social model thinking but it differs in emphasis.<sup>38</sup> It recognises the human rights of people with impairments and demands the removal barriers to their participation and equality. It begins from a focus on persons and their

<sup>35</sup> Oliver, M., *Politics of disablement*. London: Macmillan, 1990; Oliver, M., & Barnes, C., *The new politics of disablement*. London: Macmillan, 2012.

<sup>36</sup> Altman, B. M., 'Disability definitions, models, classification schemes, and applications'. In G. L. Albrecht, K. Seelman, & M. Bury (Eds.), *Handbook of disability studies*, London, SAGE, 2001, pp. 97-122; Altman, B. M., 'Definitions, concepts, and measures of disability'. *Annals of epidemiology*, 2014, 24(1), 2-7.

<sup>37</sup> Union of the Physically Impaired Against Segregation, *Fundamental Principles of Disability: Being a Summary of the Discussion Held on 22nd November, 1975 and Containing Commentaries from Each Organisation*. London: Union of the Physically Impaired Against Segregation, 1976.

<sup>38</sup> Kakoullis, E., & Ikehara, Y., 'Article 1 purpose'. In I. Bantekas, M. Stein, & D. Anastasiou (Eds.), *The Convention on the Rights of Persons with Disabilities A Commentary*, Oxford, Oxford University Press, 2018.

rights, whereas the social model begins from a focus on barriers and their removal. Nevertheless, they share basic principles. People with impairments are excluded from full participation and equality and this constitutes a form of discrimination that is institutionalised throughout society. Disability is socially created. It changes when the environment changes – i.e. a person may experience less 'disability' in places where there are fewer barriers and where there is more support. This change in the disability situation may occur when a person moves between home and work, between different jobs in the labour market, or between different Member States.

There is a **strong case for considering a social model approach to assessment**, focused on barriers rather than on people (such as accessibility audits of buildings, transport systems or websites). Such assessments help to identify and remove barriers and thereby increase inclusion. However, as outlined in chapter 1.1, the main policy function of 'disability assessment' in the Member States is to identify persons who are eligible for, and entitled to, assistance and support from public resources and private providers. These assessments also require attention to the barriers that people face but they operate at the level of the person, rather than the level of society. The present study addresses the state of the art in **personalised assessments**.

As the World Bank study on '**paradigm shift**' in disability assessment underlines:

There is a general consensus in the academic literature that the Disability approach is theoretically optimal: it seeks to directly assess disability status rather than indirectly inferring disability from proxy assessment of impairments or functional capacity; it is fully individualized and based on direct evidence both about the person and his or her environment; and it captures the best model of disability about which, again, there is universal consensus, in which **disability is understood as a person-environment interactive outcome**, rather than an intrinsic feature of the person. (p. 55)

This 'disability' approach is drawn from an interpretation of the CRPD (which is explored in more detail in the following section 2.2). The broad distinction between individual and social models of disability, and this approach is summarised in Table 2 below.

Table 2: Models of disability

Models of disability	Individual	Social	CRPD
Focus	The <b>person</b> and their <b>impairment</b> characteristics (such as a health condition or their bodily characteristics)	The <b>environment</b> and <b>societal</b> characteristics (such as accessibility or inclusiveness)	The <b>interaction</b> between a person and their environment
Implications	The person has the problem	Society has the problem	The problem arises from encounters with barriers
Solution	The person has to change, through <b>treatment</b> or <b>adaptation</b> to their circumstances	Society has to change, through the removal of <b>barriers</b> in society	Respect for the rights of persons, through <b>non-discrimination</b> and <b>reasonable adjustment</b>

Assessment	Medical or individual capacity	Social / environmental	Holistic and multidisciplinary
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## 2.2. The UN Convention as a starting point

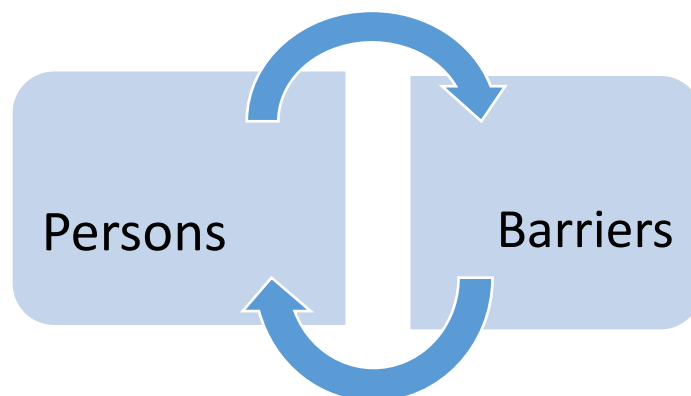
The key point of reference on disability rights, internationally, is **the United Nations Convention on the Rights of Persons with Disabilities (CRPD)**. Article 1 CRPD (Purpose) observes that:

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in **interaction** with various barriers may hinder their full and effective participation in society on an equal basis with others.

While there is no precise 'definition' of disability, this observation implies a relational model of disability. It involves 'interactions' between...

- **Persons** - 'who have long-term physical, mental, intellectual or sensory impairments', and:
- **Barriers** - 'which hinder their 'full and effective participation in society on an equal basis with others'.

**A CRPD compatible approach to disability assessment requires attention to both sides of the disability equation.** Many of the disability assessment procedures used in the Member States focus exclusively on the person (their impairments, sometimes their capacities) rather than on the barriers they face in their environment. A **more holistic disability assessment** would take account of context – what a person can do in their current situation, what help they need, what they might be able to achieve with assistance, and how to remove the barriers in their lives. For example, determining that a person is '100% disabled' or 'totally unable to work' on the basis of an abstract medical diagnosis, or performance in an functional activity assessment out of context, makes little sense, other than in extreme cases. Where possible, disability assessment should consider a person's interaction with the barriers they face, and the potential to remove these.



This tension has been observed in studies conducted since the coming into force of the CRPD, such as the ANED study, and by other commentators and by disabled people's organisations. For example, Arnould et al. argued that:<sup>39</sup>

In line with the principles and vision of the CRPD, disability assessment mechanisms must concentrate on **participation restriction and on support needs** of the disabled person more than on her/ his impairment or functional limitations. This implies also that these mechanisms take the environment into account, most often overlooked in assessments. (p. 4)

Similarly, in a joint statement in 2019, the International Labour Organisation (ILO) and International Disability Alliance (IDA) concluded that:

In order to comply with the CRPD, disability assessments should not only consider impairment and activity limitations, but also the attitudinal and environmental **barriers** faced by persons with disabilities, as well as their **support requirements**.<sup>40</sup>

In addition, Article 26.1a CRPD requires that comprehensive habilitation and rehabilitation services (such as those in the key areas of health, employment, education and social services):

Begin at the earliest possible stage, and are based on the multidisciplinary assessment of **individual needs and strengths**.

And, Article 28 requires that various social protection measures are provided in relation to 'disability-related needs' or 'disability-related expenses'.

Such considerations present some challenges to the determination of a fixed disability status to persons, as an outcome of rights-based assessment. Such assessments are likely to be more **dynamic**, more needs-focused and more relevant to social context. This has been reflected in the opinion of the UN CRPD Committee, as expressed in its recommendations to EU Member States.<sup>41</sup> For example, it has observed in relation to disability definitions that in:

- **Lithuania** (2016) – 'the definition and understanding of disability in State party laws and regulations focuses on the individual impairment, thereby neglecting the social and relational dimension of disability, including in particular, the barriers faced by persons with disabilities'.
- **Portugal** (2016) - 'disability is assessed medically and that, in the absence of legal criteria on the eligibility of persons with disabilities for the various social protection programmes, the national industrial injury and occupational illness chart serves as a substitute'

and has called upon:

- **Czechia** (2015) – to amend legislative definitions 'to make explicit reference to the barriers faced by persons with disabilities'
- **Latvia** (2017) – to 'ensure that disability determination is based on a human rights model of disability, includes an assessment of needs, will and preferences of the individuals concerned,

<sup>39</sup> Arnould, C, Barral, C, Bouffioulx, E, Castelein, P, Chiriacescu, D, & Cote, A., *Disability Assessment Mechanisms: Challenges and Issues at Stakes for the Development of Social Policies in light of the United Nations Convention for the Rights of Persons with Disabilities*, 2012, [https://www.firah.org/upload/notices2/novembre-2013/synthese\\_rapport\\_firah\\_-12p-engl.pdf](https://www.firah.org/upload/notices2/novembre-2013/synthese_rapport_firah_-12p-engl.pdf)

<sup>40</sup> International Labour Organisation, & international Disability Alliance, *Joint statement: towards inclusive social protection systems supporting the full and effective participation of persons with disabilities*, 2019 <https://www.social-protection.org/gimi/gess/RessourcePDF.action?ressource.ressourceId=55473>

<sup>41</sup> Extracted from the UN Treaty Body Database, [https://tbinternet.ohchr.org/\\_layouts/15/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=4&DocTypeID=5](https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=4&DocTypeID=5)

..., and focuses on the elimination of barriers and the promotion of full and effective participation of persons with disabilities in society’.

In 2021-2022, the Committee has continued to elaborate specifically with regard to disability assessments:

- **Hungary** (2022) – ‘The medical model of disability is still prevalent in the State party, including within its disability assessment system and in relation to the eligibility criteria for accessing necessary services and support measures, operating on the assessment of capacity of a person to understand and to live independently and “residual health” thresholds, which adversely affect the social inclusion of persons with disabilities;’
- Recommending that **Hungary** – ‘Reorient its disability assessment systems by replacing elements of the medical model of disability with principles of the human rights model of disability and by establishing systems aimed at the assessment of legal and environmental barriers to persons with disabilities and the provision of the necessary support and assistance to promote the independent living of persons with disabilities and their full social inclusion’
- **Estonia** (2021) – ‘disability-related legislation and policies have not yet been fully brought into line with the Convention and, in particular, that disability-assessment systems have a negative impact by preventing the inclusion of children with disabilities in society and limiting their access to appropriate services and required support;’
- Recommended that **Estonia** - ‘Review existing disability-related legislation and policies, including on disability-assessment systems, and bring them into line with the human rights model of disability in the Convention.

The basis for these recommendations is **not explicit in the primary text of the Convention**, in the sense that there is no definition or guidance on disability assessment, as such. Nevertheless, it is **mentioned** in Article 26 (Habitation and rehabilitation) to the extent that relevant programmes should be ‘based on **multidisciplinary assessment of individual needs and strengths**’. There is also reference to consideration of ‘disability-related needs’ and ‘disability-related expenses’ in Article 28 (Adequate standard of living and social protection). These isolated references underline the relevance of **assessing personal capacities, needs and expenses**, as outlined in the previous chapter, **in preference to abstract or medicalised assessments of impairment**.<sup>42</sup>

The meaning of the Committee’s recommendations is also apparent from interpretations and explanatory texts supporting the Treaty implementation. For example, a 2014 thematic study from the Office of the United Nations High Commissioner for Human Rights on the right to independent living,<sup>43</sup> resulting in the Committee’s 2017 General Comment,<sup>44</sup> asserted that:

<sup>42</sup> For a fuller interpretation of the CRPD model and disability assessment, see: Waddington, L., & Priestley, M., ‘A human rights approach to disability assessment’. *Journal of International and Comparative Social Policy*, 2021, 37(1), 1-15. <https://doi.org/10.1017/ics.2020.21>

<sup>43</sup> United Nations High Commissioner for Human Rights, *Thematic study on the right of persons with disabilities to live independently and be included in the community: Report of the Office of the United Nations High Commissioner for Human Rights*, A/HRC/28/37, 2014, <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/241/66/PDF/G1424166.pdf>

<sup>44</sup> Committee on the Rights of Persons with Disabilities, *General comment No. 5 (2017) on living independently and being included in the community*, CRPD/C/GC/5, 2017, <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G17/328/87/PDF/G1732887.pdf>



Eligibility criteria for access to support services need to be defined in a nondiscriminatory way. In particular, the assessment should **shift from a medical to a human rights-based approach** to disability, focus on the needs of the person rather than the impairment and respect individual choice and preferences by ensuring the participation of persons with disabilities in the decision-making process. (p. 12)

The **2018 ANED study**, and its authors' subsequent development of that analysis, goes further into the interpretation of what a CRPD compliant approach to disability assessment would look like. This involves looking across the various Articles of the Convention, and the relevant observations of its responsible Committee. For example, as with any other area of public policy, not only the methods and criteria but also the process of assessment should be compliant with CRPD principles, including equality of opportunity, non-discrimination, dignity, equality between women and men, and so on.

These considerations were developed into a set of **12 guiding principles for the design of CRPD-compliant disability assessment systems**, which are summarised in Table 3.

Table 3: Principles for a CRPD compliant approach to disability assessment

12 Principles for rights-based disability assessment	
1.	The design and conduct of disability assessments should be guided by the same general principles that animate the CRPD (Article 3)
2.	The rights enshrined in CRPD should apply to disability assessment systems at all levels (local and regional as well as national).
3.	Disability assessments should consider the interactions between persons with impairments and barriers in their environments (Article 1).
4.	The disability assessment process should be accessible to people with impairments, with 'reasonable accommodation' provided where needed (Article 9).
5.	Disability assessment processes must recognise the legal capacity of persons with disabilities on an equal basis with others (Article 12)
6.	Neither the process of disability assessment nor its outcome should deprive a person of their liberty arbitrarily (Article 14)
7.	No person should be subject to 'cruel, inhuman or degrading treatment' during disability assessment (Article 17)
8.	Disability assessments should respect and ensure the right of people with disabilities to live independently and to be included in the community (Article 19)
9.	Eligibility and evaluation criteria for disability assessment should be framed with respect for relevant substantive rights contained in the CRPD (e.g. employment, education, etc)
10.	Provisions for complaint, review or appeal of disability assessment decisions should respect a person's right of access to justice (Article 13).
11.	Training should be promoted for professionals and staff involved in disability assessments to better provide the assistance and services guaranteed by CRPD rights (Article 4 & 13).



**12.** People with disabilities and their organisations, as well as human rights bodies, should be involved in the design and review of disability assessment systems (Article 4.3 & 33.3)

Source: Adapted from Waddington and Priestley, 2021

### 2.3. International Classification of Functioning as a reference point

There have been several calls to align disability assessment methods and tools with the **WHO International Classification of Function, Disability and Health (ICF)**, as illustrated by **Petition No 1299/2020 (Spanish) on equal recognition of the degree of disability**, in which:

The petitioner wishes for the European Union to urge the Spanish Government to unify disability assessment criteria for those with rare diseases, expressing concern at disparities in this area between the different Autonomous Communities and even the provinces. A lower degree of recognised disability, which means a significant reduction in welfare assistance, is frequently the result of a subjective assessment by one or other health professional. The petitioner calls for the International Classification of Functioning, Disability and Health (CIF) to be used for assessment purposes in order to ensure fair, equal and uniform criteria.

The ICF is sometimes described as a ‘model’ of disability but, in practice, it **provides an objective technical language or glossary of description** that bridges across different models. The concept of **disability** is not defined in ICF but used as a **broad ‘umbrella’ term**, which may be considered in terms of: Bodily functions, Activities, Participation, and Environmental factors. It is compatible, but should not be confused, with the International Classification of Diseases (ICD). It accommodates approaches to disability assessment that take account of factors associated with the person and with the environment (i.e. people with impairments and disabling barriers).

The ICF framework of classification was endorsed by 191 WHO Member States in 2001 as an international standard to describe and measure health and disability.<sup>45</sup> Several EU Member States have based recent disability assessment reforms on ICF classification tools, in projects supported by EU funds for technical assistance (as shown later in chapter 4). The ICF framework therefore carries a high level of international legitimacy among governments and health authorities. Thus, Eurostat’s glossary on ‘disability’ observes simultaneously the interactive definition of disability in the CRPD, and that:

The International Classification of Functioning, Disability and Health (ICF) is a framework for defining and measurement of functioning and disability. Disability is conceived as an umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between a person’s health condition(s) and that individual’s contextual factors (environmental and personal factors).<sup>46</sup>

The ICF classification system breaks down each of these domains into sub-categories and descriptors. For example, the domain of **‘activities and participation’** includes:

- Learning and applying knowledge
- General tasks and demands
- Communication
- Mobility

<sup>45</sup> Fifty-Fourth World Health Assembly (2001) *International classification of functioning, disability and health*, Agenda item 13.9, WHA54.21 [https://apps.who.int/gb/archive/pdf\\_files/WHA54/ea54r21.pdf](https://apps.who.int/gb/archive/pdf_files/WHA54/ea54r21.pdf)

<sup>46</sup> Eurostat (2019) *Glossary: Disability* <https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Glossary:Disability>

- Self-care
- Domestic life
- Interpersonal interactions and relationships
- Major life areas
- Community, social and civic life

While the '**environment**' factors include:

- Products and technology
- Natural environment and human-made changes to environment
- Support and relationships
- Attitudes
- Services, systems and policies

In this way, across the four domains, the ICF provides a standardised technical language to describe human functioning and disability, based on a multi-dimensional model of interaction between people's 'health' characteristics and any aspect of their environment. The classification assumes that both impairment (health) and environment (barriers) may contribute to 'disability' but it is neutral on the question of causality because it does not assume that a lack of functioning is caused by one or other, or by a mix of factors.

The ICF framework also makes an important distinction between a person's current '**capacity**' to perform an activity, without intervention or assistance, and their **actual performance** of that activity in the full context of their environment and other personal factors (including factors not connected with health, such as age, gender, education and so on).<sup>47</sup> The components of the ICF, as summarised in the World Bank study, are shown in Table 4.

The ICF has provided a **conceptual framework for international data collection** concerning the population of people with impairments in official statistics, incorporating question items recommended by the United Nations Washington Group on Disability Statistics. However, their Short and Long version question sets focus on difficulties in individual aspects of basic functioning – vision, hearing, mobility, cognition and communication – rather than contextual factors.<sup>48</sup> At a basic level, they provide a simple (and mutually recognisable) tool for the identification of people with impairments, who might face disabling barriers, but do not assess the causes or remedies of their situation.

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<sup>47</sup> Bickenbach, J., Posarac, A., Cieza, A., & Kostanjsek, N., *Assessing disability in working age population: a paradigm shift from impairment and functional limitation to the disability approach*, World Bank Group, 2015, <https://documents1.worldbank.org/curated/en/272851468164970738/pdf/Disability-Assessment-Report-June-18-2015.pdf>

<sup>48</sup> Washington Group on Disability Statistics *Question Sets*, undated <https://www.washingtongroup-disability.com/question-sets/>

Table 4: Components of the ICF model

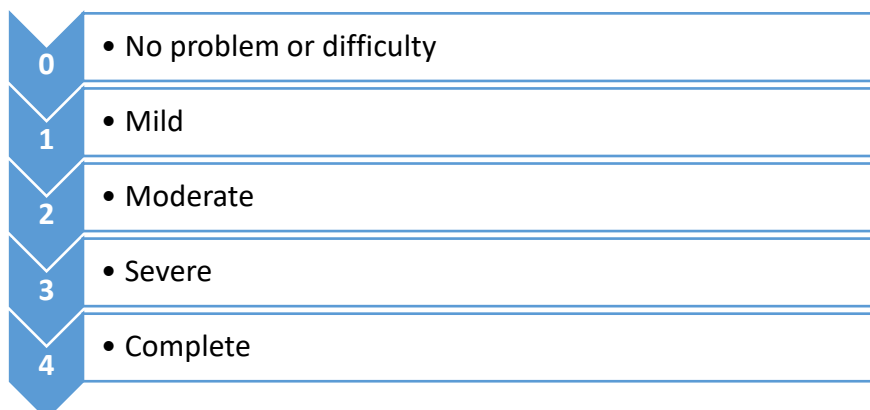
Positive	Negative
<b>Body Functions</b> are the physiological functions of body systems (including psychological functions)	<b>Impairments</b> are problems in body functions or structures such as significant deviation or loss
<b>Body Structures</b> are anatomical parts of the body such as organs, limbs and their components	
<b>Activity</b> is the execution of a task or action by an individual	<b>Activity limitations</b> are difficulties an individual may have in executing activities
<b>Participation</b> is involvement in a life situation	<b>Participation restrictions</b> are problems an individual may experience in involvement in life situations
<b>Facilitators</b>	<b>Barriers</b>
<b>Environmental Factors</b> make up the physical, social and attitudinal environment in which people live and conduct their lives and can act as facilitator or barrier	
<b>Personal Factors</b> are the particular background of an individual's life and living and comprises features of the individual that are not part of a health condition or health state.	

Source: Adapted from Table 3.1 in the World Bank study

## 2.4. Transferable assessment tools based on the ICF

For assessment purposes, any ICF component requires a qualifier to describe the degree of severity. This is usually expressed on a five-point scale from 0 (no problem or difficulty) to 4 (a complete problem or difficulty, implying a total absence of functioning in this area due to personal or environmental factors).

Figure 2: ICF qualifiers of severity



As suggested in Table 4 above, difficulties identified in the ICF domain of 'Body structures' or 'Body functions' represent 'Impairments'. Difficulties in the domain of 'Activity' represent 'Activity limitations'. Difficulties in the 'Participation' domain represent 'Participation restrictions'. For the environmental factors, a severity score refers to the extent to which that factor is an enabler or a barrier to functioning. A severity qualifier should be applied to both the capacity for performance and the actual performance

– evidencing the gap between them. For example, shopping is defined as follows in ICF category d6200 (classified under the parent categories of 'Domestic life' and 'Acquisition of goods and services'):<sup>49</sup>

Obtaining, in exchange for money, goods and services required for daily living (including instructing and supervising an intermediate to do the shopping), such as selecting food, drink, cleaning materials, household items, play and recreational materials or clothing in a shop or market; comparing quality and price of the items required, negotiating and paying for selected goods or services and transporting goods.

Thus, a person who has a 'complete' lack of capacity to walk without assistance (ICF category d450 = 4) might experience 'severe' difficulty in shopping in their current environment (d6200 = 3 for performance). This might be due to environmental barriers, such as a lack of 'Assistive products and technology for personal indoor and outdoor mobility and transportation' (category e1201) or 'Personal care providers and personal assistants' (category e340). However, the same person might experience only 'mild' difficulty in shopping if such facilitators were provided (changing the performance to d6200 = 1). In principle, the ICF general classification system provides an internationally recognised and validated technical language to express such situations, although it does not set thresholds for the scores given by individual assessors.

Based on the ICF framework, tools have been developed and tested to assist in disability assessment. These include **Core Sets of items** selected from the ICF, relevant to clinical practice and based on expert consensus.<sup>50</sup> An **ICF Checklist** was developed as 'a **practical tool to elicit and record information on the functioning and disability of an individual**'.<sup>51</sup> This suggests a standardised form for recording the scoring from an assessment of impairments, activity limitations, participation restrictions and environmental factors, along with general health information and contextual information. In this tool, the definition of qualifying scores is more explicit, and quantified:

0. **No difficulty** means the person has no problem
1. **Mild difficulty** means a problem that is present less than 25% of the time, with an intensity a person can tolerate and which happens rarely over the last 30 days.
2. **Moderate difficulty** means that a problem that is present less than 50% of the time, with an intensity, which is interfering in the persons day to day life and which happens occasionally over the last 30 days.
3. **Severe difficulty** means that a problem that is present more than 50% of the time, with an intensity, which is partially disrupting the persons day to day life and which happens frequently over the last 30 days.
4. **Complete difficulty** means that a problem that is present more than 95% of the time, with an intensity, which is totally disrupting the persons day to day life and which happens every day over the last 30 days.
8. Not specified means there is insufficient information to specify the severity of the difficulty.
9. Not applicable means it is inappropriate to apply a particular code.

<sup>49</sup> International Classification of Functioning, Disability and Health (ICF) d6200 Shopping <https://icd.who.int/dev11/l-icf/en#/http%3a%2f%2fid.who.int%2fid%2fent%2f88971939>

<sup>50</sup> Bickenbach J., Cieza A., Selb M., & Stucki G. (eds), *ICF Core Sets: Manual for Clinical Practice*, Hogrefe, Göttingen 2020 <https://www.icf-casestudies.org/introduction/introduction-to-the-icf-core-sets/icf-core-set-manual>

<sup>51</sup> ICF Checklist Version 2.1a, Clinician Form <https://cdn.who.int/media/docs/default-source/classification/icf/icfchecklist.pdf>

The **WHO Disability Assessment Schedule** (currently WHODAS 2.0) was then intended 'to provide a standardized method for measuring health and disability across cultures', as a practical tool for use by researchers or clinicians to administer in 5-20 minutes.<sup>52</sup> This includes selected items from the ICF, covering its six domains of functioning in a general way to produce standardised disability levels or 'profiles', as illustrated in Table 5.

Table 5: Scoring profile of the ICF domains using WHODAS 2.0

Difficulty	None	Mild	Moderate	Severe	Extreme
Domain	0	1	2	3	4
Cognition					
Mobility					
Self care					
Getting along					
Life activities					
Participation					

There are **different versions** of this Schedule, of varying length and format. The longest version has 36 items (see Annex A) and the shortest version has 12 items (as summarised in Table 6).

Table 6: Short-form questions from WHODAS 2.0

In the past 30 days, how much difficulty did you have in:	
<b>S1</b>	Standing for long periods such as 30 minutes?
<b>S2</b>	Taking care of your household responsibilities?
<b>S3</b>	Learning a new task, for example, learning how to get to a new place?
<b>S4</b>	Joining in community activities (for example, festivities, religious, or other activities) in the same way as anyone else can?
<b>S5</b>	How much have you been emotionally affected by your health problems?
<b>S6</b>	Concentrating on doing something for ten minutes?
<b>S7</b>	Walking a long distance such as a kilometre [or equivalent]?
<b>S8</b>	Washing your whole body?
<b>S9</b>	Getting dressed?
<b>S10</b>	Dealing with people you do not know?
<b>S11</b>	Maintaining a friendship?
<b>S12</b>	Your day-to-day work/school?

<sup>52</sup> Ustun, T., Bedirhan, K., Chatterji, S., Rehm, J. & World Health Organization, *Measuring Health and Disability: Manual for WHO Disability Assessment Schedule WHODAS 2.0*, 2010, <https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health/who-disability-assessment-schedule>

While there are some presentational tensions between WHODAS guidance and a social model or rights-based approaches, such as the terminology of 'burden of disease' in the operational manual, this kind of tool has **potential for application in a mutual recognition system**. For example, mutual recognition among the Member States of a basic personal disability scoring profile, like the WHODAS, might make mutual recognition of disability status and consequent entitlements easier to manage. This kind of scoring data is also easily encoded and translatable.

The WHODAS reference period for the assessment questions refers to 'the **past 30 days**', averaging good and bad days, whereas most disability determinations in EU Member States assume that functional limitation has lasted, or is expected to last, for a longer period (typically 6 or 12 months). For example, EU social surveys typically ask for a self-assessment of 'activity limitation' using the following **Global Activity Limitation Indicator (GALI)**.<sup>53</sup>

For at least the **past 6 months**, to what extent have you been limited because of a health problem in activities people usually do? Would you say you have been ... severely limited / limited but not severely or / not limited at all?

Similar time frames are typical of those used in national disability registration schemes or disability benefit eligibility criteria.

Nevertheless, WHODAS 2.0 is **consistent with the CRPD** in recognising an interactive concept of disability and it acknowledges that medical diagnosis is insufficient to predict service needs, benefit entitlement or work capacity, for example.

It is difficult to define and measure disability, because disability is related to many life areas, and involves interactions between the person and his or her environment (p3).

The Schedule has shown strong cross-cultural reliability. It can be considered for self-administration, or by interview or proxy completion. Testing suggests that its scoring could also be converted to the kinds of % scales used by several Member States to classify severity of impairment (see section 2.5). For example, more than 90% of the population are predicted to score less than 35 points on the long version of WHODAS 2.0, more than 98% to score less than 70, and half the population to score around 1 or 2 points. For the short version, the prediction is that half the population score zero. WHODAS has been trialled for disability certification (using the long version in Nicaragua)<sup>54</sup> and evaluated in European countries for various purposes. For example, it was found to be a useful instrument for disability assessment by general practitioners (GPs) in **France**,<sup>55</sup> for measuring functioning and disability in **Germany**,<sup>56</sup> and **Italy**.<sup>57</sup> It has been piloted and evaluated in recent disability assessment reforms in **several EU Member States** (as shown in the case studies in chapter 4). To summarise, the **WHODAS tool exists in several versions to produce a general assessment scoring profile across the ICF's six domains of functioning, which is broadly consistent with a CRPD concept of**

<sup>53</sup> Eurostat (2022), *Glossary: Activity limitation*

[https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Glossary:Activity\\_limitation](https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Glossary:Activity_limitation)

<sup>54</sup> Ministerio de Salud, *Programa Nacional de Rehabilitación. Certificación de la discapacidad en Nicaragua* [Certification of disability in Nicaragua]. Managua, Ministerio de Salud — Programa Nacional de Rehabilitación, 2004

<sup>55</sup> Norton J., de Roquefeuil G., Benjamins, A., Boulenger, J-P. & Mann, A., 'Psychiatric morbidity, disability and service use amongst primary care attenders in France', *European Psychiatry*, 2004, vol. 19, pp. 164–167.

<sup>56</sup> Posl, M., Cieza A. & Stucki G., 'Psychometric properties of the WHODASII in rehabilitation patients'. *Quality of Life Research*, 2007, 16(9), pp. 1521–1531.

<sup>57</sup> Federici S., Meloni, F., Mancini, A., Lauriola, M., & Olivetti Belardinelli, M., 'World Health Organisation Disability Assessment Schedule II: contribution to the Italian validation', *Disability and rehabilitation*, 2009, 31(7), pp. 553–564..

**disability and has been validated for purposes of disability assessment and determination in European countries.**

## 2.5. Main types of disability assessment

The **Council of Europe's 2002 study on disability assessment** set out a baseline typology of different approaches to disability assessment in use at that time, and prior to drafting of the UN CRPD. The starting point for the study was broad:

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. (p. 10)

In this context, 'something' refers to the **allocation of social benefits or allowances**. The different approaches taken to assess eligibility or entitlement to benefits in **cash** (such as disability pensions) or in **kind** (such as assistance in everyday living) were then assessed in 22 countries.<sup>58</sup>

Three main types of assessment were considered initially (characterised as Barema assessment scales, needs assessments, and functional assessments). The study found, **at that time, that most European countries legislated for some kind of 'scale' of disability of the first type (a Barema)**. A frequent feature was to express the outcome of an assessment as a **single percentage figure** – to convey the degree or level of impairment/disability that was attributed to a person (e.g. an administrative status of '50%' disabled, or having a capacity of '66%', etc.). Such scales have a long history in Europe, particularly in assessing claims for personal loss through accident or injury. Nevertheless, the **methods of scale measurement and calibration differed considerably between countries**. Some were more focused on a **person's bodily characteristics**. Others placed **more emphasis on functioning and social context**.<sup>59</sup>

Likewise, the functional category of assessment (i.e. what a person can do) has often involved the use of measurement scales but can be a qualitative assessment. The concept of needs assessment is perhaps self-explanatory, being widely used to assess needs for social support and practical assistance. It often involved more social and contextual knowledge of the person, and was often more tailored to individual circumstance. In practice, these 'types' also overlapped.

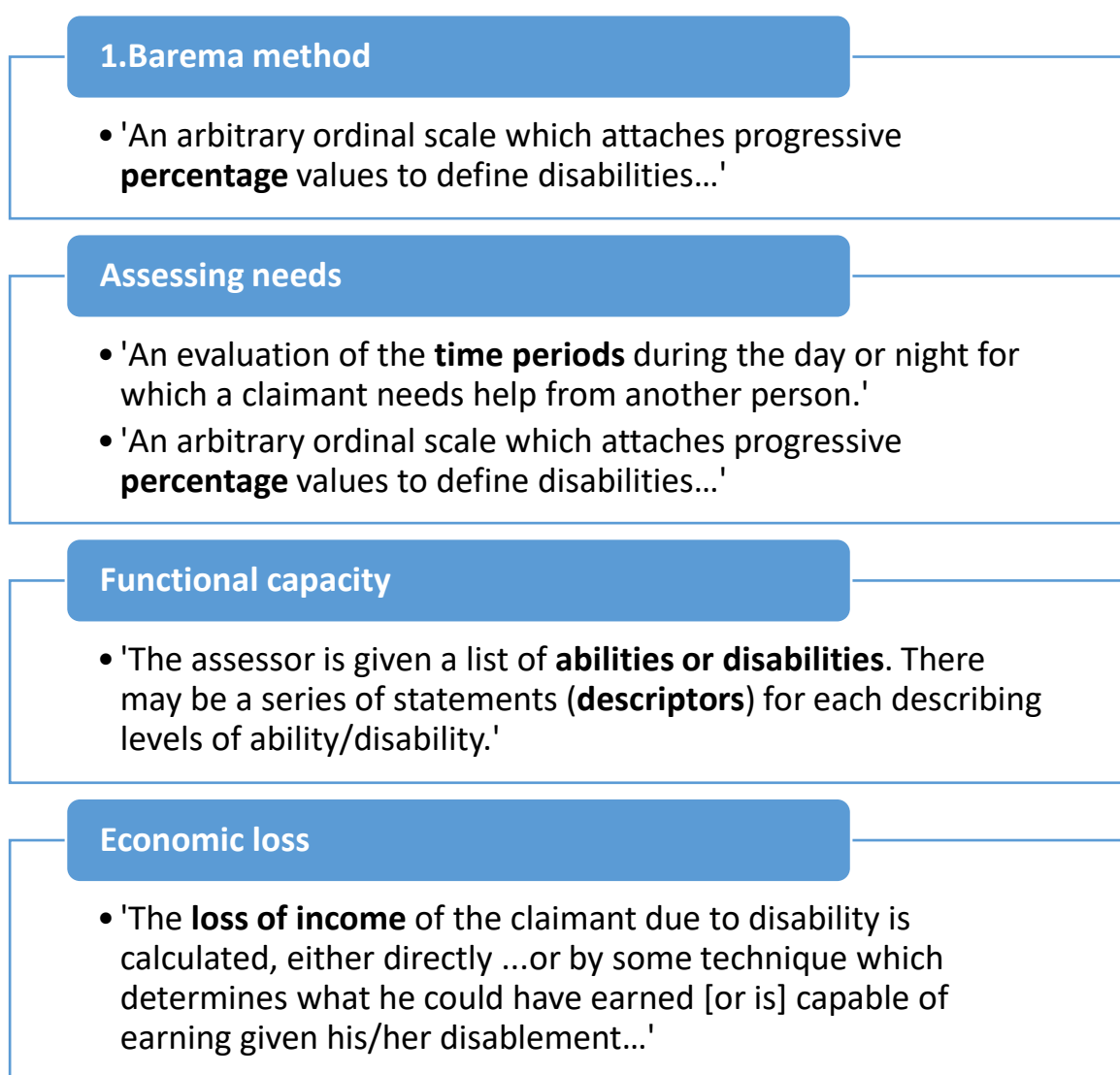
Further to assessments based on the Barema method, the assessing of needs, and functional capacity, a fourth type was then added to recognise **assessments that were based specifically on economic loss criteria** (such as a person's loss of income consequent upon disability, or additional costs of living associated with disability). These types are summarised in Figure 3.

<sup>58</sup> See table 4 in the CoE report (pp. 32-33), and table 5 (p. 33)

<sup>59</sup> Laroche, L., 'European Disability Baremas'. In Council of Europe, *Assessing Disability in Europe – Similarities and Differences*, 2002, pp. 71-134.



Figure 3: Examples of basic types of disability assessment



Source: Adapted from CoE 2002

The CoE study group identified **two trends** in disability assessment - a movement from measures of bodily impairment to measures of 'disability' (i.e. the social consequences of disability), and from a reliance on medical knowledge to multidisciplinary expertise.<sup>60</sup> This represented a shift from assessing a person's 'losses' or deficits in isolation towards assessing their capacities in context. The conclusions from their comparative analysis highlighted two concrete goals for disability assessments, to establish for each person:

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.

<sup>60</sup> Fratello, F & Scorretti, C., 'Comparative analysis of the typology of assessment criteria used for the allocation of benefits in cash and in kind to persons with disabilities', In Council of Europe, *Assessing Disability in Europe – Similarities and Differences*, 2002, pp. 135-156.



**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. (p. 155, emphasis added)

In summary, assessment needs to be **personalised** but not 'individualised' (i.e. it should consider the disability situation of the person in a holistic way, taking account of environmental factors and not only individual factors such as evidence of a health condition).

The **2015 World Bank study** also classified assessment methodologies into **three main types – impairment approaches, functional limitation approaches, and 'disability' approaches (based on an interactive interpretation of disability, broadly in line with ICF and CRPD)**.<sup>61</sup> The impairment approach assesses information mainly about health conditions, often based on medical knowledge and diagnostic criteria. The functional limitation approach focuses on performance of basic activities, such as 'activities of daily living', but often in isolation from real world tasks. The disability approach, which they base on the WHO ICF model, involves:

a full, direct and non-inferential description of all relevant dimensions of, for example, work capacity, including health condition, impairments, functional limitations and personal and environmental factors. (p. 10)

The study assessed the strengths and weaknesses of each approach and reviewed the main assessment tools available around the world to collect information and to classify results. This is summarised in Table 7).

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<sup>61</sup> Bickenbach, J., Posarac, A., Cieza, A., & Kostanjsek, N., *Assessing disability in working age population: a paradigm shift from impairment and functional limitation to the disability approach*, World Bank Group, 2015, <https://documents1.worldbank.org/curated/en/272851468164970738/pdf/Disability-Assessment-Report-June-18-2015.pdf>

Table 7: Impairment, functional and 'disability' approaches to assessment

Approach	Conception of 'disability'	Standardize tool or Guideline	Criteria
<b>IMPAIRMENT</b>	<b>Medical</b>	<b>Impairment guidelines</b>	<b>'Baremas' criteria</b>
	Health state (injury, disease or syndrome), plus problems with body functions and structures	AMA guidelines for the evaluation of permanent impairments (6th ed.)	Presence of problem at the body level as indirect indicator of 'whole person' or disability rating
<b>FUNCTIONAL</b>	<b>Functional</b>	<b>Functional capacity evaluations</b>	<b>ADL/IADL criteria</b>
	Problems or limitations in basic activities	Functional status questionnaire Disability assessment structured interview Work ability index, etc.	Presence of a problem or limitation in basic activity as indirect indicator of disability rating
<b>DISABILITY</b>	<b>Disability</b>	<b>Disability assessment</b>	<b>Bio-psycho-social criteria</b>
	Disability is the outcome of an interaction of health condition and environmental factors at the body, person and societal levels	WHODAS2 ICF Checklist ICF Core Sets	Description of kind and severity of disability as an outcome of interaction between an individual's health and functional capacity and environmental factors

Source: Adapted from Table 2.1 in the World Bank study

The typologies proposed in previous studies were further elaborated in **ANED's 2018 study of disability assessments**.<sup>62</sup> For example, this distinguished traditional Barema scales, which have been often influenced by medical concepts in their design, from disability assessments based solely on medical diagnostic labels.

In some assessments, the **confirmation of a medical diagnosis** is sufficient, on its own, to establish entitlement to a social benefit. Such diagnosis might be made by a personal physician or by a medical officer acting for the administrative authority. This might include, for example, diagnosis of a named health condition from a statutory list, or a medical diagnosis determining that a person is terminally ill. In this way, medical diagnosis (without any further assessment of functioning) sometimes serves as a short cut, or fast track, to determination of disability status. There are some cases, for example, of diagnostic shortcuts for cancer patients undergoing certain types of treatment, or for terminally ill benefit claimants. In such cases evidence of medical diagnosis/prognosis can be an administratively efficient mechanism to avoid unnecessary stress and delay in reaching a disability determination. Nevertheless, a reliance on medical diagnosis in general systems of disability assessment should be the exception rather than the rule.

Another elaboration noted by the ANED study was the identification of **'procedural' assessment** as a distinct type. Rather than assessing the person, their health conditions, or their functional capacity at a

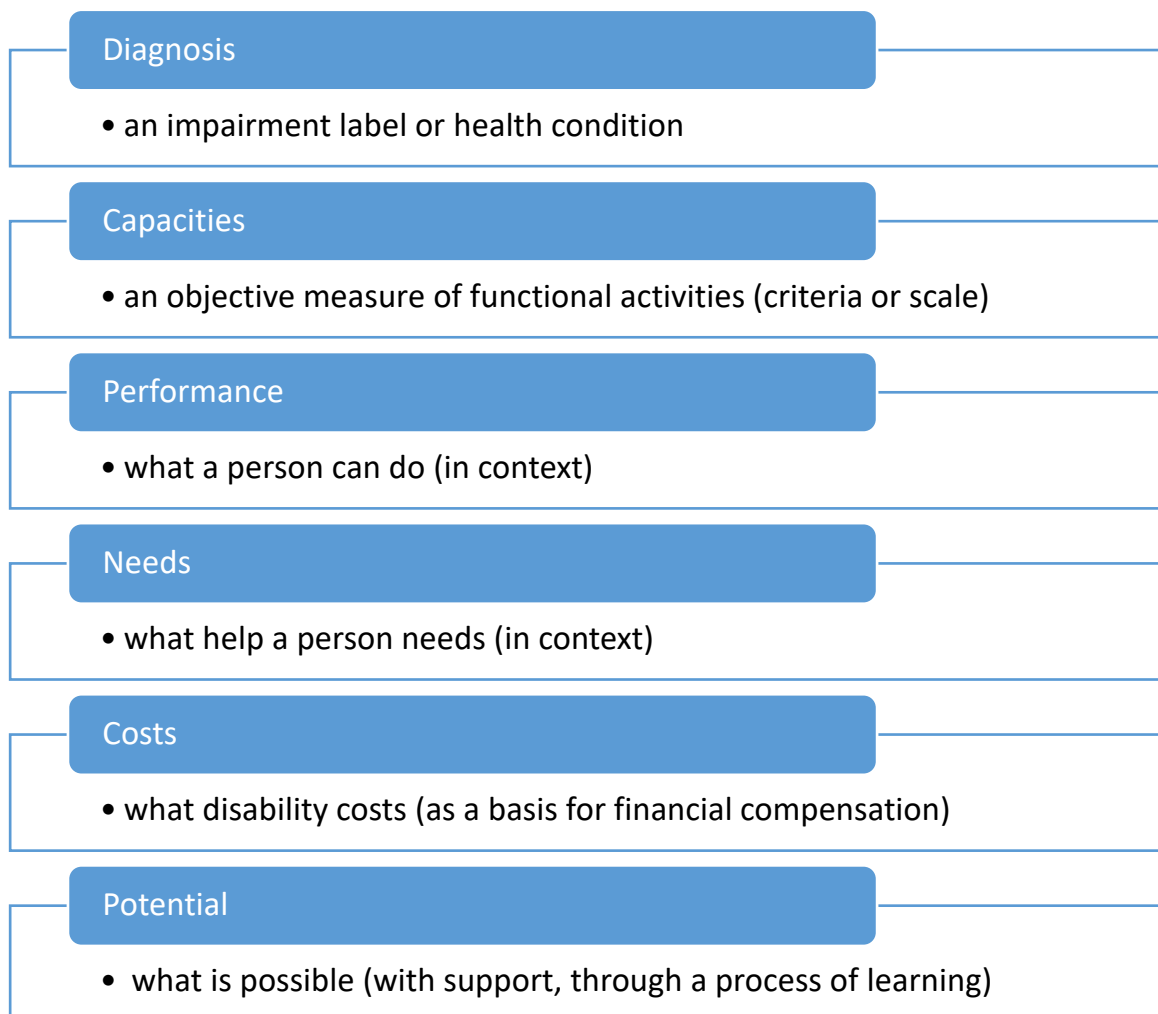
<sup>62</sup> Waddington, L., Priestley, M & Sainsbury, R., *Disability assessment in the European States*, on behalf of the Academic network of European disability experts (ANED), with contributions from the ANED country experts, 2018. <https://www.disability-europe.net/downloads/899-aned-year-3-policy-theme-synthesis-report-2017-18>

single point in time, a procedural approach suggests a more dynamic process. The CoE study used the example of a 'step by step' approach to work capacity assessment in Sweden, whereby work potential was explored over time and in context before reaching any categorical determination of disability status. This might involve multiple assessment points of different kinds, considering the outcomes of rehabilitation interventions, and the availability of suitable jobs in the labour market, before determining that disability is the key factor. Thus, the CoE 2002 study observed that:

One question about the procedural approaches which is difficult to answer clearly is whether a person who reaches the end of the process without returning to work must necessarily be classified as 'disabled'. Another way of putting this question is to ask how much flexibility institutions have to determine at some stage that the person's main obstacle to resuming employment is not disability. (p. 44)

By admitting the procedural approach as a distinct type, and adapting some of terms used in the various studies mentioned so far, a **modified typology of disability assessments** might be summarised as follows (Figure 4):

Figure 4: Modified typology of disability assessments



**Holistic forms of disability assessment might incorporate elements from several, and possibly all, of these types.** It is likely that medical diagnosis/prognosis will continue to play some part in some disability assessments, and for some people a medical diagnosis may be sufficient evidence to trigger

a rapid policy process – in exceptional cases. Likewise, the development of objective scale measures of functioning has some value in terms of efficiency but 'fixing' a person's disability status without reference to context lacks policy relevance. In practice, it is likely that the weight given to assessments of capabilities and needs, in context of a person's environment, will continue to increase. Alongside these, consideration may be given to assessments of disability-related costs and to the potential for change in a person's situation.

The following chapters in this study illustrate the strengths and weaknesses of different approaches, examples of their application in the EU Member States, recent reforms and trends (in particular, since publication of the most recent studies referred to so far). A key challenge is not only the diversity of disability assessment systems in the European context but also their compliance with the global human rights framework of the UN CRPD.

### 3. EXAMPLES OF ASSESSMENT IN THE MEMBER STATES

#### KEY FINDINGS

Existing **disability assessment approaches** in the Member States **vary widely** but **trends** are evident – moving away from medically dominated approaches and fixed scales of measurement, towards more needs-based or socially contextualised assessments. Medical diagnoses or individual assessments of functioning are not sufficient. Examples of disability assessment and classification criteria for the purposes of providing **‘invalidity’ pensions and ‘long-term care’ assistance** illustrate the differences of approach and outcome. These examples show the need to tailor disability assessments to policy function, as well as administrative efficiency. A **holistic assessment** that is sensitive to individual needs and capacities, in context of specific environments and barriers, is **preferable in practice but difficult to standardise**.

Some disability assessments lead to generic determinations of administrative disability status, which in turn lead to multiple entitlements. These are evident in the operation of national disability registers or card schemes. However, the problem framing in section 1.3 also underlined the need for sensitivity of assessment design to policy function. This is particularly evident in assessing needs for help and support (for example, at home, in education or at work).

Two policy functions help to illustrate the challenges of mutual recognition in different social policy fields. These are **assessments of work capacity**, often leading to award of a **disability pension (or ‘invalidity’ benefit)**, and **assessments of needs for support with daily living (or ‘long-term care’)**.

A summary comparison of the two policy functions used for illustration in this chapter is shown in Table 8. The variation in assessment criteria among EU Member States can be observed in more detail in the summary information they share in the EU’s Mutual Information System on Social Protection (MISSOC), as updated in January 2022. These two policy functions were also among those examined in the 2018 ANED study, and in other studies outlined in chapter 1.5. The following sections illustrate the variations among the Member States, based on this published evidence.

Table 8: Comparison of assessment and mutual recognition in two different policy functions

Assessment of	General features	Entitlement	Category	EU mutual recognition and transferability?
Work capacity	Often using fixed measurement scales and categorical determinations of disability status	Disability pension or 'invalidity' benefit (cash)	Social security	Yes  EU Regulation: contributions and entitlements are often transferable, but no harmonization of assessment methods or eligibility criteria
Needs for support with daily living	Usually needs-based and discretionary methods, prescribing the type of support required to live independently in the community	Support services, personal assistance, 'long term care' (kind)	Social assistance	No

### 3.1. Assessing capacity for work

**One of the most common policy functions of disability assessment is to determine capacity for work** (e.g. the extent to which a person is judged to have '**reduced capacity**' or '**incapacity**' for work). The policy concept is somewhat **controversial** from a social model of disability perspective, or from the perspective of the CRPD, because disability arises in the interaction between a person and an **environment**. Someone who is 'unable' to work in one set of circumstances (e.g. in an inaccessible workplace, without accessible transport to work, or with a lack of individually tailored employment support services) might be 'able' to work in a more enabling set of circumstances. Therefore, any approach to assessing capacity for work and employment should take account of **context** and **circumstances** as well as **individual functioning**, but most of these assessments rely on measures of individual functioning or diagnosis alone and do not reference actual work tasks or work environments.

The most concrete example in the Member States is the determination of **work capacity** for the purpose of awarding '**invalidity**' **pensions**. This terminology is outdated, and potentially offensive, but remains commonly in usage for categorising some regulation and data collection. In general terms, as employed within the context of social security policies, it refers to an **inability to perform 'any gainful activity' (paid employment)** and not just a person's previous occupation. The degree of reduced capacity that is required to qualify for such benefits can vary considerably between countries, but it should relate to a permanent or long-lasting condition beyond the normal time frame of temporary sickness benefits (e.g. six or 12 months).

Under the Basic Regulation (EC) No 883/2004:

For invalidity benefits, a system of **coordination** should be drawn up which respects the specific characteristics of national legislation, in particular as regards **recognition of invalidity and aggravation** thereof.

The existing regulations have established rules and mechanisms for the **mutual recognition and transferability of contributions and entitlements to such benefits, but they do not regulate the**

**method of disability assessment use to determine a person's eligibility.** This means that while a person's past contributions in one Member State might be recognised in another Member State, their level of capacity (functioning, or ability to work) might not be recognised.

The concerns of citizens, as expressed in petitions, are of two types (see chapter 1.2). On the one hand, citizens complain that they cannot easily transport disability benefits awarded in one Member State to another. On the other hand, they complain that disability assessment is not consistent between Member States or third countries. Questions concerning the portability of benefit entitlements were briefly reviewed in chapter 1.4. Suffice to say that **while some social security entitlements are portable** under existing agreements and regulations, **social assistance benefits resulting from discretionary assessment are not.** The focus here is on the assessment.

The European system of integrated social protection statistics (ESSPROSS), while including other benefits, refers within its 'Disability' category to benefits that:

provide an income to persons below standard retirement age as established in the reference scheme whose ability to work and earn is impaired beyond a minimum level laid down by legislation by a physical or mental disability;<sup>63</sup>

Determining this **minimum level of ability to work**, as a basis for awarding disability benefits, is one of the key functions of disability assessment in the Member States. As the above guidance points out:

The expression "beyond a minimum level laid down by legislation" used in this chapter implies significant differences among disability arrangements in the Member States. For example, disability is often measured in terms of inability to earn, assessed by comparison with standards, normally an average worker with the same employment status, age, skill, or training as the disabled person. In some countries there are additional criteria such the possibility or not to get a paid job (The Netherlands) or social conditions and the likelihood of deterioration or improvement (Denmark).

Within the framework of the **Mutual Information System on Social Protection in the European Union (MISSOC)**, administered by DG EMPL, the Member States exchange information on social protection.<sup>64</sup> This includes basic information about the assessment criteria and methods of determination relating to 'invalidity' benefits (validated by national authorities). The information on assessment criteria, reported by the Member States to MISSOC, is reproduced in Annex B.<sup>65</sup>

Several Member States employ a Barema type method of categorisation but the % capacity threshold that they use differs considerably. The summary information provided by Member States to the MISSOC tables show a **wide variation in the eligibility criteria applied to disability pensions.** For example, the minimum reduction in capacity that qualifies for benefit appears to vary from 20-25% in Malta, Latvia or Sweden, to 66% in Belgium, Cyprus, Italy, France or Portugal (see). But the **methods and assumptions used to arrive at these percentage values also differ** and are not directly comparable. Some reference capacity for any work. Others reference capacity for the person's most recent or usual occupation. Some are based on measures of 'health' or the attribution of different percentages to specific diagnostic labels. Similarly, while Austria, Bulgaria, Croatia, Greece, Romania and Slovenia all

<sup>63</sup> Eurostat, *European system of integrated social protection statistics — ESSPROS: manual and user guidelines*, 2016, <https://ec.europa.eu/eurostat/documents/3859598/7766647/KS-GQ-16-010-EN-N.pdf/3fe2216e-13b0-4ba1-b84f-a7d5b091235f>

<sup>64</sup> Mutual Information System on Social Protection, <https://www.missoc.org/>

<sup>65</sup> For more information refer to the MISSOC tables for 'Invalidity' at <https://www.missoc.org/missoc-database/comparative-tables/>



appear to require a minimum reduction of capacity of '50%' there are significant differences in how this is measured and determined in practice.

In general, Member States consider only long-term impairment for this type of determination, although **the time period varies** somewhat. Several Member States apply some flexibility in the criteria applied to older workers approaching retirement pension age. Table 9 shows examples of the minimum level (% of reduced capacity) required for eligibility to assistance, and the level required for a determination of total incapacity for work.

Table 9: Examples of Barema criteria for work capacity in EU Member States

Country	Minimum reduction in capacity	Total incapacity
Malta	20%	
Latvia	25%	80%
Sweden	25% (work capacity)	100%
Luxembourg	30%	
Spain	33% (capacity for normal occupation)	100%
Netherlands	35%	100%
Czechia	35% (work capacity)	
Slovakia	41% (work capacity)	70%
Lithuania	45%	75%
Croatia	50%	
Greece	50%	80%
Austria	50% (capacity for work)	
Romania	50% (work capacity)	100%
Slovenia	50% (work capacity)	100%
Bulgaria	50% (working capacity or degree of disability)	
Hungary	60% (state of health)	70%
Finland	60% (work capacity)	80%
Italy	66%	80%
Belgium	66% (earning capacity)	
Cyprus	66% (earning capacity)	
Portugal	66.66% (capacity for normal occupation)	100%
France	66.66% (work or earning capacity)	

Source: Adapted from MISSOC table V

**Not all the Member States adopt this approach**, as the following examples illustrate.

In **Germany**, the criteria for partial incapacity or total incapacity are based on an assessment of the **number of hours of work a person could be able to do**. This is based on capacity for any kind of work, rather than their previous work, and assumes a context of normal labour market conditions and requirements. In this way, a determination of total incapacity assumes capacity to work less than three hours per day (volle Erwerbsminderung), and partial capacity between three and six hours a day (teilweise Erwerbsminderung).

In **Denmark** there is no specification of a minimum level of capacity for work. A more **qualitative judgement** is made for award of the disability pension (førtidspension), to the effect that the person cannot gain a living from any type of work, even with flexibility (as assessed by the local authority and rehabilitation team).

Likewise in **Poland**, the assessment is not measured by percentages but categorised as either partial or total loss of capacity for work. The criteria consider the potential for rehabilitation or retraining (relative to age and education), as well as the current level of impairment, and ability to perform their current work or other kinds of work.

In **Ireland** there is also no specified minimum level of capacity for work. The assessment considers whether a person's restriction in working is moderate, severe, or profound, whether they are unable to work for 12 months or more (Invalidity Pension) or whether their capacity for work is reduced (Partial Capacity Benefit).

In **Estonia**, the judgement is also categorical, whether a person is partially able or not able to work. The assessment is based on parts of the ICF framework, considering whether the person can perform a range of functions repeatedly and safely, without undue stress and discomfort, and their potential for treatment and rehabilitation.

The idea of assessing work capacity more directly, rather than in proxy assessments of functioning, has gained currency. Such **assessment takes account of the working environment and not just the individual's functioning**. Examples of such assessments have been identified in **the Netherlands, Germany, Denmark, Norway, the United States of America, Canada, Australia, and New Zealand**.<sup>66</sup> These may involve assessments of the range of available jobs across the labour market, the person's actual experiences in the labour market, or subjective interpretation by the assessors. Analysing case studies of these approaches, Baumberg Geiger et al. observe the **trend from diagnostic assessment to functional assessment**, and that a similar paradigm shift can be achieved **from functional to direct assessments**. Thus they conclude that:

Direct disability assessment within social security is not just theoretically desirable, but can be implemented in practice (p. 2962).

This conclusion, and lessons learned from the case studies, reinforce some of the arguments advanced by the 2015 World Bank study,<sup>67</sup> which argued that **direct or contextual assessment is a more 'Disability' appropriate approach** than either impairment or functioning focused approaches (as

<sup>66</sup> Geiger, B. B., Garthwaite, K., Warren, J., & Bamba, C., 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*, 2018, 40(24), 2962-2970.

<sup>67</sup> Bickenbach, J., Posarac, A., Cieza, A., & Kostanjsek, N., *Assessing disability in working age population: a paradigm shift from impairment and functional limitation to the disability approach*, World Bank Group, 2015, <https://documents1.worldbank.org/curated/en/272851468164970738/pdf/Disability-Assessment-Report-June-18-2015.pdf>

outlined earlier in chapter 2.1). Based on the interactive understanding of disability embodied in the CRPD and the ICF, the authors of that study underlined that:

... the interactive model presents the phenomena of disability as continuous rather than dichotomous. This means that **disability is also a matter of 'more or less', rather than 'presence or absence'**. The policy consequences of this logical feature of the ICF are twofold: disability needs to be determined, not a priori in terms of some fixed scale but in terms of the **needs and objectives** of a specific policy; secondly, disability is a **dynamic** situation that will change over time, both as the individual health state and level of impairments change, and as the person's environment changes.

The implications are that **some of the processes and criteria used in Member States to assess and determine capacity to work, and thereby administrative disability status, are flawed or outdated**. While there is a role for evidence of diagnosis and functioning in the assessment process (and while such components may be more mutually recognisable), there is a **need for more contextual and dynamic considerations. This means going beyond the assessment of impairment or abstract functioning, to understand a person's needs, capacities and potential in their environment and in changing circumstances**. This type of assessment is more easily illustrated in the following examples.

### 3.2. Assessing needs for long-term support

An equally important policy function for disability assessment in the Member States is to inform the allocation of help in cash or kind **for long-term care and support** (for example to fund a package of help with everyday living tasks, or as a financial allowance towards the costs of arranging such help). This type of help tends to fall into the category of **social assistance** rather than social security. This is an important distinction, in terms of co-ordination and mutual recognition among the Member States, as social assistance is not governed by the same regulations and understandings. Importantly, the European Court of Justice has ruled that **any allowance based on a discretionary assessment of needs is considered as social assistance benefit** (and therefore outside the arrangements for co-ordinated social security benefits).<sup>68</sup>

Eurostat includes, as an indicator in the health and long-term care strand of the Open Method of Coordination, a measure of **'Self-perceived long-standing limitations in usual activities due to health problem'**. This is the same general indicator that is used as a **proxy for 'disability'** in EU statistics. It indicates that around one quarter of the EU population aged over 16 report such limitations, varying from 16.7% in Malta to 37.1% in Latvia in 2020.<sup>69</sup> This indicator is significantly greater among older people than younger people, as impairment onset increases rapidly with age (and therefore higher among women than among men, due to the ageing demographic).

Conceptually, the idea of relating people's experiences of disability with their reported difficulties in 'usual' or 'daily' activities is somewhat **consistent with a social interpretation, or CRPD, approach but there are some tensions**. The commonly used statistical measure defines the problem of activity limitation as being 'due to health problems', whereas the CRPD approach defines it as arising from encounters with disabling barriers. Any assessment of difficulties in daily activities should take account of both the person and their environment.

<sup>68</sup> C-433/13, Commission v. Slovakia

<sup>69</sup> Eurostat, *Self-perceived long-standing limitations in usual activities due to health problem by sex, age and degree of urbanisation* (HLTH\_SILC\_20), 2022 [https://ec.europa.eu/eurostat/databrowser/view/HLTH\\_SILC\\_20\\_custom\\_1757694](https://ec.europa.eu/eurostat/databrowser/view/HLTH_SILC_20_custom_1757694)

The SPC's 2021 *Long-Term Care Report* observed that 'There is no single internationally accepted and standardised definition of what constitutes **long-term care needs**'. The SPC has tended to use data from the **European Health Interview Survey (EHIS)** to estimate the number of people needing long-term care in Europe. EHIS includes a focus on specific activities of daily living (ADLs/IADLs). The survey captures data only from people living in private households (excluding those in residential institutions) and the questions relating to 'Difficulties in personal care and 'Difficulties in household activities' have been addressed only to older age groups. Nevertheless, these items point to the significance of such daily activities in assessing needs for support in everyday living.

#### **EHIS survey questions on 'Functional and activity limitations'**<sup>70</sup>

- **Physical and sensory functional limitations:** Prevalence of physical and sensory functional limitations according to the severity using modalities 'None, Moderate, Severe (including not able at all)'. The indicator refers to the most severe limitation based on reporting on vision, hearing and walking.
- **Difficulties in personal care activities:** Distribution of population aged 65 years and over (55 years and over in wave 3) according to the severity of difficulties in doing without help any kind of personal care activities: 'Feeding oneself, Getting in and out of a bed or chair, Dressing and undressing, Using toilets, Bathing or showering'. The modalities used for disseminating the level of activity limitation are: 'Moderate, Severe, Limited (Moderate + Severe), None'.
- **Difficulties in household activities:** Distribution of population aged 65 years and over (55 years and over in wave 3) according to the severity of difficulties in doing without help significant household activities: 'Preparing meals, Using the telephone, Shopping, Managing medication, Light housework, Occasional heavy housework, Taking care of finances and everyday administrative tasks'. The modalities used for the level of activity limitation are: 'Moderate, Severe, Limited (Moderate + Severe), None'

By contrast with the policy function of awarding disability pensions based on assessments of incapacity to work there are far fewer examples of the Barema scale method in the function of long-term care. Indeed, **most of the general criteria are needs based and non-specific** (while supplemented with detailed guidance for assessors). There are exceptions.

In **Bulgaria**, the award of a social care supplement falls under the Social Insurance Code, and requires assessment of a 90% reduced capacity to work (or degree of disability), as well as the need for ongoing assistance. This contrasts with the minimum threshold of 50% for payment of a disability benefit. In **Italy**, some benefits in kind as well as financial allowances are linked to a minimum threshold percentage of invalidity (Invalidità civile), in this case 45%. In **Latvia**, a person's capacity for independence and self-care is rated on a percentage scale, with a threshold of 75% for the first level of care provision.

Several countries use alternative point scales to measure functioning or to determine need for assistance. In **Belgium**, there are scales for determining care allowances. For example, a person scoring '11 points' on the scale for autonomy might be eligible for assistance of a third party. In **Germany**, at least '12.5 points' are needed to determine a basic level of need for care (Hilfe zur Pflege). In **Czechia** there should be need for assistance in '3 out of 10' basic living needs.

<sup>70</sup> Eurostat, *European Health Interview Survey (EHIS): Reference Metadata*, 2021, [https://ec.europa.eu/eurostat/cache/metadata/en/hlth\\_det\\_esms.htm](https://ec.europa.eu/eurostat/cache/metadata/en/hlth_det_esms.htm)

In some countries the threshold is based on the number of hours assistance that are needed. For example, in **Luxembourg** this is expressed as a need for 'assistance with basic everyday activities for at least 3.5 hours per week'. Such needs are quantified less precisely, for assistance with 'most or all' daily activities, in **Slovenia**, or 'at least once a day' in **Slovakia**. In **France**, different supplements may require need for assistance in 'the majority' of activities of daily living (majoration pour tierce personne) or in 'at least three out of 10' different activities of daily living (prestation complémentaire pour recours à tierce personne).

In approximately **half of the Member States there is no definitive minimum level of need required for the provision of assistance**, in cash or kind. The process is based mainly on **individualised assessments** of needs, usually related to a person's home environment and their circumstances. Nevertheless, similar assessments are often linked to or include measures of performance of daily living activities. These are sometimes translated into a checklist or measurement scale, which may be expressed as a point score. The key point is that disability assessments conducted for the purpose of awarding disability pensions (such as the type of 'invalidity' benefits outlined earlier) tend to adopt more objective or quantifiable methods than assessments for the purpose of providing social assistance in kind (such as personal assistance), which tend to be more holistic and needs based. Nevertheless, needs based assessments often include a quantifiable component, such as a scale referring to activities of daily living.

The variation of approach is summarised, with examples of the type of criteria used, in Table 10, and a compendium of the summary information on assessment criteria, reported by the Member States to MISSOC, is reproduced in Annex C.<sup>71</sup>

The following key findings of the *2021 Long-Term Care Report* reinforce the key points discussed so far:

- Access to social protection coverage for long-term care is often determined via an individual needs assessment
- About half of the Member States regulate a standardised needs assessment at the national level
- In many Member States, the level of support is determined by mapping the result of the needs assessment against predefined thresholds

Table 10: Determining needs for long-term care in the Member States

Country	Minimum level	Examples of assessment criteria
Austria		Need of care for more than 65 hours per month on average
Belgium		At least 11 points according to the guide used for the evaluation of the degree of autonomy
Bulgaria		Reduced capacity to work/ degree of disability exceeding 90%
Croatia		Cannot meet the basic life needs, e.g. in organizing meals, preparing and eating meals, buying groceries, cleaning, etc.

<sup>71</sup> For more information refer to the MISSOC tables for 'Long-term care' at <https://www.missoc.org/missoc-database/comparative-tables/>

Cyprus	No	Ability to carry out their daily home and personal care and to carry out daily activities outside the house (e.g. shopping, doctor visits, social activities).
Czechia	No	Need for assistance in at least 3 out of 10 basic living needs.
Denmark	No	A specific and individual assessment of need for assistance.
Estonia	No	Individual need for assistance based on assessment
Finland		Individual needs and as stipulated in legislation.
France		Not independent in at least three out of 10 activities of daily living
Germany		At least 12.5 points in the assessment
Greece	No	
Hungary		Aa certain type of disability, attested after medical examination
Ireland	No	
Italy		45% incapacity needed for benefits in kind
Latvia		A % of ability for self-care and independency
Lithuania	No	If a person is assessed as partially self-sufficient
Luxembourg		Need for assistance with basic everyday activities for at least 3.5 hours per week
Malta	No	
Netherlands	No	
Poland		Having a disability certificate stating that the person is unable to live independently
Portugal	No	
Romania		Older people who have not completely lost their autonomy and can perform activities of daily life by themselves.
Slovakia		50% of physical, sensory or mental ability to perform basic activities
Slovenia	No	Need for assistance from another person in performing most or all of their daily activities
Spain		At least once a day, requires help to carry out the most essential daily activities
Sweden	No	

Assessments supporting the allocation of support for 'long-term care' or support tend to focus on instrumental activities of daily living (ADL/iADL). The SPC Long-term Care Report suggests that 'About

**half of the Member States regulate a standardised needs assessment at the national level' for this policy function (rather than at local or regional level)** and that:

The common denominator for standardised assessments in Member States is the measurement of dependency on help with ADLs and IADLs, sometimes weighting needs differently in the final assessment ... A cross-country comparison is made difficult by the different national assessment scales, thresholds, and levels of support. **Even within a single Member State, residents in different regions or municipalities may be subject to different entitlement criteria and thresholds, depending on the level responsible for policies (national, regional, local).**<sup>72</sup>

Nevertheless, **in at least half of Member States**, disability assessments to determine claims for social assistance with long-term support, such as practical help at home, are **not standardised and are shaped at the local level** (for example, in municipal social work departments). This presents a barrier to harmonised disability assessment. Nevertheless, it may be possible to promote a common currency of mutual recognition (drawing on the concept of ADLs).

The examples assessments for work capacity and long-term support illustrate the **need to tailor disability assessments to policy function, as well as administrative efficiency**. In any 'test' procedure there is a balancing act between sensitivity and specificity. Holistic and dynamic assessments of disability have high policy relevance (sensitivity). **An assessment that is sensitive to individual needs and capacities, in context of specific environments and barriers, is preferable** but difficult to standardise. Many assessments of needs for support in daily living, in educational settings or in the workplace require this kind of sensitivity to be responsive to circumstances and to provide the right help in the right place at the right time.

On the other hand, **categorical and static determinations of disability status have high administrative efficiency (specificity)**. **The use of standardised assessment tools, with clearly defined criteria and abstract measurement scales, gives the impression of objectivity and legitimacy. They aim to reduce the scope for discretion**, to be more replicable across diverse populations and varying circumstances. The outcomes of such assessments (sometimes expressed as points or scores) can be also more easily recognised beyond the context in which the assessment was carried out. While such measures exist in **social care assessments, for example applying ADL checklists, they are much more common in assessments of eligibility for disability cash benefits** (such as assessments of work capacity for 'invalidity' pensions). They are often used to make **general determinations of disability status or degree**, for policy functions that require people to be distinguished and recognised as either 'disabled' or non-disabled. A general disability register or card recognition system performs this more categorical function (see chapter 5).

<sup>72</sup> Social Protection Committee (SPC) and the European Commission (DG EMPL), *Long-Term Care Report: Trends, challenges and opportunities in an ageing society*, 2021, pp. 38-39: <https://ec.europa.eu/social/BlobServlet?docId=24079>



## 4. EXAMPLES OF RECENT REFORMS

### KEY FINDINGS

There are several recent examples of **disability assessment reform** in the Member States, some of which are ongoing. Some notable projects have received **technical assistance funding** from the Commission and external partners, via the EU Structural Reform Support Programme (SRSP) or the Technical Support Instrument (TSI). These include **reforms of policy systems, assessment methods and administrative processes (including digitalisation)**. A recurrent theme has been the integration of internationally validated tools for functional disability assessment, specifically applications of the WHO Disability Assessment Schedule tool (**WHODAS 2.0**). This may suggest emerging opportunities for agreements among Member States to **mutually recognise** common core components of **assessment**, even where their overall systems and eligibility criteria differ.

As part of the European Disability Strategy, the **Commission** has encouraged the use of **EU technical assistance programmes to support Member States in ‘improving disability assessment methodologies and procedures to contribute to a more holistic assessment of disability that takes better account of functional capacity and individual circumstances’** (for example, in Belgium, Greece, Latvia and Lithuania).<sup>73</sup> This may include assistance in reviewing existing processes and methods, adapting assessment tools, piloting or training in new approaches. In addition to better and more transparent assessment procedures, such projects are intended to reduce administrative burden and delays (both for assessors and for people with disabilities).

Several Member States have engaged in recent or ongoing reforms of disability assessment processes or criteria, either with or without EU assistance. Several projects have been funded from the **Structural Reform Support Programme (SRSP), its successor the Technical Support Instrument (TSI) or from the Recovery and Resilience Facility (RRF)** as part of national reform programmes. The following examples illustrate this (as summarised in Table 11) and are supplemented with further examples, elicited from national experts for the purposes of this study. Ten national case studies are presented.

<sup>73</sup> European Commission, *Reforming the assessment of disability*, 2021, [https://ec.europa.eu/reform-support/reforming-assessment-disability\\_en](https://ec.europa.eu/reform-support/reforming-assessment-disability_en)

Table 11: Relevant projects supported by EU funds

Country	Project title	Funding	Year
Greece	Reform of the disability assessment system – support on the national roll-out	SRSP	2017
Poland	Disability assessment reform	SRSP	2018
Belgium	Disability assessment: introducing a new functionality tool	SRSP	2019
Greece	Technical support for the reform of the disability assessment system	SRSP	2019
Latvia	Evaluation and further development of the Latvian disability assessment system	SRSP	2019
Lithuania	Improving Disability Assessment System in Lithuania	SRSP	2020
Bulgaria	Improving the disability assessment system	SRSP	2020
Slovenia	Review of the pension and disability insurance system	SRSP	2020
Italy	Reforming the disability assessment and social protection system in Italy	TSI	2021

Source: Extracted from the project database of the Structural Reform Support Programme (SRSP) and the Technical Support Instrument (TSI)

#### 4.1. Greece

A unified system of disability assessment in Greece for disability status certification was established for some decades, providing recognition for any legal purpose. This was relatively cost effective and efficient but relied heavily on a **medical approach** to disability, largely **incompatible with CRPD** concepts of disability (relying on a Barema scale adopted in the 1990s, and open to some 'creative' interpretations in practice).<sup>74</sup>

A Centre for Certification of Disability (KEPA) was established in 2011,<sup>75</sup> as part of social security reforms (Law 3863/2010), within the medical division of the Social Security Agency (EFKA), under the Ministry of Labour, Social Security and Social Solidarity. Under its current revised regulation, KEPA remains responsible for initial assessment for disability certification, renewals and appeals.<sup>76</sup>

<sup>74</sup> Pavli, A., *Creative Disability Classification Systems: The Case of Greece 1990-2015* (PhD thesis) Swedish Institute for Disability Research, Orebro University, 2017, <http://www.diva-portal.org/smash/get/diva2:1098338/FULLTEXT01.pdf>

<sup>75</sup> KEPA, *Application for assessment and certification of disability (KPA)*, 2022, <https://www.efka.gov.gr/el/elektronikes-yperesies/aitese-axiologese-kai-pistopoieses-anaperias-kepa>

<sup>76</sup> Gazette of the Government of the Greek Republic (Sheet 4830, No. 83779), *Operating Regulations of the Disability Certification Centre (KEPA)*, 13 September 2022

An EU technical support project was implemented in Greece in **2018-2020**, funded by the Structural Reform Support Programme (SRSP).<sup>77</sup> This focused on the conditions for pilot implementation and national roll-out of a reformed disability assessment system. The project was led by the Agency for Economic Cooperation and Development (AED) in collaboration with the Hellenic Ministry of Labour, Social Insurance and Social Solidarity. This project aimed to adapt and implement a new disability assessment system, including its organisational, processes, methodological dimensions, as well as co-ordination among the implementation partners (including KEPA).

From **2022** the KEPA disability certification procedure and the disability card have been **digitalized**, via a National Disability Portal.<sup>78</sup> This includes the **simplification of online application and certification, with a new Digital Disability Register and a new Disability Card**, which replaces existing disability status documentation and linked to the Register of Benefits (as a 'one-stop' service for pensions, allowances, social and financial benefits or social services).<sup>79</sup> There is intention to implement a more **rights based approach** to disability assessment, make KEPA premises more accessible, and to make the health committees' membership more diverse, including some non-medical health professionals. The reforms are largely financed from **Recovery and Resilience Funds**.

As part of a separate SRSP technical support project on **deinstitutionalisation**, facilitated by the European Association of Service Providers for Persons with Disabilities (EASPD), a **protocol for needs assessment** was also produced in **2021**.<sup>80</sup> This set out a framework of role responsibilities and methodological approaches to needs assessment, supporting transition of childcare and social services system in Greece from institutions towards **community-based services** – by focusing on 'who the person is, not what impairment he/she has'. Hence:

Unlike many existing assessment tools solely focusing on physical, mental and intellectual functional-levels, this protocol seeks to take *a more holistic approach that reflects all aspects of the personality of the persons concerned whilst being in line with the UN Convention on the Rights of the Child (UN CRC) and the UN Convention on the Rights of Persons with Disabilities (UN CRPD)*. (p. 5) [emphasis added]

It is relevant to note that this latter type of needs assessment serves a more specific policy function (preparing people to move from institutions to community living) rather than acting as a generic gateway or passport to transferable disability status recognition.

## 4.2. Italy

There has been **no standardized disability assessment procedure in Italy to certify a legal status of disability**.

**Technical support from DG REFORM** was utilised here, in collaboration with the **OECD**, to develop a project on disability assessment reform and social protection.<sup>81</sup> This project includes development of

<sup>77</sup> AED, *Reform of the disability assessment system: technical support on pilot implementation and the national roll-out in Greece*, 2020, [https://www.aed.or.at/en/aed\\_projekte/reform-of-the-disability-assessment-system-technical-support-on-pilot-implementation-and-the-national-roll-out-in-greece-2/](https://www.aed.or.at/en/aed_projekte/reform-of-the-disability-assessment-system-technical-support-on-pilot-implementation-and-the-national-roll-out-in-greece-2/)

<sup>78</sup> National Disability Portal, <https://epan-wip.services.gov.gr/>

<sup>79</sup> Ministry of Labor and Social Affairs, *The digital KEPA and the Disability Card are coming*, press release, 23 July 2022 <https://ypergasias.gov.gr/erchontai-ta-psifiaka-kepa-kai-i-karta-anapirias/>

<sup>80</sup> European Association of Service providers for Persons with Disabilities, *Needs assessment protocol developed and adapted to Greek context*, 2021, [https://easpd.eu/fileadmin/user\\_upload/D7\\_with\\_layout\\_EN.pdf](https://easpd.eu/fileadmin/user_upload/D7_with_layout_EN.pdf)

<sup>81</sup> OECD, *Improving the disability assessment and social protection system in Italy*, 2021 <https://www.oecd.org/regional/leed/dgref-disability-italy.htm>

a strategy to improve disability information, to assess the Italian system, identify policy options and create an action plan for implementation of reforms in 2023.

A preliminary assessment indicated that **'fragmented legislation** affects Italy's ability to recognise functioning capacities of persons with disabilities... across sectors, such as in labour market, education, health and social policies' and that this results in **inequalities** (p. 2).<sup>82</sup>

In 2021, the Italian Parliament passed enabling legislation, delegating the government to adopt within two years provisions for **reorganising the disability assessment system in accordance with the CRPD and the European Disability Strategy**.<sup>83</sup> This includes a **redefinition of disability, revision of sectoral regulations, assessment processes, and supporting systems to create a multidimensional approach to assessment**:

...in order to guarantee the person with disabilities to obtain recognition of their condition, through *a congruent, transparent and easy evaluation that allows the full exercise of their civil and social rights* (Article 1) [emphasis added]

As in the previous example, the Italian project draws on ICF concepts and terminology to inform its redefinition of disability.

### 4.3. Lithuania

In Lithuania, a combined assessment of disability and work capability is conducted by a subsidiary office of the Ministry of Social Security and Labour (NDNT), which determines a person's 'level' of disability, work capacity or need for care.<sup>84</sup> There are three levels of disability.

The system has been based on medical disability assessment criteria (around 90%) with only minor attention to personal capabilities and no consideration of environmental factors and barriers. Following the reform, medical criteria should be progressively reduced in importance. As the Ministry confirms, in the existing system:

the assessment of disability is partly discriminatory, because the established level of working capacity is associated with a person's work employment or the person's ability to work, but *environmental factors, opportunities to live independently, to participate in public life on an equal basis with other persons are not assessed* at all.<sup>85</sup> [emphasis added]

Lithuania received EU **Structural Reform Support funding to review its disability policy and assessment systems in cooperation with the Commission and the World Bank**. After reporting the wider system, a study published in 2021 outlined the options for reform to incorporate consideration of individual functioning into a new system of assessment.<sup>86</sup> It reported on pilot studies and recommended application of the WHODAS 2.0 tool, in its face-to-face interview form, leading to a

<sup>82</sup> OECD, *Improving the disability assessment and social protection system in Italy: Kick-off meeting*, 2021 <https://www.oecd.org/cfe/leed/Disability-agenda-Kick-off-EN-IT-web.pdf>

<sup>83</sup> LAW 22 December 2021, n. 227, Delegation to the Government in the matter of disability. (21G00254) <https://www.normattiva.it/uri-res/N2Ls?urn:nir:stato:legge:2021-12-22:227>

<sup>84</sup> Disability and Working Capacity Assessment Office, <https://ndnt.lrv.lt/lt/>

<sup>85</sup> Ministry of Social Security and Labour, press release 22 August 2022, <https://socmin.lrv.lt/lt/naujienos/aktualu-zmonems-su-negalia-negalios-nustatymas-ir-socialines-itraukties-sistema-keisis-is-esmes>

<sup>86</sup> Posarac, A., Fellinghauer, C. & Bickenbach, J., *Options for Including Functioning into Disability and Work Capacity Assessment in Lithuania*, 2021 [https://socmin.lrv.lt/uploads/socmin/documents/files/Lithuania\\_Including%20functioning%20into%20DA\\_Final\\_August%202021.pdf](https://socmin.lrv.lt/uploads/socmin/documents/files/Lithuania_Including%20functioning%20into%20DA_Final_August%202021.pdf)

progressive **integration of more functional components into the assessment** over time. The new disability level assessment reform will come **in force not earlier than 2023**.

#### 4.4. Latvia

A similar initiative occurred in neighbouring Latvia, where the same **World Bank** team, also financed by the **EU Structural Reform Support programme** (DG REFORM), examined the disability assessment system in 2019-20.<sup>87</sup> The aim was to support the Ministry of Welfare in enhancing disability assessment through the design and piloting of a standardized measure of functioning, and its links to wider disability and labour market policies.

The Latvian system of disability assessment had been shaped by a **strong reliance on medical information**, linking medical diagnosis to a Barrême index, and classifying **disability status on three levels**. This system, administered by the State Medical Commission for the Assessment of Health Condition and Working Ability, was **amended in 2015** towards an approach informed by the WHO ICF, and taking greater account of **functioning**.<sup>88</sup> Assessment criteria and questionnaires were updated (including self-assessment) but retaining a strong emphasis on medical reports and determined without meeting the person (leading to an increase in contested decisions). This led the study to conclude that: 'Although changes to the regulatory framework have been made with the aim of increasing the importance of functioning in disability assessment, **in practice, no significant changes have taken place**' (p. 64).

A follow up study was published in 2022, along similar lines and in parallel with the Lithuanian study. This included piloting of the WHODAS 2.0 tool in Latvia with more than 2,000 applicants for disability assessment, and an evidenced based assessment of its effectiveness.<sup>89</sup> The study indicated that: 'the current system has difficulties discriminating levels of functioning' (p. 5) and that the use of WHODAS might assist in this (although there were gender effects and other effects to consider). It **recommended transition to a comprehensive disability assessment** based on three forms of evidence - functional information from the WHODAS questionnaire, health information (from medical referral), and information about the applicant's environment (based on self-assessment) concluding that: 'This proposal moves disability assessment system *toward holistic, comprehensive assessment of disability*' (p. 11). [emphasis added]

#### 4.5. Bulgaria

Entitlement to financial support for people with disabilities (under Article 68 of the Persons with Disabilities Act) is determined according to **need, on the basis of an individual assessment** conducted by the Social Assistance Agency.<sup>90</sup>

In **2018**, the **UN CRPD Committee recommended that Bulgaria 'revise** the criteria for assessing the degree of impairment, incorporate the **human rights model of disability** in the assessment process'.<sup>91</sup>

<sup>87</sup> World Bank Group, *Latvia Disability Policy and Disability Assessment System*, 2020 <https://www.lm.gov.lv/lv/media/9799/download>

<sup>88</sup> Ministry of Welfare, *Establishment of disability*, 2020 <https://www.lm.gov.lv/en/establishment-disability>

<sup>89</sup> Fellinghauer, C., Posarac, A., Bickenbach, J. & Jasarevic, M., *Options for including functioning into disability and work capacity*, 2022 <https://www.lm.gov.lv/lv/media/19880/download>

<sup>90</sup> Agency for Social Assistance, *Individual assessment of needs* <https://asp.government.bg/bg/deynosti/sotsialno-podpomagane/podkrepa-na-horata-s-uvrezhdaniya/individualna-otsenka-na-potrebnostite/>

<sup>91</sup> Committee on the Rights of Persons with Disabilities, *Concluding observations on the initial report of Bulgaria*, 2018 [https://tbinternet.ohchr.org/\\_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fBGR%2fCO%2f1](https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fBGR%2fCO%2f1)

The government announced in 2018 proposed changes to the assessment system, using a **more functional approach** based on the World Health Organization's International Classification of Functioning, Disability and Health (ICF).

In **2021**, a **comprehensive analysis of the system for disability assessment** in Bulgaria was initiated by the Ministry of Labour and Social Policy, utilizing EU project funds (EUR 400,000). This involved development of a new tool for individual functional assessment of the needs of people with disabilities in the social assistance system, based on the WHODAS framework and piloted with more than 3,000 potential beneficiaries.<sup>92</sup>

The results were presented in a knowledge exchange discussion organized by the Commission, the World Bank and the Ministry, in which the responsible Minister confirmed that: 'The study proves that *examining only people's health indicators, without considering their functionality, does not allow to make a comprehensive assessment of their capabilities*'.<sup>93</sup> [emphasis added]

## 4.6. Romania

The government requested general assistance from the **World Bank** in reforms of the social protection system, which led to more specific work on reforms of the system for disability benefits, funded in collaboration with **Japan Policy** and **Human Resources** from 2012. The aim was to: 'assist the Ministry of Labor, Family, and Social Protection (MoLFSP) to **develop a more effective protection** of persons with disabilities through **improved disability assessment** and better information on persons with disabilities for policy-making'.<sup>94</sup>

Its objectives sought to develop, 'Improved, harmonized medical and functional criteria for the assessment of disability in place, applied to all persons with disabilities', to reduce costs, and to establish a national database (disability register). It is relevant to note that these objectives, following Romania's ratification of the CRPD in 2010, still emphasised 'medical and functional' criteria for assessment rather than contextual factors. Initial proposals for harmonized criteria were in fact rejected by the Ministry and not completed until later, in 2016, and supporting a new national disability strategy, 'A Society without Barriers for People with Disabilities,' 2016–2020.<sup>95</sup> The strategy included measures to implement a **more holistic psycho-social assessment** beyond medical criteria for assessment noting that:

The evaluation system of people with disabilities still uses medical criteria, *the barriers that limit participation in society and, in particular, employment are not defined*, which, as a consequence, does not allow interventions through diversified services. (p. 23) [emphasis added]

A **National Registry for Persons with Disabilities** (NRPD) was **developed** with technical assistance but **not implemented** during the project. A new project is now in implementation and focused on

<sup>92</sup> Council of Ministers, *Action Plan for the period 2021-2022 for Implementation of the National Strategy for Persons with Disabilities (2021-2030)*, p.42.

<sup>93</sup> Bulgarian Telegraph Agency, *The WHODAS disability assessment program was applied in Bulgaria to 3118 people*, <https://www.bta.bg/bg/news/bulgaria/331777-programata-whodas-za-otsenka-na-uvrezhdaniyata-e-prilozhena-v-balgariya-varhu->

<sup>94</sup> World Bank, *Implementation report for the 'Improved policy making and institutional framework for people with disability project'*, 2018, <https://documents1.worldbank.org/curated/en/517081525364319401/pdf/125233-RO-CLEAN-04262018.pdf>

<sup>95</sup> MoLFSP, Decision approving the National Strategy "A society without barriers for people with disabilities" for the period 2015-2020 and the Operational Plan on the implementation of the national strategy "A society without barriers for people with disabilities" 2015-2020, 2015, <http://www.mmuncii.ro/j33/index.php/ro/transparenta/proiecte-in-dezbatere/4076-2015-10-08-proiecthg-strateg-diz>



‘Modernizing the disability assessment system in Romania’. This covers both assessment for administrative disability status and needs assessment. Its initial report considered the current system in context of aligning this with the ICF,<sup>96</sup> acknowledging that:

There is broad recognition among experts that Romania should reform its disability assessment and determination process, and align it with the ICF standards. (p. 9)

#### 4.7. Slovakia

In Slovakia, reform of disability assessment has been progressed in context of the **National Recovery and Resilience Plan**, which calls for a **more coherent assessment of care needs** for persons with disabilities (Reform 2).<sup>97</sup> The existing system involves various assessments carried out by different agencies. The labour office assessment (for access to financial allowances for assistive devices, personal assistance) and the municipal assessment (for access to long-term care) will be integrated. This is justified on the grounds that:

The assessment of long-term care needs for persons with disabilities is incoherent amid a **fragmented** system. While not the case for the provision of social services, the recognition of severe disabilities is a precondition for the granting of personal assistance and care allowance (p. 109).

The aim of the reform is to **rationalise** the system, ‘remove inefficiencies and red tape’ for assessors, introduce more uniform assessment criteria, and thereby improve the transparency of the assessment process. A project to train on social workers in disability assessment has also started. EU funds (RRF) will contribute to digitisation and infrastructure. Thus:

This reform shall **improve and streamline** the way persons with severe disabilities are recognised. It shall introduce a **unified framework and assessment system for personal assistance and care to persons with severe disabilities**. (p. 113) [emphasis added]

In the revised system, these disability assessments will be administered by 46 branch offices of the Ministry of Labour, Social Affairs and Family. As in the previous examples, the proposed method will be based on the **WHODAS 2.0 assessment framework**, while assessing a wide range of needs.<sup>98</sup>

#### 4.8. Spain

In **2022**, Spain **launched consultation on a draft Decree, ‘establishing the procedure for the recognition, declaration and qualification of the degree of disability’**,<sup>99</sup> and recognizing disability assessment as one of the main social policy challenges in developed countries.

The existing system dates back to 1981 (Royal Decree 1723/1981) and the unification of competences for assessment and recognition of disability status, formerly under the administration of the National

<sup>96</sup> World Bank, *Romania - Diagnosis Report on the Current Disability Assessment System (English)*. Washington, D.C. : World Bank Group, 2021, <http://documents.worldbank.org/curated/en/099450009022244916/P17115703d40a30370b88907be9ee42ef9>

<sup>97</sup> European Commission, *Annex to the Proposal for a Council Implementing Decision on the approval of the assessment of the recovery and resilience plan for Slovakia*, COM(2021) 339 final, 2021, [https://ec.europa.eu/info/system/files/com-2021-339\\_annexe\\_en.pdf](https://ec.europa.eu/info/system/files/com-2021-339_annexe_en.pdf)

<sup>98</sup> See also, Repkova, K.. *Reforming Disability Assessment: Implications for Social Work as Human-Rights Profession*. Uczelna Nauk Społecznych w Łodzi, Poland, 2022.

<sup>99</sup> Draft Royal Decree establishing the procedure for the recognition, declaration and qualification of the degree of disability, [https://www.mdsocialesa2030.gob.es/servicio-a-la-ciudadania/proyectos-normativos/documentos/RD\\_RECONOCIMIENTO\\_DISCAPACIDAD2.pdf](https://www.mdsocialesa2030.gob.es/servicio-a-la-ciudadania/proyectos-normativos/documentos/RD_RECONOCIMIENTO_DISCAPACIDAD2.pdf)



Institute of Social Services (INSERSO).<sup>100</sup> During the 1980s and 1990s, a scale was developed for disability determination and for degrees of disability qualifying for cash benefits.

Following ratification of the UNCRPD in 2007, the national Action Plan for people with disabilities 2009-2012 proposed the development of new scales of disability more consistent with the Convention and with ICF. A State Commission for Coordination and Monitoring of the Assessment of the Degree of Disability prepared a technical proposal for a **more uniform and standardized system**, in collaboration with the autonomous communities.<sup>101</sup> But consistency was also needed with the provisions of the General Law on the rights of people with disabilities.<sup>102</sup>

The latest Decree in 2022 aims:

...to regulate the procedure for the recognition, declaration and qualification of the degree of disability, the establishment of the applicable scales, as well as the determination of the competent bodies, all with the aim that the evaluation of the degree of disability that affects the person is uniform throughout the territory of the State, thereby *guaranteeing **equal conditions for the access of citizens to the rights provided for in the legislation***. (Article 1) [emphasis added]

It details the **new approach and related assessment scales, based on measures of functioning, activities, participation and environment, in line with the ICF framework** (although not explicitly administering the WHODAS 2.0 tool).<sup>103</sup>

## 4.9. Germany

Within the rehabilitation system, the Social Code (Book IX) provides for 'the uniform and verifiable determination of individual rehabilitation needs', based on systematic processes and standardized instruments. This is intended to ensure an **individualized, functional and needs-based approach** to determining whether disability exists or is likely, what impact this has on participation, the goals and services that are likely to be successful.<sup>104</sup>

Reforms aimed to unify and strengthen the approach, and have required that:

The determination of the **individual needs** of the beneficiary must be carried out by means of an instrument based on the **International Classification of Functioning, Disability and Health**.<sup>105</sup>

Further discussion is ongoing on the extent to which the instruments used by rehabilitation bodies conform with these principles and specifications. An initial study for the Ministry of Labour and Social Affairs found that the variety of assessment tools in use had not reduced, that there was a lack of co-

<sup>100</sup> Royal Decree 1723/1981, of July 24, on recognition, declaration and qualification of the conditions of subnormal and handicapped. <https://www.boe-es.translate.google/eli/es/rd/1981/07/24/1723>

<sup>101</sup> Comisión Estatal de Coordinación y Seguimiento de la Valoración del Grado de Discapacidad 2022, [https://www.imsero.es/imsero\\_01/el\\_imsero/relaciones\\_institucionales/comision\\_estatal\\_de\\_coordinacion\\_y\\_seguimiento\\_de\\_la\\_valoracion\\_del\\_grado\\_de\\_discapacidad/index.htm](https://www.imsero.es/imsero_01/el_imsero/relaciones_institucionales/comision_estatal_de_coordinacion_y_seguimiento_de_la_valoracion_del_grado_de_discapacidad/index.htm)

<sup>102</sup> Royal Decree 1/2013, of November 29, approving the Consolidated Text of the General Law on the rights of people with disabilities and their social inclusion. <https://www.boe.es/buscar/pdf/2013/BOE-A-2013-12632-consolidado.pdf>

<sup>103</sup> Royal Decree 888/2022, of October 18, establishing the procedure for the recognition, declaration and qualification of the degree of disability <https://www.boe.es/eli/es/rd/2022/10/18/888/dof/spa/pdf>

<sup>104</sup> Ministry of Justice (2018), *Book IX of the Social Code – Rehabilitation and participation of people with disabilities*, § 13 Instruments for determining rehabilitation needs, [https://www.gesetze-im-internet.de/sgb\\_9\\_2018/\\_13.html](https://www.gesetze-im-internet.de/sgb_9_2018/_13.html)

<sup>105</sup> Ministry of Justice (2018), *Book IX of the Social Code – Rehabilitation and participation of people with disabilities*, § 118 Instruments for determining needs, [https://www.gesetze-im-internet.de/sgb\\_9\\_2018/\\_118.html](https://www.gesetze-im-internet.de/sgb_9_2018/_118.html)

operative developments, and that ‘uniform determination of individual needs’ was at a very early stage:<sup>106</sup> It also found that there

The content and informative value of the social security institutions fall considerably short of the new survey instruments of integration assistance, but also of the WHO checklist. The **contextual factors are not systematically collected** for all institutions.<sup>107</sup> [emphasis added]

This underlines the key points of earlier examples, such as assessment of context and the potential for alignment with internationally validated frameworks such as the ICF.

## 4.10. Poland

Reform of disability assessments in Poland has been highlighted in reviews of the European Semester process, and previously by ANED.<sup>108</sup> The existing system has been **fragmented** by six different certification paths, which are sometimes inconsistent and difficult to navigate. The High Commissioner for Human Rights and the Congress of Persons with Disabilities argued that reform should focus on assessing the needs of the person in the labour market rather than the degree of inability.

A plan to unify the disability assessment system, in line with the CRPD, was announced in 2017 and is included in the national Strategy for Persons with Disabilities 2021-2030. An Inter-Ministerial Team for Developing a System of Disability and Inability to Work Assessment was established, chaired by the president of the Social Insurance Institution, which reported in 2018.<sup>109</sup> This development is **ongoing**,<sup>110</sup> with implementation of a first phase likely in 2024,<sup>111</sup> although the Ombudsman identified **shortcomings in public consultation** on the proposal claiming that:

the participation of representatives of two NGOs with only an adviser's voice does not meet the CRPD standard.<sup>112</sup>

This underlines **the importance of engaging people with disabilities and their organisations in all policy reforms that affect them, and in a meaningful way**. In accordance with Article 4.3 CRPD:

In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall closely consult with and actively involve persons with

<sup>106</sup> Fuchs, H. & Morfeld, M., *Study on the implementation of needs assessment tools: Implementation study for the introduction of instruments for determining rehabilitation needs according to § 13 SGB IX (Federal Participation Act)*, 2018, [https://www.gemeinsam-einfach-machen.de/GEM/DE/AS/Umsetzung\\_BTHG/Impls.studie/Studie\\_node.html](https://www.gemeinsam-einfach-machen.de/GEM/DE/AS/Umsetzung_BTHG/Impls.studie/Studie_node.html)

<sup>107</sup> See summary findings, and Figure 14, Figure 34, Figure 54 and Figure 75 of the above study, <https://www.reha-recht.de/fachbeitraege/beitrag/artikel/beitrag-d18-2021/>

<sup>108</sup> Król, A., *Country report on disability assessment – Poland*, ANED, 2018, <https://www.disability-europe.net/downloads/962-task-policy-theme-yr-2017-18-dis-assessment>

<sup>109</sup> How to improve the disability adjudication system so that it complies with the standards of the UN Convention? - ROP's speech to the Minister of Family and Labor, <https://www.rpo.gov.pl/pl/content/system-orzekania-o-niepelnosprawnosci-jak-poprawic-by-byl-zgodny-ze-standardami-konwencji-onz>

<sup>110</sup> How is the work on reforming the disability evaluation system going? MRiPS responds to the Ombudsman, <https://bip.brpo.gov.pl/pl/content/jak-wygladaja-prace-nad-reforma-systemu-orzecznictwa-ws-niepelnosprawnosci-mrips-odpowiada>

<sup>111</sup> Disability assessment reform divided into phases. Caregivers will still wait, <https://serwisy.gazetaprawna.pl/emerytury-i-renty/artykuly/8485805/orzekanie-o-niepelnosprawnosci-opiekunowie-swiadczenie-reforma.html>

<sup>112</sup> How to improve the disability adjudication system so that it complies with the standards of the UN Convention? - ROP's speech to the Minister of Family and Labor, <https://www.rpo.gov.pl/pl/content/system-orzekania-o-niepelnosprawnosci-jak-poprawic-by-byl-zgodny-ze-standardami-konwencji-onz>

disabilities, including children with disabilities, *through their representative organizations* [emphasis added]

#### 4.11. Lesson learning

The ten brief case studies reviewed in this chapter underline many of the key messages and themes established earlier in the report. EASPD's study of Greek deinstitutionalisation reforms sought assessment methods that establish 'who the person is, not what impairment he/she has', to arrive at 'a **more holistic approach** that reflects all aspects of the personality of the persons concerned whilst being in line with the UN Convention'. **Alignment with the CRPD** was emphasised throughout this report, although what this means requires some further clarification (see chapter 6).

The above desire for **more holistic or comprehensive disability assessments** is also a recurrent theme in the case studies of assessment reform, for example in the World Bank's evaluation in Latvia. The desirability of a holistic approach stems from consideration of **social and interactive models of disability**, which demand attention to environments as well as persons, to barriers as well as impairments. As concluded by the Bulgarian Ministry, an assessment of health indicators is not enough; a comprehensive assessment of **capabilities** is needed. This was evident in the lack of attention to 'environmental factors, opportunities to live independently, to participate in public life on an equal basis with other persons' in the Lithuanian system, and in the lack of systematic attention to contextual factors, despite reform attempts, in the German social security system. Similarly, the Romanian strategy acknowledged 'the barriers that limit participation in society and, in particular, employment are not defined' in assessment system.

The reform case studies focused on **efficiency and effectiveness of policy process**, as well as the **validity of the methods used**. For example, the case Slovakian personal assistance reforms suggested that a **unified framework** could 'improve and streamline the way persons with severe disabilities are recognised'. As the Spanish example highlights, the adoption of **more uniform processes throughout the territory is hoped to provide a means of 'guaranteeing equal conditions for the access of citizens to the rights provided for in the legislation'**. This is an important consideration for the present study, insofar as it may be extended to convergence or mutual recognition among the Member States in the EU territory.

Similarly, the recent commitments made to reform in Italian legislation, pledged to create, 'a **congruent, transparent and easy evaluation that allows the full exercise of their civil and social rights'**. This might be advanced in the EU context by the adoption of **shared principles for disability assessment**, consistent with a rights-based approach, and by **convergence on the kinds of assessment tools** in use. This could address some of the inconsistencies perceived by citizens and make some disability determinations easier for administrative authorities.

Lastly, as illustrated by the Polish example, **the participation of representatives of organisations of persons with disabilities** in all significant policy reforms is an **obligation under the CRPD**. This obligation extends to EU policy reforms as well as to national policy reforms.

Examples of such involvement were cited in the ANED study, for example in Czechia (where disabled people's organizations, including the Government Board for People with Disabilities and the Czech Disability Council participated in preparing new assessment guidelines for the Care Allowance, a non-insurance-based social security benefit). **The views of civil society, such as the position statement of the European Disability Form (EDF) on disability assessment procedures, and the Opinion of the EESC on shaping the EU disability agenda must be taken into account.**

## 5. DEVELOPMENT OF A EUROPEAN DISABILITY CARD

### KEY FINDINGS

**Mutual recognition mechanisms** are already familiar **within** Member States. Disability determinations by one **public authority** are often recognised by others, for different policy functions, and by **private service providers**. For example, evidence of a disability pension may be a passport to free bus travel. In many Member States there is already a **national disability register** or **card** that accredits a person's administrative disability status. There are also **examples of mutual recognition between Member States, notably the European Parking Card**. A **European card** was proposed by civil society more than a decade ago and **recommended** to the EU by the **UN CRPD Committee** in 2015. This has been successfully **piloted and evaluated** in Member States, on a voluntary basis. The EU disability strategy commits to launch a comprehensive **European Disability Card in 2023**. This scheme has scope for recognition in all Member States and across a wide range of policy functions.

Formal recognition of disability status is premised on prior determination by a legitimate authority, following a process of assessment (see chapter 1.1). The challenge for mutual recognition is whether a disability determination made in one Member State can be recognised in another. The previous chapters have addressed the underlying challenges of equivalence and reliability (i.e. national determinations are currently based on different definitions of disability, different methods of assessment, and different eligibility criteria). These problems might be addressed by the adoption of **shared principles of assessment** and by **convergence on the types of assessment tools** in use. The present chapter focuses on a different challenge – on the **mechanism for recognition** rather than the method of assessment.

As observed earlier, in most Member States, the outcome of disability assessment for one policy function (such as capacity for work) is often recognised as a 'passport' or 'gateway' to other kinds of entitlement (such as tax concessions, discounts, or access to services). This kind of transferable disability status is often evidenced by production of a **national disability card** or reference to an administrative **register**. The key debate of recent years is whether a similar kind of card or register at the EU level could assist people with disabilities, and the Member States, in **facilitating mutual recognition and free movement**. With this aim, an '**EU Disability Card**' has been piloted and promoted.

As mentioned in chapter 2.5, there are some existing regulatory arrangements in the EU for **mutual recognition or transferability** of some **rights to contributory social security benefits**, including **some categories of disability benefit** (although these do not require an explicit mutual recognition of disability status, and they do not cover entitlements to social assistance based on discretionary assessments, such as assessments of support needs).

In **2015** the **UN CRPD Committee** expressed its **concern about the 'varied practices'** of national bodies in addressing passengers with disabilities as they **travel** between Member States, and the unequal treatment that results from this. In the context of 'Personal mobility' (Article 20 CRPD) they recommended:

... that the European Union strengthen the monitoring of the implementation of legislation on passenger rights and to harmonize the work of the national enforcement bodies in order to

ensure the effective and equal enjoyment of rights by all passengers with disabilities across the European Union, including the implementation of the **European Mobility Card**.

This idea has progressed, leading to a commitment in the current European disability strategy to develop a European Disability Card as a Flagship initiative in 2023.

#### **Flagship initiative:**

The Commission will propose creating a **European Disability Card** by end of **2023** with a view to be recognised in all Member States. It will build on the experience of the ongoing EU Disability Card pilot project in eight Member States and upon the European parking card for persons with disabilities.

Source: Strategy for the Rights of Persons with Disabilities 2021-2030

## **5.1. Relevant petitions**

**The demand for this type of Card has been highlighted in several petitions.** For example, it was observed in **Petition No 0226/2021 (German) on the EU-wide introduction of laws to promote the social inclusion of people with disabilities**, that:

Petitioner calls for EU legislation for disabled persons, including the regulation of ID cards. According to the Commission, the planned European Disability Card is one of the key actions in the Commission's Strategy for the Rights of Persons with Disabilities 2021-2030, which is due to be introduced by the end of 2023. Considering specific role of PETI committee, our task is to promote, protect and monitor the UN CRPD, as an instrument setting minimum standards for rights of people with disabilities, which is legally binding for the EU. In the light of this, the petition should be discussed in the presence of petitioner.

This concern echoes those of other petitions. For example, this was an explicit concern of **Petition No 1249/2014 (German) on the European card for people with disabilities**, in which:

The petitioner maintains that his disability card is not recognised in all Member States and that this constitutes an impediment to the free movement of citizens. He calls for either European-level legislation on the disability card, or for better recognition of the card, and of the status to which it attests, among the Member States.

In **Petition No 0756/2019 (German) on an EU-wide disability card**:

The petitioner advocates EU-wide concessions for disabled people along the lines of what is provided in Germany for German nationals who have been issued with a severe-disability card. He puts forward three options: either a severe-disability card that is valid in all EU countries regardless of where it is issued; or, alternatively, a standard severe-disability card modelled on the German card could be introduced, though each Member State would be able to set its own criteria; or a standard EU-wide severe-disability card could be introduced.

And, in **Petition No 0226/2021 (German) on the EU-wide introduction of laws to promote the social inclusion of people with disabilities**:

The petitioner calls for the introduction of EU legislation for severely disabled persons, such as a regulation on ID cards for those with severe disabilities and a disability equality law. In support of his request, he cites Article 21 (Non-discrimination) and Article 26 (Integration of persons with disabilities) of the EU Charter of Fundamental Rights, and various articles of the UN Convention on the Rights of Persons with Disabilities.



The European Disability Card is proposed to address this kind of identity regulation as a supplement to, or harmonisation of, national disability card schemes among the Member States.

## 5.2. Learning from the EU Parking Card

The **EU parking card scheme, or 'Blue Badge', for persons with disabilities has existed for more than 20 years and is recognised across all Member States**. There is a **standard EU format** for this card, which makes it easily recognisable, but it is administered according to the national rules of each Member State and issued by their designated authorities, nationally, regionally or locally. For example, a resident of the Netherlands would apply for an EU parking card through their municipality or the central office for driving licences. In Ireland, the scheme is administered by the Disabled Drivers Association of Ireland (DDAI) and the Irish Wheelchair Association (IWA). In France, the parking card has been incorporated with a national Mobility Card (carte mobilité inclusion, CMI), issued via the local disability administration office (Maison Départementale des Personnes Handicapées, MDPH).

Figure 5: Example of parking card



Source: Disabled Drivers Association of Ireland

The card allows the user to **benefit from any local parking concessions afforded to disabled people** (such as free parking, extended parking, or reserved parking spaces). In practice, the card is widely used by citizens in their own country of residence but they are mutually recognised in all Member States. For example, it can be used by a tourist using a hire car while on holiday in another Member State. The card is **issued to a named person**, who has been granted a **disability status**, rather than to a vehicle. It is **transferable** to any vehicle the person may be using, either as a driver or as a passenger. The most recognisable component of the card is the use of the international disability symbol, representing a wheelchair (see Figure 5).

The Council Recommendation underpinning mutual recognition of the parking card (98/376/EC) dates back more than two decades.<sup>113</sup> Based on Commission proposals it outlined the challenge as follows:

(3) Whereas a mode of transport other than public transport constitutes, for many people with disabilities, the only means of getting about independently for purposes of occupational and social integration; whereas, in certain circumstances and with due regard to road safety, it is only right that people with disabilities should be enabled, by means of a parking card for such people, to park as near to their destination as possible; whereas people with disabilities should thus have the opportunity to avail themselves of the facilities provided by the said parking card

<sup>113</sup> Council Recommendation of 4 June 1998 on a parking card for people with disabilities (98/376/EC) Official Journal L 167 , 12/06/1998 P. 0025 - 0028

throughout the Community in accordance with the national rules applying in the country in which they happen to be

In accordance with the principle of **subsidiarity**, the mechanism of the parking card allows **national authorities to exercise their own national provisions in determining who is entitled to the card (the disability assessment) and to determine national rules for the resulting entitlement (e.g. parking concessions)**. For example, in some Member States the parking card may be available to everyone who has a national disability card, or who appears on a national disability register. It may be issued to people who receive a certain kind of disability pension/benefit, or there may be an assessment of need for the card (e.g. as part of an assessment for long-term social care/support).

Nevertheless, action by the EC/EU was justified 'to promote the understanding and mutual recognition of parking cards for people with disabilities and to **facilitate freedom of movement** for people with disabilities'. To this end, cards issued by national authorities would conform to a **standard model**, detailing the dimensions, format and layout. These provisions were extended to accession states in 2008. The card scheme is **very well established, widely used and popular with citizens**.

While the visual format of the parking card is easy to recognise, the text is printed in the **national language of the issuing authority**. Its meaning may not be immediately clear to local authorities or service providers in another Member State, unless they are familiar with the scheme. The physical dimensions of the parking card prohibit the incorporation of text in multiple languages. Consequently a **short standard text** is available in translation for all EU languages, which can be displayed voluntarily alongside the card if needed (as shown below). An index of local conditions that apply in each country is also published online.<sup>114</sup>

#### **Standard text for the parking card (examples in English, French and German)**

##### **Parking card**

The parking card displayed is based on the standardised Community model according to the Council Recommendation 98/376/EC amended by the Council Recommendation 2008/205/EC (OJ L 63, 7.3.2008, p. 43). The cardholder should benefit from all the associated parking facilities for disabled persons in every EU country.

##### **Carte de stationnement**

La carte de stationnement affichée se fonde sur le modèle communautaire uniformisé conformément à la recommandation du Conseil 98/376/CE modifiée par la recommandation du Conseil 2008/205/CE (JO L 63, 7.3.2008, p. 43). Le détenteur de la carte bénéficiera dans chaque pays de l'UE de toutes les facilités de stationnement pour personnes handicapées.

##### **Parkausweis**

Derdargestellte Parkausweis basiert auf dem standardisierten Gemeinschaftsmodell gemäß der Empfehlung des Rates 98/376/EG, abgeändert durch die Empfehlung des Rates 2008/205/EG (ABl. L 63, 7.3.2008, S. 43). Der Ausweisbesitzer sollte in jedem EU Land in den Genuss aller damit verbundenen Parkerleichterungen für behinderte Menschen kommen.

Source: Parking card for people with disabilities in the European Union, <https://op.europa.eu/s/w6sD>

<sup>114</sup> EU parking card for people with disabilities; Using your EU parking card, [https://europa.eu/youreurope/citizens/travel/transport-disability/parking-card-disabilities-people/index\\_en.htm](https://europa.eu/youreurope/citizens/travel/transport-disability/parking-card-disabilities-people/index_en.htm)



In **2011**, a **European Parliament Resolution** recognised the **importance of the parking card** initiative and called for, among other things:

... the reduction of barriers to the freedom of movement of people with disabilities, via the adoption of a European Mobility Card, based on **mutual recognition by Member States of disability cards and disability benefits and entitlements** so as to make it easier for people with disabilities to study, work and travel...<sup>115</sup>

This concept of a recognisable 'Mobility Card', for wider use beyond parking concessions, was advocated by **disabled people's organisations**. A case was developed by the **Belgian Disability Forum (BDF)**, drawing on their members' experiences. They cited examples where the existing 'Blue Badge' for parking was recognised for different purposes by providers in some Member States but not in others (e.g. for gaining discounts on national toll roads, accessing tourist facilities, or other local services, while travelling).<sup>116</sup>

All of the above examples of difficulties and barriers bring us to the conclusion that a solution is clearly needed. Preferably, this solution would come in a format that would be easy to use, widely recognized, and which would provide competent authorities with the minimal amount of personal information and not require further questioning of the card holder to elicit personal information about the disability. (p. 163)

Early proposals for an EU Disability Card were thus initiated by people with disabilities and their organisations, dating back at least to the **BDF's 2008 proposal for a Mobility Card**, which was **submitted to the EDF, and subsequently to the Commission in 2011** (as shown below).

#### **Proposal for a European Mobility Card**

The Card would ideally have an accessible and convenient format and meet the following requirements:

1. The EU Mobility Card would be issued nationally and to every person registered/recognized as having a disability at national level.
2. The EU Mobility Card would be accepted and recognized in every EU Member State and it would be translated into every official language of the EU.
3. The EU Mobility Card need only be displayed by its owner on a voluntary basis, following a 'no display = no service' principle.
4. The EU Mobility Card would guarantee freedom of movement and free access to a range of existing services, equal to those available to a national with a disability of the host Member State.
5. Every Member State would have to publish a comprehensive list of services which the EU accessibility card gives access to. These lists would be available on a dedicated web site.

Source: Belgian Disability Forum.

In this way they developed a **conceptual shift** from a mechanism for mutual recognition of concessions when '**parking**', to the wider context of **driving**, and from there to '**mobility**', and to enabling '**freedom of movement**'.

<sup>115</sup> European Parliament resolution of 25 October 2011 on mobility and inclusion of people with disabilities and the European Disability Strategy 2010-2020 P7\_TA(2011)0453. OJ C 131E, 8.5.2013, p. 9-25

<sup>116</sup> Gyselinck, G., Marliere, G. & Magritte, O., 'The Need for a European Mobility Card for Persons with Disabilities: A Contribution from the Belgian Disability Forum'. In *European Yearbook of Disability Law*. pp. 159-168, 2014

It is worth noting that there have also been some developments in thinking about technological options to supplement the standard format of the physical European Parking Card with **digital** functionality. For example, the SIMON project, funded by the Competitiveness and innovation Framework Programme, sought to **enhance the Card with digital technologies to allow contactless and mobile user identification** (partly in response to concerns about fraud and data privacy).<sup>117</sup> This example highlights the **potential to integrate physical disability cards with digital registers and forms of recognition** (as the example of national assessment reform in Greece, outlined earlier in chapter 0, illustrates).

A **digital format for a European Disability Card** would enable checks on the validity of the card, and might address some of the challenges of card recognition in multiple languages, but this would require the creation of, and wide access to, a shared European database of card users. This presents some administrative and data privacy challenges but there are examples already in operation, such as schemes for digital validation of personal driving licence information.

### 5.3. Towards a European Disability Card

As Van Dijck observed in 2018:

In Member States like **Germany, France and Denmark, there is a well-established system of national Disability Cards, while in Sweden, Italy or Greece such cards do not exist.** This means national disability cards are **not recognised in all EU countries** at the moment and there is no equal access to certain specific benefits, creating uncertainty for people with a disability when traveling within the EU.<sup>118</sup>

As shown in the preceding review of the EU disability parking card, the campaign for introduction of a wider disability card recognition scheme began with proposals from civil society (EDF) to the Commission in 2011. This idea has progressed during the intervening decade, through more concrete specification, a pilot scheme in eight Member States, and subsequent evaluation. This led, in 2021, to a commitment in the **EU Strategy for the Rights of Persons with Disabilities 2021-2030** to develop a European Disability Card as a Flagship initiative by the end of **2023** (as highlighted at the beginning of this chapter).

Framing this initiative in the context of 'Moving and residing freely' (action 3.1), the Strategy acknowledges the difficulties experienced by persons with disabilities in **having their disability status recognised** when moving from one Member state to another – as workers, students or travellers. With this in mind, the Commission commits to work with the Member States 'to **expand the scope of the mutual recognition of disability status in areas such as labour mobility and benefits related to conditions of service provision**'. The Disability Card initiative is positioned as the central measure in achieving this.

<sup>117</sup> Ferreras, A., Solaz, J., Muñoz, E. M., Serrano, M., Marqués, A., López, A., & Laparra, J., 'SIMON: Integration of ICT Solutions for Mobility and Parking', *International Conference on Computers Helping People with Special Needs*, Springer, Cham., 2016, pp. 281-284.

<sup>118</sup> Van Dijck, C. 'Case Study—The European Disability Card'. In *Co-Production and Co-Creation* (pp. 145-147). Routledge, 2018, [https://library.oapen.org/bitstream/handle/20.500.12657/25001/9781138700116\\_text.pdf?sequence=1#page=159](https://library.oapen.org/bitstream/handle/20.500.12657/25001/9781138700116_text.pdf?sequence=1#page=159)

## 5.4. Piloting the Card in Member States

In **2015**, the Commission launched a **call for proposals for a Disability Card pilot project, financed under the Rights, Equality and Citizenship Programme**.<sup>119</sup> **Eight Member States launched pilot projects, during 2016-18: Belgium, Cyprus, Estonia, Finland, Italy, Malta, Romania, and Slovenia.** These national projects adopted some common core principles but **developed in differing ways**, for example in the organisation and administration of the scheme, its relationship to existing disability status administration, the type of partners involved and the presentation of information to card users.

For example, in **Belgium** the card is available to anyone who is recognized by one of five institutions responsible for disability policy. These include the Federal Public Service Social Security, the Agence pour une Vie de Qualité (AViQ, Wallonia), Vlaams Agentschap voor Personen met een Handicap (VAPH, Flanders), Service Personne Handicapée Autonomie Recherche (Service Phare, Brussels), and Dienststelle für Selbstbestimmtes Leben (DSL).<sup>120</sup>

**Service providers** are encouraged to register voluntarily online, and to state the type of benefits they will offer to holders of the European Disability Card. In return, they receive permission to use a badge that promotes their profile as a disability friendly provider. By September 2022, more than 600 providers were listed on the website - 459 in Flanders, 83 in Wallonia, and 59 in Brussels.<sup>121</sup> These are primarily providers of **culture, sports and leisure services** (such as cinemas, theatres, museums, visitor attractions or leisure parks) and include, for example, the **European Parliament** in Brussels.

In **Cyprus**, the card is available to people who have been certified as moderately, severely or completely disabled by the Evaluation Centres of the Department for Social Inclusion of Persons with Disabilities (which is medically informed assessment). However, this certification is a formality for anyone who is already receiving one of the main disability benefits in cash or kind. Implementation of a European Disability Card will replace the issuance of the existing 'Disabled Person Booklet' that has been issued in Cyprus since 2009. The published list of benefits includes **concessions on bus travel**, sanctioned by the Ministry of Transport, **free entrance to public festivals and cultural sites, as well as private galleries, museums and so on**.<sup>122</sup>

In **Finland**, the card scheme was developed in collaboration between government Ministries, disability organizations and service providers. The scheme is co-ordinated by the Developmental Disabilities Service Foundation, supported by the Funding Centre for Social Welfare and Health Organisations (STEA). The card is available to anyone who can evidence an existing official decision giving access to any of a list of disability benefits and concessions in cash or kind (with a special 'A' designation for persons already assessed as needing to be accompanied by an assistant).<sup>123</sup> It is currently a separate card to the one issued by Kela for the purpose of national disability status recognition. A **database of collaborating providers** is provided online, which is searchable by area and by type of accessibility need (such as accessible parking places, toilets, induction loops, clear signage, etc).

<sup>119</sup> European Commission, *Call for proposals to support national projects on a mutually recognised European Disability Card and associated benefits*, VP/2015/012, 2015, <https://ec.europa.eu/social/main.jsp?catId=629&langId=en&callId=456>

<sup>120</sup> Where to get it (Belgium) <https://eudisabilitycard.be/en/where-get-it>

<sup>121</sup> The partners of the European Disability Card (Belgium), <https://eudisabilitycard.be/en/partners-european-disability-card>

<sup>122</sup> Department for Social Inclusion of Persons with Disabilities, *List of Benefits: European Disability Card*, undated <https://www.eudisabilitycard.gov.cy/uploads/documents/1f9287f949.pdf>

<sup>123</sup> Vammais Kortti (Disability Card): How do I apply for a card? <https://vammaiskortti.fi/miten-haen-korttia/>

Figure 6: Example of a searchable database of participating service providers

On this page, you can find Disability Card destinations, i.e. all the cultural, sports and tourism destinations as well as service providers that take disabled people into account in their own services with the help of the Disability Card. The list shows only those service providers who have registered as a Disability Card target through these pages. Please check the current accessibility information directly on the object's own website.

Limit by area

Helsinki (34)

Limit based on accessibility

All

**Finnish National Opera and Ballet**  
Helsinki

- With A marking, an assistant is free of charge
- Accessibility information on the website
- Accessible parking
- Barrier-free entry and passage from one space to another
- Accessible toilet

**Hop on Hop off, bus tour (Stromma)**  
Helsinki

- With A marking, an assistant is free of charge
- Accessibility information on the website
- With a disability card, an assistant is free of charge

Search

- ☐ With A marking, assistant free of charge (26)
- ☐ Accessible parking (14)
- ☐ Barrier-free entry and passage from one space to another (22)
- ☐ Accessible toilet (24)
- ☐ Accessibility information on the website (26)
- ☐ Induction loop (13)
- ☐ Wheelchair spaces in the auditorium (17)
- ☐ One wheelchair and one rollator can be borrowed for the duration of the visit (0)
- ☐ Clear signage in offices (20)
- ☐ Assistant with disability card free of charge (21)
- ☐ The holder of a disability card is entitled to a swimming and gym card for special groups (0)

● Induction loop

Source: Finland, Vammais Kortti (Disability Card): Destinations, <https://vammaiskortti.fi/vammaiskorttikohdeet/>

A similar function is provided for the **Malta** card scheme, which is searchable by category of service provider and locality, as well as keyword search.<sup>124</sup> This includes mainly **discounted prices on goods and services, or free admission for the card holder or an assistant**. The card is issued by direct application to the Commission for the Rights of Persons with Disability, but requires submission of medical certification by a doctor.

In **Slovenia** also there is also a searchable **database** with mapping of the participating providers.<sup>125</sup> There is also a mobile phone application incorporating this function. The pilot scheme was developed by the Ministry of Labour, Family, Social Affairs and Equal Opportunities, with the National Council of Disabled Organizations of Slovenia, and legislated in the Act on the Equalization of Opportunities for Persons with Disabilities.

Finally, the EU Disability Card has been adopted in **Italy**, following participation in the pilot study by the Italian Federation for Overcoming Disability (FISH) and disabled people's organisations from 2016.<sup>126</sup> A preliminary analysis was conducted of existing disability concessions and criteria for access to leisure and transport services.<sup>127</sup> The criteria and provisions for issuing the Card were enacted through a Decree of the President of the Council of Ministers in November 2020 (published in the

<sup>124</sup> Commission for the Rights of Persons with Disability (undated) EU Disability Card: Where can I use it in Malta? <https://www.eudisabilitycard.org/mt/search/>

<sup>125</sup> Discounts for the disabled in one place <https://www.invalidska-kartica.si/>

<sup>126</sup> FISH, *Lancio Progetto Nazionale European Disability Card*, undated, <https://www.disabilitycard.it/wp-content/uploads/2022/03/comunicato-lancio-progetto.pdf>

<sup>127</sup> FISH, *Progetto EU Mobility card – Disability card: Rilevazione preliminare – i risultati*, undated <https://www.disabilitycard.it/wp-content/uploads/2022/03/sintesi-dati.pdf>

Official Gazette in December 2021). **Since February 2022, the Card is now available for applications** from the national social security agency (INPS), via its website.<sup>128</sup>

## 5.5. Assessing the benefits of the Card

**In 2019-2020, the European Commission assessed the pilot project, with a study** published in 2021.<sup>129</sup> This study analysed the implementation of the Disability Card across the **eight pilot projects**, its **usefulness** and **cost-effectiveness**. It concluded that **the pilot was effective in supporting mutual recognition within the scope of access to culture, leisure, sport and transport services**. It was **efficient** in terms of implementation costs, and the **benefits** outweighed these costs. The objectives of the pilot scheme remained relevant to the participants and coherent with EU law and policy objectives, and that it could have **added EU value** if expanded in scope. In this way, the **Disability Card enables a mutual recognition** between Member States, which would not have been achieved without EU support.

The study was unable to confirm the number of persons using the scheme or the number of cards issued by the responsible authorities in all countries. It established, however, that **more than 300,000** cards had been produced. In contrast with the production of EU format parking cards by national authorities, the standard information on the card was printed in **English** rather than national languages.

It confirmed that **in most cases the criteria for receiving the EU Disability Card were same** as those used to grant **access to disability benefits** for residents in the Member State (as shown earlier, an existing entitlement often provided a passport or gateway to the EU Card, but there were exceptions where a separate assessment was required).

A sample of card users were surveyed about their experiences and outcomes (21 service providers and 363 persons with disabilities), as well as focus groups. Of the users, **two thirds** (63%) reported that **their cultural participation had increased**, at least to some extent. There were also economic benefits for the participating providers in advertising their services and attracting new customers (and additional gains for their customers, as many of them reported improvements to the accessibility of their facilities resulting from the participation). More than 1,200 of them participated in the pilot programme. Nevertheless, both users and providers felt that **the scheme should be extended, across a wider range of providers and to all EU Member States**. Hence:

Only in case the Card was extended to **all Member States** and the participation of service providers was **compulsory**, all services and benefits provided to persons with disabilities in one Member State would be automatically extended to Cardholders from all the other Member States. Under this scenario, the Card can act as an important EU law enforcement tool. In fact, by providing for a system of **mutual recognition** of disability status, the Card would prevent the occurrence of situations in which service providers deny the provision of disability-related services to non-nationals with disabilities. (p. 8)

<sup>128</sup> INPS (2022) Message n° 853 of 22-02-2022

<https://servizi2.inps.it/Servizi/CircMessStd/VisualizzaDoc.aspx?sVirtualUrl=/messaggi/Messaggio%20numero%20853%20del%2022-02-2022.htm>

<sup>129</sup> European Commission, Directorate-General for Employment, Social Affairs and Inclusion, Chiattelli, C., Abbasciano, C., Schizzerotto, A., et al., *Study assessing the implementation of the pilot action on the EU Disability Card and associated benefits : final report*, Publications Office, 2021, <https://data.europa.eu/doi/10.2767/429261>

The study recommended that:<sup>130</sup>

- Member States adopting the Card should cover **all the four sectors** in scope (culture, leisure, sport and transport)
- Participation of national service providers should be **mandatory**
- Service providers should follow and/or implement clear **accessibility standards**
- The use of the Card should be regularly **monitored** at relevant levels
- Consistency should be ensured in the provision of **information** about the Card

## 5.6. Risks and opportunities

Reviewing the Disability Card pilot as a case study in 2018, Van Dijck observed the evident **lack of a legal framework to harmonise national eligibility criteria or entitlement rules**. Each Member State reserves the authority to determine who is eligible, according to their national definitions and procedures (as shown in the earlier chapters of the present study). This has great benefits but also raises questions of equity between citizens resident in different Member States. The mechanism of mutual recognition means that citizens with an EU Disability Card issued in one Member State can be recognised by providers in another Member State, even if they would not qualify for the card if they were assessed in that Member State.<sup>131</sup> Conversely, a disabled citizen who was ineligible for an EU Disability Card in their country of residence might be unable to access benefits and concessions in another Member State, where they would have qualified for one if they applied as a resident there.

In terms of equal rights, this does not ensure that a citizen who would be eligible for the card in country A is eligible for the card in country B, but it does guarantee that everyone eligible for the card in their own country can enjoy all benefits connected to it in all countries that signed the protocol for the European Disability Card. Compared to the current situation, this coproduction increases the EU-wide benefits for a large portion of EU citizens with a disability, yet not for all. In time **this project could open the door for a mutual baseline in terms of eligibility criteria in practice, bypassing the difficulties of creating legislation to make that happen.** (p. 147)

These observations highlight **policy tensions between the divergent assessment methods and criteria** used to establish disability status in the Member States, and the **convergent mechanism of the EU Disability Card to establish mutual recognition** between them. **It would be relevant therefore to consider, alongside mutual development of the Disability Card, the potential for greater harmonisation or shared principles of disability assessment (e.g. via EU support for the voluntary incorporation or mutual recognition of one or more core components of assessment).**

As highlighted by civil society representatives, in dialogue with the Commission:

<sup>130</sup> An extensive tabulation of these recommendations is provided in Table 33 of the pilot study report (pp. 115-121)

<sup>131</sup> Van Dijck, C., 'Case Study—The European Disability Card'. In T Brandsen et al. (eds) *Co-Production and Co-Creation*, Routledge, 2018, pp. 145-147, [https://library.oapen.org/bitstream/handle/20.500.12657/25001/9781138700116\\_text.pdf?sequence=1#page=159](https://library.oapen.org/bitstream/handle/20.500.12657/25001/9781138700116_text.pdf?sequence=1#page=159)



The core demand of EDF's campaign was to establish a Card which is recognized throughout the EU and gives its holders **the same disability related rights and discounts as a national of the Member States that the person is visiting**.<sup>132</sup>

This aspiration to realise freedom of movement reaches further than the Card as a physical mechanism of administrative recognition. If people with disabilities are to exercise 'the same disability related rights', with freedom of movement, then the underlying basis of their recognition, as well as the mechanism to evidence it, requires attention.

Groce et al. observe that an **increasing number of countries are considering disability identification cards**.<sup>133</sup> They suggest three justifications for this – enabling access to help beyond the mainstream of social protection programmes (where the holder may not be known to the provider), as part of an administrative data collection system to enable better service planning, and that:

The issuing of an ID card is a **political statement** by the government that it officially recognizes its responsibility to address the rights and needs of persons with disabilities, and when a government takes such responsibility there is an additional benefit as that acknowledgement of responsibility provides advocates with additional leverage to fight for the expansion of rights and services attached to the card. (p. 96)

As with the EU's increasing efforts to collect disability equality data and publish statistical indicators, this kind of 'expressive function' is a relevant consideration.<sup>134</sup> The EU Disability Card certainly has potential to advance the **wider promotion of disability rights recognition** (as the EU parking card has raised public awareness of disabled vehicle users). It may also act as a lever to **promote awareness and positive practices among providers of goods and services who participate in the scheme**. There is also a risk, however, that the Disability Card scheme may reinforce outdated mechanisms of disability assessment in Member States by equalising their recognition with more progressive approaches and reforms. As Groce et al. also conclude:

Moving rapidly to implement a disability ID system before ironing out certain issues related to the purpose of the card and who is eligible, how assessment will take place and the administrative capacity to implement the system could create long term structural problems that increase the costs and reduce the efficiency of disability related programmes and policies. (p. 100)

The EU's strategic ambition to expand the scope of mutual recognition **beyond** the pilot areas of **culture, leisure, sport and transport services is welcome**. It has the potential open doors for disabled people to exercise their rights and freedoms to employment and social protection more easily and on an equal basis with others. There are also **some risks** that, as the scope of mutual recognition expands to new and significant policy areas, the inequalities arising from uneven disability assessment criteria become further entrenched.

There is scope therefore in the Commission's support for Member States both to establish **wider use** of the Disability Card, and to support further **cooperation and coordination of common principles and best practices for disability assessment, at EU level**. This would be consistent with the EU's

<sup>132</sup> European Disability Forum, *Discussion on the Future of the European Disability Card: Summary Report*, 2021, <https://www.edf-feph.org/content/uploads/2021/10/Report-on-Disability-Card-workshop-20210916.pdf>

<sup>133</sup> Mont, D., Palmer, M., Mitra, S., & Groce, N., 'Disability identification cards: Issues in effective design', *Development*, 2019, 62(1), 96-102, <https://doi.org/10.1057/s41301-019-00216-1>

<sup>134</sup> See, Priestley, M., & Grammenos, S., 'How useful are equality indicators? The expressive function of 'stat imperfecta' in disability rights advocacy'. *Evidence & Policy*, 2021, 17(2), pp. 209-226.



obligations to implement its policies in compliance with the **CRPD**, which is shared at a national level by all Member States, in line with their domestic ratifications of the same international Treaty.

In its 2019 Opinion on shaping the EU disability agenda, the **European Economic and Social Committee** (EESC) reinforced the view that people with disabilities are 'prevented from exercising the right to free movement in the EU because of the lack of harmonised recognition of disability assessment and the inability to transfer entitlement to support services and allocations when moving to another MS' (para. 4.2.1), and advocated as an urgent action the development of 'a **directive harmonising the recognition of disability assessment across the EU to facilitate the freedom of movement of PWD**' (para. 1.8).<sup>135</sup> The Opinion emphasises the significance of an **expanded scope** for mutual recognition in this regard, notably in '**ensuring the portability of social security benefits**' and '**Equivalent rights and eligibility for services...including personal assistance**' (para. 4.2.2).

This view was reinforced in the **European Parliament resolution of 7 October 2021 on the protection of persons with disabilities through petitions**.<sup>136</sup> The supporting report of the PETI Committee noted that mutual recognition of disability in the Member States was among the most common disability equality concerns of petitioners, and that the Disability Card will be an important instrument in addressing this.<sup>137</sup> The Resolution acknowledged the lack of mutual recognition as a hindrance to free movement, across multiple policy domains, and urged that the EU Disability Card should be made mandatory in all Member States:

Calls on the Commission and the Member States to establish a **common definition of disability** in line with the concluding observations of the CRPD Committee on the initial report of the European Union adopted in 2015, and to ensure **mutual recognition of disability status** across the Member States, so as to ensure the free movement of persons with disabilities and the proper exercise and recognition of their **EU citizenship rights**; (para. 22)

There are two elements here. There is **no precise definition of disability in the Convention**. Nevertheless, as shown throughout this study, it clearly implies that disability is a relational concept – disability arises when people with impairments encounter disabling barriers that limit their full participation and equality in society. Many disability assessments in the Member States determine who 'people with impairments' are but lack direct reference to the barriers they face in their life situation. The 'mutual recognition' of people with impairments is facilitated by convergence in some of the core components of disability assessment but holistic assessments need to consider people's capacities, needs and potential, **in context of their life situation**.

A '**common definition**' of disability, in line with the CRPD, will begin from a **contextual model of disability and a rights-based approach**. This could support the adoption of **shared principles of disability assessment** among the Member States (see chapters 2 and 6). People who move between Member States clearly benefit from '**mutual recognition**' of their impairments, and **recognition of the kinds of barriers they face** when exercising mobility. This would be greatly assisted by rapid recognition of their capacities, via a **passport mechanism or mutual recognition of core assessment**

<sup>135</sup> Vardakastanis, I. (Rapporteur), *Shaping the EU agenda for disability rights 2020-2030: a contribution from the European Economic and Social Committee (own-initiative opinion)* SOC/616, 2019 <https://www.eesc.europa.eu/en/our-work/opinions-information-reports/opinions/shaping-eu-agenda-disability-rights-2020-2030-contribution-european-economic-and-social-committee-own-initiative-opinion>

<sup>136</sup> European Parliament resolution of 7 October 2021 on the protection of persons with disabilities through petitions: lessons learnt, P9\_TA(2021)0414 [https://www.europarl.europa.eu/doceo/document/TA-9-2021-0414\\_EN.html](https://www.europarl.europa.eu/doceo/document/TA-9-2021-0414_EN.html)

<sup>137</sup> Agius Saliba, A., *Report on the protection of persons with disabilities through petitions: lessons learnt* A9-0261/2021, 2021, [https://www.europarl.europa.eu/doceo/document/A-9-2021-0261\\_EN.html](https://www.europarl.europa.eu/doceo/document/A-9-2021-0261_EN.html)

**profile scoring between Member States.** However, people who move also find themselves in a **new disability situation** and will benefit from the right to a comprehensive and holistic rights-based assessment in this new context, particularly if they living, working or studying for any length of time. Mutual recognition of prior assessment in a previous context is not always a substitute for this.

## 6. OPTIONS FOR MUTUAL RECOGNITION

### KEY FINDINGS

The study identifies significant challenges but also opportunities. The **challenges** include **barriers** to freedom of movement for citizens with disabilities and questions of **subsidiarity** for the Member States. The **opportunities** include shared commitments to the **CRPD** and convergence in recent national assessment reforms. Existing EU card recognition schemes have also proved successful. The development of a wider mutual recognition system would need to progress incrementally, and on a voluntary basis, but with a comprehensive ambition to extend its scope across areas of labour mobility, benefits and access to services. The most concrete first steps would be EU support for: (a) joint commitment to **common principles of assessment**, in line with the CRPD; (b) knowledge sharing and **mutual recognition of core components** for assessing personal capacities, based on ICF tools; (c) universal adoption of the **European Disability Card**, with digital security enhancements.

### 6.1. Starting points

The evidence and arguments presented in each chapter are reviewed in the Executive Summary. Some of the main cross-cutting conclusions can be summarised as follows:

**People with disabilities face additional barriers to mobility in the EU**, whether they are travellers, cross-border workers, job seekers or residents. Citizens' petitions and evidence collected by civil society demonstrates these concerns. Among these barriers are the **different criteria and procedures** that are applied to disability assessments, and to consequent entitlements or benefits, in each country (whether from public or private providers). There is a **strong case for adopting shared principles of disability assessment**, in line with international human rights and best practice, and for agreement on mechanisms for the **mutual recognition of disability status**.

**The principles of equality, accessibility and non-discrimination are well established in obligations under EU and international law** and in the domestic legislation of most Member States. A specific duty of non-discrimination on grounds of disability already applies under EU employment law. There is a European Accessibility Act. In principle, all providers should make their services accessible, and offer reasonable adjustments, to all people with disabilities. These rights exist in most cases with or without evidence of formal accreditation, either on request or in anticipation of their customers' needs. Nevertheless, there are **many situations in which proof of disability status is either required or helpful**. There are many more where it makes recognition quicker and easier.

**Service providers often request evidence for certain kinds of disability concessions**, such as reduced fares on public transport, priority seating at a sporting event, or free admission for a personal assistant to a museum. Some people with disabilities might be informally 'recognised' by providers of transport, retail and leisure services according to the visibility of their impairments (for example, a wheelchair user boarding a bus or a guide dog user entering a café). Most are not, however, and notably those with invisible impairments (including many people with chronic illnesses, sensory impairments, cognitive impairments, autism or mental health conditions). National card recognition schemes exist but a **standardised EU format**, like the existing European Parking Card (Blue Badge), is one way of

easing the problem for travellers who do not possess domestic identification in the Member State they are visiting.

**People with disabilities also face barriers to their free movement rights within the EU**, in addition to those faced by travellers. Persons who have been determined to have an administrative disability status in one Member State are rarely recognised as having this status in another Member State, even where national procedures for establishing this may be similar. Some social security entitlements are portable but social assistance rights are not. For jobseekers, cross-border workers, students and internal migrants the need for re-assessment and determination of disability status introduces delays in accessing disability benefits, practical help to live independently, support in education or in the workplace. **Mutual recognition of disability status** has been proposed as a policy mechanism to ease this problem too.

**Recognition is an end point rather than a starting point.** It is important to distinguish between three administrative concepts - assessment, determination and recognition. Disability **assessment** tests and measures evidence about the type and extent of disability that a person experiences. This may involve evidence about the person and/or their environment. Disability **determination** attributes an administrative status, or classification, to the findings from assessment. This may involve the application of statutory criteria to determine who is, or is not, 'disabled' for different policy purposes. Disability **recognition** is often based on proof of a status resulting from assessment. This may involve reference to a disability register or card.

**There are different definitions and practices of disability assessment and determination - among the Member States and in different policy fields.** Citizens' petitions raise concerns about this. Different approaches may result in similar determinations in different Member States, while similar approaches may result in different determinations. The study examines the principles of disability assessment, the different approaches taken in the Member States, and recent efforts to innovate and reform these processes. The evidence shows significant areas of difference but also some areas of potential convergence in assessment design. **Harmonising assessment is difficult but common entry points are possible**, for example in adopting shared principles from the **CRPD** or shared technical language from the **ICF**.

**The UN Committee on the Rights of Persons with Disabilities has observed failures of disability assessment or recognition in the EU and in Member States.** Disability assessment and determination procedures in several Member States have been identified as problematic from a disability rights perspective, either because they adopt an individualised and medicalised approach to disability or because they function in an arbitrary or exclusionary way. A common theme in UN recommendations to Member States is for **greater alignment of disability assessment with the principles of the CRPD**. In 2015 the EU was also recommended to address failures in the right to personal mobility for persons with disabilities with the introduction of a mutually recognisable '**European Mobility Card**' (a concept first proposed by civil society organisations). The development of a **European Disability Card** was successfully piloted and is now a Flagship initiative in the EU Disability Strategy, for development in 2023. The **Committee on Civil Liberties (LIBE)** also calls to extend the benefits of this Card.

**The EU Disability Card provides an administrative model for a mutual recognition mechanism.** Several EU Member States maintain administrative registers of disabled persons, based on a recognition of disability status for the purposes of targeted employment support (or exemption) and entitlement to various social protection benefits. This kind of statutory disability status is often recognised by other agencies and service providers on a voluntary basis, as a basis for offering other

entitlements (e.g. discounts, concessions). In some countries this kind of categorical status recognition does not exist. There are also examples of mutual recognition of disability status, including the well-established **European Parking Card**. An **EU Disability Card** has been in eight Member States with favourable results.

## 6.2. Challenges to existing systems

The 2015 World Bank study observed that:

The credibility and perceived legitimacy of a country's disability assessment procedure depends on a few fundamental considerations. First of all, **the assessments must be valid** to minimize 'false positives' (people assessed as disabled and receiving benefits but are not disabled) or 'false negatives' (people who should be assessed as having a disability and receiving benefits, but they are not) – see four examples above. Second, the procedure must be **reliable**, in the sense that two assessors following the same rules and criteria should be able to come to the same assessment of the same person (often called 'inter-rater reliability'). And lastly, the **decisions must be transparent and standardized**, so that the grounds for the decision-making are publicly known and their application in particular cases, when needed and applicable, independently evaluated. In short, the legitimacy of the disability assessment process depends on it being, and be seen to be, impartial, fair, and based on objective evidence.<sup>138</sup>

These concerns are magnified in the context of mutual recognition between EU Member States. **Challenges** arise in three situations: (a) where different assessments result in different scores on the same scale; (b) where different assessments are scored on different scales; and (c) where different awarding authorities recognise different scales.

- The first case represents **a problem of reliability or validity**, which may occur where the design of the assessment method or guidance relies on a high degree of discretion among the assessors or where there is a lack of moderation and quality control. In this case, Member States might be supported to improve reliability through the sharing of international best practice and the development of validated **scoring tools**.
- The second case represents **a problem of duplication or fragmentation**, which may occur when different disability assessments are used for similar purposes by different administrative authorities. It is relevant to underline that different policy functions often do require different disability assessments (e.g. establishing a level of need for support with daily living may require a different assessment, in a different environmental context, to establishing a level of capacity for employment). In this case Member States might be supported to **harmonise** shared elements of assessment for a common purpose.
- The third case represents a problem of recognition. This may arise from the problems above, but the difficulty is one of recognition, not of assessment. It is more analogous to the European challenge of recognising academic or professional qualifications awarded by different bodies in different Member States, such as the Bologna Process on mutual recognition of qualifications

<sup>138</sup> Bickenbach, J., Posarac, A., Cieza, A., & Kostanjsek, N., *Assessing disability in working age population: a paradigm shift from impairment and functional limitation to the disability approach*, World Bank Group, 2015, <https://documents1.worldbank.org/curated/en/272851468164970738/pdf/Disability-Assessment-Report-June-18-2015.pdf>

in the European Higher Education Area.<sup>139</sup> In this case, Member States might be supported by establishment of an equivalence framework and co-ordination of effort.

Evidence from the ANED study indicates that disability assessments in European countries often:

- adopt a medicalised or deficiency model of functioning and capacity, while neglecting the social and relational dimension of disability
- focus on a person's impairments, skills and capabilities, rather than the barriers that they face in context
- use diagnostic criteria that exclude some categories of persons, particularly persons with psychosocial or intellectual impairments
- fail to establish appropriate definitions of disability in legislation, at national and regional levels, or across sectors
- applied inconsistently in practice, or lack the support of adequate or appropriate training, leading to disparities in access to support and services

### 6.3. Gathering evidence

The **CoE study** (p. 11) observed that disability assessments may involve a variety of **evidence sources**, such as:

- 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 traditional centrality of medical knowledge, and of physicians, in disability assessment systems is well known. For example, Wind et al. compared the role of physicians in European social insurance assessments of work capability.<sup>140</sup> This was a feature highlighted by the Commission-funded study on disability definitions in 2002.<sup>141</sup> This study framed four types of disability assessment by weighing **reliance on medical evidence** against the level of discretion afforded to the assessors (medical or otherwise), as illustrated in Figure 7. Applying this scheme to the typology adopted so far helps to underline some of the differences between diagnostic and needs based assessment, and between objective and subjective criteria for evaluation. This study concluded that, while 'medically-oriented systems may enjoy wider legitimacy', systems with a lower emphasis on medical evidence scored higher on social policy relevance (p. 64).

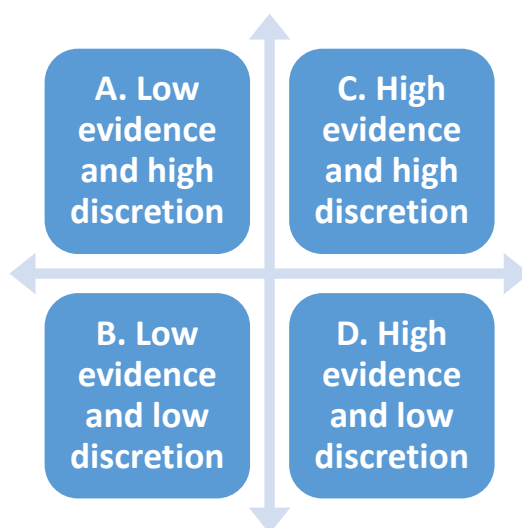
The following figure, adapted from this conceptualisation, extrapolates beyond the input of 'medical' evidence to represent the relationship of evidence to discretion in assessment more generally.

<sup>139</sup> European Higher Education Area and Bologna Process <http://www.ehea.info/>

<sup>140</sup> Wind, A., Dekkers-Sánchez, P., & Godderis, L., The role of European physicians in the assessment of work disability: A comparative study. *Edorium Journal of Disability and Rehabilitation*, 2016, 2, pp. 78-87.

<sup>141</sup> Brunel University, *Definitions of Disability in Europe, A Comparative Analysis*, European Commission, 2002, [www.ec.europa.eu/social/BlobServlet?docId=2088&langId=en](http://www.ec.europa.eu/social/BlobServlet?docId=2088&langId=en)

Figure 7: Evidence and discretion in disability assessment



Source: Adapted from Brunel University and European Commission, 2002

The **balancing of medical legitimacy against policy relevance** was examined also in Baumberg's study of the UK's work capability assessment system.<sup>142</sup> While arguing for improvements in the supply of medical evidence to non-medical assessors, he observed that a reliance on this type of evidence is risky:

Not only is medical evidence often unavailable, but claimants' treatment history only provides indirect evidence about their impairments. Assessors therefore combine this evidence with their wider medical knowledge to decide if the reported impairments are 'likely', potentially leading them to make unfair decisions where people's impairments are unusual, or where there are other reasons for a lack of treatment. (p. 12)

As EDF's position paper on assessment points out,<sup>143</sup> this is a concern because:

Several countries leave their assessments entirely up to medical professionals or officers of the municipality or State, who often do not have an understanding of what a human-rights based model of disability entails. Assessments that only consider a medical condition or a percentage of "incapacity" do not consider the lived experience of the person with a disability or the barriers they encounter on a daily basis. (p. 6)

Not all disability assessments will consider the same evidence, the need for which may vary between different policy functions but also between different individual circumstances. When designing an assessment system it is therefore vital to consider the sensitivity and specificity of the evidence required to reach a decision, the flexibility that may be needed, and the administrative burden of evidence collection (for the administrative authority, for assessors, and for the person being assessed). Table 12 summarises the kinds of considerations that may help to inform the design of disability assessment systems.

<sup>142</sup> Baumberg Geiger, B., 'Legitimacy is a balancing act, but we can achieve a much better balance than the WCA' – 'A Better WCA is Possible', *Demos*, 2018, p. 59.

<sup>143</sup> European Disability Forum (EDF), *Improving Disability Assessment Procedures in the EU*, 2021 <https://www.edf-feph.org/content/uploads/2021/09/Disability-Assessment-Position-Paper.docx>



Table 12: Considerations in evidence gathering for assessment

<b>How useful (and how necessary) is evidence of...?</b>
<ul style="list-style-type: none"> <li>• a medical diagnosis/prognosis</li> <li>• the person's functional capacities in general</li> <li>• the barriers in their environment (e.g. at home, at school, at work)</li> <li>• the type of help they want/need</li> </ul>
<b>How useful (and necessary) is evidence from...?</b>
<ul style="list-style-type: none"> <li>• the person</li> <li>• other people close to the person (e.g. family, school, employer...)</li> <li>• medical or health professionals</li> </ul>
<b>How useful (and necessary) is it to collect evidence in...?</b>
<ul style="list-style-type: none"> <li>• a structured form</li> <li>• written statements/letters</li> <li>• conversation with the person and/or their representative (by video, telephone, meeting)</li> <li>• observation of the person in their environment</li> </ul>
<b>How useful (and necessary) is a meeting...?</b>
<ul style="list-style-type: none"> <li>• Are some cases easier to decide than others?</li> <li>• Is there a 'fast track' route for some cases?</li> </ul>
<b>At which stage can a decision (such as a disability determination) be made...?</b>
<ul style="list-style-type: none"> <li>• at the first point of application</li> <li>• after written evidence is submitted</li> <li>• after meeting the person</li> <li>• after reviewing all of these stages independently</li> </ul>
<b>Who should...?</b>
<ul style="list-style-type: none"> <li>• review the evidence</li> <li>• make the decision</li> <li>• What kind of knowledge and training do they need?</li> </ul>
<b>How can disabled people be involved in...?</b>
<ul style="list-style-type: none"> <li>• self-assessment</li> <li>• supporting other disabled people in their assessment</li> <li>• helping to assess other disabled people</li> <li>• reviewing and evaluating system performance</li> <li>• reforming and re-designing the assessment system</li> </ul>

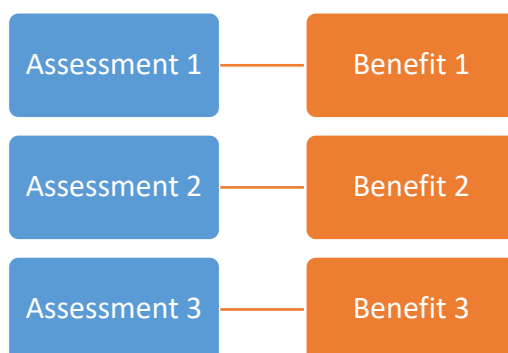
## 6.4. Matching recognition to policy function

This study has illustrated at length the technical complexity and contextual sensitivity of disability assessment. **Assessments needs to be matched to policy functions.** It is not realistic to expect an EU system for mutual recognition of disability to serve all policy functions. The following policy design options are therefore important to consider, at national level and in any shared agreements. The options may be divided into three types.

### Option 1: The specialist model

This option maximises **sensitivity of assessment to policy function** (i.e. to a person's needs and capacities in a specific context). It assumes that **different contextual assessments are needed for different functions** (as represented in Figure 8). An assessment for access to support at college requires a different approach, or expertise, to one for support in the workplace, or in the home. An assessment providing entitlement to a disability pension (compensating for loss of earnings) requires different evidence than an assessment of additional cost of living compensation. It favours a personalised approach but risks duplication and administrative burden.

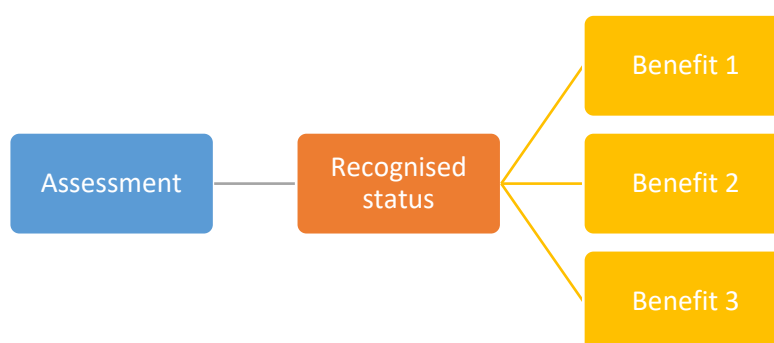
Figure 8: A specialist model of assessment



### Option 2: The passport model

This model maximises the specificity of assessment to reach a **stable determination of disability status** that is **transferable between policy functions**, often using a **fixed scale or classification**. This approach is more typical of a **disability register or card recognition system**, which then acts as a **passport or gateway to wide range of benefits** (either statutory or voluntary). It is easily recognised but risks the attention to environmental factors in context demanded by an interactive model of disability. This is illustrated in Figure 9.

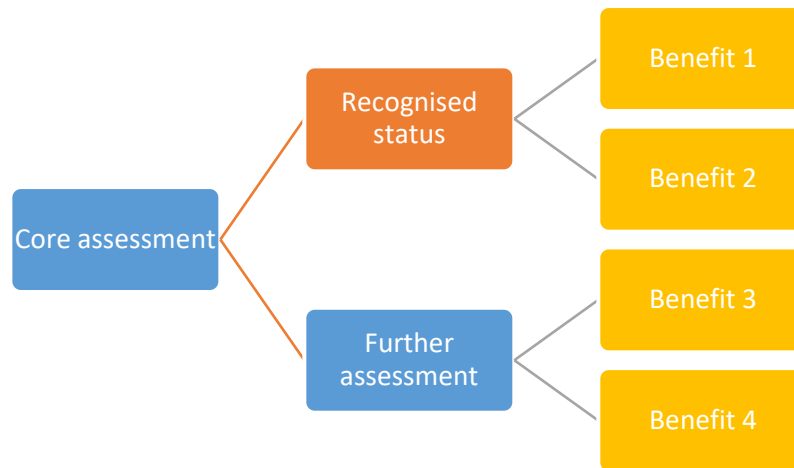
Figure 9: A passport model of assessment



### Option 3: The hybrid model

Taking account of the strengths and weaknesses of the preceding models, the third and recommended option for mutual recognition is a **hybrid**. In this model, a **core, or baseline, component of assessment** provides sufficient evidence to act as a **passport** for some benefits but requires **additional assessments** sensitive to other policy functions. For example, a core assessment of capacities and performance based on ICF tools might be sufficient to issue a disability card, which is recognised for some cash benefits or concessions. But a further holistic assessment in context might be needed to establish what type and amount of support the person needs to live independently in the community. This can be characterised as a **core and branching model**, as illustrated in Figure 10.

Figure 10: A core and branch model of assessment



## 6.5. A statement of shared principles and commitments

The shared commitment of the EU and all Member States to implement the CRPD, under their respective domestic obligations as parties to that Treaty, presents an opportunity to frame a joint statement of commitment to shared principles. All parties are publicly committed to **an interactive model of disability** in principle, as embodied in Article 1 CRPD. Reaffirming this commitment in a joint EU position would go some way to reinforcing the need to address environmental as well as personal dimensions of disability across all relevant policies (and specifically in disability assessment policies).

As a first step towards mutual recognition in the disability field the EU institutions could encourage and support the Member States to **adopt a common statement of general principles on the implementation of disability assessment in line with CRPD**. The **'12 principles' for rights-based assessment elaborated through the ANED study** (and listed in chapter 2.2) provide a template or a starting point for such a statement. In addition, the **EDF position paper on assessment** concludes, on grounds of CRPD compliance, that disability assessments should be designed so that:

- Assessment should focus on the requirements of the person linked to **barriers** within society, rather than solely on their impairment;
- Support for persons with disabilities should be assessed, through a **personalised** approach, and tailored to the specific activities and actual barriers that persons with disabilities face in being included in the community;

- The assessment should acknowledge that persons with disabilities require access to participate in activities that vary over **time**, and thus be flexible to reassessment when it is felt more support is needed;
- The process should be **multidisciplinary**;
- Assessment should include **face-to-face** assessment that fully involves the person with disabilities;
- Assessment should take into account, and follow a person's will and preferences, and ensure the full **involvement** of persons with disabilities in the decisionmaking process.

## 6.6. Sharing good practice

Several Member States have received recommendations from the UN CRPD Committee to reform their disability assessment systems and these reinforce the above principles. This has encouraged the trend of recent reforms, from a reliance on medical and functional knowledge towards more holistic disability assessments that take greater account of environmental factors. CRPD recommendations have stimulated initiatives to review existing systems and evaluate new approaches, often supported by technical assistance from international organisations with EU funding (see chapter 4). There would be scope for the EU to support the Member States in **sharing these experiences and synthesising good practice** from the lessons learned.

A mutual disability recognition system in the EU needs to contend with:

- Different models of disability
- Different methods of assessment
- Different types of evidence
- Different ways of managing the process

While a statement of general principles goes some way to resolving the first difference, lesson learning is important in addressing the remaining ones. There is already **some convergence** in recent national reforms, notably in the adoption and adaptation of disability assessment tools developed in line with the ICF framework. Drawing general lessons from the implementation of these approaches could assist other Member States in developing their own reforms, and increase the likelihood of mutual recognition for assessments that have been conducted in different Member States using similar tools for evidence collection and recording.

The EDF position paper also calls for specific **improvements** to disability assessment process, in addition to general principles, that could be advanced by sharing good practice, such as to:

- Provide opportunities for persons with disabilities to **be part of their own assessment process**. It should allow them to offer their insights and evaluations of their disability and their support needs. This could be done through a face-to-face meeting with the assessor or via a self-assessment that they complete.
- Improve the understanding of **"hidden" or "invisible" disabilities**, as well as rare conditions, of all professionals who are part of the disability assessment process to avoid misdiagnosis or absence of diagnosis. Professionals should also be better trained into the way different conditions and disabilities manifest themselves in women, who have a greater tendency to be misdiagnosed.

- Focus on reducing waiting times for people awaiting disability assessment and reduce excessive demands for reassessment. Continued assessment should be done in a reasonable and measured way and only when justified, so as not to place the person with disability under unnecessary stress.

The recent Social Protection Committee report on needs-based assessment for access to long-term care draws on findings from the ANED research to argue that:

Good practices for the design and application of any needs assessment make this procedure as easy and user-friendly as possible. ... This can usefully include: the involvement of non-governmental organisations and stakeholders in the design of the assessment; eliminating multiple (methods of) assessment, which should reduce the burden on applicants; and independent, regular reviews of assessment processes. The assessment should be conducted in a way that allows for the identification and elimination of obstacles and barriers to its accessibility.<sup>144</sup>

**In summary, as articulated in the ANED study, disability assessment should:**

- Start from a **social and human rights model** of disability
- **Involve** disabled people's organisations and human rights bodies in the design
- Include **multidisciplinary** expertise in the disability assessment system
- Provide accessible and user-friendly **information** about application processes, eligibility criteria, appeal and support options
- Support the **active participation** of disabled persons in generating the evidence on which their individual disability assessments are made
- **Reduce** duplication and administrative **burden** for applicants (and systems)

## 6.7. A common core standard for disability assessment

**A fully harmonised system of disability assessment and recognition, among all Member States and across all policy functions is challenging.** The legal, technical and political considerations are significant. Different methods of assessment branching, tailoring and specialism are fitted to different policy functions in different national and local contexts. Nevertheless, there are **opportunities to consider the development of a mutually recognisable 'common core' for disability assessment.**

As a minimum, Member States could be supported towards a **joint agreement** recognising the currency of internationally validated assessment tools as admissible evidence in their domestic disability assessments. These might include components of the **ICF Checklist** or **WHODAS 2.0** (as well as common diagnostic criteria based on **ICD**). This could lead to **development of a mutual recognition framework for ICF scoring profiles, representing a person's individual 'capacities' and the kinds of 'environmental' barriers they have faced** (actual 'performance' depends on the current situation). In many cases, the mutual recognition of a **core disability profile** might provide a sufficiently robust **passport** to fast-track entitlements to some policy functions in another Member State. It would at least speed the process and reduce the administrative burden of re-assessment when people move.

<sup>144</sup> Social Protection Committee (SPC) and the European Commission (DG EMPL), *Long-Term Care Report: Trends, challenges and opportunities in an ageing society*, 2021, p. 52 <https://ec.europa.eu/social/BlobServlet?docId=24079>

Although codified scores, like those used in the ICF tools, are simplistic, they have the advantage of being **easily translatable in a shared technical language, with high validity and international currency**. They are at least as reliable as the currency of study credits and grade averages already used for mutual recognition of academic qualifications across the EU.

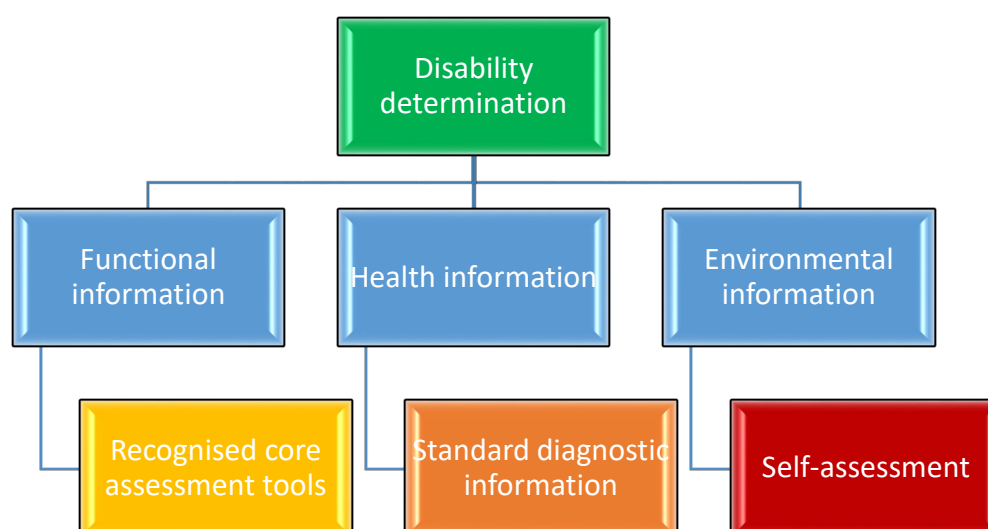
The potential for comparability with **national scales of disability** (Baremas) has also been considered. Such scores are no substitute for holistic and qualitative assessments of needs, access to which must remain a right for the allocation of appropriate individualised support, but they may be sufficient to establish a baseline of mutual status recognition. As illustrated in chapter 2.4, the most widely validated tools cover, to varying extent, the following areas of human functioning:

- Cognition – understanding and communicating
- Mobility – moving and getting around
- Self-care – hygiene, dressing, eating and staying alone
- Getting along – interacting with other people
- Life activities – domestic responsibilities, leisure, work and school
- Participation – joining in community activities

There are also checklists related to activities of daily living (see chapter 3.2).

Based on existing convergence trends, and the potential for mutual recognition of a common core (drawing on the Latvian case study summarised in chapter 4.4, and the 'hybrid' model outlined in 6.4) a schema for core disability status determination is suggested in Figure 11:

Figure 11: A framework for recognisable core evidence in disability determination



Based on agreement among the Member States it might be possible to **establish a basis for mutual recognition of qualifying criteria for a European Disability Card**, while retaining the principle of **subsidiarity over national rules of eligibility for social benefits in cash or kind**. Agreement on a common core might also facilitate information sharing of selected assessment scores through secure digitisation of the Card record, if required (e.g. in a similar way to the sharing of national digital driving licence information with car rental companies).

There are some policy tensions between the divergent assessment methods and criteria used to establish disability status in the Member States, and the convergent mechanism of a European Disability Card for mutual recognition between them. It would be relevant therefore to consider, alongside mutual development of the Card, the potential for **greater harmonisation or shared principles of disability assessment** (e.g. via EU support for the voluntary incorporation or mutual recognition of one or more core components of assessment).

People who move between Member States find themselves in a **new disability situation**. They would benefit from **rapid 'recognition'** of their existing capacities and the kinds of barriers they face. This would be greatly assisted by a passport mechanism, like the European Disability Card, backed by a verifiable digital record, and with mutual recognition of core assessment scoring between Member States. This could provide **accelerated access to a range of benefits and services** (see Table 1), **either with or without additional evidence tailored to the policy function**. However, people who move also retain their **right to a comprehensive and holistic assessment of their needs in the context of their new environment**, particularly if they will be living, working or studying there for any length of time. Mutual recognition of disability status based on prior assessment in a previous context is much needed while also ensuring each person's right to needs-based assessment in context of their changing life situations.



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## ANNEXES

### A: The 36-item WHODAS 2.0

In the past 30 days, how much difficulty did you have in:
<b>Understanding and communicating</b>
D1.1 Concentrating on doing something for ten minutes?
D1.2 Remembering to do important things?
D1.3 Analyzing and finding solutions to problems in day-to-day life?
D1.4 Learning a new task, for example, learning how to get to a new place?
D1.5 Generally understanding what people say?
D1.6 Starting and maintaining a conversation?
<b>Getting around</b>
D2.1 Standing for long periods such as 30 minutes?
D2.2 Standing up from sitting down?
D2.3 Moving around inside your home?
D2.4 Getting out of your home?
D2.5 Walking a long distance such as a kilometer [or equivalent]?
<b>Self-care</b>
D3.1 Washing your whole body?
D3.2 Getting dressed?
D3.3 Eating?
D3.4 Staying by yourself for a few days?
<b>Getting along with people</b>
D4.1 Dealing with people you do not know?
D4.2 Maintaining a friendship?
D4.3 Getting along with people who are close to you?
D4.4 Making new friends?
D4.5 Sexual activities?
<b>Life activities</b>
D5.1 Taking care of your household responsibilities?
D5.2 Doing most important household tasks well?
D5.3 Getting all the household work done that you needed to do?
D5.4 Getting your household work done as quickly as needed?
D5.5 Your day-to-day work/school?
D5.6 Doing your most important work/school tasks well?



D5.7 Getting all the work done that you need to do?
D5.8 Getting your work done as quickly as needed?
<b>Participation in society in the past 30 days:</b>
D6.1 How much of a problem did you have in joining in community activities in the same way as anyone else can?
D6.2 How much of a problem did you have because of barriers or hindrances in the world around you?
D6.3 How much of a problem did you have living with dignity because of the attitudes and actions of others?
D6.4 How much time did you spend on your health condition, or its consequences?
D6.5 How much have you been emotionally affected by your health condition?
D6.6 How much has your health been a drain on the financial resources of you or your family?
D6.7 How much of a problem did your family have because of your health problems?
D6.8 How much of a problem did you have in doing things by yourself for relaxation or pleasure?

Source: WHODAS



## B: Assessment criteria for capacity to work

The following excerpts were extracted from MISSOC Table V 'Invalidity / Conditions / Assessment criteria and categories of capacity/incapacity for work' (version 1 January 2022)

Country	Assessment criteria and categories of capacity / incapacity for work
Austria	Reduction in capacity for work of at least 50%. Decisions regarding entitlement or reports in this regard are always made on a case-by-case basis. The decision as to whether the person is deemed incapacitated/incapable of working will be based on a doctor's report detailing the applicant's capacity for performing their job.
Belgium	Reduction of earning capacity of at least 66%. It is the responsibility of the medical officer to recognise the incapacity of an insured person (see category Covered risk - Definitions).
Bulgaria	Benefit entitlement: 50% reduction in working capacity/ degree of disability. Different criteria are used depending on the nature of the disability.
Croatia	The assessment is carried out on the basis of the Decree on Examination Methodology, which also contains two methods of measuring: a list of the damage to organs and a list form of disability and impairment of functional abilities. In this way, a comprehensive assessment is made of the person concerned, with a unique set of criteria applied for determining their state of disability Minimum level of reduction in work capacity: 50%.
Cyprus	The invalidity pension is payable to insured employees and self-employed persons and to voluntarily insured persons working for a Cypriot employer overseas who have been off work for at least 156 days and who, within that period, demonstrate that they are going to remain permanently incapable of work i.e. that they are unable to obtain, in the context of an activity which they would in principle be able to perform under normal circumstances, an income above one third of the amount generally earned by a healthy person with the same level of education exercising the same occupation in the same region; or, in the case of people aged from 60 to 63, to those incapable of earning an income greater than half of that amount.
Czechia	The assessment of the invalidity focuses on long-term (i.e. more than one year or expected to last more than one year) disability and loss of working ability. To establish the degree of invalidity, the physician assesses the reduction in working capacity, the capacity to resume work and the possibility to follow retraining/education for another type of gainful activity if the person is unable to perform their previous job. Minimum level of reduction in capacity to work: First degree invalidity (První stupeň invalidity): 35% reduction in working capacity .
Denmark	Disability pension (førtidspension): The capacity for work for a person between 40 and pensionable age must be permanently reduced to an extent that the person cannot assure his/her subsistence, not even by working in a flexi-job in any kind of work. The capacity for work is measured by the municipality and the rehabilitation team in each case. For a person aged between 18 and 39, it must be absolutely evident that they will never be able to work.

	<p>Senior Pension (seniorpension): The capacity for work is reduced to less than 15 hours a week in the latest job. The capacity for work is measured by the Senior Pension Unit (Seniompensiosenhed).</p> <p>No official minimum level of capacity for work specified.</p>
Estonia	<p>No minimum level of work ability (incapacity). The beneficiaries must be assessed as partially able to work or not able to work.</p> <p>Work Ability Assessment is based on The International Classification of Functioning, Disability and Health (ICF). During the assessment process a working age person's health status and restrictions arising therefrom that should be taken into consideration in order to facilitate working life participation (finding and keeping job) are clarified.</p> <p>A person's activity capability is assessed in following domains:</p> <ul style="list-style-type: none"> <li>* Moving</li> <li>* Manual performance</li> <li>* Communication</li> <li>* Self-care and consciousness</li> <li>* Learning and applying knowledge/skills</li> <li>* Adaption to changes and perception of safety</li> <li>* Interpersonal interaction</li> </ul> <p>The activities being assessed have to be performable repeatedly, safely, in a usual manner (without any disturbing pain).</p> <p>While assessing activity capability it is assumed that the treatment (if possible) to compensate a health disorder is prescribed and that a person is following physician's recommendations.</p>
Finland	<p>National pension (Kansaneläke):</p> <p>Disability pension can be granted if the person has illness, injury or defect that prevents from earning a reasonable living. Age, education, professional skills and previous jobs are taken into account when assessing the ability to function. From the age of 60 more lenient criteria are applied to disability pension. Persons under 20 cannot get pension until their rehabilitation prospects have been assessed.</p> <p>Statutory earnings-related pension (Työeläke):</p> <p>The assessment criteria used to assess eligibility are related to the degree of the capacity to perform any kind of work which reflects the ability to earn of the person concerned. Criteria take into account employee's formal training, previous activities, age, residence and other comparable issues.</p> <p>If the working capacity varies, the employee's annual earnings are taken into account. Also the vocational nature of the disability is taken into account for persons who turned 60.</p> <p>According to the remaining working capacity, the following benefits are available:</p> <ul style="list-style-type: none"> <li>* Disability pension (Työkyvyttömyyseläke): No more than 2/5 of working capacity left;</li> <li>* Partial disability pension (Osatyökyvyttömyyseläke): No more than 3/5 of working capacity left.</li> </ul> <p>If the ability to work is assessed to be restorable, the person concerned is entitled to a temporary Cash rehabilitation benefit (Kuntoutustuki), i.e. a time-limited disability pension.</p>
France	<p>Any person suffering from an at least 2/3 (66.66%) loss in capacity to work or earn money is deemed disabled.</p> <p>There are three different levels of invalidity:</p> <ul style="list-style-type: none"> <li>* 1st group: medically able to work;</li> </ul>

	<ul style="list-style-type: none"> <li>* 2nd group: medically unable to work;</li> <li>* 3rd group: medically unable to work and in need of daily care from a third person.</li> </ul>
Germany	<p>Partial incapacity (teilweise Erwerbsminderung): Capacity for any work from 3 and up to 6 hours a day, regardless of the person's job prior to claiming the benefit. The usual labour market conditions and requirements are taken as a basis.</p> <p>Total incapacity (volle Erwerbsminderung): Capacity for any work less than 3 hours a day.</p>
Greece	<p>Assessment criteria: A person is considered to have normal invalidity (ΣΥΝΗΘΗ ΑΝΑΠΗΡΙΑ) when, as a result of illness or physical or mental disability which appeared or worsened after affiliation, he/she cannot earn from work that responds to his/her strengths, skills and education and his/her usual professional employment, more than a third of the normal earnings of a mentally and physically healthy person in the same occupational category and educational level during at least 1 year.</p> <p>A person is considered to have partial invalidity (ΜΕΡΙΚΗ ΑΝΑΠΗΡΙΑ) when, as a result of illness or physical or mental disability which appeared or worsened after affiliation, he/she cannot earn from work that responds to his/her strengths, skills and education and his/her usual professional employment more than half of the normal earnings of a mentally and physically healthy person in the same occupational category and educational level in the same prefecture during at least six months.</p> <p>A person is considered to have severe invalidity (ΒΑΡΙΑ ΑΝΑΠΗΡΙΑ) when, as a result of illness or physical or mental disability which appeared or worsened after affiliation, he/she cannot earn more than a fifth of the normal earnings of a person of the same educational level during at least 1 year.</p> <p>The results of applying these criteria are expressed in percentage:</p> <ul style="list-style-type: none"> <li>* severe invalidity: invalidity of more than 80%;</li> <li>* normal invalidity: invalidity between 67% and 79.99%;</li> <li>* partial invalidity: invalidity between 50% and 66.99%.</li> </ul> <p>Minimum level to be eligible to invalidity pension: 50%.</p> <p>For civil servants the criteria used to assess eligibility for invalidity pension depend on the capacity to perform their duties in the civil service. The results are not expressed in percentage.</p>
Hungary	<p>All applicants are examined by the rehabilitation body of the county government office. Those with a state of health equals to 60% or less are entitled to the benefit. If their state of health is assessed as being below 31%, their self-sufficiency is examined (those who can be employed with permanent assistance are self-sufficient).</p> <p>No minimum levels of capacity/incapacity for work specified.</p>
Ireland	<p>Invalidity Pension is a payment for insured people who are permanently incapable of work because of an illness or incapacity.</p> <p>To qualify the person must have been incapable of work for at least 12 months and be likely to be incapable of work for at least another 12 months, or be permanently incapable of work.</p> <p>Where persons have been in receipt of Illness Benefit (for a minimum of 6 months) or Invalidity Pension and wishes to return to work, they may qualify for Partial</p>

	Capacity Benefit if their capacity for work is reduced by a medical condition. The restriction on capacity for work must be assessed as moderate, severe, or profound. No minimum level of capacity/incapacity for work specified.
Italy	<p>The main criteria used to assess eligibility for invalidity benefits are related to the extent to which a person's ability to function and perform everyday tasks is impaired.</p> <p>Impairment is measured by way of medical assessments carried out by ad hoc commissions within both the Local health authorities and the legal medical department at INPS. The remaining capacity to perform either the previous job or any kind of work is measured against given reference values (e.g. Katz scale, see "Table XII, Long-term care, indicators and categories of need")</p> <p>Invalidity is expressed as a percentage of the normal capacity to work:</p> <ul style="list-style-type: none"> <li>* between 66% and 99% of the capacity to work for the Invalidity allowance (assegno ordinario d'invalidità, AOI);</li> <li>* 100% incapacity for work for the Incapacity pension (pensione di inabilità).</li> </ul> <p>The minimum level of reduced capacity to work is 66%.</p>
Latvia	<p>Eligibility to invalidity benefit (Invaliditātes pensija) is related to the degree of incapacity to work.</p> <p>According to Disability Law, people with disabilities aged between 18 and pensionable age are divided into 3 groups according to their limited ability to work:</p> <ul style="list-style-type: none"> <li>* Group I, if the loss of ability to work is 80-100% - very severe disability,</li> <li>* Group II, if the loss of ability to work is 60-79% - severe disability,</li> <li>* Group III, if the loss of ability to work is 25-59% - moderate disability.</li> </ul> <p>Minimum reduction in ability to work: 25%.</p>
Lithuania	<p>The extent of the work capacity is determined by assessing the medical, functional, professional conditions of the person concerned.</p> <p>The professional conditions are assessed by completing a Personal Activity and Ability Questionnaire, while The personal health information is provided by the treating doctor.</p> <p>The loss of capacity is expressed as a percentage of the total incapacity for work. It can be:</p> <ul style="list-style-type: none"> <li>* full if the loss of the loss of capacity to work is between 75-100%;</li> <li>* partial if it is between 45-75%.</li> </ul> <p>There is a minimum level of incapacity to work of 45% in order to be entitled the Work incapacity Pension (Neteko darbingumo pensija).</p>
Luxembourg	<p>Invalidity pension (pension d'invalidité):</p> <p>A person is disabled when his/her capacity to work is reduced to the extent that he/she can no longer perform his/her last profession or any other occupation corresponding to his/her strengths and skills.</p> <p>No minimum level of capacity/incapacity to work is specified.</p> <p>Income for the severely disabled people (revenu pour personnes gravement handicapées):</p> <ul style="list-style-type: none"> <li>* the person must present at least a 30% reduced ability to work because of a physical, mental, sensorial or psychological impairment and/or because of psychosocial difficulties aggravating the impairment;</li> <li>* the impairment must have diagnosed before the age of 65;</li> <li>* the person must present a state of health incompatible with any strain of work or have his/her skills reduced to such extent that is impossible to adapt, within the ordinary or sheltered environment, a workstation to his/her needs.</li> </ul>

Malta	<p>The main criteria used to assess eligibility for invalidity pension relate to: the extent to which the persons' ability to perform work and everyday tasks is impaired after their condition has been properly and fully treated.</p> <p>The extent of the impairment determines the medical condition of the claimant as:</p> <ul style="list-style-type: none"> <li>* permanent, i.e. it is likely to persist for at least one year after the diagnosis and treatment;</li> <li>* temporary, i.e. either affecting the person for less than one year or not yet diagnosed or treated.</li> </ul> <p>Based on these criteria, a percentage of reduced working capacity is determined for each category.</p> <p>The minimum level of reduced working capacity in order to be entitled to the pension is 20%.</p>
Netherlands	<p>WIA/WAO</p> <p>If after two years of illness the earning capacity is still reduced due to invalidity, a doctor and occupational expert of the Employee Insurance Agency (UWV) will carry out an examination to determine the degree of the work incapacity by establishing the so-called wage loss, i.e. the loss of earnings due to the illness or disability in relation to the claimant's previous earnings.</p> <p>In the Netherlands, no distinction is made as to the cause of incapacity (invalidity or employment injury). The examination also considers the steps taken by the employer and the employee to facilitate the return to work (see Table III, "Return to active working life").</p> <p>Wajong before 2015</p> <p>People were eligible for Wajong when earning capacity was below 70% of the reference person (maatman) (in most cases 70% of minimum wage), and the work incapacity occurred before the age of 18 (or before 30 if studying).</p> <p>Wajong from 2015</p> <p>To be eligible, invalidity must occur before the age of 18 (or before 30 in the case of study). A doctor and occupational expert of UWV carry out an examination to determine whether the work incapacity is permanent (duurzaam geen arbeidsvermogen), i.e. when someone: cannot perform a task in a work organisation and/or does not have basic employee skills and/or cannot work consecutively for at least one hour and/or is not capable to work for at least four hours a day.</p> <p>Minimum level of reduced working/earning capacity in order to be entitled to benefit:</p> <ul style="list-style-type: none"> <li>* WAO (previous scheme): 15%</li> <li>* WIA (current scheme): 35%</li> <li>* Wajong: 100%</li> </ul>
Poland	<p>Eligibility for the invalidity pension is related to the person's total or partial loss of capacity to work due to illness or disability.</p> <p>The criteria to assess the eligibility relate to: the extent of the impairment and the possibility of restoring it through medication and rehabilitation; and the ability to perform current work or another kind of work and the likelihood of occupational retraining (considering also education and age).</p> <p>Incapacity is not defined in percentages or points, but as either "total" or "partial" according to the remaining working capacity:</p> <ul style="list-style-type: none"> <li>* total if the person has lost its capacity to perform any work. This gives entitlement to Permanent Invalidity Pension (Renta stała);</li> </ul>

	<p>* partial if the person has lost – to a considerable degree – the capacity to perform the work corresponding to their qualification. This gives entitlement to partial Invalidity Pension (Renta okresowa).</p> <p>No minimum level of capacity/incapacity for work specified.</p>
Portugal	<p>The existence of a permanent invalidity is evaluated on the basis of the physical, sensory and mental functioning, the general condition, the age, the professional skills and the remaining capacity to work.</p> <p>An invalidity can be relative or absolute according to the level of incapacity.</p> <p>Relative invalidity: 66.66% reduction of capacity for performing normally the current or previous occupation; the disabled person is not allowed to earn in his/her current occupation more than one third of the salary normally received and is considered as not able to recover within a period of 3 years the capacity to earn more than 50% of the current salary.</p> <p>Absolute invalidity: 100% permanent and definitive incapacity to carry out any working activity; the disabled person is not allowed to return to work, and till he/she turns 65.</p>
Romania	<p>Main criteria: loss of at least 50% of the working capacity. The social insurance expert doctor assesses the work capacity on the basis of a scale which indicates the functional loss with repercussions on the performance of tasks according to age, qualification and existing socio-cultural factors.</p> <p>Invalidity categories:</p> <ul style="list-style-type: none"> <li>* Category I – total loss of work capacity and self-sufficiency,</li> <li>* Category II – total loss of work capacity, but preservation of self-sufficiency,</li> <li>* Category III – loss of at least half of work capacity, the person being able to perform a professional activity for at most half of full working time.</li> </ul>
Slovakia	<p>Eligibility to invalidity benefit is related to the degree of impairment of the person, i.e. the extent to which long-term adverse health conditions cause a decrease in the ability to perform a gainful activity for at least a year.</p> <p>The reduction in the work capacity is assessed on the basis of the physical and mental conditions of the person by assigning a specific percentage for each type of illness or disability (as indicated in the Annex of the Act).</p> <p>To be entitled to the benefit, the minimum level of reduction in the capacity to work compared to a healthy individual is 41%. If the loss of the capacity is higher than 70%, invalidity is considered as full invalidity (Plná invalidita).</p>
Slovenia	<p>The main criteria used to assess eligibility for invalidity benefits relate to the degree of the capacity to work.</p> <p>The assessment criteria are based on the reduced capacity to perform professional tasks related to their previous and any kind of job. Based on this, there are three categories of invalidity:</p> <ul style="list-style-type: none"> <li>* Category I: capacity to engage in any gainful employment activity is totally lost;</li> <li>* Category II: capacity for work is reduced by 50% or more;</li> <li>* Category III: capacity to work full-time is impaired, but the person concerned is capable of working in a certain job at least on a part-time basis; or the capacity to work in the occupation for which they have been trained for is reduced by less than 50%; or they can continue to work on a full-time basis but cannot perform the same job they had before.</li> </ul> <p>Results of the assessment are expressed as a percentage of the capacity to work.</p> <p>No minimum level of capacity/incapacity for work specified.</p>



Spain	<p>Permanent invalidity, whatever its determining cause, is classified according to the percentage of reduction of the capacity for work:</p> <ul style="list-style-type: none"> <li>* partial permanent incapacity for the usual occupation (incapacidad permanente parcial para la profesión habitual): disability that causes the worker's ability to perform his/her usual profession to be reduced by 33% or more, without keeping the worker from performing the basic tasks of the profession;</li> <li>* total permanent incapacity for the usual occupation (incapacidad permanente total para la profesión habitual): disability that keeps the worker from performing all main tasks in his/her profession, but the worker is able to take up a different profession;</li> <li>* absolute permanent incapacity for all types of work (incapacidad permanente absoluta): disability that prevents the worker from performing any type of work or trade;</li> <li>* severe incapacity (gran invalidez): when the permanently disabled worker requires the assistance of another person to carry out the most basic activities.</li> </ul> <p>To be entitled to the invalidity benefits (pensiones de incapacidad), the worker is required to have a reduction of at least 33% in his/her normal ability to perform his/her usual profession.</p>
Sweden	<p>Sickness compensation (sjukersättning) or Activity compensation (aktivitetsersättning) can be paid to individuals with fully or partially reduced work capacity due to illness or other impairments to the physical or mental capacity for work.</p> <p>If the person has a partial disability, a reduced benefit is paid at <math>\frac{3}{4}</math>, <math>\frac{1}{2}</math> or <math>\frac{1}{4}</math> of the full benefit according to the assessed degree of disability.</p> <p>The reduced capacity to work is expressed as 1/1, <math>\frac{3}{4}</math>, <math>\frac{1}{2}</math> and <math>\frac{1}{4}</math>. The minimum reduction in capacity to work is <math>\frac{1}{4}</math> (except for Sickness compensation (sjukersättning) for ages 19-29, which is only granted if the capacity to work is 1/1 reduced).</p> <p>The reduced capacity to work is assessed in this manner regardless of whether the benefit will consist of guaranteed compensation (garanti-ersättning), income-related sickness/activity compensation (inkomstrelaterad sjukersättning/aktivitetsersättning) or both.</p>

Source: Missoc Comparative Tables, V. Invalidity, Conditions (Updated 1 January 2022)



## C: Assessment criteria for access to long-term care

The following excerpts were extracted from MISSOC Table XII 'Long-term care / Conditions / Minimum level of dependency' (version 1 January 2022)

Country	Minimum level of dependency
Austria	<p>Entitlement to Long-term care allowance (Pflegegeld) only exists for persons who are in need of care for more than 65 hours per month on average and that lasts presumably for at least 6 months. The long-term care allowance is granted for a limited period of time if, at the time of the decision, the cessation of a prerequisite for the granting of a long-term care allowance can be determined with certainty or a very high degree of probability.</p> <p>24-hour care can be funded as of benefit category 3.</p>
Belgium	<p>Sickness and invalidity insurance (nursing care at home and assistance of a third party), integration allowance (allocation d'intégration/integratietegemoetkoming) and allowance for assistance to the elderly (allocation pour l'aide aux personnes âgées/tegemoetkoming voor hulp aan bejaarden):</p> <p>Lack or reduction of autonomy.</p> <p>Assistance of a third party: the beneficiary must obtain a total of at least 11 points according to the guide used for the evaluation of the degree of autonomy according to the legislation on allowances for persons with disabilities and the assistance of a third party must be deemed absolutely necessary for a continuous period of at least 3 months.</p> <p>Flanders : Flemish social protection (Vlaamse sociale bescherming):</p> <p>Care budget for persons with disabilities (Zorgbudget voor mensen met een handicap):</p> <p>No minimum degree of dependency is applied to the beneficiaries of this care budget in general. Only two groupes of beneficiaries are indeed eligible on the basis of a minimum degree of dependency:</p> <ul style="list-style-type: none"> <li>* minors and young people who have at least 12 points on the medico-social scale for the granting of care allowances for children with specific support needs (or additional family allowances);</li> <li>* young people under 26 having at least 12 points on the medico-social scale for the granting of the integration allowance (since 1st anuary 2021, young adults with a first valid score (at least 12 points) for the integration allowance do not receive a care budget).</li> </ul> <p>Other groups of beneficiarries are eligible on the basis of separate criteria such as the date on which they have been registered on the waiting list for care to persons with disabilities (see "Field of application").</p> <p>Care budget for severely dependent persons (zorgbudget voor zwaar zorgbehoevenden):</p> <ul style="list-style-type: none"> <li>* a score of at least B on the Katz scale in a care institution (certificate available from the mutual insurance fund);</li> <li>* a total score of at least 13, or 6 points at least for the sum of the AIVQ and AVQ modules of the BelRAI Screener, taken within the framework of the care budget (indication) or within the framework of the family care or the additional home care (certificate);</li> <li>* a score of at least 15 on the socio-economic scale (with the view of the review of the entitlement to the integration allowance, to the budget care for elderly persons requiring care or to the assistance allowance for elderly persons);</li> </ul>

	<ul style="list-style-type: none"> <li>* score C or Cd on the Katz scale in a care institutions;</li> <li>* a score of at least 18 on the medico-social scale (comprising pillars P1, P2 and P3) for the care allowance for children with specific support needs (or additional family allowances);</li> <li>* certificate for palliative care allowance or palliative flat-rate amount: only valid for a first application for the care budget for severely dependent persons;</li> <li>* Kine-E: only valid if you have received, for three years, a positive decision based on an indication with the BEL scale or the BelRAI Screener.</li> </ul> <p>Care budget for elderly persons requiring care (zorgbudget voor ouderen met een zorgnood):</p> <p>7 points at least on the medico-social scale assessing the loss of autonomy.</p> <p>Walloon Region:</p> <p>Personal assistance budget for persons with disabilities: this personal assistance budget (BAP) enables to receive a support in life habits. It also gives the possibility for the relatives to receive some help and human support in assuming family and work responsibilities. The eligibility to the benefit of the BAP requires the fulfilment of various criteria: the applicants must be Belgian citizens or be assimilated to a person having the Belgian nationality or 5 years of continuous residence in Belgium; be domiciled in the French-speaking Walloon territory (i.e. in one of the Walloon communes except the 9 communes of the German-speaking Community); be less than 65 when submitting their first application for an intervention; have a disability.</p> <p>German-speaking Community: no minimum dependency degree is currently required, but counselling requirement through the German-speaking Community Office for self-determined life (Dienststelle für Selbstbestimmtes Leben – DSL). A counselling certificate (Beratungsbescheinigung) is requested for a stay in a rest home or in a retirement and nursing home, as well as for assistance to families and seniors. No standardized minimum level for psychiatric nursing homes and protected housing, but an individual analysis performed by the host institution.</p> <p>Joint Community Commission:</p> <p>In Brussels, the degree of dependency is assessed using the Katz scale. The categories of this scale taken into account for the financial intervention are categories O, A, B, C, D and “C dément” (suffering from dementia). This level is assessed by a doctor or by a multidisciplinary team (comprising at least one doctor) appointed by Iriscare, according to a guide established by ministerial decree. During a transition period (ending on 1st January 2022 at the latest (for assessments performed upon a request) or on 1st January 2024 (for assessments performed within the framework of a review)), the assessment will be performed by the doctors or multidisciplinary teams previously appointed by the Federal public service for social security.</p> <p>See also “Organisation”, “1. Evaluation of dependency”.</p>
Bulgaria	<p>In case of a supplement for care under the Social Insurance Code:</p> <ul style="list-style-type: none"> <li>* Reduced capacity to work/ degree of disability exceeding 90%.</li> <li>* The need of permanent assistance of a carer.</li> </ul>
Croatia	<p>There is a special list of injuries in which injuries are listed in% as well as a % of invalidity in accordance with that, impairment of functional abilities according to which determinations of the right is being recognized, not in terms of specific minimum of dependency.</p>

	<p>The right to allowance for help and care can be recognized if the person cannot meet the basic life needs, eg in organizing meals, preparing and eating meals, buying groceries, cleaning, etc.</p> <p>Personal disability allowance can be recognized for persons with severe disabilities or other severe permanent changes in health.</p> <p>The right to the status of a parent caregiver or caregiver can be recognized in relation to a child or a person who is completely dependent on the assistance and care of another person for the maintenance of life; who is completely immobile and with orthopedic aids or has more severe damage</p>
Cyprus	<p>Social Welfare Services (Υπηρεσίες Κοινωνικής Ευημερίας):</p> <p>There is no legal minimum level of dependency.</p> <p>Entitlement to long-term social care is based upon need, i.e. on the person's ability to carry out their daily home and personal care and to carry out daily activities outside the house (e.g. shopping, doctor visits, social activities).</p> <p>Department for Social Inclusion of Persons with Disabilities (Τμήμα Κοινωνικής Ενσωμάτωσης Ατόμων με Αναπηρίες)</p> <p>Social Benefits are granted to persons with moderate, severe or total disability.</p>
Czechia	<p>Minimum level of dependency for the Care Allowance (Příspěvek na péči): need of everyday assistance (incl. supervision) with at least 3 out of 10 basic living needs.</p> <p>No minimum level of dependency for in-kind benefits.</p>
Denmark	<p>No specific minimum level of dependency. Any request for personal and practical assistance must be considered on the basis of a specific and individual assessment of the need for assistance.</p>
Estonia	<p>There is no minimum level of dependency. The qualification for long-term care benefits is related to the person's individual need for assistance based on assessment.</p>
Finland	<p>The minimum level of dependency depends on the service or benefit required. Municipalities grant services on the basis of an assessment of individual needs and as stipulated in legislation.</p>
France	<p>Supplement for a third party (majoration pour tierce personne):</p> <p>Need of assistance of another person to perform the majority of activities of daily life.</p> <p>Supplementary benefit for recourse to a third party (prestation complémentaire pour recours à tierce personne):</p> <p>Incapacity which prevents the person concerned from performing independently at least three out of 10 activities of daily living as included in a grid.</p> <p>Special education supplement for a disabled child (complément d'allocation d'éducation de l'enfant handicapé):</p> <p>Degree of incapacity of 80%. Incapacity of at least 50% in case of attendance at a special institution or in case of specific coverage.</p> <p>Disability compensation allowance (prestation de compensation du handicap, PCH):</p> <p>Disability generating permanently or for a foreseeable period of minimum one year an absolute difficulty to perform at least one basic activity or serious difficulties to perform at least two basic activities.</p>

	<p>Allowance for loss of autonomy (allocation personnalisée d'autonomie, APA): Group 4 of the grid AGGIR (autonomie gérontologie groupes iso-ressources), which includes 6, depending on the degree of dependency. Only the first four GIR (groups iso-ressources) open entitlement to the allowance for loss of autonomy. GIR 4 concerns elderly persons who cannot perform their own transferring but who, once they are up, are able to move around in their home. They also need help bathing and getting dressed. This group also concerns elderly persons who have no mobility problems but who need help for bodily functions and meals. See also Table XII "Organisation. 1. Evaluation of dependency: indicators and categories of need".</p>
Germany	<p>Long-term care insurance (Pflegeversicherung): Prerequisite for being eligible for care services is the allocation of the person in need of care to one of five possible care levels, which is carried out by the medical service of the other assessors appointed by the care fund. To attain care level 1 (minor impairment of the person's independence or abilities), at least 12.5 points must be determined in the assessment. Because impairments are minor for care level 1, this group of persons in need of care does not have access to all long-term care benefits; the focus is on benefits allowing the person to stay in their home environment. All long-term care insurance benefits are available from care level 2 onwards.</p> <p>Social assistance (Sozialhilfe) As with long-term care insurance, the need for long-term care (Hilfe zur Pflege) requires at least care level 1.</p>
Greece	No minimum level of dependency.
Hungary	<ol style="list-style-type: none"> <li>1. Long-term care services for the elderly: Provided according to the person's dependency level (i.e. the person needs ongoing care and nursing, or the person has a certain degree of dementia, or the person lives alone in a degraded accommodation, or lives alone and is aged over 80, or lives alone and receive disability support or benefit).</li> <li>2. Long-term care services for people with disabilities: The person must have a certain type of disability, attested after medical examination (medical opinion).</li> <li>3. Long-term care services for psychiatric patients and persons with addictions: Serious dependency level is required (the person has to be unable to carry out activities of daily living sufficiently), as well as need for medical treatment (medical opinion).</li> <li>4. Long-term care services for homeless persons: Serious dependency level is required (the person has to be unable to carry out activities of daily living sufficiently due to age or mental/health condition).</li> </ol>
Ireland	For Nursing Homes Support Scheme, the minimum level of dependency is based on the fact that the person has been assessed as needing long-term residential care through the Care Needs Assessment. This means that generally the person needs 24 hours of nursing care, but not acute care.
Italy	<p>The levels of dependency/degree of incapacity required are as follows: Civilian invalidity (Invalidità civile): * 45% for benefits in kind;</p>

	<p>* 74% for the monthly Allowance paid to disabled with a reduced work capacity and income below poverty level (Assegno mensile di assistenza per invalidi con ridotta capacità lavorativa in stato di bisogno economico);</p> <p>* 100% for the Incapacity pension for Disabled not performing any gainful activity (Pensione di inabilità per invalidi civili).</p> <p>Constant attendance allowance (indennità di accompagnamento): 100% level of dependency.</p>
Latvia	<p>Evaluated and expressed in % of maximum ability for self-care and independency.</p> <p>Maximum level: 100% ability for self-care and independency.</p> <p>Minimum dependency level for qualifying for long-term care (level I of care): 75% ability for self-care and independency.</p>
Lithuania	<p>Social services are provided in cases where a person is assessed as partially self-sufficient'</p> <p>Long-term medical treatment with nursing services is provided according to the health condition of the person and the progress of any disease.</p>
Luxembourg	<p>Benefits under the dependency insurance are granted if the dependent person is in need of assistance and care for basic everyday activities for at least 3.5 hours per week and if his/her dependency condition is likely to last longer than 6 months or to be irreversible.</p>
Malta	<p>Required levels of dependency to qualify for long-term care services vary according to the type of service being requested.</p> <p>For community long-term care services, there is no particular minimum level of dependency although the level of need for such benefits is professionally evaluated before a decision is taken on entitlement.</p> <p>For residential care services, a multi-disciplinary professional assessment is carried out and entitlement to the care is based on the level of dependency (i.e. medium or high dependency) which is determined according to the Barthel Score for those who have been diagnosed with dementia.</p>
Netherlands	<p>Long-term care act (Wet langdurige zorg):</p> <p>Long-term care is only provided if people need permanent supervision or continuous 24-hour care close by.</p> <p>No other minimum level of dependency.</p>
Poland	<p>No general minimum level of dependency but different rules apply based on different benefits:</p> <p>* Medical Care Supplement (Dodatek pielęgnacyjny): granted to persons entitled to an old-age, invalidity or survivors' pension who are totally incapable of work and require assistance from another person.</p> <p>* Medical Care Allowance (Zasiłek pielęgnacyjny), Special Attendance Allowance (specjalny zasiłek opiekuńczy), Nursing benefit (świadczenie pielęgnacyjne), Allowance for caregiver (Zasiłek dla opiekuna): granted to persons with considerable or moderate level of disability which is based on the capacity to work.</p> <p>* Supplementary benefit for persons unable to live independently (Świadczenie uzupełniające dla osób niezdolnych do samodzielnej egzystencji): granted to persons unable to live independently due to functional limitations caused by significant impairments and incur excessive costs related to their</p>

	<p>daily existence. It is granted when the following conditions are fulfilled:</p> <ul style="list-style-type: none"> <li>* being at least 18 years old;</li> <li>* having a disability certificate stating that the person is unable to live independently;</li> <li>* not receiving pre-existing social benefits financed from public funds or receiving a total amount of benefits not exceeding PLN 1,772.08 (€386);</li> <li>* having Polish residency.</li> </ul> <p>* Social pension (Renta socjalna): granted to adults, who have been recognised as completely incapable of work due to impairment of body functions which occurred before reaching the age of 18 or 25 if they were in education at school or an institution of tertiary education. It is also payable if the impairment of body functions occurred in the course of doctoral studies or academic post-graduate studies.</p>
Portugal	No specific minimum level.
Romania	<p>People with disabilities: The degree and type of disability gives rise to benefits. Only people with a severe disability may qualify for long-term care benefits.</p> <p>Older people: The degree of dependency gives rise to benefits. The minimum level of dependency is Grade III B (which corresponds to older people who have not completely lost their autonomy and can perform activities of daily life by themselves).</p>
Slovakia	<p>The minimal degree of dependency is defined differently according to the various social services (see "Organisation, Indicators and categories of need"). Severely disabled persons are those with 50% of physical, sensory or mental ability to perform basic activities.</p> <p>The 5th degree (out of 6) of dependency is required to receive the Attendance Service Benefit (Peňažný príspevok na opatrovanie).</p>
Slovenia	<p>Comparable criteria of dependency for different cash benefits are taken into account. In general, cash benefits are granted to persons who need assistance from another person in performing most or all of their daily activities. No minimum level of dependency for care services. Criteria of dependency for benefits in kind differ according to the legislation concerned.</p>
Spain	<p>Long-term care (dependencia): Situation of a person who, at least once a day, requires help to carry out the most essential daily activities.</p> <p>Severe incapacity (gran invalidez): Situation of a person who needs assistance from another person to perform basic everyday tasks.</p>
Sweden	As long as persons need assistance in order to reach a reasonable standard of living, they are entitled to that support regardless of the level of dependency.

Source: Missoc Comparative Tables, XII. Long-term care, Conditions (Updated 1 January 2022)

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This study, commissioned by the European Parliament's Policy Department for Citizens' Rights and Constitutional Affairs at the request of the Committee on Petitions (PETI), examines the progress made on mutual recognition of disability status, and the challenges this presents. There are different definitions and practices of disability assessment, among the Member States and in different policy fields. Citizens' petitions raise concerns about this, and about the need for mutual recognition. Harmonising assessment is difficult but common entry points are possible. The EU Disability Card provides an administrative model for mutual recognition.

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