



Disability Assessment in European States ANED Synthesis Report

By Lisa Waddington
With contributions from Mark Priestley and
Roy Sainsbury

On behalf on the European network of academic experts in
the field of disability (ANED)



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Contributors

Editors: Lisa Waddington, with contributions from Mark Priestley and Roy Sainsbury
Supported by Roy Sainsbury and Ivette Groenendijk

ANED countries

Austria	Ursula Naue and Petra Plieger
Belgium	Geert van Hove and Shannen De Bruycker
Bulgaria	Slavka Kukova
Croatia	Tihomir Žiljak
Cyprus	Katerina Mavrou and Anastasia Liasidou
Czech Republic	Jan Siska
Denmark	Steen Bengtsson
Estonia	Luule Sakkeus and Lauri Leppik
Finland	Teppo Kröger, Katja Valkama and Hisayo Katsui
France	Serge Ebersold and Carole Nicolas
FYR Macedonia	Zvonko Shavreski and Elena Kochoska
Germany	Monika Schröttle
Greece	Eleni Strati
Hungary	Tamás Gyulavári and Péter László Horváth
Iceland	James Gordon Rice and Rannveig Traustadóttir
Ireland	Clíona de Bhailís and Sinéad Keogh
Italy	Giampiero Griffo and Ciro Tarantino
Latvia	Daina Podzina
Liechtenstein	Wilfried Marxer and Patricia Hornich
Lithuania	Jonas Ruskus and Aidas Gudavičius
Luxembourg	Arthur Limbach-Reich
Malta	Vickie Gauci, Amy Camilleri-Zahra and Lara Bezzina
Montenegro	Nenad Koprivica
Netherlands	José Smits
Norway	Johans Tveit Sandvin and Trond Bliksvaer
Poland	Agnieszka Król
Portugal	Paula Pinto and Yuliya Kuznetsova
Romania	Loredana Totoliciu
Serbia	Kosana Beker
Slovakia	Darina Ondrusova, Daniela Keselova and Kvetoslava Repkova
Slovenia	Darja Zaviršek
Spain	Miguel Verdugo and Cristina Jenaro
Sweden	Johanna Gustafsson
Turkey	Betul Yalcin
United Kingdom	Mark Priestley and Anna Lawson

Introduction

The focus of this synthesis report is disability assessment, and specifically how disability is assessed in the context of a variety of benefits and support schemes across European states. Assessment of disability is widely used to determine eligibility for entitlements, services and benefits. In light of the adoption and widespread ratification of the UN Convention on the Rights of Persons with Disabilities (CRPD), as well as in the context of an extended period of economic austerity, many states have sought to revise and tailor their definitions of disability and the related assessment mechanisms, often with the stated aim of targeting those most in need. At the same time, some states have sought to adopt assessment systems which are in line with the CRPD. In the broad context of the CRPD, disability does not reside in a fixed status, but ‘results from the interaction between persons with impairments and attitudinal and environmental barriers’ (Preamble). However, the CRPD does not provide specific guidance either for developing disability assessment mechanisms or for determining disability. Nevertheless, Carlyne Arnould et al. have argued, ‘in line with the principles and vision of the CRDP [sic], 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’.¹

Disability assessment mechanisms can have different aims, functions and models of functioning. It is therefore not surprising to find that a study published in 2007 concerning assessment of work-related disability revealed differences among the evaluation / assessment processes relating to the steps involved, the use of professional assessors and duration.² Assessment mechanisms may aim to ensure that benefits are provided only to those who meet tightly defined eligibility criteria, thereby serving to ration scarce resources – or, from another perspective, to direct allocated resources to those who most need them. Alternatively, rationing or limiting budgets may not be seen as a key concern, and assessment mechanisms may aim to identify the needs of the person being assessed and to find the best match between that person’s needs and the services and benefits which are available. Assessments may also restrict access to certain types of services, such as mainstream schooling, by referring a child to a special institution or, conversely, by restricting access to education at a disability-specific institution by referring a child to a mainstream school. Seen from another perspective, such assessments serve the purpose of granting access to certain types of services.

Disability assessment mechanisms may serve different functions or purposes. Many European states hold a register of disabled people, and people who are registered as disabled, who are often issued with an identity card confirming that they have this status, are entitled to certain benefits or protection, such as reduced-cost or free healthcare and eligibility for employment under a quota system. Disability assessment mechanisms are used to determine whether someone meets the criteria to be registered as disabled or otherwise to be officially recognised as disabled.

¹ Arnould, C., Barral, C., Bouffioulx, E., Castelein, P., Chiriacescu, D., Cote, A. (undated), Disability Assessment Mechanisms: Challenges and Issues at Stake for the Development of Social Policies in light of the United Nations Convention for the Rights of Persons with Disabilities.

² De Boer, W., Besseling, J., Willems, J. (2007), ‘Organisation of disability evaluation in 15 countries’, *Pratiques et Organisation des Soins*, vol. 38, no. 3, p. 205.

Assessments can also be used to determine eligibility for a specific benefit, such as a disability pension. A further function of disability assessment mechanisms is to identify an individual's functional capacity, with a view to giving access to additional support in specific areas, such as education or employment. Assessment mechanisms can also serve the purpose of identifying an individual's need for support or care, with a view to providing support to meet that need. Lastly, an assessment can be used to decide upon appropriate referral and orientation services. For instance, it can determine whether an individual could benefit from the support of employment agency staff who are specialised in helping individuals with disabilities find appropriate training or work.

Two basic models of functioning can be identified. Under one model, the assessment mechanism can be based on a 'one-stop-shop' approach, whereby one assessment is used to determine access to all possible benefits, with either the assessment and the benefits being offered by the same institution, or with multiple institutions collaborating to offer an assessment and benefits system. Alternatively, each benefit (issuing institution) can require a separate assessment, meaning that individuals have to go through multiple assessments if they seek a variety of benefits, such as a pension, support for independent living, or a disabled person's parking permit. In practice, many European states have some assessments which consider eligibility for several benefits, with additional and separate assessments being required for some other benefits. In some cases, the assessment mechanism involves two separate assessments, with individuals first having to be recognised as meeting the criteria of one assessment, such as the assessment to enter the general register of disabled people, before being allowed to apply for a second and separate assessment for another benefit.

Structure of the report

This synthesis report explores different aspects of disability assessment from a European perspective. The report is structured as follows. Part I of the report follows on from this introduction to explore various aspects and dimensions to disability assessment mechanisms from a generic perspective. On the basis of a literature search, this section first seeks to identify and discuss various different approaches to assessing disability. Part I concludes by considering the guidance that the UN Committee on the Rights of Persons with Disabilities, linked to the CRPD, has issued on disability assessment in its Concluding Observations to States Parties. Part II of the report explains the methodology used to collect information from ANED country experts relating to national disability assessments and provides a short overview of the overall findings. Part III contains the synthesis based on the information provided by a number of ANED country experts, making use of the template on national disability assessment mechanisms. A representative sample of national assessment mechanisms is classified and discussed in accordance with the assessment mechanisms identified and discussed in Part I of the report. The classification of national approaches is based on the assessment method used, rather than the benefit or entitlement which each assessment relates to. The focus is on the kinds of assessment mechanisms used, although the benefit linked to each assessment discussed is also noted. The report will identify trends in approaches to assessments based on the analysis of the assessment methods covered. In Part IV, elements of assessment mechanisms which can be regarded as good practice are identified, and the impact of the CRPD, as well as the compatibility of various assessment methods

with the CRPD, are discussed. It is worth noting that elements of the overall evaluation that determine eligibility for a particular benefit which are not directly or indirectly related to disability, such as an individual's history of social security contributions, are not considered in this synthesis report, although they may be covered in the related country reports.

Part I: An overview of disability assessment methods

A number of different methods or approaches can be used to assess the existence of 'disability'. The starting point for any such assessment is the chosen definition of disability, and this is intrinsically linked to both the assessment mechanism and the determination of eligibility for benefits.³ Having said that, a 2007 study on work-related disability assessments found that 'legal criteria are formulated in general terms and are fairly similar',⁴ and that definitions of disability were broadly based on the same common elements. The common elements of legal definitions of disability identified in the study were: the claimant's ability (or inability) to perform work that one could reasonably expect from a worker in their profession; health conditions that account for these abilities (or inabilities), and opportunities and obligations to undergo treatment / reintegration.⁵ Arnould et al. have argued that eligibility criteria and models of assessment also 'result from the choice of disability paradigm and the social and economic context'.⁶

Assessment methods can focus on the existence of a diagnosed medical condition, which is then automatically equated to a disability, on difficulties experienced in carrying out certain tasks or activities (the environmental context), or on an interaction between the two. Moreover, even within these various approaches, different approaches can be used.

An assessment may aim to establish whether an applicant currently has a disability. However, the assessment could also seek to establish whether the disability is of a particular type or is sufficiently limiting. These two dimensions relate to the quality and the quantity of the disability respectively. The assessment could further seek to establish if the disability results from an appropriate cause from the perspective of the benefit, such as whether it results from an industrial injury or occupational illness. Lastly, the assessment could seek to establish if the disability will persist for long enough to entitle the applicant to the benefit.⁷ Any of these assessment methods could be based on a concept of disability defined from a medical or a more social or environmental perspective.

The following sub-sections provide an overview of various methods of assessment.

³ Arnould, C., Barral, C., Bouffouix, E., Castelein, P., Chiriacescu, D., Cote, A. (undated), Disability Assessment Mechanisms: Challenges and Issues at Stake for the Development of Social Policies in light of the United Nations Convention for the Rights of Persons with Disabilities, p. 3.

⁴ De Boer, W., Besseling, J., Willems, J. (2007), 'Organisation of disability evaluation in 15 countries', *Pratiques et Organisation des Soins*, vol. 38, no. 3, p. 205.

⁵ De Boer, W., Besseling, J., Willems, J. (2007), 'Organisation of disability evaluation in 15 countries', *Pratiques et Organisation des Soins*, vol. 38, no. 3, p. 214 This finding was also reflected in de Boer, W., Donceel, P., Brage, S., Rus, M., Willems, J. (2008), 'Medico-legal reasoning in disability assessment: A focus group and validation study', *BMC Public Health*, 8: 335, p. 2.

⁶ Arnould, C., Barral, C., Bouffouix, E., Castelein, P., Chiriacescu, D., Cote, A. (undated), Disability Assessment Mechanisms: Challenges and Issues at Stake for the Development of Social Policies in light of the United Nations Convention for the Rights of Persons with Disabilities, p. 2.

⁷ Council of Europe (2002), *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), p. 14.
<https://rm.coe.int/16805a2a27>.

1 Medical-based assessments of disability

It has been argued that medical assessments are almost universally used in disability assessments.⁸ However, where this happens it does not necessarily imply that an assessment procedure is exclusively based on a medical assessment, and other dimensions, such as an assessment of need or functional capacity, can be involved alongside a medical assessment. Two procedures which do rely exclusively or mainly on medical assessment procedures are discussed below.

1.1 Diagnosis of a specific impairment or condition

Where disability is defined in terms of having a specific impairment or illness, the assessment is based on the existence of a medical diagnosis which identifies an individual as having that impairment or illness. The diagnosis could be made and confirmed by a treating doctor, who provides documentary proof to the agency making the assessment, or it could be confirmed by an independent insurance doctor or physician who makes an assessment on behalf of the agency. In both cases, the assessment is purely medical or diagnosis based, and does not take account of the actual ability or needs of the person being assessed. Such assessments are used in the case of benefits which are targeted at individuals with specific types of impairment or illnesses.

1.2 The Barema method or use of impairment tables

This assessment method involves the use of a fixed scale set out in a table according to which a certain percentage of disability is attached to specific impairments. A Council of Europe report describes the Barema assessment method as involving an 'arbitrary ordinal scale which attaches progressive percentage values to define disability'.⁹ The Barema list or table is divided into chapters covering physical or mental components of the body or the body system, and guidance is set out regarding medical benchmarks against which assessments should be made. Measurements such as joint mobility, respiratory displacement, blood pressure, and vision are used to establish the benchmarks.¹⁰ The assessment may involve a standard form for the medical report, and the assessment is made by a doctor in line with guidance or protocols, which can help to promote consistent decision making across different assessors and offices, although there is some disagreement as to whether Baremas do promote consistency in practice. The impairments of the person who is being assessed are compared against this list and the list automatically assigns percentage values to each impairment. As an example, a loss of a finger might equate to a 1 % disability, while the loss of a thumb would equate to a 5 % disability, and the loss of an arm, a 40 % disability. Since, under the Barema system, impairment is assessed in 'parts', the overall level of impairment may be the sum of impairment ratings for several different

⁸ De Boer, W., Besseling, J., Willems, J. (2007), 'Organisation of disability evaluation in 15 countries', *Pratiques et Organisation des Soins*, vol. 38, no. 3, p. 205.

⁹ Council of Europe (2002), *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), p. 13. <https://rm.coe.int/16805a2a27>.

¹⁰ Brunel University, European Commission (2002), *Definitions of Disability in Europe, A Comparative Analysis*, p. 47. www.ec.europa.eu/social/BlobServlet?docId=2088&langId=en.

parts of the body.¹¹ In terms of the relevant disability percentage linked to a specific impairment, a 2002 Council of Europe report found ‘no information on the reasons for choosing the levels set out in the Baremas’.¹² The same report also found that, in some cases, there was ‘no mechanism for reviewing and updating Baremas in light of changes in epidemiology and medical progress affecting the management and prognosis of conditions, let alone social pressures on the benefit system’.¹³

The Barema method has a long history. The earliest Baremas attached percentage ratings to physical injury resulting from war or industrial accidents, and have been used as far back as mediaeval times in Europe.¹⁴ However, modern Baremas no longer simply cover physical injuries and impairments, but also provide for the assessment of diseases and internal injuries, as well as intellectual and psychological impairments,¹⁵ although mental health conditions are regarded as particularly difficult to assess using the Barema method.¹⁶ ‘Classical’ Baremas assess the degree of disability directly from the description of a person’s medical condition in terms of impairment. For example, specific degrees of loss of sight or hearing, measured using precise medical equipment, may be translated directly into a disability percentage. A Brunel University report for the European Commission on the *Definitions of Disability in Europe* refers to this as the ‘direct measurement’ approach.¹⁷ The report also notes that, in practice, it is difficult to rate the impact of a person’s impairments without considering their consequences for important life activities of that person. The European Commission report noted that some modern Baremas do not rely entirely on ‘direct measurement’, but allow consideration of ‘disabling effects’, and this is also noted in the Council of Europe report.¹⁸ In some cases, the ‘disabling effects’ approach provides methods for

¹¹ Brunel University, European Commission (2002), *Definitions of Disability in Europe, A Comparative Analysis*, p. 47. www.ec.europa.eu/social/BlobServlet?docId=2088&langId=en.

¹² Council of Europe (2002), *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), p. 15. <https://rm.coe.int/16805a2a27>.

¹³ Council of Europe (2002), *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), p. 15. <https://rm.coe.int/16805a2a27>.

¹⁴ Council of Europe (2002), *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), p. 14. <https://rm.coe.int/16805a2a27>.

¹⁵ Brunel University, European Commission (2002), *Definitions of Disability in Europe, A Comparative Analysis*, p. 47. www.ec.europa.eu/social/BlobServlet?docId=2088&langId=en.

¹⁶ Council of Europe (2002), *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), p. 15. <https://rm.coe.int/16805a2a27>.

¹⁷ Brunel University, European Commission (2002), *Definitions of Disability in Europe, A Comparative Analysis*, p. 47. www.ec.europa.eu/social/BlobServlet?docId=2088&langId=en.

¹⁸ Council of Europe (2002), *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), p. 15. <https://rm.coe.int/16805a2a27>, where the report states, regarding the American Medical Association ‘Guidelines’ used to assess impairment, that ‘some of the requirements set out to narrow the initially wide percentage bands related to disability rather than impairment’. See: <https://rm.coe.int/16805a2a27>. In contrast, Jerry Spanjer et al. describe the AMA guide as measuring impairment rather than disability. Spanjer, J., Krol, B., Brouwer, S., and Groothoff, J.,

measuring impact or severity, which avoids some of the limitations of technical measures. For example, a respiratory condition may be described in terms of its effects on a person's mobility rather than in terms of the displacement of air from the lungs.¹⁹ The European Commission report referred to this as including both a 'direct measurement' and 'disabling effects' assessment.²⁰

The use of Barema tables can be cost efficient, in that the assessment method can be based directly on a pre-existing diagnosis which only needs to be confirmed, and it may promote a consistent approach, in that individuals with the same impairments should always be assessed in the same way with the same result. However, the Brunel study for the European Commission notes that, in practice, there can be considerable flexibility in how the tables are applied.²¹ The Council of Europe study also found that, as there can be a wide range of effects associated with specific impairments, assessors could be left with 'considerable latitude' in attributing disability percentages.²² Writing in 2002, the authors of that report also found that 'there was no clear evidence ... of how clinicians applying such scales make their decisions'.²³

The Council of Europe report concluded that a Barema-based assessment worked better for some types of assessment than for others. The authors noted that Baremas

seemed to work well for awards of compensation, usually for injuries sustained from military service, or in civilian work, or from acts of violence and in civil disorders where no perpetrator could be identified to recompense the victim. The fact that Baremas allow awards to be made for impairment, or disability, or a mixture of the two is an advantage in this situation. It allows the lawmakers to decide whether to compensate for having been injured, or only for disablement arising from the injuries, again allowing a sensitive control of benefit costs which can be wrapped up in apparently technical details. Problems seem to arise when Barema percentages are applied to other benefits, for example when a part pension is awarded at 30 %, and a whole one at 70 % of some scale. It then becomes extremely difficult to issue clear instructions to those applying the Barema. This is what is called the 'threshold problem'.²⁴

'Sources of variation in work disability assessment', in Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, p. 25.

¹⁹ Brunel University, European Commission (2002), *Definitions of Disability in Europe, A Comparative Analysis*, p. 47. www.ec.europa.eu/social/BlobServlet?docId=2088&langId=en.

²⁰ Brunel University, European Commission (2002), *Definitions of Disability in Europe, A Comparative Analysis*, p. 47. www.ec.europa.eu/social/BlobServlet?docId=2088&langId=en.

²¹ Brunel University, European Commission (2002), *Definitions of Disability in Europe, A Comparative Analysis*, p. 48. www.ec.europa.eu/social/BlobServlet?docId=2088&langId=en.

²² Council of Europe (2002), *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), p. 15. <https://rm.coe.int/16805a2a27>.

²³ Council of Europe (2002), *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), p. 15. <https://rm.coe.int/16805a2a27>.

²⁴ Council of Europe (2002), *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), p. 17. <https://rm.coe.int/16805a2a27>.

In essence, the authors view the Barema system as working best where there is no relevant 'threshold' or minimum percentage of disability which triggers entitlement to a benefit. In such cases, they feel that medical assessors may make an overall assessment as to whether the applicant should qualify for the benefit, and then tailor their findings accordingly.²⁵ They noted that the Working Group which prepared the report 'had the impression that the problems of Barema threshold were recognised as a serious problem in most countries using such threshold, which might imply that this use of Baremas would gradually disappear'.²⁶ However, research conducted by ANED experts reveals that assessments based on the use of Baremas are still in use today, and in Greece this is the main disability assessment method which is in use.

²⁵ Council of Europe (2002), *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), p. 16. <https://rm.coe.int/16805a2a27>.

²⁶ Council of Europe (2002), *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), p. 17. <https://rm.coe.int/16805a2a27>.

2 Context-based assessment methods

A number of disability assessment methods go beyond considering an individual's medical diagnosis or health status to consider the impact that this has on an individual's ability to carry out certain tasks or on a person's needs, in light of environmental and other factors. The two main examples of such assessment methods involve the assessment of an individual's functional capacity and the assessment of care needs. However, disability assessment methods which calculate economic loss and a procedural assessment method also take account of environmental factors, although these forms of assessment are less common in European states than assessments based on care needs or functional capacity.

2.1 Functional capacity method

A functional capacity assessment seeks to establish functional limitations. Such limitations can be defined as 'limitations in or inability to perform certain physical activities such as walking and lifting, or mental activities such as concentrating or conflict handling'.²⁷ This assessment method therefore involves identifying the abilities and inabilities of an individual, where the lack of ability is related to a health condition. Assessment may involve a series of statements (descriptors) for each task, describing different levels of ability or inability. The assessment may involve standardised tests which measure performance and the ability of an individual to perform certain activities. The assessor describes the abilities and inabilities of the person being assessed, or the closest descriptor to the situation of that person is indicated. Jerry Spanjer et al. have argued that 'functional limitations can be distinguished from symptoms (such as pain and fatigue), activity limitations (such as self-care tasks and gardening) and participation restrictions (such as leisure time activities and work)'.²⁸

From the perspective of a disability assessment, abilities or functional capacity are frequently assessed in two areas: the ability to work, which is frequently linked to an assessment of eligibility for a full or partial disability pension or social assistance allowance, and the ability to care for oneself, which is frequently linked to an assessment of eligibility for care-related support, or support with independent living. These two dimensions to a functional capacity assessment are considered in more detail below. However, such an assessment can also be linked to a decision on support in other areas of life, such as educational or employment support, or access to a specialised form of transport services or a disabled person's parking permit.

2.1.1 Functional capacity and employment

In the context of employment, this kind of assessment involves comparing an individual's capacity to work with the demands of the labour market. Disability is

²⁷ Spanjer, J., Brouwer, S., and Groothoff, J., 'Instruments used to assess functional limitations in workers' compensation claimants: a systematic review', in Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, p. 33.

²⁸ Spanjer, J., Brouwer, S., and Groothoff, J., 'Instruments used to assess functional limitations in workers' compensation claimants: a systematic review', in Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, p. 33.

therefore defined in terms of a reduced ability or complete inability to undertake paid employment. However, since individuals can be unemployed or otherwise out of work for a number of reasons, any disability assessment must make a connection between reduced working capacity and health status. Where individuals are out of work or unable to obtain work for another reason, such as lack of qualifications or skills, low motivation or a generally poor labour market, they should not be assessed as having a disability.²⁹

A work capacity disability assessment can involve identifying a person's capacities and comparing them with the capacities needed to engage in paid work.³⁰ However, the ability to work can be described using different concepts.³¹ The assessment can involve assessing a person's abilities to carry out tasks which are regarded as generally useful in the labour market, such as walking, lifting and standing for a period of time, or it may involve an assessment of their ability to carry out activities applicable to specific occupations, such as the ability to use or wear specialised equipment. Various kinds of assessment instrument exist. A 2010 literature-based study identified four kinds of instrument for assessing functional limitations in claimants for workers' compensation: two questionnaires (the Roland-Morris Disability Questionnaire and the Patient-Specific Functional Scale), a performance test (the Isernhagen Work System (IWS)) and an instrument combining a questionnaire and examination by physicians (the Multiperspective Multidimensional Pain Assessment Protocol).³² Some of these were only intended to assess functional limitation related to specific conditions, such as musculoskeletal problems or pain. The study did not identify any instruments for assessing the mental functional limitations of claimants and, of the four instruments identified, only the IWS was work oriented, with the others being focused on clinical or rehabilitation settings and used to assess limitations in people's daily lives. The IWS measures 28 physical items and gives a grading for each item. It measures 'patients' performance; in addition, there has to be an assessment of the sincerity of the patient's effort, the ability to perform work outside a laboratory setting, and whether activities are considered medically safe'.³³ Assessments using the IWS take two days, and two to three hours on each day.³⁴ However, none of these methods was identified as being in use in the assessments covered in this synthesis report.

²⁹ Brunel University, European Commission (2002), *Definitions of Disability in Europe, A Comparative Analysis*, p. 43. www.ec.europa.eu/social/BlobServlet?docId=2088&langId=en.

³⁰ Brunel University, European Commission (2002), *Definitions of Disability in Europe, A Comparative Analysis*, p. 45. www.ec.europa.eu/social/BlobServlet?docId=2088&langId=en.

³¹ De Boer, W., Besseling, J., Willems, J. (2007), 'Organisation of disability evaluation in 15 countries', *Pratiques et Organisation des Soins*, vol. 38, no. 3, p. 214.

³² Spanjer, J., Brouwer, S., and Groothoff, J., 'Instruments used to assess functional limitations in workers' compensation claimants: a systematic review', in Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen.

³³ Spanjer, J., Brouwer, S., and Groothoff, J., 'Instruments used to assess functional limitations in workers' compensation claimants: a systematic review', in Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, p 40.

³⁴ Spanjer, J., Brouwer, S., and Groothoff, J., 'Instruments used to assess functional limitations in workers' compensation claimants: a systematic review', in Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, p 40.

With regard to the standards, or the kinds of employment, against which a person's capacity to work can be assessed, a number of possibilities exist:

- The person's own job, i.e. the one they have recently been doing. This test can only be used for those who have worked recently and whose period off work is relatively short.³⁵
- An (unspecified) job which may be defined as:
 - one suitable for this particular person, taking account of their age and skills as well as their disability (i.e. some 'non-medical' factors);
 - one which is reasonable considering its location, type and the earnings it will provide compared with those from the previous occupation (even more 'non-medical' factors);
 - one which is theoretically available in the economy;
 - one which is actually available in the economy (i.e. that type of job is available in the locality at present);
 - a real job which is the subject of a current vacancy.³⁶

It is worth noting that these possible points of comparison are not exclusive, and some systems incorporate several of these possibilities. Ben Baumberg Geiger, in a report for the UK charity DEMOS, argues that a 'real-world' assessment should be made, meaning one which considers 'whether a person with impairments would realistically be able to find a job they can do, given who they are'.³⁷ He notes that 'this goes beyond their work capability: it takes into account whether they would *realistically* be able to get a job that they can do, given factors like their age, location or education'.³⁸ Generally, when assessing abilities or capacities it is important to bear in mind against which criteria the capacities of an individual are being assessed. Changing the criteria in apparently technical ways will allow access to the benefit to be controlled, which also means that the overall costs of the benefit can be controlled.³⁹

Ben Baumberg Geiger has identified three different types of direct work capability assessments, which he labels expert assessments, demonstrated assessments and structured assessments.⁴⁰ Expert assessments involve a medical, occupational health or labour market professional who uses his or her expertise to determine whether an individual is capable of work. However, Ben Baumberg Geiger noted a number of

³⁵ However, a study published in 2007 found no evidence of claims being assessed in relation to the person's own work. Instead, regulations referred to work in general. de Boer, W., Besseling, J., Willems, J. (2007), 'Organisation of disability evaluation in 15 countries', *Pratiques et Organisation des Soins*, vol. 38, no. 3, p. 214.

³⁶ Council of Europe (2002), *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), pp. 11-12. <https://rm.coe.int/16805a2a27>.

³⁷ Baumberg Geiger, B. (2018), 'Legitimacy is a balancing act, but we can achieve a much better balance than the WCA' – 'A Better WCA is Possible', Demos, p. 62.

³⁸ Baumberg Geiger, B. (2018), 'Legitimacy is a balancing act, but we can achieve a much better balance than the WCA' – 'A Better WCA is Possible', Demos, p. 62. Emphasis in original.

³⁹ Council of Europe (2002), *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), p. 12. <https://rm.coe.int/16805a2a27>.

⁴⁰ Baumberg Geiger, B. (2018), 'Legitimacy is a balancing act, but we can achieve a much better balance than the WCA' – 'A Better WCA is Possible', Demos, p. 57.

issues with expert assessments, including that these assessments can be made by doctors or health professionals who do not have training in occupational health, and the absence of information about what assessors consider to be the general demands of the workplace. He notes that ‘insurance physicians tend not to mention job requirements explicitly when making individual decisions about work capability’.⁴¹ He argued that a solution to this problem might be to involve ‘a new professional category of specialists who have more relevant expertise and more explicit reporting requirements, such as the Dutch professional category of “labour market experts”’.⁴² A further problem he identified with this kind of assessment is that shows ‘high variability and often low reliability’⁴³ and that there are concerns about ‘consistency and validity – and stringency’.⁴⁴ Ben Baumberg Geiger believes that standardisation can help to address this, but acknowledges that, even with high levels of standardisation, such as exists in the Netherlands, where there are interview protocols and disease-specific guidelines, obtaining consistent work capability judgments from expert assessments is difficult.⁴⁵ Ben Baumberg Geiger et al. also note that concerns regarding the validity of expert assessments exist ‘because the assumed requirements of the workplace are generally opaque’ and ‘insurance physicians tend not to mention job requirements explicitly when making individual decisions about work capacity’.⁴⁶ They note that there is no ‘clear idea of what assessors consider to be the general demands of the workplace, nor whether their understanding is correct’.⁴⁷ As a consequence, ‘there can be a considerable gap between the formal definition of work capacity being assessed and the actual criteria used by assessors’.⁴⁸ Ben Baumberg Geiger concludes on expert assessments:

Overall, experts can assess work capability with some degree of legitimacy, and are used in many systems around the world. Nevertheless, there are some concerns over the validity and reliability of their judgments. These may be partially mitigated through appropriating training and expertise, and standardisation of inputs, decision protocols and reporting requirements.⁴⁹

⁴¹ Baumberg Geiger, B. (2018), ‘Legitimacy is a balancing act, but we can achieve a much better balance than the WCA’ – ‘A Better WCA is Possible’, Demos, p. 58.

⁴² Baumberg Geiger, B. (2018), ‘Legitimacy is a balancing act, but we can achieve a much better balance than the WCA’ – ‘A Better WCA is Possible’, Demos, p. 57.

⁴³ Baumberg Geiger, B. (2018), ‘Legitimacy is a balancing act, but we can achieve a much better balance than the WCA’ – ‘A Better WCA is Possible’, Demos, p. 58.

⁴⁴ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), ‘Assessing work disability for social security benefits: international models for the direct assessment of work capacity’, *Disability and Rehabilitation*.

⁴⁵ Baumberg Geiger, B. (2018), ‘Legitimacy is a balancing act, but we can achieve a much better balance than the WCA’ – ‘A Better WCA is Possible’, Demos, p. 58.

⁴⁶ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), ‘Assessing work disability for social security benefits: international models for the direct assessment of work capacity’, *Disability and Rehabilitation*.

⁴⁷ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), ‘Assessing work disability for social security benefits: international models for the direct assessment of work capacity’, *Disability and Rehabilitation*.

⁴⁸ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), ‘Assessing work disability for social security benefits: international models for the direct assessment of work capacity’, *Disability and Rehabilitation*.

⁴⁹ Baumberg Geiger, B. (2018), ‘Legitimacy is a balancing act, but we can achieve a much better balance than the WCA’ – ‘A Better WCA is Possible’, Demos, p. 58.

The second type of direct work capability assessment identified by Ben Baumberg Geiger is what he calls 'demonstrated assessments'. This assessment method is discussed below under the heading 'Procedural assessment method'.

The third type of direct work capability assessment which Ben Baumberg Geiger identifies is what he refers to as the 'structured assessment'. He notes that this is exemplified by the Dutch system, where the full set of claimants' functional capacities are assessed, and then compared with the required functional profiles.⁵⁰ These profiles are the combination of capacities which someone needs to do a particular job, with 7 000 existing jobs and related capacities being identified in a database. He notes that the database 'covers 28 different functional domains against which claimants are assessed, allowing variation between regular demands and peak demands, as well as covering the required work pattern, education, experience and skills of the job. This provides an empirically based assessment of jobs that the individual can perform'.⁵¹ The actual assessment is made by an employment expert who is experienced in occupational health. Ben Baumberg Geiger points to some weaknesses with structured assessments. He notes that, while they can provide valid judgments about eligibility for financial support, they do not necessarily help people get back to work. 'They ignore psychosocial factors, do not start from the priorities of the individual in question, and do not consider what would help the individual to work'.⁵² He also notes that collecting data about a large number of job requirements can be expensive. The Dutch system covers about 20 % of all possible jobs, and these are weighted towards 'lower-level' jobs that are potentially available to all claimants.⁵³ The system nevertheless requires 35 full-time specialists to make on-site observations of jobs in the Netherlands.

In addition to functional capacity, a disability assessment made for the purposes of determining eligibility for a disability pension can involve a number of other factors, including 'the socio-medical history, including the development and severity of the claimant's health condition, his/her previous efforts to regaining health and return to work, and his/her job and social career', 'the individual prognosis of work disability' and 'the feasibility of interventions to promote recovery and return to work'.⁵⁴ The assessment may therefore seek to establish if the individual has made sufficient effort to undergo treatment and rehabilitation, among other factors.

Anner et al. argue that the International Classification of Functioning Disability and Health (ICF), and specifically the ICF component 'activities and participation' can be used to assess (or 'capture') functional capacity, including with regard to

⁵⁰ This assessment seeks to measure a claimant's reduced earning capacity rather than their functional capacity to undertake employment. It does this by identifying the kinds of employment the individual is able to undertake.

⁵¹ Baumberg Geiger, B. (2018), 'Legitimacy is a balancing act, but we can achieve a much better balance than the WCA' – 'A Better WCA is Possible', Demos, p. 61.

⁵² Baumberg Geiger, B. (2018), 'Legitimacy is a balancing act, but we can achieve a much better balance than the WCA' – 'A Better WCA is Possible', Demos, p. 61.

⁵³ Baumberg Geiger, B. (2018), 'Legitimacy is a balancing act, but we can achieve a much better balance than the WCA' – 'A Better WCA is Possible', Demos, p. 62.

⁵⁴ Anner, J., Schwegler, U., Kunz, R., Trezzini, B., de Boer, W. (2012), 'Evaluation of work disability and the international classification of functioning, disability and health: what to expect and what not', *BMC Public Health*, 12:470, p.2.

employment.⁵⁵ The ICF,⁵⁶ which was developed by the World Health Organization, is a classification of health components of functioning and disability structured around three broad components: body functions and structure; activities (related to tasks and actions by an individual) and participation (involvement in a life situation); with additional information on severity and environmental factors. It understands functioning and disability 'as a dynamic interaction between health conditions and contextual factors, both personal and environmental'. This is promoted as a 'bio-psycho-social model' which is a 'workable compromise between medical and social models'.⁵⁷ According to this view 'disability is the umbrella term for impairments, activity limitations and participation restrictions, referring to the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors)'.⁵⁸

Anner et al. argue that the ICF 'reflects modern thinking in disability evaluation', and that it 'allows for the medical expert to describe work disability as a bio-psycho-social concept', and the ICF definitions of body function, structures, activity and participation, and environmental factors 'cover essential parts of disability evaluation'.⁵⁹ However, they also note that other elements of a disability assessment, including 'the dynamic time perspective or the restricted causal connection between functional capacity and the health condition' are not incorporated within the ICF framework.⁶⁰ De Boer et al. found the ICF to be insufficient for a complete evaluation of work disability. Unlike Anner et al., they found that 'the ICF model could be applicable to the grounds of health condition that had to be evaluated' but that it was not applicable to 'the grounds of fair trial, rehabilitation and compliance'.⁶¹ Heerkens et al. are also critical of the ICF and, based on a literature review and interviews with experts in the Netherlands, they argue that the ICF scheme (wrongly) gives the impression that the medical perspective, rather than the biopsychosocial perspective, is dominant.⁶² Heerkens and her colleagues identify several criticisms of the ICF relating to both content and applicability⁶³ and propose a number of alternatives to the ICF in their article. Amongst

⁵⁵ It should be noted that other instruments can be used in this context. These include the documentation produced by the American Medical Association, a Functional Independence Measure and a Functional Ability List. See Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, p 22.

⁵⁶ <http://www.who.int/classifications/icf/en/>, accessed 14 February 2018.

⁵⁷ World Health Organization and the World Bank (2011), *World Report on Disability*, p. 4.

⁵⁸ World Health Organization and the World Bank (2011), *World Report on Disability*, p. 4

⁵⁹ Anner, J., Schwegler, U., Kunz, R., Trezzini, B., de Boer, W. (2012), 'Evaluation of work disability and the international classification of functioning, disability and health: what to expect and what not', *BMC Public Health*, 12:470, p.1.

⁶⁰ Anner, J., Schwegler, U., Kunz, R., Trezzini, B., de Boer, W. (2012), 'Evaluation of work disability and the international classification of functioning, disability and health: what to expect and what not', *BMC Public Health*, 12:470, p.7.

⁶¹ De Boer, W., Donceel, P., Brage, S., Rus, M., Willems, J. (2008), 'Medico-legal reasoning in disability assessment: A focus group and validation study', *BMC Public Health*, 8: 335, p. 7.

⁶² Heerkens, Y., de Weerd, M., Huber, M., de Brouwer, C., van der Veen, S., Perenboom, R., van Gool, C., Ten Napel, H., van Bon-Martens, M., Stallinga, H., van Meeteren, N. (2018), 'Reconsideration of the scheme of the international classification of functioning, disability and health: incentives from the Netherlands for a global debate', *Disability and Rehabilitation*, vol. 40, no. 5, pp. 603-611.

⁶³ Heerkens, Y., de Weerd, M., Huber, M., de Brouwer, C., van der Veen, S., Perenboom, R., van Gool, C., Ten Napel, H., van Bon-Martens, M., Stallinga, H., van Meeteren, N. (2018), 'Reconsideration of the scheme of the international classification of functioning, disability and

the criticisms of the ICF are its ambiguity, the lack of a clear differentiation between activity and participation, the lack of a classification of personal factors, the lack of many relevant items in the classification of environmental factors, such as factors related to the working environment, and the concern that the ICF is not easily applicable in daily practice, with more than 1 400 categories, which are not easy to choose from. Nevertheless, the 2011 World Report on Disability notes that the ICF can be useful for a range of purposes, including determining eligibility for welfare benefits,⁶⁴ and that, while many formal assessment processes still use predominantly medical criteria, there has been a move towards adopting a more comprehensive approach focusing on functioning and using the ICF.⁶⁵ It is worth noting that the European Union of Medicine and Assurance in Social Security has recently developed a 'core set' of ICF categories designed to facilitate disability assessment or the purposes of social security,⁶⁶ although these have been criticised for not including environmental factors.⁶⁷ One example of a functional capacity assessment which makes use of the ICF has been identified in this synthesis report. In Latvia, applicants for a general disability assessment, which can give entitlement to a disability pension and registration as a disabled person, are required to submit a referral from a treating doctor when making an application. This should describe the health disorder, and doctors should make use of the International Classification of Diseases (2010) and the descriptions of functional disorders found in the ICF.⁶⁸

Bickenbach et al. have argued for a form of assessment which directly assesses an individual's capacity to work, and which recognises that disability results from an interaction between functional limitations and the particular demands of an individual's work environment.⁶⁹ They term this 'the disability approach', although they note that policymakers have no guidance on how to implement such an assessment. They argue that the 'fundamental weakness' of disability assessments that seek to measure functional capacity in general 'is that it is difficult to come up with the domains of areas of functional capacity that are highly and consistently correlated with a standardized "capacity to work", given the enormous variety of work requirements and kinds of employment situations'.⁷⁰

health: incentives from the Netherlands for a global debate', *Disability and Rehabilitation*, vol. 40, no. 5, pp. 606-607.

⁶⁴ World Health Organization and the World Bank (2011), *World Report on Disability*, p. 5.

⁶⁵ World Health Organization and the World Bank (2011), *World Report on Disability*, p. 11.

⁶⁶ Brage, S., Donceel, P., Falez, F. (2008), 'Development of ICF core set for disability evaluation in social security', *Disability Rehabilitation*, vol. 30, pp. 1392-1396, cited in Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

⁶⁷ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

⁶⁸ See section 2.1.3 for further discussion.

⁶⁹ Bickenbach, J., Posarac, A., Cieza, A., Konstanjsek, N. (2015), *Assessing Disability in Working Age Population: A Paradigm Shift from Impairment and Functional Limitation to the Disability Approach*, World Bank.

⁷⁰ Bickenbach, J., Posarac, A., Cieza, A., Konstanjsek, N. (2015), *Assessing Disability in Working Age Population: A Paradigm Shift from Impairment and Functional Limitation to the Disability Approach*, World Bank. Quotes in Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

Others have criticised functional capacity assessments on different grounds. Pransky et al. argue that such assessments 'ignore psychosocial factors, do not start from the priorities of the individual in question, and do not consider what would help the individual to work. Moreover, they consider the way that the workplace presently is, rather than how it might be changed'.⁷¹

Where this form of assessment finds that an individual has a disability, measured in terms of a reduced ability to work, it can be expressed in a variety of different ways: as a percentage, as a degree of disability, or in terms of the number of hours an individual can work.⁷² Anner et al. identified examples of all three approaches in their 2012 study.⁷³

2.1.2 Functional capacity and self-care

A disability assessment relating to functional capacity and self-care is based on an assessment of a person's capacity to care for themselves. The assessment is made using a list of activities, such as the ability to wash oneself unaided or the ability to transfer from a bed to a chair unaided, against which an individual's abilities are assessed. The assessment can be made by an occupational therapist or other qualified individual. This assessment often merges with an assessment of care needs, in that an individual will need care or support to meet their basic care needs, which they are unable to do alone. Therefore, it is appropriate to identify an individual's functional capacity to care for themselves in order to determine what care needs they have. The assessment of care needs is discussed further below (section 2.2).

2.1.3 Assessing functional capacity using the World Health Organization disability assessment schedule 2.0 (WHODAS 2.0)

The World Health Organization (WHO) has developed WHODAS 2.0 as a generic assessment instrument for health and disability. WHODAS 2.0 is directly linked to the ICF. However, since the ICF is 'impractical for assessing and measuring disability in daily practice', the WHO developed WHODAS 2.0, which is intended to be 'a standardized way to measure health and disability across cultures'.⁷⁴ WHODAS 2.0 is described as being 'useful for assessing health and disability levels in the general population through surveys and for measuring the clinical effectiveness and

⁷¹ Pransky, G., Shaw, W., Franche R-L., Clarke A. (2004), 'Disability prevention and communication among workers, physicians, employers, and insurers – current models and opportunities for improvement', *Disability and Rehabilitation*, vol. 26, pp. 625-634. Quote from Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bamba, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

⁷² Anner, J., Schwegler, U., Kunz, R., Trezzini, B., de Boer, W. (2012), 'Evaluation of work disability and the international classification of functioning, disability and health: what to expect and what not', *BMC Public Health*, 12:470, p.2.

⁷³ Anner, J., Schwegler, U., Kunz, R., Trezzini, B., de Boer, W. (2012), 'Evaluation of work disability and the international classification of functioning, disability and health: what to expect and what not', *BMC Public Health*, 12:470, p.2.

⁷⁴ World Health Organization, (Üstün, T., Kostanjsek, N., Chatterji, S., Rehm J. (editors)) (2010), *Measuring Health and Disability, Manual for WHO Disability Assessment Schedule, WHODAS 2.0*, p. 3.

productivity gains from interventions'.⁷⁵ There was also some very limited evidence of it also being used to characterise and certify disability,⁷⁶ although it does not seem to have been tested or used extensively in this context.

WHODAS 2.0 measures 'functioning (i.e. an objective performance in a given life domain)',⁷⁷ and supersedes a previous instrument, WHODAS II. Spanjer has noted that WHODAS II 'register[ed] the disability claimed by a patient rather than an expert's assessment' and therefore could not be used to document work disability.⁷⁸ WHODAS 2.0 covers six domains of functioning:

- Cognition – communication and thinking activities;
- Mobility – moving and moving around;
- Self-care – hygiene, dressing, eating and being alone;
- Getting along – interacting with other people;
- Life activities – domestic responsibilities, leisure, work and school (day to day activities); and
- Participation – social dimensions, such as community activities, barriers and hindrances in the environment, and other issues, such as maintaining personal dignity.⁷⁹

WHODAS 2.0 is intended 'to assess the limitations on activity and restrictions on participation experienced by an individual, irrespective of medical diagnosis',⁸⁰ and to be used across all diseases, including mental, neurological and addictive disorders. It involves a questionnaire which is described as 'short, simple and easy to administer (5 to 20 minutes)'.⁸¹ WHODAS 2.0 exists in seven different versions, which vary in length (from 12 to 36 questions) and intended mode of administration. The questions cover functioning difficulties experienced by the respondent in the six domains in the preceding 30 days, and the answers can be translated into an overall functioning score.

⁷⁵ World Health Organization, (Üstün, T., Kostanjsek, N., Chatterji, S., Rehm J. (editors)) (2010), *Measuring Health and Disability, Manual for WHO Disability Assessment Schedule, WHODAS 2.0*, p. v

⁷⁶ WHODAS 2.0 seems to have been used for this purpose in Nicaragua. No other examples of WHODAS 2.0 being used in this way were given in the manual. World Health Organization, (Üstün, T., Kostanjsek, N., Chatterji, S., Rehm J. (editors)) (2010), *Measuring Health and Disability, Manual for WHO Disability Assessment Schedule, WHODAS 2.0*, p. 28. In Taiwan WHODAS 2.0 has been used to analyse data on people who applied to the national disability registration system, although the actual assessment used for that system was not based on WHODAS 2.0. The assessment system uses ICF qualifiers, Chi W-C et al. (2014), *Measuring Disability and Its Predicting Factors in a Large Database in Taiwan Using the World Health Disability Assessment Schedule 2.0*, *Int. J. Environ. Res. Public Health*, 11 (12) 12148-12161.

⁷⁷ World Health Organization, (Üstün, T., Kostanjsek, N., Chatterji, S., Rehm J. (editors)) (2010), *Measuring Health and Disability, Manual for WHO Disability Assessment Schedule, WHODAS 2.0*, p. 12.

⁷⁸ Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, p 25.

⁷⁹ World Health Organization, (Üstün, T., Kostanjsek, N., Chatterji, S., Rehm J. (editors)) (2010), *Measuring Health and Disability, Manual for WHO Disability Assessment Schedule, WHODAS 2.0*, p. 13.

⁸⁰ World Health Organization, (Üstün, T., Kostanjsek, N., Chatterji, S., Rehm J. (editors)) (2010), *Measuring Health and Disability, Manual for WHO Disability Assessment Schedule, WHODAS 2.0*, p. 11.

⁸¹ At: <http://www.who.int/classifications/icf/whodasii/en/>.

The versions can be administered by a lay interviewer, by the person themselves or by a proxy, such as a family member, friend or carer.

The WHODAS 2.0 questionnaire is being used as an element of disability assessment in a pilot project in Greece (see Part III, 9.1.3), as a supplement to the main Barema-based assessment method that is used to determine eligibility for disability welfare benefits. It is worth pointing out that the use of WHODAS 2.0 was not well received by the Greek Disabled People's Organisation, which feared that it could lead to, or be used to bring about, a reduction in eligibility for benefits and fail to capture functional limitations for all people with disabilities. This is explored further in Part III, section 9.1.3, below.

In addition to the WHODAS 2.0 questionnaire, a second set of questions designed to identify disability has been developed at the international level. The Washington Group on Disability Statistics established under the United Nations Statistical Commission has the task of promoting and coordinating international cooperation in the area of health statistics, and focuses on developing disability data collection tools suitable for censuses and national surveys.⁸² To date the Group has developed three questions sets: a short set of disability questions, an extended set of disability questions, and questions on child functioning.⁸³ The short set of disability questions⁸⁴ covers six core functional domains, where difficulties are related to a 'health problem': seeing, hearing, walking, cognition (remembering, concentrating), self-care, and communication (language) 'difficulties'. Intellectual, psychological and related impairments are not covered, and the questions do not address the duration of the difficulties. The extended set of questions⁸⁵ cover more domains including affect (anxiety and depression), pain, fatigue and upper body functioning.

There are a number of differences between WHODAS 2.0 and the disability questions developed by the Washington Group on Disability Statistics. The Washington Group questions focus more of impairments (e.g. seeing, hearing) although some degree of 'participation' is involved. WHODAS 2.0 focuses more on life domains and corresponds to the ICF's 'activity and participation' dimensions. The six domains covered by WHODAS 2.0 are broader than the six core functional domains covered by the Short Set of Disability Questions developed by the Washington Group. Secondly, while the Washington Group's short set of questions is intended for use in census and surveys, WHODAS 2.0 is a generic assessment instrument for health and disability. Thirdly, WHODAS 2.0 allows for five responses indicating level of difficulty (0 = No Difficulty, 1 = Mild Difficulty, 2 = Moderate Difficulty, 3 = Severe Difficulty, 4 = Extreme Difficulty or Cannot Do) while the Washington Group questions foresee four possible responses (1. No, no difficulty, 2. Yes, some difficulty, 3. Yes, a lot of difficulty, 4. Cannot do it at all). Finally, numbers used in the Washington Group questions have an ordinal value, meaning that they are only used to help order the answers, (i.e. more or less). One can use the responses to identify people with at least one moderate difficulty, people with at least two moderate difficulties, etc. Under WHODAS 2.0 the

⁸² <http://www.washingtongroup-disability.com/>.

⁸³ <http://www.washingtongroup-disability.com/washington-group-question-sets/>.

⁸⁴ <http://www.washingtongroup-disability.com/washington-group-question-sets/short-set-of-disability-questions/>.

⁸⁵ <http://www.washingtongroup-disability.com/washington-group-question-sets/extended-set-of-disability-questions/>.

numbers amount to scores and have a cardinal value. This means that 'moderate' is understood as twice as much as 'mild'.

2.2 Assessment of care or support needs

This assessment method makes a connection between health status, the ability to perform essential self-care or other basic tasks, and the need for care or support.⁸⁶ The assessment involves an evaluation of the time periods during the day or night when an individual needs help from another person in order to care for themselves or carry out a specific activity such as learning / studying.⁸⁷ Since health problems are likely to be the cause of a person's restrictions in their ability to carry out these kinds of activities, an assessment of an individual's need for help can be understood as an assessment of disability.⁸⁸ The needs which provide the basis for the assessment may be defined very precisely, with the assessor able to indicate different levels of dependency or care needs for each individual activity, or they may be identified in a more vague and generic fashion, giving more discretion to the assessor to determine care needs. The assessment is often based on the person's ability to perform what are known as activities of daily living (ADLs). Typical ADLs against which an individual's care needs are assessed include washing, dressing, personal hygiene, eating, and independent mobility around the house. Other ADLs which can be assessed include mobility and transport-related activities, ability to do housework, ability to communicate and aspects of social participation.⁸⁹

The Barthel Index of Activities of Daily Living is an assessment tool sometimes used to assess care needs. The Index was first introduced in 1965 in the US,⁹⁰ and was further refined in 1988.⁹¹ The Index is an ordinal scale which covers 10 basic activities of daily living (faecal incontinence, urinary incontinence, and the need for help with regard to the following activities: grooming, toilet use, feeding, transfer, mobility, dressing, stairs and bathing).⁹² An individual is ranked using a scale related to a number of points for each activity. The lowest ranking (zero) equates to a complete inability to do the task, full dependency or incontinence, whilst the highest ranking for each activity (between one and three) equates to the ability to carry out the activity independently, if necessary, with the use of aids such as a stick. The assessment can take account of environmental factors which affect the person's ability to carry out an activity. The total possible score ranges from 0 to 20, with the lower scores indicating higher degrees of disability. The related guidelines indicate that the 'patient's

⁸⁶ Brunel University, European Commission (2002), *Definitions of Disability in Europe, A Comparative Analysis*, p. 38. www.ec.europa.eu/social/BlobServlet?docId=2088&langId=en.

⁸⁷ Council of Europe (2002), *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), p. 13. <https://rm.coe.int/16805a2a27>.

⁸⁸ Brunel University, European Commission (2002), *Definitions of Disability in Europe, A Comparative Analysis*, p. 38. www.ec.europa.eu/social/BlobServlet?docId=2088&langId=en.

⁸⁹ Brunel University, European Commission (2002), *Definitions of Disability in Europe, A Comparative Analysis*, p. 39. www.ec.europa.eu/social/BlobServlet?docId=2088&langId=en.

⁹⁰ Mahoney, F. and Barthel, D. (1965), 'Functional evaluation: the Barthel Index', *Maryland State Medical Journal*, vol. 14, pp. 56-61.

⁹¹ Collin, C., Wade, D., Davies, S., Horne V., 'The Barthel ADL Index: a reliability study', *International Disability Studies*, vol. 10(2), pp. 61-63.

⁹² The relevant assessment form can be found at: <http://camapcanada.ca/Barthel.pdf>, accessed 14 February 2018.

performance should be established using the best available evidence. Asking the patient, friends/relatives, and nurses will be the usual source, but direct observation and common sense are also important. However, direct testing is not needed', and individuals should be assessed based on what they have done in the preceding 24-48 hours. The guidance also provides that selection of the middle category on the assessment form implies 'that the patient supplies over 50 % of the effort' and that 'use of aids to be independent is allowed'.⁹³ This synthesis report reveals that the Barthel Index is used as the key element in the Latvian assessment of the ability to carry out daily life activities to determine a need for special care (see Part III, section 9.2) and in the Maltese assessment for Increased Severe Disability Assistance (see Part III, section 9.1.3.4).

In some cases, the assessment will seek to identify care needs precisely, and will lead to the allocation of a benefit either in cash or in kind to meet the identified care need, while in other cases the assessment may result in the allocation of a broader range of benefits than those necessary to meet the specific care needs identified. Alternatively, the assessment may seek to identify indicators rather than exact needs.⁹⁴ An assessment of need can also be used to determine access to other benefits, such as support with education or employment, access to specialised forms of transport or a disabled person's parking permit.

2.3 Assessment of economic loss

This assessment method involves calculating the loss of income due to disability of the person who is being assessed. This can be done directly from the individual's income or tax returns, or by some technique which determines what the individual could have earned if he/she were not disabled. The notional figures are then compared with each other, leading to a percentage figure based on lost income.⁹⁵

2.4 Procedural assessment method

The procedural or demonstrated assessment approach is based on an 'iterative learning process' to assess an individual's capabilities.⁹⁶ In the context of employment this involves an assessment based on a process in which options for medical and/or vocational rehabilitation and other routes to return to work are explored. In this context, the identification of a person as disabled marks the end of this process, where the process has not been successful and a continuing inability to work has been demonstrated. During the intervening stages, the person may be classified as sick or as in rehabilitation. If a person has reached the end of the set of procedures and has still not been placed in employment, a decision must be made whether to classify them as disabled, or to classify them as unemployed or having some other status. This

⁹³ Guidelines for the Barthel Index of Activities of Daily Living, available at: <http://camapcanada.ca/Barthel.pdf>, accessed 14 February 2018.

⁹⁴ Brunel University, European Commission (2002), *Definitions of Disability in Europe, A Comparative Analysis*, p. 39. www.ec.europa.eu/social/BlobServlet?docId=2088&langId=en.

⁹⁵ Council of Europe (2002), *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), p. 14. <http://rm.coe.int/16805a2a27>.

⁹⁶ Baumberg Geiger, B. (2018), 'Legitimacy is a balancing act, but we can achieve a much better balance than the WCA' – 'A Better WCA is Possible', Demos, p. 59.

decision can be difficult to make where a number of factors contribute to an individual being unemployed and, in general, this process allows for the exercise of discretion at various points, including with regard to the final decision of disability status, but also with regard to appropriate steps in the process regarding rehabilitation and (return to) work activities.⁹⁷

Ben Baumberg Geiger points to a number of weaknesses or sources of criticism regarding this assessment method. Individuals who are undergoing rehabilitation usually receive lower benefits than disability pensions and, for those individuals who have no realistic chance of working, this assessment process can lead to what is effectively a benefit cut.⁹⁸ This is because they will be required to go through a rehabilitation process, even though they have no realistic chance of being able to work at the end of the process, before becoming eligible for a disability pension. During the period of rehabilitation, they will receive lower benefits than disability pensioners, and, the rehabilitation process will simply delay the award of the pension. The system requires a great deal of expertise in interpreting an individual's past experiences and deciding whether future rehabilitation activities are useful, and the model only provides an accurate view of work capability if the rehabilitation offered maximises work capacity, although this does not always happen. Furthermore, assessments for rehabilitation and disability pensions can be in tension with each other and can focus on different factors – such as work motivation, which is relevant for rehabilitation but not a benefit assessment.⁹⁹ Ben Baumberg Geiger et al. have argued that 'the overlap with rehabilitation is partial, because of the different nature of benefit eligibility assessment and rehabilitation assessment'.¹⁰⁰ They note that 'the claimants' relationship with the assessor may be one of distrust when being evaluated for benefits (the assessors' goal being to appropriately restrict access) but more trusting when their rehabilitation needs are being evaluated. It is also because there are pressures for benefit eligibility to be standardised, but for rehabilitation assessment to be personalised'.¹⁰¹ Ben Baumberg Geiger et al. have pointed to one further challenge with this assessment method in another publication. They note that 'claimants often find the logic of the system contradictory: they are told that in order to prove they cannot work; they have to try to get back to work (or even do a work trial)'. They also note though that this 'is perhaps less of a contradiction that [sic] it might appear, but it may nevertheless reduce both claimant motivation and the perceived legitimacy of the system'. For these reasons such 'dual-purpose' assessments may be inefficient, although Ben Baumberg Geiger notes that they are regarded as working in Denmark.¹⁰²

⁹⁷ Brunel University, European Commission (2002), *Definitions of Disability in Europe, A Comparative Analysis*, pp. 43-44. www.ec.europa.eu/social/BlobServlet?docId=2088&langId=en.

⁹⁸ Baumberg Geiger, B. (2018), 'Legitimacy is a balancing act, but we can achieve a much better balance than the WCA' – 'A Better WCA is Possible', Demos, p. 59.

⁹⁹ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

¹⁰⁰ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

¹⁰¹ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

¹⁰² Baumberg Geiger, B. (2018), 'Legitimacy is a balancing act, but we can achieve a much better balance than the WCA' – 'A Better WCA is Possible', Demos, p. 60.

3 Assessments involving several different approaches

In practice, many assessments combine elements of two or more of the various assessment methods identified above. Boer et al. have noted that all legal definitions of disability 'are couched in terms of damage to health, although the exact terminology used in the legal instrument varies', implying that some form of medical assessment is always involved.¹⁰³ For example, both the assessment methods based on care needs and those based on functional capacity require that an individual's need for care or reduced (working) capacity be related to a health condition, and this implies that the assessment procedures must also involve some degree of medical assessment to determine if an individual has a health condition which potentially qualifies them as disabled. Assessments related to a disability pension can involve both an assessment of work (functional) capacity and earning capacity (economic loss), or one or the other.¹⁰⁴ Similarly, an assessment for support through long-term care may seek to assess both the ability (functional capacity) of the applicant, as well as their actual need for care. As a result, assessments can sometimes use one part of one approach and part of another, and some tests are extremely complicated. Where an assessment involves multiple elements, including a medical dimension, a functional capacity dimension and/or a needs-based dimension, as well as explicitly taking into account the impact of environmental factors on the situation of a given individual, it can be regarded as holistic. Very few such assessment methods were identified for the purposes of this synthesis report.

Boer et al. argue that the grounds on which the conclusions of the doctors or insurance physicians making the assessments are based can be of different natures: 'legal (representing the legal criteria), scientific (representing socio-medical evidence), or social (representing social norms as to how to deal with disabled people).'¹⁰⁵

¹⁰³ De Boer, W., Besseling, J., Willems, J. (2007), 'Organisation of disability evaluation in 15 countries', *Pratiques et Organisation des Soins*, vol. 38, no. 3, p. 214.

¹⁰⁴ De Boer, W., Besseling, J., Willems, J. (2007), 'Organisation of disability evaluation in 15 countries', *Pratiques et Organisation des Soins*, vol. 38, no. 3, p. 212.

¹⁰⁵ De Boer, W., Donceel, P., Brage, S., Rus, M., Willems, J. (2008), 'Medico-legal reasoning in disability assessment: A focus group and validation study', *BMC Public Health*, 8: 335, p. 2.

4 Procedural differences in disability assessments

In addition to the various assessment methods discussed above, assessment procedures can differ in a number of other ways. This section considers various (procedural) factors which distinguish disability assessment methods: the kinds of evidence which is taken into account, who makes the assessment, the role of doctors (or insurance physicians) in the process, the assessment interview, and protocols and guidelines on disability assessment.

4.1 Evidence

The way in which disability assessments take place vary widely, and various kinds of evidence may be considered. Jerry Spanjer, who is an insurance assessment physician and academic in the Netherlands, has identified three ways in which information can be collected in the context of disability assessments: questionnaires, performance tests and medical assessments. He notes that questionnaires, whether filled in by the applicant or an expert during a semi-structured interview 'generally ... only register what the patient reports, without an actual assessment'.¹⁰⁶ Performance tests measure the performance of the individual in a research or clinical centre, and involve activities such as lifting weights. However, Spanjer argues that 'the validity of the results is questionable because the sincerity of effort, ability to perform work outside a laboratory setting and the prediction of injury are difficult to measure'.¹⁰⁷ The medical assessment, which involves an interview with the applicant carried out by a doctor specialised in assessing disability for the purposes of benefit claims, can cover a variety of topics. In the Dutch context,¹⁰⁸ Spanjer identifies the main topics as medical history and the registration of complaints, functioning in daily life and work, the opinion of the applicant about the disability and their possibilities, a description of a usual day and detailed examples of the disabilities experienced.¹⁰⁹ He notes that observation and a physical examination can also contribute to the assessment. The assessment interview is considered in more detail below (4.4). A further source of evidence can be the individual's medical records, which can potentially easily be accessed by an assessor in digital format where there is a developed e-health system. However, it should be borne in mind that such information is sensitive and subject to data protection legislation. Moreover, assessors should only be able to access such information with the informed consent of the individual who is being assessed.

¹⁰⁶ Spanjer, J., Krol, B., Brouwer, S., and Groothoff, J., 'Sources of variation in work disability assessment', in Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, p. 23.

¹⁰⁷ Spanjer, J., Krol, B., Brouwer, S., and Groothoff, J., 'Sources of variation in work disability assessment', in Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, p. 23.

¹⁰⁸ Relating to an assessment of eligibility for a disability pension or worker's compensation.

¹⁰⁹ Spanjer, J., Krol, B., Brouwer, S., and Groothoff, J., 'Sources of variation in work disability assessment', in Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, pp. 23-24.

The assessment itself may be based on a simple declaration by an individual that he/she qualifies for the benefit, although it is unlikely that this kind of evidence will be sufficient for most kinds of assessment or benefit awards. However, self-assessment forms indicating activity limitations are often an important part of the evidence which is taken into account. Spanjer argues that ‘when claiming disability benefits patients may tend to emphasize their disabilities in order to qualify for a work pension’¹¹⁰ and that ‘assessments based on self-reported activity limitations reveal more limitations than assessments based on medical information’.¹¹¹ Secondly, some supporting evidence may be submitted from a neighbour or trustworthy acquaintance who knows the applicant’s situation. A third and very common form of evidence is documentation from a healthcare professional who has treated the applicant, who may confirm a diagnosis or indicate what capacities or needs an individual has in light of their health condition. Information from the individual’s employer may also be considered in the case of employed individuals who apply for a disability pension and are unable to work (to the full extent of their contract) for a health-related reason. With regard to self-assessments or supporting evidence, it is important to take into account the source of the information ‘to estimate its merit’.¹¹² In addition, an assessment may well involve medical or other professionals acting on behalf of the insurance agency. Assessments have traditionally been carried out by doctors, but nowadays they increasingly involve a multidisciplinary team.¹¹³

The assessment may always involve an interview, and possibly a medical examination or performance test, of the applicant, or this may only be carried out where the documentary evidence provides insufficient information. In some circumstances the interview could be carried out remotely, by telephone or using the internet. Examinations and performance tests must be carried out in person.

4.2 The assessor(s)

A number of individuals can be involved in making the assessment. While a self-assessment by the applicant, using a standard form, is often one element of the assessment, it is generally not sufficient for a decision to be made on eligibility or disability status. A variety of medical professionals, ranging from medical doctors to nurses, psychologists, therapists (such as physical therapists or occupational therapists) and rehabilitation specialists can be involved in the assessment. The particular role of doctors or insurance physicians who carry out assessments is

¹¹⁰ Spanjer, J., Krol, B., Brouwer, S., and Groothoff, J., ‘Sources of variation in work disability assessment’, in Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, p.21.

¹¹¹ Spanjer, J., Krol, B., Popping, R., Groothoff, J., and Brouwer, S., ‘Disability assessment interview: the role of detailed information on functioning in addition to medical history-taking’, in Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, p 55.

¹¹² Spanjer, J., Krol, B., Brouwer, S., and Groothoff, J., ‘Sources of variation in work disability assessment’, in Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, p.22.

¹¹³ Council of Europe (2002), *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), p. 11.
<https://rm.coe.int/16805a2a27>.

considered in more detail below (4.3). Medical professionals who are involved in the process may either be individuals who are already familiar with the applicant, and who provide him or her with treatment, or a medical professional who is working on behalf of the assessment agency. Medical doctors involved in the assessment are sometimes formally recognised and registered insurance physicians, although this profession does not exist in all European states.¹¹⁴ Other professionals who can be involved include social workers and employment specialists. The European Commission report prepared by experts at Brunel University in 2002 reflected on the role of medical professionals in disability assessments. The report noted that, while it would be interesting to be able to classify approaches to assessment according to their degree of 'medicalisation', this was not a simple task. It was argued that medical knowledge and skills are used in a wide variety of ways in disability assessment, and that doctors are often asked to make judgments which are not strictly medical. Doctors may, for example, be asked to visit a person in the home and report on aspects of the social environment. They can be expected to make an assessment of functional capacity, which does not rely on medical data. Consequently, medical personnel may be asked to implement a non-medical model of disability, perhaps reflecting their role as trusted professionals in the community rather than their specialist skills. The fact that doctors and other medical professionals are involved in the assessment of disability does not mean that that assessment is purely or mainly medically based. The assessment could very well be based on assessing need or functional capacity.¹¹⁵

In some cases, a multidisciplinary team involving two or more professionals is responsible for the assessment. Arnoud et al. have noted that 'If the assessment is multidimensional, and if it includes the assessment of participation restrictions and environmental obstacles, the decision-making process should allow for a more efficient allocation of benefits. Conversely, an assessment limited to only impairments and functional limitations of the person bears the risk to end up in a uniform allocation system based on a categorization of the disabled population'.¹¹⁶ An assessment is multidimensional if it collects information on several dimensions which should be taken into account in a process of allocation of benefits (Arnoud et al.).¹¹⁷ argue that multidimensional assessments which consider participation limitations and environmental obstacles are more efficient – meaning that this kind of assessment secures a better match between an individual's needs and the services or benefits they receive.

Multidisciplinary teams were similarly viewed with approval in the 2002 Council of Europe Report, which noted that 'Most respondents felt that multidisciplinary teams were more in keeping with modern views on people with disabilities and what society should do for them. Considering participation in the widest sense, and in a group where

¹¹⁴ De Wind, A., Donceel, P., Dekkers-Sánchez, P., Godderis, L. (2016), 'The role of European physicians in the assessment of work disability: A comparative study', *Edorium J Disabil Rehabil*, 2, p. 79.

¹¹⁵ Brunel University, European Commission (2002), *Definitions of Disability in Europe, A Comparative Analysis*, p. 60 onwards. www.ec.europa.eu/social/BlobServlet?docId=2088&langId=en.

¹¹⁶ Arnould, C., Barral, C., Bouffioulx, E., Castelein, P., Chiriacescu, D., Cote, A. (undated), *Disability Assessment Mechanisms: Challenges and Issues at Stake for the Development of Social Policies in light of the United Nations Convention for the Rights of Persons with Disabilities*, p. 7.

¹¹⁷ Arnould, C., Barral, C., Bouffioulx, E., Castelein, P., Chiriacescu, D., Cote, A. (undated), *Disability Assessment Mechanisms: Challenges and Issues at Stake for the Development of Social Policies in light of the United Nations Convention for the Rights of Persons with Disabilities*, p. 6.

no single professional group was dominant, and which could involve the person being considered in the decision-making process, seemed a good model for both people with disabilities and those who try to help them'.¹¹⁸

Spanjer has noted that the experience and education of the assessor, as well as their cultural background, norms and values, can influence the assessment. As an example, he states that 'research has shown that independent medical examiners assess lower levels of disability than treating physicians due to differences in opinion rather than skills or training'.¹¹⁹ He also notes that the 'rank effect' – 'that is, previous assessment influences the subsequent assessment', and 'confirmation bias' – 'the tendency to search for or interpret new information in such a way as to confirm preconceptions and overlook information and interpretations conflicting with prior beliefs' can influence the outcome of disability assessments.¹²⁰

The final decision to award a benefit or disability status could be made by medical professionals or, based on a report drawn up by such professionals, the decision could be made by an administrative officer. De Boer et al. argue that this is commonly the approach and, where this is the case, the formal decision is usually in line with the recommendation of the medical assessor.¹²¹ The social insurance institution whose employees carry out the assessment and make decisions regarding the awarding of benefits can be wholly independent institutions, or they can be part of the Ministry of Social Affairs, the municipality or the health insurance fund.¹²²

4.3 The role of insurance physicians in disability assessments

Annette de Wind et al. carried out a comparative study investigating the role of insurance physicians in the assessment of work disability, and found a number of similarities across European states.¹²³ An assessment of a work disability or of the ability to work where a reduced working ability is related to a health condition is generally carried out to determine an individual's eligibility for a disability pension. In this context, insurance physicians have an important role to play. In general, de Wind et al. found that the core of the tasks which insurance physicians perform when

¹¹⁸ Council of Europe (2002), *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), p. 20. <https://rm.coe.int/16805a2a27>.

¹¹⁹ Spanjer, J., Krol, B., Brouwer, S., and Groothoff, J., 'Sources of variation in work disability assessment', in Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, p. 26.

¹²⁰ Spanjer, J., Krol, B., Brouwer, S., and Groothoff, J., 'Sources of variation in work disability assessment', in Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, p. 26.

¹²¹ De Boer, W., Besseling, J., Willems, J. (2007), 'Organisation of disability evaluation in 15 countries', *Pratiques et Organisation des Soins*, vol. 38, no. 3, p. 210.

¹²² De Boer, W., Besseling, J., Willems, J. (2007), 'Organisation of disability evaluation in 15 countries', *Pratiques et Organisation des Soins*, vol. 38, no. 3, p. 207.

¹²³ De Wind, A., Donceel, P., Dekkers-Sánchez, P., Godderis, L. (2016), 'The role of European physicians in the assessment of work disability: A comparative study', *Edorium J Disabil Rehabil*, 2, p. 78. The study covered 14 states: Belgium, the Czech Republic, Finland, France, Germany, Ireland, Italy, the Netherlands, Norway, Romania, Slovenia, Slovakia, Sweden and the United Kingdom.

assessing long-term work-related disability show many similarities, and that this also applies to the knowledge, skills and competencies that are required of such physicians.

De Wind et al. note that physician assessors generally have to apply 'medico-legal reasoning ... the purpose of which is not to diagnose or treat a medical condition, but to address the legal question whether the claimant is eligible for the benefit', and that this involves a series of technical steps and the need to communicate with others (interpersonal processes).¹²⁴ They noted that, in all countries studied, the assessment involved 'some sort of collaboration within the social security agencies or assessing companies, since no assessment was carried out solely by the physician'.¹²⁵ Like de Boer,¹²⁶ they found that, following the assessment, either the assessor can take the final decision on the award of the benefit, or another person can take the final decision on the basis of written advice about the remaining work capacity, which is provided by the assessor physician.¹²⁷

In terms of the roles played by physicians, de Wind et al. found that insurance physicians carrying out long-term work disability assessment took on similar roles.¹²⁸ They noted that the roles identified were being 'fulfilled to a greater or lesser extent depending on the national legislation and operationalization of the assessment'.¹²⁹ However, they also noted that physicians who carry out such assessments require specific knowledge, skills and competences, in addition to general medical knowledge. These relate to knowledge of current laws and regulations regarding social security, labour factors and communication skills.¹³⁰

De Wind et al. did note some differences between the role of insurance physicians in this context. They noted that the medical speciality of the insurance physician or doctor only exists in some countries and that countries where such a speciality existed, or where a separate education programme existed to train insurance physicians or doctors, were more likely to provide specific guidelines for the assessment of (work) capability. In other countries, the guidelines were more likely to relate to general

¹²⁴ De Wind, A., Donceel, P., Dekkers-Sánchez, P., Godderis, L. (2016), 'The role of European physicians in the assessment of work disability: A comparative study', *Edorium J Disabil Rehabil*, 2, p. 81.

¹²⁵ De Wind, A., Donceel, P., Dekkers-Sánchez, P., Godderis, L. (2016), 'The role of European physicians in the assessment of work disability: A comparative study', *Edorium J Disabil Rehabil*, 2, p. 81.

¹²⁶ De Boer, W., Besseling, J., Willems, J. (2007), 'Organisation of disability evaluation in 15 countries', *Pratiques et Organisation des Soins*, vol. 38, no. 3, p. 210.

¹²⁷ De Wind, A., Donceel, P., Dekkers-Sánchez, P., Godderis, L. (2016), 'The role of European physicians in the assessment of work disability: A comparative study', *Edorium J Disabil Rehabil*, 2, p. 81.

¹²⁸ De Wind et al. identified seven roles based on the Can MEDS roles: medical expert (central role), communicator, collaborator, manager, health advocate, scholar and professional. de Wind, A., Donceel, P., Dekkers-Sánchez, P., Godderis, L. (2016), 'The role of European physicians in the assessment of work disability: A comparative study', *Edorium J Disabil Rehabil*, 2, p. 80.

¹²⁹ De Wind, A., Donceel, P., Dekkers-Sánchez, P., Godderis, L. (2016), 'The role of European physicians in the assessment of work disability: A comparative study', *Edorium J Disabil Rehabil*, 2, p. 85.

¹³⁰ De Wind, A., Donceel, P., Dekkers-Sánchez, P., Godderis, L. (2016), 'The role of European physicians in the assessment of work disability: A comparative study', *Edorium J Disabil Rehabil*, 2, p. 85.

medical examinations.¹³¹ In addition, in some but not all countries, there were 'specific deontological and ethical rules for the (social) insurance practice, such as a code of conduct for the insurance physician and specific guidelines for data exchange and protection'.¹³²

4.4 The assessment interview

As noted above, insurance physicians frequently interview applicants as part of the assessment procedure and, in some countries, they are guided by protocols or guidelines. Jerry Spanjer, who is himself an insurance physician and researched disability assessment structured interviews, has identified three interview models which are used by insurance physicians in the Netherlands when assessing work-related disability.

First, there is the methodical assessment interview: 'The interview is semi-structured and has 10 topics including work possibilities, motivation, personal ideas about the pathology, vitality, personal changes, life events, thoughts about the future, medical history, work history and a description of a normal day. The arguments by the patient for the claim are important, with an emphasis placed on the functional limitations and abilities described in the claim. The patient is responsible for his own disability and recovery.'¹³³ A manual provides further guidance on this interview method.¹³⁴

Secondly, there is the multi-causal analysis: 'This is an interview with a limited structure that includes five broad fields which can be interchanged. These fields include medical history and complaints, functioning, personal characteristics, work factors and personal factors. The physician engages the patient in the interview, and has an attitude of involvement, respect and attention. Perception and understanding of the patient are important'.¹³⁵

The third model of interview is the Disability Assessment Structured Interview (DASI): 'This is a semi-structured interview protocol with fixed topics which are largely based on the International Classification of Functioning Disability and Health (ICF). ... The main topics are: introduction, work, impairments, the limitations to activity that are experienced, participation, the patient's opinion, and the physician's opinion. Each

¹³¹ De Wind, A., Donceel, P., Dekkers-Sánchez, P., Godderis, L. (2016), 'The role of European physicians in the assessment of work disability: A comparative study', *Edorium J Disabilt Rehabil*, 2, p. 84.

¹³² De Wind, A., Donceel, P., Dekkers-Sánchez, P., Godderis, L. (2016), 'The role of European physicians in the assessment of work disability: A comparative study', *Edorium J Disabilt Rehabil*, 2, p. 80.

¹³³ Spanjer, J. (2010), The disability assessment structured interview: its reliability and validity in work disability assessment, University Medical Center Groningen, University of Groningen, Chapter 1, p. 13.

¹³⁴ De Boer, W., Duin, J., Herngreen, H. (1997), Handleiding Methodisch beoordelingsgesprek (Manual Methodical Assessment Interview), referenced in Spanjer, J. (2010), The disability assessment structured interview: its reliability and validity in work disability assessment, University Medical Center Groningen, University of Groningen, Chapter 1, p.13.

¹³⁵ Spanjer, J. (2010), The disability assessment structured interview: its reliability and validity in work disability assessment, University Medical Center Groningen, University of Groningen, Chapter 1, p. 13.

topic is subdivided into other topics. Concrete and detailed examples play important roles in defining the patient's limitations and abilities'.¹³⁶

The interview is often of key importance for making the disability assessment. In the case of the Netherlands, insurance physicians are taught these three interview methodologies as part of their specialised training. However, in practice, physicians often do not use one single interview model, but combine elements of all three models.¹³⁷ Each type of interview identified above involves discussing an individual's ability to carry out certain activities, as well as some other factors. This is in line with Spanjer's findings that, in disability assessment interviews, insurance physicians should ask for medical information as well as detailed information on participation and activity limitations.¹³⁸ He argues that 'it seems logical to ask patients in detail which functional limitations they encounter in daily life, when it is their functional limitations which need to be assessed'.¹³⁹ In the Dutch context, Spanjer notes that the decisions of an insurance physician on an individual's work limitation are based, for the most part, on an interview, although other paper-based evidence (a report from the employer; medical information from the occupational doctor, and a self-assessment questionnaire) is also considered.¹⁴⁰

4.5 Protocols and guidelines on disability assessment

Documents such as protocols and guidelines can assist assessors in making a decision and can also promote consistency among different assessors when presented with individuals with the same medical conditions and similar levels of impairments, who are facing similar environmental barriers. Consistency in assessment is important because it contributes to the validity and the trust of applicants in the system. De Wind et al. note, such protocols or guidelines are more likely to exist in European states which have a recognised medical speciality of insurance physician, or where a separate education programme exists to train insurance physicians or doctors.¹⁴¹ The Netherlands is one such state. However, Spanjer et al. concluded that 'these guidelines and laws cannot prevent differences between assessors ... laws and guidelines can be interpreted differently and professionals do not always follow prescribed guidelines ... guidelines are not always sufficiently well known ... given the

¹³⁶ Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, Chapter 1, p. 13. Footnote omitted.

¹³⁷ Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, Chapter 8, p. 105.

¹³⁸ Spanjer, J., Krol, B., Popping, R., Groothoff, J., and Brouwer, S., 'Disability assessment interview: the role of detailed information on functioning in addition to medical history-taking', in Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, p. 46.

¹³⁹ Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, Chapter 8, p. 114.

¹⁴⁰ Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, Chapter 1, pp. 12-13.

¹⁴¹ De Wind, A., Donceel, P., Dekkers-Sánchez, P., Godderis, L. (2016), 'The role of European physicians in the assessment of work disability: A comparative study', *Edorium J Disabil Rehabil*, 2, p. 84.

complexity of what is sought to be measures, not every patient or situation will fit within existing guidelines ...[and] disability assessment is often less a technical matter than a normative one but guidelines are based on formal rationality and deny the normative dimension'.¹⁴² In short, guidelines and protocols for (medical) assessors can only promote consistency to some extent and, given the subjectivity of all the parties who are involved, diversity is likely to remain. This reflects the broader point that much of the detail of implementing assessment mechanisms is not in law, but in attitudes and practices, which are themselves a reflection of local culture.¹⁴³

¹⁴² Spanjer, J., Krol, B., Brouwer, S., and Groothoff, J., 'Sources of variation in work disability assessment', in Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, p. 24.

¹⁴³ Council of Europe (2002), *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), p. 23. <https://rm.coe.int/16805a2a27>.

5 The CRPD and disability assessment

As noted in the introduction to this report, the CRPD does not contain any explicit guidance on how to assess disability. The CRPD refers directly to ‘assessment’ only in relation to habilitation and rehabilitation (Article 26), which should be based on an early and ‘multidisciplinary assessment of individual needs and strengths’. The concepts of assistance for ‘disability-related needs’ and assistance with ‘disability-related expenses’ also appear in Article 28, but without reference to how eligibility might be assessed. However, in line with the principles and vision of the CRPD, disability assessment mechanisms should focus more on participation restrictions and on support needs than on impairment or functional limitations (i.e. taking the environment and context into account).

In its Concluding Observations addressed to States Parties, the UN Committee on the Rights of Persons with Disabilities, which is linked to the CRPD, has repeatedly expressed its concerns about definitions of disability for the purposes of acquiring benefits, and about the processes of disability assessment. The issues of concern, and the guidance given, are reviewed below in order to identify the Committee’s view on a CRPD-compatible way of assessing disability. Given the many utterances of the Committee on this topic, the review is primarily restricted to findings and advice in Concluding Observations addressed to European states covered by ANED. Other Concluding Observations are only mentioned to the extent that they add something to the Observations addressed to European (ANED) states.

With regard to Hungary, the Committee expressed concern ‘that definitions of disability and persons with disabilities in the State party’s legislation focus on the impairments of an individual rather than on the barriers he/she faces’ and that ‘such definitions fail to encompass all persons with disabilities, including those with psychosocial disabilities’.¹⁴⁴ In the case of Italy, the Committee noted that ‘disability continues to be defined through a medical perspective, and the revised concept of disability, as proposed by the National Observatory on the Status of Persons with Disabilities, is not aligned to the Convention and lacks binding legislation at both national and regional levels’.¹⁴⁵ With regard to Latvia, the Committee noted that ‘there is a deficient-oriented approach to disability assessment, which is based on the medical model and which focuses on incapacity to work’.¹⁴⁶ In the Concluding Observations addressed to Lithuania, the Committee expressed its concern that ‘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’.¹⁴⁷ With regard to Luxembourg, the Committee was ‘concerned that disability continues to be defined in laws, policies and practices using a medical model. It is also concerned that the different assessment criteria for the eligibility of services continues to focus on the

¹⁴⁴ Committee on the Rights of Persons with Disabilities (2012), Concluding observations on the initial report of Hungary, 22 October 2012, CRPD/C/HUN/CO/1, para. 10.

¹⁴⁵ Committee on the Rights of Persons with Disabilities (2016), Concluding observations on the initial report of Italy, 6 October 2016, CRPD/C/ITA/CO/1, para. 5.

¹⁴⁶ Committee on the Rights of Persons with Disabilities (2017), Concluding observations on the initial report of Latvia, 10 October 2017, CRPD/C/LVA/CO/1, para. 6.

¹⁴⁷ Committee on the Rights of Persons with Disabilities (2016), Concluding observations on the initial report of Lithuania, 11 May 2016, CRPD/C/LTU/CO/1, para. 5.

degree of impairment and result in exclusion, particularly of persons with psychosocial or intellectual disabilities'.¹⁴⁸ With regard to Portugal, the Committee was concerned 'by the use of medical assessment of disability and that there are no legally-binding criteria for the eligibility of persons with disabilities in relation to access to various social programmes, and instead the National Table of Incapacities caused by Work Accidents and Occupational Diseases is used by analogy'.¹⁴⁹ With regard to Serbia, the Committee expressed its concern that, 'despite the provision of multidisciplinary committees, assessment of working capacity continues to be based on a medical model of "incapacity"'.¹⁵⁰ Generally, a repeated refrain in the Concluding Observations is that disability assessment or determination should be based on 'a human rights model of disability', and references to the inappropriate continued use of the medical model of disability and/or the need to move to the human rights model were common. Words to this effect were included in the Concluding Observations addressed to Belgium,¹⁵¹ the Czech Republic,¹⁵² Cyprus,¹⁵³ Montenegro¹⁵⁴ and Slovakia.¹⁵⁵

A further area of concern was the lack of consistency in applying the human rights model. Thus, in the Concluding Observations addressed to the United Kingdom, the Committee observed with concern 'the lack of consistency across the State party in the understanding of, adapting to and applying the human rights model of disability and its evolving concept of disability'.¹⁵⁶ In the case of Austria, the Committee noted that 'there are different concepts of disability across the State Party's laws and policies. The Committee is concerned that the State Party misunderstands the difference between defining disability and identifying groups of persons who can benefit from different kinds of services. The Committee is concerned that some of these definitions constitute a medical model of disability'.¹⁵⁷ The Committee has also been critical in the case of differing definitions of disability leading to differences in terms of access to benefits. Therefore, with regard to Italy, it noted its concern 'that there are different

¹⁴⁸ Committee on the Rights of Persons with Disabilities (2017), Concluding observations on the initial report of Luxembourg, 10 October 2017, CRPD/C/LUX/CO/1, para. 6.

¹⁴⁹ Committee on the Rights of Persons with Disabilities (2016), Concluding observations on the initial report of Portugal, 18 April 2016, CRPD/C/PRT/CO/1, para. 7.

¹⁵⁰ Committee on the Rights of Persons with Disabilities (2016), Concluding observations on the initial report of Serbia, 21 April 2016, CRPD/C/SRB/CO/1, para. 53.

¹⁵¹ Committee on the Rights of Persons with Disabilities (2014), Concluding observations on the initial report of Belgium, 28 October 2014, CRPD/C/BEL/CO/1, paras. 7-8.

¹⁵² Committee on the Rights of Persons with Disabilities (2015), Concluding observations on the initial report of Czech Republic, 15 May 2015, CRPD/C/CZE/CO/1, para. 7. In this Concluding observation, the Committee did not explicitly refer to the 'human rights model', but instead noted that the various definitions of disability were 'not in line with the provisions of the Convention on the Rights of Persons with Disabilities'.

¹⁵³ Committee on the Rights of Persons with Disabilities (2017), Concluding observations on the initial report of Cyprus, 8 May 2017, CRPD/C/CYP/CO/1, para. 5.

¹⁵⁴ Committee on the Rights of Persons with Disabilities (2017), Concluding observations on the initial report of Montenegro, 22 September 2017, CRPD/C/MNE/CO/1, para. 6.

¹⁵⁵ Committee on the Rights of Persons with Disabilities (2016), Concluding observations on the initial report of Slovakia, 17 May 2016, CRPD/C/SVK/CO/1, paras. 11-12.

¹⁵⁶ Committee on the Rights of Persons with Disabilities (2017), Concluding observations on the initial report of United Kingdom of Great Britain and Northern Ireland, 3 October 2017, CRPD/C/GBR/CO/1, para. 6.

¹⁵⁷ Committee on the Rights of Persons with Disabilities (2013), Concluding observations on the initial report of Austria, 13 September 2013, CRPD/C/AUT/CO/1, para. 8.

definitions of disability across sectors and regions leading to disparity in access to support and services'.¹⁵⁸

Specific remarks were made in the Concluding Observations to the United Kingdom regarding the Employment and Support Allowance, where the Committee was concerned that 'the Work Capability Assessment emphasizes a functional evaluation of skills and capabilities, rather than recognizing the interactions between impairment and barriers faced by persons with disabilities'.¹⁵⁹

In short, based on these Concluding Observations, the concerns of the Committee with regard to the assessment of disability can be summarised as:

- Assessments focusing on (degree of) impairment(s) of individuals rather than the barriers that individuals face;
- Assessments focusing on a 'deficient-oriented approach' / the medical model of 'incapacity', including focusing on incapacity to work;
- Assessments focusing on the functional evaluation of skills and capabilities, rather than recognising the interaction between impairments and barriers;
- Assessment criteria which result in exclusion, particularly of persons with psychosocial or intellectual disabilities;
- Definitions of disability which are based on a medical perspective;
- Definitions and understandings of disability which neglect the 'social and relational dimension of disability';
- Definitions of disability which fail to cover all people with disabilities, and particularly people with psychosocial disabilities;
- Absence of legally-binding criteria determining eligibility for benefits / Absence of binding legislation at national and regional levels regarding the definitions of disability;
- Use of different definitions of disability across sectors and regions leading to disparities in access to support and services;
- Lack of consistency in applying the human rights model of disability across the States Parties.

An analysis of Concluding Observations from non-European States Parties reveals a handful of further concerns regarding disability assessment:

- An understanding of 'disability as a health condition or "disorder" which is "continuous" or "considerable" ... and prioritizes the prevention of impairment, medical treatment, and rehabilitation of persons with disabilities';¹⁶⁰
- The absence of 'a procedure for certifying degrees of disability';¹⁶¹

¹⁵⁸ Committee on the Rights of Persons with Disabilities (2016), Concluding observations on the initial report of Italy, 6 October 2016, CRPD/C/ITA/CO/1, para. 5.

¹⁵⁹ Committee on the Rights of Persons with Disabilities (2017), Concluding observations on the initial report of United Kingdom of Great Britain and Northern Ireland, 3 October 2017, CRPD/C/GBR/CO/1, para. 56.

¹⁶⁰ Committee on the Rights of Persons with Disabilities (2017), Concluding observations on the initial report of Iran (Islamic Republic of), 10 May 2017, CRPD/C/IRN/CO/1, para. 8(a).

¹⁶¹ Committee on the Rights of Persons with Disabilities (2016), Concluding observations on the initial report of Guatemala, 29 September 2016, CRPD/C/GTM/CO/1, para. 9.

- Assessments that are made on the basis of a 'medical or charity-based approach';¹⁶²
- Criteria for the accessing services and funds which 'rely heavily on a medical assessment';¹⁶³
- The lack of professional training for and understanding of the rights of persons with disabilities among public officials and professionals;¹⁶⁴
- Systemic limitations on the eligibility of persons with disabilities for welfare services and personal assistance based on their ratings;¹⁶⁵
- A failure to set clear standards for conducting assessments and making decisions to define the lack of capacity to work;¹⁶⁶
- The use of family-based assessments to determine a person's eligibility for certain benefits;¹⁶⁷
- Use of different standards by doctors who approve disability allowances.¹⁶⁸

Lastly with regard to the concerns of the Committee, in the Concluding Observations to Mauritius, the Committee explicitly stated that definitions of disability which reflect the medical approach of disability were 'incompatible with the concept of disability in the Convention'.¹⁶⁹

The Committee has also made concrete recommendations to States as to how they could bring definitions of disability and related assessment procedures into line with the CRPD. Those recommendations are reported on below, with a focus, once again, on the Concluding Observations issued to European (ANED) states.

A fairly elaborate recommendation was made to Latvia, that it

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, ..., and focuses on the elimination of barriers and the promotion of full and effective participation of persons with disabilities in society.¹⁷⁰

¹⁶² Committee on the Rights of Persons with Disabilities (2016), Concluding observations on the initial report of Guatemala, 29 September 2016, CRPD/C/GTM/CO/1, para. 9.

¹⁶³ Committee on the Rights of Persons with Disabilities (2016), Concluding observations on the initial report of Thailand, 12 May 2016, CRPD/C/THA/CO/1, para. 9.

¹⁶⁴ Committee on the Rights of Persons with Disabilities (2015), Concluding observations on the initial report of Ukraine, 2 October 2015, CRPD/C/MUS/CO/1, para. 7.

¹⁶⁵ Committee on the Rights of Persons with Disabilities (2014), Concluding observations on the initial report of Republic of Korea, 28 October 2014, CRPD/C/MUS/CO/1, para. 8.

¹⁶⁶ Committee on the Rights of Persons with Disabilities (2014), Concluding observations on the initial report of Republic of Korea, 28 October 2014, CRPD/C/MUS/CO/1, para. 49.

¹⁶⁷ Committee on the Rights of Persons with Disabilities (2012), Concluding observations on the initial report of China, 15 October 2012, CRPD/C/CHN/CO/1, para. 79. This statement was made in relation to Hong Kong.

¹⁶⁸ Committee on the Rights of Persons with Disabilities (2012), Concluding observations on the initial report of China, 15 October 2012, CRPD/C/CHN/CO/1, para. 79. This statement was made in relation to Hong Kong.

¹⁶⁹ Committee on the Rights of Persons with Disabilities (2015), Concluding observations on the initial report of Mauritius, 30 September 2015, CRPD/C/MUS/CO/1, para. 5.

¹⁷⁰ Committee on the Rights of Persons with Disabilities (2017), Concluding observations on the initial report of Latvia, 10 October 2017, CRPD/C/LVA/CO/1, para. 7(a).

In the case of Luxembourg, the Concluding Observations recommended that criteria for social protection measures and access to services should be ‘in line with the human rights model of disability’.¹⁷¹ References to the need to adopt a human rights model or human rights-based approach to disability, generally with regard to a broad area covering, for example, all laws, policies and measures, or new and existing legislation, were also found in the Concluding Observations issued to Cyprus,¹⁷² Montenegro,¹⁷³ Slovakia,¹⁷⁴ and the United Kingdom,¹⁷⁵ which was also advised to ensure that eligibility criteria and assessments for certain named benefits were ‘in line with the human rights model of disability’.¹⁷⁶ In the cases of Belgium and Cyprus, this recommendation was accompanied by the advice to consult with disabled persons’ organisations.¹⁷⁷ Italy was simply advised to ‘adopt a concept of disability in line with the Convention and ensure legislation is enacted that incorporates the new concept in a homogeneous manner across all levels and regions of government and territories’.¹⁷⁸ Similarly, Lithuania was recommended to ‘amend the legal definition of disability in accordance with the criteria and principles provided in articles 1 to 3 of the Convention and [ensure] that it effectively apply the amended legal definition in all laws and regulations’.¹⁷⁹ Comparable recommendations were made to Austria,¹⁸⁰ Germany¹⁸¹ and Portugal.¹⁸² Somewhat more elaborate recommendations were made to the Czech Republic:

to amend the definitions of disability and person with disabilities in ... legislation and to make explicit reference to the barriers faced by persons with disabilities in ... definitions, in order to harmonize them with the definitions in the Convention.¹⁸³

¹⁷¹ Committee on the Rights of Persons with Disabilities (2017), Concluding observations on the initial report of Luxembourg, 10 October 2017, CRPD/C/LUX/CO/1, para. 7.

¹⁷² Committee on the Rights of Persons with Disabilities (2017), Concluding observations on the initial report of Cyprus, 8 May 2017, CRPD/C/CYP/CO/1, para. 6.

¹⁷³ Committee on the Rights of Persons with Disabilities (2017), Concluding observations on the initial report of Montenegro, 22 September 2017, CRPD/C/MNE/CO/1, para. 7.

¹⁷⁴ Committee on the Rights of Persons with Disabilities (2016), Concluding observations on the initial report of Slovakia, 17 May 2016, CRPD/C/SVK/CO/1, paras. 12.

¹⁷⁵ Committee on the Rights of Persons with Disabilities (2017), Concluding observations on the initial report of United Kingdom of Great Britain and Northern Ireland, 3 October 2017, CRPD/C/GBR/CO/1, para. 7(c).

¹⁷⁶ Committee on the Rights of Persons with Disabilities (2017), Concluding observations on the initial report of United Kingdom of Great Britain and Northern Ireland, 3 October 2017, CRPD/C/GBR/CO/1, para. 59(c).

¹⁷⁷ Committee on the Rights of Persons with Disabilities (2014), Concluding observations on the initial report of Belgium, 28 October 2014, CRPD/C/BEL/CO/1, paras. 8. Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of Cyprus, 8 May 2017, CRPD/C/CYP/CO/1, para. 6.

¹⁷⁸ Committee on the Rights of Persons with Disabilities (2016), Concluding observations on the initial report of Italy, 6 October 2016, CRPD/C/ITA/CO/1, para. 6.

¹⁷⁹ Committee on the Rights of Persons with Disabilities (2016), Concluding observations on the initial report of Lithuania, 11 May 2016, CRPD/C/LTU/CO/1, para. 6.

¹⁸⁰ Committee on the Rights of Persons with Disabilities (2013), Concluding observations on the initial report of Austria, 13 September 2013, CRPD/C/AUT/CO/1, para. 9.

¹⁸¹ Committee on the Rights of Persons with Disabilities (2015), Concluding observations on the initial report of Germany, 13 May 2015, CRPD/C/DEU/CO/1, para. 8(a).

¹⁸² Committee on the Rights of Persons with Disabilities (2016), Concluding observations on the initial report of Portugal, 18 April 2016, CRPD/C/PRT/CO/1, para. 8.

¹⁸³ Committee on the Rights of Persons with Disabilities (2015), Concluding observations on the initial report of Czech Republic, 15 May 2015, CRPD/C/CZE/CO/1, para. 8.

Similarly, Hungary was advised to

incorporate an inclusive definition of disability and persons with disabilities that is firmly rooted in the human rights-based approach to disability and encompasses all persons with disabilities, including those with psychosocial disabilities.¹⁸⁴

With regard to the United Kingdom, the Committee made recommendations regarding, *inter alia*, the qualifications and training of people who are responsible for making disability assessments. It advised that the United Kingdom should

ensure that the legal and administrative requirements of the process to assess working capabilities ... are in line with the human rights model of disability, and that those who conduct the assessments are qualified and duly trained in that model, and that the assessments take into consideration work-related as well as other personal circumstances.¹⁸⁵

The Committee also paid particular attention to the assessment of working capacity in its Concluding Observations to Serbia, where it advised the State Party 'to review the assessment of working capacity to eliminate the medicalised approach and to promote the inclusion of persons with disabilities in the open labour market'.¹⁸⁶ In the case of Croatia, the Committee turned its focus to another form of benefit, where it recommended that 'benefits aiming at alleviating increased costs arising from disability should be based on an assessment of the individual's support needs, and should disregard any financial assets test'.¹⁸⁷

Further relevant recommendations made in Concluding Observations addressed to non-European states include the harmonisation of definitions of disability in line with the human rights model,¹⁸⁸ making the procedure for the certification of disability 'accessible, simple and free of charge',¹⁸⁹ expansion of the register of persons with disabilities, especially to rural and the most remote areas,¹⁹⁰ removing references to 'invalids' or 'persons with limited abilities' from legislation and policy documents,¹⁹¹ adopting a 'social' (as well as a 'human rights') model of disability,¹⁹² and ensuring that

¹⁸⁴ Committee on the Rights of Persons with Disabilities (2012), Concluding observations on the initial report of Hungary, 22 October 2012, CRPD/C/HUN/CO/1, para. 12.

¹⁸⁵ Committee on the Rights of Persons with Disabilities (2017), Concluding observations on the initial report of United Kingdom of Great Britain and Northern Ireland, 3 October 2017, CRPD/C/GBR/CO/1, para. 57(c).

¹⁸⁶ Committee on the Rights of Persons with Disabilities (2016), Concluding observations on the initial report of Serbia, 21 April 2016, CRPD/C/SRB/CO/1, para. 54.

¹⁸⁷ Committee on the Rights of Persons with Disabilities (2015), Concluding observations on the initial report of Croatia, 15 May 2015, CRPD/C/HRV/CO/1, para. 44.

¹⁸⁸ Committee on the Rights of Persons with Disabilities (2017), Concluding observations on the initial report of Morocco, 25 September 2017, CRPD/C/MAR/CO/1, para. 7.

¹⁸⁹ Committee on the Rights of Persons with Disabilities (2016), Concluding observations on the initial report of Bolivia, 4 November 2016, CRPD/C/BOL/CO/1, para. 9.

¹⁹⁰ Committee on the Rights of Persons with Disabilities (2016), Concluding observations on the initial report of Colombia, 29 September 2016, CRPD/C/COL/CO/1, para. 13.

¹⁹¹ Committee on the Rights of Persons with Disabilities (2015), Concluding observations on the initial report of Ukraine, 2 October 2015, CRPD/C/UKR/CO/1, para. 6.

¹⁹² Committee on the Rights of Persons with Disabilities (2015), Concluding observations on the initial report of Turkmenistan, 13 May 2015, CRPD/C/TKM/CO/1, para. 10.

the assessment for determining disability 'reflects the characteristics, circumstances and needs of persons with disabilities'.¹⁹³

As can be seen, a key recommendation found across many of the Concluding Observations was that definitions of disability, disability assessments and determinations should be based on the human rights model of disability or should be in accordance with the Convention. An understanding of the human rights model of disability has been provided by the current chair of the CRPD Committee (at the time of writing), Theresia Degener. Degener has identified six key elements of the human rights model of disability, which also serve to distinguish this model from the social model of disability. Firstly, the human rights model of disability requires recognition of that fact that impairment does not hinder human rights capacity. Secondly, the human rights model of disability encompasses both civil and political rights as well as economic, social and cultural rights. Thirdly, the human rights model acknowledges adverse life circumstances, such as pain, deterioration of quality of life or early death due to impairment, and requires that these are taken into account when social justice theories are developed. The human rights model therefore values impairment as part of human diversity. Fourthly, the human rights model allows room for identity politics, and acknowledges that disabled persons may have many different identities related to, for example, gender, age or ethnic origin, as well as acknowledging that different impairments may contribute to disability. Fifthly, the human rights model allows for policies to prevent impairment. Lastly, the human rights model seeks to promote change and social justice.¹⁹⁴ Degener notes that the Committee has embraced the term 'human rights model' of disability in its more recent Concluding Observations, but that reports from different states do not yet reflect a clear understanding of the model, and that the model is not yet reflected in implementation.¹⁹⁵ However, the precise implications of this model in terms of disability assessment in the context of benefits and support for disabled persons is unclear – other than to the extent that this is addressed in the Concluding Observations discussed above.

Nevertheless, based on a reading of the Convention as a whole, and bearing in mind the human rights model of disability, one can reach some conclusions about what a disability human rights compatible approach to disability assessment should involve:

First, the design and conduct of disability assessments should be guided by the General Principles established in Article 3 CRPD. These are:

- Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
- Non-discrimination;
- Full and effective participation and inclusion in society;
- Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;

¹⁹³ Committee on the Rights of Persons with Disabilities (2014), Concluding observations on the initial report of Republic of Korea, 28 October 2014, CRPD/C/KOR/CO/1, para. 9.

¹⁹⁴ Degener, T., 'A New Human Rights Model of Disability' in Della Finna, V., Cera, R., Palmisano, G. (eds.) (2017), *The United Nations Convention on the Rights of Persons with Disabilities: A Commentary*, pp. 41-59.

¹⁹⁵ Degener, T., 'A New Human Rights Model of Disability' in Della Finna, V., Cera, R., Palmisano, G. (eds.) (2017), *The United Nations Convention on the Rights of Persons with Disabilities: A Commentary*, pp. 56.

Equality of opportunity;
Accessibility;
Equality between men and women;
Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Assessment methods which breach these principles will not be in line with the CRPD.

Second, it is worth noting that the provisions of the Convention ‘extend to all parts of federal States without limitation or exceptions’ (Art. 4(5)). This is relevant where assessments are carried out at the municipal level.

Third, in line with the purpose of the CRPD, disability assessments should aim to consider the interactions between ‘persons with long-term physical, mental, intellectual or sensory impairments’ and the ‘various barriers that hinder their full and effective participation in society on an equal basis with others’ (Article 1 CRPD). They should assess the scope for ‘reasonable accommodation’ to remove such barriers. The assessment of impairment is not a substitute for the assessment of disability. The assessment mechanism should also allow for reasonable accommodations when needed in individual cases.

Fourth, the assessment should be conducted in a way that allows for the identification and elimination of obstacles and barriers to its accessibility in accordance with Article 9 CRPD. This includes access to any buildings used, to all forms of information and communication provided about the assessment process, to its application forms and assessment tools. Any rules which prevent individuals from being supported during the assessment where this is needed for an impairment-related reason, must be removed. In brief, assessment mechanisms must both be accessible and, where needed, allow for individualised reasonable accommodations.

Fifth, disability assessment processes must recognise the legal capacity of persons with disabilities on an equal basis with others (Article 12 CRPD). This means that ‘the rights, will and preferences of the person’ should be respected in an assessment ‘free of conflict of interest and undue influence’ and with minimum restriction, so far as possible and proportional to their circumstances. This reflects the first element of the human rights model described above.

Sixth, neither the process nor outcome of a disability assessment should deprive a person of their liberty arbitrarily, and ‘the existence of a disability shall in no case justify a deprivation of liberty’ (Article 14 CRPD). Deprivation of liberty through any process must be accompanied by rights guarantees.

Seventh, neither the process nor the outcome of a disability assessment should subject a person to ‘cruel, inhuman or degrading treatment’ and must respect the ‘physical and mental integrity’ of the person (Article 17 CRPD), especially in avoiding bodily interference or harm to health. These issues can be relevant in the context of medical examinations and tests which are carried out to assess physical or mental capacity, and also to work placements which are intended to assess an individual’s working capacity.

Eighth, the provisions for review or appeal of disability assessment decisions, as well as the conduct of assessment process, should respect a person's right of access to justice (Article 13 CRPD). This means that, amongst other, that in reaching a judgment there should be 'procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants' at all stages of proceedings.

Ninth, in accordance with General Obligations of the CRPD, training should be promoted for 'professionals and staff working with persons with disabilities in the rights recognized in the present Convention so as to better provide the assistance and services guaranteed by those rights' (Article 4 and 13 CRPD). This applies to all individuals involved in the assessment process.

Tenth, disability assessments provide access to a wide range of social supports and entitlements (in cash or in kind). Social needs assessments should begin from respect for the right to live independently and to be included in the community (Article 19 CRPD). The scope of such assessment should never prejudice 'the opportunity to choose their place of residence and where and with whom they live' or presume any obligation 'to live in a particular living arrangement'. It should include consideration of the full range of supports, including personal assistance, as well as access to community facilities.

Lastly, across the range of purposes, and where appropriate, specific eligibility and evaluation criteria in disability assessments should be framed with respect for the rights contained in the following CRPD Articles:

- Article 23 – Respect for home and the family;
- Article 24 – Education;
- Article 25 – Health;
- Article 26 – Habilitation and rehabilitation;
- Article 27 – Work and employment;
- Article 28 – Adequate standard of living and social protection;
- Article 29 – Participation in political and public life;
- Article 30 – Participation in cultural life, recreation, leisure and sport.

This means that assessments tailored to specific benefits, such as access to support for employment and access to support to educational support, will need to take the relevant obligations of the CRPD into account.

Changes may be needed to ensure assessment methods comply with these principles and obligations. This reflects the sixth element of the human rights model identified by Degener above.

Part II: Overview of findings from ANED survey¹⁹⁶

6 Online survey findings

In the first stage of research, 190 examples of disability assessment were identified from 34 countries.¹⁹⁷ The aim was to establish baseline information about the range and diversity of disability assessment procedures used in European countries across a range of policy functions. These included assessments for disability benefits in cash or in kind, beneficial treatment (such as eligibility to apply for quota jobs) or other discounts and concessions available to persons with disabilities.

This information was collected from ANED country experts using a structured online survey. It is the largest dataset ever collected on disability assessments, although it does not provide a comprehensive catalogue of all assessment procedures in all countries. The sample prioritises diversity over the statistical representation of all available assessment procedures but, in practice, it captures the large majority of disability assessments currently in use in Europe.

These examples were incorporated into Part 1 of the respective country reports, as a prelude to the more in-depth case studies concerning selected disability assessment methodologies. For each example, summary information was collected and coded on the following aspects of the assessment process:

- Country.
- Short title for the assessment process.
- Department or institution responsible.
- Who can apply for this assessment, and where? (including a public web link where citizens can go for more information, or to make an application for assessment).
- How is 'disability' assessed? The general type of approach.
- What level of impairment or disability criteria must be met to 'pass' this assessment or to qualify for the purpose? (i.e. in practice, what measure or definition of 'disability' is used in this assessment?)
- How the disability assessment is administered.
- Who carries out the assessment?
- The types of supporting evidence that can be considered.
- Who makes the final decision?
- Further information about the assessment protocol or instruments used (e.g. web link to the assessment questionnaires, measurement scales, or official guidance provided to assessors).
- Type of notification or proof the person receives after completing the assessment process.
- Whether the person can appeal the decision about their qualifying level of disability.

The number of examples identified in each country does not necessarily represent the precise number in existence. Nevertheless, a key finding from the initial survey was

¹⁹⁶ This part of the report was written by ANED's scientific director, Mark Priestley.

¹⁹⁷ In some cases, further examples were added to the country reports after completion of the initial survey.

that the number of different disability assessment procedures varies quite considerably between countries and particularly in countries where one core disability assessment process defines an administrative disability status that may be used as a passport to other policy functions or considerations of benefit entitlement without further assessment. The number of cases identified per country in the first phase of research is indicated in Table 1.

Table 1: Number of examples collected from the baseline survey

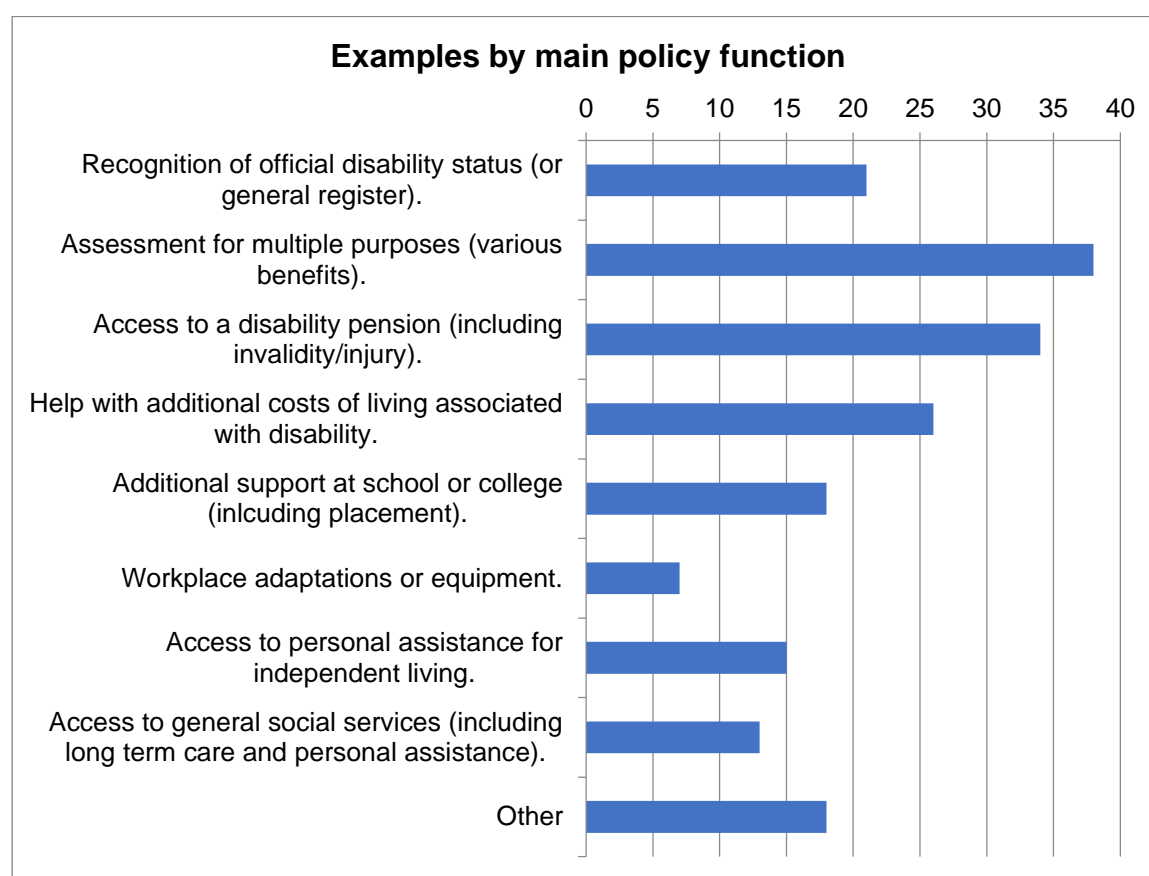
Country	Cases
Austria	9
Belgium	7
Bulgaria	5
Croatia	5
Cyprus	6
Czech Republic	4
Denmark	9
Estonia	2
Finland	3
France	6
Germany	1
Greece	3
Hungary	9
Iceland	4
Ireland	9
Italy	7
Latvia	3
Liechtenstein	5
Lithuania	10
Luxembourg	7
Macedonia (FYR)	1
Malta	8
Montenegro	4
Netherlands	8
Norway	6
Poland	0
Portugal	6
Romania	3
Serbia	4
Slovakia	7
Slovenia	3
Spain	5
Sweden	11
Turkey	3
United Kingdom	7
TOTAL	190

The diverse examples covered a wide range of policy functions. These were coded under eight categories, as shown in

Table 2.

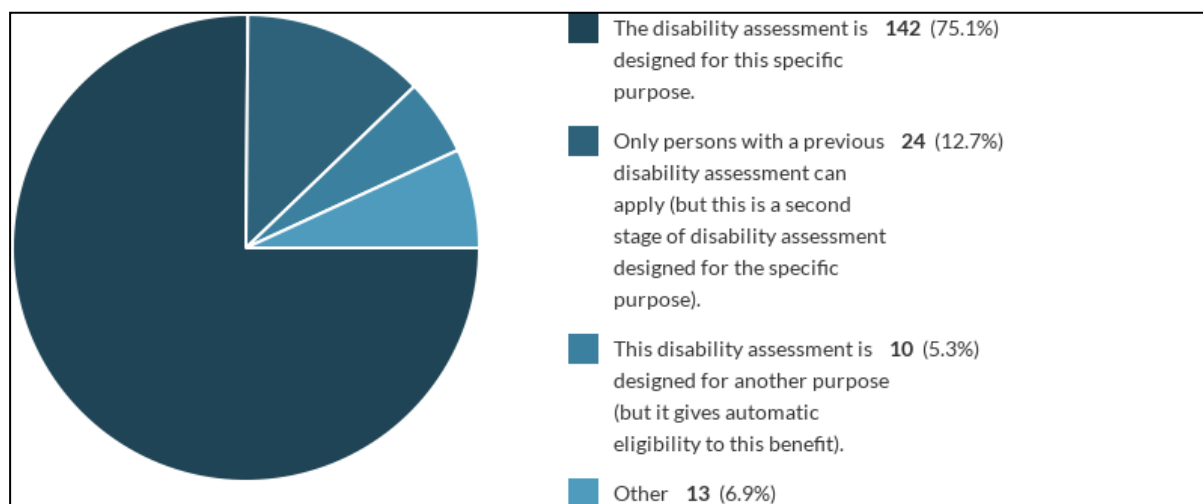
In practice, a number of cases (34) were initially coded as ‘Other’. Where possible, these examples were recoded based on the information provided. The residual cases concerned specific assessments for parking, driving or transport concessions (10), adapted housing (3), and legal capacity or guardianship decisions (2). This overview data again illustrated the use of disability assessments providing multiple entitlements or passporting to more than one entitlement (and combined with examples of general disability registration). In practice, assessments for long-term care and support exist in all countries but may not be framed as disability assessments (although in some countries this is explicit).

Table 2: Number of examples by main policy function



In most cases, the disability assessment procedure was designed as a primary tool specifically for the policy function, as shown in Figure 1.

Figure 1: Specificity of assessment design



The range of methodological approaches employed in disability assessments are discussed in detail elsewhere in this report. It was often difficult to categorise assessments with a single approach on the basis of initial information, for example where the use of a barometric scale was combined with assessments of functional activity or where it involved mixed methods but was not 'holistic'. Nevertheless, the initial baseline data showed the widespread diversity of disability assessment methods in use with numerous examples of medical, Barema, functional and needs-based approaches as identified by the country experts. Given the wide range of policy functions covered in the initial phase of research, a more significant question is the extent to which different approaches to disability assessment are used for similar policy functions. This is addressed in more depth later through the analysis of comparable case studies.

The diversity of disability assessment protocols was evident in the examples given of the criteria needed to 'pass' the assessment (e.g. to be considered 'disabled' or to qualify for entitlement on disability grounds). Some indication of qualifying criteria was given in 184 cases. Many of these were expressed in terms of percentage impairment/disability, indicating the use of a Barema-type methodology. In other cases, a points-based system of scoring was evident, but actual cost considerations and qualitative criteria were also cited as examples. Medical diagnosis and authority still plays a part in disability assessments for social benefits. The following examples are illustrative:

Medical diagnosis or authority

- the decision of the medical commission
- diagnosis of a named medical condition
- terminally ill

Typical Barema

- impairment must be higher than 33 %
- level of impairment of 50 % or over
- a level of reduced working capacity of 50 % or higher

Points scored on an assessment tool

- the score must be equal to or higher than 25 points
- 8 points for the standard rate and 12 points for the enhanced rate of entitlement
- functionality is assessed according to a five-point scale

Quantifiable need

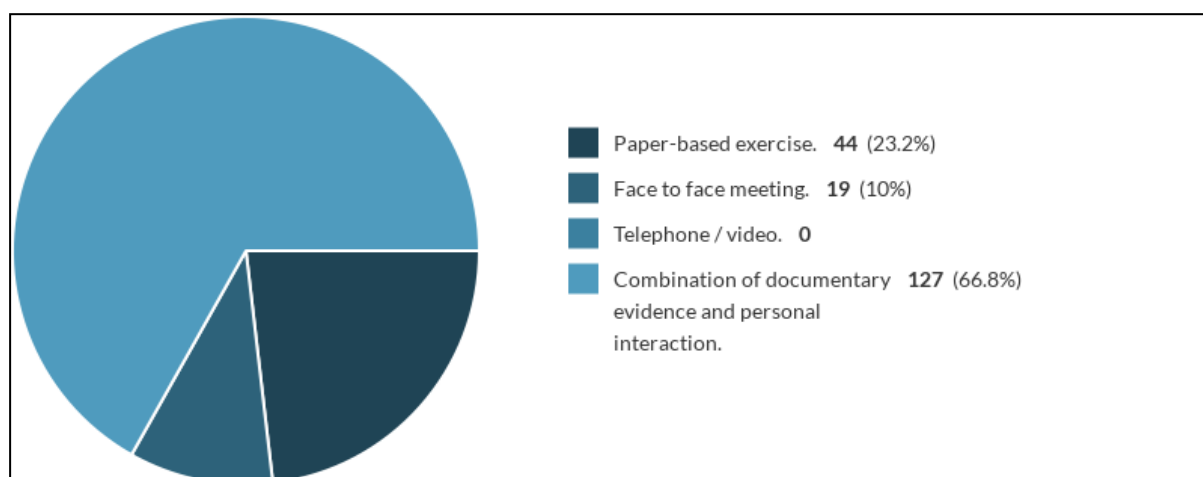
- additional daily living costs of more than EUR 875 per year
- care dependency level (at least 2 hours daily)
- not able to walk more than 100 metres

Qualitative need

- dependent on another person's assistance
- substantially restricted in undertaking work that would otherwise be suitable
- needs cannot reasonably be met within the existing resources

The baseline survey also provided information on the types of administrative procedure used to carry out disability assessments. The large majority of examples relied upon either a face-to-face meeting or a combination of documentary and personal interaction (as shown in Figure 2).

Figure 2: Administration of the assessment procedure



There was considerably more variation in the range of professionals involved in carrying out the assessment process, as shown in

Figure 3. This data indicated the widespread involvement of medical doctors in disability assessment processes, including those that were more functional or needs based in approach. Doctors were not necessarily acting alone, in cases of multiple input, although they did in many cases. This was also reflected in the types of evidence considered during the assessment, where again there was a high prevalence in the examples of evidence based on medical expertise (although there were also numerous examples where self-assessment and non-medical opinion played a part, as shown in Figure 4). The person carrying out the disability assessment procedure is not necessarily the final decision maker, and this information is detailed for each example in the country reports.

Figure 3: Range of assessors in the examples

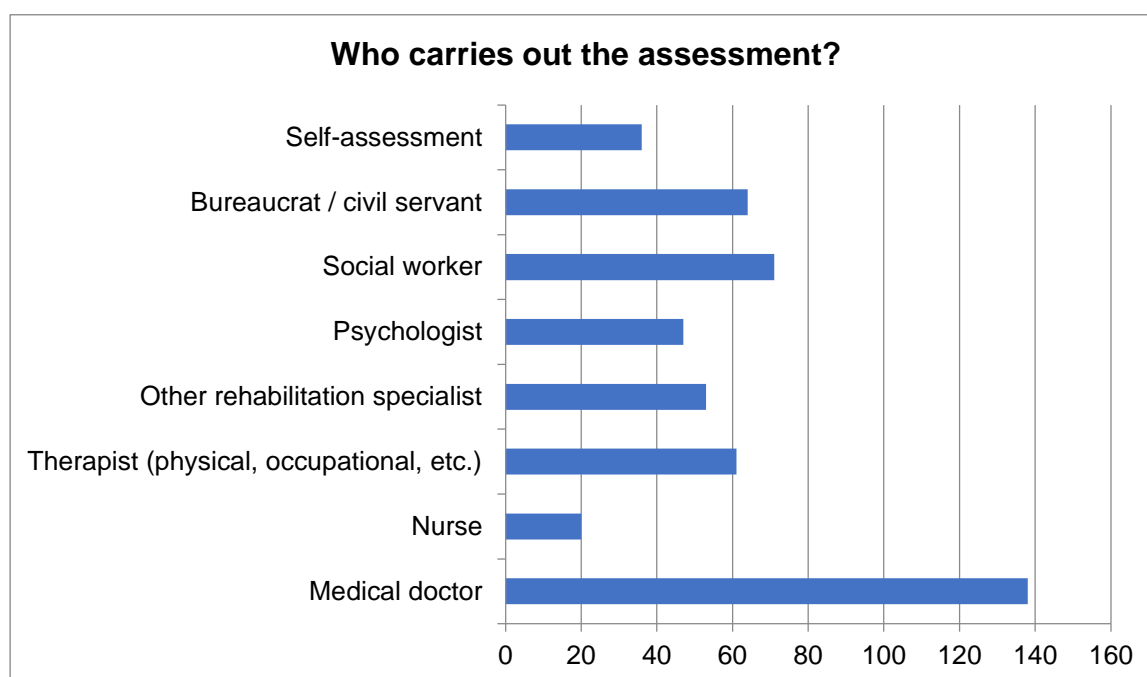
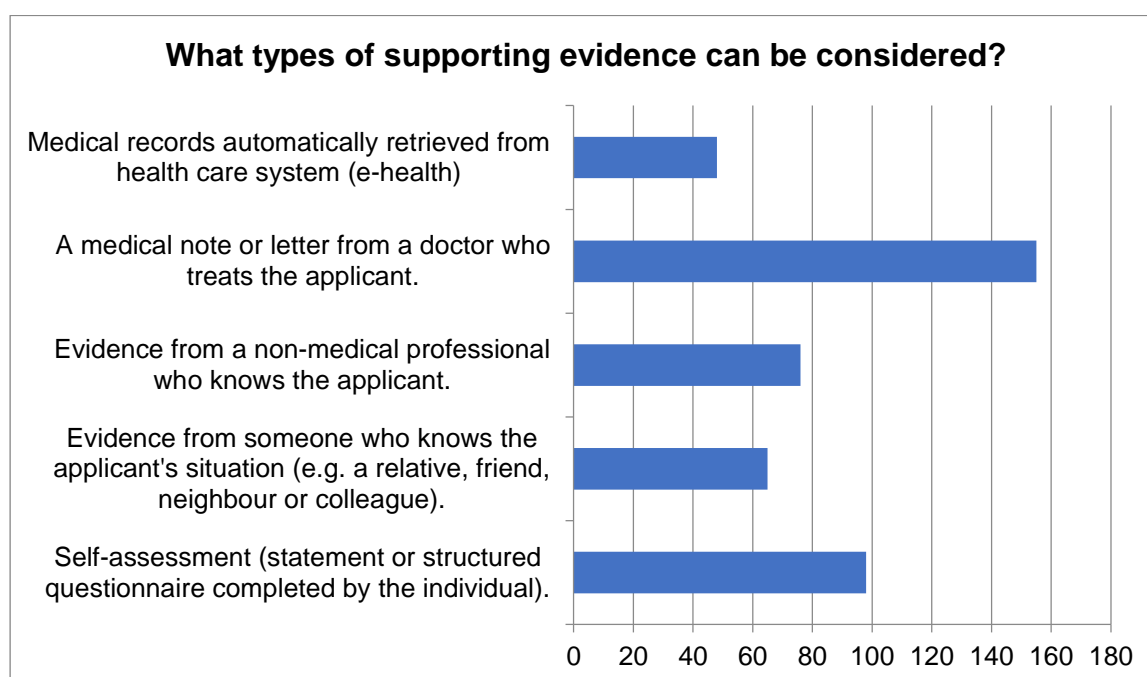


Figure 4: Evidence used in disability assessment



In the examples considered, applicants are mostly advised of the outcome of the assessment procedure by receipt of a letter or when they are issued a certificate or card (e.g. proof of disability status). The decision may or may not be accompanied by a copy of an assessment report, an action plan or a referral to another agency. In the large majority of cases, it is possible to appeal the disability assessment decision, although in 29 of the examples (15.5 %) it was not.

Part III: Synthesis report

This synthesis report explores disability assessment mechanisms across a diverse range of European states.¹⁹⁸ The states covered come from the Nordic region (Denmark, Iceland and Sweden); Western Europe (Austria, Belgium, Liechtenstein, the Netherlands and the United Kingdom); Central Europe (the Czech Republic and Latvia); and Southern Europe (Cyprus, Greece and Malta). The first part of the synthesis classifies and describes a selection of assessment mechanisms from these states in line with the typology identified in Part I of this report. It therefore explores the different assessment methods in use. The second part of the synthesis explores a number of other issues related to disability assessment, including the kind of evidence considered in assessments; eligibility requirements related to having a pre-existing disability identification / benefit entitlement; the use of single assessments with regard to multiple benefits; the identity of the assessor(s); and linkages between specific types of assessments and related benefits.

Section A: Examples of assessments – Disability assessment mechanisms in use

This part of the report firstly considers examples of assessments which adopt a (largely) medical assessment (assessments based on a specific medical diagnosis and the Barema method) and then considers examples of assessments which adopt a more contextual approach (functional capacity assessment, assessment of need, assessment of economic loss, procedural assessment and holistic assessment).

¹⁹⁸ Parts of this synthesis report draw closely on the text in the country reports submitted by the relevant ANED experts.

7 Assessment base on proof of a specific medical diagnosis

In spite of clear statements from the CRPD Committee regarding the inappropriateness of disability assessments which are based purely on medical diagnoses, a number of such assessments were identified in the national case studies covered. Two such assessments concerning children were identified in Latvia, and the approach is also used in an assessment for multiple purposes in Cyprus, and when assessing eligibility for some disability pensions and the award of the disability card in Malta. In addition, medical diagnosis plays an important part in an assessment of children used in Iceland. Further examination of some (but not all) of these assessments indicates that they contain positive elements, which seem to align with the goals of the CRPD.

7.1 Assessment of children (Iceland and Latvia)

Disability is assessed on the basis of a specific medical diagnosis in the case of children and young people with Autism Spectrum Disorder (ASD) in Iceland. In Latvia, assessments of children are made with regard to official registration as disabled as well as to identify children with disabilities who have a need for special care.

Assessment of children for multiple purposes, Iceland

In Iceland, an assessment for multiple purposes is carried out to identify children and young people with Autism Spectrum Disorder. The assessment is designed to identify whether a child or young person has this specific medical condition and, once the child or young person has been assessed with the condition, this assessment can act as a passport, providing access to a number of services.

The assessment is carried out by the State Diagnostic and Counselling Centre, which has amongst its the tasks the assessment of children and young people with severe developmental disorders. The Centre operates under specific legislation.¹⁹⁹ Children and young people are referred to the Centre for an assessment by a primary healthcare provider or other healthcare professional, a school, or social services, with a view to providing a confirmed diagnosis, counselling and access to the support needed.

The assessment is performed by a multidisciplinary team, and includes assessments and clinical observations carried out by professionals such as psychologists, medical doctors, rehabilitation specialists and social workers. Various diagnostic tools are used, and the selection of tools to use is decided on by the professionals on a case-by-case basis. The Centre does not use a single test or assessment method to diagnose ASD, but instead has access to a variety of international recognised guidelines or protocols. These include the ASD Diagnostic Observations Schedule, Second Edition (ADOS-2),²⁰⁰ the ASD Diagnostic Interview (ADI-R),²⁰¹ a Social Communication Questionnaire (SCQ),²⁰² a ASD Spectrum Screening Questionnaire

¹⁹⁹ Act on the State Diagnostic and Counselling Centre, at:

<https://www.greining.is/is/tungumal/english/act-on-the-state-diagnostic-and-counselling-centre>.

²⁰⁰ At: <https://www.wpspublish.com/store/p/2648/ados-2-autism-diagnostic-observation-schedule-second-edition>.

²⁰¹ At: <https://research.agre.org/program/aboutadi.cfm>.

²⁰² At: <https://www.wpspublish.com/store/p/2954/scq-social-communication-questionnaire>.

(ASSQ)²⁰³ and the Vineland Adaptive Behaviour Scale – Second Edition (VABS –II).²⁰⁴ Other assessment protocols can also be used. In general, the ICD-10 classifications (International Statistical Classification of Diseases and Related Health Problems) play a significant role in the assessment process. ICD-10 is a medical classification system devised by the WHO. There is a synergy between the diagnostic tools and the ICD-10 classification system in that the diagnostic tools provide the evidence for the condition, while ICD-10 provides the label of ASD.

It is usual to carry out multiple assessments involving assessors with different specialisations. Non-medical information, such as family circumstances, is also considered in the assessment. The diagnostic process is flexible, and allows for the collection of additional information. The child who is being assessed can provide information, as can his or her parents and school. Consistency is ensured by beginning the assessment with the collection of standard information about the child, which is provided by parents and teachers through questionnaires, and then proceeding to collect further information as needed.

The final diagnosis of ASD and developmental disorders is based on the opinion of a specialised paediatrician, analytical interviews, direct observations of behaviour, developmental measurements, responses to questionnaires on behaviour and well-being, information from the child, parents and school, and an interdisciplinary assessment of this information. Nevertheless, the assessment remains medically based, and ANED country experts²⁰⁵ reported that some stakeholders think that there should be more emphasis on the needs and preferences of the child who is being assessed and his or her family, the strengths of the child and the family, and the environment. Perhaps because of the complexity of the assessment, the average waiting time for a completed assessment was a year, which is one of the longest identified in this synthesis report. Given the complexity of the assessment, it seems that the goal is not simply to diagnose a medical condition, but also to identify appropriate ways to support the child, family and school. This goal is compatible with the CRPD. In contrast, some of the other medical assessments identified in this section are confined to diagnosing a medical condition or impairment, and do not seek to go beyond that.

Assessment for official recognition as disabled and assessment to receive special care, Latvia

For children in Latvia, disability assessment is also based on the existence of medical diagnosis. People with disabilities can be officially recognised as disabled under the Disability Law.²⁰⁶ Having such a status gives them access to a number of benefits and rights. For children, the relevant assessment for this status is based on the existence of a specific medical condition which has been diagnosed by a treating doctor who has provided documentation to confirm the diagnosis. This is also the assessment procedure for a second benefit, concerning the right of a disabled child to receive

²⁰³ At: <https://gillbergcentre.gu.se/english/research/screening-questionnaires/assq>.

²⁰⁴ At: <https://cloudfront.ualberta.ca/-/media/ualberta/faculties-and-programs/centres-institutes/community-university-partnership/resources/tools---assessment/vinelandjune-2012.pdf>.

²⁰⁵ James Rice, Rannveig Traustadóttir, Snæfríður Þóra Egilson, Þóra Leósdóttir and Þórdís Linda Guðmundsdóttir.

²⁰⁶ Latvia, Disability Law, 2010, at: <https://likumi.lv/doc.php?id=211494>.

special care. In both cases, the assessment takes place under the auspices of the State Medical Commission for the Assessment of Health Condition and Working Ability, following an application made on behalf of the child (typically by a parent). The assessment is carried out by an expert medical doctor (similar to an insurance physician) on the basis of the submitted documentation, and the child who is being assessed is not present.

The assessment takes place in accordance with the 'Criteria for Determination of Disability and Provision of Opinion on the Necessity of Special Care for Person up to 18 Years of Age'.²⁰⁷ These guidelines define both the criteria for determining the disability of a child and the criteria for issuing an opinion on their need for special care. The first part of the instrument identifies the criteria for determining disability. These criteria are based on named diseases and pathological conditions, as well as characteristics of clinical and functional conditions of the nervous system, mental and behavioural disorders, ear and parotid gland diseases, diseases of eye and visual accessory organs, diseases of the internal organs, surgical diseases, endocrine, nutrition and metabolic diseases, skin diseases, oncological diseases, diseases of the blood and blood-forming organs, immune system disorders, congenital malformations, deformities, metabolic diseases and chromosomal abnormalities and combined pathology. For example, if a child has epilepsy, disability is determined if a child has major epileptic seizures at least six times a year or frequent small epileptic seizures (several times a week). The second chapter includes 24 criteria which provide the basis for an opinion on the need for special care. These criteria are based on named diseases and pathological conditions. For example, a child with a diagnosis of 'F – 73 Profound mental retardation' has the right to special care, if the diagnosis is confirmed by a certified child psychiatrist. In the case of a child with a malignant tumour with very severe functional impairments, the child has the right to special care if the diagnosis is confirmed by a children's clinical university hospital oncology department.

In short, the assessment is based on the existence of a specific medical condition which has been diagnosed by a treating doctor who has provided documentation to confirm the diagnosis. In the case of a specific illnesses (specific diagnosis), a disabled child has a right to benefit from 'special care'. It is worth noting that adults can also be officially recognised as disabled or can benefit from special care. However, the assessment methods for adults is very different from that of children and involves an assessment of their functional abilities.

If a child is identified as disabled, they receive an official notification / certificate, and they can also be awarded special care. The State Medical Commission can also award other benefits.

Conclusion

Whilst both the Icelandic and Latvian assessments are based on the diagnosis of a specific medical condition in children, there are a number of important differences. The

²⁰⁷ Latvia, Criteria for Determination of Disability and Provision of Opinion on the Necessity of Special Care for Person up to 18 Years of Age; Annex 4 Regulation no. 805 – Regulations Regarding the Criteria, Time Periods and Procedures Determining Predictable Disability, Disability, and the Loss of Ability to Work, 2014, available at: <https://likumi.lv/ta/id/271253-noteikumi-par-prognozejamas-invaliditates-invaliditates-un-darbspeju-zaudejuma-noteiksanas-kriterijiem-terminiem-un-kartibu>.

Icelandic assessment is focused on ASD and development disorders, and does not cover other health conditions or diagnoses, whilst the Latvian assessment covers all children with disabilities, irrespective of the underlying medical or health condition. Secondly, the Icelandic assessment involves an extensive set of medical examinations and assessments, and a potentially wide range of international assessment protocols. The assessment involves multiple tools and individuals from various disciplines, and the child or young person is assessed in person. In contrast, the Latvia, assessment is a purely paper-based exercise, drawing on evidence of a medical condition or disability which is listed in the relevant legal provision, with this evidence being provided by the treating doctor.

7.2 Assessment for multiple purposes / recognition of disability status (Cyprus)

In Cyprus, the main disability assessment process is used to recognise an individual as officially disabled, as well as to give access to a variety of disability benefits, including cash payments. The Department of Social Inclusion for People with Disabilities defines the assessment process as holistic; however, in the view of ANED country experts,²⁰⁸ representatives of the Cypriot disability movement and a number of academics, the assessment is predominantly medically based and is designed to confirm the existence of a diagnosed medical condition / impairment, which is identified in terms of the ICF classifications.

The assessment is carried out when an applicant applies for one of the benefits provided by the Department of Social Inclusion for People with Disabilities,²⁰⁹ the Disability Allowance (included within the Guaranteed Minimum Income (GMI)) or to be classified as eligible to be employed under the quota law, which covers public sector employers.²¹⁰ Consequently, the same assessment procedure is used to determine eligibility for a variety of benefits, although separate application forms cover each specific benefit. It is worth noting that the implementation of a single assessment system for multiple benefits is potentially one of the strengths of this system. However, the assessment does not give access to all benefits available to people with disabilities in Cyprus, and separate assessments are still necessary in some cases.²¹¹

The applicant must obtain and submit a governmental medical report which is filled in by the treating doctor. This accompanies the application form. The medical report contains information on the medical diagnosis and a reference letter for the disability assessment. The Centre for Disability Assessment, under whose auspices the assessment takes place, may request the applicant to submit further information to support their application, including further medical reports. The applicant is also asked to complete a General Information Questionnaire, although no information is available

²⁰⁸ Katerina Mavrou and Anastasia Liasidou.

²⁰⁹ See: http://www.mlsi.gov.cy/mlsi/dsid/dsid.nsf/index_gr/index_gr?opendocument; see under 'Social Provision Schemes'.

²¹⁰ Cyprus, the Recruitment of Persons with Disabilities in the Wider Public Sector (Special Provisions) Law of 2009 (N.146(I)/2009), available at: http://www.cylaw.org/cgi-bin/open.pl?file=nomoi/enop/ind/2009_1_146/preamble-pr5e5a5a44-4dbb-cd45-1dc3-7d194767d5c2.html&qstring=%E1%ED%E1%F0%E7*.

²¹¹ This applies to the other state departments and services within the Ministry of Labour and Social Insurance (this is the same Ministry under which the Department for Social Inclusion of People with Disabilities operates).

about the content of this questionnaire. Once all the information has been collated, an official from the Centre for Disability Assessment compiles a file on the application, and a decision is made on the composition of the Council of Medical Doctors, which will assess the individual. Members of the Council are selected based on the relevant medical specialisations needed.

The assessment takes place in a face-to-face meeting between the applicant and the Council of Medical Doctors which can last approximately 20 to 30 minutes. During this meeting, the applicant is assessed through a personal interview, a medical assessment and clinical observations, which mainly focus on physical conditions and functions. ANED experts have been informed by individuals who have undergone the disability assessment that the process involves a typical medical and basic neurological examination, which is guided by an assessment protocol. An applicant can also request an assessment of functionality, which is designed to provide advice on how the applicant can achieve greater functionality, for instance through the receipt of additional support or services, or to determine eligibility for employment under the quota law. This is a second assessment, which involves a longer meeting with a team of multidisciplinary professionals, such as physiotherapists, social workers, occupational therapists and speech and language therapists.

In the case of the first assessment, the Council completes a Disability Assessment Protocol. The Council which carries out the functionality assessment also completes a Functionality Assessment (Investigation) Protocol. Both protocols are internal documents which are not publicly available. However, research by ANED experts revealed that the protocols are based on the areas of life covered in the ICF, as adapted and localised to the Cypriot context. The Department for Social Inclusion of People with Disabilities drafted the protocol, and a report prepared by the department provides information on how the ICF was adapted and is used in Cyprus.²¹² According to this report, a survey was carried out which identified a number of problems with the previous disability assessment procedure. These included the lack of a coordinated and comprehensive service delivery system and an emphasis on medical diagnosis, rather than the day-to-day functionality of persons with disabilities. The report proposed a new system for assessing disability and functionality, which was intended to be holistic and to combine the ICF coding with the ICD-10 diagnosis tool coding. More specifically, the new assessment protocols (which, as stated above, are not publicly available), were designed with five disability types in mind.²¹³ The five types relate to mobility, visual, hearing, intellectual and mental (meaning mostly behavioural

²¹² Department for Social Inclusion of People with Disabilities (2014), Implementation of the ICF in Cyprus, available at:

[http://www.mlsi.gov.cy/mlsi/dsid/dsid.nsf/9DD712B70A442853C2257D25003B05C9/\\$file/%CE%95%CE%A6%CE%91%CE%A1%CE%9C%CE%9F%CE%93%CE%97%20%CE%A4%CE%97%CE%A3%20%CE%94%CE%99%CE%95%CE%98%CE%9D%CE%9F%CE%A5%CE%A3%20%CE%A4%CE%91%CE%9E%CE%99%CE%9D%CE%9F%CE%9C%CE%97%CE%A3%CE%97%CE%A3%20%CE%A4%CE%97%CE%A3%20%CE%9B%CE%95%CE%99%CE%A4%CE%9F%CE%A5%CE%A1%CE%93%CE%99%CE%9A%CE%9F%CE%A4%CE%97%CE%A4%CE%91%CE%A3%20%CE%91%CE%9D%CE%91%CE%A0%CE%97%CE%A1%CE%99%CE%91%CE%A3%20%CE%9A%CE%91%CE%99%20%CE%A5%CE%93%CE%95%CE%99%CE%91%CE%A3%20%CE%A3%CE%A4%CE%97%CE%9D%20%CE%9A%CE%A5%CE%A0%CE%A1%CE%9F.pdf](http://www.mlsi.gov.cy/mlsi/dsid/dsid.nsf/9DD712B70A442853C2257D25003B05C9/$file/%CE%95%CE%A6%CE%91%CE%A1%CE%9C%CE%9F%CE%93%CE%97%20%CE%A4%CE%97%CE%A3%20%CE%94%CE%99%CE%95%CE%98%CE%9D%CE%9F%CE%A5%CE%A3%20%CE%A4%CE%91%CE%9E%CE%99%CE%9D%CE%9F%CE%9C%CE%97%CE%A3%CE%97%CE%A3%20%CE%A4%CE%97%CE%A3%20%CE%9B%CE%95%CE%99%CE%A4%CE%9F%CE%A5%CE%A1%CE%93%CE%99%CE%9A%CE%9F%CE%A4%CE%97%CE%A4%CE%91%CE%A3%20%CE%91%CE%9D%CE%91%CE%A0%CE%97%CE%A1%CE%99%CE%91%CE%A3%20%CE%9A%CE%91%CE%99%20%CE%A5%CE%93%CE%95%CE%99%CE%91%CE%A3%20%CE%A3%CE%A4%CE%97%CE%9D%20%CE%9A%CE%A5%CE%A0%CE%A1%CE%9F.pdf), accessed 10 January 2018.

²¹³ Department for Social Inclusion of People with Disabilities (2014), Implementation of the ICF in Cyprus, p. 51.

and emotional) disability, as well as one category not covered by any of the other categories. Each of the assessment protocols, which are related to these types of disabilities, covers body functions (e.g. sensory, voice and speech, cardiovascular and reproduction systems), body structures (e.g. motion and neurological conditions), activity, participation and environmental factors (e.g. mobility, learning and relationships). The new Disability Assessment Protocol is based on two axes: body functions and body structures, as defined by the ICF. For each person who is assessed, a series of ICF codes is selected indicating the level of 'damage'. The Functionality Assessment (Investigation) Protocol is based on a definition of functionality in terms of the health situation (disorder or disease), which is defined by body functions and structure, activities and limitations to activities, and participation and limitations to participation. Environmental and personal factors are taken into account.²¹⁴ Limitations are defined as the difficulties a person faces in performing an activity or participating in a given situation. Under the protocols, limitations are assessed on a five-level scale, ranging from full independence / participation to no independence / participation. For a functionality assessment, indicators of barriers and facilitators are also assessed on a five-level scale in terms of environmental factors, and ICF codes are used as descriptors. The report on the implementation of the ICF indicates that the newly recruited assessors (medical doctors and members of other professions) were trained in the use the ICF when making disability and functionality assessments and in the completion of the assessment protocols and assessment outcome documents. This seems to indicate that the assessment method used is not based simply on a medical assessment. However, as discussed below, this is in fact the case in the view of ANED country experts and a number of others.

One of the changes resulting from the reports' proposals was the establishment of the Centre for Disability Assessment, which has been applying the new assessment method since December 2013.²¹⁵ The Centre initially carried out pilot assessments, but now this is the standard disability assessment method used in Cyprus, and it is carried out in Centres in three cities (Nicosia, Limassol and Larnaca). The Department for Social Inclusion of People with Disabilities regards the system as operating well and providing obvious benefits, although ANED experts note that no clear evidence is provided in the department's annual reports to support this claim.

As noted above, following the assessment(s), the Council prepares a Disability Assessment Outcome Document and well as providing suggestions for appropriate benefits. The Disability Assessment Outcome Document certifies the level of disability (mild, moderate, severe or total) and the kind of disability (motor, other physical, visual, hearing, intellectual or emotional). The document also indicates if the decision (disability) is permanent, or if an individual will need to be reassessed and, if so, after what period of time. It further identifies the benefits the individual is eligible to receive. These benefits include, for example, Profound Motor Disability Allowance, Mobility Allowance, funding for the acquisition of a car and eligibility for supported employment schemes. Where a functionality assessment has also been carried out, the applicant receives a report containing suggestions for adaptations, services and support which could help to improve their functionality. These assessment processes can therefore result in advice on, and entitlement to receive, aids and benefits provided by the

²¹⁴ Department for Social Inclusion of People with Disabilities (2014), Implementation of the ICF in Cyprus, p. 65.

²¹⁵ Excluding the period January – March 2014, when its work was suspended.

Department for Social Inclusion of People with Disabilities, and no further assessment is needed in order to obtain these benefits. The applicant does not have to indicate that he or she wishes to receive a certain benefit for it to be included in the advice given in the Disability Assessment Outcome Document. This proactive approach to assessment is one of the strengths of the system. However, if the applicant actually wishes to receive the benefit after being assessed, he or she must submit the relevant application form. If they do so, the benefit is awarded based on the results of the initial assessment. Nevertheless, ANED experts are critical of the amount of information applicants receive after they have been assessed, noting that they do not receive any detailed information, a description of the assessment protocol, or any information on how it was applied during the assessment. They also note that suggestions for improving functionality are rather general and do not take into account the applicant's personal situation or environment, or any benefits that could result from reasonable accommodations.

The formal decision on disability status and related benefits is issued by the Director (or another employee) of the Department for Social Inclusion of People with Disabilities or a representative of the Centre for Disability Assessment, and has the status of a legal administrative decision. In practice, the decision-maker follows the advice of the Council of Medical Doctors or the Council assessing the person's functionality.

As noted above, ANED country experts argue that this assessment process is in fact medical and is based on a diagnosis of medical conditions or impairments, rather than being holistic, as stated by the Department for Social Inclusion of People with Disabilities. ANED experts base this claim on a number of points. They note that the implementation report,²¹⁶ in which the process is described, argues that the use of disability types and disability discourse was chosen to avoid the medicalisation of disability. However, the new protocols use terms such as 'degree of damage' and 'disease' (νόσος), and 'disabled' is defined as a 'general "umbrella" term for the *damage*, limitations in activity and limitations in participation'.²¹⁷ This indicates a medical perspective. The experts also note that the outcome documents and decision letters indicate the use of the medical model of disability. For example, disability type and level are identified, and terms such as 'level of incompetence' are used. They argue that the Outcome Document does not provide any information that can be understood in terms of the social model of disability, human rights or social justice, and that this seems to be communicated to applicants throughout the process. The latter argument is based on anecdotal evidence provided through informal discussions with persons who have been assessed under the system. Assessed individuals felt the assessment 'was a way to verify the level of my incompetence' or 'my inability to function on my own'. Other individuals informed ANED experts that they just followed their doctor's instructions and responded to questions, and went through a brief medical examination during the assessment. Individuals who were assessed described

²¹⁶ Report on the Results of the Project 'Implementation of the New System for the Assessment of Disability and Functionality in Cyprus' (2014), available at: [http://www.mlsi.gov.cy/mlsi/dsid/dsid.nsf/766972A1933824E1C2257A7C002CE732/\\$file/%CE%92%CE%B9%CE%B2%CE%BB%CE%B9%CE%AC%CF%81%CE%B9%CE%BF%20%CE%91%CF%80%CE%BF%CF%84%CE%B5%CE%BB%CE%AD%CF%83%CE%BC%CE%B1%CF%84%CE%B1%20%CF%84%CE%BF%CF%85%20%CE%88%CF%81%CE%B3%CE%BF%CF%85.pdf](http://www.mlsi.gov.cy/mlsi/dsid/dsid.nsf/766972A1933824E1C2257A7C002CE732/$file/%CE%92%CE%B9%CE%B2%CE%BB%CE%B9%CE%AC%CF%81%CE%B9%CE%BF%20%CE%91%CF%80%CE%BF%CF%84%CE%B5%CE%BB%CE%AD%CF%83%CE%BC%CE%B1%CF%84%CE%B1%20%CF%84%CE%BF%CF%85%20%CE%88%CF%81%CE%B3%CE%BF%CF%85.pdf), accessed 10 January 2018.

²¹⁷ Report on the Results of the Project 'Implementation of the New System for the Assessment of Disability and Functionality in Cyprus' (2014), p. 64, translation and emphasis by ANED experts.

(orally and informally communicated to ANED experts) a very short process (10-15 minutes) of medical and basic neurological examination (i.e. impairment diagnosis), in which they played no active role. The individuals who make the assessment are medical doctors or, in the case of a functionality assessment, rehabilitation professionals for the most part. The assessors overwhelmingly come from a medical background, although they have been trained to use the ICF protocols for assessing disability with regard to various areas of life.

The new assessment method has also been the subject of criticism from representatives of disabled people's organisations and academics. According to Demosthenous,²¹⁸ Symeonidou,²¹⁹ and ACM Cyprus SIGACCESS, 2014,²²⁰ representatives of disability organisations as well as academics have expressed their reservations regarding the system in both published academic and other work, and in direct correspondence with government officials (i.e. the Department for Social Inclusion of People with Disabilities, the President of the Republic of Cyprus, the Ministry of Labour and Social Insurance and the House of Parliament). These reservations, among others, highlight the fact that, even though it was partly financed through European Funds,²²¹ the new assessment method was designed and developed based on a medical understanding of disability exclusively focused on the use of ICF, and that the ICF has been criticised by a number of academics²²² on the ground that it still supports the medical model. Moreover, implementing the ICF is not among the priorities of the European Union as stated in the European Disability Strategy 2010–2020. Symeonidou has argued:

in the case of Cyprus, the state presents the ICF as a comprehensive international document, published by a highly regarded organization. As such, the ICF is 'served' as the perfect basis for the development of a transparent assessment system ... behind the rhetoric for socially just policies for disabled people lies the state's intention to further control the allocation of scarce resources to an oppressed social group that is presented as a passive group of 'patients'.²²³

In addition, the disability movement has expressed concerns about the interpretation of the term 'functionality' in the new assessment system. The Director of the

²¹⁸ Demosthenous, M. (2013). A Critique of the Assessment System of Disability and Functioning.

²¹⁹ Symeonidou, S. (2014). 'New policies, old ideas: the question of disability assessment systems and social policy', *Disability & Society*, DOI: 10.1080/09687599.2014.923751.

²²⁰ ACM Cyprus Chapter for SIGACCESS (2014), Correspondence with the President of the Republic: Reservations and Thoughts on the New Assessment System of Disability and Functioning, 30 January 2014, Nicosia.

²²¹ Work to develop the new assessment method was co-funded by the Cypriot Government and the European Social Fund as part of the national Operational Programme for Employment, Human Capital and Social Cohesion 2007–2013.

²²² Levasseur, M., Desrosiers, J., St-Cyr, T. (2007) 'Comparing the disability creation process and international classification of functioning, disability and health models', *Can J Occup Ther*, vol. 74, pp. 233–242; Walsh, R. (2011), 'Looking at the ICF and human communication through the lens of classification theory', *Int J Speech Lang Pathol*, vol.13, pp. 348–359; Bornbaum, C., Doyle, P., Skarakis-Doyle, E., Theurer, J. (2013), 'A critical exploration of the international classification of functioning, disability, and health (ICF) framework from the perspective of oncology: recommendations for revision', *J Multidiscip Healthc*, vol. 6, pp. 75–86.

²²³ Symeonidou, S. (2014). 'New policies, old ideas: the question of disability assessment systems and social policy', *Disability & Society*, p. 13, DOI: 10.1080/09687599.2014.923751.

Department for Social Inclusion of People with Disabilities (DSIPD), in a report on the results of the new disability assessment system project,²²⁴ notes that the disability movement in Cyprus focused on whether the way in which the term ‘functionality’ would be interpreted could lead to benefit cuts and a reduction in allowances for people who, despite their disability-related needs, would be assessed as functional, and hence not eligible for certain benefits. The process could therefore disregard the additional financial needs and cost of living of individual people with disabilities. The Cyprus Confederation of Organisations of the Disabled (CCDO) also expressed concerns about the following:²²⁵

- The establishment of disability assessment centres under the exclusive responsibility of health professionals, which they feared would promote the ‘omnipotence’²²⁶ of the non-disabled professionals, who would decide on the future of individuals with disabilities, if no provision was taken to place the individual at the centre of the procedure and the decision-making process.
- The new system does not comply with the CRPD, and does not focus on the removal of barriers and social and environmental limitations to participation, but rather on the medical diagnosis of disability.²²⁷
- Inappropriate use of resources. The CCDO believes that the cost of certification and diagnosis of disability should not be high (referring to the budget and cost for the establishment of the system), but rather that the relevant budget should focus on the improvement of social infrastructures for social and educational inclusion and for the employability of people with disabilities.
- The assessment procedure, which the CCDO argues should be transparent and clear and should highlight the human rights perspective.

The CCDO, whilst initially supporting work on the new assessment method, challenged the pilot assessment project run by the Centre for Disability Assessment. As a result of an appeal made by the CCDO to Parliament, the Centre’s work on the new assessment method was suspended for three months between January and March 2014, when the Parliament suspended the relevant budget.²²⁸ The budget was

²²⁴ Report on the Results of the Project ‘Implementation of the New System for the Assessment of Disability and Functionality in Cyprus’ (2014), available at: [http://www.mlsi.gov.cy/mlsi/dsid/dsid.nsf/766972A1933824E1C2257A7C002CE732/\\$file/%CE%92%CE%B9%CE%B2%CE%BB%CE%B9%CE%AC%CF%81%CE%B9%CE%BF%20%CE%91%CF%80%CE%BF%CF%84%CE%B5%CE%BB%CE%AD%CF%83%CE%BC%CE%B1%CF%84%CE%B1%20%CF%84%CE%BF%CF%85%20%CE%88%CF%81%CE%B3%CE%BF%CF%85.pdf](http://www.mlsi.gov.cy/mlsi/dsid/dsid.nsf/766972A1933824E1C2257A7C002CE732/$file/%CE%92%CE%B9%CE%B2%CE%BB%CE%B9%CE%AC%CF%81%CE%B9%CE%BF%20%CE%91%CF%80%CE%BF%CF%84%CE%B5%CE%BB%CE%AD%CF%83%CE%BC%CE%B1%CF%84%CE%B1%20%CF%84%CE%BF%CF%85%20%CE%88%CF%81%CE%B3%CE%BF%CF%85.pdf), accessed 10 January 2018.

²²⁵ CCDO correspondence for the New Disability and Functional Assessment System (2014), available at: <http://www.kysoa.org.cy/kysoa/page.php?pageID=69> (see letters dated 14 January 2014 and 12 February 2014).

²²⁶ CCDO correspondence for the New Disability and Functional Assessment System (2014), available at <http://www.kysoa.org.cy/kysoa/page.php?pageID=69> (see letters dated: 14 January 2014 and 12 February 2014), p. 2.

²²⁷ This view is supported in a book by the disability activist M. Demosthenous, in Demosthenous, M. (2013), *A Critique of the Assessment System of Disability and Functioning*, Parga, Nicosia (in Greek), in which he argues, based on discourse and content analysis of policy documents and studies, that the new assessment is based on a medical model perspective. The work of Symeonidou provides additional evidence to support this view. Symeonidou, S. (2014). ‘New policies, old ideas: the question of disability assessment systems and social policy’, *Disability & Society*, DOI: 10.1080/09687599.2014.923751.

²²⁸ Report on the Results of the Project ‘Implementation of the New System for the Assessment of Disability and Functionality in Cyprus’ (2014), available at:

subsequently released, and the pilot project resumed following consultation meetings between the CCDO and the Department for Social Inclusion of People with Disabilities as well as other stakeholders, but the CCDO continues to express its concern about the new assessment method, as does the Pan-Cyprian Alliance for Disabilities.²²⁹

In terms of compatibility with the CRPD, ANED experts note that the ICF, on which the Cypriot system is based, was published in 2001, before the CRPD was negotiated and adopted, and that the Convention does not refer to the ICF, or to disability and functionality assessment, but rather to the assessment of needs and abilities to access rights and increase participation. The ANED experts support the views of Symeonidou,²³⁰ who argues that a comparison between ICF and the CRPD made by the Department for Social Inclusion of People with Disabilities,²³¹ which attempts to show the compatibility of a system based on the ICF with the CRPD, in fact seeks to compare non-comparable things and does not provide convincing arguments. Symeonidou points out that one of the studies produced by the Department for Social Inclusion of People with Disabilities (Study A.2) contains a comparison table where the items compared do not seem comparable and the authors attempt to show compatibility of particular extracts of the articles from the CRPD with a code from the ICF without any further explanation of what this means and how these are compatible or respond to each other. Hence, the reader is not in a position to follow this argument and there is an effort to compare non-comparable items. More broadly Symeonidou argues that although the ICF was adopted in 2001, well before the CRPD in 2006, the Convention does not make any reference to the ICF or to issues of disability and functionality assessment, but rather to assessment of needs and abilities with regard to accessing rights and increasing participation. Symeonidou also notes that the two documents are products of different organisations and have different purposes, and that the Convention was adopted by consensus by various countries worldwide and has been embraced by the disability movement, while this is not the case for the ICF.

[http://www.mlsi.gov.cy/mlsi/dsid/dsid.nsf/766972A1933824E1C2257A7C002CE732/\\$file/%CE%92%CE%B9%CE%B2%CE%BB%CE%B9%CE%AC%CF%81%CE%B9%CE%BF%20%CE%91%CF%80%CE%BF%CF%84%CE%B5%CE%BB%CE%AD%CF%83%CE%BC%CE%B1%CF%84%CE%B1%20%CF%84%CE%BF%CF%85%20%CE%88%CF%81%CE%B3%CE%BF%CF%85.pdf](http://www.mlsi.gov.cy/mlsi/dsid/dsid.nsf/766972A1933824E1C2257A7C002CE732/$file/%CE%92%CE%B9%CE%B2%CE%BB%CE%B9%CE%AC%CF%81%CE%B9%CE%BF%20%CE%91%CF%80%CE%BF%CF%84%CE%B5%CE%BB%CE%AD%CF%83%CE%BC%CE%B1%CF%84%CE%B1%20%CF%84%CE%BF%CF%85%20%CE%88%CF%81%CE%B3%CE%BF%CF%85.pdf), accessed 10 January 2018.

²²⁹ Pancyprrian Alliance for Disability (2017), 'Submission to the List of Issues of the Committee on the Rights of Persons with Disabilities in relation to the initial report of Cyprus', available at: http://www.kysoa.org.cy/kysoa/userfiles/file/Suymvasi%20OHE/20170217_Reply%20to%20LOI%207S.pdf; Pancyprrian Alliance for Disability (2016), 'Alternative report on the implementation of the UNCRPD', August 2016, available at: http://www.kysoa.org.cy/kysoa/userfiles/file/Suymvasi%20OHE/20160905_Cyprus%20Alternative%20Report.pdf, and: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=INT%2fCRPD%2fCSS%2fCYP%2f26904&Lang=en; Pancyprrian Alliance for Disability (2017), 'Alternative Disability Action Plan 2017-2020 Based on Concluding Observations and Recommendations from the UN CRPD Committee, 11 August 2017.

²³⁰ Symeonidou, S. (2013), *Report on the Implementation of ICF in Cyprus*, available at: http://www.kysoa.org.cy/kysoa/userfiles/file/Allilografia/sistema-aksiologisis-icf/20130214_Ekthesi%20Simoni%20Simeonidou_ICF.doc; and Symeonidou, S. (2014), 'New policies, old ideas: the question of disability assessment systems and social policy', *Disability & Society*, DOI: 10.1080/09687599.2014.923751.

²³¹ 'Design and Preparation for the Implementation of the New System for the Assessment of Disability and Functionality in Cyprus, on the basis of ICF and WHO, Studies A1 and A2' (not available online but made available to ANED expert by the CCDO).

In short, in the view of the ANED country experts:

challenges and weaknesses that emerged from the actual implementation of the [disability assessment] system as well as the lack of effective communication between the responsible bodies and the disabled people's organisations, created a gap between the rights of people with disabilities and the way the UN CRPD was implemented and interpreted by the new disability assessment system in Cyprus.²³²

7.3 Assessment for specific types of disability pension (Malta)

In Malta, assessment for eligibility for some kinds of non-contributory disability pensions is based on identifying whether the applicant has a qualifying medical condition or impairment. This is the case for Severe Disability Assistance (SDA), Disability Assistance (DA) and Assistance for the Visually Impaired (BLD). All three pensions are means tested, although recipients are allowed to earn an income from employment. SDA and DA are awarded to individuals aged 16 or over, while BLD is awarded to individuals aged 14 or over. Recipients must have become disabled before reaching the age of 60. For all three pensions, the applicant has to submit an application form²³³ (which is common to all three benefits) through their medical doctor or consultant. The applicant also has to submit relevant specialist reports.²³⁴ The application is made to any district social security office or sent by post to the Department of Social Security.

In order to qualify for SDA, an individual must have a medical condition or impairment which is listed in the Social Security Act.²³⁵ Article 27 lists the relevant medical conditions or impairments for eligibility for SDA as 'mental severe sub-normality', cerebral palsy or one of the conditions listed in Article 2 of the Act, according to which a person can be recognised as severely disabled.²³⁶ Article 2 in turn contains a list of various conditions including 'total deaf mutism', 'dwarfism', various neurological conditions, multiple sclerosis, cystic fibrosis, 'permanent total paralysis', amputation of both upper or lower limbs, epilepsy with a frequency of attacks exceeding four per month, and congenital indifference to pain. The individual must have a permanent disability in order to qualify as a Severely Disabled Person. The assessment consists of a medical examination at the national public hospital in Malta, when a Medical Board appointed under the Social Security Act and consisting of three doctors decides if the applicant has one of the relevant listed medical conditions or impairments. A similar assessment procedure applies for Disability Assistance. In this case, the qualifying medical conditions or impairments are 'total paralysis or permanent total severe malfunction or permanent total disability, whether through amputation or otherwise, of one or the upper or lower limbs'.²³⁷ The assessment method for Assistance for the Visually Impaired is slightly different. Individuals are eligible for this pension if they are completely or partially visually impaired and their visual acuity has been certified by an

²³² Katerina Mavrou and Anastasia Liasidou, Task 2017-18, Disability assessment – country report Cyprus.

²³³ Available at: <https://socialsecurity.gov.mt/en/Pages/Application-Forms.aspx#age-pension>.

²³⁴ Available at: <https://socialsecurity.gov.mt/en/Pages/Application-Forms.aspx#invalidity-pension>.

²³⁵ Available at: <http://justiceservices.gov.mt/DownloadDocument.aspx?app=lom&itemid=8794>.

²³⁶ Malta, Article 27(1)(b) Social Security Act.

²³⁷ Malta, Article 27 (4)(b) Social Security Act.

ophthalmologist as so low as to render the individual unable to perform any work for which eyesight is essential. The assessment, which takes the form of a medical examination, is carried out by an ophthalmologist working for the benefits agency (Department of Social Security).

In all three cases, the assessments are carried out by doctors on behalf of the Department of Social Security, and the assessment simply aims to establish if the applicant has a qualifying medical condition or impairment or not.

7.4 Assessment for award of a disability card (Malta)

In Malta, a disability assessment takes place to establish eligibility for a Special Identity Card (SID) which is issued by the Commission for the Rights of Persons with Disability. SID recipients are also included in the Register of Persons with Disabilities. Holders of a SID card benefit from reductions in admission fees and receive discounts from various companies, and the SID also provides proof of disability status for some services provided by other bodies, such as the incontinence service and some social housing schemes.

The Equal Opportunities (Persons with Disability) Act 2000 defines disability as ‘a long-term physical, mental, intellectual or sensory impairment which in interaction with various barriers may hinder one’s full and effective participation in society on an equal basis with others’.²³⁸ This definition is clearly drawn from the CRPD. Individuals who are disabled may receive a SID. In order to apply, individuals need to submit the application form, which is available from the Commission’s offices or online.²³⁹ The application must be accompanied by a doctor’s certificate providing information on the medical diagnosis, as established by the treating doctor. The doctor’s certificate may also provide information on the consequences of the condition for the applicant.

Once the application has been submitted, the assessment of disability is carried out under the authority of the Commission for the Rights of Persons with Disabilities, and two forms of assessment are possible, one of which involves a paper-based medical assessment. This assessment method is followed in those cases in which the Executive Director of the Commission for Rights of Persons with Disability is able to establish eligibility for a SID based on the information and diagnosis provided in the doctor’s certificate accompanying the application. Examples of diagnoses which would give an entitlement to a SID and would not require a more detailed assessment are, for example, a spinal injury, amputation, incontinence or Down’s Syndrome. The assessment is therefore based on medical evidence provided by the treating doctor, and is a purely medical assessment. In spite of this, the assessment is quick, fairly informal and does not involve a medical examination or face-to-face interview which could be experienced as stressful by the applicant.

If the Executive Director cannot determine that the applicant qualifies for the SID based on the medical evidence and diagnosis, the applicant is referred for a more detailed assessment, which adopts a holistic approach. This is discussed further below in Part III, section 13. It is important to note that a medical assessment is not the only assessment procedure used in assessing disability in the context of applications for a

²³⁸ Available at: <http://www.justiceservices.gov.mt/downloaddocument.aspx?app=lom&itemid=8879>.

²³⁹ Available at: <http://crpd.org.mt/services/special-id-card/>.

SID, and an individual's application is never rejected because the medical diagnosis as evidenced by their doctor's certificate is insufficient in order to establish eligibility. The medical or diagnosis-based assessment is therefore a first stage of the assessment, and identifies those individuals who do not require a more detailed and time-consuming assessment.

7.5 Concluding comments on assessments based on proof of a specific medical diagnosis

It is notable that three of the assessment methods examined in this sub-section relate to children. This may well be because other common assessment methods, such as an assessment of functional capacity or an assessment of need for care, are better suited to assessing the situation of adults with disabilities, and are therefore less likely to be applied to children. Functional capacity assessments often examine capacity for work, which is simply not relevant in the case of children. Functional capacity assessments can also assess ability to care for oneself, whilst a needs-based assessment can assess need for care. However, both these assessments can also present problems in the case of children with disabilities, since all children, disabled or not, have limitations in their ability to care for themselves and have care-related needs, and it may be difficult to identify the disability-related element of their reduced capacity or need for care. This may help to explain the use of purely medical or impairment-based assessments in the case of children.

This short overview also reveals the importance of not taking the identified assessment method at face value, and the need to examine the actual practice of the assessment method. There seems to be some consensus amongst the disability community and independent experts regarding the nature of the multi-purpose disability assessment carried out by the Centre for Disability Assessment in Cyprus, and significant concerns that, in spite of the stated aim to move away from a medical and diagnosis-based approach, this approach has in fact largely been retained. On the other hand, such concerns do not seem to exist in Malta regarding how the Commission for the Rights of Persons with Disabilities assesses applications for a Special Identity Card available to persons with disabilities. Whilst the preliminary assessment for the Card is based on a medical approach, with disability established by medical evidence indicating a relevant diagnosis or impairment, applicants who are not regarded as disabled on this basis are not rejected, but are referred for a more detailed holistic assessment. In this respect, this approach saves time and money, to the benefit of both applicants and the Commission, through a quick and simple medical assessment, but it does not reject anyone who is not immediately recognised as disabled. However, the nature of the benefit linked to this assessment – namely a card which confers certain benefits to holders, such as reduced entry fees – may indicate why such a simple assessment method is acceptable. Where more significant benefits such as a pension or other cash benefit are at stake, a more detailed assessment may be needed. However, it is notable that a fairly simple medical assessment, albeit one where the applicant not only has to submit medical evidence, but also requires to undergo a medical assessment in person, is used for some disability pensions in Malta.

Lastly, it is worth noting that two of the assessment methods identified make use of the ICD-10 classifications (International Statistical Classification of Diseases and Related Health Problems). This is the case for the Icelandic assessment to identify children and

young people with Autism Spectrum Disorder and for the Cypriot assessment process. In both these assessments, ICD-10 is used as a diagnostic coding tool – i.e. it is used to identify the specific medical conditions which an individual has. In Cyprus, the Disability Assessment Protocol also makes use of ICF classifications, in that ICF codes are used to indicate the level of 'damage' linked to the individual who is being assessed.

8 Barema method of assessment

The Barema assessment method also adopts a medical approach to disability, and results in an indication of disability which is expressed in percentage terms. A number of Barema assessments have been identified for the purposes of this synthesis report, and they serve different functions. The most common use of the Barema method identified is to assess eligibility to be registered as disabled or to receive a Disabled Person's Card, this being the assessment method used in Austria in the case of all people with disabilities, and in the United Kingdom, where a Barema-like assessment is used for the registration of people who have a visual impairment. In Greece, the Barema method is the main disability assessment method, and is used in assessments for disability-related benefits in cash and kind, including pensions, as well as to determine eligibility to be registered as disabled. In Liechtenstein, a Barema-like assessment is used to determine eligibility to receive the blind person's allowance. The sub-sections below first review assessment methods applied across the full spectrum of people with disabilities (in Austria and Greece) and then assessments only applicable to people with visual impairments (in Liechtenstein and the United Kingdom).

8.1 Assessment for a Disabled Person's Card (Austria)

In Austria, individuals are eligible to receive a Disabled Person's Card, which confers certain benefits on the holder if they are assessed as being at least 50 % disabled. Applicants complete an application form,²⁴⁰ which is available online, and submit this to the Social Ministry Service. The application must include a list of health-related impairments which the applicant has, the relevant diagnosis or diagnoses, and should identify the treating doctor and medical facilities where treatment has been provided. The health-related impairments must be certified by medical documentation dated within two years, as well as reports from treating doctors and medical facilities. Applicants should provide proof of eligibility for other disability-related allowances (long-term care allowance, invalidity or incapability employment pension, increased family allowance or accident pensions) if applicable. Applicants must also indicate which entitlements and impairments they wish to see indicated on the badge.²⁴¹

The Social Ministry Service is responsible for the assessment procedure. As a first step, a member of staff at the ministry completes an internal questionnaire based on the information provided in the application. The questionnaire is not publicly available, but it covers the identification of the relevant impairment and indicates what degree of disability is associated with the identified impairments based on the relevant Barema table. The whole dossier, including the original application and completed questionnaire, is subsequently sent to the Department for the Administration of Assessments, which is part of the Social Ministry Service. An initial assessment is made to see if a final decision can be made regarding the award of the Disabled Person's Card based on the available documentation. If that is not the case, the

²⁴⁰ Link to the official application form at:

https://www.sozialministeriumservice.at/cms/site/attachments/9/4/9/CH0053/CMS1455313602631/behindertenpass_antrag_bundesweit_08_2017.doc.

²⁴¹ See list of additional entries available in English at:

https://www.sozialministeriumservice.at/cms/site/attachments/1/5/5/CH0053/CMS1474285872242/behindertenpass_zusatzeintragungen_bundesweit_englisch.doc.

applicant is referred for a medical examination, and the medical expert or experts (doctors) are selected. Most applicants are referred for a medical examination. The medical experts are independent doctors covering all medical specialities who have been approved by the Social Ministry Service to carry out assessments. One or more doctors can carry out the assessment, and an applicant may have to see several doctors on separate occasions in order to be assessed.

The medical doctor or doctors are responsible for carrying out the assessment based on the Barema method. The assessment involves a medical examination to identify the relevant health conditions or impairments, and this is carried out in line with the Assessment Regulation (*Einschätzungsverordnung*), which is included in the Federal Act for the assessment regulation.²⁴² The Act contains an 82-page attachment, which lists impairments and provides official guidance for all medical assessment procedures, i.e. it indicates how to evaluate the degree of disability. The attachment constitutes an integral part of the Act.²⁴³ An applicant must have one of the listed impairments, and their disability must amount to at least 50 % in accordance with the Regulation, in order to receive a Disabled Person's Card. The list contains a catalogue of different types of physical, sensory and psychosocial impairments. For each impairment group, a detailed and differentiated list of specific impairments, malfunctions and diseases, each linked to a certain degree of disability expressed in percentage terms, is given. For example, a mild depressive disorder or manic disorder is to be classified as between 10 and 40 % disability, with further guidance given as to how to select the appropriate percentage. The actual assessment protocols are not publicly available. The task of the assessing doctor is to identify the relevant impairment of health condition based on a medical assessment, and then indicate the relevant disability percentage based on the Assessment Regulation. This reflects the Barema assessment methodology.

Once the doctor has completed the assessment, he or she submits a report to the Social Ministry Service indicating the specific impairment(s) and related disability percentage. This needs to be approved by a doctor working at the Social Ministry Service, and then, based on the reports, approved a second time by another Social Ministry Service employee. The department which received the original application is then informed, and it communicates the decision to the applicant.

Approximately 45 000 disability assessments, including reassessments, are carried out in Austria each year. From these, about 20 % of applicants do not qualify for the Disabled Person's Card, because they are assessed as having an impairment which is associated with less than 50 % disability in line with the Regulation. While the average waiting time for an assessment is three months, it can be shorter if the applicant is not referred for a medical examination, or longer if several examinations are required.

²⁴² *Federal law gazette II* no. 261/2010. See:

<https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=20006879>.

²⁴³ See:

https://www.ris.bka.gv.at/Dokumente/Bundesnormen/NOR40141063/BGBI_II_Nr_261_2010_Anlage_1.pdf.

The current Assessment Regulation was introduced in 2010, and replaced an outdated Regulation dating from 1957. According to the National Action Plan on Disability: 'The 2010 Assessment Regulation created modern medical criteria and parameters to determine the extent of a disability during an examination by medical experts'.²⁴⁴ The action plan also states: 'Weighting social aspects sufficiently and in the best possible way is a constant challenge in the assessment of disabilities. The definitions and assessment of disabilities have to reflect the social model of disability as defined by the UN Convention.'²⁴⁵ However, in the view of ANED country experts,²⁴⁶ the current assessment procedure does not reflect any efforts in this direction. They note:

The assessment regulation completely relies on medical input, medical opinions and medical reports focusing on the degree of impairment of body functions. Psychological opinions and reports are requested and considered only additionally and only in certain cases. Although the assessment regulation was introduced after Austria had ratified the CRPD in 2008, it is completely based on a medical and deficit-oriented model of disabilities. By no means does it reflect a human rights or social model approach to disability.

8.2 Assessment for multiple purposes (Greece)

In Greece, the Barema method is the main disability assessment method, and is used to assess eligibility for benefits in cash, such as disability pensions and welfare benefits; benefits in kind, including access to services; as well as eligibility for certain positive action measures, such as entitlement to be employed under the quota scheme or to enter university under a quota scheme, and discounts and concessions such as tax benefits. The Barema assessment method is therefore used to certify or establish disability for a variety of purposes.

The assessment is carried out under the auspices of the Centre for Certification of Disability (KEPA),²⁴⁷ which is part of the Social Security Agency, which operates, in turn, under the Ministry of Labour, Social Security and Social Solidarity. Applicants can be referred for a disability assessment by a public body, such as the Social Security Agency or a welfare agency, or they can apply without such a referral. In the latter case, the applicant must pay a fee of EUR 46. Otherwise, the assessment is without charge. When applying, applicants must complete a form and submit a 'disability folder', which contains medical information provided by the medical specialist who is treating the applicant.

The assessment is carried out by a KEPA health committee, which is made up of three specialised insurance physicians who have been trained in the disability assessment process and who are employed by KEPA. The assessment takes place in a KEPA regional office, or at the applicant's home or a hospital or rehabilitation centre in cases

²⁴⁴ BMASK (2013), National Action Plan on Disability 2012-2020. Strategy of the Austrian Federal Government for the Implementation of the UN-Disability Rights convention, p. 16. Available at: <https://broschuerenservice.sozialministerium.at/Home/Download?publicationId=225>.

²⁴⁵ BMASK (2013), National Action Plan on Disability 2012-2020. Strategy of the Austrian Federal Government for the Implementation of the UN-Disability Rights convention, p. 16. Available at: <https://broschuerenservice.sozialministerium.at/Home/Download?publicationId=225>.

²⁴⁶ Petra Flieger and Ursula Naue.

²⁴⁷ Available at: http://www.efka.gov.gr/_faq/home.cfm.

where the treating doctor has indicated that the applicant is unable to travel to a KEPA regional office for assessment. There is limited information available about the actual assessment, but it seems to involve a medical examination to review and confirm the information related to the applicant's health condition which was provided by the treating doctor.

The assessment makes use of the Barema method, and is guided by the Single Table of Disability Percentage Determination, which was initially adopted in 2011,²⁴⁸ and which has since been modified twice, in 2012²⁴⁹ and 2017.²⁵⁰ The 2011 Single Table replaced the Regulation for Disability Assessment,²⁵¹ which had been used to assess the disability of people employed in the private sector since 1993, and which similarly used the Barema scale. In the current version of the Single Table of Disability Percentage Determination, medical conditions and impairments are grouped under 19 chapters, covering specific physical, sensory, psychosocial and intellectual disorders. Similarly to the Austrian system, each chapter identifies a number of specific conditions and then attributes a disability percentage to that condition, depending on its degree of severity. For example, the chapter on Mental Health Disorders covers dementia, 'emotional' disorders, intellectual impairments and genetic syndromes. Under the heading of dementia, a disability percentage of 10-50 % is attributed in the case of a mild condition; 67-80 % in the case of an incipient condition; and more than 80 % in the case of advanced dementia. Specific disability percentages are also identified under the other sub-headings.

To date, one independent evaluation of the work of the Centre for Certification of Disability (KEPA) has been carried out. This was undertaken by the Greek Ombudsman in 2013.²⁵² According to the Ombudsman's report, there have been more than 350 complaints from citizens regarding assessment of disability since the new assessment system was introduced in 2011. These complaints relate to partial or full exclusion from disability benefits, including pensions and healthcare. This was the result of both organisational failures (such as long delays or gaps between reassessments), and the new assessment attributing reduced disability percentages to people who had previously been assessed as having a higher disability percentage, and who lost their eligibility to various benefits under the new assessment system. In the latter cases, the Greek Ombudsman highlighted problems regarding insufficiently justified decisions by the committees, and objections by the administration to (higher) disability percentages. These resulted in long periods of exclusion from healthcare and disability benefits for individuals, 'proving futile and hampering as much for the insured

²⁴⁸ *Journal of Government* 2611/B/2011, available at: <https://drive.google.com/file/d/0B2q6YQEWX7zLZWE2NzlhYjMtYmM5ZC00YjY5LWE5MTctMTExNDgyZDMzNjQw/view>.

²⁴⁹ *Journal of Government* 1506/B/2012, available at: https://www.ika.gr/gr/infopages/kepa/FEK_1506_B_4-5-2012.pdf.

²⁵⁰ *Journal of Government* 4591/B/2017, available at: <http://www.nomotelia.gr/photos/File/4591B-17.pdf>.

²⁵¹ *Journal of Government* 819/B/1993, available at: <https://drive.google.com/file/d/0B2q6YQEWX7zLZDI0MzNhNTMtYzYxYy00MjZmLWFkNjQtZGExZTcyOTJiMjJk/view>.

²⁵² The Greek Ombudsman (2013), *Special Report on KEPA* (Centralised Certification Centre for Disability), available at: <http://www.synigoros.gr/resources/docs/130404-special-report.pdf>.

as for the security system'.²⁵³ The Ombudsman also raised concerns about an exclusive focus on diagnosis during assessments, rather than giving full consideration to symptoms, needs, possible side-effects or the ineffectiveness of the medical treatment followed.²⁵⁴

The problem of long delays in assessment processes was partly tackled by Law 4331/2015,²⁵⁵ which made it possible to extend benefits and status until the actual date of reassessment. In addition, people who have certain impairments (43 listed impairments) no longer require reassessment.²⁵⁶ This includes people with, for example, paraplegia/tetraplegia, amputations, hearing impairment, visual impairment, genetic syndromes, intellectual impairments, or Autism Spectrum Disorder. Lobbying by the disability movement also played a significant role in making these changes.²⁵⁷

The National Federation of Disabled People has responded favourably to the introduction of a single disability assessment method. The National Federation actively supported the development of a centralised system using a single disability percentage table in order to address the issue of people with disabilities being stereotyped as being involved in benefit fraud. They felt that the new system would be more reliable and trusted, and so fraud would be seen as less likely.²⁵⁸ In general, the new system is seen as cost effective for applicants and the administration, and a common approach to assessment, rather than multiple and diverse assessment methods, as was previously the case, is now in place.

Moreover, representative disability organisations have not objected to the use of the Barema method in principle, although they have challenged specific aspects of it, particularly where pre-existing eligibility for pensions and benefits has been threatened. Percentages attributed to specific impairments have altered periodically, and the ANED expert for Greece,²⁵⁹ as well as others,²⁶⁰ argue that this reflects political agendas and has been done with a view to restricting eligibility for disability benefits. A prominent example was the decision to reduce the minimum disability percentage attributed to autism from 67 % to 50 % in 2012. This decision was subsequently overturned following intense lobbying by disabled people's organisations. However, downward modifications again occurred in 2017.

²⁵³ The Greek Ombudsman (2013), *Special Report on KEPA* (Centralised Certification Centre for Disability), p. 11, available at: <http://www.synigoros.gr/resources/docs/130404-special-report.pdf>.

²⁵⁴ The Greek Ombudsman (2013), *Special Report on KEPA* (Centralised Certification Centre for Disability), p. 9, available at: <http://www.synigoros.gr/resources/docs/130404-special-report.pdf>.

²⁵⁵ Available at: <http://www.esamea.gr/legal-framework/laws/2620-n-4331-2015-metra-gia-tin-anakoyfisi-ton-atomon-me-anapiria-amea-tin-aplopoiisi-tis-leitoirgias-ton-kentron-pistopoiisis-anapirias-ke-p-a-katapolemisi-tis-eisforodiatygis-kai-synafi-asfaltika-zitimata-kai-alles-diataxeis>.

²⁵⁶ Ministerial Decision of 2013, *Journal of Government (FEK)* 2906/B/2013, available at: https://www.noesi.gr/sites/default/files/posts/lista-43-mi-anastrepsimes-pathiseis-fek-2906_18_11_2013-noesigr.pdf.

²⁵⁷ Pavli, A. (2017), *Creative Disability Classification Systems: The Case of Greece 1990-2015*, PhD thesis, Swedish Institute for Disability Research, Örebro University.

²⁵⁸ Pavli, A. (2017), *Creative Disability Classification Systems: The Case of Greece 1990-2015*, PhD thesis, Swedish Institute for Disability Research, Örebro University, p. 190.

²⁵⁹ Eleni Strati.

²⁶⁰ Pavli, A. (2017), *Creative Disability Classification Systems: The Case of Greece 1990-2015*, PhD thesis, Swedish Institute for Disability Research, Örebro University; and The Greek Ombudsman (2013), *Special Report on KEPA* (Centralised Certification Centre for Disability), available at: <http://www.synigoros.gr/resources/docs/130404-special-report.pdf>.

Organisations representing people on the autistic spectrum seem to have been especially vocal in criticising specific aspects of the assessment, although they, too, have not been critical of the Barema method overall. A 2018 briefing paper submitted jointly by national associations for the rights of people on the autistic spectrum specifically requested easier access to the ‘application folder’ and notes on the assessment made by the assessing committee in the case of an appeal, as well as a prolongation of the period within which one can raise an appeal from 10 to 60 days.²⁶¹ The representative organisations for the rights of people on the autistic spectrum also requested that combined tools be used for the assessment of autism, such as the Vineland Adaptive Behaviour Scales and the Autism Diagnostic Observation Schedule,²⁶² along with clinical observation and interview (ADI-R), which are claimed to ‘ensure a reliable diagnosis, planning for suitable interventions and assessment of autism as distinct from other developmental disorders’.²⁶³ As seen above (Part III, sub-section 7.1.1), these kinds of internationally recognised guidelines or protocols are used in Iceland to assess people on the autistic spectrum.

Nevertheless, the ANED expert concludes:

the assessment method, which focuses exclusively on impairment and individual limitations, and the process which relies heavily on medical judgment, have not been brought into question in the ongoing dialogue over disability assessments.

8.3 Assessment to receive the blind person’s allowance / be registered as blind (Liechtenstein and the United Kingdom)

In Liechtenstein and the United Kingdom, assessment of visual impairment with a view to determining eligibility for specified benefits is carried out in a similar way, based on a method similar to the Barema method. However, it is not a standard Barema method, since it does not cover all forms of disabilities, and specific medical diagnoses are not linked to a set percentage of disability – rather, the disability percentage is largely intended to reflect the measurable degree of reduced vision. The assessment therefore takes account of actual ability, and expresses or calculates this on a percentage scale (expressed as a fraction). The benefits resulting from the two assessments are substantially different, and there are a number of other differences in the assessment process.

Blind person’s allowance, Liechtenstein

In Liechtenstein, the assessment of eligibility to receive the blind person’s allowance,²⁶⁴ which is a cash benefit compensation for additional costs related to

²⁶¹ EODAFF/ EDAAF, ‘2018 Brief the Rights of People in the Autistic Spectrum’, available at: https://www.noesi.gr/sites/default/files/posts/ypomnima_goneon_melon_thesmikon_foreon_gia_ta_atoma_me_diatarahi_ayistikoy_fasmatos_08.02.2018.pdf.

²⁶² Available at: https://www.special-learning.com/article/vineland_adaptive_behavior_scales, <https://research.agre.org/program/aboutados.cfm> and <https://research.agre.org/program/aboutadi.cfm>.

²⁶³ EODAFF/ EDAAF, ‘2018 Briefing Paper for the Rights of People in the Autistic Spectrum’, pp. 39-40, available at: <https://www.psychologynow.gr/psychology-news/ti/4598-ypomnima-goneon-melon-thesmikon-foreon-gia-ta-atoma-me-diataraxi-aftistikoy-fasmatos.html>.

²⁶⁴ The Liechtenstein Disability Insurance provides a fact sheet about the blind person’s allowance and their entitlement to claim the allowance. The fact sheet provides information about the application

blindness, uses the Barema method. A person qualifies for the allowance if they are resident in Liechtenstein and their vision is impaired in one of the following ways:

- No vision in both eyes or the person is only able to recognise light, but projects it incorrectly, and thus cannot find their way in unfamiliar surroundings when unaccompanied (fully blind);
- Visual acuity in the better eye does not exceed 1/60;
- Visual acuity in the better eye is no more than 1/35 in the case of visual field restriction to 30 degrees or less;
- Visual acuity in the better eye is no more than 1/20 in the case of visual field restriction to 15 degrees or less (practically blind);
- Visual acuity in the better eye is 6/60 or less with ordinary aids;
- Good central visual acuity, where the visual field is restricted to 15 degrees or less;
- Good central visual acuity, where there is a high degree of glare sensitivity due to lack of pigment leaf or iris (highly weak vision).

The measured values are based on an individual's vision when corrected with ordinary aids.

An applicant submits an application, using the application form which is available online,²⁶⁵ to the Liechtenstein Disability Insurance. The application must contain a medical assessment of blindness, i.e. a medical report provided by an ophthalmologist. This is based on a medical assessment carried out by the ophthalmologist using a standard letter or symbol chart at a fixed distance (on the Snellen scale). The person is asked to read the letters/symbols of decreasing size until they make persistent errors. The ophthalmologist completes a certificate of vision impairment (CVI) which includes the patient's personal details and a simple categorical declaration, in line with the kind of visual impairments identified above.²⁶⁶ The latter is indicated by the ophthalmologist, ticking a box for the category assessed. The applicant is responsible for obtaining the CVI.

The Liechtenstein Disability Insurance can either take a preliminary decision on the application based on the evidence provided or refer the applicant for a specialist examination to confirm the original diagnosis. Once this process has been completed, the Disability Insurance informs the applicant of the preliminary decision, and the applicant can comment on this. This may lead the Disability Insurance to revise its decision, but it always take decisions in line with the legal requirements regarding eligibility for the allowance. A formal notification of the decision is then issued. Individuals who receive the blind person's allowance must be periodically reassessed to determine whether they remain eligible.

procedure, entitlement and the amount of the allowance. Available at:
https://www.ahv.li/fileadmin/user_upload/Dokumente/Online-Schalter/MB/AHV-IV-FAK-MB-7-01--BB.pdf.

²⁶⁵ Link to the official form at: https://www.ahv.li/fileadmin/user_upload/Dokumente/Online-Schalter/FORM/AHV-IV-FAK-FORM-7-01--Antrag_Gewaehrung_BB.pdf.

²⁶⁶ In addition to the fact sheet on the blind person's allowance, the Liechtenstein Disability Insurance publishes a general fact sheet about requirements for medical reports submitted to the Liechtenstein pension and disability insurance body, available at:
https://www.ahv.li/fileadmin/user_upload/Dokumente/Online-Schalter/MB/AHV-IV-FAK-MB-3-08--Medizinische_Gutachten.pdf.

In 2016, 45 people were eligible to receive the blind person's allowance (11 'fully blind', 10 'practically blind' and 24 with 'highly weak vision'). One or two new applicants are typically assessed per year.

There is no publicly available independent evaluation of the assessment method. In addition, the Liechtenstein Association of the Blind is not directly involved in the assessment or application procedures. The association does inform blind persons about the allowance and the application procedures, but does not act as a monitoring body or as a contact point for evaluations. Nevertheless, no criticism of the current approach has been made public by the Liechtenstein Association of the Blind.²⁶⁷

In the view of the ANED country experts for Liechtenstein,²⁶⁸ the assessment for the certification of visual impairment is medically oriented, and more transparency on the assessment method would be welcome, with a view to ensuring that functional and needs-based perspectives are considered in the process.

Register of people with a visual impairment, the United Kingdom

In the United Kingdom, a similar assessment method is used to assess people's eligibility to be registered as having a visual impairment. Local authorities have a legal duty²⁶⁹ to establish and maintain such a register, and individuals who are registered are entitled to receive a number of benefits, such as tax allowances, leisure discounts and free public transport. As in Liechtenstein, individuals need to undergo a medical assessment and receive a Certificate of Visual Impairment in order to be registered – however, registration is voluntary and individuals who receive the Certificate are not automatically registered. The registration contains two categories: 'sight impaired' (previously referred to as 'partial sight') and 'severely sight impaired' (previously referred to as 'blind').

An individual is eligible to be registered if, on the Snellen scale of visual acuity, their vision is 10 % or less of normal vision ('sight impaired') or 5 % or less of normal vision ('severely sight impaired'). A person can be registered even if they have better acuity, if there is 'clinically significant contracted field of vision' which results in functional impairment.

The assessment, or medical measurement of visual acuity, is carried out by a senior ophthalmologist in a face-to-face meeting. An individual must be referred to a specialist hospital eye clinic for an assessment. The initial referral could come from a general practitioner or an optometrist (ophthalmic optician), although it might be initiated by a recommendation from another professional, such as a social worker. There are no fixed criteria for referral. Simplified guides to the process are provided by several voluntary organisations, such as the Royal National Institute for Blind Persons (RNIB).²⁷⁰

The ophthalmologist conducts standard optometric tests in two areas – visual acuity (clearness of distance vision) and visual field (the extent of peripheral vision). The

²⁶⁷ Link at: <http://www.lbv.li/>.

²⁶⁸ Patricia Hornich and Wilfried Marxer.

²⁶⁹ Under Section 77 of the Care Act 2014. At: <http://www.legislation.gov.uk/ukpga/2014/23/section/77>.

²⁷⁰ Available at: <http://www.rnib.org.uk/eye-health/registering-your-sight-loss>.

assessment protocol and instructions on certification are detailed in the Explanatory Notes for Consultant Ophthalmologists and Hospital Eye Clinic Staff in England.²⁷¹ A medical diagnosis is not a requirement of the assessment protocol for certification of sight impairment, although it is usually recorded on the CVI.

Visual acuity is measured using a standard Snellen test (letter chart) at a fixed distance (six metres) and with the aid of any prescribed lenses, if applicable. The person is asked to read letters of decreasing size until a persistent error is made. This test can be adapted for persons who do not read letters by using alternative symbol charts. Visual field is also measured by the ophthalmologist. Standard tests are used, although the exact method and the tools used may vary (often using a computer-aided test to measure responses to randomly presented targets on a screen at different points in the visual field). The assessment criteria are also less clearly defined. It is possible to be certified as 'sight impaired' if there is 'a clinically significant contracted field of vision' which results in functional impairment. Loss of sight in one eye does not affect the outcome of a field test if the other eye is functioning normally. There are no quantified criteria against which to measure field test results, although some qualitative descriptor examples are included in the certification categories. In carrying out the assessments, the ophthalmologist usually has access to the patient's medical records.

The assessment methodology uses a Barema-type measure. The results can be considered in percentage terms, but are expressed as a fraction, e.g. 3/60 or 5 %. The criterion for being assessed as being 'sight impaired' is 6/60 or less (i.e. 10 % of standard vision), which means that a person can read at 6 metres what a normally sighted person could read at 60 metres. For 'severely sight impaired' the criterion is 3/60 or less (i.e. 5 % of standard vision). The measure is thus based on significance of statistical deviation from the norm (where the norm is 6/6).²⁷² If an individual meets one of these criteria, the ophthalmologist is obliged to indicate the relevant status ('sight impaired' or 'severely sight impaired') on the CVI. However, the ophthalmologist can also classify someone with a greater degree of vision as 'sight impaired' or 'severely sight impaired' if there are relevant concerns regarding overall visual function or prognosis. The guidance notes state 'it is ultimately a matter of professional judgment for the consultant ophthalmologist as to how the person's vision loss impairs their day to day activities and ability to function'. The guidance suggests that the person's ability to undertake tasks should be fully considered as well as 'an overview of the individual's case'.²⁷³ The ANED country experts²⁷⁴ argue that this suggests that the assessment is intended as a measure of function in everyday life rather than a clinical measurement.

Following the assessment, the ophthalmologist decides whether the individual is not eligible, 'sight impaired' or 'severely sight impaired'. As noted above, the ophthalmologist may exercise clinical judgment in reaching an opinion based on a

²⁷¹ Available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/637590/CVI_guidance.pdf.

²⁷² Further sub-divisions exist within these two categories, depending on the degree of visual impairment which exists. More information on this is provided in the UK ANED report on disability assessment (case study 1).

²⁷³ More information is provided in the UK ANED report on disability assessment (case study 1).

²⁷⁴ Mark Priestley and Rosa Morris.

combination of test results and other information about the person's circumstances. If the individual meets the conditions for registration, the ophthalmologist completes a Certificate of Vision Impairment (CVI) to evidence this. As in Liechtenstein, the CVI includes the patient's personal details and a simple categorical declaration by the ophthalmologist, which involves ticking a box indicating the selected category.²⁷⁵ In general, individuals who have a CVI are not subject to mandatory reassessment, although a subsequent examination may be requested. The CVI²⁷⁶ also records the clinical test results, the medical diagnosis, the patient's consent and ethnicity monitoring information, and includes a self-assessment about additional impairments, their social situation and support. These are intended to assist the local authority in making an assessment of needs for other services. These parts of the form may be completed by members of the clinic staff other than the ophthalmologist, such as an Eye Clinic Liaison Officer, in discussion with the patient. The ANED country experts note:

the overall experience of the assessment process for a person may include medical, functional and needs-based conversations but the assessment of sight impairment itself is a medical-functional one, carried out by a medical doctor using mainly a Barema scale methodology to record visual acuity as a percentage or fraction of normal vision.

Data from the UK's National Health Service suggests that almost 2 million people have some level of visual impairment across the whole of the UK, while about 360 000 are registered. The epidemiological evidence suggests significant under-registration, notably of 'sight impaired' persons (who are also likely to be older persons). Under-registration may occur because of lack of assessment or lack of registration, which is voluntary. In 2016-17 the numbers of persons registered as 'severely sight impaired' and 'sight impaired' were quite closely balanced, with 141 525 people in the former category and 148 950 in the latter.²⁷⁷ The prevalence of sight impairment rises rapidly with age, notably among people aged over 75.

RNIB publishes an unofficial but more comprehensive Sight Loss Data Tool. This indicates that the total number of CVIs issued in England in 2015-16 was 22 973 (or 42 per 100 000 head of population). In the same year, the data records 20 605 new registrations as 'severely sight impaired' and 'sight impaired', which suggests a conversion rate of 89.7 % (with a non-registration rate of just over 10 %).²⁷⁸ Certification is meant to be an important trigger alerting local social services to the existence of a person with significant sight impairment with possible needs and entitlements but, as noted above, both referral and registration remain voluntary. This means that the ability of hospital clinic staff to obtain a patient's consent for such a referral, at the point of assessment, may have a gatekeeping effect, although a refusal to give consent at the point of certification would not prevent a person from seeking

²⁷⁵ This certificate is designated by different names in different parts of the UK (e.g. as a BP1 form in Scotland or an A655 in Northern Ireland).

²⁷⁶ Available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/637591/CVI_form.pdf.

²⁷⁷ See table in the UK ANED report on disability assessment.

²⁷⁸ Information taken from the UK ANED report on disability assessment.

social care support later if they chose to do so. However, many of the benefits associated with registration can also be obtained on production of a CVI.

In 2012, the RNIB published a substantial research report on *The Certification and Registration Processes: stages, barriers and delays*.²⁷⁹ This included a review of the benefits of registration, epidemiological evidence and evidence of the experience of patients and professionals. The research showed that rates of certification and registration declined despite an increasing prevalence of visual impairment in the ageing population. Official data returns from SSDA902 in 2014 showed a 3 % decrease in blind ('severely sight impaired') registrations since 2011 but an increase in partially sighted ('sight impaired') registrations by the same degree.²⁸⁰ Registration has increased for children under both categories.

The RNIB's reported experiential data suggesting that patients often felt 'shocked' or 'overwhelmed' at the point of certification and that the process was 'life changing for many'. Process failures identified included failure by clinicians to certify when necessary, failure by clinic staff to complete or forward the certificate, and failure by social services to register where consent has been given. There were variations in practice and process between different consultants, different hospitals and different local authorities that affected support outcomes for patients.

Although the UK's assessment method for the certification of visual impairment is medically oriented, there have been revisions to ensure that functional and needs-based perspectives are also considered in the process of support and service coordination for the person concerned. The incorporation of a facilitated self-assessment of needs with Eye Clinic Liaison Officers at the hospital registration clinic, following a recommendation for certification of sight impairment, provides a mechanism for closer communication between the health and social care authorities. Research and lobbying by the RNIB has influenced some of these improvements. Two strengths of this assessment process are that it functions as an assessment for multiple purposes and is an efficient form of generic disability recognition. However, separate assessments must be undertaken in order to obtain cash welfare services or needs-based services.

8.4 Concluding comments on assessments based on the Barema method

A limited number of assessments using the Barema method were identified in this synthesis report. However, it is notable that two of the four assessments covered relate exclusively to visual impairment (in Liechtenstein and the United Kingdom), and follow the same basic approach, using the Snellen scale of visual acuity, with assessments being carried out by ophthalmologists. Greece is a notable case, in that the Barema method is the main disability assessment tool in use, and the assessment determines eligibility for multiple benefits, including the disability pension. Other countries covered in this synthesis report adopt different assessment methods for determining eligibility for disability pensions. The degree of information concerning assessment methods, and the related Barema scale (i.e. the assessment protocol) differed across these four

²⁷⁹ Available at:

https://www.rnib.org.uk/sites/default/files/Certification_and_Registration_Processes_Full_report.doc.

²⁸⁰ Available at: <http://digital.nhs.uk/catalogue/PUB14798>.

assessments. A protocol exists in the United Kingdom, while a list of impairments or health conditions and related disability percentages is contained in the relevant legislation in Austria and in the Single Table of Disability Percentage Determination in Greece. It is notable that the UK protocol explicitly allows some discretion to examining doctors, while the wide range of possible disability percentages which can be attributed to specific health conditions or impairments under the Greek Table of Disability Percentage Determination also reveals evidence for the exercise of discretion. The UK approach, whilst being predominantly medical, also allowed for some assessment of functional capacity and need, and the individual being assessed can complete a self-assessment form detailing the impact of the impairment. Not surprisingly, given the medical nature of this assessment, it is carried out by medical professionals (doctors) in all cases, although there was some difference in the willingness to accept medical reports from external experts. In some cases, the relevant (insurance) agency would accept these at face value, but some assessment methods, such as the assessment for a Disabled Person's Card in Austria, allow the agency to refer the applicant for a separate medical examination where the agency does not regard the original medical report as providing enough evidence. Lastly, it is worth noting that this synthesis report has identified some disability assessments which are ostensibly based on a functional capacity assessment, but which in fact display strong elements of the Barema method. This is the case for the Cypriot assessment to determine eligibility for the disability pension and the Czech assessment to determine disability status and eligibility for the disability pension and employment support. These are discussed further below in Part III, sub-section 9.1.1.1.

9 Functional capacity assessment

While the assessment of functional capacity is used fairly widely, there is a great deal of variety in what functional capacity is actually being assessed, and how it is assessed. A distinction can generally be made between assessment methods which seek to assess a person's capacity to work and assessment methods which seek to assess a person's capacity to undertake activities of daily living. There are examples given in this section of both kinds of assessment being used to determine eligibility for a disability pension, although the assessment of work capacity is more usual in this context. As noted above, Ben Baumberg Geiger has identified three different types of direct work capability assessments, which he labels expert assessments, structured assessments and demonstrated assessments (Part I, sub-section 2.1.1).²⁸¹ Expert assessments involve a medical, occupational health or labour market professional who uses his or her expertise to determine whether an individual is capable of work. Structured assessments involve identifying the applicant's functional capacities, and then comparing those to functional profiles required for specific jobs or work-related skills. Demonstrated assessments involve a process by which the applicant's ability to work is demonstrated through actually carrying out work-related activities. This third form of assessment is discussed separately in this synthesis report under the heading 'Procedural assessment method' (Part III, section 12). This report also identifies a fourth form of functional capacity assessment as applied in the specific content of employment-related benefits, including, in particular, disability pensions for people with reduced working capacity. This assessment involves identifying an individual's functional capacity restrictions, and then drawing conclusions based on this assessment regarding the individual's capacity to work. This assessment process is referred to as assessment of capacity to carry out activities of daily living for the purpose of awarding employment-related benefits. In this sub-section, various examples of what Ben Baumberg Geiger refers to as expert assessments and structured assessments are discussed, as well as assessments of daily activities for the purpose of awarding employment-related benefits. The first sub-section considers assessments of capacity to work (expert and structured), before moving on to assessments of ability to carry out activities of daily living for the purpose of awarding benefits linked to reduced working capacity, such as disability pensions. The second section considers assessments of the capacity to carry out activities of daily living where this is not linked to an assessment of reduced working capacity.

9.1 Assessment of capacity for work

9.1.1 Expert assessments

The majority of functional capacity assessments relating to the ability to work that have been identified for this synthesis report involve expert assessments. Ben Baumberg Geiger has noted that this is the most common form of directly assessing work

²⁸¹ Baumberg Geiger, B. (2018), 'Legitimacy is a balancing act, but we can achieve a much better balance than the WCA' – 'A Better WCA is Possible', Demos, p. 57; and Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

capacity.²⁸² Expert assessments relating to work capacity and determining eligibility for disability pensions were identified in Belgium, Cyprus, the Czech Republic and Malta. In Sweden, this form of assessment is used to determine admission to the public employment service register of disabled persons. In these assessments, a great deal of responsibility is placed on experts who, for the most part, are doctors or have a medical background.

9.1.1.1 Assessment to determine eligibility for a disability / invalidity pension (Belgium, Cyprus, the Czech Republic and Malta)

Belgium

In Belgium, the RIZIV, which is responsible for the medical care and disability insurance scheme, carries out a functional capacity assessment to determine eligibility for a replacement income or invalidity pension. Individuals apply to their health insurance fund for the benefit, and the individual's general practitioner provides some supporting evidence when the application is submitted. The general practitioner provides information on the individual's symptoms, diagnosis or functional disorders. This can be done in accordance with ICD-10 (the International Statistical Classification of Diseases and Related Health problems) or ICPC-2 (International Classification of Primary Care).²⁸³

The doctor working for the health insurance fund must then assess the application and decide if the individual is 'incapable of work'. This first assessment is based on whether the individual can carry out his or her current job. The doctor carries out a home visit to make this assessment. This assessment can take professional and social difficulties into account.²⁸⁴ Some two months after being declared 'incapable of work', an individual, at his/her own initiative or on the initiative of a doctor, can start a reintegration programme, where different options for returning to the labour market can be explored and developed. At this stage, an investigation as to whether the individual can carry out other work on the labour market is also carried out.²⁸⁵ After seven months of being 'incapable of work', an individual is obliged to undergo a further medical assessment at a local investigation centre. At this assessment, the doctor can decide that the individual is no longer able to carry out his or her current (or previous) profession, but does not indicate what specific job the individual can do. The assessing doctor drafts an advice note based on the assessment, and, on the basis of this, the Medical Council of Invalidity decides whether the individual is still 'incapable of work'. These assessment methods are used both for the award of a replacement income for people who are 'incapable of work' for a period of less than 12 months, and for long-term invalidity benefit.

²⁸² Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

²⁸³ Application form (needs to be filled out by a doctor). See:

https://www.cm.be/media/Aangifteformulier-loontrekkenden_tcm47-17358.pdf.

²⁸⁴ Guidance file. See: https://www.cm.be/media/Folder-arbeidsongeschied_tcm47-12965.pdf; for document in English, see: https://www.cm.be/media/Arbeidsongeschied_En_tcm47-19644.pdf.

²⁸⁵ See: <http://www.riziv.fgov.be/nl/themas/arbeidsongeschied/werknemers-werklozen/Paginas/reintegratietraject.aspx#.WtI9uxTCsT8>.

Guidance documents²⁸⁶ do not provide any information about the method of assessment. In essence, it seems the assessment decision is based on the clinical opinion of the assessing doctor, using medical information obtained through an examination.

Cyprus

In Cyprus, a functional capacity assessment is used to determine eligibility for the disability pension, which applies to individuals who became disabled through an industrial or work accident,²⁸⁷ and eligibility for the general invalidity pension.²⁸⁸ In both cases, the assessed disability is expressed in percentage terms, using a scale similar to that used in the Barema method.

The application forms for both kinds of benefit need to be accompanied by a medical report from the treating doctor. Once an application has been submitted, the applicant is invited to an assessment meeting with a Council of Medical Doctors by the Department of Social Insurance. During the assessment for the invalidity pension, the Council of Medical Doctors carries out a medical examination to determine the applicant's diagnosis and decide if this allows the applicant to work or not. The Council also identifies the relevant disability percentage and establishes whether the applicant is permanently unable to work. During the assessment for the (occupational) disability pension, an assessment of functional capacity is made. This involves assessing the applicant's ability to carry out specified tasks or activities, and is usually based on medical diagnoses and a basic medical or neurological assessment. The assessment is made in relation to the tasks a person is required to perform in his/her current job or similar kinds of work. The Council then indicates to what degree a claimant can continue to perform her/his current job or a comparable job. For both kinds of assessments, a table of disability percentage is provided to assessors as guidance. Information provided to ANED country experts seems to indicate that applicants have a passive role during the assessment.

After the assessment, the Council of Medical Doctors completes an advisory document, which is submitted to the head of the Department of Social Insurance Services. While in practice the decision is made by the Council, the formal decision is made by a civil servant, who communicates the decision to the applicant.

²⁸⁶ See previous three footnotes.

²⁸⁷ Disability Pension Application form, available at:

[http://www.mlsi.gov.cy/mlsi/sid/sidv2.nsf/All/E3D0B025BCF1FE7EC2257B18003C3EA8/\\$file/%CE%A5%CE%9A%CE%91%203-011%20%CE%91%CE%AF%CF%84%CE%B7%CF%83%CE%B7%20%CE%B3%CE%B9%CE%B1%20%CE%A0%CE%B1%CF%81%CE%BF%CF%87%CE%AE%20%CE%BB%CF%8C%CE%B3%CF%89%20%CE%91%CE%BD%CE%B1%CF%80%CE%B7%CF%81%CE%AF%CE%B1%CF%82%20\(1-2013\).pdf](http://www.mlsi.gov.cy/mlsi/sid/sidv2.nsf/All/E3D0B025BCF1FE7EC2257B18003C3EA8/$file/%CE%A5%CE%9A%CE%91%203-011%20%CE%91%CE%AF%CF%84%CE%B7%CF%83%CE%B7%20%CE%B3%CE%B9%CE%B1%20%CE%A0%CE%B1%CF%81%CE%BF%CF%87%CE%AE%20%CE%BB%CF%8C%CE%B3%CF%89%20%CE%91%CE%BD%CE%B1%CF%80%CE%B7%CF%81%CE%AF%CE%B1%CF%82%20(1-2013).pdf)

²⁸⁸ Guide for illness allowance and invalidity pension, available at:

[http://www.mlsi.gov.cy/mlsi/sid/sidv2.nsf/0/28617AEBE533EF95C2257C920046F903/\\$file/%CE%9F%CE%B4%CE%B7%CE%B3%CF%8C%CF%82%20%CE%95%CF%80%CE%B9%CE%B4%CF%8C%CE%BC%CE%B1%CF%84%CE%BF%CF%82%20%CE%91%CF%83%CE%B8%CE%B5%CE%BD%CE%B5%CE%AF%CE%B1%CF%82%20%CE%BA%CE%B1%CE%B9%20%CE%A3%CF%8D%CE%BD%CF%84%CE%B1%CE%BE%CE%B7%CF%82%20%CE%91%CE%BD%CE%B9%CE%BA%CE%B1%CE%BD%CF%8C%CF%84%CE%B7%CF%84%CE%B1%CF%82.pdf](http://www.mlsi.gov.cy/mlsi/sid/sidv2.nsf/0/28617AEBE533EF95C2257C920046F903/$file/%CE%9F%CE%B4%CE%B7%CE%B3%CF%8C%CF%82%20%CE%95%CF%80%CE%B9%CE%B4%CF%8C%CE%BC%CE%B1%CF%84%CE%BF%CF%82%20%CE%91%CF%83%CE%B8%CE%B5%CE%BD%CE%B5%CE%AF%CE%B1%CF%82%20%CE%BA%CE%B1%CE%B9%20%CE%A3%CF%8D%CE%BD%CF%84%CE%B1%CE%BE%CE%B7%CF%82%20%CE%91%CE%BD%CE%B9%CE%BA%CE%B1%CE%BD%CF%8C%CF%84%CE%B7%CF%84%CE%B1%CF%82.pdf)

In addition to carrying out the assessment, the Council can ask the applicant to participate in therapy or a vocational training programme. This is the case even if a permanent pension is awarded and the therapy or training is not intended to enable the person to return to work. A refusal to participate can result in payment of the invalidity pension being suspended.

As noted above, the assessment determines the disability percentage of the applicant, and the disability percentage determines the amount of the financial benefits which an individual can receive. The Council of Medical Doctors carries out the assessment on the basis of the guidelines found in the Social Insurance Act of 2010 (59(I)/2010).²⁸⁹ Table 6 of this Act refers to the disability percentages based on impairment or functional loss. For example, the loss of two limbs, the loss of both hands or all fingers and the total loss of vision all equate to a 100 % degree of disability. The system is strikingly similar to the Barema method.²⁹⁰ The table does not take account of the individual situation of the applicant in terms of the skills needed to carry out specific work, however, nor the impact that a particular impairment has on a specific individual. It is unclear how the assessment takes these matters into account, or whether this happens at all. In brief, the assessment is based on the medical approach, even though the goal is to assess an individual's ability to work. Health and rehabilitation professionals, as well as labour market experts, are not involved in the assessment.

The assessment method has been criticised in the press for being time consuming and inflexible. The latter criticism relates to the fact that the opinions of external experts are not considered, and external professionals are not allowed to attend the assessment, even at the appeal stage.²⁹¹ In addition, while as discussed under Part III, sub-section 7.1.2 above,²⁹² there have been some attempts to develop a single assessment system in Cyprus, this has not happened in practice, and the assessment method

²⁸⁹ Available at: http://www.cylaw.org/nomoi/enop/non-ind/2010_1_59/full.html. English information available at: http://www.mlsi.gov.cy/mlsi/sid/sidv2.nsf/page16_en/page16_en?OpenDocument and [http://www.mlsi.gov.cy/mlsi/sid/sidv2.nsf/0/CFC7F0DD3FCB4E94C2257A170036EE4D/\\$file/Social%20Insurance%20in%20Cyprus.pdf](http://www.mlsi.gov.cy/mlsi/sid/sidv2.nsf/0/CFC7F0DD3FCB4E94C2257A170036EE4D/$file/Social%20Insurance%20in%20Cyprus.pdf).

²⁹⁰ Other guides directed at members of the public and applicants are available via the department's homepage: Disability Pension: Guide for Job Accidents' and Illness Benefits, available at: [http://www.mlsi.gov.cy/mlsi/sid/sidv2.nsf/All/78A356D08A40FF49C2257C92004737CB/\\$file/%CE%9F%CE%B4%CE%B7%CE%B3%CF%8C%CF%82%20%CE%B3%CE%B9%CE%B1%20%CE%A0%CE%B1%CF%81%CE%BF%CF%87%CE%AD%CF%82%20%CE%95%CF%81%CE%B3%CE%B1%CF%84%CE%B9%CE%BA%CF%8E%CE%BD%20%CE%91%CF%84%CF%85%CF%87%CE%B7%CE%BC%CE%AC%CF%84%CF%89%CE%BD%20%CE%BA%CE%B1%CE%B9%20%CE%95%CF%80%CE%B1%CE%B3%CE%B3%CE%B5%CE%BB%CE%BC%CE%B1%CF%84%CE%B9%CE%BA%CF%8E%CE%BD%20%CE%91%CF%83%CE%B8%CE%B5%CE%BD%CE%B5%CE%B9%CF%8E%CE%BD.pdf](http://www.mlsi.gov.cy/mlsi/sid/sidv2.nsf/All/78A356D08A40FF49C2257C92004737CB/$file/%CE%9F%CE%B4%CE%B7%CE%B3%CF%8C%CF%82%20%CE%B3%CE%B9%CE%B1%20%CE%A0%CE%B1%CF%81%CE%BF%CF%87%CE%AD%CF%82%20%CE%95%CF%81%CE%B3%CE%B1%CF%84%CE%B9%CE%BA%CF%8E%CE%BD%20%CE%91%CF%84%CF%85%CF%87%CE%B7%CE%BC%CE%AC%CF%84%CF%89%CE%BD%20%CE%BA%CE%B1%CE%B9%20%CE%95%CF%80%CE%B1%CE%B3%CE%B3%CE%B5%CE%BB%CE%BC%CE%B1%CF%84%CE%B9%CE%BA%CF%8E%CE%BD%20%CE%91%CF%83%CE%B8%CE%B5%CE%BD%CE%B5%CE%B9%CF%8E%CE%BD.pdf); Invalidity Pension: Guide for Illness Allowances and Invalidity Pension, available at: [http://www.mlsi.gov.cy/mlsi/sid/sidv2.nsf/0/28617AEBE533EF95C2257C920046F903/\\$file/%CE%9F%CE%B4%CE%B7%CE%B3%CF%8C%CF%82%20%CE%95%CF%80%CE%B9%CE%B4%CF%8C%CE%BC%CE%B1%CF%84%CE%BF%CF%82%20%CE%91%CF%83%CE%B8%CE%B5%CE%BD%CE%B5%CE%AF%CE%B1%CF%82%20%CE%BA%CE%B1%CE%B9%20%CE%A3%CF%8D%CE%BD%CF%84%CE%B1%CE%BE%CE%B7%CF%82%20%CE%91%CE%BD%CE%B9%CE%BA%CE%B1%CE%BD%CF%8C%CF%84%CE%B7%CF%84%CE%B1%CF%82.pdf](http://www.mlsi.gov.cy/mlsi/sid/sidv2.nsf/0/28617AEBE533EF95C2257C920046F903/$file/%CE%9F%CE%B4%CE%B7%CE%B3%CF%8C%CF%82%20%CE%95%CF%80%CE%B9%CE%B4%CF%8C%CE%BC%CE%B1%CF%84%CE%BF%CF%82%20%CE%91%CF%83%CE%B8%CE%B5%CE%BD%CE%B5%CE%AF%CE%B1%CF%82%20%CE%BA%CE%B1%CE%B9%20%CE%A3%CF%8D%CE%BD%CF%84%CE%B1%CE%BE%CE%B7%CF%82%20%CE%91%CE%BD%CE%B9%CE%BA%CE%B1%CE%BD%CF%8C%CF%84%CE%B7%CF%84%CE%B1%CF%82.pdf); information on Invalidity Pension plans and application form available at: <http://www.mlsi.gov.cy/mlsi/sid/sidv2.nsf/All/C1B87BDD649E99E2C2257B18003B63D2?OpenDocument>.

²⁹¹ Press article on Evdokia's case for invalidity pension termination (dated 13 January 2018), available at <http://24h.com.cy/2018/01/13/sygklonise-evdokia-sto-dikastirio/>.

²⁹² On the assessment for multiple purposes and recognition of disability status in Cyprus.

described in this sub-section exists alongside the assessment method described above in section 7.1.2. As a result, there is no consistency or coherence in how people with disabilities are assessed in Cyprus.

The Czech Republic

In the Czech Republic, disability assessment is carried out by the Medical Assessment Service, which falls under the Social Security Administration of the Ministry of Labour and Social Affairs under the authority of the Ministry of Labour and Social Affairs. The assessment is intended to establish the disability status of applicants and to determine their eligibility for the disability pension and employment support. The ministry regards the assessment method as involving an assessment of functional capacity.²⁹³ However, the method strongly resembles the Barema method, in that it involves an ordinal scale which attaches percentage values to specific impairments. The impairments of the individual who is being assessed are compared with those listed on the scale, and a percentage is thereby obtained. In addition, some factors related to functional capacity are considered.

The applicant submits an application, which usually includes a medical report from their general practitioner. The applicant is not required to fill in a self-assessment questionnaire. The assessment is then carried out by a specialised insurance physician who works for the Medical Assessment Service.²⁹⁴ This falls under the Social Security Administration of the Ministry of Labour and Social Affairs. The work of the Medical Assessment Service is governed by the Act on Organising and Performing Social Security 582/1991.²⁹⁵ The insurance physician requests the applicant's general practitioner to carry out a medical examination and submit a medical report. The insurance physician may also ask other medical professionals to examine the applicant and provide additional medical reports. The insurance physician may request an individual meeting with the applicant in order to carry out a functional assessment and medical examination – but in most cases this does not happen. Once all documentation has been submitted, the insurance physician proposes a disability status and invalidity grade in accordance with the Pension Insurance Act 155/1995.²⁹⁶ The Act differentiates between three disability/invalidity grades (*stupně invalidity*). Invalidity grade 1 involves a reduced working capacity of between 35 % and 49 %; invalidity grade 2 involves a reduced working capacity of between 50 % and 69 %; and invalidity grade 3 involves a reduced working capacity of at least 70 %.

When making the assessment and proposal for a disability status, the insurance physician refers to the Annex to the Edict on Invalidity Assessment 359/2009.²⁹⁷ This annex contains a list of types of impairments and medical diagnoses, each of which is linked to a percentage indicating reduced working capacity. The insurance physician

²⁹³ MoLSA (2010) *Nový způsob posuzování invalidity od 1. ledna 2010* (New method of disability assessment since 1 January 2010). Available at: <https://www.mpsv.cz/cs/7888>.

²⁹⁴ Lékařská Posudková posudková služba in Czech.

²⁹⁵ Czech Republic, Zákon č. 582/1991 Sb. *Zákon České národní rady o organizaci a provádění sociálního zabezpečení*. Available at: <https://www.zakonyprolidi.cz/cs/1991-582>.

²⁹⁶ Available at: <https://www.zakonyprolidi.cz/cs/1995-155>.

²⁹⁷ Czech Republic, Vyhláška č. 359/2009 Sb. *Vyhláška, kterou se stanoví procentní míry poklesu pracovní schopnosti a náležitosti posudku o invaliditě a upravuje posuzování pracovní schopnosti pro účely invalidity (vyhláška o posuzování invalidity)*. Available at: <https://www.zakonyprolidi.cz/cs/2009-359>.

identifies the relevant impairment and diagnosis and then matches it to the identified percentage. For example, a mild intellectual disability with an IQ of 70-95, where the applicant performs some daily living activities with difficulty, is linked to a reduced working capacity (disability percentage) of 10-20 %, while a moderate functional impairment or a moderate motor, sensory, speech or cognitive dysfunction, whereby some daily activities are limited, is linked to a reduced working capacity (disability percentage) of 40-60 %. The tables in the annex cluster the impairment / diagnoses into 15 main chapters, which are sub-divided into units. If a specific health condition is not listed in the annex, the closest comparable condition is used to identify the relevant percentage. In addition to impairment and diagnosis, there is scope for considering functional capacity, although information about how this is done is not available judging from the desk research carried out for ANED.

In general, the identified disability status / invalidity grade is not permanent, and the Medical Assessment Service identifies the period of validity of its decision in the assessment report. This is not a standard decision, and it is dependent on the situation of the applicant.

While the Ministry of Labour and Social Affairs considers Edict 359/2009 as representing a modern functional capacity assessment,²⁹⁸ it is in fact based on medical diagnosis and medical evidence. Disabled people's organisations in the Czech Republic do not share the ministry's view, and argue that the assessment is based on medical indicators and does not reflect modern assessment methods which are used elsewhere in Europe. They argue that the assessment should focus on an individual's ability to function in society, and should involve not only medical doctors, but also other professionals such as vocational therapists and social workers.²⁹⁹

The assessment method is not subject to regular evaluations and there is no official report on the effectiveness of the system or independent evaluations. However, the ANED country expert³⁰⁰ refers to anecdotal evidence indicating that the assessment period is lengthy, and the Medical Assessment Service, which carries out a number of different kinds of disability assessment, is understaffed.

Malta

In Malta, a functional capacity assessment is used to determine eligibility for the contributory invalidity pension. The applicant must complete the relevant application form³⁰¹ and submits this to any district Social Security office or online.³⁰² Amongst the

²⁹⁸ MoLSA (2010) *Nový způsob posuzování invalidity od 1. ledna 2010* (New method of disability assessment since 1 January 2010). Available at: <https://www.mpsv.cz/cs/7888>.

²⁹⁹ The Czech Disability Council (2011), *Open Letter to Minister of Labour and Social Affairs*. 16 February 2011. Available at: <http://www.nrzp.cz/aktualne/informace-predsedy-nrzp-cr/430-otevreny-dopis-predsedy-nrzp-cr-vaclava-krazy-ministru-prace-a-socialnich-veci-cr.html>; Document from the Government Board of Persons with Disabilities, available at: <https://www.vlada.cz/en/ppov/vvzpo/uvod-vvzpo-en-312/>; Document from the Czech Disability Council, available at: <http://www.nrzp.cz/english-info.html>.

³⁰⁰ Jan Šiška.

³⁰¹ Available at: <https://socialsecurity.gov.mt/en/Pages/Application-Forms.aspx#invalidity-pension>.

³⁰² Available at: <https://socialsecurity.gov.mt/en/eforms/Pages/default.aspx>.

additional information which needs to be included are medical certificate showing that the applicant has been unfit for work for six months.³⁰³

If the applicant has made sufficient contributions to the social security system and has submitted a complete application, the Medical Board carries out an assessment. There is no face-to-face meeting with the applicant. Rather, the assessment is based on information contained in the application form, information provided by the treating doctor, who can be a general practitioner or specialist, and, if necessary, information in the claimant's medical file, which is available to the Board. Additional medical information or evidence can be requested from the applicant. The Board therefore adopts a medical perspective, and makes the assessment in line with the guidance provided in the Social Security Act. The Act lists various medical conditions which qualify an individual to receive an invalidity pension, and the Board has to decide if the applicant has a listed condition.³⁰⁴ The invalidity pension is awarded if the applicant is unable to work full time or part time for a period of between one and three years. At the end of the relevant period, which is decided on by the Board, the individual is reassessed to determine whether he or she remains eligible. The applicant is informed of the decision by the Department of Social Security.

9.1.1.2 Assessment to determine admission to the public employment register of disabled persons / additional support with employment (Sweden)

One expert assessment of functional capacity which does not relate to eligibility for a disability pension is the Swedish assessment concerning admission to the public employment register of disabled persons. Individuals who are on the register are entitled to receive extra support with finding and maintaining employment, and the register is a source of statistical data, which is used to plan resource allocation.

An individual does not apply to be placed on the register as such. Rather, an official from the Public Employment Service starts the process of placing a job-seeker on the register. In most cases the official will require a doctor's certificate or certificate from another medical professional who knows the individual, which describes the individual's medical condition and how this affects his or her work capacity, in order to place the individual on the register. Individuals who have congenital deafness or a learning disability and who attended special schools only need to submit proof that they attended such schools to be entered on the register. In these two cases, the assessment is made based on medical evidence or other evidence establishing the existence of an impairment and the official's knowledge of the disabled job-seeker.

Where it is not clear whether the job-seeker has a disability which entitles him or her to additional employment support, the official refers the individual to a specialised assessor at the Public Employment Service. The assessor, who is specialised in work rehabilitation, assesses the individual's capacity for work and related limitations. Assessors can come from a number of different disciplines: psychology, social consultancy, occupational therapy, and specialisms relating to visual and hearing impairments. The assessment takes place through a face-to-face interview and can also involve self-assessment and a variety of tests (e.g. psychological tests mapping

³⁰³ This requirement does not apply to people who are terminally ill.

³⁰⁴ For information on the medical conditions listed in the Social Security Act, see Part III, sub-section 7.1.3 above.

interests and aptitudes, tests for intelligence, logic, spatial ability, language comprehension and mathematical skills and/or examinations by an occupational therapist to test movement, pain, motor skills, comprehension of instructions, and process skills such as problem solving), as well as an examination of the results of previous work trials. A social consultant can also meet with the individual to find out about social factors affecting the job-seeker's capacity to find a job. Therefore, a wide variety of assessment mechanisms exist, and it is up to the specialist assessor leading the assessment to decide on which techniques to use. Research reveals that most assessors regard the face-to-face interview as the most important assessment tool, but that other tests are also used to a considerable extent.³⁰⁵ For individuals who have a social-medical disability, an investigation by another authority, such as the Social Services Department, or by a social consultant at the Public Employment Service, is carried out to confirm the social-medical condition and to determine how this impacts on working capacity. Assessment protocols used by assessors are not publicly available, but staff at the Public Employment Service are provided with training and internal guidance on the assessment process.

After the assessment, the assessor prepares a recommendation on future action, and the Public Employment Service official decides on what action to take. The individual can accept or reject the decision to enter them on the register.

A large number of job-seekers are registered as disabled. In 2016 about a quarter of all job-seekers were in this category (almost 179 500 people).³⁰⁶ Research also reveals that the number of people entered on the register of disabled job-seekers has increased significantly in recent decades.³⁰⁷

In 2006 the Government made changes to elements of the assessment process to include a greater emphasis on environmental factors. Prior to 2006, the term used by the Public Employment Service in relation to job-seekers with disabilities was 'work disabled' ('*arbetshandikappade*'). This covered individuals who had 'a reduced workability due to physical, mental, cognitive or social-medical impairment, which gives or is expected to cause difficulties to get or maintain regular employment'.³⁰⁸ The use of the term 'work disabled' was criticised by disabled people's organisations and in public evaluations.³⁰⁹ The criticism was based on the argument that the term '*arbetshandikappade*' involved an individual model of disability which associated disability with a specific impairment and focused on personal limitations, instead of environmental conditions. The term was also criticised for emphasising a lack of ability instead of the person's actual capacity to work. A Government report of 2003³¹⁰ recommended that the term should be abolished and instead replaced by two terms:

³⁰⁵ Jacobsson, K. and Seing, I. (2013), 'En möjliggörande arbetsmarknadspolitik? Arbetsförmedlingens utredning och klassificering av klienters arbetsförmåga, anställbarhet och funktionshinder', *Arbetsmarknad & arbetsliv*, vol. 19:1.

³⁰⁶ See: <https://www.arbetsformedlingen.se/Om-oss/Statistik-och-publikationer/Rapporter/Arsredovisningar.html>.

³⁰⁷ Jacobsson, K. and Seing, I. (2013), 'En möjliggörande arbetsmarknadspolitik? Arbetsförmedlingens utredning och klassificering av klienters arbetsförmåga, anställbarhet och funktionshinder', *Arbetsmarknad & arbetsliv*, vol. 19:1.

³⁰⁸ Sweden, Ordinance 1991:333.

³⁰⁹ For example in SOU 2003:95.

³¹⁰ Available at: <http://www.regeringen.se/49baf0/contentassets/e3e1b1108a4645c597a431a2fd3a9160/arbetskraft>.

‘reduced work capacity’ and ‘need for special support’. This was implemented by the Government, and the new terminology entered into force on 1 January, 2006.³¹¹ The concept of ‘work capacity’ is not defined in law, but internal documents of the Public Employment Service³¹² establish that ‘work capacity’ is to be determined by assessing the interaction between a job seekers’ individual characteristics, a specific task and the working environment.

Nevertheless, although the new approach involves a greater emphasis on environmental factors, there is still a predominance of the medical perspective in the assessment, as there is a need for a medical statement describing the extent of disability and how it affects the job-seeker’s working capacity. Research also indicates an on-going ‘medicalisation’ of unemployment, as the probability of being registered as a disabled job seeker increases if a job-seeker is assessed as having ‘social problems’ and has a history of long-term unemployment. Studies from IFAU³¹³ evaluating disability registration by the Public Employment Service found a positive correlation between increased age, being a man, having a lower socio-economic position and being registered as a disabled job-seeker. The studies also found that, in cases of long-term unemployment, it became more likely for an individual to be registered as having a psychosocial, socio-medical or learning disability, rather than being registered as having another kind of disability.³¹⁴ This is also reflected in the increase in the number of people registered as disabled, which has been most noticeable for people with psychosocial disabilities and general and specific learning difficulties. The increase has also taken place during periods of falling unemployment. Jacobsson and Seing³¹⁵ therefore argue that the increase in the number of people registered as disabled can be explained through social and organisational relationships, rather than the changing functional capacity of individuals.

Various pieces of research have further identified evidence of the ‘medicalisation’ of unemployment through the registration of people who are long-term unemployed as disabled. Holmqvist examined the assessment and classification process through interviews with officers at the Public Employment Service and concluded that most job-seekers classified as disabled do not identify themselves as disabled and that being unemployed, rather than having any biological impairment or objective disorder, is the main the reason for their being classified as disabled.³¹⁶ Johansson and Skedinger found that the Service’s assessment of disability was more strongly correlated with previously accumulated unemployment than with self-reported assessments of

³¹¹ Sweden, Lag (2006:471) om ändring i lagen (2002:546) om behandling av personuppgifter i den arbetsmarknadspolitiska verksamheten, available at: <http://rkrattsdb.gov.se/SFSdoc/06/060471.PDF>.

³¹² See: https://medicine.gu.se/digitalAssets/1459/1459653_arbetslivsinriktad-rehabilitering--13-sept.pdf.

³¹³ IFAU is a research institute under the Ministry of Labour, which assesses labour market policy and actors influencing labour market policy.

³¹⁴ See: <https://www.ifau.se/sv/Forskning/Publikationer/Working-papers/2014/Factors-associated-with-occupational-disability-classification/>.

³¹⁵ Jacobsson K., and Seing, I. (2013), ‘En möjliggörande arbetsmarknadspolitik? Arbetsförmedlingens utredning och klassificering av klienters arbetsförmåga, anställbarhet och funktionshinder’, *Arbetsmarknad & arbetsliv*, vol. 19:1.

³¹⁶ Holmqvist, M. (2008), ‘Creating the disabled person: A case study of recruitment to ‘work-for-the-disabled’ programme’, *Scandinavian Journal of Disability Research*, vol. 10(3), pp. 91-207.

disability.³¹⁷ A study by Garsten and Jacobsson, based on interviews with employees at the Rehabilitation Department within the Public Employment Service, found similar results and argued that persons experiencing long-term unemployment or barriers to the labour market are registered as disabled in order to obtain extra support.³¹⁸

The IFAU study notes that the Public Employment Service's classification of disability is not an objective one, but rather an administrative measure of impairment or disability, and may therefore contain a measurement error.³¹⁹ The concept of 'reduced work capacity' is somewhat fluid, and is not defined in a definitive way. There is therefore some room for discretion, which can lead to what might be seen as arbitrary assessments. On the part of the Public Employment Service, annual volume and performance targets can influence how many, and which, job-seekers, may optimally register as disabled. Political factors can therefore influence the number of people assessed as disabled.

Overall, the assessment process seems to be open to influence from outside elements, and this appears to indicate and explain a 'medicalisation' of unemployment, whereby individuals experiencing long-term problems on the labour market are classified and registered as having a (psychosocial or social-medical) disability, so that they can obtain additional support on the labour market. It should not be excluded that such external factors are also influencing assessment practices in other Member States.

9.1.1.3 Conclusion on expert assessments

This overview of expert assessments to identify functional capacity in the context of work reflects some of the findings of Ben Baumberg Geiger discussed in Part I, sub-section 2.1.1. above. He argued that assessments can be made by doctors or health professionals who do not have training in occupational health, and referred to the absence of information about what assessors consider to be the general demands of the workplace. He also argued that insurance physicians tend not to mention job requirements explicitly when making individual assessments.

It is notable that, in spite of these four assessments for a disability or invalidity pension discussed in Part III, sub-section 9.1.1 above being ostensibly based on an assessment of functional capacity, and specifically the capacity for work, in practice, in the case of Cyprus, the Czech Republic and Malta, the assessments are highly medically orientated and seem to involve determining whether the applicant has a specific medical condition – and, in the case of Cyprus and the Czech Republic, awarding a disability percentage on the basis of a Barema-like table. It is not clear how the assessment is made in Belgium, as guidance or additional information is not available. Therefore, a clear link with work-related skills and the demands of the labour market does not seem to be made in the assessments.

³¹⁷ Johansson, P. and Skedinger, P. (2009), 'Misreporting in register data on disability status: evidence from the Swedish Public Employment Service', *Empirical Economics*, vol. 37(2), pp. 411-434.

³¹⁸ Garsten, C. and Jacobsson, K. (2013), 'Sorting people in and out: The plasticity of the categories of employability, work capacity and disability as technologies of government', *Ephemera: Theory and Politics in Organization*, vol. 13(4), pp. 825–850.

³¹⁹ See: <https://www.ifau.se/globalassets/pdf/se/2014/r-2014-22-Vilka-arbetssookande-kodas-som-funktionhindret-av-Arbetsformedlingen.pdf>.

In the case of the Swedish assessment to determine eligibility for additional support in the labour market, the assessment is often detailed and carried out by a rehabilitation expert in combination with other experts, who aim to assess all elements of the individual's functional capacity for work. Nevertheless, as with the assessments in Cyprus, the Czech Republic and Malta, much emphasis is placed on medical statements during the assessment. However, societal and structural barriers are clearly considered as well. The Swedish assessment also allows room for considering the perspective of the individual being assessed. These latter elements reflect some promising practice. The exact method of assessment is not transparent, and the assessment protocols are not publicly available.

9.1.2 Structured assessment – disability pension / compensation (Sweden)

As noted in the introduction to this section above, structured assessments involve identifying the applicant's functional capacities, and then comparing them to functional profiles or abilities required for specific jobs. One example of such a structured assessment is the assessment to determine eligibility for the Swedish disability pension / compensation.³²⁰

The pension or compensation takes two forms: activity compensation for people aged 19-30 and sickness compensation for people aged 19-64. Activity compensation is awarded to insured individuals who are unable to work full time in any job due to illness, injury or disability for at least one year. Sickness compensation is awarded to individuals who will never be able to work full-time because of illness, injury or disability. The assessment process for both forms of compensation is very similar. Individuals are assessed as having no reduced working capacity, or a 25 %, 50 %, 75 % or 100 % reduced working capacity. The Social Insurance Agency views the concept of work capacity from a medical insurance perspective,³²¹ and does not take factors external to the individual, such as the labour market situation, or factors related to the economic or social situation of the individual, into account when making the assessment.

In most cases, individuals apply directly to the Social Insurance Agency to obtain one of these benefits.³²² The application must include a medical report from a treating doctor describing the applicant's medical condition. A contact person from the Social Insurance Agency reviews the application and can request additional information, such as a more detailed medical report, from the applicant. The contact person also makes arrangements for a face-to-face meeting with the applicant to discuss their application. This initial contact takes place within one week of the application being submitted.

A key part of the assessment carried out by the Social Insurance Agency is the so-called DFA chain. This consists of obtaining information on three elements:

Diagnosis – the diagnosis of the relevant medical condition or conditions.

³²⁰ A second example is the assessment of the disability pension in the Netherlands, as discussed in Part III, sub-section 11.2 below.

³²¹ See: <http://www.diva-portal.org/smash/get/diva2:1193895/FULLTEXT01.pdf>.

³²² In other cases, the Social Insurance Agency can decide for itself to replace an award of sickness benefit with an award for activity or sickness compensation.

Impairment (*'funktionsnedsättning'*) – identifying the function or functions which are impaired by the medical condition(s) which the applicant has been diagnosed with, and the observations which support this view.

Activity restrictions – identifying the consequences of the diagnosed medical condition(s) and/or impairment(s).

This information is firstly provided by the treating doctor in a medical report. The report should include information regarding the views of the applicant. Activity restrictions are to be described in terms of the consequence of specifically diagnosed medical conditions, based on observations made during a medical examination and linked to an identified impairment. It should be reasonably foreseeable that an identified activity restriction could result from the diagnosed condition. The Social Insurance Agency then makes the DFA assessment based on this information.

In cases where the Social Insurance Agency requires more information, the Agency can arrange for the applicant to be assessed by a specialised insurance physician,³²³ in which case the Agency carries out an Activity Ability Assessment (*aktivitetsförmågeutredning*, AFU) or Insurance Medical Examination.³²⁴ This assessment method has been in use since 2010. The assessment is intended to identify in detail the consequences of the disease or impairment for the applicant's functioning and ability to work. The medical assessment is carried out by one of the approximately 100 insurance physicians employed by the Social Insurance Agency, who also assist the Agency's officers to understand and interpret medical information submitted by applicants. The officer of the Social Insurance Agency then uses the results of the medical examination to identify what capacity the applicant has to work and to complete the assessment.

The AFU is a standardised assessment method which is intended to provide comprehensive information on the applicant's impairments and activity restrictions, as well as on the applicant's remaining work capacity. The assessment consists of three parts: a medical examination; the applicant's self-reported assessment of ability and their view regarding opportunities to work; and a comparison of the collected information with a 'knowledge base' of skills needed to carry out specific jobs in the labour market. As with the medical report submitted by the treating physician, the medical examination aims to identify the applicant's diagnosis, impairment and related activity restriction. The SIA's guidelines³²⁵ provide information on how to assess the latter two elements:

Impairment

An impairment means a loss or a deviation in physical or mental function. Functions are the different abilities of the body, such as being able to tense a

³²³ Depending on the expertise required, the assessor can be a specialised insurance physician, psychologist, physiotherapist or occupation therapist. All assessors have received the Social Insurance Agency's basic training in insurance medicine.

³²⁴ See: https://www.forsakringskassan.se/!ut/p/z0/hcoxDslwDEDRszB4rBLExIYhLgBL1QWZxhQT6kR2Eq7fHqAS43_6bnSDGwUbz1g4CX63Hn7Tcs5Y3nA89eAvSQpJuV8fN7KcxLgRePvU2FAD-FdSw6gssy0UeGLZM4vY1aIUZENU8FqfyrH7e7oc-8MK4ugLTw!!/.

³²⁵ See: <https://www.forsakringskassan.se/sjukvard/sjukdom/utlatande-for-sjukersattning>.

muscle or focus attention. Functional impairment is when a function is reduced compared with the normal range of ability. The reduction should be a detectable variation from what can be considered normal. Such impairments that are not possible to observe directly can be clarified by observation of the patient's behaviour. For example, the doctor may pay attention to memory and concentration difficulties through targeted questions or standardised questions and tests. The doctor can note if the patient has difficulty maintaining the thread of conversation or forgets what has just been discussed.

Activity restriction

The activity restriction is the consequence of a disease or impairment for the individual's ability to work. The assessment of the activity restriction should be carried out in relation to what can be expected in daily life or for a particular task. In the medical report the doctor should describe the activity restrictions caused by the impairment.³²⁶

The assessors – whether treating physicians or Social Insurance Agency insurance physicians – can consult the National Board of Health and Welfare's recommendations³²⁷ for sick leave based on illnesses and conditions. This provides information about activity restrictions commonly linked to specific medical conditions.

The first stage of the AFU assessment involves a meeting between the applicant and a Social Insurance Agency officer, who informs the applicant about the assessment process. The applicant is asked to sign a consent form and to complete a self-assessment form on current and expected future work ability.³²⁸ Subsequently, additional information from the treating physician may be requested.

The second stage of the assessment involves an interview and medical examination carried out by a Social Insurance Agency insurance physician. The previously completed self-assessment form and medical information received from the treating physician serve as starting points for the interview and medical examination, which can also involve further medical tests. The medical examination is carried out in accordance with a manual and the results are recorded on a special form.³²⁹ The examination assesses the applicant's abilities related to physical functions, physical strength and mobility as well as physical endurance, their abilities related to vision, speech and hearing, their abilities related to balance, coordination and fine motor skills, and their abilities related to mental functions, learning, memory, concentration and executive and affective function as well as mental endurance.

The assessment also involves an interview with the applicant, based on the content of the self-assessment form. In addition, the physical and psychological status of the applicant is examined. If the applicant has a psychiatric diagnosis, he or she undergoes a structured neuropsychiatric interview, based on several established assessment

³²⁶ Some examples of how this assessment is applied with regard to specific impairments (motion and pain) are given in the ANED country report for Sweden.

³²⁷ See: <https://roi.socialstyrelsen.se/fmb>.

³²⁸ This covers expected work ability in the subsequent six months.

³²⁹ FK7269, available at: https://www.forsakringskassan.se/wps/wcm/connect/ee9248d0-b479-4e0e-b6b1-7bdc2a28e4e9/FK7269_006_F_002.pdf?MOD=AJPERES&CVID=.

instruments. All the results are summarised in an overall description of the diagnosis, the impairment and the link made between the diagnosis, impairment and activity restrictions, as well as the individual's own view of the opportunities to work. The description also notes whether the individual agrees with the assessment or not. More detailed examinations can be conducted if some of the required information is missing. These examinations make use of standard tests (e.g. WAIS IV and AWP)³³⁰ and instruments, and are reported on a special form.³³¹ The insurance physician has a final follow-up meeting with the applicant to inform him or her of the results of the medical assessment, and it is recorded whether the applicant agrees with the assessment.

The last part of the assessment is carried out by Social Insurance Agency officials, who determine the applicant's ability to work on the basis of the medical assessment. They do this using a 'knowledge base'.³³² The 'knowledge base' describes the relevant requirements or abilities needed to carry out a wide variety of jobs based on the four groups of abilities which are assessed by the insurance physician during the medical examination: physical functions; vision, hearing and speech; balance, coordination and motor skills; and mental functions. The assessment of an individual's ability to work involves identifying the activity limitations that an individual has, and links that to the abilities needed to work in specific sectors. Individuals are assessed on a five-point scale, ranging from 0, which equates to no activity limitation, to 4, which implies significant or total incapacity in a specific field. The 'knowledge base' includes lengthy descriptions of abilities needed to carry out particular forms of work and relevant activity limitations. An example of the information contained in the 'knowledge base' relating to one particular kind of job (work as a receptionist or providing customer service), is included in the Swedish ANED country report. Social Insurance Agency officials must have received specialised training in order to make the AFU assessment and use an internal guidance document, which explains the relevant laws and regulations, case law and the Agency's legal task. The guidance also describes how to handle cases and the methods to be used to maintain efficiency and quality.³³³ Guidance for the general public on how to apply for a disability pension and on the assessment process is available via the Social Insurance Agency homepage.³³⁴

The number of assessments carried out for activity compensation has increased from just over 8 800 in 2011 to over 10 500 in 2016.³³⁵ Applications for sickness compensation decreased in 2011, but then increased again in 2015 and 2016. The proportion of rejected applications has increased for both forms of compensations in recent years. In February 2016, approximately 342 000 people received sickness compensation or activity compensation. In February 2017 the number had fallen to almost 329 000, with just over 290 000 people receiving sickness compensation and

³³⁰ See: https://www.forsakringskassan.se/wps/wcm/connect/9dd66268-5dfb-4d37-809c-30fe96a67101/manual_utvidgad_undersokning_2013.pdf?MOD=AJPERES.

³³¹ FK7431, available at: https://www.forsakringskassan.se/wps/wcm/connect/e9d75a25-b5e0-467c-9475-bd87eddee725/FK7431_001_F_002.pdf?MOD=AJPERES&CVID=.

³³² See: https://www.forsakringskassan.se/wps/wcm/connect/8288c5c8-3524-4a00-b6ce-e45c782bba2e/kunskapsunderlaget_131108.pdf?MOD=AJPERES.

³³³ See: <https://www.forsakringskassan.se/wps/wcm/connect/3f5ddb79-86a0-462f-a56e-e80001a418a7/vagledning-2013-02.pdf?MOD=AJPERES>.

³³⁴ See: www.forsakringskassan.se.

³³⁵ Statistics in this part are presented in this report: <https://www.forsakringskassan.se/wps/wcm/connect/e4bd4374-6d2f-414d-ae0f-091117c14eed/regeringsuppdrag-nybeviljande-av-sa.pdf?MOD=AJPERES&CVID=>.

almost 39 000 people receiving activity compensation. This is the lowest level since 2003, when the compensation schemes were introduced. The decrease relates to awards of sickness compensation, as the number of people transitioning to the old-age pension exceeds the number of people who are awarded sickness compensation, and fewer new applications are being approved. The number of people receiving sickness compensation is decreasing by about 4 % each year, while the number of people receiving activity compensation is increasing by approximately 10 % on average per year.

Research reveals that processing times have become longer for several of the Agency's more investigative assessments, such as sickness compensation and activity compensation.³³⁶ In 2016, only 60 % of sickness insurance cases were concluded within the target of 120 days. The Agency has stated that its efforts to improve the accuracy of assessments has meant that applications are taking longer to process. The time needed for reassessment has also increased, and the Agency is failing to keep up with the increased inflow of cases. The number of applications is increasing because insured persons are now more likely to receive a negative decision and subsequently apply for reassessment or appeal. In light of these factors, the Social Insurance Agency claims that it requires the equivalent of 10 additional full-time officers to meet the demand.³³⁷

In spite of applying such a detailed assessment process, there seem to be significant problems with the quality of the assessments carried out. Quality monitoring carried out by the legal department at the Social Insurance Agency reveals that the assessment process needs to be improved.³³⁸ In the case of activity compensation, quality monitoring has revealed that in nearly one-third of the cases examined, the assessment procedure was incorrect. In cases where the assessment procedure was considered to be correct, the final decision was considered to be doubtful in almost half the cases. The monitoring indicated that there was scope to improve the consultations carried out by the insurance physicians when meeting applicants, and that the quality of the final written reports prepared by the insurance physicians needed to be improved.

Further evidence comes from the Swedish Social Insurance Inspectorate (ISF), which has the task of reviewing the quality (legal certainty) and appropriateness of individual decisions.³³⁹ An ISF review revealed differences in medical assessments concerning

³³⁶ See: http://www.inspsf.se/publicerat/Publikation+detaljvy//forsakringskassans_produkativitet_och_effektivitet_2016.cid6172.

³³⁷ See: https://www.riksrevisionen.se/download/18.78ae827d1605526e94b2ddac/1518435506867/RiR_2015_07_Aktivitetsters%C3%A4ttning_Anpassad.pdf.

³³⁸ See: <https://www.forsakringskassan.se/wps/wcm/connect/0f426dc9-8ed1-4146-a1b5-2d7d5b233301/rattslig-uppoljning-2016-06.pdf?MOD=AJPERES&CVID=>; and https://www.forsakringskassan.se/wps/wcm/connect/50ee2e96-c40c-44de-b3e4-43cdbc2f44d/Likformiga_och_rattssakra_beslut_om_sjukersattning.pdf?MOD=AJPERES&CVID=.

³³⁹ The ISF describes its objectives as follows: 'The Swedish Social Insurance Inspectorate (*Inspektionen för social-försäkringen, ISF*) is an independent supervisory agency for the Swedish social insurance system. The objectives of the agency are to strengthen compliance with legislation and other statutes, and to improve the efficiency of the social insurance system through system supervision and efficiency analysis and evaluation'.

men and women who had undergone an AFU.³⁴⁰ The differences related in particular to assessments of strength, mobility and mental endurance. ISF recommended that the Social Insurance Agency should investigate this further to establish if the assessment method treats men and women equally, or whether it tends to disadvantage or fail to accurately assess in the case of one sex.

The ISF review showed that the AFU and the related 'knowledge base' need quality assurance. The 'knowledge base', which matches specific skill sets with particular jobs, is based on a theoretical and gender-neutral labour market, not on the real, highly gender-segregated Swedish labour market. Furthermore, the 'knowledge base' is not quality assured regarding the validity of the skill levels for work capacity in the occupational areas which it covers, so there is a risk that a set of skills indicated as being sufficient for a certain kind of work is in fact not sufficient. The ISF review also showed that there were significant shortcomings in the quality assurance of the assessments made in the AFU. The shortcomings relate to the reliability of the assessments carried out by insurance physicians and officers at the Social Insurance Agency and, secondly, to the issue of whether officers were able to use the medical assessments provided by the insurance physicians to identify accurately applicants with a reduced work capacity who were able to return to work. This implies that there is a significant risk that assessments of applicants are not being done in a uniform manner through the AFU. The ISF review also reported that there are shortcomings in the 'knowledge base', based on the facts that the various components of the 'knowledge base' have not yet been validated, and that the 'knowledge base' is not yet fully developed and does not cover all occupational areas in the labour market. The ISF therefore believes that the reliability of the current version of the 'knowledge base' is questionable.

Since there is no documentation on individual cases, it is not possible to check if the AFU assesses the ability of applicants to work in jobs which are usually present in the labour market. The ISF believes that clear and systematic guidelines are needed to identify when and in what cases AFU is a suitable assessment tool. Clear guidelines and continuous competence development are needed in order to support the Social Insurance Agency officers and to enable them to achieve a more unified assessment process. In addition, according to the ISF review, documentation in case records needs to be improved, both to achieve transparency in the assessment and decision-making process and to enable AFU follow-ups and evaluations.

Lastly, an audit by the Swedish National Audit Office of the processing of activity compensation claims revealed that officers at the Social Insurance Agency usually prioritise processing of applications for activity compensation over follow-up and coordination when there is a shortage of time.³⁴¹ This is due, among other things, to the fact that the Agency collects internal statistics on how many applications are processed on time, but no corresponding statistics are collected on follow-up and coordination.

³⁴⁰ See: http://www.inspsf.se/digitalAssets/5/5636_3summary_2016-4.pdf.

³⁴¹ See: https://www.riksrevisionen.se/PageFiles/22157/RiR_2015_07_Aktivitetsters%c3%a4ttning_Anpassad.pdf.

In conclusion, the AFU assessment adopts a medical-functional methodology. The individual's perspective is taken into account as the applicant carries out a self-assessment of activity restrictions. The capabilities needed to carry out specific jobs are taken into account and, together with the individual's diagnosis and activity restrictions, these form the basis for the assessment. The assessment recognises that disability is partly caused by environmental factors. There are detailed guidelines, many of which are available to the public, and a clear structure for making assessments seems to have been identified. This is in contrast to many of the other assessment methods identified in this report. However, quality evaluations show that the AFU can be criticised for not being conducted in a uniform manner, and there are inadequacies in terms of the database ('knowledge base'), which identifies job-related skills, both in terms of checking the AFU's accuracy (quality assurance) and in ensuring that it only covers a selection of jobs on the labour market.

This assessment system reflects a degree of complexity which is not apparent in most of the other assessment mechanisms considered in this synthesis report. This reflects the fact that it seeks to do the difficult job of identifying the specific functional limitations that an individual has, and of identifying the impact of these limitations on people carrying out real work in the labour market. This assessment approach might come close to that called for by Bickenbach et al., who have argued for a form of assessment which directly assesses an individual's capacity to work and which recognises that disability results from an interaction between functional limitations and the particular demands of an individual's work environment.³⁴² However, it is unclear whether the Swedish assessment method pays sufficient attention to the interaction between functional limitations and environmentally created barriers in the work environment. In the view of the Swedish country expert for ANED,³⁴³ the assessment method seems to mostly take into account physical and individual abilities/hindrances, and does not take into account the psychosocial environment, such as attitudes, information and communication and support from others, which are also part of the work environment. According to the ANED country expert, the AFU is, in this sense, reductionist, and fails to take into account the highly important psychosocial environment and its impact on an individual's ability to work.

9.1.3 Assessments of capacity to carry out activities of daily living for the purpose of awarding benefits linked to reduced working capacity

This synthesis report has identified a number of functional capacity assessments which seek to identify a person's capacity to carry out activities of daily living, and to use this assessment as the basis for determining their eligibility to receive a benefit which is linked to reduced working capacity, such as a disability pension. In these cases, it is a person's capacity to carry out daily activities that are assessed, and this is regarded as the basis for assessing their ability to work. The ability to carry out activities of daily living is seemingly treated as a proxy or indicator for work-related capacities. The underlying assumption is that, if an individual has difficulty undertaking basic activities needed for daily life, they will also have difficulty undertaking work. Such assessments have been identified in Greece, Iceland, Latvia, Malta and the United Kingdom. All

³⁴² Bickenbach, J., Posarac, A., Cieza, A., Konstanjsek, N. (2015), *Assessing Disability in Working Age Population: A Paradigm Shift from Impairment and Functional Limitation to the Disability Approach*, World Bank.

³⁴³ Johanna Gustafsson.

assessments could result in the applicant being awarded a cash benefit on the grounds that they have a reduced capacity or complete incapacity to work for a reason related to a disability.

9.1.3.1 Pilot assessment for disability welfare benefits (Greece)

An assessment of the ability to carry out activities needed in daily life forms the basis of an assessment being used in Greece, which is currently being piloted in one region. The assessment is being carried out in addition to the standard assessment used with regard to disability welfare benefits, which is based on the Barema method and is discussed in Part III, sub-section 8.2 above.

The pilot assessment was established by Law 4512/2018³⁴⁴ for the assessment of disability welfare benefits.³⁴⁵ The pilot is implemented by KEPA, which is also responsible for carrying out standard Barema-based assessments. Under the pilot, KEPA must now also assess an applicant's functional capacity in performing daily activities using the WHODAS 2.0 questionnaire. The pilot assessment applies to individuals who have applied for welfare benefits for the first time between February and June 2018 in the Region of Attica, which includes the city of Athens.

For the purposes of the pilot, the existing KEPA health committees which carry out assessments additionally consist of a rehabilitation physician or occupational doctor who, 'in collaboration with candidate' completes the 12-item WHODAS 2.0 questionnaire 'regarding limitations faced in daily life activities, his/her current living conditions, the nature and range of the living conditions and obstacles to full social inclusion'.³⁴⁶ The findings of the questionnaire are annexed to the final decision and are taken into account in the assessment. No further guidance on how KEPA health committees are using the questionnaire is available, other than the WHODAS 2.0 questionnaire itself.³⁴⁷ Therefore, at the time this report was completed, it was not clear how the new assessment method is being interpreted and implemented in terms of eligibility for disability benefits.

It is worth noting that the 'introduction of the concept of functionality in the disability certification process' was rather negatively received by the National Federation of Disabled People, which represents a number of disabled people's organisations across the country. The Federation stated that the pilot assessment 'can only be acceptable' if the new process does not involve changing eligibility criteria, reducing disability benefits or disrupting the existing certification process.³⁴⁸ Other disabled people's

³⁴⁴ Greece, Article 215, Law 4512/2018, available at: http://opeka.gr/wp-content/uploads/2018/02/pilotiko-pronomiakon-paroxon-atoma-me-anapiria-215_n4512-2018.pdf. See also the Ministerial Decision at: <http://opeka.gr/wp-content/uploads/2018/02/KYA-atoma-me-anapiria.pdf>

³⁴⁵ These are benefits available to people who do not have insurance. See list of benefits provided at: <https://opeka.gr/atoma-me-anapiria/pliories/>.

³⁴⁶ See: <https://www.dikaiologitika.gr/eidhseis/asfalish/191122/vima-vima-to-pilotiko-programma-ton-pronoiakon-epidomaton-anapirias>.

³⁴⁷ See: <http://www.who.int/classifications/icf/whodasii/en/>.

³⁴⁸ National Federation of Disabled People press release, 12 January 2018, available at: <http://esaea.gr/pressoffice/press-releases/3691-i-esamea-gia-to-polynomosxedio-sti-boyli-i-apaitisi-ton-daneiston-tis-xoras-gia-tin-eisagogi-tis-leitoirgikotitas-stin-pistopoiisi-tis-anapirias-einai-paralogi-adikaiologiti-kai-exthriki>.

organisations also expressed concern about the assessment used in the pilot project. For instance, the National Federation for the Rights of People in the Autistic Spectrum (EODAF) informed Parliament and relevant stakeholders that, in its view, the WHODAS 2.0 tool focuses on functionality and intelligence, and fails to capture limitations in the case of autism. They regarded this approach as threatening to lead to a reduction in benefits to the detriment of people on the autistic spectrum. The Federation further emphasised that ‘the complex structure of assessment criteria, the huge social and cultural deviation, and the high specialisation (i.e. of the assessors) required’ make the assessment process ‘impossible to be implemented in the right way in the Greek State’.³⁴⁹ The issue of ‘cultural deviation’, as the EODAF terms it, is a controversial issue for disabled people’s organisations in Greece. They fear that the new assessment method will focus on individual functionality, but that this will be stripped of contextual factors, and will potentially be interpreted in a way that effectively reduces eligibility for disability benefits. An example illustrating this fear is given in an interview reported by Antonia Pavli, noting that a blind person who stays at home may be assessed as ‘eligible for an escort’, whereas a blind person who has a job or studies at university, despite facing obstacles and possibly using their own resources, may be deemed functional and thus assessed with a lesser percentage of disability or need for support.³⁵⁰ However, it should be noted that these concerns were expressed before the pilot was launched, and it is possible that actual experiences have been more positive than initially envisaged.

9.1.3.2 Assessment for disability pension (Iceland)

An assessment of the ability to carry out activities needed in daily life forms the basis of the assessment used in Iceland to determine eligibility for the disability pension (*Örorkulífeyrir*). The application is initiated when the applicant’s general practitioner, in agreement with the applicant, sends an initial assessment, containing information on the applicant’s impairment, to the Social Insurance Administration (*Tryggingastofnun*). The applicant is then required to complete and submit a questionnaire, which is available online.³⁵¹ The questionnaire covers fifteen activities, such as sitting on a chair, bending or kneeling, reaching for objects, eyesight, speech and mental problems and, for each activity, the applicant is asked to indicate whether they experience difficulties. Subsequently, the applicant has a face-to-face meeting with an insurance physician. At this meeting the physician administers a points-based assessment (*Örorkumat*), which is a functional capacity measure which seeks to assess the individual’s ability to perform daily tasks.³⁵² The applicant must receive a rating of either 15 points from the physical component of the test, 10 points from the mental

³⁴⁹ EODAFF/ EDAAF, ‘2018 Briefing Paper for the Rights of People in the Autistic Spectrum’, p. 22, available at: <https://www.noesi.gr/post/ypomnima-goneon-melon-thesmikon-foreon-gia-ta-atoma-diatarahi-ayistikoy-fasmatos-08022018>.

³⁵⁰ Pavli, A. (2017), *Creative Disability Classification Systems: The Case of Greece 1990-2015*, PhD thesis, Swedish Institute for Disability Research, Örebro University, p. 171. The full text is available at: <http://www.diva-portal.org/smash/get/diva2:1098338/FULLTEXT01.pdf>.

³⁵¹ The questionnaire is available on the website of the Social Insurance Administration (in Icelandic at: [Örorkumatsstaðall](https://www.orkumat.is/)), or in English in the form of a [Word.doc](#).

³⁵² The Icelandic system (<https://www.tr.is/oryrkjar/ororkumatsstadall/>) draws heavily on the UK’s older PCA (Personal Capability Assessment) questionnaire. Basic tests include those on how long someone can you walk or stand. If a person cannot stand up from a seated position, for instance, they receive 15 points; 7 points if they need to hold on to something to stand up and 0 points if they have no problem standing up. Although the PCA was replaced by the Work Capability Assessment in the United Kingdom in 2008, Iceland has not followed suit.

component, or at least 6 points from each section to be evaluated as having a 75 % 'invalidity', which will lead to entitlement to a full disability pension (*Örorkulífeyrir*). Individuals who are assessed as having a lesser degree of disability or 'invalidity' may still be eligible to receive some benefits in the form of 'disability allowances'. Once this stage of the assessment has been completed, the information from the treating doctor and the information from the assessment conducted by an insurance physician, in addition to the information provided by the individual, is assessed by the senior physician (*Is. yfirlæknir*) of the Social Insurance Administration. The applicant is informed of the decision by letter.

The information derived from this assessment process provides information on how the individual copes with tasks involved in daily life, but does not address specific work-related questions.

In carrying out the assessment, the Social Insurance Administration, which falls under the Ministry of Welfare, is subject to Social Security Act No. 100/2007 and Regulation 379/1999³⁵³ concerning disability pension assessments. Specific information about the assessment carried out by the insurance physician and the application of the points-based system is available online.³⁵⁴

The Icelandic government does not provide information about the number of people who undergo assessments for the disability pension, or about the number or percentage of people who are assessed as eligible or ineligible. Information on waiting time for assessments is not publicly available either.

In recent years the Ministry of Welfare has been investigating the possibility of replacing the current system (a functional capacity assessment regarding activities of daily living), which has been in place since 1999, with a work capability assessment (*Is. starfsgetumat*). A conference in the autumn of 2017³⁵⁵ sought the views of the ministry, rehabilitation specialists, disability activists and disabled people's organisations, and revealed a consensus that the existing assessment system was problematic, overly complicated and flawed in various ways. However, the rehabilitation sector supported replacing the current medicalised system with one which emphasised rehabilitation and employment participation. In contrast, looking at the experience outside of Iceland, activists remained suspicious about whether a work capacity assessment method would result in any substantive change, other than potentially reducing the number of these people for the purposes of benefits, with little attention paid to the reality of labour market conditions for disabled people. These points mirror some of the concerns of sections of the Greek disability movement regarding the introduction of WHODAS 2.0 discussed above (Part III, sub-section 9.1.3). Icelandic disability activists called for any future system to take the requirements of the CRPD into consideration.

9.1.3.3 Assessment for multiple purposes, including eligibility for a disability pension and registration as a disabled person (Latvia)

³⁵³ See: <https://www.reglugerd.is/reglugerdir/allar/nr/379-1999>.

³⁵⁴ See: <https://www.tr.is/oryrkjar/ororkumatsstadall/>.

³⁵⁵ Information available at: <https://www.virk.is/is/moya/news/starfsgetumat-stadan-og-naestu-skref>.

In Latvia, the assessment of adults for multiple purposes, including to determine a person's eligibility to receive a disability pension and to be registered as a disabled person, is based on a combination of medical diagnosis and an assessment of functional limitations. Functional limitations are assessed with regard to a number of daily activities, although the assessment itself indicates a loss of working ability expressed in percentage terms. The assessment is regulated by the Disability Law³⁵⁶ and the Regulations Regarding the Criteria, Time Periods and Procedures Determining Predictable Disability, Disability, and the Loss of Ability to Work.³⁵⁷ In this context, a disability is defined as 'a long-term or non-transitional very severe, severe or moderate level limited functioning which affects a person's mental or physical abilities, ability to work, self-care and integration into society'.³⁵⁸ As an alternative to being assessed as 'disabled', applicants can be assessed as having a 'predictable disability', which is 'a limited functioning caused by a disease or trauma which, in cases where the required medical treatment and rehabilitation services are not provided, may be a reason for determining disability (i.e. officially recognising someone as having a disability)'.³⁵⁹ This overview describes the process for assessing the 'disability' of adults; additional information on the assessment of a 'predictable disability', which is similar to the assessment of 'disability', may be found in the ANED country report for Latvia.

Individuals who are assessed as disabled are divided into three groups, based on the assessed reduced ability to work:

Group I disability, where the loss of ability to work is 80-100 % – very severe disability;
 Group II disability, where the loss of ability to work is 60-79 % – severe disability;
 Group III disability, where the loss of ability to work is 25-59 % – moderate disability.

The assessment is carried out by the State Medical Commission for the Assessment of Health Condition and Working Ability (hereafter: Commission), which is a public institution operating under the Ministry of Welfare.³⁶⁰ In order to apply for a disability assessment, an individual or his or her legal representative submits an application to the Commission. This consists of a number of documents: a referral to the Commission made by a medical doctor treating the applicant;³⁶¹ a self-assessment of functional ability; a sick-leave certificate B,³⁶² if this has been issued; and other documents, such

³⁵⁶ Latvia, Disability Law, 2010, available at: <https://likumi.lv/doc.php?id=211494>.

³⁵⁷ Latvia, Regulations Regarding the Criteria, Time Periods and Procedures Determining Predictable Disability, Disability, and the Loss of Ability to Work, Regulation No.805, 2014, available at: <https://likumi.lv/ta/id/271253-noteikumi-par-prognozejamas-invaliditates-invaliditates-un-darbspeju-zaudejuma-noteikšanas-kriterijiem-terminiem-un-kartibu>.

³⁵⁸ Latvia, Section 5. Disability, Disability Law, 2010, available at: <https://likumi.lv/doc.php?id=211494>.

³⁵⁹ Latvia, Section 4. Predictable Disability, Disability Law, 2010, available at: <https://likumi.lv/doc.php?id=211494>.

³⁶⁰ State Medical Commission for the Assessment of Health Condition and Working Ability; see: <http://www.vdeavk.gov.lv/en/about-us/about-the-institution/>.

³⁶¹ Form No. 088/u 'Referral to the State Medical Commission for the Assessment of Health Condition and Working Ability'. Latvia, Regulation No. 265 Procedures for Keeping Medical Documents (2006); see: <https://likumi.lv/ta/id/132359-medicinisko-dokumentu-lietvedibas-kartiba>.

³⁶² According to the Medical Treatment Law (1997, available at: <https://likumi.lv/doc.php?id=44108>) and Regulation No.152 Procedures for Issuance of Sick-Leave Certificates (2001, available at: <https://likumi.lv/ta/id/6675-darbnespajas-lapu-izsniegšanas-kartiba>), in general cases a family doctor or an attending doctor initially issues a sick-leave certificate A, should the period of work disability continue for no longer than 14 days. (This sickness period is paid for by the employer.) If

as additional medical reports, if the assessor (an expert medical doctor) or the applicant thinks these are needed. The application can be made by post or online. Other information can be obtained from online medical records, the applicant's employer, an educational institution, or a state or local government institution.

The referral³⁶³ from the treating doctor must indicate the conditions which the applicant has been diagnosed with according to the 2010 International Classification of Diseases; describe the health disorder, previous treatment and diagnostic tests and expected prognosis; list periods of inability to work in the previous six months linked to the applicant's health condition; and indicate the reason for the referral (e.g. for assessment for disability or predictable disability, indication for special care needs, indication for support to acquire an adapted vehicle or transport allowance etc.). The referral is valid for two months from the date of submission. When filling in the referral form, the treating doctor can be assisted by the 'Criteria for Health Disorders Assessment'³⁶⁴ and Recommendations for filling in the referral form,³⁶⁵ which are available on the Commission's website. The 'Criteria for Health Disorders Assessment' includes classifications of different diseases according to the International Classification of Diseases (2010) and descriptions of functional disorders according to the International Classification of Functioning, Disability and Health (ICF). This document also identifies the necessary medical examinations that justify diagnosis and functional disorders. The Recommendations advise doctors what kind of information should be included in the form.

As noted above, the documentation submitted as part of the application also includes a self-assessment form completed by the applicant. This has only been a part of the assessment since 2015. If the applicant is unable to fill in this form, it can be completed by an authorised person, social worker or treating doctor. The self-assessment form is available at doctors' surgeries and on the Commission's website.³⁶⁶ The first part of the form asks for basic information about the applicant, including their employment history over the previous three years. The second part of the form contains questions relating to 19 activities, and the applicant has to evaluate the difficulty they have carrying out the relevant activities on a five-point scale (ranging from no difficulty to very severe difficulty). The 19 activities include understanding and communication; mobility; self-care; and home life and work, and each activity is broken down into a number of separate activities. The self-care activity, for example, covers washing, dressing, eating and staying alone for a few days. Applicants can indicate what problems they have in carrying out specific activities and can include additional information in the form. When determining the degree of difficulty, applicants should note whether the performance of the activity requires major effort or leads to discomfort or pain, the speed at which they can perform the activity, and if the way in which the

the work disability continues for more than 14 days, the doctor issues a sick-leave certificate B. (This sickness period is paid for by the State Social Insurance Agency.)

³⁶³ Form No. 088/u 'Referral to the State Medical Commission for the Assessment of Health Condition and Working Ability. Latvia, Regulation No. 265 Procedures for Keeping Medical Documents (2006); see: <https://likumi.lv/ta/id/132359-medicinisko-dokumentu-lietvedibas-kartiba>.

³⁶⁴ The State Medical Commission for the Assessment of Health Condition and Working Ability; see: <http://www.vdeavk.gov.lv/informacija-par-procesu-pie-gimenes-arsta/>.

³⁶⁵ The State Medical Commission for the Assessment of Health Condition and Working Ability; see: <http://www.vdeavk.gov.lv/informacija-par-procesu-pie-gimenes-arsta/>.

³⁶⁶ The State Medical Commission for the Assessment of Health Condition and Working Ability; see: <http://www.vdeavk.gov.lv/eksportizei-nepieciesamie-dokumenti/>.

activity is performed has changed as a result of a health condition. The self-assessment should only indicate difficulties that arise due to health reasons. Additional supporting materials, including the booklet 'Evaluate what you have'³⁶⁷ and the video also entitled 'Evaluate what you have'³⁶⁸ are available on the Commission's website.³⁶⁹

The assessment is carried out by an expert medical doctor (similar to an insurance physician) on the basis of the documentation submitted. In general, the applicant does not meet with the expert medical doctor who carries out the assessment. A face-to-face meeting is only held as part of the assessment in cases where the documentation submitted provides insufficient evidence or is contradictory. In making the assessment, the insurance physician takes into account the diagnosed health disorders and functional restrictions of the applicant. The assessment is based on the information contained in the application and related (medical) documentation, the assessor's expert knowledge and experience, and the criteria set out in Regulation No. 805 (Criteria for Assessment of Health Disorders and Functional Abilities.)³⁷⁰ This Regulation describes how the assessment is to be carried out.³⁷¹

The 'Criteria for Assessment of Health Disorders and Functional Abilities' document includes assessment tables of health disorders and functional abilities relating to adults. In order to determine the severity of health disorders, information on symptoms, and the results of physical examinations and laboratory investigations are taken into account. A mild health disorder exists if the symptoms are controlled by treatment or mild symptoms are periodic, regardless of treatment, and physical findings are normal, or if a mild physical impairment exists on a periodic basis and there is no change or a slight change periodically. A moderate health disorder exists if mild symptoms persist despite continuous treatment, or if moderate symptoms exist periodically despite continuous treatment and the results of physical examinations reveal mild or periodically moderate symptoms and slight changes or periodic moderate changes, as measured through laboratory investigations. A severe health disorder exists in cases where, despite continuous treatment, moderate symptoms persist, or there are severe symptoms on a periodic basis and a physical examination reveals moderate or periodically severe symptoms, and if moderate changes or periodically severe changes remain, as measured by laboratory investigations. A very severe health disorder exists in cases where, despite continuous treatment, severe symptoms persist or there are very severe symptoms periodically, and physical examinations reveal severe or periodically very severe symptoms, and if severe changes or periodically very severe changes are revealed by laboratory investigations.

³⁶⁷ 'Evaluate what you have' booklet, the State Medical Commission for the Assessment of Health Condition and Working Ability, available at: http://www.vdeavk.gov.lv/wp-content/uploads/2014/11/Noverte_A5buklets_viegls.pdf.

³⁶⁸ 'Evaluate what you have' video, the State Medical Commission for the Assessment of Health Condition and Working Ability, available at: https://www.youtube.com/watch?v=L0s_S5q0sLY&feature=youtu.be.

³⁶⁹ The State Medical Commission for the Assessment of Health Condition and Working Ability; see: <http://www.vdeavk.gov.lv/iesniegums-un-funkcionalo-speju-pasvertejuma-anketa/>.

³⁷⁰ Criteria for Assessment of Health Disorders and Functional Abilities, Annex 5, Regulation no. 805 – Regulations Regarding the Criteria, Time Periods and Procedures Determining Predictable Disability, Disability, and the Loss of Ability to Work, 2014, available at: <https://likumi.lv/ta/id/271253-noteikumi-par-prognozejamas-invaliditates-invaliditates-un-darbspeju-zaudejuma-noteiksanas-kriterijiem-terminiem-un-kartibu>.

³⁷¹ The assessment criteria are described in the section headed 'Sources of official guidance and assessment protocols' pp.18-20.

The assessment table of functional abilities includes functional domains and categories in line with the ICF. Categories covered include: specific mental functions, sensory functions and pain, cardiovascular, haematopoietic, immune and respiratory system functions, nervous-musculoskeletal and motion-related functions, learning and knowledge use, communication, mobility, self-care, interaction and relationships with other people. Restrictions are assessed on a five-point scale, ranging from 0, which equates to no restriction, to 4, which equates to very severe restriction. When performing the assessment of functional abilities and determining the degree of functional or activity restriction, the assessing expert medical doctor should take into account how the restriction manifests itself, the performance of the activity, the pace of activity, the energy consumed, and the result achieved.

In addition to the 'Criteria for Assessment of Health Disorders and Functional Abilities', a number of other guidance instruments are intended to promote uniformity in the assessment results. These are the Commission's internal regulations, the Procedure of the State Medical Commission for the Assessment of Health Condition and Working Ability ensuring provisions regarding the application of the Criteria defined in Annexes 3, 4, 5 and 6 of the Regulations of the Cabinet of Ministers of 23 December 2015, and Regulation No. 805 Regarding the Criteria, Time Periods and Procedures Determining Predictable Disability, Disability, and the Loss of Ability to Work. These rules are used by all assessors.

Once the assessment has been completed, the expert medical doctor completes and uploads the assessment report to the Commission's intranet. Subsequently, an official at the Commission takes a decision on the disability assessment, including which disability group, if any, to place the applicant in. A decision on disability status is valid for a set period, varying between six months and five years. This assessment is made in accordance with the Annex to Regulation No. 805.³⁷² The official may decide not to follow the advice given in the assessment report, but no information is available about the circumstances in which this may happen. The official can also issue binding opinions. A binding opinion on eligibility for specific kinds of benefits, such as support for the acquisition of an adapted vehicle or an allowance to cover transport expenses, entitles the applicant to receive the benefit. The Commission notifies the applicant of the decision and any related opinions and recommendations in accordance with the Law on Notification.³⁷³ Applicants who are officially recognised as disabled are issued with a disability certificate.

In summary, the assessment is based on a combination of medical diagnosis and an assessment of functional limitations leading to difficulties in carrying out certain specified activities. A treating doctor assesses health disorders and functional abilities. The applicant carries out a self-assessment of functional abilities. Based on all this information, an expert medical doctor assesses the specific situation of the applicant and records the results in an assessment record. Thereafter, an official at the

³⁷² Criteria for Assessment of Health Disorders and Functional Abilities, Annex 3, Regulation no. 805 – Regulations Regarding the Criteria, Time Periods and Procedures Determining Predictable Disability, Disability, and the Loss of Ability to Work, 2014, available at: <https://likumi.lv/ta/id/271253-noteikumi-par-prognozejamas-invaliditates-invaliditates-un-darbspeju-zaudejuma-noteiksanas-kriterijiem-terminiem-un-kartibu>.

³⁷³ Latvia, Law on Notification, 2010, available at: <https://likumi.lv/ta/id/212499-pazinosanas-likums>.

Commission takes a decision regarding the determination of disability. The disability group which an individual is placed in correlates to a specific percentage of reduced working capacity – however, as seen above, the assessment does not specifically assess or measure capacity to work, but rather, to some extent, a person's capacity to carry out daily activities.

The number of people assessed by the Commission has been increasing over recent years. Between 2010 and 2012, approximately 54 000 people were assessed each year. Since 2012 the number of assessments has been steadily rising, and was over 65 000 in 2016.³⁷⁴ In 88.9 % of cases the assessment was conducted without the applicant being present. There has been an increase in the number of people assessed as being in Group 1 (very severe disability). Reasons for this include long waiting lists for medical treatment and delays in providing rehabilitation. The increase in the number of applications, as well as poorly completed referrals made by treating doctors and the need for additional information, has resulted in delays to the assessment procedure and the process not always being completed within the one-month target. As one way of dealing with this, the Disability Law³⁷⁵ was amended to allow the Commission to extend the validity of a previously issued certificate or decision for up to six months, thus allowing the Commission additional time to adopt a new decision.

The assessment system is evaluated by the Commission, which has a system of internal control. The Commission official who receives the assessment report of the expert medical doctor is obliged to check the quality of the assessment. In addition, the Director of the Commission issued an order which required the Commission to check 300 assessments in more detail on a random basis, and to provide a comprehensive analysis of a further 60 assessments. On the basis of this, a report was prepared, and conclusions and recommendations made.³⁷⁶ The Commission's Department of Decisions and Appeals also checks the quality of decisions during the appeals and control process.³⁷⁷ In 2016, the Commission carried out a survey of users to identify the degree of satisfaction with the service provided.³⁷⁸ A total of 435 responses were received. 96 % of respondents were at least largely satisfied (i.e. satisfied or more satisfied than not) with the application process. 91 % of respondents were at least largely satisfied with the assessment itself. 94 % of respondents were at least largely satisfied with the justification given for the decision, and 87 % of applicants were at least largely satisfied with the availability of information about the assessment process. This seems to reflect a fairly high satisfaction rate.

The Government is currently considering changes to the assessment procedure. In 2017 the Director of the Department of Social Inclusion Policy, Mrs Elina Celmina,

³⁷⁴ Table 1 in ANED country report for Latvia. The State Medical Commission for the Assessment of Health Condition and Working Ability, Public Report 2016, available at: http://www.vdeavk.gov.lv/wp-content/uploads/2014/09/Parskats_2016_1.puse_www.pdf.

³⁷⁵ Latvia, Disability Law, 2010, available at: <https://likumi.lv/doc.php?id=211494>. The amendment is valid until 31 December 2018.

³⁷⁶ This report was submitted to Director of the Commission and is not available for a wider public.

³⁷⁷ The State Medical Commission for the Assessment of Health Condition and Working Ability, Public Report 2016, available at: http://www.vdeavk.gov.lv/wp-content/uploads/2014/09/Parskats_2016_1.puse_www.pdf.

³⁷⁸ The State Medical Commission for the Assessment of Health Condition and Working Ability; Public Report 2016; http://www.vdeavk.gov.lv/wp-content/uploads/2014/09/Parskats_2016_1.puse_www.pdf.

pointed out that the planned changes to the assessment process relate to a reorientation from an assessment based primarily on medical diagnoses to an assessment of work abilities. She said: 'There is a desire to provide greater support to those who, despite the restrictions, actively use their work abilities and integrate within the labour market. To establish the conditions for those, who have partial capacity restrictions, but they are not active. These people do not study, they are not looking for retraining opportunities or looking for a job. There is also a need to review the support measures. The Ministry meets with non-governmental organisations, sets out proposals for the changes, listens to the views, comments and questions and only constitutes the common proposal document, which will be put to public consultation. Therefore, it is too early to conclude that there are already planned specific changes.'³⁷⁹

Disabled people's organisations have been involved in the development of the evaluation method of disability assessment. DPOs had the opportunity to give their opinions on the revised disability assessment system in 2015³⁸⁰ and, in 2017, on changes to the assessment process for disability and loss of working ability, through the National Council for Disability Matters.³⁸¹

9.1.3.4 Increased severe disability assistance (Malta)

In Malta, the increased severe disability assistance, which is a form of disability pension, is awarded to persons aged 16 and over who are rated 0-8³⁸² on the Barthel Index and, due to having a condition referred to in the Social Security Act (Chapter. 318),³⁸³ are completely unable to work. Further information on the Barthel Index, which is a tool used to assess capacities to carry out activities of daily living, is given in this synthesis report in Part I, sub-section 2.2 above. An individual is eligible to receive Increased Severe Disability Allowance if, in line with Article 2 of the Social Security Act (Chapter 318) they have a condition which renders them 'severely disabled'³⁸⁴ or if they have 'mental severe sub normality', which is defined as having 'arrested or incomplete development of mind, resulting in a marked lack of intelligence which in turn renders the person affected incapable of living an independent life or of guarding himself against serious exploitation or will render him so incapable when of age to do so'.³⁸⁵

In order to be eligible, the applicant must have become disabled prior to reaching the age of 60. A multidisciplinary Medical Board consisting of a psychiatrist or geriatrician, a psychologist, an occupational therapist and a social worker, visits the applicant at home to make the assessment. The Board decides whether the case falls within the medical parameters and makes an assessment using the Barthel Index. While the

³⁷⁹ See: <http://nra.lv/latvija/221158-verte-jaunu-pieeju-invaliditates-noteiksana.htm>.

³⁸⁰ The National Council for Disabled, protocol no. 2, Ministry of Welfare, available at: http://www.lm.gov.lv/upload/invaliditate/2015/ilnp_sedes_protokols_170615.pdf.

³⁸¹ Ministry of Welfare (2017), 'Work Plan of the National Council for Disability Matters', available at: <http://www.lm.gov.lv/text/559> and http://www.lm.gov.lv/upload/invaliditate/invaliditates/ilnp_28062017_protokols.pdf.

³⁸² As of January 2018 (It was previously 0-4).

³⁸³ Available at: <http://justiceservices.gov.mt/DownloadDocument.aspx?app=lom&itemid=8794&l=1>.

³⁸⁴ See above Part III, section 7.1.3 for further explanation of the conditions that are regarded as leading to a person being regarded as 'severely disabled' under the Social Security Act.

³⁸⁵ Malta, Parts 1 and 2, Social Security Act (Chapter 318).

Barthel Index is designed to assess a person's ability to carry out daily living activities, in this context it is used to assess whether they are able to work. This assessment method therefore involves a medical assessment, to determine whether the applicant has a medical condition which means they are potentially eligible for the allowance, and a functional capacity assessment, which is based on the Barthel Index.

9.1.3.5 Work capability assessment (United Kingdom)

A further example of a functional capacity assessment which determines eligibility for a disability pension is the Work Capability Assessment carried out in the United Kingdom. In spite of its name, this assessment does not directly assess capability or capacity to work,³⁸⁶ although it is carried out to determine eligibility for the Employment and Support Allowance (ESA), which is a cash replacement income for people who are unable to work for disability or health-related reasons, and is therefore a kind of disability pension. Only individuals who have a 'limited capacity for work'³⁸⁷ are eligible to receive the ESA, which means their 'capability for work is limited by their physical or mental condition and it is not reasonable to require them to work'.³⁸⁸ The Work Capability Assessment is designed to establish this by gauging a person's performance of a range of functional activities using a points-based scale. Specifically, the assessment is defined as 'an assessment of the extent to which a claimant with a specific disease or bodily or mental disablement is capable, or is incapable, of carrying out specified activities'.³⁸⁹ The inability to perform any activity must arise from a specific illness, disease or disablement or from its medical treatment. For persons assessed as having a 'limited capacity for work', a further 'limited capability for work-related activity assessment' is applied to divide the group into two.

The assessment falls under the auspices of the Department for Work and Pensions, which has sub-contracted the functional assessment task to a private company, the Health Assessment Advisory Service (HAAS). The department remains responsible for designing the assessments and monitoring the work of HAAS.

Applicants submit an application for ESA by phone or by post. The form used to apply for the ESA³⁹⁰ is lengthy. The application acts as an initial screening of personal circumstances and determines which variant of the ESA benefit the individual is eligible to apply for. Applications from individuals who are terminally ill are fast-tracked for assessment. Other applicants are required to provide a standard sick note from their general practitioner.³⁹¹ The note relates to the applicant's fitness for work in general, and is not job-specific. It provides general information about the individual's health condition, its impact on functioning and the prospects for a return to work. In most

³⁸⁶ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

³⁸⁷ United Kingdom, Section 1, Welfare Reform Act 2007.

³⁸⁸ See:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/658287/dmgch42.pdf

³⁸⁹ See:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/661575/admg1.pdf.

³⁹⁰ ESA 1. See: <https://www.gov.uk/government/publications/employment-and-support-allowance-claim-form>.

³⁹¹ Med 3 or 'fit note'. See: <https://www.gov.uk/government/collections/fit-note>.

cases, applicants are also asked to complete a detailed self-assessment form, the 'Capability for Work questionnaire'.³⁹² The questionnaire asks about the applicant's impairment or health condition, how it affects them, and if there is anything else the applicant thinks the assessor should know. Information on treatment is also requested. The questionnaire largely covers the same activities or tasks which are covered in the face-to-face assessment, and applicants can also give examples of their functional restriction on the questionnaire. Applicants have four weeks to return this form to HAAS, although claimants who indicate that they are claiming on grounds of 'mental function' will be offered a face-to-face assessment, even if they fail to return the form.

Once this documentation has been received by the Department for Work and Pensions, the claim is referred to HAAS for assessment. The documentation is reviewed by a healthcare professional who is employed by the organisation carrying out the assessment. This individual must be a registered medical practitioner, nurse, occupational therapist or physiotherapist who has been practising for at least two years. Most applicants are then invited to a regional assessment centre, although home assessments are made if an individual is unable to travel to a centre. While HAAS arranges and carries out the assessment, the service is provided by the Centre for Health and Disability Assessments, operated by the private company Maximus.

The self-assessment form and the face-to-face interview adopt a functional assessment method.³⁹³ The applicant is assigned varying levels of points based on their ability to carry out specific activities or tasks. These activities are not specific to a particular occupation, but are relevant to daily life. The activities are specified in Schedule 6 to the Universal Credit Regulations 2013 and are divided into two parts, covering 'physical disabilities' (ten specific activities) and 'mental, cognitive and intellectual function' (seven activities).³⁹⁴ Examples of activities covered under 'physical disabilities' include standing and sitting; manual dexterity; making oneself understood through speaking, writing, typing, or other means which are normally or could reasonably be used unaided by other persons; and consciousness during waking moments. Examples of activities covered under 'mental, cognitive and intellectual function' are learning activities; awareness of everyday hazards; coping with change; and getting about.³⁹⁵ Descriptors are provided for each activity, and each of these is allocated a specified number of points (between 0 and 15, where 0 represents no difficulty and 15 represents an inability to perform the activity without help from another person).³⁹⁶ The assessment determines which descriptor best characterises the applicant's capability to perform each of the 17 activities, and the assessor selects the correct descriptor. The points from the highest-scoring descriptor for each activity are added together to produce a total score. A minimum total of 15 points is needed across all 17 activities to establish limited capability for work. The assessment is made on the

³⁹² ESA50 or UC50. See: <https://www.gov.uk/government/publications/capability-for-work-questionnaire>.

³⁹³ In a few cases, applicants can be fast tracked and may not be required to complete a self-assessment form or attend a face-to-face interview. This can be the case for applicants who the treating doctor indicates have a 'severe functional limitation' when compared with the descriptors used in the assessment, for applicants who are terminally ill, receiving chemotherapy or radiotherapy, or for those who are pregnant with a serious health risk.

³⁹⁴ See: <https://www.legislation.gov.uk/uksi/2013/376/schedule/6>.

³⁹⁵ A full list of all covered activities is included in the ANED UK country report.

³⁹⁶ The number of points attached to each descriptor is stipulated in Schedule 6 to the Universal Credit Regulations 2013, available at: <https://www.legislation.gov.uk/uksi/2013/376/schedule/6>.

assumption that the claimant is using any prostheses, aids or appliances that might reasonably be available and that any prospective employer would comply with the duty under UK law to make a reasonable accommodation / reasonable adjustment.³⁹⁷ In addition, an applicant who would not otherwise qualify for the ESA can be assessed as eligible if the individual:

suffers from some specific disease or bodily or mental disablement and by reasons of such disease or disablement, there would be a substantial risk to the mental or physical health of any person if he were found not to have limited capability for work-related activity.³⁹⁸

If an applicant is assessed as having limited capability for work, a further 'limited capability for work-related activity assessment' (LCWRA) is applied to allocate the applicant into one of two groups or levels – a 'support group' and a 'work-related activity group'. Individuals placed in the 'support group' receive a higher rate of benefit, are not required to participate in work or work-related activities, and usually qualify for additional disability-related benefits.³⁹⁹ Individuals placed in the 'work-related activity group' receive a lower rate of benefit, and must attend a series of interviews with a work coach who will decide what work-related activities they are required to undertake. There are benefit sanctions resulting from non-compliance with these obligations. The assessment to decide which group to place an applicant in refers, essentially, to the same set of activities as are assessed in the Work Capability Assessment, and does not require a further assessment, but its criteria refer only to the maximum scoring descriptors for each activity (i.e. the 15 point descriptors). If an applicant has the equivalent of 15 points from one category ('physical disability' or 'mental, cognitive and intellectual function'), they are considered to have an LCWRA and are recommended for the Support Group.

Applicants are not normally required to attend more than one face-to-face assessment interview. The information provided through the self-assessment form, the face-to-face meeting and any other pieces of submitted evidence, such as medical reports, are taken into account when making the overall assessment. The interview usually employs an open-ended question technique to gain an overall picture of how the applicant's impairment/health condition impacts on their day-to-day life (not specifically at work), as well as any clinical examinations needed to allocate the points-based functional descriptors. Any clinical examinations will usually attempt to simulate the activities described in the physical function questions (e.g. lifting and reaching).

The Department of Work and Pensions published detailed official guidance on the Work Capability Assessment in 2013 in a handbook for healthcare professionals. This was updated in 2017.⁴⁰⁰ A parallel handbook (staff guide) for designated Decision

³⁹⁷ Section G1056 of the *Advice for Decision Making Guide*, see: <https://www.communities-ni.gov.uk/sites/default/files/publications/communities/dm-adm-chapter-g1.DOCX>.

³⁹⁸ This also arises from past case law established in *Howker v. Secretary of State for Work and Pensions*, available at: <http://lexisweb.co.uk/cases/2002/november/howker-v-secretary-of-state-for-work-and-pensions-and-another>.

³⁹⁹ See: <https://www.gov.uk/employment-support-allowance/what-youll-get>.

⁴⁰⁰ See: <https://www.gov.uk/government/publications/work-capability-assessment-handbook-for-healthcare-professionals>.

Makers⁴⁰¹ (civil servants) was replaced with updated advice for Universal Credit (which will replace a variety of other cash benefits) claims in 2017.⁴⁰²

The assessor uses a computer programme (LiMA) to carry out the face-to-face assessment. This software, accompanied by the 252-page training handbook, guides assessors in what to assess, providing a series of drop-down menus and suggesting 'logical' outcomes (in terms of points awarded) from the options selected, although the assessor may override these outcomes (in which case the assessor must justify this).

Each question also has a response section for 'observed behaviour'. This requires the assessor to select whether ability or inability in observed behaviour is consistent or inconsistent with the history, examination and medical knowledge of the condition. The software will suggest whether the behaviour is consistent or inconsistent, although again the assessor can override this. Consequently, an applicant's functional capacity to meet the descriptors is determined by both active assessment questions and tests, of which the claimant is fully aware, but also by more discrete observations.

The assessor is asked to consider all the health conditions and medication mentioned. In the case of mental health conditions, assessors are advised to 'explore, sensitively and fully, psychiatric symptoms in claimants with mental health problems, including suicidal ideation if relevant, and details of therapy'.⁴⁰³ If an applicant has a fluctuating condition, the assessor is advised to consider their functioning ability on the majority of days, but must also provide information on their capacity on other days, and how often such days occur. Lastly, when considering functional capacity for all the activities, assessors should take into account whether a claimant can do them repeatedly, reliably and safely, and not just whether they can do them in the face-to-face meeting.

Following the assessment, a report is drawn up and sent to the Department of Work and Pensions. A civil servant, who is the designated Decision Maker, takes a decision on the application. The applicant is then informed – usually first by phone and subsequently by letter.

In May 2017, 2.4 million people claimed ESA. Of these claimants, almost 66 % were in the Support Group (LCWRA), 17 % were in the Work-Related Activity Group, 13 % were still in the assessment phase, and the progress of 3 % of cases could not be determined from the data.⁴⁰⁴ The total number of beneficiaries has declined since the introduction of the Work Capability Assessment.

There is a target of completing assessments within 13 weeks of the initial application, but there have been problems with meeting this target. In April 2017 the average assessment time was 16 weeks, with applicants having to wait a further 4 weeks, on average, for the process to be completed with a decision by the Department of Work and Pensions.⁴⁰⁵

⁴⁰¹ See: <https://www.gov.uk/government/collections/decision-makers-guide-staff-guide>.

⁴⁰² See: <https://www.gov.uk/government/publications/advice-for-decision-making-staff-guide>.

⁴⁰³ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/634850/wca-handbook.pdf, p. 60.

⁴⁰⁴ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/659423/dwp-quarterly-benefit-stats-summary-november-2017.pdf.

⁴⁰⁵ Figure 10, ANED UK country report.

The Work Capability Assessment has been subject to five independent reviews since it was introduced in 2008. The first review identified a need for some descriptors to be improved to better understand and capture those health conditions which were subject to more 'subjective' assessment (i.e. not susceptible to precise medical diagnosis / not able to be measured objectively). It concluded that more could be done at each stage of the assessment process to make it 'fairer and more effective'. It called for civil service Decision Makers in the Department of Work and Pensions to have a greater role in the assessment, and believed this would reduce the rate of appeals. It also recommended that the company conducting the assessments employ 'mental, intellectual and cognitive champions' in each assessment centre to raise the profile of, and sensitivity towards, these types of impairment, which were perceived to be less well understood than physical and sensory impairments.⁴⁰⁶

The second review noted that, with the expertise and support of major charities and clinicians, there had been improvements to both the descriptors and guidance, resulting in notable improvements to the process.⁴⁰⁷ Nevertheless, improvements were still required to the communication, transparency and quality of the assessments. The third review was conducted in similar manner – some improvements were noted, but there was frustration at the slow pace of change. It recommended continued dialogue to improve descriptors, including a comprehensive review of the mental, intellectual and cognitive descriptors.⁴⁰⁸

The fourth review involved a new reviewer, who noted how complex the system was and how this could increase the likelihood of claimants finding it difficult to understand.⁴⁰⁹ This review also noted that 'the underlining points score system is somewhat arbitrary' and 'emphasising the points scale gives a false impression of scientific validity and appears to drive unhelpful behaviours'. It recommended that less emphasis be placed on a score, with more focus on whether a threshold for benefit eligibility had been reached. It suggested there were problems in the decision-making process, which appeared to give 'undue weight' to 'information from medical records which rarely describe capacity', resulting in outcomes skewed towards finding people unfit for work. It also recommended simplifying the process and, again, called for improvements to be made to assessor expertise in understanding mental health conditions.

The fifth and final review included consideration of an evidence-based review, which tested the Working Capability Assessment against alternative descriptors.⁴¹⁰ While acknowledging that its methodology was not ideal, it concluded that there was no strong case for replacing the Assessment. This review called for more attention to be paid to people with learning difficulties in the assessment process and for improved communication methods. Another focus was the increase in the number of applicants

⁴⁰⁶ See: <https://www.gov.uk/government/publications/work-capability-assessment-independent-review-year-1>.

⁴⁰⁷ See: <https://www.gov.uk/government/publications/work-capability-assessment-independent-review-year-2>.

⁴⁰⁸ See: <https://www.gov.uk/government/publications/work-capability-assessment-independent-review-year-3>.

⁴⁰⁹ See: <https://www.gov.uk/government/publications/work-capability-assessment-independent-review-year-4>.

⁴¹⁰ See: <https://www.gov.uk/government/publications/work-capability-assessment-independent-review-year-5>.

being placed in the Support Group. This increase appeared to be driven largely by the assessors' liberal interpretations of the Regulations concerning the overriding consideration of a 'substantial risk' of harm that might result from a decision to find someone capable of work (i.e. a 'risk to the mental or physical health of any person').⁴¹¹ This led to a change in guidance, limiting the discretionary use of this clause, and to a noticeable decrease in the numbers being placed in the Support Group.

Several changes were made to both the application form and the descriptors in an attempt to address the issues raised by the reviews. These included stressing that, in order to satisfy a descriptor, someone must be able to complete the relevant activity 'reliably, safely and repeatedly'.

Evidence collected by the Government at the end of 2017 suggested that a 'significant minority' of claimants were still being failed by the assessment process. Failures included 'fundamental errors' which 'bore little or no relation' to a claimant's situation or what had happened in assessments (such as relevant information being missing from assessors' reports and stated results of physical tests which were not undertaken at the assessment).⁴¹² People expressed concerns about the lack of knowledge and expertise of assessors and judgments based on informal observations, which led assessors to disbelieve claimants' own descriptions of their conditions and capacity. Concerns were also expressed about mandatory reconsideration (or reassessment) and the appeal process, both in terms of how long they took and regarding the fact that most reconsiderations appeared to 'rubber stamp' the initial decision, whereas appeals appeared to take a more thorough review of the case.

A parliamentary report by the Work and Pensions Select Committee, published in February 2018, made a number of criticisms of the assessment process.⁴¹³ These included: 'extraordinary basic deficiencies in the accessibility' of the assessment process (including lack of accessible communication with applicants, failure to offer home visit alternatives etc.); a failure to consider the specialist expertise of individual assessors in assigning cases; and errors in assessment reports. These led to a 'belief among some claimants and their advisers that assessors are encouraged to misrepresent assessments deliberately in a way that leads to claimants being denied benefits'. Whilst the report notes that these are 'unsubstantiated' beliefs, it concluded that the poor delivery of assessments had contributed to these beliefs. Its recommendations included working with 'expert stakeholders' to create more accessible guidance on both the self-assessment form and face-to-face assessment, including how to make the process 'less distressing' for applicants. It also recommended recordings of assessments and the provision of the assessor report to all applicants by default.

Issues regarding the quality of the assessments have also been revealed by the number of successful appeals against decisions. Official data indicate that, in the

⁴¹¹ This relates to the situation where an applicant, who would not otherwise qualify for the ESA, can be assessed as eligible if the individual: suffers from some specific disease or bodily or mental disablement and by reasons of such disease or disablement, there would be a substantial risk to the mental or physical health of any person if he were found not to have limited capability for work-related activity.

⁴¹² See: <https://publications.parliament.uk/pa/cm201719/cmselect/cmworpen/355/355.pdf>.

⁴¹³ See: <https://publications.parliament.uk/pa/cm201719/cmselect/cmworpen/829/829.pdf>.

period 2008-2015, 39 % of the 465 400 appeals heard against 'fit for work' decisions in initial claim assessments resulted in the original decision being overturned. This includes both mandatory reconsiderations and tribunal hearings, and reached a peak of 59 % under the previous assessment provider contract.⁴¹⁴ The high number of appeals results in increased costs.

The current provider of assessments, Maximus, has not met all its contractual targets and been repeatedly fined as a result.

Finally, the Work Capability Assessment process was criticised by the UN Committee on the Rights of Persons with Disabilities (UNCRPD) during their UK inquiry, which found that welfare reforms had led to 'grave and systematic violations' of disabled people's rights.⁴¹⁵ In relation to the ESA assessment process, it concluded the following:

- Evidence indicates several flaws in the processes related to the Employment and Support Allowance. In particular, the Committee notes that, despite several adjustments made to the Work Capability Assessment, the assessment has continued to be focused on a functional evaluation of skills and capabilities, and puts aside personal circumstances and needs, and barriers faced by persons with disabilities to return to employment, particularly those of persons with intellectual and/or psychosocial disabilities. In the initial period covered by the present report, evidence indicates a significant percentage of assessments were overturned by tribunals.⁴¹⁶
- Despite the training delivered to assessors and decision makers, evidence indicates a persisting lack of awareness and limited knowledge of disability rights and the specific needs of persons with disabilities, particularly of persons with intellectual and/or psychosocial disabilities. The Committee also collected evidence of lack of reasonable accommodation and inaccessible information about the assessment process.
- While the Committee notes the effort of the authorities to shorten the length of mandatory reconsideration procedures, evidence indicates that claimants requesting reconsideration have frequently experienced long waiting periods. The Committee also observes that, during the mandatory reconsideration procedure, Employment and Support Allowance benefits are suspended.
- Evidence collected points to significant hardship, including financial, material and psychological, experienced by persons with disabilities undergoing assessments. Persons who have been compelled to undergo a new assessment shortly after a first assessment have been particularly affected.

Nevertheless, and in spite of these significant problems, the UK Government maintains that the majority of claimants are satisfied with the assessment process. The

⁴¹⁴ See: <https://www.gov.uk/government/statistics/esa-outcomes-of-work-capability-assessments-including-mandatory-reconsiderations-and-appeals-march-2017>.

⁴¹⁵ See: <http://www.ohchr.org/Documents/HRBodies/CRPD/CRPD.C.15.R.2.Rev.1-ENG.doc>.

⁴¹⁶ See: <https://www.gov.uk/government/statistics/esa-outcomes-of-work-capability-assessments-including-mandatory-reconsiderations-and-appeals-march-2017>.

systematic and open process of review and public scrutiny has resulted in some improvements, and disabled people and their organisations have been able to provide evidence of their experiences and suggest improvements. The Government has worked with organisations with experience of certain impairments to improve the assessment descriptors. While there is considerable evidence of weaknesses and problems, it is fair to say that no other assessment process considered in this report has been subject to such close scrutiny and independent evaluation, and this openness to review and the need to improve the system can be regarded as good practice.

9.1.3.6 Assessment for income replacement allowance (Belgium)

Lastly, it is worth noting that the Belgian Federal Public Service Social Security also carries out an assessment of capacity to carry out activities of daily living to determine eligibility for the income replacement allowance for people with disabilities who face difficulties in the labour market. This assessment method also applies to a number of cash benefits not directly related to reduced working capacity, and is discussed further below (Part III, sub-section 9.2 under *Assessment of ability to carry out Activities of Daily Living not (only) carried out for the purpose of awarding benefits linked to reduced working capacity*).

9.1.3.7 Conclusion on assessments of capacity to carry out activities of daily living for the purpose of awarding benefits linked to reduced working capacity

The four functional capacity assessments⁴¹⁷ identified in this section seek to identify the ability of applicants to carry out activities of daily living and use this as a proxy to determine the person's capacity to work and eligibility for an income replacement allowance, such as a disability pension. All the assessment mechanisms make use of medical information received from a treating doctor, a self-assessment questionnaire, and a points-based system to indicate the applicant's functional capacity restrictions. Detailed guidance on how to make the assessments is sometimes publicly available. In these respects, these assessment mechanisms display more commonalities than is the case for several other assessment mechanisms discussed in this synthesis report, such as the expert assessments discussed above in Part III, sub-section 9.1.1. Disabled people's organisations have either been involved in the development of the evaluation of the assessment method (as in Latvia) or, more commonly, have expressed their views on the assessment mechanism.

9.1.4 Overall conclusion of assessment of capacity for work

Three different kinds of functional capacity assessment were identified with regard to assessing an individual's capacity for work: expert assessments; structured assessments; and assessments of capacity to carry out activities of daily living, which are regarded as also providing evidence of working capacity.

The expert assessments identified in this synthesis report were largely medically oriented, in spite of them ostensibly assessing working capacity. In some cases, the

⁴¹⁷ This does not include the Belgian assessment, which is discussed in more detail below (Part III, sub-section 9.2).

assessments seemed to involve determining whether the applicant has a specific medical condition and, in the case of Cyprus and the Czech Republic, awarding a disability percentage on the basis of a Barema-like table. The Swedish assessment to determine eligibility for additional support in the labour market also placed heavy emphasis on medical statements during the assessment, although societal and structural barriers are clearly considered as well.

Only one structured assessment was identified in this section: the Swedish AFU, which is used to determine eligibility for a disability pension or compensation. This assessment adopts a medical-functional methodology, and makes use of an interview and a medical examination to identify functional limitations, which are then compared with a 'knowledge base' to identify skills needed for specific occupations. The individual's perspective is taken into account, as the applicant carries out a self-assessment of activity restrictions, and the assessment recognises that disability is partly caused by environmental factors. However, evaluations have revealed a number of problems with this complex assessment system, relating to the lack of uniformity and problems with the 'knowledge base'.

Lastly, a number of capacity for work assessments based on identifying applicants' ability to carry out activities of daily living have been identified. These are based on the underlying assumption that information about a person's capacity to undertake activities of daily living can be used to make an assessment of their work capacity, as a reduced ability or inability to make a living from employment is the reason for granting a disability pension or other cash benefit. There is no attempt to assess an applicant's ability to carry out specific work-related skills, or to compare their capacity with the needs of the labour market. These assessments of daily living activity mechanisms display a number of commonalities, which were also identified in the Swedish AFU assessment, but which are not necessarily found in other assessment mechanisms. These include the use of a self-assessment questionnaire and a points-based system to indicate the applicant's functional capacity restrictions.

The two assessments which reveal the most complexity, and which have been subject to the most intensive evaluations, are the Swedish AFU and the British Work Capability Assessment. A comparison of these two functional capacity assessments reveals a number of similarities and differences. The most important difference is that the Swedish AFU assessment seeks to establish the ability of applicants to carry out specific work in the labour market and, once a medical examination has revealed abilities in four specified areas, the assessment compares those abilities and related activity restrictions with the skills needed to carry out specific kinds of work to identify any reduced functional capacity. In contrast, in the United Kingdom, the functional ability of individuals is assessed in terms of skills or abilities under two separate headings concerning activities of daily living, but there is no attempt to link an individual's abilities and related activity restrictions with specific kinds of work. Nevertheless, a number of similarities were identified. These include the use of self-assessment forms and the consideration of the views of the applicant in the assessment; the use of a points-based system to identify activity restrictions;⁴¹⁸ the failure to complete a large number of assessments within the specified target time; extensive guidance and training for assessors and the use of detailed and structured

⁴¹⁸ As noted above, these have also been noted as characteristics of daily activity functional capacity assessments more generally in this synthesis report.

forms during the assessment; negative decisions leading to an increased number of appeals, which is placing further pressure on the systems; and the division of the assessment tasks between insurance physicians (in Sweden) or healthcare professionals training in assessment (UK), and civil servants. A further similarity is the high number of evaluations and reviews of the assessment systems, which have revealed a variety of weaknesses and problems. It seems that such complicated systems, which attempt to provide a detailed assessment of each applicant's ability (to work), are prone to weaknesses. However, this does not imply in the least that less transparent assessment systems, which are evaluated less frequently or not at all, are functioning better.

9.2 Assessment of the capacity to carry out activities of daily living not linked to an assessment of reduced working capacity

Functional capacity assessments can aim to assess a person's capacity to undertake activities of daily living, rather than their capacity to work, and these assessments are examined in this sub-section. Unlike the assessments discussed in Part III, sub-section 9.1.3 above, these assessments are not carried out (only) with a view to establishing the capacity of applicants to work. The distinction between expert and structured assessments, which was developed by Ben Baumberg Geiger with employment-related assessments in mind, seems not to apply to assessments of ability to carry out activities of daily living. While structured assessments in the context of employment firstly identify activity restrictions, and then link those restrictions to ability to work, it appears that assessments regarding ability to carry out activities of daily living will frequently only identify this ability, without first identifying underlying capacities.

9.2.1 Assessment of ability to carry out activities of daily living for combined employment and non-employment-related benefits (Belgium)

In Belgium, the Federal Public Social Security Service carries out a functional assessment of a person's ability to carry out activities of daily living to determine their eligibility for five (mainly cash) benefits: the income replacement allowance, for people of working age who experience difficulty on the labour market for a reason related to disability; the integration allowance, for people of working age who experience difficulty in activities for a reason related to a disability; the allowance for help for seniors or elderly people; the increased child allowance, for children who have a disability; and other benefits, such as the disabled person's parking permit or eligibility for discounts on public transport. These benefits are linked to an official recognition of disability status by the Social Security organisation.

Disability is defined in legislation as any long-term and significant participation problem experienced by a person and attributable to a combination of functional disorders of a mental, psychic, physical or sensory nature, limitations in the performance of activities, and personal and external factors.⁴¹⁹ An individual must be assessed as meeting this

⁴¹⁹ For example, in the Flemish Government's Decree of 25 April 2014 on personal funding for persons with disabilities and on reforming the funding arrangements for providing care and support to persons with disabilities:
http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=nl&la=N&table_name=wet&cn=20140425J0 (in Dutch). For further information on relevant legislation, see:
<http://handicap.belgium.be/docs/nl/wetgeving-tegemoetkomingen.pdf>.

definition in order to be officially 'recognised' as disabled. The assessment is mainly a functional assessment, and is based on a questionnaire. In addition, some of the activity scores which are covered in the questionnaire assess the impact of the environment.

Prior to applying, applicants are advised to complete an online screening. This is intended to provide information about the possible benefits which the applicant is eligible for, and the applicant can use this information to prepare for the application and to improve the chances of receiving a positive decision. The application is initiated when the applicant completes an online questionnaire, called 'My Handicap',⁴²⁰ and submits the relevant application form. The online questionnaire covers six daily activities and fields, and applicants can indicate whether they have difficulty carrying out activities in the relevant field using a four-point score. The activities covered relate to mobility, preparing and eating food, personal care and dressing, household activities, interpretation of danger and social interaction.

The starting point for the assessment is the documentation which has been submitted, including information regarding health status. If necessary, additional information from doctors who treat the applicant can be requested. In general, the applicant is asked to attend an assessment interview with an insurance physician, where the information provided in the questionnaire is explored in more detail. However, in some cases, the assessment is made purely on the basis of the evidence submitted. In such cases, the assessment seems to be based on medical reports and documentation.

The assessment is not intended to result in a medical diagnosis. Moreover, the assessment does not relate directly to the impairment, but rather to the impact which the impairment has on the applicant's daily life, as identified in the six fields covered in the questionnaire. The insurance physician uses a four-point scale to assess the applicant's capacity to carry out daily activities. Each activity can be graded 0 to 3, with 0 meaning no difficulty in carrying out the activity, and 3 meaning that it is impossible for the applicant to carry out the activity unaided. This means an individual can score a maximum of 18 points. If an individual is assessed as having less than 7 points, they are not recognised as disabled. Differing levels of benefits are awarded for individuals who score between 7 and 18 points. In the case of the integration allowance, individuals are recognised as falling into category 1 disability if they have 7 or 8 points; category 2 if they have 9 to 11 points; category 3 if they have 12 to 14 points, and category 4 if they have 15 or more points.⁴²¹ Individuals in higher disability categories receive higher levels of benefits. These requirements are set out in the Ministerial Decision of 30 July 1987, which also includes a manual for assessing the degree of 'self-reliance' (or the ability to care for oneself) of applicants for the purposes of the integration allowance.⁴²² The manual indicates that each of the six activities is to be assessed through a set of sub-questions, which are listed. The manual is not available via the Service's website so, in that sense, it is not transparent. Individuals who apply for the income replacement allowance are also required to undergo a medical assessment. Once the assessment has been completed, and a decision taken, the applicant is informed by letter, which also contains information on any benefits the applicant is entitled to. The assessment time for these different benefits varies from

⁴²⁰ See: <http://handicap.belgium.be/docs/nl/myhandicap-handleiding-burger-nl.pdf>.

⁴²¹ Belgium, Article 1, Ministerial Decision of 30 July 1987.

⁴²² See: <http://www.ejustice.just.fgov.be/eli/bsluit/1987/07/30/1987022219/justel>.

benefit to benefit and from region to region. The assessment method has not been evaluated, although a master's thesis by K. Somers revealed that many applicants experience difficulties with the assessment because of the length of the procedure and the complicated process. Individuals often needed professional help to fill in the application, and the face-to-face interview with the insurance physician was found to be difficult. As a result, many people withdrew their application.⁴²³

9.2.2 Assessment of ability to carry out activities of daily living to determine need for special care (Latvia)

The assessment carried out by the State Medical Commission for the Assessment of Health Condition and Working Ability was described above in Part III, sub-section 9.1.3. Concurrently with this assessment, in the case of adults assessed as having a severe disability (Group I), the Commission assesses whether the individual has a need for special care. This involves a functional capacity assessment based on the person's ability to perform everyday activities and undertake self-care. The assessment is carried out in accordance with the 'Criteria for Provision of Opinion on the Necessity of Special Care for Person from 18 Years of Age'.⁴²⁴

In order to carry out the assessment, the Commission may request information from a social worker or ergo therapist, who fills in a 'Questionnaire of Assessment of Everyday Activities and Environment of the Person'.⁴²⁵ This questionnaire contains basic information about the applicant and an assessment of their living conditions, their environment, and their ability to carry out different activities. The assessment of living conditions includes information on the place where person lives, nearby facilities, and the means by which they may reach these facilities. The social worker or ergo therapist assesses the applicant's mobility outside the residence on a flat road in dry conditions, and indicates any difficulties or need for assistance. The applicant's self-care, mobility and daily activities in connection to home life are assessed using the Barthel Index.⁴²⁶ The social worker or ergo therapist evaluates the applicant's ability to carry out some everyday activities on a four-point scale, where 0 points equates to complete inability to do the activity, 1-2 points equates to the applicant needing some degree of assistance to do the activity; and 3 points equates to the applicant being able to do the activity unaided. The social worker or ergo therapist evaluates abilities regarding eating, moving from bed to chair, mobility (walking or use of wheelchair), using stairs or other alternative heights (for example, a ramp or lift), dressing, taking care of appearance, bathing, stools, urination and toilet use. They will then indicate the

⁴²³ Somers, K., (2017). *Not-use of support systems by people with a disability*. Master thesis submitted at KULeuven in partial fulfillment of the requirements for the degree of Master in Social work and social policy. https://www.scriptieprijs.be/sites/default/files/thesis/2017-10/Somers_kaat_Masterproef.pdf.

⁴²⁴ Latvia, Criteria for Provision of Opinion on the Necessity of Special Care for Person from 18 Years of Age, Annex 8, Regulation no. 805 – Regulations Regarding the Criteria, Time Periods and Procedures Determining Predictable Disability, Disability, and the Loss of Ability to Work, 2014, available at: http://vvc.gov.lv/export/sites/default/docs/LRTA/MK_Noteikumi/Cab._Reg._No._805_-_Loss_of_Ability_to_Work.pdf.

⁴²⁵ Latvia, Questionnaire of Assessment of Everyday Activities and Environment of the Person, Annex 2, Regulation no. 805 – Regulations Regarding the Criteria, Time Periods and Procedures Determining Predictable Disability, Disability, and the Loss of Ability to Work, 2014, available at: http://vvc.gov.lv/export/sites/default/docs/LRTA/MK_Noteikumi/Cab._Reg._No._805_-_Loss_of_Ability_to_Work.pdf.

⁴²⁶ For more information on the Barthel Index see Part I, sub-section 2.2.

corresponding points and make comments. Points given for these actions are added together. Additionally, the social worker or ergo therapist assesses the activities required for household maintenance – cooking, cleaning, laundry, other household activities (collecting water or firewood, heating a furnace, clearing snow, garden care or pet care) and shopping, indicating whether the person does this activity independently, independently but with difficulties, needs assistance or cannot do them.

The social worker or ergo therapist assesses the applicant's ability to undertake other activities: in particular, their ability to drive a car, use public transport, take part in recreation and engage in hobbies. The social worker or ergo therapist also assesses the extent to which the applicant's functional restrictions hamper communication with their family, friends or neighbours. They identify the main conclusions of the assessment in a report and make suggestions for further action. The social worker or ergo therapist can refer to the Commission's methodological guidelines when completing the questionnaire.⁴²⁷

The assessment is carried out in accordance with the 'Criteria for Provision of Opinion on the Necessity of Special Care for Person from 18 Years of Age', which specifies that persons with group I disability are entitled to special care if one of the following criteria is met:

- 24-hour assistance and supervision due to limited mental capacity is required if the treating psychiatrist has established stable, non-treatable behavioural disorders that cause a person to endanger his or her health, safety or life;
- the combination of points awarded in the assessment of self-care, mobility and home-based activities carried out in accordance with the Barthel Index is lower than 7 points.

Once the assessment has been completed, the Commission electronically submits the information on the recognised disability group and their opinion regarding the need for special care to the State Social Insurance Agency. The Agency is obliged to follow this advice.

9.2.3 Conclusion

These two assessments of functional capacity to carry out daily activities relate to different kinds of benefits. In the case of Belgium, the assessment determines eligibility for cash benefits, including, but not only, benefits paid to people with disabilities who are regarded as having a reduced working capacity based on the assessment.⁴²⁸ In Latvia, the assessment determines eligibility for additional care or support. In the case of Latvia, what is being assessed – the ability to care for oneself – seems to relate more closely to the benefit that can be awarded as a result of the assessment. In the case of Belgium, the assessment seems to be used as a proxy to determine a need for additional financial support or other benefits. Both assessments make use of a points-based system to grade an applicant's capabilities or abilities in designated areas.

⁴²⁷ The State Medical Commission for the Assessment of Health Condition and Working Ability, see: <http://www.vdeavk.gov.lv/personas-ikdienas-aktivitasu-un-vides-novertejums/>.

⁴²⁸ Some additional benefits can also be awarded, such as a disabled person's parking permit.

10 Assessment of care or support needs

Assessments aimed at identifying care or support needs were identified in most of the countries covered in this synthesis report. In most cases, the assessment was designed to determine eligibility for a care allowance or another benefit which provides assistance, such as a certain number of hours of support. However, two other examples of benefits linked to this kind of assessment were also identified: the Danish assessment to determine eligibility to receive a cash benefit to cover additional expenses, and the Greek assessment to determine eligibility to receive additional support at school. This part of the report firstly discusses assessments related to care allowances or benefits, and then discusses the two assessments in Denmark and Greece separately.

10.1 Assessments for care allowances, benefits or support for independent living

A number of such assessments were identified, including the assessment for user-controlled personal assistance⁴²⁹ in Denmark, regulated under the Social Service Law;⁴³⁰ the assessment for the care allowance in Liechtenstein administered by the Liechtenstein Disability Insurance and the Family Assistance Association;⁴³¹ and the assessment for financial support under the Independent Community Living Scheme administered by *Agenzija Sapport* in Malta. Further information about these assessments can be found in the relevant country reports. This sub-section concentrates on seven other assessments linked to care allowances or benefits or support for independent living used in Austria, Belgium, Iceland, the Netherlands, Sweden and the United Kingdom.

10.1.1 Personal assistance provided by the Centre for Independent Living Innsbruck (State of Tyrol, Austria)

In general, Austria's regional governments are responsible for providing personal assistance, such as support for independent living. This means that different assessments and different levels of support are available across the country. In the State of Tyrol, the Centre for Independent Living in Innsbruck⁴³² plays an important role in the assessment process, and is also the main provider of personal assistance, which is financed by the regional government.⁴³³

⁴²⁹ Brugerstyret personlig assistance.

⁴³⁰ See: <https://www.retsinformation.dk/Forms/R0710.aspx?id=197036>. In Denmark, the Social Service Law is administered by the municipalities. There no central agency such as exists in many other countries.

⁴³¹ *Familienhilfe Liechtenstein*: see: <http://www.familienhilfe.li/Organisation.aspx>.

⁴³² Website of the Centre for Independent Living in Innsbruck: <http://www.selbstbestimmt-leben.net/assistentz>.

⁴³³ The official description of personal assistance as a service provided by the State of Tyrol is included in the catalogue of services, available at: https://www.tirol.gv.at/fileadmin/themen/gesellschaft-soziales/soziales/Sonstiges/Qualitaetsstandards-Leistungskatalog/Qualitaetsstandards_und_Leistungskatalog_Stand_7_Mai_2015.pdf (see pages 61-65).

Persons with disabilities receive comprehensive information about the concept of personal assistance as support for independent living before they apply for the benefit. This information is provided by peer counsellors at the Centre for Independent Living in Innsbruck, and all applicants need to receive this information before making an application. Moreover, applicants can only apply for the benefit with the support of the Centre, so the Centre acts as both a facilitator and filter.

The assessment commences with a self-assessment by the applicant of the number of hours of personal assistance needed per month. In making this assessment, the applicant is supported by a peer counsellor from the Centre. This is done through a face-to-face meeting which takes about one hour. The counsellor at the Centre uses a questionnaire to help identify an individual's support needs. This form is not publicly available and is only for internal use. However, an organisation in Vienna uses a similar form, which is publicly available.⁴³⁴ This covers information on the applicant's disability, the living situation of the applicant, the current situation regarding support and assistance, and the description of goals to be achieved with personal assistance. The applicant is also asked to indicate if there is a need for support in a specific sphere (other than in higher or vocational education and employment, which fall under the responsibility of the Federal Government), and to indicate the amount of support needed in that sphere. The spheres of life covered include basic self-care activities, household tasks, healthcare (e.g. taking medications, appointments with medical practitioners), and other spheres of life such as going to the cinema or theatre, attending sporting activities and going on holiday. There are no specific standards which determine the number of care hours an applicant needs, and this is identified on an individual basis.

The peer counsellor at the Centre for Independent Living also assists the individual in making their official application. The official form used to apply for personal assistance is the same as that used for any other kind of disability service granted by the social department of the Tyrolean regional government.⁴³⁵ Individuals can only apply for personal assistance if they have already been officially recognised as disabled, meaning that they have to be in receipt of either an increased family allowance or a long-term care allowance, or be in possession of a Disabled Persons Card (see Part III sub-section 8.1 above). The application indicates the name of the benefit which is being applied for and the number of hours of support being requested. The application also includes the applicant's medical records, proof of their official registration as a person with disabilities, and the level of care allowance granted if applicable. An informal letter written by the peer counsellor at the Centre for Independent Living is attached to the application. This letter explains why the requested number of hours of personal assistance is needed by the applicant. The Centre for Independent Living forwards the application to the Department for Social Affairs of the Tyrolean Regional Government, where an official decides if, and to which extent (in terms of hours per month), the applicant can receive personal assistance.

⁴³⁴ Questionnaire for self-evaluation regarding the need for personal assistance: see: https://www.fsw.at/downloads/behinderung/PGE_PA-Antrag_elektronisch.xls (for electronic completion); and https://www.fsw.at/downloads/behinderung/PGE_PA-Antrag_handschriftlich.pdf (for handwritten completion).

⁴³⁵ Link to the official form for applying for rehabilitation measures in the State of Tyrol: https://www.tirol.gv.at/fileadmin/themen/gesellschaft-soziales/soziales/Formulare/Antrag_auf_Gewaehrung_einer_Leistung.doc.

It may take up to two months for a decision to be made and, in the case of first-time applications, the assessment also usually involves a face-to-face meeting with a medical doctor and social worker. The doctor and social worker are required to submit statements indicating whether they support the application or not. No further information is available on how this element of the assessment is made.

If the application is approved, the applicant receives a notification, which indicates the number of hours per month granted for personal assistance. In general, the maximum number of hours granted is 250 per month. Complete refusals are rare because of the counselling provided by the Centre for Independent Living, which helps to filter out applications which are unlikely to succeed. However, a lesser number of support hours than requested may be granted. Currently, the decision cannot be appealed. Personal assistance is granted for a maximum period of two years. After this period, a new application and assessment procedure must be carried out.

In 2016, a total of 401 persons with disabilities received personal assistance services in Tyrol (63.3 % women, 36.6 % men).⁴³⁶ In 2016, 32 persons who applied for personal assistance for the first time went through the assessment. No official evaluation of the assessment method has been carried out. However, the authors of an evaluation of a pilot project on direct payments for personal assistance in Tyrol concluded: 'It becomes clear that a majority of the participants cannot cover their personal need for support through personal assistance.'⁴³⁷ The report found that most recipients still needed additional support from relatives, friends and neighbours to cover all their support needs. This indicates that many persons do not receive personal assistance which matches their actual needs. In addition, persons with disabilities living in institutions and persons with psychosocial disabilities are explicitly excluded from personal assistant services in Austria.⁴³⁸ Disabled people's organisations in Austria have criticised this practice for years, but this has not resulted in any changes.

A positive aspect of the assessment is that it considers persons with disabilities in their individual living situation, as long as that is a private household. The assessment and related benefit focuses on inclusion and societal participation, and the assessment allows for the consideration of the individual situation of the applicant, which can lead to a tailored decision regarding support.

10.1.2 Personal budget for adults and children, Flemish Agency for Disabled Persons (Flanders, Belgium)

The Flemish Agency for Disabled Persons (VAPH) provides a number of different benefits to persons with disabilities in Flanders, including the personal assistance budget for minors and the personal budget for adults, which can be used to purchase care and support. The definition of disability used by the VAPH is:

⁴³⁶ Independent Living Innsbruck (2017), Annual report 2016, p. 5f. Unpublished report.

⁴³⁷ Pfahl, L., Plangger, S.; Anegg, M. (2018), Report on the scientific evaluation of the pilot project on 'personal budget' in Tyrol. University of Innsbruck, not yet published.

⁴³⁸ See p. 62 of the official description of services for persons with disabilities in Tyrol, at: https://www.tirol.gv.at/fileadmin/themen/gesellschaft-soziales/soziales/Sonstiges/Qualitaetsstandards-Leistungskatalog/Qualitaetsstandards_und_Leistungskatalog_Stand_7_Mai_2015.pdf.

... any long-term and significant participation problem experienced by a person and attributable to a combination of functional disorders of a mental, psychic, physical or sensory nature, limitations in the performance of activities, and personal and external factors.⁴³⁹

This definition allows for an individualised approach. Different application and assessment procedures apply for adults and minors. However, in general the assessment carried out by the VAPH aims to identify support needs, and is based on evidence which can be collected, including medical information indicating results of diagnostic tests and diagnosis, information about current support, and information indicating whether that support is adequate or not. The latter information is based on reports from medical practitioners such as therapists and social workers who know the applicant. A multidisciplinary team makes the assessment and decides what support would be appropriate.

Application forms and information about the application and support for applying is available via the VAPH homepage. In the case of minors, the following information is recorded via an online tool known as the A-document:⁴⁴⁰ – identification of the applicant and basic information about other members of the family; the needs of the applicant, divided into complaints and problems, positive aspects, desired changes and desired help and support; results of diagnostic tests and diagnosis; and additional information.

These issues are addressed from the perspective of both the ‘client’ (or applicant) and the ‘professional’, who can judge the context and needs of the applicant. The online tool is also used to indicate what kind of support the applicant is assessed as needing and the support the applicant will actually receive.

A number of technical instruments are used to identify the care needed by an applicant who is a minor. The first is the IZIKA (*Instrument ter bepaling van de intensiteit van Zorg voor Kinderen en Adolescenten* or Instrument to Determine the Intensity of Care for Children and Adolescents (6-18 years old)), which is derived from the American Child and Adolescent Service Intensity Instrument (CASII); the second is the IZIIK (*Instrument voor infants en kleuters* or Instrument for Infants and Toddlers (0-5 years old)), which is derived from the American Early Childhood Service Intensity Instrument (ESCII).

Adults apply for a personal budget by filling in a support plan, and can receive help in doing so from the Support Plan Service.⁴⁴¹

⁴³⁹ See: <https://www.vaph.be/wie-kan-een-beroep-doen-op-het-vaph>: Elk langdurig en belangrijk participatieprobleem van een persoon dat te wijten is aan het samenspel tussen functiestoornissen van mentale, psychische, lichamelijke of zintuiglijke aard, beperkingen bij het uitvoeren van activiteiten, en persoonlijke en externe factoren.

⁴⁴⁰ For children: A-document via intersectoral access portal (IAP). See: <https://www.vfg.be/VAPH/Pages/Aanvraagprocedure-voor-minderjarigen.aspx>; <https://www.jongerenwelzijn.be/professionelen/jeugdhulpaanbieders/intersectorale-toegangspoort/> (IAP by the Flemish Agency for Young People’s Well-being).

⁴⁴¹ Support plan via VAPH office, available at: <https://www.vaph.be/sites/default/files/documents/ondersteuningsplan-persoonsvolgend-budget-op-pvb/2016-001-05-ondersteuningsplan-persoonsvolgend-budget.pdf>.

In general, the assessment methods used are paper based, and medical and non-medical information is considered in a balanced way. The function of the assessment is to decide on the person's non-medical support needs. In order to identify these needs, daily functioning (non-medical factors) and diagnosis or impairment (medical factors) are taken into account.

A report on the IZIKA and IZIIL⁴⁴² found that the instruments were valid and useful in determining the care needed in the case of children with behavioural and emotional disorders, but it was less clear that they were appropriate for children with physical, mental or sensory disabilities. The report concluded that, to avoid inconsistent interpretations, the instruction manual on how to apply the assessments needed to be adapted. A second independent evaluation looked at the quality of the so-called A-documents between January and April 2015.⁴⁴³ Its main findings were that the participation of clients was insufficient in many cases; the experience of the 'care history' was often under-reported, and the perspective of the 'client' and the desired care was not clearly recorded. In addition, the evaluation identified a lack of a holistic perspective, with factors related to family and context too often not being taken into account, and the resources and capacities of the child being ignored at times. A third problem was the lack of scientifically accurate diagnostics – in some A-documents non-standardised tests were used, the date of the diagnostic process was not given, or no diagnosis was given at all, although the decision in the next phase had been made as if there was a diagnosis.

One benefit of this application process is that, in the case of minors, VAPH is part of the broader 'integrated youth care', and applications for all relevant benefits can be made through the 'intersectoral access portal', thus reducing the application burden on young people with disabilities and their families.

10.1.3 Municipal long-term care and support (City of Reykjavik, Iceland)

Long-term care and support is provided at the municipal level in Iceland. The assessment method examined in the Icelandic country report in this context relates to the city of Reykjavik, and it should not be assumed that a similar assessment method is used elsewhere in the country.

The allocation of benefits and services to persons with disabilities in Reykjavik is regulated by the Regulation on support services for the City of Reykjavik.⁴⁴⁴ The five key forms of support provided are counselling and support to enhance social participation, based upon the criteria and goals defined by the individual (*Persónuleg ráðgjöf*); in-home assistance or guidance for disabled parents or the parents or guardians of disabled children (*Tilsjón*); social support to enhance community participation, based on the criteria and goals of the individual (*Liðveisla*); further

⁴⁴² Diels, V. and Van Puyenbroeck, J. (2015), *Onderzoek naar de validiteit van het IZIKA en IZIIL instrument voor de doelgroep kinderen en jongeren met een handicap*, <https://jongerenwelzijn.be/professionelen/assets/docs/jeugdhulpaanbieders/publicaties/rapport-kwaliteitscentrum-diagnostiek-kwaliteit-a-doc.pdf>.

⁴⁴³ Kwaliteitscentrum voor diagnostiek vzw (2016), *Onderzoeksrapport kwaliteit A-documenten*, <https://jongerenwelzijn.be/professionelen/assets/docs/jeugdhulpaanbieders/publicaties/rapport-kwaliteitscentrum-diagnostiek-kwaliteit-a-doc.pdf>.

⁴⁴⁴ *Reglur um stuðningsþjónustu í Reykjavík* 2012.

assistance due to the increased need for services due to disability for those people who live in their own homes and to prevent the need to live in a group home or institutional facility (*Frekari liðveisla*); and family support to give parents a temporary reprieve from parenting duties in the case of disabled children with significant support needs (*Stuðningsfjölskyldur*).⁴⁴⁵ The support provided is based on the Act on the Affairs of Disabled People, No. 59/1992.

Adults are required to have been assessed as eligible to receive the disability pension (*örorkumat*) in order to apply for the relevant benefits (see Part III, sub-section 9.1.3 above), and must submit proof of this as part of their application. In the case of children, the basic eligibility requirement entails having proof of a chronic illness or disability diagnosis (see Part III, sub-section 7.1 above). The process is usually initiated by the applicant making a telephone call or sending an email to the local social services centre. The applicant is required to complete an application form,⁴⁴⁶ which provides information on the form of support being requested and for whom. This is followed by a face-to-face meeting with a specialist⁴⁴⁷ from the local municipal social services centre to determine the scale and scope of the support that is needed to meet the applicant's objectives and determine a service plan. The main factors that the assessor considers are the consequences of the impairment and how it affects daily life; the applicant's social circumstances and living arrangements; and the applicant's level of social participation and existing social support network. For each area considered, points are awarded, which are linked to categories of the applicant's need (small, average, great, very great; i.e. the lower the score/point, the lower the need for support). Each category/point range corresponds to a number of service hours or, in the case of family support, 24-hour periods, and the combination of all points determines whether the applicant is eligible for the support. The points awarded therefore translate into the number of service hours provided for each form of support requested. In general, the assessment aims to determine the scale and scope of the individual's support needs. As noted above, the assessors are bound by the Regulation on support services for the City of Reykjavik and the Act on the Affairs of Disabled People, No. 59/1992. Details concerning the guidance provided to assessors, the methodology used and the assessment scales are not publicly available, although some general information about the process is found in the Regulation and a brochure⁴⁴⁸ published by the Support Services of the City of Reykjavik.

Information regarding the number of people receiving specific benefits is publicly available via the internet,⁴⁴⁹ but no information is available on the number of people assessed during a given period, nor are the results of assessments.

⁴⁴⁵ These are the main forms of support services as defined by the City of Reykjavík's [department of welfare](#).

⁴⁴⁶ Available at: https://rafraen.reykjavik.is/content/files/public/Umsokn_um_studningsthjonustu_2016.pdf.

⁴⁴⁷ These are generally social workers who have had additional training and/or have taken academic courses in disability studies.

⁴⁴⁸ Available at: https://reykjavik.is/sites/default/files/ymis_skjol/skjol_utgefid_efni/studningsthjonustaireykjavik.pdf.

⁴⁴⁹ Via the PX-Web interface. See: <http://velstat.reykjavik.is/PXWeb/pxweb/is/VELSTAT/?rxid=8d9f623e-d472-43de-9d48-c908186a3177>.

Official, unofficial or academic evaluations of these specific municipal services are limited, and there is no focused study of the assessment methods underlying them. A specialist with a municipal service centre informed the ANED country experts for Iceland that the CRPD has been raised in recent years in the area of disability services, and greater attention is being paid to applying the Convention to the service system behind the scenes, but this not very apparent in official information, and even less so with regard to assessment methods specifically. The methods of assessment have not been developed in conjunction with disabled people and their organisations, and they remain a largely top-down, professional exercise.

10.1.4 Assessment for long-term or residential care (the Netherlands)

In the Netherlands, long-term care is provided under the Long Term Care Act, which came into force in 2015. Assessments are carried out by the *Centrum indicatiestelling zorg* (CIZ)⁴⁵⁰ or Centre for Care Indication Statements.⁴⁵¹ The assessment to determine eligibility to receive long-term or residential care involves a two-step process. The first stage involves a medical or impairment-related assessment. Children must have an intellectual disability to be eligible,⁴⁵² and this is assessed via an IQ test. Adults must have a 'somatic illness, psychogeriatric disease or an intellectual, physical or sensory disability' in order to be eligible.⁴⁵³ The first part of the assessment is usually based on medical records provided by the applicant. If the medical criteria are met, the second stage of the assessment determines whether the applicant meets the other eligibility requirements: in need of 'constant supervision in order to prevent escalation or serious harm for the applicant; in need of 24 hour care in close proximity because the applicant cannot call for help in relevant moments; the applicant has such physical problems that he/she would be in serious harm unless there is constant assistance, nursing care or constant need of an assistant taking over of self-care, taking over of tasks and taking over of decision-making in daily life activities'.⁴⁵⁴ This element of the assessment is therefore an assessment of need for care.

Assessments are carried out by a social worker at the CIZ. The social worker decides if a face-to-face interview is needed. If so, this is carried out during a visit to the applicant's place of residence. Applicants can be supported by an independent adviser during the assessment. The assessment is carried out in line with a set of policy rules,⁴⁵⁵ established on an annual basis and published by CIZ. The CIZ adopts the policy rules based on directions issued by the Ministry of Health, Welfare and Sports.

⁴⁵⁰ See: <https://www.ciz.nl/>.

⁴⁵¹ Unofficial translation.

⁴⁵² The Netherlands, Article 3.1.5, b Long Term Care Act, <http://wetten.overheid.nl/BWBR0035917/2018-01-01> and Beleidsregels indicatiestelling Wet langdurige zorg (Wlz) 2018 (Policy rules assessment Long Term Care Act 2018), p. 11. See: https://www.ciz.nl/images/pdf/beleidsregels/Beleidsregels_indicatiestelling_Wlz_2018.pdf.

⁴⁵³ The Netherlands, Article 3.2.1 Long Term Care Act, <http://wetten.overheid.nl/BWBR0035917/2018-01-01> and Beleidsregels Indicatiestelling Wet langdurige zorg (Wlz) 2018 (Policy rules assessment Long Term Care Act 2018), p. 5. See: https://www.ciz.nl/images/pdf/beleidsregels/Beleidsregels_indicatiestelling_Wlz_2018.pdf.

⁴⁵⁴ The Netherlands, Beleidsregels indicatiestelling Wet langdurige zorg (Wlz) 2018 (Policy rules assessment Long Term Care Act 2018), p. 7, available at: https://www.ciz.nl/images/pdf/beleidsregels/Beleidsregels_indicatiestelling_Wlz_2018.pdf.

⁴⁵⁵ The latest version of the rule dates from 2018 and is available at: <https://zoek.officielebekendmakingen.nl/stcrt-2017-69975.html>.

The rules establish the exact steps and the sequence the assessor must follow. The rules also provide interpretations of terms such as 'serious harm', 'constant supervision', and so on. The rules indicate what the assessor must take into account when assessing the severity of functional limitations for self-care, for instance, but they do not make it clear how the assessor should do this. The rules also clarify in what circumstances an applicant might be referred to a care insurance company or local municipality.

If the applicant is assessed as being eligible for long-term care, the ClZ decides on the specific kind of care package the applicant is entitled to. The care packages are described in terms of the number of hours available for group assistance and the individual assistance or treatments the applicant is entitled to, and are dependent on the type and severity of the disability. The assessment also establishes whether and to what extent other people in the household are required to provide care. The care packages describe what kind of care the applicant is entitled to, based on what residential care providers usually offer. The ClZ takes a decision on the application within eight weeks of it being made.

The ClZ carries out assessments under the Long Term Care Act. Long-term care is provided by care providers which have won contracts from publicly funded care insurers (*zorgkantoren*). Care providers have to meet specific criteria (such as publishing their financial results and the education level of their workers and management. In 2015, when the current system came into force, the ClZ assessed 104 777 new applicants, the majority of whom were over 75 years of age.

The Long Term Care Act replaced a previous system (the AWBZ or General Medical Expenses Act). The new Act established a new allocation of care roles between municipalities, public care insurers and commercial care insurers. The purpose of the reform was to limit the eligibility for residential care for elderly people and long-term care for children with disabilities. These groups are not left without care and support but, under the new system, they are more dependent on the provision of social support and residential care from local municipalities. Municipalities are free to decide on how to assess for social support and youth care and who carries out that assessment.

The outcome of the reform is being evaluated in a series of studies and is regularly discussed in Parliament. Eligibility, as well as the conditions and assessment procedures for social support and youth care, vary widely among municipalities, which makes it difficult to identify the number of people assessed and the assessment outcomes across the country as a whole.

A recent study carried out by the BMC research agency, 'Access to care under the Long Term Care Act',⁴⁵⁶ concluded that applicants usually know little about eligibility conditions and the application process. The study found that the majority of applicants were informed about, and were referred for, an application by medical professionals such as nurses, general practitioners or care providers. Nurses who provide care at home for people with disabilities may decide at some point that residential care is more suitable for the individual and, in such cases, the nurse usually makes the application

⁴⁵⁶ BMC rapport Toegang tot zorg vanuit de Wet langdurige zorg, February 2017, available at: <https://www.rijksoverheid.nl/documenten/rapporten/2017/02/24/bmc-rapport-toegang-tot-zorg-vanuit-de-wet-langdurige-zorg>.

on behalf of the applicant. The study reported that only 22 % of applicants for long-term care decided on their own to apply for long-term care or were advised to do so by families or friends. The research also found that the majority of applicants do not know that they have the right to be assisted by an independent advisor during the application process.

The BMC reported that, according to the CIZ, 96.6 % of all new applicants for long-term care benefit will have a personal contact with a CIZ staff member, either through a house call or an appointment at a CIZ office. However, only three out of five applicants who were interviewed for this study reported having any personal contact during the application process. The study reported that the majority of applicants were satisfied with the application process. They were reported as appreciating the personal contact and the outcome, but were somewhat dissatisfied with the information they received about the Long Term Care Act and the assessment process. According to the study, the assessors at the CIZ were satisfied with the application process and the guidance they received. They reported specific problems in assessing the needs of certain groups, namely elderly people with severe somatic diseases, but no cognitive deficiencies; children and young adults for whom it is unclear whether their disability is permanent; and people with a slight intellectual disability and psychiatric problems. Under the relevant rules, individuals with such conditions are not eligible for long-term care, but assessors were unhappy about denying such care if the applicants were regarded as vulnerable, and if it was uncertain whether municipalities would provide alternative social support.

Disabled people's organisations were not involved in developing the assessment method, and it has not been evaluated with a view to establishing its compatibility with the CRPD.

10.1.5 Supplementary support for persons with disabilities (Sweden)

In Sweden, entitlement to supplementary support for persons with significant and long-term functional disabilities is regulated through Law 1993:387.⁴⁵⁷ The law, known as LSS, provides for a wide range of support including personal assistance, short-term stays outside the home, short-term supervision of children over 12, specialised housing and accommodation, daily activities and assistance in drawing up individual plans. Law 1993:387 restricts beneficiaries to persons with developmental disabilities (i.e. intellectual disabilities), persons with autism or autism-like states (*Personkrets 1*); persons who have a brain injury where the cause of brain damage was an accident, injury or disease, and the person must have acquired the brain injury in adulthood (*Personkrets 2*); and persons who have physical or psychosocial disabilities which are not due to the normal ageing process (*Personkrets 3*).⁴⁵⁸

In all cases, the disability should be long-lasting, and the applicant should demonstrate difficulties in daily life and be unable, on his or her own, to manage everyday activities, such as personal hygiene, toilet visits, dressing, food storage, indoor and outdoor mobility, etc. The difficulties in carrying out activities should heavily impact on several important areas of life at the same time, such as housing, leisure and the need for

⁴⁵⁷ Available at: http://www.demenscentrum.se/globalassets/lagar_foreskrifter_pdf/svensk-forfattningsamling-lss.pdf.

⁴⁵⁸ See: <http://www.notisum.se/rnp/sls/lag/19930387.HTM>.

habilitation / rehabilitation. Difficulties must exist on a daily basis in different situations and environments.

In the case of persons who have *personkrets* 1 or 2 status, eligibility must be certified through a psychological or medical statement, where the diagnosis expressly complies with the requirements of Law 1993:387. The medical statement is provided by a medical expert, such as a general practitioner or other doctor, or a psychiatrist. The medical statement must identify the support needs the individual has in light of the diagnosed medical condition. Based on the needs described in the medical statement and those expressed by the applicant, the municipal administrators make an assessment of their support needs. The assessment therefore consists of two elements: establishing that the applicant has been diagnosed with a medical condition which is listed in the law, this being evidenced by a medical report from a treating physician; and identifying the applicant's need for support flowing from having that medical condition.

In the case of a person falling within the *personkrets* 3 status, eligibility is based not on a medical statement, but on the expressed needs of the applicant, which are assessed by administrators. However, the administrators may still require a certificate of diagnosis and advice from a treating doctor or psychologist, and a statement from an occupational therapist, physiotherapist or others. Individuals falling within this group are re-evaluated by an administrator at each reassessment.

The benefits are provided at municipal level, and therefore each municipality has its own application and assessment procedure. The Swedish country report for ANED discussed the application and assessment used in Örebro. The procedure presented here is therefore from the municipality of Örebro.

In general, individuals are expected to apply on their own behalf, although parents, guardians or legal representatives can apply on behalf of minors or people who are unable to apply on their own. The applicant, or his or her representative, submits an application to the LSS Assessment Unit in the municipality. The application form can be obtained from the office of the Assessment Unit or online.

The assessment is carried out by an administrator, who is delegated to act on behalf of the municipality. The administrator should contact the applicant within a week of their application being submitted. The applicant then usually meets with an administrator for about an hour. The meeting can take place at the LSS Assessment Unit, in the applicant's home or elsewhere. The administrator asks questions about the difficulties the applicant faces in his or her daily life, the applicant's social situation, employment, family, living, leisure, and other relevant issues. The assessment considers the entire situation of the individual in order to assess the extent of the need for care. This means that living conditions for persons with disabilities are compared with living conditions for people without disabilities, who are of a similar age and live under similar conditions.

The assessment and investigation are individualised and are intended to identify the need for support, and specifically whether the applicant is entitled to support under Law 1993:387 (LSS), as well as whether the applicant's support needs are already being met or not. Information obtained from the meeting, together with medical

statements, form the basis for the final decision, which should be taken as quickly as possible once all other elements of the assessment have been completed. The processing of decisions and the provision of support are documented. The documentation records the decisions and actions required in the case, as well as facts and events relevant to the need for support. Actions relating to personal circumstances are treated as confidential information. All the information collected is taken into account in the assessment, and the applicant is informed by post. The letter also contains information about how to appeal.

When a decision is taken to provide support, responsibility passes to the coordinator of the Public Administration Offices at the municipality. The coordinator registers the decision and assigns a body to implement the decision. The Public Administration Offices also act as a control unit. They follow up on all decisions, check that they are executed as soon as possible, collect statistics and report to the Municipal Council, the City Council and the Inspectorate for Care (IVO) if a decision of support is not acted on within 3 months. All support must be provided urgently. Representatives of the responsible provider must contact the applicant or his/her representative as soon as possible after the decision has been taken to provide support, but no more than two weeks later. The provision of the various kinds of support always takes place in consultation and dialogue with the applicant and/or his/her representative. If the person declines the offered support, a new assessment may be required.

The decision is reviewed by an administrator every two years. A review may take place more quickly if the applicant's situation has changed in a relevant material way. The applicant can also request a reassessment.

Studies⁴⁵⁹ show that decisions regarding the number of hours of personal assistance are appealed to the municipal level in just over 25 % of cases. In the case of persons who have previously received assistance from the Swedish Social Insurance Agency, but have had that assistance withdrawn, the proportion of appeals is approximately 60 %.

Statistics⁴⁶⁰ from the National Board of Health and Welfare show that in 2016, 71 400 people received services from the municipalities, with 118 600 separate services being provided. In a 10-year period, the number of people receiving these care services has increased by 26 %, with boys and men over 65 receiving more support than girls and women over 65.

The municipalities have official guidance on how to apply, as well as about the assessment process, on their homepages. The National Board of Health and Welfare also provides guidelines⁴⁶¹ for the documentation of the activities conducted as part of the assessments. The guidelines state, for example, that treatment plans and the basis for decisions should be set out in writing.

The specific guidelines for assessing the need for care or support are produced by the individual municipalities, which results in considerable variation.⁴⁶² Some guidelines

⁴⁵⁹ See: <https://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/19758/2015-3-7.pdf>.

⁴⁶⁰ See: <http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/19914/2015-9-3.pdf>.

⁴⁶¹ See: <http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/19453/2014-5-19.pdf>.

⁴⁶² See: <https://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/19758/2015-3-7.pdf>.

address all forms of support covered under Law 1993:387,⁴⁶³ while others only address personal assistance. Some guidelines are fairly general; others contain information on in-depth questions and/or describe specific practices in the assessment. Some of the guidelines adopt a legal perspective and describe various legal dimensions to processing and assessment. Other guidelines adopt an administrative perspective, and describe how administrators should carry out their work from a procedural perspective.

In January 2015, the National Board of Health was asked by the Government to map and analyse the way the personal assistance benefit under Law 1993:387 was dealt with by municipalities.⁴⁶⁴ The report revealed that more than half (57 %) of the municipalities stated that they had guidelines for assessing the need for personal assistance, and the majority of municipalities stated that the purpose of the guidelines was to provide guidance to the administrators, leading to more uniform assessments. The mapping also showed that only a few municipal guidelines contained information about how the amount of personal assistance to be provided should be calculated. Almost all the municipal guidelines did not set any upper limit on how many assistant hours could be granted, nor did they specify a minimum level of need for the individual to be entitled to personal assistance. With the exception of a few municipal guidelines, there was no requirement that the opinion of a medical expert should always be obtained when assessing personal assistance needs.

The study found that many municipalities emphasised in their guidelines that decisions on the right to personal assistance must be based on an individual assessment, and three quarters of the guidelines stated that individual needs should always govern the decision. However, in the view of the National Board of Health, the guidelines were so tightly defined that they risked negatively affecting the ability of the assessor to exercise discretion in some cases. The study also found that a considerable proportion of the guidelines were different for each municipality, and that it was not always clear on what basis the municipalities provided different detailed guidelines. Some differences were so pronounced that there was a risk of different decisions being made regarding individuals in similar circumstances, undermining the fairness of the process.

The National Board of Health and Welfare concluded that there was a need for clearer regulation in the law. This was needed in order to achieve more uniform application across the country and to ensure that the legislation meets the needs of individuals for support and service. While the municipalities use guidelines to ensure consistency of decision making, ensuring that local residents are treated equally, the impact of differing municipal guidelines might lead to significant differences across the country. The National Board of Health and Welfare therefore found there was a need for clearer national regulation to achieve more uniform application of Law 1993:387 across the country, and to reduce the need for local guidelines.

10.1.6 Adult social care (United Kingdom)

⁴⁶³ The services provided in the LSS are: personal assistant, companion service, assignment of contact person, replacement support at home, short-term stay outside the home, short-term supervision for schoolchildren over 12 years, accommodation in family homes for children and youth, housing with special service for children and adolescents, housing with special service for adults, daily activities and requests for the establishment of individual plans.

⁴⁶⁴ See: <https://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/19758/2015-3-7.pdf>.

In the United Kingdom, local authorities are responsible for carrying out assessments to determine eligibility for long-term care-related benefits. In this respect, they act under the auspices of the Department for Health and Social Care. The benefits can be paid in kind through the provision of social services, or in cash, which is provided in lieu of services, and which can be used to purchase personal assistance. These benefits are means tested.

The assessment is needs based – however, it also includes elements of a functional capacity assessment as, in order to receive adult social care services, a person must be considered unable to achieve certain functional outcomes.

The regional governments have a role to play in defining eligibility criteria. In England, under the Care Act 2014, all local authorities have a legal duty to provide or arrange social care for adults if there is a need for care arising from ‘physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury’. A similar duty applies in Wales under the Social Services and Well-being (Wales) Act 2014. The information below relates to the assessment mechanism used in England, where local authorities have a legal (statutory) duty to make a ‘needs assessment’ for any adult where it appears that there is a need for care or support, including where this need applies to a carer.

The process of assessment for long-term care is usually triggered by a request for help from the person or their family to a local authority social services department. An assessment may also be offered after the identification of a need by a health or social care worker, or a third party. The assessment begins with the gathering of information about an applicant’s situation. There is no prescription about how this should take place, but it could include face-to-face meetings, supported self-assessment, a telephone or online assessment, or a joint assessment by multiple agencies using diverse methods.

Local authorities are encouraged to be flexible and adaptable. In practice, there may be direct contact with any of a wide range of professionals working for, or on behalf of, the local authority, such as social workers or assistants, or occupational or physical therapists. The applicant’s active involvement in the assessment should be supported, including by providing for a (supported) self-assessment. This might involve formal or informal advocacy for some people (e.g. professional, family or peer support to articulate goals and needs), and any known carer must be involved in the process. Applicants are to be provided with an Independent Mental Capacity Advocate if required.⁴⁶⁵ The Care and Support Statutory Guidance⁴⁶⁶ states that ‘[p]utting the person at the heart of the assessment process is crucial to understanding the person’s needs, outcomes and wellbeing, and delivering better care and support’.⁴⁶⁷

Nevertheless, certain steps must be followed in the assessment. This includes compliance with the minimum threshold for providing care and support set out in the national eligibility criteria, although local authorities may also provide support to people who do not reach the threshold. The introduction of eligibility criteria was intended to

⁴⁶⁵ UK, Para. 6.32, Care and Support Statutory Guidance.

⁴⁶⁶ Available at: <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance>.

⁴⁶⁷ UK, Para. 6.30, Care and Support Statutory Guidance.

provide transparency in a situation where assessments and support are provided by different local authorities across the country. Under Section 13 of the Care Act 2014, the local authority must ‘determine whether any of the identified needs meet the eligibility criteria’,⁴⁶⁸ which are in turn defined by the Care and Support (Eligibility Criteria) Regulations⁴⁶⁹ and the Care and Support Statutory Guidance. These require that the needs: arise from or are related to a physical or mental impairment or illness; mean that the person is unable to achieve two or more from a list of specified outcomes; and this significantly affects their wellbeing.

The Care and Support Statutory Guidance defines the assessment as ‘one of the key interactions between a local authority and an individual’ and advises that ‘[t]he process must be person-centred throughout, involving the person and supporting them to have choice and control’.⁴⁷⁰ The guidance also states that ‘[a]n assessment must seek to establish the total extent of needs before the local authority considers the person’s eligibility for care and support and what types of care and support can help to meet those needs’.⁴⁷¹ In this sense, the approach to assessment remains needs-led and holistic in scope, including an assessment of ‘how the adult, their support network and the wider community can contribute towards meeting the outcomes the person wants to achieve’.⁴⁷²

Assuming that a need for care or support is identified, the eligibility criteria must be considered. These are defined in Section 2 of the Care and Support (Eligibility Criteria) Regulations, and involve three requirements, as noted above.⁴⁷³ The local authority must determine that the requirements for care or support ‘arise from or are related to a physical or mental impairment or illness’, that this results in the adult being ‘unable to achieve two or more of the outcomes specified’, and that this results in ‘a significant impact on the adult’s well-being’.

The Regulations do not prescribe how the first of these three criteria (arise[s] from or [is] related to a physical or mental impairment or illness) should be assessed, but no medical diagnosis is required. The guidance provides only the following interpretation for assessors:

The first condition that local authorities must be satisfied about is that the adult’s needs for care and support are due to a physical or mental impairment or illness and that they are not caused by other circumstantial factors. Local authorities must consider at this stage whether the adult has a condition as a result of either physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury. The authority should base their judgment on the assessment of the adult, and a formal diagnosis of the condition should not be required.⁴⁷⁴

For the second criterion (‘unable to achieve two or more of the outcomes specified’), a list of 10 outcomes are specified in Section 2(2) of the Regulation, covering a range of

⁴⁶⁸ Available at: <http://www.legislation.gov.uk/ukpga/2014/23/section/13>.

⁴⁶⁹ Available at: http://www.legislation.gov.uk/uksi/2015/313/pdfs/ukxi_20150313_en.pdf.

⁴⁷⁰ UK, Para. 6.1, Care and Support Statutory Guidance.

⁴⁷¹ UK, Para. 6.10, Care and Support Statutory Guidance.

⁴⁷² UK, Para. 6.10, Care and Support Statutory Guidance.

⁴⁷³ See: <http://www.legislation.gov.uk/uksi/2015/313/contents/made>.

⁴⁷⁴ UK, Para. 6.104, Care and Support Statutory Guidance.

functional and life domains. Further interpretation of each outcome is provided in the guidance.⁴⁷⁵ The 10 outcomes are:

- (a) managing and maintaining nutrition;
- (b) maintaining personal hygiene;
- (c) managing toilet needs;
- (d) being appropriately clothed;
- (e) being able to make use of the adult's home safely;
- (f) maintaining a habitable home environment;
- (g) developing and maintaining family or other personal relationships;
- (h) accessing and engaging in work, training, education or volunteering;
- (i) making use of necessary facilities or services in the local community including public transport, and recreational facilities or services; and
- (j) carrying out any caring responsibilities the adult has for a child.

When considering whether someone is 'unable' to achieve any of these outcomes, the local authority must establish what the applicant can do, with or without assistance, and, where this fluctuates, over whatever time period is deemed 'necessary to establish accurately the adult's level of need'. This allows the assessor significant discretion but, for an individual to be eligible for adult social care services, at least one of the following criteria must be met for at least two of the 10 outcomes for the individual:

- (a) is unable to achieve the outcome without assistance;
- (b) is able to achieve the outcome without assistance, but doing so causes the adult significant pain, distress or anxiety;
- (c) is able to achieve the outcome without assistance, but doing so endangers or is likely to endanger the health or safety of the adult, or of others; or
- (d) is able to achieve it without assistance, but takes significantly longer than would normally be expected.

With regard to the third criterion (being unable to achieve two or more outcomes results in 'a significant impact on the adult's well-being'), the guidance notes that the term 'significant' is not defined and 'must therefore be understood to have its everyday meaning'.⁴⁷⁶ It acknowledges that impact varies with personal circumstances, and a number of fictional case studies are provided to guide assessors. However, assessors have discretion as to how to interpret the guidance. The principle of 'wellbeing' is defined in Section 1(2) of the Care Act 2014 in the following way:⁴⁷⁷

'Well-being', in relation to an individual, means that individual's well-being as it relates to any of the following:

- (a) personal dignity (including treatment of the individual with respect);
- (b) physical and mental health and emotional well-being;
- (c) protection from abuse and neglect;
- (d) control by the individual over day-to-day life (including over care and support, or support provided to the individual and the way in which it is provided);

⁴⁷⁵ UK, Para. 6.106, Care and Support Statutory Guidance.

⁴⁷⁶ UK, Para. 6.109, Care and Support Statutory Guidance.

⁴⁷⁷ UK, Section 1(2), Care Act 2014, <http://www.legislation.gov.uk/ukpga/2014/23/section/1>.

- (e) participation in work, education, training or recreation;
- (f) social and economic well-being;
- (g) domestic, family and personal relationships;
- (h) suitability of living accommodation;
- (i) the individual's contribution to society.

The Care Act also establishes the underpinning principle of participation in decision making and 'the importance of beginning with the assumption that the individual is best-placed to judge the individual's well-being'.⁴⁷⁸

In essence, the assessment method involves three different approaches which, in combination, can be regarded as an assessment of need. The first strand requires the establishment of an impairment or illness. To some extent, this can be regarded as a medical assessment, although no formal medical diagnosis is required. The second strand is a functional capacity assessment relating to a wide range of skills and capacities. The third strand, concerning impact on 'well-being', is not commonly found in other assessment methods explored in this synthesis report, at least not explicitly, and brings an element of 'needs' perspective into the assessment. In short, adult social care will be 'needed' where it is required in order to guarantee the applicant's 'well-being'.

Once the assessment has been completed, the local authority must provide the applicant with a copy of their decision. If no eligible needs have been identified, the authority should still provide information and advice. Where the assessment identifies a need for care or support, and where the applicant also meets the minimum eligibility threshold, then the local authority must agree with the person 'which of their needs they would like the local authority to meet' and how.⁴⁷⁹

In 2015-2016, local authorities carried out 1 811 000 new assessments in the context of adult social care.⁴⁸⁰ London received the lowest number of applications per 100 000 adults, while Yorkshire and the Humber received the highest number of applications, with over twice as many as London.⁴⁸¹ More than half (57 %) of requests for support resulted in no direct support being provided, including more than half a million (515 000 requests) where no needs were identified, either as a result of a formal assessment or due to other eligibility criteria, such as not being ordinarily resident in the local authority area or because the applicant did not pass the means test .

The Social Care Institute for Excellence (SCIE) provides resources for practitioners to explain and contextualise the adult social care needs assessment method and its context.⁴⁸² It also promotes knowledge-based good practice. A 2012 SCIE report identified considerable challenges with the process with 'no shortage of assessment tools and methodologies already in existence' but 'no appetite for the introduction of a new tool'.⁴⁸³ However, it strongly promoted the values of self-assessment and personalisation. The report stated:

⁴⁷⁸ UK, Section 1(3)(a) Care Act 2014.

⁴⁷⁹ UK, Para. 6.134, Care and Support Statutory Guidance.

⁴⁸⁰ See: <http://digital.nhs.uk/catalogue/PUB21934>.

⁴⁸¹ See figure 13, UK ANED country report.

⁴⁸² Available at: <https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/eligibility/>.

⁴⁸³ Available at: <https://www.scie.org.uk/publications/reports/report57.asp>.

The experience in many other countries is that assessment tools are often functional and focus on measuring people's capacity to undertake activities of daily living, but are less successful in capturing people's preferences, aspirations and aspects of psychosocial wellbeing. This approach tends to be concerned with things that a person is unable to do, rather than with supporting people to maximise their independence. It would be a backward step if the search for greater objectivity and clarity in social care assessment led to a tool that was similarly 'deficit' focused, rather than addressing assets, outcomes and aspirations.⁴⁸⁴

Current SCIE guidance to 'ensuring assessment is appropriate and proportionate' emphasises that 'the assessment process [should be] adapted to the person's circumstances, needs (communication needs, level of complexity, etc.) and preferences'.⁴⁸⁵

In the view of ANED country experts, 'the assessment methodology ... offers a well-conceived model that has broad support', although they note problems with implementation and the provision of adult social care in a situation where the budgets of local authorities are severely stretched.

10.2 Financial support to cover additional disability-related expenses (Denmark)

In Denmark, disabled individuals can apply for a cash benefit from their local municipality if they incur disability-related expenses that they would not have incurred but for their disability, of at least EUR 875 per year. The assessment can be regarded as an assessment of need and, in this case, need (or eligibility) is demonstrated by the level of disability-related costs which an individual incurs. This benefit is not means tested.

Applications to the municipality are made using a standard form⁴⁸⁶ or online.⁴⁸⁷ The applicant must include information on their reduced functional ability and estimate the additional costs which accrue as a result. They are asked to provide information on both existing and ongoing costs and expected future costs. The application must also include information on the applicant's health insurance and indicate which medical professionals can be contacted for further information.

The assessment is paper based. A social worker reviews the application, and may contact the named medical professionals. A face-to-face meeting with the applicant does not take place. The executive order⁴⁸⁸ providing for the benefit provides very little information on how to make the assessment. It states:

⁴⁸⁴ SCIE Report 57: Crossing the threshold: The implications of the Dilnot Commission and Law Commission reports for eligibility and assessment in care and support, p. iv, available at: <https://www.scie.org.uk/publications/reports/report57.asp>.

⁴⁸⁵ See: <https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/appropriate-proportionate/>.

⁴⁸⁶ Available at: <http://www.kl.dk/blanketter/blanketsamling/>.

⁴⁸⁷ For example, see the home page of the Aarhus municipality: <https://www.aarhus.dk/da/borger/oekonomi/Sociale-ydelser/Merudgiftsydelse-for-voksne.aspx>.

⁴⁸⁸ 'Bekendtgørelse om nødvendige merudgifter ved den daglige livsførelse', <https://www.retsinformation.dk/pdfPrint.aspx?id=144516>.

Grants are only granted for additional expenses incurred as a result of the reduced physical or mental functioning of the person applying. The need is assessed in relation to non-disabled people [of the] same age and same life situation. The expenses for daily life that the person himself would have incurred if no special costs incurred due to the reduced functional capacity must be borne by the person himself. The amount of additional expenses is independent of income and is not taxable. (§5 Executive Order).

The municipalities can determine the service level they provide, as long as it meets the minimum standard set out in the Executive Order. This means all municipalities must provide a minimum degree of benefits. The *Ankestyrelsen* (Appeal Board) occasionally reviews the assessment process for the additional costs' benefits. The last review in 2014⁴⁸⁹ found that municipalities made correct decisions in 77 % of cases, the applicant was involved in making nearly all assessments, and applicants received a written decision. *Ankestyrelsen* found that the documentation linked to the decision revealed that the applicant was involved in the assessment to a large extent in 91 % of cases, and to some extent in 5 % of cases. It is not apparent from *Ankestyrelsen's* report how this involvement took place. *Ankestyrelsen* also found that most decisions were well documented, with 86 % of files not missing any information. *Ankestyrelsen* only assessed whether the municipalities met the minimum requirements set out in law. No other evaluations have been carried out.

10.3 Provision of additional support at school (Greece)

In Greece, a new assessment method to determine eligibility for additional support at school was recently introduced through the new Law on Reform of Support Structures in Primary and Secondary Education.⁴⁹⁰ The reform has been influenced by the CRPD and is intended to mark a clear shift from a medical diagnostic assessment to a holistic assessment, which identifies the educational support needs of children. At the time of writing, the methodology of the new assessment has not been finalised and it has not been implemented – the information below is therefore based on the draft law, which had not been adopted at the time of writing. It is expected that the new assessment and support structures will be operational from September 2018, coinciding with the start of the school year.

According to the new Law on Reform of Support Structures in Primary and Secondary Education, the responsibility for conducting educational needs assessment and providing support is shared equally between the Interdisciplinary Educational Assessment and Support Committee (EDEAY),⁴⁹¹ established in each mainstream primary and secondary school, and the Centres for Educational and Counselling

⁴⁸⁹ Available at: <https://ast.dk/publikationer/ankestyrelsens-praksisundersogelse-om-merudgifter-til-voksne>.

⁴⁹⁰ Reform of Support Structures in Primary and Secondary FEK102 A/12.06.2018, see: https://www.hellenicparliament.gr/UserFiles/bcc26661-143b-4f2d-8916-0e0e66ba4c50/e-anadec-pap_apospasma.pdf; Ministry of Education, Research and Religious Affairs Press Release, 16 March 2018, available at: <https://www.minedu.gov.gr/rss/33503-16-03-18-sti-diavoylefisi-to-sxedio-nomou-gia-tis-domes-2>.

⁴⁹¹ Greece, Law 4115/2013 (Art. 39); Ministerial Decision FEK 315/B/2014; latest update of Educational Draft Law on Reform of Support Structures in Primary and Secondary Education (Public Consultation March 2018). See: <http://www.opengov.gr/ypepth/wp-content/uploads/downloads/2018/03/ypepth.pdf>.

Support (KESY),⁴⁹² operating at regional level as part of the Regional Education Directorate, under the auspices of the Ministry of Education, Research and Religious Affairs. Both these organisations existed under the previous assessment and support system, but they have been renamed and given somewhat different tasks under the new system.

There are multiple routes for accessing an educational needs assessment and related support. The EDEAY is primarily responsible for identifying pupils who encounter difficulties in the learning process. The EDEAY Committee assesses ‘the type of difficulties and potential educational, psychosocial, and other barriers to learning’⁴⁹³ and may refer specific cases to the KESY, if it decides that those cases need further assessment and support, ‘*despite* support measures being taken by the school’.⁴⁹⁴ Support measures provided at the school level can include differentiated teaching methods and alternative forms of learning, as well as working with psychosocial support services in the community.⁴⁹⁵

A parent or guardian can also directly refer a pupil to the regional KESY. Additionally, the KESY can potentially identify pupils with special educational needs who could benefit from support during regular needs assessment activities.⁴⁹⁶ These cases will first be referred to the school unit’s support committee, which is responsible for implementing a first assessment and providing a short-term intervention; if these are deemed to be inadequate, the case will be referred back to the KESY.⁴⁹⁷

In all cases, in order for a secondary-level assessment at the KESY to take place, a parent or guardian must have made a written application, and a recommendation for a further assessment must have been issued by the teaching staff body of the school unit, together with supporting evidence showing that ‘all necessary supportive interventions’ have been carried out by the school unit. This must also include the results of the interventions, including the short-term intervention programme implemented by the EDEAY.⁴⁹⁸

Each the EDEAY, which, as noted above, has a first-line role to play in the assessment, consists of:⁴⁹⁹

⁴⁹² Greece, Draft Law on Reform of Support Structures in Primary and Secondary FEK102 A/12.06.2018, https://www.hellenicparliament.gr/UserFiles/bcc26661-143b-4f2d-8916-0e0e66ba4c50/e-anadec-pap_apospasma.pdf; Law on Reform of Support Structures in Primary and Secondary Education (Public Consultation March 2018); see: <http://www.opengov.gr/ypepth/wp-content/uploads/downloads/2018/03/ypepth.pdf>.

⁴⁹³ Greece, Art.10 para. 2, Law on Reform of Support Structures in Primary and Secondary Education FEK102 A/12.06.2018.

⁴⁹⁴ Greece, Art. 11 para. 3, Law on Reform of Support Structures in Primary and Secondary Education FEK102 A/12.06.2018, emphasis added by ANED country expert.

⁴⁹⁵ Greece, Art. 11 para. 8, Law on Reform of Support Structures in Primary and Secondary Education FEK102 A/12.06.2018.

⁴⁹⁶ Greece, Art. 7 para. 2a, Law on Reform of Support Structures in Primary and Secondary Education FEK102 A/12.06.2018.

⁴⁹⁷ Greece, Art.7 para. 3a, Law on Reform of Support Structures in Primary and Secondary Education FEK102 A/12.06.2018.

⁴⁹⁸ Greece, Art.10 para. 3, Law on Reform of Support Structures in Primary and Secondary Education FEK102 A/12.06.2018.

⁴⁹⁹ Greece, Art.10 para. 3, Law on Reform of Support Structures in Primary and Secondary Education FEK102 A/12.06.2018.

- The headmaster of the school unit (coordinating role);
- One educational staff member specialised in special education;
- One psychologist;
- One social worker; and
- Members of teaching staff who teach the individual pupil being assessed.

The parents of the pupil assessed are able to participate in meetings of the EDEAY, and the EDEAY may request further assistance from other educational staff in the school's wider educational support network.

The KESY, which carries out the secondary-level assessments, employs staff specialised in special education,⁵⁰⁰ including pre-school, primary and secondary levels, psychologists, social workers, speech therapists, occupational therapists, therapists in mobility and daily living skills of people with visual impairments, staff specialised in Greek Sign Language, and educational staff specialised in career counselling.⁵⁰¹

The main outcome of the assessment carried out by the KESY is an Individualised Educational Plan, which may include recommendations about the appropriate school environment (i.e. parallel support, integration class, or special education), the provision of technical aids and ICT, use of differentiated instruction methods and the substitution of written exams with oral exams at all levels of primary and secondary education. Since the purpose of the assessment is to provide advice and facilitate suitable supportive interventions according to the educational needs of disabled pupils, there are not any 'qualifying levels of disability' as such. No appeals process is foreseen.

It is worth stressing that the new law foresees no role for 'diagnosis' in the assessment of the need for additional educational support. In contrast, the system which it is replacing treated 'diagnosis' as a key element in the assessment. It is indicative that, under the previous legislation, EDEAY stood for '*Diagnostic Educational Assessment and Support Committee*', while support structures at regional level were instead called '*Centres for Differential Diagnosis, Diagnosis and Support of Special Educational Needs (KEDDY)*'.⁵⁰² The emphasis in the new system is on 'ensuring equal access of all pupils to education without exception and safeguarding their psychosocial development and progress' by providing support based on a holistic assessment of needs within education.⁵⁰³

The assessment method and processes are not detailed in the new legislation, presumably because this primarily concerns the restructuring of the support services, which will also carry out the assessments. It can be expected that updated guidance will be issued once the new structures are operational, including the newly established Regional Centres for Educational Planning (PEKES), which are responsible for

⁵⁰⁰ In the Greek context, this is the term used to describe the scientific and policy field as much as the administration structures around disability and education. Although seemingly a paradox, as a field of knowledge it strongly includes the concept, method and practice of inclusive education.

⁵⁰¹ Greece, Art. 9, Law on Reform of Support Structures in Primary and Secondary Education.

⁵⁰² Greece, Law 3699/2008 on Special Education and Education of persons with disability or with special educational needs (Article 4). Emphasis added.

⁵⁰³ Greece, Art. 1, Law on Reform of Support Structures in Primary and Secondary Education FEK102 A/12.06.2018.

programming, coordinating and monitoring educational activities as a whole, for providing scientific guidance for educational staff, and for coordinating the activities of the KESYs.⁵⁰⁴

It should be noted that EDEAYs have existed since 2014, with a similar composition and purpose. They are also referred to in the new law, although with a slightly changed name, as noted above, and they will be given more responsibility in making sure that support is provided in the school before any case is referred to the regional level (KESY). The current official guidance on the role of EDEAYs, which makes explicit reference to the CRPD,⁵⁰⁵ has not been repealed or amended by the new law. The guidance describes the aspects to be considered in the educational assessment process.⁵⁰⁶ This includes educational factors,⁵⁰⁷ social, financial, environmental, and family factors that may obstruct access to school or create inequalities or discrimination against pupils with disability,⁵⁰⁸ and psychological aspects, including emotional and cognitive profile.⁵⁰⁹

Given that the new assessment and support system has not yet become fully operational, there is clearly no evidence of implementation and outcomes, nor is there any evaluation. This is also largely the case, however, for the previous system, whereby the regional support structures known as KEDDY (to become KESY under the new system) had the key task of issuing a diagnosis in the case of students with learning disabilities, while this role was taken on by public health committees for students with other forms of impairments ('sensory, mobility or other physical impairments, as well as severe or chronic illness').⁵¹⁰ Eustathiou, an academic, notes that 'despite their long presence, there is no systematic record' of their operation in practice.⁵¹¹

Data from the Greek Statistical Service reveals that 10 037 students with disabilities and/or special educational needs attended special education units in the school year 2015-16.⁵¹² However, attendance at special education units is only one of several possible outcomes of the educational needs assessment and support procedures. Other research reveals the difficulties in implementing the diagnostic assessment for pupils with Autistic Spectrum Disorders from the perspective of staff at KEDDY. These related to 'the validity and responsiveness of the diagnostic process, the difficulties responding to an increasing number of cases, the effective involvement of parents in the assessment process, the choice of a suitable school environment and the significance of drafting the IEP [individualised education plan]'.⁵¹³ Research has also

⁵⁰⁴ Greece, Art. 4, Law on Reform of Support Structures in Primary and Secondary Education FEK102 A/12.06.2018.

⁵⁰⁵ Greece, Art. 1, Ministerial Decision FEK 315/B/2014.

⁵⁰⁶ More details of the elements to be considered under each of these headings is provided in the ANED country expert report for Greece.

⁵⁰⁷ Greece, Art. 4, Ministerial Decision FEK 315/B/2014.

⁵⁰⁸ Greece, Art. 5, para. 2, Ministerial Decision FEK 315/B/2014.

⁵⁰⁹ Greece, Art. 6, Ministerial Decision FEK 315/B/2014.

⁵¹⁰ Greece, Art. 5, para.1, Law 3699/2008.

⁵¹¹ Eustathiou (2016), *Qualitative and Quantitative Characteristics of Special Education Structures in the Region of Ipiros*, p. 1, available at: <https://www.esos.gr/arthra/47787/poiotika-kai-posotika-harakteristika-ton-domon-eidikis-agogis-kai-ekpaideysis-stin>.

⁵¹² Greek Statistical Service, 2017. See: <http://www.statistics.gr/el/statistics/-/publication/SED41/->.

⁵¹³ Papatrecha et al. (2013) 'The views of staff of a KEDDY unit about diagnosis and support of children at the Autistic Spectrum in Primary Education', *Pedagogical Inspection* 55/2013, p. 141.

reported professionals reporting 'limited availability and adequacy of assessment tools', as well as a lack of specialised training offered by the public service for conducting the assessment.⁵¹⁴

Even though the new legislation aims to place the assessment procedures as a whole in a rights-based framework, the fact that the method and assessment processes used to date (i.e. diagnostic assessment) remain largely unaddressed suggests that practice is not likely to change automatically. This will only happen if gaps and weaknesses are identified and improvements are brought about. One important positive change in this respect is that the draft legislation foresees educational programming as a whole being based on regular monitoring and evaluation carried out at a regional level, to be conducted by the Regional Centres for Educational Planning (PEKES). Previously, no such regular official evaluations took place.⁵¹⁵ Overall, in the view of the ANED country expert, 'dismissing the function of diagnosis in educational needs assessments has significant potential in promoting inclusive education'.

10.4 Conclusion

The assessments of care or support needs discussed in this section reveal a focus on taking the individual situation of the applicant into account and, on occasions, the goals or outcomes which the applicant wishes to achieve through the individualised support. An individualised approach was explicitly mentioned by ANED country experts when describing the assessments from Austria, Belgium, Greece, Sweden and the United Kingdom covered in this section. Many of the assessment methods were also described as taking social and environmental factors into account, perhaps indicating that a human rights or social-contextual model of disability underlies the assessment. Generally speaking, these assessment methods may more closely reflect the model espoused by the CRPD than some of the other assessments considered in this synthesis report.

The Danish assessment of need was unusual and significantly different from the other assessments discussed in this section, in that need was assessed solely in terms of additional costs incurred as a result of a disability, and a certain level of additional costs gave an entitlement to a cash benefit. Need was therefore simply measured in monetary terms, and this was not means tested.

⁵¹⁴ Papatrecha et al. (2013) 'The views of staff of a KEDDY unit about diagnosis and support of children at the Autistic Spectrum in Primary Education', *Pedagogical Inspection* 55/2013, p. 140.

⁵¹⁵ PESEA (2014), 'Proceedings 7th National Scientific Conference on Special Education', *Special Education Issues*, vol. 66, pp. 1-112.

11 Assessment of economic loss

An assessment of economic loss aims to identify the reduced or lost earning capacity resulting from a disability or impairment. This assessment is potentially suited to an assessment of eligibility for a disability pension. Only two such assessment methods were identified for the purposes of this synthesis report: the assessment for a disability pension in Liechtenstein and the assessment for a disability pension in the Netherlands. As with functional capacity assessments, such assessments can either be expert based or structured assessments.⁵¹⁶ The assessment in Liechtenstein is an expert assessment, while the assessment in the Netherlands is a structured assessment.

11.1 Assessment for a disability pension (Liechtenstein)

In Liechtenstein, a disability pension (or invalidity insurance benefit) is paid to individuals who are partially or wholly restricted in carrying out their occupational activity or their previous activity due to a long-lasting health restriction. In the case of people with a history of employment, the assessment is based on measuring reduced earning capacity. In the case of people who do not have a history of employment, an alternative assessment method is used, measuring reduced ability to carry out previous activities. In all cases, the measured disability is expressed as a percentage. If the disability is assessed as being at least 40 % but below 50 %, a quarter pension is paid. If the disability is assessed as at least 50 % but below 67 %, a half pension is paid. A full pension is paid if an individual is assessed as having at least a 67 % disability.

Applicants⁵¹⁷ submit the relevant form to the Liechtenstein Disability Insurance, which then requests additional information from the general practitioner treating the applicant and the current or past employer of the applicant. The requested medical information relates to the cause of the reduced capacity to work, the nature and extent of the medical treatment, and the applicant's account of their medical history. The treating doctor must also provide information on previous activities, possible work-related integration measures and what adapted activities the applicant can perform. This information is provided through a standardised questionnaire.⁵¹⁸ The (former) employer, who is also requested to supply information to the Liechtenstein Disability Insurance, is asked to provide information about the work situation of the claimant and some brief information about their future work possibilities. The (former) employer should also provide information on the employment relationship, salary and specific activities which are or were involved in the applicant's work, and any absences due to illness or accident.⁵¹⁹ A variety of other documentation or information can be requested by the Liechtenstein Disability Insurance, depending on the situation and disability of

⁵¹⁶ See Baumberg Geiger, B. (2018), 'Legitimacy is a balancing act, but we can achieve a much better balance than the WCA' – 'A Better WCA is Possible', Demos, p. 57, discussed further in Part I, section 2.1.1 of this report.

⁵¹⁷ The application form can be found at: https://www.ahv.li/fileadmin/user_upload/Dokumente/Online-Schalter/FORM/AHV-IV-FAK-FORM-3-01--Antrag_Erwachsene.pdf.

⁵¹⁸ Available at: <https://www.ahv.li/online-schalter/formulare/formulare-iv/>. A general fact sheet about the requirements for these medical reports is available at: https://www.ahv.li/fileadmin/user_upload/Dokumente/Online-Schalter/MB/AHV-IV-FAK-MB-3-08--Medizinische_Gutachten.pdf.

⁵¹⁹ See: <https://www.ahv.li/online-schalter/formulare/formulare-iv/>.

the applicant. Much of this supplementary information also concerns medical information and is to be provided by treating doctors and specialists.⁵²⁰

Where all this documentation is sufficiently clear for a decision to be taken on the award of a pension, the assessment takes the form of a paper-based exercise carried out by the resident physician of the Liechtenstein Disability Insurance. If this is not the case, additional medical examinations are carried out by specialists or clinics which have a contract with the Disability Insurance.

As noted above, in the case of people with a history of employment, the assessment is based on measuring their reduced earning capacity related to their disability. The disability is expressed as a percentage. In the case of employed persons, the degree of disability is determined by comparing the income the applicant could earn if he/she did not have a disability with the income that they can actually earn, and the degree of disability pension entitlement corresponds to the percentage of loss of earnings. The Disability Insurance therefore determines the income that could be earned if there was no health-related restriction, and deducts from this the income which the applicant could reasonably be expected to earn given the health-related restriction after the integration measures are implemented, irrespective of whether that income is actually earned or not. This results in the calculation of the disability-related loss of earning power.⁵²¹ This assessment could, for example, be applied to a person who, because of a disability, was unable to carry out his/her previous well-paid job, and is forced to take up a less well-paid post. If the individual's original income was CHF 50 000, and the income which the individual could reasonably be expected to be able to earn with the disability is CHF 22 000, the difference between the two incomes is CHF 28 000. This loss or reduction corresponds to 56 % reduction in income. The assessed disability percentage is also 56 %, which would result in a half pension. No further information about the assessment process is publicly available, and it is not clear how the assessment and calculation is carried out.

A slightly different approach is adopted in the case of people with no or limited employment history (part-time workers). In the case of people who do not have a history of employment, such as home keepers, the disability percentage reflects the extent to which they are restricted in their daily lives from carrying out their former activities. In the case of people who work part-time, the percentage reflects a dual approach: measuring both reduced earning capacity and the impact on their previous non-employment activities.

Based on the information provided through the medical examination and proposed disability percentage, the Liechtenstein Disability Insurance takes a preliminary decision and informs the applicant. The applicant then has the opportunity to comment on the decision, which could lead to a revised decision. However, the Disability Insurance must always comply with the requirements set down by law, and it is only allowed limited discretion under the legislation. Following the applicant's response and any appropriate reconsideration, a formal decision is taken and the applicant is informed.

⁵²⁰ For further details, see the list of questionnaires and forms used by Liechtenstein Disability Insurance listed in the Liechtenstein ANED country report on disability assessment.

⁵²¹ See: https://www.ahv.li/fileadmin/user_upload/Dokumente/Online-Schalter/MB/AHV-IV-FAK-MB-3-01--Leistungen_IV.pdf.

The Liechtenstein Disability Insurance carried out 440 assessments in the context of applications for a disability pension in 2016. The comparable figures were 547 in 2015 and 523 in 2014. The proportion of applicants who were awarded a pension varied between 39.9 % in 2015 and 42.4 % in 2014 (the figure was 40.7 % in 2016).⁵²² The system has not been evaluated independently and there are no court cases or publicly available complaints regarding the system. ANED experts⁵²³ nevertheless feel that more transparency and information regarding the assessment process and the calculation of the relevant disability percentage would be welcome.

11.2 Assessment for a disability pension (the Netherlands)

In the Netherlands, the assessment procedure for the disability pension for people who were employed at the time they acquired a disability or illness (*WIA*), and for people who became disabled before the age of 18 or before they finished their tertiary education (*Wajong*), is based on an assessment of economic loss.

In the case of the *WIA* pension, an individual is obliged to apply for an assessment 11 weeks before their 24 months of sick leave comes to an end. The application, which is submitted online,⁵²⁴ must be accompanied by documentation such as a report from the occupational doctor. This is submitted by the doctor directly to the Employee Insurance Agency (UWV), and the applicant may request a copy. The applicant must provide information about their employment history over the past five years, contact details of their general practitioner and information on their education and qualifications. If the applicant receives long-term care or support, this must also be communicated. Applicants for the *Wajong* pension typically submit their applications 11 weeks before their 18th birthday.

The applicant is assessed by an insurance physician and a labour expert who both work for the UWV. The insurance physician first assesses the applicant's functional limitations, then a labour expert assesses the amount of money they are theoretically able to earn from suitable work.

The insurance physician bases the assessment of functional limitations on an interview with the applicant, a medical examination and information from treating doctors, and uses no other specific instruments. Most of the information is gathered during a face-to-face interview between the physician and the applicant. The limitations which are assessed can be both physical and mental.⁵²⁵ In the interview, the insurance physician asks the applicant about, among other things, their medical history, specific complaints and problems in functioning.⁵²⁶ The applicant's work limitations are registered in a

⁵²² Source: annual statement of the Liechtenstein Disability Insurance, available at: https://www.ahv.li/fileadmin/user_upload/Dokumente/Ueber/Jahresberichte/AHV-IV-FAK-Jahresbericht--2016.pdf.

⁵²³ Patricia Hornich and Wilfried Marxer.

⁵²⁴ Information is available at: <https://www.uwv.nl/particulieren/formulieren/aanvragen-wia-uitkering.aspx>.

⁵²⁵ Spanjer, J., Brouwer, S., and Groothoff, J., 'Instruments used to assess functional limitations in workers' compensation claimants: a systematic review', in Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, p 33.

⁵²⁶ Spanjer, J., Krol, B., Popping, R., Groothoff, J., and Brouwer, S., 'Disability assessment interview: the role of detailed information on functioning in addition to medical history-taking', in Spanjer, J.

standardised list, the Functional Ability List (FAL). The assessment covers 28 different functional domains.⁵²⁷

The second stage of the assessment involves the labour expert identifying the jobs the applicant can carry out and the income that could potentially be earned in light of the functional restrictions which have been identified by the insurance physician. This may also involve a face-to-face meeting with the applicant. Baumberg Geiger et al. describe this process in the following way:

Claimants' functional capacities are assessed, then compared to the functional requirements of 7 000 actually existing jobs in the Netherlands in a database called CBBS ['Claim Beoordelings- en Borgingssysteem;'], usually translated as 'Claim Assessment and Assurance System;']. This provides an empirically based assessment of jobs that the individual can do, and the percentage earnings reduction that their disability causes compared to their previous occupation, which then underpins their eligibility for disability benefits.⁵²⁸

The labour expert therefore assesses the theoretical earning capacity of the applicant on the basis of their identified functional limitations and the requirements of specific jobs which are theoretically available in the labour market. The applicant must be able to do at least three jobs (full-time or part-time) as identified on the CBBS database for an assessment to be made. The theoretical earning capacity is then compared with the last earned wage, and the disability-related or health-related earning loss is identified. An individual needs to have at least a 35 % reduced earning capacity to receive a *WIA* pension – meaning that if an applicant is assessed as capable of earning at least 65 % of his or her previous wage, the applicant will not qualify for a *WIA* pension. The required reduction in earning capacity is much higher for *Wajong* applicants, and is set at 80-100 %. This means that a person who could theoretically earn at least 20 % of the minimum wage will not qualify for a *Wajong* pension. It is not relevant whether or not an applicant might actually be hired to do the jobs which he or she is identified as capable of doing, and assessments do not consider whether applicants are actively trying to find employment or not. The labour expert uses his or her professional judgment to identify the correct disability or reduced earning capacity percentage, although the degree of discretion given to the expert is fairly constrained.⁵²⁹

The database used for the *WIA* assessment contains information on the functional requirements of 7 000 jobs and is drawn up and maintained by a team of about 35 full-

(2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, p 47.

⁵²⁷ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

⁵²⁸ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

⁵²⁹ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

time specialists working for the UWV, who make on-site evaluations.⁵³⁰ Baumberg Geiger et al. note: 'Given the prohibitive cost of covering all jobs nationally, CBBS covers about 20 % of all of the possible occupational codes in the Netherlands, weighted towards "lower level jobs" that are potentially available to all claimants'.⁵³¹

A somewhat different approach is used when assessing eligibility for the *Wajong* disability pension. This is not done on the basis of the CBBS database, but using the SMBA assessment method (*Sociaal- Medische Beoordeling van Arbeidsvermogen* or 'Socio-Medical Assessment of Work Capacity'). This focuses on the functional requirements of a much smaller number of jobs than the CBBS, which are then used as reference points for assessing earning capacity. Baumberg Geiger et al. note that 'SMBA focuses on functional profiles of 15 relatively light minimum wage jobs (e.g., "parking lot attendant", "receptionist"), which are each meant to be representative of the requirements of wider groups of jobs nationally'.⁵³² One benefit of this approach is that such a database is much easier to maintain than the far broader CBBS database. Baumberg Geiger et al. also note:

SMBA addresses some of the problems of structured assessments by supplementing these with personalised expert judgments as to possible adjustments to these jobs that would enable the person to work, which labour market experts must explain within a structured report. A further new development in SMBA is to break apart jobs into their component tasks using the principles of job carving. Individuals who could not earn the minimum wage but who could do 40 % of a standard job will be put in the 'Banenafpraak' group, and if employed, will have their practical work capacity assessed within a specific job, which will then determine the subsidy received by the employer.⁵³³

Once an application has been submitted, UWV has eight weeks to complete the assessment and issue a decision. This period can be prolonged in the case of complicated decisions. In 2017, the average waiting time for the more complicated decisions was 16 weeks for the WIA pension and 14 weeks for the *Wajong* pension.⁵³⁴ The applicant is informed of the decision in a letter.

⁵³⁰ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

⁵³¹ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

⁵³² Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

⁵³³ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

⁵³⁴ Source: answers to questions in Parliament no. 2017Z10587, available at: <https://www.rijksoverheid.nl/binaries/rijksoverheid/documenten/kamerstukken/2017/08/22/beantwoording-kamervragen-over-de-derde-monitor-artsencapaciteit-uwv/beantwoording-kamervragen-over-de-derde-monitor-artsencapaciteit-uwv.pdf>.

Guidance is provided to assessors, and information on the methodology to be used is set out in the Decree on Assessment or '*Schattingsbesluit*'.⁵³⁵ More informal information on how the decree works is available through the homepage of the FNV trade union.⁵³⁶ There is no regular evaluation of how the Decree is working or being used. The Dutch ANED country expert⁵³⁷ notes that evaluations are carried out to identify the number of pension recipients, and these have led to changes to the eligibility thresholds with a view to reducing the number of claimants.

According to Baumberg Geiger et al., '[t]he Dutch case ... was suggested by expert informants as international best practice for the direct assessment of work capacity'.⁵³⁸ The system has nevertheless been subject to various criticisms. Jerry Spanjer, who is an academic and an insurance physician, argues that research has shown that, although insurance physicians have the opportunity to obtain detailed information on participation and activity limitations during the interview, they only do so superficially. Spanjer and his co-authors note: 'Thus, although the physicians should assess work limitations, during the interview they did not inquire thoroughly after the activity limitations experienced by the patient'. Spanjer also notes that the reliability and validity of these assessments are questionable.⁵³⁹

Baumberg Geiger et al. have reported that a previous version of the assessment, known as FIS, was the subject of a 2004 court judgment which held that the 'assessment was valid in principle, but insufficiently transparent, verifiable, and testable in practice'.⁵⁴⁰ This was addressed, and the system now 'seems to produce benefit eligibility judgments that are widely accepted as valid'.⁵⁴¹ The same authors also note the 'substantial effort' involved in maintaining the CBBS database.

There is also some evidence that people who earned high wages before they became ill or disabled are more likely to be assessed as eligible to receive the WIA pension than people who previously earned lower wages.⁵⁴² This is because, in the case of previous high earners, the gap between the last earned wage and the theoretical earning capacity is more likely to exceed 35 %. People who receive the minimum wage can, after they become ill or disabled, be assessed as able to work in a wide range of

⁵³⁵ The text of the decree is available at: http://wetten.overheid.nl/BWBR0011478/2017-07-01/0/#Hoofdstuk3_Paragraaf1_Artikel7.

⁵³⁶ Available at: <https://werkwacht.nl/artikel/schattingsbesluit/>.

⁵³⁷ Jose Smits.

⁵³⁸ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

⁵³⁹ Spanjer, J., Brouwer, S., and Groothoff, J., 'Instruments used to assess functional limitations in workers' compensation claimants: a systematic review', in Spanjer, J. (2010), *The disability assessment structured interview: its reliability and validity in work disability assessment*, University Medical Center Groningen, University of Groningen, p 33.

⁵⁴⁰ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

⁵⁴¹ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*. This finding was based on expert interviews.

⁵⁴² See: <https://www.sprengersadvocaten.nl/publicaties/wat-iedere-arbeidsrechtjurist-zou-moeten-weten-van-de-wao-en-wia-but-was-afraid-to-ask/>.

other jobs paid at minimum wage level and therefore they may be less likely to qualify for a pension.⁵⁴³

⁵⁴³ An explanation of the system by a firm of lawyers, with examples of a highly paid employee compared with a low-paid employee (they have the same illness, but only the higher-paid employee is eligible for the benefit) can be found here:
<https://www.sprengersadvocaten.nl/publicaties/wat-iedere-arbeidsrechtjurist-zou-moeten-weten-van-de-wao-en-wia-but-was-afraid-to-ask/>.

12 Procedural assessment method: disability pension (Denmark)

The clearest example of the procedural assessment identified in this report is found in Denmark, where this form of assessment is commonly used to determine eligibility for the disability pension. As discussed in part I, the procedural (or demonstrated) assessment approach is based on an 'iterative learning process' to assess an individual's capabilities.⁵⁴⁴ In the context of employment, this involves an assessment based on a process in which options for medical and/or vocational rehabilitation and other routes to return to work are explored. In this context, the identification of a person as disabled marks the end of this process, where the process has not been successful and a continuing inability to work related to disability has been demonstrated.

In Denmark, the award of a disability pension is a possible outcome of a rehabilitation process and is generally not a benefit that an individual applies for as such. There are, however, some opportunities to apply directly for a pension without first undergoing a rehabilitation process. In such cases, the applicant is assessed based on their current situation. In practice, this means that the likelihood of the pension being granted is fairly low, as there may well be insufficient evidence to establish that the applicant is unable to work. Individuals who are less than five years from retirement are also assessed based on their existing situation, and are not directed towards rehabilitation.

The disability pension can be awarded to individuals aged 40-64 and, in exceptional cases, to individuals aged 18-39. An individual can only receive the pension if they are completely unable to work, and the assessment process is designed to assess this.

The procedural assessment process begins when an individual with a disability who is unable to find work is provided with additional support by the municipal job centre. The job centre can provide special facilities and tools to enable the person to work and refer them for medical treatment if needed, and will try to place the individual in an internship. In this respect, Ben Baumberg Geiger et al. argue that a 'crucial (and ... longstanding) aspect of the Danish system is that individuals are often sent on a work trial/work test ("arbejdsprøvning") for several months in order to clarify their work capacity (as described in several expert interviews). These take place in either a private company or an activation service, and are not meant to replace existing jobs, but instead to test which tasks individual are capable of within a work setting'.⁵⁴⁵ The same authors report that there is anecdotal evidence of work trials that are poorly matched to the individual in question.⁵⁴⁶

If, after a number of years of trying such measures, the person is still not in employment, the job centre may initiate a so-called resource activation

⁵⁴⁴ Baumberg Geiger, B. (2018), 'Legitimacy is a balancing act, but we can achieve a much better balance than the WCA' – 'A Better WCA is Possible', Demos, p. 59.

⁵⁴⁵ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

⁵⁴⁶ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

(ressourceforløb).⁵⁴⁷ This is an intensive rehabilitation process that may last for up to five years. The purpose of the process is to decide whether the individual should remain on the ordinary job market, be placed in a 'flex job' – which is job in the open labour market specifically adapted to the needs of an individual with a disability⁵⁴⁸ – or be awarded a disability pension. Ben Baumberg Geiger et al. note that 'in practice the majority of claimants – and nearly all claimants under 40 – are required to go through ... Resource Activation ...for one to five years'.⁵⁴⁹

However, even if an individual is not employed after having following a resource activation course and is unable to carry out a flex job, the municipality may still decide that there is further scope for rehabilitation. Such a decision may be made even if a doctor's declaration reaches the opposite conclusion.

The assessment and the procedure are set out in an executive order,⁵⁵⁰ which also describes the procedures to be followed by municipal caseworkers. Some information on the process is available to applicants online.⁵⁵¹

Recently there have been around 2 200 assessments every three months, leading to about 2 000 awards of a pension and 200 refusals.⁵⁵² Only 200-250 of the assessments have been based on the applicant's existing status, and not following a rehabilitation and/or resource activation. Of these 200-250 assessments, only 30-80 have resulted in a pension being awarded, meaning that most refusals come from this group. In 2016, four municipalities (among them Copenhagen) awarded less than 10 disability pensions for every 10 000 inhabitants, and 32 municipalities awarded more than 30 disability pensions for every 10 000 inhabitants. The remaining 62 municipalities awarded between 10 and 30 disability pensions per 10 000 inhabitants.

There have been some criticisms of the way in which the process is implemented. Ben Baumberg Geiger et al. have reported:

there has been considerable media and political attention on those placed in work trials or Resource Activation who have very low levels of assessed work capacity (e.g., 30 min of work capacity at low speed, twice per week). Not only are there claims by some doctors that these are damaging to people's health (which spurred a national TV documentary), but as a consultant at one trade union put it: It is very rare that a medical certificate is 100 percent watertight. There is always a little hope that the health will improve, or another treatment option that

⁵⁴⁷ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

⁵⁴⁸ For more information on the flex job scheme, see Waddington, L., Pedersen, M., Ventegodt Liisberg, M. (2016), 'Get a Job! Active Labour Market Policies and Persons with Disabilities in Danish and European Union Policy', *Dublin University Law Journal*, vol. 39(1), pp. 1-26.

⁵⁴⁹ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

⁵⁵⁰ Bekendtgørelse om rehabiliteringsplan og rehabiliteringsteamets indstilling om ressourceforløb, fleksjob, førtidspension mv. See: <https://www.retsinformation.dk/Forms/r0710.aspx?id=183304>.

⁵⁵¹ At: <https://www.borger.dk/pension-og-efterloen/Foertidspension-oversigt/Foertidspension-nye-regler>.

⁵⁵² See: <https://ast.dk/publikationer/tendenser-for-fortidspension>.

can be tried. So the process is nonsense. With the new law, municipalities say no to early retirement if you could handle even the smallest of Flex-Jobs.⁵⁵³

The ANED country expert for Denmark⁵⁵⁴ also notes that the system has been criticised for being too severe, and because the basis on which decisions are made is unclear.

Further criticism of the system can be found in the work of Iben Nørup of Aalborg University.⁵⁵⁵ On the basis of qualitative research, Nørup has criticised the pension reform of 2013, whereby the disability pension scheme was restricted to mainly cover persons aged 40-64 and resource activation was introduced, thereby establishing more restrictive eligibility criteria and reducing the number of awards significantly. Nørup argues that, following the reform, the practice has become far too restrictive for young people with chronic diseases.⁵⁵⁶ The Danish employers' organisation's newsletter *Agenda* shows that, in the period 2013-2016, less than 3 % of participants in the resource activation courses obtained ordinary employment, while 25 % of participants were approved for a flex job, half of whom succeeded in getting one. Following resource activation, 47 % of participants were awarded a disability pension, whereas 7 % of participants received social assistance. As it is the municipality that decides whether an individual may benefit from further rehabilitation, it is often possible for the case worker to reach this finding, and there are considerable differences between the municipalities in how many disability pensions they award. *Agenda* also showed that municipalities differ drastically as to the successful use of resource activation. In Hedensted, 36 % of the participants in resource activation ended up in job, flex job or education, whereas the corresponding rate in Sønderborg was only 6 %. The newsletter does not offer possible explanations for these differences. The fact that decisions are taken at the municipal level is an important factor in explaining the huge differences revealed in research.

A further assessment revealing elements of the procedural approach is found in Iceland, where, when considering whether an individual is eligible to receive a disability pension, evidence related to the results of rehabilitation is considered. Specifically, if an applicant for a pension has undergone a process of rehabilitation, their application must include a document from a rehabilitation specialist to certify that the rehabilitation process has been completed. The rationale for requiring this certification is to show that this avenue has been tried and exhausted and that the person is unable to enter the labour market.

⁵⁵³ Baumberg Geiger, B., Garthwaite, K., Warren, J., and Bambra, C. (2017), 'Assessing work disability for social security benefits: international models for the direct assessment of work capacity', *Disability and Rehabilitation*.

⁵⁵⁴ Steen Bengtsson.

⁵⁵⁵ Iben Nørup, Aalborg University. See: [http://vbn.aau.dk/da/persons/iben-noerup\(e581beb1-8553-4e82-84ee-8b86e3df4b7e\)/publications.html](http://vbn.aau.dk/da/persons/iben-noerup(e581beb1-8553-4e82-84ee-8b86e3df4b7e)/publications.html).

⁵⁵⁶ Hultqvist, S., Nørup, I. (2017), 'Consequences of activation policy targeting young adults with health-related problems in Sweden and Denmark', *Journal of Poverty and Social Justice*, vol. 25, no. 2, pp. 147–61.

13 Holistic assessment method: assessment for the Special Identity Card (Malta)

One assessment that can be described as ‘holistic’ is considered in this section. This assessment relates to determining eligibility to receive the Special Identity Card which is available to persons with disabilities in Malta. The relevant assessment was also discussed above in Part III sub-section 7.1.4, where it was described as an assessment based on proof of a specific medical diagnosis. Information regarding relevant benefits and application procedures is included in that sub-section.

If, on the basis of the medical information submitted to the Commission for the Rights of Persons with Disabilities, the Executive Director of the Commission cannot determine whether the applicant is eligible, the applicant is referred for a more detailed holistic assessment to ensure that their application is considered in detail and the applicant receives a fair hearing. This would apply, for example, in cases where the indicated diagnosis is anxiety or depression.

The holistic assessment combines assessments related to impairment, functional capacity and environmental factors. In such cases, the applicant is required to attend a face-to-face meeting with an assessor employed by the Commission. The assessor is a medical professional, such as a general practitioner, occupational therapist or physiotherapist, and has the task of deciding whether the applicant is eligible to receive the Special Identity Card. The assessor must determine if the applicant has an impairment or condition that leads to them facing obstacles in their daily lives. The assessment is tailored to the individual, and the assessor can ask questions to obtain information which they think will help them make the assessment. During the meeting, the applicant also has the opportunity to tell the assessor how the impairment or condition affects them, and they can be expected to be asked about this. All assessors have been trained in the social model of disability, and are aware of the impact of environmental factors.

Section B: Comparative analysis

14 Key elements of disability assessment procedures

This second section (B) of part III builds on section A and provides an overview of how various key issues are addressed in the assessment procedures which have been discussed above. Once again, this section builds on the information in the relevant country reports. However, it only covers the assessment procedures which have been explored in the first section (A) of Part III. Assessment procedures that are described in the country reports which form the basis of this synthesis but that are not covered in this synthesis report, as well as assessment procedures described in ANED country reports which were not used at all for this synthesis report, are not covered. This means that the findings of the analysis and comparison cannot necessarily be extrapolated to disability assessment procedures in Europe in general although, where the evidence reveals a clear tendency or direction, this may reflect a more general trend. The information is presented in table format to indicate how each assessment covered in this synthesis report addresses a specific issue. The assessment mechanisms are listed in the order in which they appear in this report, and the relevant section headings are also included to help distinguish between different types of assessment.

14.1 Kind of evidence considered in assessments

This overview reveals that the disability assessments covered in this synthesis report almost universally require that applicants submit medical evidence provided by a treating doctor. This will usually include at the very least a diagnosis, but could well also include a more detailed medical history, information on the results of medical tests and possibly the treating doctor's view of how the applicant is affected or impaired by the diagnosed medical condition.

The table below also reveals that self-assessments are less likely to be a part of the assessment where the assessment is based on the existence of a specific medical diagnosis or the Barema method. Self-assessments were not often used in the case of expert assessments to determine capacity for work. However, such assessments were more likely to be used in assessments of an individual's ability to carry out activities of daily living, whether in the context of assessing reduced working capacity or in the context of other benefits. Such self-assessments also sometimes had a role to play in assessing the need for care or support.

Most assessments involved either a face-to-face interview or a meeting with assessors (which could also involve a medical examination), or a medical examination. Medical examinations seemed to be more likely to be used than a face-to-face interview in the case of assessments based on a specific medical diagnosis or the Barema method. In such examinations, the applicant has a passive role to play. Face-to-face interviews, where the applicant may have the opportunity to participate more actively in the assessment, seem to be more common for structured assessments relating to working capacity, assessments of capacity to undertake activities of daily living, and assessments of the need for care or support.

In some cases, other kinds of evidence are taken into account, and this is inevitably the case in procedural assessments, where key evidence relates to the results achieved through rehabilitation and work trials.

Kind of evidence ⁵⁵⁷	Medical evidence from treating doctor	Self-assessment	Face-to-face interview (which may also include a medical examination)	Medical Examination	Other
Specific Medical Diagnosis					
Assessment of children, Iceland			X		Info from parents or guardian (unspecified)
Assessment of children, Latvia	X				
Assessment for mult. purposes / disability registration, Cyprus	X	X (general questionnaire)	X		
Types of disability pension (SDA, DA and BLD), Malta	X			X	
Disability card, Malta	X			X	
Barema method					
Disabled Person's Card, Austria	X			X	
Assessment for mult. purposes, Greece	X			X	
Blind Allowance, Liech.	X			X	
Blind Registration, UK				X	
Functional Capacity Assessment					
Assessment of capacity for work – expert assessments					
Disability pension, Belgium	X		X		

⁵⁵⁷ More detailed information is available in the relevant country report.

Kind of evidence ⁵⁵⁷	Medical evidence from treating doctor	Self-assessment	Face-to-face interview (which may also include a medical examination)	Medical Examination	Other
Disability pension, Cyprus	X			X	
Disability pension, Czech Rep.	X			X (in most cases there is no such meeting / examination)	
Disability pension (contributory invalidity pension), Malta	X				
Public Employ. Register, Sweden	X	X	X		
Assessment of capacity for work – structure assessments, Disability pension, Sweden	X	X	X	X	
Assessment of Activities of Daily Living (ADL) for benefits linked to reduced working capacity					
Pilot welfare benefits, Greece	X	X	X		
Disability pension, Iceland	X	X	X (only where decision cannot be made based on documentation submitted).		
Assessment for mult. purposes, Latvia	X	X	X (in some cases)		
Increased Severe Disability Assistance, Malta	X		X	X	

Kind of evidence ⁵⁵⁷	Medical evidence from treating doctor	Self-assessment	Face-to-face interview (which may also include a medical examination)	Medical Examination	Other
Work Capability Assessment, UK	X	X	X		
Assessment of ADL not linked to reduced working capacity					
Assessment of ability to carry out ADL, Belgium	X	X	X		
Need for special care, Latvia					Questionnaire completed by worker or ergo therapist (at the request of the Commission)
Care or Support Needs					
Care Allowances					
Personal assistance, Tyrol, Austria	X	X	X		
Personal budget, Flanders, Belgium	X				X ⁵⁵⁸
Long-term care, Reykjavik, Iceland			X		
Long-term care, NL	X		X (occasionally)		
Supp. support, Sweden	X		X		
Adult social care, UK		X	X		

⁵⁵⁸ The assessment of needs is highly divergent. The assessment is based on all the 'evidence' that can be collected. This includes medical information (e.g. diagnosis), but also information about the support or care that is currently provided but which is not sufficient or adequate. The latter information is based on reports from therapists, social workers etc. who know the applicant and who have treated or assisted the applicant. A multidisciplinary team goes through all this information to decide on what support is appropriate for the applicant.

Kind of evidence ⁵⁵⁷	Medical evidence from treating doctor	Self-assessment	Face-to-face interview (which may also include a medical examination)	Medical Examination	Other
Add. disability expenses, Denmark		X (applicant estimates expenses, but must also identify e.g. a doctor whom the municipality can contact)			Info on health status and related additional expenses
Add. support at school, Greece					Info on educational support already received and results. Evidence from pupil, parents, teaching staff
Economic Loss					
Disability pension, Liech.	X			X	Info from (former) employer
Disability pension, NL	X		X		
Procedural					
Disability pension, Denmark					Evidence of results of rehabilitation / work trials
Holistic					
Disability card, Malta	X		X		

14.2 Identity of assessors

The table below reveals the strong tendency to only involve medical doctors in disability assessments. This could be a specialised insurance physician, a doctor employed by the assessment agency who has not followed any recognised specialist training in insurance assessments (although a course may be provided internally by the insurance agency), or a team of doctors who may or may not be trained insurance physicians. It was noted in Part I of the report that the involvement of medical doctors in the assessment does not necessarily mean that the assessment is purely medically based. Nevertheless, in light of the human rights model of disability embodied by the CRPD, and the need to take into account the role that environmental factors play in disabling people, it seems advisable to involve multidisciplinary teams in disability

assessment. This is inevitable in some forms of assessment, and particularly for structured assessments (as used in Sweden and the Netherlands), where both functional capacity restrictions or impairments and their impact on the individual's ability to carry out real jobs which are available in the labour market are taken into account. In addition, multidisciplinary teams involving medical and non-medical assessors were more likely to be involved in assessments of care or support needs than was the case for other forms of assessments covered in this synthesis report. However, assessments involving multidisciplinary teams made up only of medical specialists such as doctors, nurses, physiotherapists and occupational therapist, or of a combination of medical and non-medical specialists, such as social workers and labour market experts, were the exception rather than the rule in the assessments covered in this synthesis report.

In the context of this synthesis report, it is also notable that assessments of care or support needs were more likely than other assessment mechanisms to rely on non-medical assessors than is the case for other types of assessment. Several such assessments were identified as being carried out by social workers, relevant committees or administrators. This was also the case for the one procedural assessment included in the synthesis report.

Assessors (if final decision is made by civil servant, the team which carries out the assessment on which that decision is based is identified) ⁵⁵⁹	One or more doctors (generally specialised insurance physicians or doctors employed by the social security body)	Multidisciplinary team only involving medical specialists	Multidisciplinary team involving medical and non-medical specialists	Other
Specific Medical Diagnosis				
Assessment of children, Iceland			X	
Assessment of children, Latvia	X			
Assessment for mult. purposes / disability registration, Cyprus ⁵⁶⁰	X			
Types of disability pension (SDA, DA and BLD), Malta	X	X		

⁵⁵⁹ More detailed information is available in the relevant country report.

⁵⁶⁰ If functionality is also assessed, a multidisciplinary team consisting entirely of medical specialists is also involved.

Assessors (if final decision is made by civil servant, the team which carries out the assessment on which that decision is based is identified) ⁵⁵⁹	One or more doctors (generally specialised insurance physicians or doctors employed by the social security body)	Multidisciplinary team only involving medical specialists	Multidisciplinary team involving medical and non-medical specialists	Other
Disability card, Malta				Executive Director of the Commission for the Rights of Persons with Disabilities
Barema method				
Disabled Person's Card, Austria	X			
Assessment for mult. purposes, Greece	X			
Blind Allowance, Liech.	X			
Blind Registration, UK	X			
Functional Capacity Assessment				
Assessment of capacity for work – expert assessments				
Disability pension, Belgium	X			
Disability pension, Cyprus	X			
Disability pension, Czech Rep.	X			
Disability pension (contributory invalidity pension), Malta	X			
Public Employ. Register, Sweden			X	

Assessors (if final decision is made by civil servant, the team which carries out the assessment on which that decision is based is identified) ⁵⁵⁹	One or more doctors (generally specialised insurance physicians or doctors employed by the social security body)	Multidisciplinary team only involving medical specialists	Multidisciplinary team involving medical and non-medical specialists	Other
Assessment of capacity for work – structure assessments, Disability pension, Sweden			X	
Assessment of Activities of Daily Living (ADL) for benefits linked to reduced working capacity				
Pilot welfare benefits, Greece		X		
Disability pension, Iceland	X			
Assessment for mult. purposes, Latvia	X			
Increased Severe Disability Assistance, Malta			X	
Work Capability Assessment, UK				X – Initial screening of self-assessment form by civil servant + usually face-to-face assessment by single health professional
Assessment of ADL not linked to reduced				

Assessors (if final decision is made by civil servant, the team which carries out the assessment on which that decision is based is identified) ⁵⁵⁹	One or more doctors (generally specialised insurance physicians or doctors employed by the social security body)	Multidisciplinary team only involving medical specialists	Multidisciplinary team involving medical and non-medical specialists	Other
working capacity				
Assessment of ability to carry out ADL, Belgium	X			
Need for special care, Latvia	X		X (in cases when Commission requests)	
Care or Support Needs				
Care Allowances				
Personal assistance, Tyrol, Austria			X	
Personal budget, Flanders, Belgium			X	
Long-term care, Reykjavik, Iceland				Social Worker
Long-term care, NL				Social Worker
Supp. support, Sweden				Administrator
Adult social care, UK			X	
Add. disability expenses, Denmark				Social Worker
Add. support at school, Greece				School / Educational Committees
Economic Loss				
Disability pension, Liech.	X			
Disability pension, NL			X	
Procedural				

Assessors (if final decision is made by civil servant, the team which carries out the assessment on which that decision is based is identified) ⁵⁵⁹	One or more doctors (generally specialised insurance physicians or doctors employed by the social security body)	Multidisciplinary team only involving medical specialists	Multidisciplinary team involving medical and non-medical specialists	Other
Disability pension, Denmark				Municipal Board / Administrators
Holistic				
Disability card, Malta	X			

14.3 Requirement to have a pre-existing disability identification / benefit entitlement

The table below reveals that, in almost all assessments reviewed in this synthesis report, applicants do not need to have already been recognised as disabled in order to apply for the relevant benefit and undergo a second assessment. This was only the case for a handful of assessments and related benefits, largely related to care or support needs.

Individual must have already been recognised as 'disabled' (undergone prior assessment) in order to apply ⁵⁶¹	Yes	No
Specific Medical Diagnosis		X
Assessment of children, Iceland		X
Assessment of children, Latvia		X
Assessment for mult. purposes / disability status, Cyprus		X
Types of disability pension (SDA, BLD and DA), Malta		X
Disability card, Malta		X
Barema method		
Disabled Person's Card, Austria		X
Mult. purposes, Greece		X
Blind Allowance, Liech.		X
Blind Registration, UK		X
Functional Capacity Assessment		
Assessment of capacity for work – expert assessments		
Disability pension, Belgium		X
Disability pension, Cyprus		X
Disability pension, Czech Rep.		X
Disability pension (contributory invalidity pension), Malta		X
Public Employ. Register, Sweden		X
Assessment of capacity for work – structure assessments, Disability pension, Sweden		X

⁵⁶¹ More detailed information is available in the relevant country report.

Individual must have already been recognised as ‘disabled’ (undergone prior assessment) in order to apply ⁵⁶¹	Yes	No
Assessment of Activities of Daily Living (ADL) for benefits linked to reduced working capacity		
Pilot welfare benefits, Greece		X
Disability pension, Iceland		X
Mult. purposes, Latvia		X
Increased Severe Disability Assistance, Malta		X
Work Capability Assessment, UK		X
Assessment of ADL not linked to reduced working capacity		
Assessment of ability to carry out ADL, Belgium		X
Need for special care, Latvia	X	
Care or Support Needs		
Care Allowances		
Personal assistance, Tyrol, Austria	X	
Personal budget, Flanders, Belgium	X	
Long-term care, Reykjavik, Iceland	X	
Long-term care, NL		X
Supp. support, Sweden		X
Adult social care, UK		X
Add. disability expenses, Denmark		X
Add. support at school, Greece		X
Economic Loss		
Disability pension, Liech.		X
Disability pension, NL		X
Procedural		
Disability pension, Denmark	X	
Holistic		
Disability card, Malta		X

14.4 Use of single assessments to determine eligibility for multiple benefits

The table below reveals that it is common for an assessment to be linked to only one benefit, although the report also identified a good number of assessments which potentially give access to a number of benefits. Assessments which assess eligibility to receive several benefits reduce the burden on applicants, who often find assessments stressful and unpleasant, as well as reducing the administrative burden on the state bodies which must carry out assessments. Several assessments involving specific medical diagnoses potentially providing access to multiple benefits were identified (in Iceland, Latvia and Cyprus), and this was also the case for some Barema-based assessments (in Greece and the United Kingdom). Assessments to determine eligibility for a disability pension seemed more likely to relate only to this particular benefit (in Belgium, Cyprus, the Czech Republic, Sweden, Iceland, the United Kingdom, Liechtenstein the Netherlands and Denmark), although examples of assessments covering multiple benefits, including the disability pension, were also identified (in Greece and Latvia). Some of the assessments relating to care and support also potentially give access to multiple benefits.

Assessment for Single or Multiple benefits ⁵⁶²	Single	Multiple
Specific Medical Diagnosis		
Assessment of children, Iceland		X – passport to a number of services
Assessment of children, Latvia		X
Assessment for mult. purposes / disability registration, Cyprus		X – e.g. cash payments and disability allowances. A separate application form is needed for each benefit, but a single assessment is used for benefits provided by the Department for Social Inclusion of Persons with Disabilities.
Types of disability pension (SDA, DA, BLD), Malta	X	
Disability card, Malta	X (although card will give access to various benefits)	
Barema method		
Disabled Person's Card, Austria	X (although card will give access to various benefits)	
Assessment for mult. purposes, Greece		X – Disability pension, welfare benefits, services, concessions, employment under quota scheme, tax benefits
Blind Allowance, Liech.	X	
Blind Registration, UK		X – Tax benefits, leisure discounts, free public transport
Functional Capacity Assessment		
Assessment of capacity for work – expert assessments		
Disability pension, Belgium	X	
Disability pension, Cyprus	X	
Disability pension, Czech Rep.	X	
Disability pension (contributory invalidity pension), Malta	X	
Public Employ. Register, Sweden	X	

⁵⁶² More detailed information is available in the relevant country report.

Assessment for Single or Multiple benefits ⁵⁶²	Single	Multiple
Assessment of capacity for work – structure assessments, Disability pension, Sweden	X	
Assessment of Activities of Daily Living (ADL) for benefits linked to reduced working capacity		
Pilot welfare benefits, Greece		X – See Assessment for mult. purposes, Greece, above
Disability pension, Iceland	X	
Assessment for mult. purposes, Latvia		X – registration as disabled, disability pension and various additional benefits
Increased Severe Disability Assistance, Malta	X	
Work Capability Assessment, UK	X	
Assessment of ADL not linked to reduced working capacity		
Assessment of ability to carry out ADL, Belgium		X – income replacement allowance; integration; support allowance for seniors or elderly people; increased child allowance; other benefits e.g. disabled person's parking permit or eligibility for discounts on public transport
Need for special care, Latvia	X	
Care or Support Needs		
Care Allowances		
Personal assistance, Tyrol, Austria	X	
Personal budget, Flanders, Belgium		X – for minors, the assessment gives access to all relevant benefits through 'integrated youth care'
Long-term care, Reykjavik, Iceland		x- counselling and support to enhance social participation; in-home assistance or guidance for disabled parents or the parents or guardians of disabled children; social support to enhance community participation; further assistance due to the increased need for services due to disability for

Assessment for Single or Multiple benefits ⁵⁶²	Single	Multiple
		those people who live in their own homes; family support
Long-term care, NL	X	
Supp. support, Sweden		X – e.g. personal assistance, short-term stays outside the home, short-term supervision of children over 12, specialised housing and accommodation, daily activities and assistance in drawing up individual plans
Adult social care, UK	X	
Add. support at school, Greece	X	
Economic Loss		
Disability pension, Liech.	X	
Disability pension, NL	X	
Procedural		
Disability pension, Denmark	X	
Holistic		
Disability card, Malta	X (although card will give access to various benefits)	

14.5 Links between specific types of assessments and related benefits

A number of trends are revealed through an analysis of the assessment methods discussed in this synthesis report. Firstly, two benefits specifically targeting children with disabilities (in Iceland and Latvia) were identified, and these both relied on an assessment based on the existence of a specific medical diagnosis. This may reflect the fact that functional capacity assessments (relating to a person's ability to work or ability to carry out activities of daily living) and assessments of care needs are difficult to carry out on children, since even children without disabilities have restricted capacities in comparison with adults, and such children also have care needs. The existence of a specific medical condition linked to a recognised diagnosis may therefore be regarded by assessors as a good indicator of eligibility for a disability-related benefit in the case of children.

Secondly, the overview revealed a wide variety of assessment tools being used to determine eligibility for a disability pension, the award of which can be presumed to be linked to a reduced capacity to work. Only two of these assessments (the structured assessments in Sweden and the Netherlands) actually sought to identify the capacities or abilities of applicants and to compare them with the abilities needed to carry out jobs which are available in the labour market, while the Danish procedural assessment sought to test an individual's ability to work through rehabilitation and work placements. In all other assessments, some form of proxy was used to assess working ability or

capacity. This could be the existence of a specific medical diagnosis (Malta), a disability percentage identified after a Barema-based assessment (Greece), an assessment of capacity for work made by experts where no structured comparison seemed to be made between capacities and the demands of the labour market (Belgium, Cyprus, the Czech Republic), or an assessment of the individual's ability to carry out activities of daily living (rather than employment-related activities) (Iceland, Latvia, Malta). Assessments to determine eligibility for a disability pension therefore reveal a great deal of variety, and usually do not actually assess the ability of a person with a disability to carry out work which is available in the labour market. Boer et al. have also noted what seems to be a mismatch between the goal of identifying reduced working capacity and the assessments used in this context. They found that the criteria for a given concept of disability (labour capacity or earning capacity) was not 'significantly reflected in the structure of the evaluations' and they found no clear relationship between the legal definitions (including the concepts used) and 'elements of the processes' structure'.⁵⁶³ More generally, Jerry Spanjer et al. argued: 'Despite the fact that the assessment of functional work limitations worldwide is an important issue, we found that almost no validated and reliable instruments for this assessment are described'.⁵⁶⁴

On the other hand, there does seem to be more consensus in assessments related to care or support benefits, where an assessment of need or an assessment of the ability to carry out activities of daily living seem to be the favoured assessment methods. These forms of assessments appear to relate directly to the benefit which can be awarded as a result.

⁵⁶³ De Boer, W., Besseling, J., Willems, J. (2007), 'Organisation of disability evaluation in 15 countries', *Pratiques et Organisation des Soins*, vol. 38, no. 3, p. 214.

⁵⁶⁴ Spanjer, J. (2010), The disability assessment structured interview: its reliability and validity in work disability assessment, University Medical Center Groningen, University of Groningen, Chapter 8, p 107.

Part IV: Influence of the CRPD on disability assessments and compilation of good practice

15 Influence of the CRPD on disability assessment

The ANED country reports which formed the basis of the synthesis in Part III of the report made a number of references to the Convention on the Rights of Persons with Disabilities. Many of these references noted that a particular assessment was either not in compliance with the CRPD or had not been adapted in order to bring it into line with the CRPD, or that there was no indication that the CRPD had been taken into account in formulating the assessment process. This was the case for at least one assessment covered in a case study in a country report, or was mentioned in the conclusion to the country report, for the reports on Austria, Cyprus, the Czech Republic, Iceland, Sweden and the United Kingdom. No reference was made to the CRPD or to the possible compatibility or incompatibility of assessment methods in the reports from Belgium, Denmark and the Netherlands.

However, a small number of assessment methods were identified as containing elements which were compatible with the CRPD in the ANED country reports. This was the case for one or more assessments in Austria and Sweden, while a generally positive trend in developments regarding disability assessments was noted in Latvia.

In the Austrian State of Tyrol, the Centre for Independent Living in Innsbruck plays an important role in the assessment process for personal assistance to support independent living, and is also the main provider of personal assistance, which is financed by the regional government (see Part III, sub-section 10.1). In the views of the Austrian ANED country experts, this assessment procedure comes the closest to meeting the requirements of the CRPD of the assessments currently in place in Austria. The experts note that the 'assessment considers persons with disabilities in their current and individual living situation ... The procedure has a focus on inclusion as well as on full participation in society. In the assessment procedure, there is much space for explaining the personal and individual living situation of the applicant which might lead to a rather individualised assessment of the needs for support'.

Elements of various assessment mechanisms used in Sweden were identified as being in line with the CRPD by the Swedish country expert. One element of the assessment to determine eligibility for admission to the public employment register of disabled persons (see Part III, sub-section 9.1.1.2) was regarded by the Swedish country expert as being in line with the CRPD. This involves taking the perspective of the individual into account during the assessment. Furthermore, the involvement of the applicant in the assessment by the Social Insurance Agency to determine eligibility for a disability pension or compensation (see Part III, sub-section 9.1.2) through a self-assessment of activity restrictions was also regarded as being in line with the CRPD. However, considering these assessment processes as a whole, the Swedish expert did not regard either of these assessments as representing good practice. Lastly, the assessment for supplementary support for persons with disabilities carried out in Sweden (see Part III, sub-section 10.1.5) was regarded as being in line with the CRPD to the extent that the individual's perspective was taken into account, and the applicant was asked about individual needs and wishes at the face-to-face meeting with the assessor.

The Latvian country expert noted a general trend of moving away from purely medical assessments to also assessing functional capacities, and to involving the person with a disability in assessment procedures. She felt that this ‘marks the beginning of the transition from the medical to the social model, which takes into account the interactions between people and the environment that meets the CRPD’.

Two assessment processes were identified which were explicitly linked with the CRPD and which had compliance with the CRPD as one of their goals. The first is the assessment for the provision of extra support at school, which was recently introduced in Greece (see Part III, sub-section 10.3). The reform to the assessment process has been influenced by the CRPD and is intended to mark a clear shift from a medical diagnostic assessment to a holistic assessment, which identifies the educational support needs of children. Moreover, the current official guidance on how to implement parts of the assessment makes explicit reference to the CRPD. This guidance will remain in force under the new assessment system. The second such assessment is that used to determine eligibility for a Special Identity Card for persons with disabilities carried out by the Commission for the Rights of Persons with Disabilities in Malta (see Part III, sub-section 7.1.4 and section 13). The Executive Director and Commissioner for the Rights of Persons with Disabilities aims to ensure that all medical assessors are familiar with the principles underlying the CRPD, and, in the view of the Commission:

The application process is in line with the UNCRPD. Application forms are available in various formats, as are assessments (when they are required). The assessments are done in face-to-face sessions and there are no tick-box questionnaires used as part of the procedure: it is entirely related to the applicant and their individual circumstances.

In addition to the disability assessment methods considered in detail in this synthesis report, brief mention will also be made of two other assessment methods which were reported as having been influenced by the CRPD in ANED country reports, but which have not been covered elsewhere in this report.

In Estonia the legal definition of disability contained in the Social Benefits for Disabled Persons Act⁵⁶⁵ has been influenced by the CRPD. The Act defines disability as:

... a loss of or an abnormality in an anatomical, physiological, or mental structure or function of a person, which in conjunction with different relational and environmental restrictions, prevents participation in social life on an equal basis with others.⁵⁶⁶

The Social Benefits Act has been in force since 1999; however, the Act’s definition of disability was amended in 2008 following the adoption of the CRPD, which Estonia ratified in 2012. The Act ‘provides the classes of social benefits for disabled persons, the conditions of entitlement thereto, the amounts of benefits and the procedure for the grant and payment thereof’.⁵⁶⁷ In terms of defining the concept of disability, the first

⁵⁶⁵ Available in English at: <https://www.riigiteataja.ee/en/eli/509012015003/consolide>.

⁵⁶⁶ Section 2(1). This definition resulted from an amendment to the Act adopted in 2007: RT I 2007, 71, 437, entry into force 1 October 2008.

⁵⁶⁷ Section 1(1) Social Benefits for Disabled Persons Act.

paradigmatic change occurred in 1999, when the Soviet influenced definition of 'invalidity', which was primarily based on medical diagnoses, was replaced with the concept of disability referring to the loss of or an abnormality in an anatomical, physiological, or mental structure or function. The 2008 amendment added a reference to the interplay with relational and environmental restrictions which influences possibilities for equal participation.

In Italy, the Biennial Government Programme on Disability (2018-2020)⁵⁶⁸ contains an action that provides for an adjustment of the assessment system on the basis of the ICF and the CRPD. The system currently in use is based on a Barema scale.

⁵⁶⁸ See: <http://www.lavoro.gov.it/temi-e-priorita/disabilita-e-non-autosufficienza/Documents/PDA-Disabilita-2016-def-dopo-DG-dic2016.pdf>.

16 Good and promising practice in disability assessments⁵⁶⁹

As mentioned in the introduction to this report, ‘in light of the adoption and widespread ratification of the UN CRPD, as well as in the context of ... economic austerity, many states have sought to revise and tailor their definitions of disability and related assessment mechanisms’. The pressures of economic austerity have tended to lead to a reduction in provision for people with disabilities through social security systems and social services programmes. Nevertheless, it is also possible to identify developments and changes that can be seen in a more positive light using the ANED country reports. ANED experts were asked for examples of what they considered to be ‘good’ or ‘promising’ practice in disability assessments in their countries. In four of the countries covered in this synthesis report, no such examples were reported (Denmark,⁵⁷⁰ Iceland, Liechtenstein and the Netherlands). In the remaining countries, however, a diverse range of good practice was reported, which has been grouped into four broad types, each of which in some way reflects (either directly or indirectly) the substance and the spirit of the CRPD. This section additionally refers to some good practice mentioned in two ANED country reports (France and Hungary) which have not been covered elsewhere in this report.

These types are:

1. Involvement of disabled people and their organisations in disability assessment design and practice.
2. Assessments that are not based solely on the medical model of disability.
3. Developments that address the complexity and diversity of assessments by consolidating and integrating assessments and services.
4. Developments that increase the quality, transparency and accountability of disability assessments.

In addition, there were a number of miscellaneous examples of practice or developments reported as promising or good practice.

16.1 Involvement of disabled people and their organisations in disability assessment design and practice

Many country reports referred to instances of changes to disability assessment methods that to some degree were based on the active input of disabled people’s organisations. This input could either be through the participation of disabled people’s organisations in decision making or through consultations with disabled people’s organisations. The latter could involve the organisations participating in reviews of current arrangements or having the opportunity to comment on Government proposals. In contrast, some other changes related to giving persons with disabilities an increased role in disability assessment processes as applicants, claimants or service users.

Examples of such involvement by disabled people’s organisations were reported from Austria, Cyprus, the Czech Republic, Latvia, Malta and the UK.

⁵⁶⁹ This section of the report was largely written by Professor Roy Sainsbury of the University of York.

⁵⁷⁰ In Denmark the municipalities run social provision systems independently of each other, and it is not common practice to identify or promote examples of ‘good practice’.

In Austria, members of the Independent Living Movement in Vienna were involved in developing the procedure for assessing applications for personal assistance.

In the Czech Republic, a number of disabled people's organisations, including the Government Board for People with Disabilities and the Czech Disability Council, participated in preparing the new assessment guidelines for the Care Allowance, which is a non-insurance-based social security benefit paid to persons recognised as dependent on the care of another person. The Ministry of Labour and Social Affairs also recently worked closely with Czech disabled people's organisations to deal with an acute problem that arose because of a shortage of staff and an increasingly high workload at the Medical Assessments Service, which makes disability pension assessments. An agreement on how to eliminate long delays was reached by ministerial and disabled people's organisations' representatives by removing the necessity for the Medical Assessment Service to carry out a physical examination of applicants with a disability.

In Latvia in 2015, disabled people's organisations had the opportunity to give their opinions on the disability assessment system that determines whether individuals can enter the general register of persons with disabilities, and they also contributed to the development of the evaluation method for disability assessment. In 2017, disabled people's organisations gave their opinions through the National Council for Disability Matters on changes to how loss of working ability is determined.

In Malta, disabled people's organisations have been involved in developing and evaluating the assessment methods to determine eligibility for the disability pension, and there are ongoing discussions between the competent authorities and stakeholders. Regarding the Independent Community Living Scheme (the financial package offered to persons with disabilities to enable them to live more independently), the standard operating procedures and eligibility criteria have been developed by persons with disabilities in conjunction with the respective organisations. The Commission for the Rights of Persons with Disability, which is part of the Ministry of Family, Children's Rights and Social Solidarity, was involved throughout.

In the UK, the main eligibility test for Employment and Support Allowance and Universal Credit (the out-of-work benefits for people with disabilities and people with long-term health conditions) is the Work Capability Assessment. Despite the Work Capability Assessment attracting a range of criticisms, there has been a systematic and open process of statutory review, public scrutiny and evaluation, resulting in some process improvements. In these reviews, persons with disabilities and their organisations were offered the opportunity to provide evidence of their experiences and suggestions for improvement. There is also evidence of Government working with organisations with expertise on certain impairment conditions to improve the assessment descriptors – for example, descriptors about which types of treatment qualify someone for exemption from work-related activity have been changed, following advice from the charity Macmillan Cancer Support. Although the UK's assessment method for the certification of visual impairment is medically oriented, there have been revisions to ensure that functional and needs-based perspectives are also considered in the process of support and service coordination for the person concerned. Research and lobbying by the Royal National Institute for the Blind (RNIB) has influenced some of these process improvements.

In Cyprus, the Confederation of Disability Organisations (CCDO) has a long track record of engagement with the Ministry of Labour and Social Insurance with regard to disability assessment, including making the case for empowering people with disabilities to access the labour market and the need to identify and acknowledge individual needs in assessing applications for the Cyprus Disability Card. More recently, the CCDO has engaged with the Director of the Department for Social Inclusion of People with Disabilities to express their organisations' dissatisfaction and disagreement with a number of issues related to the design and development of the new system of disability and functionality assessment (see above Part III, sub-section 7.1.2). Although it is positive that there is a substantial level of engagement between the Government and the CCDO, this has not guaranteed that the arguments behind the criticisms of the CCDO have been acted upon. As the Cyprus country experts explain in their report: 'the main discussion with respect to disability assessment in Cyprus is currently focused on the New System for the Assessment of Disability and Functioning which has raised great concerns and debate among the disability movement and other stakeholders in the country. The implementation of the new System for the Assessment of Disability and Functioning of Persons in Cyprus is not informed by a human rights-based approach to disability'.

The above information relates to the involvement of disabled people's organisations in the development of the policy and practice of disability assessment. However, at the level of the individual claimant or service user, several country reports drew attention to increases in the participation of persons with disabilities in the sense of them playing a more active and engaged role in the assessment process, rather than just having a limited responsive or passive role in assessment interviews and medical examinations. Examples of this increased role for disabled people came from the country reports from Austria, the Czech Republic and the UK. It is noticeable that almost all of these examples relate to assessment procedures for social care provision, rather than disability-related cash benefits.

In Austria, personal assistance is currently provided with varying quality and quantity in the nine *Länder* (the administrative regions of Austria), and almost entirely as a benefit in kind. In the State of Tyrol, persons with disabilities are directly and actively involved in the evaluation of their support needs for personal assistance, with particular regard to their current living situation. The assessment procedure, which is carried out in collaboration with the Centre for Independent Living, is based on a social model of disability.

In the Czech Republic, an important part of the assessment for the Care Allowance⁵⁷¹ involves an examination that takes place at the applicant's home to evaluate their ability to undertake self-care activities. The examination guidelines have recently been revised, partly to enhance the role of the applicant during the process.

The UK ANED country report refers to improvements in the assessment of social care needs, which includes a key role for applicants in providing information about their social and support networks.⁵⁷²

16.2 Assessments that are not based solely on the medical model of disability

⁵⁷¹ Further information on this assessment can be found in the Czech ANED country report.

⁵⁷² This assessment procedure is described more fully in the next sub-section.

Many of the criticisms of the assessment procedures identified throughout this report have focused on their continued basis on the medical model of disability. However, in some countries (Austria, Greece and the UK), there was evidence of changes to assessment criteria and processes that reflected a recognition of the social-contextual model of disability, whether in addition to medical criteria or partially replacing them. These were seen as examples of promising practice.

As mentioned above, in the Tyrol region of Austria, the Centre for Independent Living has been at the heart of changes to the assessment procedure for personal assistance. The assessment is now reported to be based on a social model of disability that depicts people with disabilities as active citizens in society, e.g. as parents or as volunteers in their leisure time. Persons with disabilities are directly and actively involved in the evaluation of their actual support needs with particular regard to their current living situation.

A further promising development was reported by the Greek expert in relation to the assessment procedure for additional support at school (including both primary and secondary education). A new law⁵⁷³ which has recently been adopted redefines the responsibility for the existing educational needs assessment and support within mainstream settings, sharing it among interdisciplinary networks across the educational community, at school and regional levels. This was identified as being influenced by the CRPD, and it involves a clear shift from a diagnostic to a holistic needs-based assessment.

In the UK, the approach to needs assessment for adult social care in England is reported as being positive in several respects. It is underpinned in primary legislation by the principle of 'wellbeing' and an assumption of full participation by persons with disabilities in the decision-making process. It defines a broad spectrum of need in a holistic way, and allows for flexibility and discretion in the interpretation of real-life, outcome-based criteria, rather than relying on explicitly medical or functional activity definitions. It allows for a multidisciplinary approach, by encouraging the utilisation of expertise from any profession that is relevant to assessing the needs expressed, as well as the consideration of a person's wider networks of community support. While there are very significant implementation issues now arising from Government funding cuts, the assessment methodology is regarded as a well-conceived model that has broad support.

A different indicator of the increasing acknowledgement of the social-contextual model of disability is the adoption of multidisciplinary teams of assessors who contribute in various ways to the assessment of disability, either as providers of information or as final decision makers. Particular attention was drawn to this feature of assessments in the country reports of Greece, in the assessment of additional educational support for primary and secondary school pupils, and the UK, in the needs assessment of adults applying for adult social care.

16.3 Developments that address the complexity and diversity of assessments by consolidating and integrating assessments and services

⁵⁷³ Greece, Law on Reform of Support Structures in Primary and Secondary Education FEK102 A/12.06.2018. See: https://www.hellenicparliament.gr/UserFiles/bcc26661-143b-4f2d-8916-0e0e66ba4c50/e-anadec-pap_apospasma.pdf.

One of the criticisms of disability assessment processes is that they lack consistency, thereby creating inequities, confusion and barriers for people with disabilities trying to access benefits and services. Three examples of attempts to improve access by reducing complexity were identified in Belgium, Cyprus and France.

In Belgium, the new 'integrated youth care' system in Flanders has a single point of access known as the 'intersectoral access portal'. Since March 2014, the portal allows applications for support from several sectors/service providers, such as the Flemish Agency for Disabled Persons (VAPH, i.e. the disability sector) and representatives of the youth care sector (which includes mental health care and child and family services). This means that the VAPH is not an isolated and separate service, but is part of the broader 'intersectoral access portal'. As a result, a child who is blind and also has a mental illness, for instance, does not have to apply for separate benefits from different sectors and service providers, but can apply in one step, through the 'intersectoral access portal', for all relevant benefits. The Belgium report concludes positively: 'the intersectoral access portal is an example of promising practice. All sectors / service providers work together, all taking into account the person's needs for support, whether it is a person with a disability, a person with a medical diagnosis, a difficult context in which the child grew up'.

In Cyprus, it was reported that the disability assessment for accessing public day-care facilities for people with disabilities seemed to be gradually being withdrawn (as a positive step towards de-institutionalisation), with access to long-term care benefits being largely dependent on the assessments carried out as part of the new system for disability and functionality assessment mentioned above (See Part III, sub-section 7.1.2). The Cypriot report notes that this is a step forward towards consolidating the disability assessment process in Cyprus and the collaboration of the various disability services for consolidated procedures.

In France, the departmental offices for disabled persons (*maisons départementales des personnes handicapées* or *MDPH*), which operate at departmental level, carry out assessments based on socio-medical criteria. The departmental offices serve as 'points of single contact'. The assessment is carried out by a multidisciplinary team which focuses on identifying the means needed to compensate for the limitations in activity or restrictions in participation that the applicant faces, and which need to be overcome if the applicant is to achieve his or her goals ('life project') and obtain the rights he/she is entitled to. The assessment is clearly complex and is not solely based on medical factors. As a result of the assessment, an applicant can receive all kinds of support in a diverse range of areas (education, professional participation, housing, working place adaptations and other services). The assessment also results in a 'personalised compensation plan' (*plan personnalisé de compensation, PPC*), which identifies all the services and support needed by the applicant. The assessment is holistic in nature, and aims to assess the needs of the applicant in relation to his/her impairment and environment. In the view of the ANED country experts,⁵⁷⁴ this assessment is in line with the CRPD, especially as the assessment leads to an equality of rights in terms of social participation.

⁵⁷⁴ Carole Nicolas and Serge Ebersold.

16.4 Developments that increase the quality, transparency and accountability of disability assessments

A number of country reports drew attention to the importance of providing benefit claimants and applicants for services with good information, firstly on what benefits and services were potentially available to them (Latvia) and secondly on how to claim them (Czech Republic and Latvia). In addition, some country reports recognised the importance of good guidance for decision makers in order for good-quality decisions to be made (Belgium, Malta and Hungary).

A promising practice was noted in Latvia. Applicants to the general disability register (for the award of a disability identity card) are provided with opportunities to obtain information and to receive e-services through accessing data related to their disability assessment. They can then apply for services electronically by using the state and local government services portals.

In the Czech Republic, the Human Rights League (an NGO) provides user-friendly information related to the rights of persons with disabilities on their website. One of the themes covered in the website is the disability pension. Users can find information related to entitlement to a disability pension, how disability is defined, how and where to apply, and information related to assessment processes, the decision-making process and how to appeal.

In Latvia, the portal mentioned above provides information on a range of e-services to help disabled people make claims for benefits and services (for example, the 'Application to the State Medical Commission for the Assessment of Health Condition and Working Ability about Disability Assessment' and 'My Data in the Commission') and enables applicants to communicate with the Commission quickly and directly. This reduces the administrative burden for persons with disabilities and the Commission, establishes good management practices for applicants, and provides for up-to-date data collection and exchange.

In the Belgian report, attention was drawn to the detailed guidance available to assessors in making their assessments to determine eligibility for five (mainly cash) benefits. To make this assessment as 'unbiased' as possible, the 'manual' in the Ministerial Decision of 30 July 1987 provides a clear framework about the way in which the grade of disability is decided on. The scoring (on a simple scale of 0-3) for each domain of the assessment (daily living activities including moving, eating and dressing) can therefore be done thoroughly and transparently.

A practice noted in the Malta report that might serve as a useful lesson for other countries relates to the training of medical assessors. In Malta, all medical assessors are interviewed by the Executive Director and Commissioner of the Commission for the Rights of Persons with Disability to ensure that they are conversant with the principles underlying the CRPD. In addition to this, they receive guidance on the eligibility criteria and the way they should be applied, as well as to the need to always consider any extenuating circumstances faced by the applicants.

In Hungary, complex needs assessments are carried out in the context of an assessment for supported housing. Assessors need to have successfully completed

the accredited 30-hour further training on ‘complex needs assessment methodology and practice’⁵⁷⁵ or to be registered as a support needs assessment mentor. Assessors are supported by a 68-page detailed guide,⁵⁷⁶ which was published in 2017 (Guidance on the methodology for assessing the support needs of people with disabilities, psychiatric problems and addicts, and for supported housing) as well as a 22-page detailed data sheet,⁵⁷⁷ also published in 2017 (Complex support needs assessment tool – data sheet). The guidance is based on identifying and defining needs and covers key areas affecting quality of life and their indicators. It determines the main principles and characteristics (e.g. client-centredness and the module system) of the assessment, and identifies difficulties which can be encountered in the assessment (e.g. individual functional barriers, the need for questions to be individualised, flexible adaptation to unknown and new life situations, lack of experience on the part of the applicant and communication barriers). In the view of the ANED country experts,⁵⁷⁸ the assessment framework is CRPD-compliant, and assessors are supported by a detailed guide.

Although there were examples in a number of country reports of some form of review of one or more disability assessment methods, this has only been systematised into regular independent scrutiny in the UK. As mentioned above (Part III, sub-section 9.1.3.5), there has been an independent statutory review for a number of years of the disability assessment for Employment and Support Allowance (the UK’s long-term out-of-work benefit for people with disabilities). This is thought to have resulted in some process improvements, although the fundamental basis of the assessment has not altered despite criticisms.

The Belgian report was positive about the use of assessment instruments relating to youth care decisions being based on American validated instruments, adapted to the Belgian context. This is an example of countries adopting or adapting existing assessment instruments (such as a standard Barthel scale) rather than designing them from scratch.

16.5 Conclusion – Working towards a CRPD compliant disability assessment mechanism

The data used in this section is drawn from the country reports in which experts responded to a request in the country template to provide examples of ‘good’ or ‘promising’ practice in their countries. The data has therefore relied on the subjective assessments of the experts as to what constitutes ‘good’ practice and, as a result, is not systematic. For example, many assessment processes (reported in Part 1 of the country reports) rely to some extent on the input of different professionals and specialists (including medical practitioners, social workers, educationalists, occupational health specialists and others), sometimes in multidisciplinary teams. This aspect of disability assessments was mentioned by some but not all experts as an example of good practice.

⁵⁷⁵ See: http://www.kezenfogva.hu/files/kezenfogva/15_tsza.pdf.

⁵⁷⁶ See: https://szgyf.gov.hu/phocadownload/tsza_utmutato_2017_FSZK_SZGYSZF.pdf.

⁵⁷⁷ See: <https://szgyf.gov.hu/hu/szakmai-ajanlasok/tamogatott-lakhatas-komplex-szuksegletfelmeres>.

⁵⁷⁸ Tamás Gyulavári and Péter László Horváth.

Nevertheless, the analysis provided by the experts is useful in identifying instances of good practice that together might be considered to constitute a model of 'best' practice for the design and implementation of disability assessments. In light of the overview of the obligations flowing from the CRPD provided in section 5 and below, these 'best practices' can also be regarded as elements of a CRPD compliant disability assessment mechanism. A non-exhaustive list of 'good practice' which is line with the requirements of the CRPD therefore includes:

- The involvement of disabled people's organisations in the design of disability assessments;
- Recognition and incorporation of the social-contextual or human rights model of disability in assessments;
- The active engagement of persons with disabilities in generating the information on which individual disability assessments are made, for example through self-assessment questionnaires;
- Eliminating multiple (methods of) assessment, which should reduce the burden on applicants, and aiming to promote consistency and transparency in decision making;
- The provision of user-friendly information for benefit applicants and claimants using appropriate media and formats covering application processes, eligibility criteria and the services available;
- Independent, regular reviews and scrutiny of disability assessment processes;
- Use of multidisciplinary teams to make disability assessments.

Moreover, as identified in section 5, based on a reading of the Convention as a whole, and bearing in mind the human rights model of disability, one can reach some more general conclusions about what a disability human rights compatible approach to disability assessment should involve:

First, the design and conduct of disability assessments should be guided by the General Principles established in Article 3 CRPD. These are:

Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
Non-discrimination;
Full and effective participation and inclusion in society;
Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
Equality of opportunity;
Accessibility;
Equality between men and women;
Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Assessment methods which breach these principles will not be in line with the CRPD.

Second, it is worth noting that the provisions of the Convention 'extend to all parts of federal States without limitation or exceptions' (Art. 4(5) CRPD). This is relevant where assessments are carried out at the municipal level.

Third, in line with the purpose of the CRPD, disability assessments should aim to consider the interactions between ‘persons with long-term physical, mental, intellectual or sensory impairments’ and the ‘various barriers that hinder their full and effective participation in society on an equal basis with others’ (Article 1 CRPD). They should assess the scope for ‘reasonable accommodation’ to remove such barriers. The assessment of impairment is not a substitute for the assessment of disability. The assessment mechanism should also allow for reasonable accommodations when needed in individual cases.

Fourth, the assessment should be conducted in a way that allows for the identification and elimination of obstacles and barriers to its accessibility in accordance with Article 9 CRPD. This includes access to any buildings used, to all forms of information and communication provided about the assessment process, to its application forms and assessment tools. Any rules which prevent individuals from being supported during the assessment where this is needed for an impairment-related reason, must be removed. In brief, assessment mechanisms must both be accessible and, where needed, allow for individualised reasonable accommodations.

Fifth, disability assessment processes must recognise the legal capacity of persons with disabilities on an equal basis with others (Article 12 CRPD). This means that ‘the rights, will and preferences of the person’ should be respected in an assessment ‘free of conflict of interest and undue influence’ and with minimum restriction, so far as possible and proportional to their circumstances.

Sixth, neither the process nor outcome of a disability assessment should deprive a person of their liberty arbitrarily, and ‘the existence of a disability shall in no case justify a deprivation of liberty’ (Article 14 CRPD). Deprivation of liberty through any process must be accompanied by rights guarantees.

Seventh, neither the process nor the outcome of a disability assessment should subject a person to ‘cruel, inhuman or degrading treatment’ and must respect the ‘physical and mental integrity’ of the person (Article 17 CRPD), especially in avoiding bodily interference or harm to health. These issues can be relevant in the context of medical examinations and tests which are carried out to assess physical or mental capacity, and also to work placements which are intended to assess an individual’s working capacity.

Eighth, the provisions for review or appeal of disability assessment decisions, as well as the conduct of assessment process, should respect a person’s right of access to justice (Article 13 CRPD). This means that, amongst other, that in reaching a judgment there should be ‘procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants’ at all stages of proceedings.

Ninth, in accordance with General Obligations of the CRPD, training should be promoted for ‘professionals and staff working with persons with disabilities in the rights recognized in the present Convention so as to better provide the assistance and services guaranteed by those rights’ (Article 4 and 13 CRPD). This applies to all individuals involved in the assessment process.

Tenth, disability assessments provide access to a wide range of social supports and entitlements (in cash or in kind). Social needs assessments should begin from respect for the right to live independently and to be included in the community (Article 19 CRPD). The scope of such assessment should never prejudice ‘the opportunity to choose their place of residence and where and with whom they live’ or presume any obligation ‘to live in a particular living arrangement’. It should include consideration of the full range of supports, including personal assistance, as well as access to community facilities.

Lastly, across the range of purposes, and where appropriate, specific eligibility and evaluation criteria in disability assessments should be framed with respect for the rights contained in the following CRPD Articles:

- Article 23 – Respect for home and the family;
- Article 24 – Education;
- Article 25 – Health;
- Article 26 – Habilitation and rehabilitation;
- Article 27 – Work and employment;
- Article 28 – Adequate standard of living and social protection;
- Article 29 – Participation in political and public life;
- Article 30 – Participation in cultural life, recreation, leisure and sport.

This means that assessments tailored to specific benefits, such as access to support for employment and access to support to educational support, will need to take the relevant obligations of the CRPD into account.

A final point is worth considering. In the report by Brunel University on *Definitions of Disability in Europe* published in 2002,⁵⁷⁹ the authors noted that one possible interpretation of the social model of disability was that special disability categories should be eliminated, and rights and entitlements should be formulated in a general way as much as possible. The authors implied that such an approach would involve not an assessment which seeks to determine if a person has a disability (which is of the right kind) and which could lead to an entitlement to receive a particular benefit, but rather whether a person needs a particular benefit or service, irrespective of their disability or health status. Nevertheless, in order for such an approach to truly recognise and meet needs, it would still have to take account of any disability-specific or disability-related needs on the part of applicants, and so should not ignore the concept of disability or regard the existence of a disability or health condition as irrelevant. It would also need to involve a sufficiently rigorous assessment mechanism, as eligibility would be potentially open-ended. Such an assessment system could be regarded as intrusive and overly demanding of applicants. With the possible exception of the newly devised Greek assessment to determine eligibility for additional support at school (see Part III, sub-section 10.3), which no longer requires a medical diagnosis or adopts a medical approach, no evidence was found of such assessment mechanisms in this synthesis report.

⁵⁷⁹ Brunel University, European Commission (2002), *Definitions of Disability in Europe, A Comparative Analysis*, p. 47. www.ec.europa.eu/social/BlobServlet?docId=2088&langId=en.