

**The implementation of EU social inclusion and social protection strategies in European countries with reference to equality for disabled people.**

**Report prepared for the Academic Network of European Disability Experts (ANED)**

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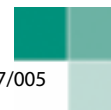
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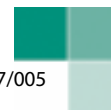
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## 1. Executive summary

The purpose of this report is to provide information regarding the implications for people with disabilities (PwDs) arising from the national policy developments during 2006-2008, in accordance with the EU strategies for social protection and inclusion. Furthermore, this report aims to examine the national implementation of the Open Method of Coordination (OMC) in social inclusion and social protection from a disability equality perspective and to provide useful information in support of disability policy mainstreaming. The report is based on the information submitted in national reports for the following countries: Austria, Bulgaria, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Malta, the Netherlands, Norway, Poland, Portugal, Romania, the Slovak Republic, Sweden and the United Kingdom.<sup>1</sup>

In particular, the report provides evidence of new policy measures such as anti-discrimination laws, while analysing available information on poverty risks and the role of disability-related benefits, which contribute to the social protection of vulnerable groups among PwDs. Furthermore, the report draws attention to those integration policies and measures that aim to shift the approach of social policies towards social inclusion. It focuses on health and long-term care issues, such as new measures introduced with the purpose of achieving de-institutionalisation and enhancing independent living. It also focuses on barriers to accessing long-term care services. Finally, it presents best practice examples identified by the national experts in the framework of social inclusion and social protection of PwDs, as well as conclusions and recommendations that emphasise in particular specific areas of future research and/or policy development.

This report shows that in some European Union Member States (EUMSs) the mainstreaming disability approach has seen some improvements according to the established objectives. Nevertheless, some country experts report that in their countries attention has been addressed to specific needs of PwDs rather than streamlining disability in all strands of the social inclusion and social protection strategy of EUMSs.

Country experts demonstrate that there has been progress concerning non-discrimination and equality legislation for people with disabilities in general. Nevertheless, shortcomings still exist, mainly because the provision of anti-discrimination law does not guarantee its implementation.

PwDs face a high risk of poverty and are often at risk of social exclusion. Hence this report attempts to provide existing information on the poverty risk of PwDs and the allocation of social expenditure to contributory, means-tested disability benefits or other disability-related income support. For several governments the primary concern has been the income support for PwDs rather than their social inclusion and participation. The medical model is still dominant in some EUMSs and continues to be an impediment to applying a social model which would focus on functioning abilities rather than on non-functioning ones. Some EUMSs have nevertheless begun to move towards focusing on the concepts of working ability and participation.

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<sup>1</sup> Considering the complexity of the topic we will report the information made available by the national experts clustered in six broad sections. In each section, whenever we have evidence from all the countries we list them, otherwise we provide examples of countries or select some of them for illustration.

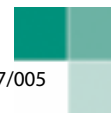
Most of the countries reported that various measures have been taken to reduce poverty among people with disabilities but poverty levels have persevered. People with disabilities face a higher risk of exclusion, their income is for the vast majority inferior compared to the total population and families with a household member with a disability have a lower average level of income. According to the national reports, women and elderly people with disabilities suffer more from poverty and exclusion compared to men and younger people, while another study based on a slightly different sample of EUMSs (Applica, CESEP & ALPHAMETRICS, 2007) suggests that the proportion of men living below the poverty line with limitations in carrying out activities is higher than the proportion of women.

Countries have taken a number of policy measures towards improving independent living of PwDs, although not all countries are presently at the same stage concerning this issue. Among these policy measures are the promotion of de-institutionalisation and the provision of direct payment schemes. The latter constitute a promising development towards empowerment of PwDs to choose and manage their own care. However, many of these schemes have only recently been introduced and more independent evaluation and research will be needed to fully understand their implications, both for independent living of the beneficiaries and for public budgets.

There are still important barriers to accessing long-term care services, which in particular affect groups of PwDs. People with mental health conditions, learning or intellectual disabilities and those with complex or severe care needs face increased difficulties in accessing adequate care and support due to legal barriers, unavailability of care and limited choice. Institutionalisation seems to be a particular concern for young people with disabilities, which may be a result of being born with a disability, as opposed to acquiring a disability during their working life. Affordability also remains a possible barrier to accessing adequate quality care.

A common shortcoming raised in all the reports is the lack of statistical information and empirical research. The shortage of empirical evidence, monitoring and evaluation of the needs of PwDs and their actual situation is an issue frequently raised in the national reports. More research would be required, starting with the improvement of data collection on poverty among PwDs, the evaluation of existing disability programmes, the monitoring and practical implementation of designed disability programmes, as well as efficiency analysis of such measures.

Finally, the report concludes that national experts have expressed gaps between proposed objectives in policy documents and actual measures undertaken. Little or no evaluation has been carried out on the implemented measures. The EU may wish to stress the need for proper evaluation of measures and policies by its Member States, as well as a cost/benefit analysis and monitoring of the impact of policies on the beneficiaries.



## 2. Introduction

Key to the EU Disability Action Plan is the concept of ‘mainstreaming’ disability in all policy areas, and the extent to which equality for people with disabilities (PwDs) is integrated or remains a separate concern is important. The challenge is to set common socio-economic values to enable people with disabilities to enjoy their right to dignity, equal opportunities, independent living and participation in society.<sup>2</sup> According to the EU Disability Action Plan and the Open Method of Coordination (OMC), the approach of mainstreaming disability in the context of social protection and social inclusion means that the needs of disadvantaged people should be taken into account in all policy areas and at all stages of policy development, without restrictions to specific measures. Consequently, the EU Member States (EUMSs), while designing and implementing their national policies in accordance with the OMC, should follow this approach.<sup>3</sup>

The purpose of this report is to provide evidence on the disability implications of national policy developments during 2006-2008 vis-à-vis EU strategies for social protection/inclusion. Furthermore, the report aims to examine the national implementation of the OMC in social inclusion and social protection, and in particular the National Strategic Reports of the Member States from a disability equality perspective, and to provide useful evidence in support of disability policy mainstreaming. The thematic report is mainly based on national experts’ reports but also draws on evidence from selected recent European comparative research. Consequently, the analysis and comparison allows us to identify to what extent PwDs are included in these National Action Plans for Social Inclusion and Protection of the EUMSs and the selected countries, and whether disability is being ‘mainstreamed’ or treated separately and what are the most important gaps in these plans.

The National Action Plans and the OMC play a crucial role in transforming the common objectives agreed at EU level to the national level. Therefore, this thematic report reviews the national implementation of the OMC in the context of mainstreaming disability by focusing on three key areas: (a) social inclusion, (b) pensions and (c) health and long-term care.

More specifically, within the strand of social inclusion we will focus on different measures and new policies introduced by the Member States such as: equal access to resources, rights and services for PwDs, the fight against discrimination and towards increasing integration and how PwDs and their organisations are involved in decision-making and coordinating these policies.

National experts who have analysed social inclusion and social protection strategies in their respective countries provide the main input for this thematic report. In addition, gaps in the relevant national research within each of the areas of interest were identified. Moreover, the national experts have identified good measures and examples of good practice in the implementation of social inclusion and social protection targeted to PwDs.

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<sup>2</sup> See ‘Common Objectives’, [http://ec.europa.eu/employment\\_social/spsi/common\\_objectives\\_en.htm](http://ec.europa.eu/employment_social/spsi/common_objectives_en.htm)

<sup>3</sup> See: ‘Discussion paper from the Disability High Level Group on Disability Mainstreaming in the new streamlined European Social Protection and Social Inclusion Process’, [http://ec.europa.eu/employment\\_social/spsi/strategy\\_reports\\_en.htm](http://ec.europa.eu/employment_social/spsi/strategy_reports_en.htm)

Nevertheless, comparing different disability policies and measures from the EU level perspective is a challenge in itself. The first difficulty arises due to the heterogeneous definition of disability in EUMSs, which consequently leads to the second difficulty: the variety in approaching disability issues as well as diverse disability-related policies addressed at PwDs. Therefore, the diversity in the defining and designing of disability policy makes the assessment complex and it has relevant implications for the objective of forging a common approach in the EUMSs to the social model of disability.<sup>4</sup>

The report is divided into eight sections:

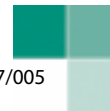
- The first section focuses on disability mainstreaming in the context of social inclusion and protection of PwDs and how EUMS government strategies address this issue.
- The second section introduces policy measures within the framework of combating social exclusion, such as anti-discrimination laws, with the purpose of providing legal protection, which would guarantee PwDs equal rights with all other citizens.
- The third section analyses the poverty risk and the role of disability benefits, disability allowance and income support programmes, which contribute to the social protection of vulnerable groups of PwDs.
- Section four draws attention to those integration policies and measures that aim to shift from a protection to an inclusion approach, such as measures related to inclusive education.
- Section five addresses new measures introduced with the purpose of securing independent living, namely through de-institutionalisation.
- Section six focuses on barriers to accessing long-term care services.
- Section seven discusses the involvement of PwDs in the assessment and decision-making process of policy measures addressed at them.
- Section eight highlights best practice examples identified by the national experts which improve the social inclusion and social protection of PwDs.
- Conclusions and recommendations are presented in the last two sections, which also include specific areas of future research and/or policy development.

### **3. Mainstreaming disability**

The main focus of the report is to provide evidence about the implementation of social inclusion and social protection policies affecting disabled people in European countries and the mainstreaming of disability issues. The review and analysis of the national experts' reports synthesises the evidence of policy change and new measures introduced by the EUMSs from the perspective of mainstreaming disability.

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<sup>4</sup> Ibid.



### **Mainstreaming disability**

National Action Plans on Social Inclusion identify people with disabilities as a vulnerable population, the challenge is to develop effective multi-level responses to a complex set of factors impacting on people with disabilities and their families.

The concept of mainstreaming disability refers to the inclusion of disability issues in the planning, implementation, monitoring, evaluation and revision of policies and actions at all levels of society, locally, regionally, nationally and internationally. Effective mainstreaming must address some key issues at different levels of national and international governance:

Societies must accept and believe in the principle of equality

Societies must implement the existing human rights (i.e. UN Standard Rules, UN Convention on Civil and Political Rights, etc)

Information about people with disabilities living in certain areas must be available. It is therefore important to ensure that all groups and individuals are covered and to ensure that people with invisible impairments are included

Knowledge about support and service needs must be available

Authorities must establish a good, continuous cooperation with organisations representing people with disabilities. These are a genuine source of information about the needs of people with disabilities; they should also be involved in planning and implementing measures and monitoring the implementation and planning of new measures

Authorities at all levels (local, regional, national) must have good knowledge of what mainstreaming is, why it is important and what it means in practice and in everyday work

Mentalities and attitudes must change from protection to inclusion

Inclusive legislation and human-rights-based legislation must have appropriate implementation structures

All actors in poverty reduction must be mobilised (governments, NGOs, etc.)

The family and informal support structures must be strengthened

More involvement in European programmes to promote cooperation and best practice should be encouraged.

*Source: Inclusion Europe (2006).*

Policy mainstreaming is defined as the extent to which countries are including disability equality in mainstream social policies or creating new policies specifically for people with disabilities.

Effective mainstreaming must address some key issues at different levels of national and international governance such as the principle of equality; the implementation of existing human rights (i.e. UN Standard Rules, the UN Convention on Civil and Political Rights, etc); good, continuous cooperation with disabilities organisations; their involvement in the planning, implementing and monitoring of new measures; change in the approach of



disability from protection to inclusion; and finally the fight against poverty and the strengthening of family and informal support structures.<sup>5</sup>

Furthermore, the OMC highlights that when mainstreaming disability into social protection and social inclusion, the UN Convention on the Rights of Persons with Disabilities must be taken into account. For example, Article 28 emphasises that the right to an adequate standard of living and to social protection should be provided in the same way as to the rest of the population, stating that States Parties shall recognise:

*“The right of persons with disabilities to an adequate standard of living for themselves and their families, including adequate food, clothing and housing, and to the continuous improvement of living conditions, and shall take appropriate steps to safeguard and promote the realisation of this right without discrimination on the basis of disability.”<sup>6</sup>*

The mainstreaming of disability in social inclusion and social protection (SISP) plans following the approach of the OMC has seen relevant improvements according to its objectives, for example, legislation and new policy measures have been put into action. New laws have been introduced with the aim of combating discrimination and improving the social inclusion of people with disabilities. One of the findings from the reports is that there is more involvement of PwDs in governmental programmes addressing the needs of PwDs. Networks of PwDs have been created and have been actively involved in contributing to policy development, examination and evaluation of policy measures targeted to PwDs, as well as exchange of services and experience in the implementation and monitoring of such policies.

Some of the EUMS governments have started to introduce into their national long-term strategies policy measures aiming to improve the life chances of PwDs (UK, Iceland, Portugal etc.). Efforts have also been made to improve the integration of PwDs into the labour market and the development of social policies and activation of instruments that help PwDs to conduct an independent living. De-institutionalisation and improved provision of community-based care seems to be a general policy trend (Applica, CESEP and European Centre, 2007), present in most policy documents and debates quoted in the national reports. Similarly, some EUMSs have introduced personal budgets or direct payments, however, their availability is still limited to a few countries and to a specific group of beneficiaries.

*Table 1: Examples of countries attempting to mainstream disability in the context of social protection and social inclusion.*

<b>Countries</b>	<b>Policy measures</b>
UK	The British government already includes in the Prime Minister's Strategy Unit document ( <i>Improving the life chances of disabled people</i> (PMSU 2005)), a 20-year vision for the inclusion of disabled people by 2025.
Cyprus	The Strategy for Social Inclusion, 2006-2008 of the Cypriot government reports that social inclusion of PwDs falls within all the priorities of this Strategy.
Iceland	There is no national action plan (NAP) policy strategy for social inclusion.

<sup>5</sup> Source: Inclusion Europe (2006). *Poverty and intellectual disability in Europe Report*, Brussels: Inclusion Europe, available at: [www.inclusion-europe.org](http://www.inclusion-europe.org)

<sup>6</sup> Source: Convention on the Rights of Persons with Disabilities, <http://www.un.org/disabilities/convention/conventionfull.shtml>

	However, the policy strategy 'Shaping the future: services for disabled children and adults 2007-2016', addresses the importance of assisting and integrating people with disabilities into the labour market and guaranteeing them the rights and the means to achieve adequate employment, rehabilitation, education and housing.
Poland	In Poland special emphasis has been placed on the integration of people with disabilities into the labour market, on the development of social policies and on the reinforcement of links between the guaranteed minimum income and activation instruments.
Norway	Disability policy is mainstreamed according to the principle of sector responsibility, meaning that education of disabled people is included in policy documents on education, accessibility to the built environment is included in the building codes and employment is discussed as part of employment policies.
Italy	Mainstreaming policies exist in Italy. Organisations of disabled people seek to ensure greater inclusion, to implement the European policies and to adapt the law to the United Nations Convention on the Rights of Persons with Disabilities.

Source: National reports.

Nevertheless, the examples above indicate that attention has been addressed towards the specific needs of PwDs rather than streamlining disability in all strands of the social inclusion and social protection strategy of EUMSs. As a result, major challenges lie ahead in terms of mainstreaming the EU disability social model concerning the improvement of equal rights and equal opportunities for PwDs. Many EU governments continue to treat disability as a special issue and offer special programmes and measures for people with disabilities or with special needs, hence the successful mainstreaming of disability has not yet been achieved. Socially active inclusion through education, training and employment has been highlighted and implemented independently rather than in a cooperative approach.

*Table 2: Some examples of gaps reported by the national experts in relation to mainstreaming disability in the context of social protection and social inclusion.*

<b>Countries</b>	<b>Policy measures</b>
Denmark	The mainstreaming disability principle has been advocated since 1940, but research shows that not much policy has been explicitly concerned with attitudes and discrimination.
Cyprus	The prevention of children with special needs from being socially excluded from the education system is not being mainstreamed in the overall plans for inclusion. Children with special needs are expected to be educated in mainstream schools, but they are placed in special units with special teachers, which leads to segregation rather than integration. The issue of non-discrimination and equal opportunities is emphasised within the Disabled People's Act 2004 but this law has not yet been implemented.
Norway	The Action Plan for Combating Poverty (AID 2006) hardly mentions the issue of disability. Disabled people are not included among the vulnerable groups. The White Paper (2006) is criticised by the disability movement for being severely biased towards care for elderly people.
The Slovak Republic	The issue of life-long learning opportunities accessible for people with disabilities, which would directly improve their labour market position, is not sufficiently addressed. In addition, national strategy documents pay

	insufficient attention to improving access for people with disabilities to the mainstream educational system.
Bulgaria	The disability-related problems that require governmental actions and policy measures are those concerning de-institutionalisation, environmental barriers and participation in the community.

Source: National reports.

In particular the *UK* is a country where much attention has been focused on disability issues in different strands of social inclusion and social protection, such as policy commitments on promoting equality, reforming welfare and transforming social care. The 'rights and responsibilities' approach places increasing emphasis on work and employment for adults with disabilities, while the 'personalisation' agenda emphasises greater flexibility, choice and control. Research evidence is improving but more reliable indicators of equality are required.

There is evidence that investment in independent living is more cost-effective than traditional institutions and services and that recipients do benefit from improved life choices. However, there is also evidence of substantial relative poverty and the uneven implementation of support for independent living. There is emerging concern about the relative disadvantage of mental health service users and, by implication, the poverty of women with disabilities, particularly Muslim women. Further research is needed to monitor equality of outcomes, best practices in personalised social care and the relative exclusion of specific groups.

In contrast, in the case of *Bulgaria* it is suggested that the whole disability policy should undergo a fundamental change starting with the replacement of its disability paradigm, which focuses on the disabilities rather than the abilities of PwDs, continuing with education, employment, accessibility, launch of new independent living schemes etc.

#### 4. Combating social exclusion: the contribution of anti-discrimination measures

The purpose of this section is to look at those policy measures within the framework of combating social exclusion, such as anti-discrimination laws aiming to provide legal protection and guaranteeing rights to PwDs equal to all other citizens.

Article 5 of the UN Convention on the Rights of Persons with Disabilities, on equality and non-discrimination, recognises that all people are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.<sup>7</sup>

*"States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds. In order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided."*<sup>8</sup>

There is evidence from the literature that in EUMSs people with severe disabilities and/or complex needs and their families face a higher risk of being discriminated against in all

<sup>7</sup> Source: Convention on the Rights of Persons with Disabilities, <http://www.un.org/disabilities/convention/conventionfull.shtml>

<sup>8</sup> Ibid.

aspects of their lives.<sup>9</sup> Moreover, they are one of the most vulnerable groups of citizens in the EUMSs.

Reasons for encountering discrimination include limitations with respect to communication, interaction and participation in society.<sup>10</sup> Furthermore, another risk for discrimination is the perception of a person with severe disabilities or complex needs as not being capable of assuming socially accepted mainstream roles in life.

The first finding from the national experts' reports and recent studies is that the existing anti-discrimination laws in some EUMSs are often restricted to specific issues rather than to a broader and more comprehensive anti-discrimination perspective. For instance, during the last two decades, anti-discrimination laws have been implemented and amended by some countries in relation to employment (*Germany, the Netherlands, Greece, Latvia, Norway, Estonia, Ireland etc*), by others in relation to equal opportunities (*Cyprus, Estonia, Hungary, the UK, etc*) and by others in relation to accessibility (*Norway, The Slovak Republic, Ireland, Portugal, etc*).

For example, in *Greece*, anti-discrimination legislation is limited to equal treatment at work and the employer's duty to ensure accessibility in the workplace and there is no anti-discrimination law in other aspects of life, such as education, public structures and services and accessibility in the built environment. At present, the *Czech Republic* does not have comprehensive anti-discrimination legislation to ensure protection from discrimination for people with disabilities. There is a Labour Code in force in the area of employment but outside this area similar protection against discrimination is not yet in place.

The second finding is that a number of recent and major actions have been embarked on by some EUMSs to combat discrimination and increase integration for people with disabilities. There has been an improvement concerning non-discrimination and equality legislation for people with disabilities in general. New laws have been introduced, such as anti-discrimination acts and equal rights acts. Some countries which have recently introduced new laws into their national legislation, in coordination with the European non-discrimination directives, are *Germany, Hungary, Cyprus, the UK, Norway, France* and *Bulgaria*.

*Table 3: Examples of countries which have recently introduced anti-discrimination measures*

<b>Countries</b>	<b>Policy measures</b>
Cyprus	The Disabled People's Act of 2000 defines disabled people's rights in different areas of life and alongside the amended legislation. The Disabled People's (Amended) Act of 2004 emphasises the issue of non-discrimination and equal opportunities for PwDs.
UK	The former Disability Rights Commission (DRC) was abolished and a new Equality and Human Rights Commission (EHRC) established in 2007. It mainstreams disability equality within a generic human rights agency.
Hungary	The Constitution of the Republic of Hungary prohibits discrimination in general. Since 2003 the Act CXXV on Equal Treatment and the Promotion of Equal Opportunities provides the basis for the prohibition of discrimination as understood in a broad sense. A positive practical, anti-discrimination example is the 'Don't Let Yourself (be discriminated against)' programme by

<sup>9</sup>Source: *The specific risks of discrimination*, Volume 1, [http://ec.europa.eu/employment\\_social/index/cns\\_volume\\_1\\_en.pdf](http://ec.europa.eu/employment_social/index/cns_volume_1_en.pdf), p.4.

<sup>10</sup> Ibid.

	the Hand in Hand Foundation aimed at the development of a national discrimination indicator system.
Germany	The General Equality Act (2006) is an implementation of the European non-discrimination directives into German law. It protects people with disabilities against discrimination not only under employment law, but also in civil law.

Source: National reports.

In *Germany* new legal acts have recently been implemented which significantly mark the shifts in German disability policy: the Act to Combat Unemployment among Severely Disabled Persons enhanced rehabilitation and participation and improved training and employment for the severely disabled. The goal is to improve social inclusion, participation and self-determination for PwDs. The priority of the German government is employment, the smooth integration into the labour market of PwDs and the shift from the principles of care and welfare to those of self-determination and participation.

In *Ireland* the key legislative developments affecting people with disabilities are the Disability Act 2005, the Employment Equality Act and the Equal Status Acts. The Disability Act approved in 2005 represents significant progress in disability policy but it also has a number of weaknesses e.g. entitlement to services is conditional on budgetary constraints and not a right in itself and there are no provisions for challenging the assessment. The Equal Status Act protects PwDs against discrimination in accessing goods and services, accommodation and education. The Employment Equality Act 1998 and 2004 protects PwDs against discrimination related to employment, including job advertising; equal pay; access to employment; vocational training and work experience; and terms and conditions of employment and employees in the public and private sector.

*Portugal* has achieved significant improvements through the rehabilitation policy instruments (2005), the new Law on Accessibility (2006) and the law prohibiting discrimination based on disability.

In *Norway* policies and measures recently introduced which are actively used to combat discrimination and improve accessibility include an act on discrimination in the availability and accessibility of services (access to ICT, building legislation, the public procurement act, transport regulations, etc).

Nevertheless, from the national reports it became clear that, although a number of new laws have been introduced which aim to combat discrimination and improve the social inclusion of people with disabilities there are a number of weaknesses related to existing and planned laws.

Some of these weaknesses are due to the fact that anti-discrimination laws are often restricted to a specific issue rather than being comprehensive. This means that in some countries the anti-discrimination legislation is targeted at specific issues, e.g. equal treatment at work, access to the health system, long-term care, buildings, transport etc. These restrictions of anti-discrimination laws to specific disability issues do limit the protection and integration of PwDs particularly to these specific areas.

The attempts of the *Dutch* government to eradicate discrimination consist of laws introduced in 2006 to improve the participation of PwDs in the labour market and society, while in contrast *Bulgaria* introduced the Anti-discrimination Act in 2003, which regulates

the protection of all individuals against all forms of discrimination, thus re-enforcing positive measures for equal opportunities.

In addition to the weaknesses mentioned above, others derive from the process of the implementation of new and existing legislation. In some countries with anti-discrimination law provision, these laws did not receive sufficient attention with respect to the implementation phase. In particular, research identifies that, although measures for enhancing accessibility are in place (access to healthcare services, access to information and access to transportation, e-inclusion and ITC), their utilisation by PwDs still remains very low.

Some of the national experts claimed to identify weaknesses in the planning and implementation of anti-discrimination legislation and uncertainty about the effects of the laws introduced by their governments. For example, in *Iceland* specific anti-discrimination clauses receive little attention in 'Shaping the future 2007-2016', a recent policy strategy regarding the inclusion of PwDs. Ensuring equal rights, access to services and income support focus directly on the circumstances and needs of disabled people, whereas anti-discrimination measures are focused on wider society, where barriers such as negative views about and attitudes towards disabled people are produced and reproduced.

In *Cyprus*, particularly, the rights of PwDs in different areas of life are legislated for by the 2000 Disabled People's Act and its amendment in 2004 emphasises the issue of non-discrimination and equal opportunities. However, advocates for PwDs feel that not much has been done to implement the Disabled People's Act (2004) in relation to non-discrimination and equal opportunities and thus it remains a 'framework legislation' (Symeonidou, 2005a).

In *Latvia* new policies and legislation have been developed during the last ten years but they do not ensure the inclusion and social protection of PwDs, in particular people with intellectual disabilities. Disabled people are considered as a generic group and there is no attention to the different needs of people with different kinds of disabilities.

The national reports identified important gaps in the research and lack of evidence concerning: multiple discrimination in the population; severity of the disability; and distribution by gender and ethnicity. Moreover it is considered that it would be important to conduct impact analysis to monitor the results of anti-discrimination measures that aim to ensure more equality for PwDs.

## **5. Social protection and poverty reduction**

One of the priorities of the OMC is to combat poverty and provide adequate and sustainable incomes. PwDs are among the social groups facing a higher risk of poverty and there is a causality relationship between being disabled and being poor meaning that disabled people tend to be poorer than the rest of the population and poor people are more likely to be disabled compared to the total population. A 2003 study by the Organisation for Economic Co-operation and Development (OECD) shows that in many OECD countries the income levels of households with PwDs are in general broadly similar to that of the population as a whole, indicating a relatively high level of income security among PwDs. However, this is partly explained by the high incomes of other household members. The relative economic well-being of households is interconnected with the structure of the disability benefit system and the level of benefit amounts. In some



countries full disabled population coverage with disability benefits and high earnings related insurance benefits is provided, while other countries focus on means-tested programmes. The former countries provide the highest relative incomes to PwDs, while the latter, which are characterised by lower public spending on benefits, offer the lowest levels of benefits.

It is generally recognised that the main reasons for the higher risk of poverty for people with disabilities are lack of appropriate education, lack of participation in the labour market, barriers to accessing health care and social security, as well as inadequate income support.<sup>11</sup> The findings of an OECD report on Norway, Poland and Switzerland (2006) demonstrates that PwDs have an average disposable income below the average of the total working-age population (10-15 per cent lower).

Relative economic well-being and poverty differ among age groups and educational levels attained, with income levels lower among younger, older and less highly educated people. An OECD report on Australia, Luxembourg, Spain and the United Kingdom (2007) showed that in these countries, the employment of PwDs plays a decisive role in reducing the risk of poverty, while inactivity and in particular unemployment reduces the income position of PwDs. Thus, in the case of Spain, the very high level of unemployment of PwDs and their low rate of employment remain an issue of concern, while in the United Kingdom, the main challenges are the very large number of disability benefit recipients and the low level of income of PwDs in spite of a high rate of employment.

**In this context, the present report analyses the available evidence concerning the poverty risk for PwDs, allocation of resources to disability pension, income support, disability allowances for PwDs, the possibility of combining disability benefit with earnings from employment and the effectiveness of this in securing a decent level of income in order to provide people with disabilities the opportunity to live in dignity.<sup>12</sup> 5.1 Disability pensions**

The disability pension is mostly provided by the social insurance system, conditional on a certain number of eligibility criteria, such as a minimum period of insurance contributions, age and the degree of (dis)ability. Most countries make distinctions between disability benefits: those which are part of the contributory insurance system and non-contributory benefits which are means-tested and provided by the social assistance system.

Those PwDs who do not satisfy the criteria for the contributory scheme are assisted by special non-contributory allowances or by general guaranteed minimum income schemes.

Firstly, from the reports it can be observed that the EUMSs apply diverse eligibility criteria concerning contributory benefits and other disability-related benefits. Moreover, the definition of disability and reduced capacity required for eligibility to receive a disability benefit is different among the selected countries.<sup>13</sup> For instance, the contributory disability benefits are provided to those PwDs who have been assessed as having reduced working capacity and are unable to earn income through gainful employment. Nevertheless, in

<sup>11</sup> Inclusion Europe (2006).

<sup>12</sup> In addition to this section, please see Annex B, for information about the possibility of combining disability benefit with earnings from employment and the effectiveness of this in securing an adequate level of income.

<sup>13</sup> In Annex B, Table 11, we summarise the main disability benefits, contributory and non-contributory, the eligibility conditions and respective amounts of disability benefits.

several countries it is possible to combine these benefits with earnings from work. Consequently, the amount of disability benefit will depend not only on the degree of (dis)ability but also on the ceiling of earned income from employment. PwDs are often also entitled to additional rehabilitation allowances, technical support and other means-tested benefits. It is obvious that disability benefits are predominantly heterogeneous, reflecting not only the diversity among categories of disability but also the diverse disability approach among EUMSs.

Secondly, from the reports it can be seen that the clustering of the EUMSs according to the disability approach falls within two main categories: the medical model of disability and the social model. The first model emphasises the reduced capacity and compensates for the loss of ability to work and the special needs of PwDs, while the second model concentrates on the remaining abilities of PwDs, their rehabilitation and participation.

The *Czech Republic* is an example of a country which applies the medical approach of disability to people with intellectual disabilities, by stressing the importance of reduced capacity and not taking adequately into account the capabilities and employment potential of these people. In *Greece* the medical approach to disability is restricted mostly to care and rehabilitation measures, thus dominating measures for social integration.

In contrast, countries which apply an integrative social approach, emphasising the remaining capacity to work, are, for example, *Denmark* where the eligibility conditions to receive the disability pension (*Førtidspension*) is not disability or any medical diagnosis, but just “working ability”, defined as the ability to fulfil the requirements involved in a particular job and to earn an income for full or partial maintenance.

Thirdly, concerning current major policy trends, evidenced by the national reports, it can be seen that other EUMSs, such as the *Czech, French, Italian* and *German* governments, are moving towards the approach of working ability and participation by abandoning the medical approach to disability. For other countries, it emerges that the primary concern has been financial support for PwDs rather than the social inclusion and participation of PwDs.

The concern has been the level of disability benefits, contributory and non-contributory, such as would provide PwDs with a subsistence-level of income rather than compensation for the loss of ability and promotion of further rehabilitation and integration in employment. For example, in some countries, such as *Bulgaria, Greece, Estonia, Iceland* and *Portugal*, the medical model still persists and continues to be an impediment to the application of a social model which would focus on functioning abilities rather than non-functioning ones.

The identified differences, emphasised above, highlights the fact that disability benefits could serve as an alternative to withdrawing earlier from the labour market. Hence, EUMSs are introducing new measures aiming at a more accurate functional assessment of working ability for the entitlement to disability benefits, in order to reduce withdrawal from the labour market because of incapacity to work.

Fourthly, the issue of how to approach disability turns out to be even more significant when we investigate what the statistical data demonstrate with respect to the number of people with disabilities receiving disability benefits. With reference to recent administrative register data (Applica, CESEP and European Centre (2007), p.19) it can be observed that the number of people in receipt of disability pensions who are of working



age varies sharply across countries and has increased between 2000 and 2005 in countries like *Belgium, the Czech Republic, Estonia, Ireland, Spain, France, Italy, Cyprus, Lithuania, Hungary, Austria, Norway and Sweden*. In countries such as *Denmark, Germany, Latvia, Luxembourg, the Netherlands, Poland, Portugal, Slovenia, The Slovak Republic, Finland and the UK* the number of benefit recipients has, in principle, decreased.<sup>14</sup>

Furthermore, the study on PwDs as recorded by administrative register data (Applica, CESEP and European Centre, 2007) shows that, even though the number of women receiving disability benefits is relatively lower compared to men, there is an increasing trend of women among new disability pension recipients. However, it can be seen that in countries such as *Portugal, Latvia and Finland* the number of disability pension recipients is higher among males, while in *Spain, Italy, Hungary, Finland and the UK* the number of female recipients is higher compared to males registered as receiving non-contributory disability benefits.<sup>15</sup>

In addition, statistical information on social expenditure (Annex B, Figure 1) presents the percentage of GDP allocated to disability pensions.<sup>16</sup> It can be seen that in 2005 this ranges from 0.3 per cent in *Cyprus* to 2.6 per cent in *Sweden and Norway*, while the average level for the EU27 is 1.1 per cent. The statistics also indicate that in 2005, for more than half of EUMSs, the percentage of social expenditure spent on disability pensions as a share of GDP was below the average level of the EU27. However, countries such as *Norway, Sweden and Netherlands* show a level which is almost double that of the EU27. In addition, between 2000 and 2005, some of the countries in the group above the average level of the EU27 showed a decrease in the percentage of GDP spent on disability pensions (*the UK, the Netherlands, Finland, Austria and Luxembourg*).

These data highlight the fact that EUMSs allocate their national resources differently on disability pensions and this differentiation is considerable. This difference in social expenditure on disability pensions underpins the diversity of approaches to disability issues in the EUMSs and the diverse level of priority that EUMSs dedicate to this area.

In exploring the data on the levels of disability pensions in Euro per inhabitant (Annex B, Figure 2) it can be seen that the new EUMSs and southern EU countries such as *Italy, Greece and Spain* allocate an amount which is lower than the average for the EU27.<sup>17</sup>

Despite the increase in benefit levels between 2000 and 2005, disability pensions in the new EUMSs are much lower compared to the EU27 and the rest of the EU countries. In contrast, the Nordic countries, e.g. *Norway and Sweden*, demonstrate a much higher level of average amount of disability pension per inhabitant and, in addition, a remarkable increase in the amounts paid.

Distinguishing between means-tested and non-means-tested disability benefits (Annex B, Figure 3), it can be observed that between 2000 and 2005 the total expenditure on disability benefits in general compared to expenditure on means-tested and non-means-tested disability benefits (in Euro per inhabitant at constant 1995 prices) has increased for

<sup>14</sup> See Annex B, Table 10. Source: Applica, CESEP and European Centre (2007), p.19.

<sup>15</sup> Source: Applica, CESEP and European Centre (2007), Table 2, p.22.

Other studies have shown that in Nordic countries (*Denmark, Norway and Sweden*) women are in majority among disability pension recipients. See: *Social protection in the Nordic countries 2005*, Nordic Social Statistical Committee, 2007, Table 7.14.

<sup>16</sup> Source: Eurostat 2008.

<sup>17</sup> Source: Eurostat 2008. (Level of disability benefits in Euro per inhabitant (at constant 1995 prices))

most of the countries, but has decreased for *Portugal, Romania, Latvia, the UK, Slovenia, Poland, Italy, Germany, the Netherlands and Spain*. This is also confirmed by the increase in the overall level of social expenditure on disability benefits, means-tested and non-means-tested ones.

The evidence of a fall in the number of disability benefit recipients along with an increase in social expenditure and the level of benefits, contributory and non-contributory, indicates an increase in the generosity of such schemes. This implies that fewer PwDs are receiving higher amounts on average. For example, this fact is confirmed in countries such as *Finland, Denmark and Iceland*. In contrast, countries such as *the UK, Poland and Latvia* present a simultaneous decrease in the number of benefit recipients, level of benefits and level of social expenditure on all disability benefits schemes. Moreover, between 2000 and 2005, these countries show a significant fall in the percentage of GDP spent on disability pensions.

Finally, these trends in the amount and the percentage of GDP spent on disability pensions, along with an increase in numbers of benefit recipients, confirm the necessity for new policy measures and the modernisation of social security systems in order to guarantee disability benefit recipients an adequate level benefit, together with the financial sustainability of the system.

*Table 4: Cluster of countries by the change in number of recipients and expenditure on disability pensions*

	Change in expenditure on disability benefits in terms of percentage of GDP (2000-2005)		
		Increase	Decrease
Change in the number of disability benefit recipients (2000-2005)	Increase	LU, NL, AT, PL, PT, SL, UK, LV, EL, ES, FI	DE, SK
	Decrease	FR, IT	BE, CZ, DK, EE, IE, CY, LT, HU, LT, SE

It can be seen that, in *Greece, Austria, Spain, Luxembourg and Finland*, the reduction in GDP expenditure and recipients has been accompanied by higher amounts of disability pensions, including means-tested and non-means-tested schemes (Table 9, Figures 1-4, Annex B). However, social protection for PwDs should be achieved through their integration into the labour market. The decrease in GDP expenditure and numbers of recipients of disability pensions should correspond to an increase in the number of people with disabilities who are in gainful employment and receiving adequate wage levels, rather than shifting to other clusters of benefits recipients, e.g. general means-tested benefit or unemployment benefits.

In the *Netherlands, Poland, Slovenia, Latvia and the UK* there has been a decrease in the number of recipients and of GDP expenditure on disability pensions. However, the amounts received have also decreased. Hence the remaining recipients are not better off.

However, in the case of *Belgium, the Czech Republic, Ireland, Cyprus, Lithuania and Malta*, it can be seen that there has been an increase in the numbers of recipients as well as in GDP expenditure on disability pensions. Moreover, these increases have been accompanied by an increase in the amount of disability pensions, including means-tested and non-means-

tested benefits (Figures 1-4, Annex B), indicating that a greater number of recipients are better off.

## 5.2 Poverty among people with disabilities

The EUMS strategies against poverty and social exclusion have been initiated but there is still a long way to go. Most of the countries reported that various measures have been taken to eradicate poverty among people with disabilities but that poverty still persists. People with disabilities face a higher risk of exclusion, their income level for the vast majority is inferior compared to the total population and families with a household member with a disability have a lower average level of income. Women and elderly people with disabilities suffer more from poverty and exclusion compared to males and younger people. With regard to people living in institutions, although the risk of poverty is lower, social exclusion is more probable.

Several countries (*Hungary, Bulgaria, Iceland, Italy, the Slovak Republic, Sweden and France*) consider the situation of financial income for PwDs as a priority and are facing a major challenge in terms of financial sustainability, due to the increase in the number of disability pensions and levels of benefits. However, other countries such as *Denmark, Latvia and Finland* do not recognise this issue as a primary political concern.

In order to provide PwDs with a decent level of income, some of the EUMSs have launched proposals to increase their benefit levels to a certain percentage of the minimum wage. However, while in some countries (*Malta, the Netherlands and Latvia*) the gap between disability benefits and minimum wages has been narrowed, in some others (e.g. *Iceland*) this gap has expanded in recent years.

Table 5: Examples of countries which link disability benefits to the minimum wage or social subsistence minimum

<b>Countries</b>	
France	Proposal to create a universal basic income equal to the amount of the guaranteed minimum wage. For PwDs living in institutions the amount received must increase by 30 per cent of the guaranteed minimum wage.
Latvia	Latvia has established by law a minimum level of disability pension, which is approximately the same as the minimum salary
Malta	The social security benefits do not exceed the level of the minimum wage
Netherlands	The level of disability benefits is minimally 70% of the minimum wage and has recently been raised to 75%.
Poland	In 2007 people with disabilities are entitled to social pension and nursing supplements at a level, which is above the legal poverty line but below the social minimum.
Czech Republic	The Act on Living and Subsistence Minimum was introduced in 2007
Slovak Republic	PwDs entitled to a partial disability pension receives 75% of the statutory minimum wage and a person who is beneficiary of a full disability pension the 50% of minimum wage.

Source: National reports.

Focusing on income level, it can be identified from the national reports that in some EUMSs (*France, Germany, Iceland, Italy and Malta*) the majority of PwDs are in the lower income brackets and have an income level below the poverty line. It can also be seen that PwDs live with a very modest level of income and families with PwDs tend to have a higher burden of financial costs. In most cases people with disabilities and their families rely on means-tested and other disability benefits. For example, in the *UK* even though there is a mainstreaming approach in relation to child poverty through support for families, there are no special measures to take into consideration the additional costs of parenting a disabled child or the additional difficulties that parents may have in working. In *Iceland* the level of disability pension is 27-40 per cent below the minimum subsistence level of income. In the *Netherlands* PwDs generally have an income level at or just above the poverty line; in particular the vast majority of people with intellectual disabilities live below or on the poverty line.

Concerning the issue of poverty, the country experts reported that among PwDs there is a significant level of poverty and that families with disabled members tend to live in poor conditions. Moreover, it is reported that, among people with disabilities, women have the higher risk of poverty and tend to be poorer compared to men. The socio-economic situation of women and the elderly is inferior to that of men and PwDs of working age (for example, in *Latvia, Germany, Iceland, Malta and Sweden*). In *Norway* the financial situation of PwDs is more satisfactory. The gender gap in income among PwDs is smaller than in the total population (the mean disposable income of disabled women being 80 per cent that of men). Concerning the age difference, the income gap between disabled and non-disabled people appears to be smaller among those below the age of 40 compared with those aged 40-66.

*Table 6: People with disabilities living below the poverty line compared to the total population*

	Year	PwDs receiving disability pensions below the poverty line	Total population with an income level below the poverty line
Austria	2007	18%	12%
Greece	2005	19.6%	unavailable
Norway	2004	6%	10%
Poland	2005	21.2%	17%

Source: National reports<sup>18</sup>

In *Austria* PwDs face a higher risk of poverty compared to the total population and the major causes of a higher risk of poverty for PwDs are considered to be deprivation, social exclusion and lack of participation and integration (Schenk 2007). The statistics showed that 39 per cent of all PwDs cannot afford to go on holiday, 12 per cent cannot afford to buy new clothes, six per cent cannot afford to heat their accommodation properly and 37 per cent cannot afford to incur unexpected expenses (Statistik Austria 2007).

In *Norway* it is reported that in the late 1990s about 10 per cent of people in receipt of disability pensions received an income of less than 60 per cent of the median level, which was about the same figure as the total population. In 2004 this proportion reduced to six per cent, whereas it remained stable among the general population.<sup>19</sup>

<sup>18</sup> Data for Poland refers to the poverty risk compared to the minimum subsistence level in households with at least one disabled person versus those families without disabled members.

<sup>19</sup> Source: Public Committee Report on Revised Disability Pensions, 2007.

The fact that the existing disability benefit system is characterised by an increase both in the number of recipients and levels of benefits accentuates the concern for its financial sustainability.

The statistical information showed that in *Greece* the rate of individuals living below the poverty line was 19.6 per cent in 2005 against 20.7 per cent in 2003 and the EU25 average of 16 per cent. For those PwDs over the age of 65 the difference is greater: 28 per cent compared to the EU25 average of 18 per cent. Of PwDs living below the poverty line, 68 per cent are unemployed, of whom 27 per cent are pensioners and 33 per cent are economically inactive.

In *Poland* 21.2 per cent of households with at least one person with disabilities, were living below the relative poverty line (50 per cent of the median income) versus 17 per cent of families without people with disabilities.

The report on Denmark, Finland, Ireland and the Netherlands (OECD, 2008) shows that, for the period between 1995 and 2005, using as thresholds 50 per cent and 60 per cent of the median income, the relative risks for PwDs of working age and in the lower income segments did not increase in the Netherlands for both thresholds, whereas it did increase in Denmark and Finland – but only for the 60 per cent median income poverty threshold. In the case of Ireland, the poverty risk almost doubled over the period studied, with 25 per cent of PwDs receiving less than 50 per cent and 37 per cent less than 60 per cent of the median income.<sup>20</sup>

The findings of the OECD (2006) demonstrate that the poverty rates among PwDs are higher than the rest of the population in Poland and Switzerland, but not in Norway. The study shows that in Norway lower incomes among disabled people do not translate into higher poverty risks, because public social transfers (minimum and maximum benefits, means-tested supplementary benefits) contribute to alleviate income inequality. In Switzerland, the higher poverty rates are primarily due to a more unequal income distribution among disabled people, whereas in Poland the higher poverty levels are due to the low employment rates for PwDs. Lower levels of education as a determinant of relative economic wellbeing and income level are more evident in Poland and Switzerland than in Norway and PwDs who have completed tertiary education generally have a lower risk of poverty than the total working-age population.

Consulting other sources of statistical evidence of poverty among PwDs, it can be seen that, in general, people who are limited in the activities they can carry out are at higher risk of poverty (Applica, CESEP & ALPHAMETRICS, 2007)<sup>21</sup>. This report, using EU Statistics on Income and Living Conditions (EU-SILC) data, shows that more than 17 per cent of people aged 16-64 who are severely limited in the activities they can carry out had an income level 60 per cent below the median income compared to 10 per cent of those who have no limitations.<sup>22</sup>

<sup>20</sup> See OECD (2008), Volume 3, p.51.

<sup>21</sup> Source: *Men and women with disabilities in the EU: statistical analysis of the LFS ad hoc module and the EU-SILC*, Final report, Table 32 (APPLICA, CESEP & ALPHAMETRICS, 2007).

<sup>22</sup> This study used two sources of data. The first source is the Labour Force Survey (2002) of people with disabilities and long-term health problems and covers all EU Member States (excluding Latvia, Poland and Bulgaria and including Norway). The second source is the EU-SILC (2004) and covers the EU15 (excluding Germany, the Netherlands and the United Kingdom, but including Estonia and Norway).

The higher proportion of PwDs with an income level below the poverty line compared to the proportion of those without limitations on what they can do implies that the social transfers are insufficient to protect PwDs against poverty and that they face a higher risk compared to the rest of the population.

In addition, the report by Applica, CESEP & ALPHAMETRICS (2007) shows that for those aged 55-64 the difference was even greater, with 17 per cent of those strongly limited in what they can do below the poverty line compared to 9 per cent of those without limitations. These findings confirm the tendency of an increasing gap with respect to earnings as age advances. Concerning gender differences, the statistical data demonstrate that the proportion of men with strong limitations on what they can do who are below the poverty line is higher compared to women, both for the age category 16-64 and those aged 65 and above (respectively 19.6 per cent versus 15 per cent and 20 per cent versus 14 per cent). In addition, the comparison of those strongly limited in what they can do with those individuals without limitations confirms that the gap is wider among men compared to women. As a conclusion, the relative income levels of women with limitations on what they can do are to some extent higher than their male counterparts with the effects of benefits on income level being greater among women compared to men.

However, the national experts reported that there is a shortage of research and statistical data about disabled people's equality and social inclusion. For several countries it is claimed that there is insufficient research on poverty and inequality in general and for different categories of PwDs in particular (e.g. *Hungary, Iceland, Latvia, Netherlands and The Slovak Republic*). Other countries (e.g. *Cyprus, the Czech Republic, Denmark and Estonia*) claim that studies analysing the link between disability and poverty have not been subject to any research.

Seemingly, it would be relevant to initiate research projects which would document poverty risk and inequality among PwDs. Statistical data by degree of disability, category of disability, gender and age differences, income of different groups of PwDs and in relation to ethnic minorities are still very scarce.

In addition, the lack of research is connected to the complexity of finding information on PwD income levels and the diversity of circumstances of PwDs. Another difficulty arises with the various definitions and interpretations of the concept of poverty and the fact that the general trend is to identify disability as a multi-dimensional phenomenon. The OECD identifies five dimensions in which "people are deprived and perceived as incapacitated in different societies and local contexts".<sup>23</sup> These dimensions are linked to economic, political, human, socio-cultural and protective capabilities, which are interrelated and influence each other, hence making poverty multidimensional.

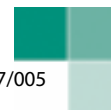
More research is required, starting with the improvement of data collection on poverty among PwDs, evaluation of existing disability programmes and monitoring and practical implementation of designed disability programmes, as well as efficiency analysis for such programmes.

Therefore, new initiatives aimed at data collection and availability must be launched in order to pave the way for future research on monitoring of EUMS disability-oriented strategies.

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<sup>23</sup> *The DAC guidelines*, OECD, pp 38-39.





## 6. Active social inclusion in education

In this section we highlight those integration policies and measures which aim to shift from a protection to an inclusion approach, such as measures related to education, e.g. policy interventions that can contribute to the integration of PwDs, starting with education during childhood. On average, PwDs receive a lower level of qualification and education compared to the rest of the population. It is recognised that education has a significant influence on the social and economic lives of PwDs, in particular for their future, employment and integration into the labour market. The literature has shown that significant numbers of children and young people with disabilities are largely excluded from educational opportunities for primary and secondary schooling. Exclusion, poverty and disability are linked and education is widely recognised as a means to develop human capital, to improve economic performance and to enhance people's skills and choices. Therefore exclusion from education can result in a significant loss of freedom and productivity in the labour market.<sup>24</sup>

Moreover, the research shows that efforts must be made in some Member States and by the European Commission to ensure that children with complex needs are included in all actions to reduce early school leaving and promote the acquisition of key skills. Among other areas, children with complex needs should be considered in all actions to improve IT skills and e-learning. A further recommendation was that provisions for inclusive education and inclusive environments for people with severe disabilities or complex needs should be provided from early childhood.<sup>25</sup>

According to the OECD (2003) study on transitions within the education system and transitions from education to work for young people with disabilities, many OECD member countries have started to promote inclusive education in mainstream schools for children with disabilities in order to improve the equality of opportunity between PwDs and the rest of the population.<sup>26</sup>

The OECD stresses that access to mainstream education affects the opportunities of PwDs; limited access to the institutions that award the qualifications required for entrance to universities certainly restricts their possibility of admission. The mainstreaming of education may seem unwarranted if it does not allow PwDs to complete their education. In addition, the quality of provision for PwDs in higher education is relevant not only from the viewpoint of equal rights but also for the purpose of their accessibility to the labour market. Hence the recommendation of the OECD was to encourage and support PwDs throughout their lifetime in education, their quality of life and their progress. Furthermore, it is important to develop a funding strategy for higher education that stimulates a good balance between more specialised and more generalised institutions in terms of providing full access to PwDs and adequately compensating inclusive higher education institutions.

The national reports demonstrate that most of the PwDs, especially those with intellectual disabilities, attain only primary education and the percentage of those having pursued secondary and tertiary levels of education is much lower, which lessens their likelihood of entering the labour market.

<sup>24</sup> Peters (2003). Peters, S. (2003), *Inclusive education: achieving education for all by including those with disabilities and special education needs*, report prepared for the Disability Group, World Bank, available at:

<http://siteresources.worldbank.org/DISABILITY/Resources/2806581172610312075/InclusiveEduPeters.pdf>

[provide fuller reference as this is the first time this publication has been mentioned (I think)]

<sup>25</sup> *The specific risks of discrimination*, Volume 1, p.13.

<sup>26</sup> *Disability in higher education*, OECD (2003).

The roots of this complex issue are considered to be the inadequate formal education opportunities for PwDs; difficulty in accessing the system (e.g. access in relation to the education programme, as well as access to buildings, etc); educational difficulties and the lack of support services (e.g. training for support workers for disabled children and their families); negative attitudes and stigma in the community or school system concerning PwDs; limited training for teachers on working with PwDs; and segregation at school of children with disabilities.

Children with disabilities and special needs have the right to equal opportunities to attend standard schools with other children. Consequently, to overcome some of these challenges and improve the situation of children with disabilities, a number of EUMSs have launched new inclusive education measures aimed at mainstreaming in education. One priority has been mainstreaming education and introducing measures to cope with the special needs of PwDs in education. Policy measures have been introduced which contribute to improving school monitoring along with precautionary measures to avoid children with disabilities dropping out of school early.

For example, in *Denmark* the Egmont High School is a state school where about half of the students have disabilities. This school integrates young people with disabilities and other young people. It has the same functions as an ordinary state high school and young people with disabilities are involved and participate like the non-disabled students. A counter example is *Greece*. One of the priorities of the Greek government for disabled people is education, vocational training and lifelong learning, with the aim of putting in place an integrated system to simultaneously cover education, training and career guidance. Nevertheless, it was reported that the national strategy is very limited to special Education, Social Care and Training Centres for People with Disabilities (KEKYKAMEA). In *Cyprus* the Education of Children with Special Needs Act, in force since 1999, emphasises the concept of 'special educational needs' and legitimises the integration of children with special needs into mainstream schools without abolishing special schooling. However, in practice, segregation is still dominant and special education is organisationally considered as a distinct educational service. In *Portugal* inclusive education policies and practice have contributed to reducing the number of institutionalised children with disabilities.

*Table 7: Examples of some countries which have introduced education mainstreaming measures*

<b>Countries</b>	<b>Policy measures</b>
Greece	There are currently 24 special training centres (KEKYKAMEA), which contribute to improving the situation of PwDs concerning education, vocational training and lifelong learning.
Finnish	The initiative 'Growing Together' promotes inclusive practices in schools and local communities in cooperation with municipalities, schools and other partners. The project focused on the principle of inclusion, meaning every child's right to participate as an equal member in the activities of her/his local community and schools. The project supported the development of inclusive practices in municipalities and schools.
Cyprus	The Education of Children with Special Needs Act legitimised the integration of children with special needs into mainstream schools without abolishing special schooling. Moreover, special education is organisationally considered as a distinct educational service with special teachers and Special Education Co-ordinators, which manages all



	programmes related to the education of children with special needs. There are currently 17 support programmes for children with special needs provided by voluntary organisations.
Estonia	The Preschool Childcare Institution Act focuses on the early detection of children with special needs and the application of intervention education.

Source: National reports

As can be seen, the mainstreaming of education in some EUMSs has attempted to provide children and young people with disabilities the opportunity to study together with other children and young people at schools, colleges and universities. The approach of an inclusive education system facilitates and increases the chances for PwDs to integrate into social life and the work environment by focusing on their abilities and the optimal use of their skills rather than their special needs.

Nevertheless, it is important that other measures are established to improve the situation of children and PwDs with respect to communication and the creation of a positive physical and psychological environment for them; to improve the accessibility of buildings and IT systems; and to improve the implementation in practice and to monitor the progress of new policy measures targeted at an inclusive education for children and young PwDs. The involvement and participation of PwDs and their representatives in public awareness campaigns would also contribute to building an inclusive education system.

## 7. Independent living

Long-term care is an important tool in providing people with disabilities with the necessary means to live an independent life, not least of all because “long-term care services are those which affect the greatest number”<sup>27</sup> of people with disabilities. In the context of this report, long-term care refers to a wide range of services and living arrangements for people with disabilities who depend on help to carry out basic activities of daily living, during a continuous period of time. Some of the care analysed here may also include basic health services, while rehabilitation and children are not specifically addressed here (see 6. Active social inclusion in education).

Besides long-term care services, access to appropriate housing and transport will also be covered in the second section of this chapter. Access to transport and particularly housing are not only fundamental to ensure independent living, but act as supportive policies for de-institutionalisation.

### De-institutionalisation in long-term care services

Article 19 of the UN Convention on the Rights of Persons with Disabilities sets out the “equal right of all persons with disabilities to live in the community, with choices equal to others”, namely the opportunity to choose their place of residence, access to services that allow them to live in the community and services that are responsive to their needs. The countries surveyed in this report reveal different degrees of adaptation of their long-term care services and facilities to the needs of people with disabilities and to the goal of promoting independent living.

As the national reports confirm, states have to various degrees relied on de-institutionalisation (provision of care to people in their own home environment for as long

<sup>27</sup> Applica, CESEP and European Centre (2007), p.103.

as possible, as opposed to care received in institutions) and direct payments (cash benefits which beneficiaries can manage freely to acquire necessary care) as policies to enhance independent living of people with disabilities through their long-term care systems.

De-institutionalisation and improved provision of community-based care seems to be a general policy trend (Applica, CESEP and European Centre, 2007), present in most policy documents and debates quoted in the national reports (*Greece* being the exception). Nevertheless, not all countries have taken decisive steps towards providing people in need of care with the possibility of receiving appropriate support in their own living environment, as opposed to institutions, particularly in the new Member States (*Malta, Hungary, Latvia, Bulgaria, Poland, Cyprus and Estonia*) and in *Greece and Portugal*. Similarly, enhanced choice and responsibility of care users in managing their own care, namely through the introduction of personal budgets or direct payments, is still limited to a few countries and to specific groups of beneficiaries.

De-institutionalisation of people with disabilities has been a long-standing issue in the Nordic countries, which has led these countries to take important steps towards developing community-based services, although not through direct payments (Table 8: Examples of policy measures towards de-institutionalisation reported in the Nordic countries). The adaptation of some institutions into individual service dwellings, where care can be provided 24 hours a day to individuals otherwise living in home-like settings, has blurred the boundaries between community-based care and institutional care.

*Table 8: Examples of policy measures towards de-institutionalisation reported in the Nordic countries*

<i>Countries</i>	<i>Policy measures</i>
Denmark	Since 1998 institutions have been transformed into individual dwellings where care services are provided free and beneficiaries only pay for rent and personal services. Care support and services have been made identical irrespective of where they are provided (in institutions or at home).
Finland	Combination of increased supply of home-care, with adaptation of existing institutions and ban imposed on the establishment of new ones.
Norway	Community-based care replaced institutions as the means to provide care for mentally disabled people; at the same time, most people with disabilities have resettled in group houses, sheltered apartments or independently, with care provided through ambulatory services; personal assistant schemes were introduced in 1994 and have been extended to people with cognitive/intellectual disabilities.
Iceland	There are no formal institutions of care but group homes with shared facilities; personal assistant schemes are still limited to pilot programmes, although this has become a pivotal issue for disability rights organisations.
Sweden	Increase in supported housing arrangements, the most common being group accommodation located in ordinary housing areas with interconnected flats with social support granted according to needs. Development of personal assistants employed directly by the municipalities, providing help with activities of daily living.

Source: National reports

Despite these efforts towards de-institutionalisation, the national reports mention several obstacles that still stand in the way of the goal of ensuring independent living. Thus, even when adapted, institutions may still have the same approach to care as before, not least if

re-training of staff does not receive enough attention (e.g. *Denmark*). Support for independent living, such as personal assistants, home help and support, may be under-resourced (e.g. *Ireland*). Moreover, once de-institutionalisation of some groups of people with disabilities is achieved, the efforts to extend it to other groups may come to a halt, with the issue of de-institutionalisation eventually falling off the priority agenda in official discourse and research (e.g. *Austria*, after the *Enthospitalisierung* – de-institutionalisation of people with learning disabilities from psychiatric hospitals).

Although only the report on *Germany* clearly refers to regressive tendencies regarding de-institutionalisation, with the number of available places in institutions increasing by 10 per cent between 1998 and 2003, in several countries the push towards de-institutionalisation seems to have stagnated. Besides the above-mentioned example of *Austria*, countries like *Malta*, the *Czech Republic*, *Latvia* and *Poland* reported that care in institutions remains predominant or that there are still large numbers of PwDs in institutions. In *Bulgaria*, the Plan to Reform the Institutional Care System focuses on improving institutionalised care, rather than developing the appropriate conditions for people to live in their own homes. The recent Social Services and Equipments Network Programme (PARES) aims to substantially increase the capacity of home-care services for PwDs in *Portugal*, but despite these efforts, institutionalised care remains predominant. Additionally, large institutions, some with more than 100 residents, remain an issue in some countries (*Austria*, *Hungary* and *Poland*).

De-institutionalisation *per se* is no guarantee of increased choice: *Iceland* reports on a system of care and support that “is arguably weighted in favour of the care-providers rather than the users”, with limited user control over the care received, its regularity and who is the assistant. Some research in the *Netherlands* (Kwekkeboom (2006)) pointed out the fact that living in ordinary neighbourhoods is not by itself sufficient to achieve social inclusion.

Another policy trend identified in the national reports is the implementation of cash benefits paid directly to people with disabilities to allow them to choose and manage their own care, although the characteristics and outcomes of different schemes vary considerably. To various degrees, these schemes may also allow beneficiaries to pay relatives or friends as part of their care options. Early evaluation of personal budget schemes (Deutsche Bundesregierung (2006) and Challis et al. (2007)) has found them to be capable of securing independent living (*Germany*) or to at least have the potential to improve choice and control by users (*UK*).

*Table 9: Summary information on existing direct payments as available in the national reports*

<i>Countries</i>	<i>Information on direct payments</i>
UK	Direct payments, whose introduction dates back to the 1980s, are the main tool for achieving personalised care and support for people with disabilities; the benefit is currently being extended to include several sources of available support to care under one single budget that beneficiaries can use to choose their preferred form of care.
Slovak Republic	Personal budget allocated to people with disabilities, introduced in 1999, although there are restrictions imposed in relation to paying relatives as carers. Number of beneficiaries remains low (6,000 in comparison to 20,000 receiving home care and 27,405 adults in institutions in 2006)
Germany	Personal budgets for people with severe disabilities were introduced (Social Code Book IX, in 2001) first as a pilot experiment and then generalised,

	assuming the form of lump-sum payments or vouchers. Since 2008 personal budgets have become a legal right, no longer dependent on the approval of the rehabilitation provider. Compulsory long-term care insurance established in 1995, under which the beneficiary may choose between a cash benefit that can be used to pay relatives or friends providing care or service provision of home care or institutionalised care.
Italy	A personal budget may be provided, but only if specific support services are not available.
Austria	A long-term care cash benefit has been available since 1993, with assessment still following a medical approach. Cash benefit may be used to pay for informal care, although activity of personal assistants is not regulated. Several local authorities have started a scheme similar to direct payments, while in Vienna, Innsbruck and parts of Tyrol beneficiaries manage their own care and support through existing Centres for Independent Living.
Czech Republic	Direct payments, currently being introduced, can be used to pay for support from relatives, professional home care or care in institutions. The possibility of paying a family member for care is expected to reduce the demand for more expensive institutional care.
Netherlands	Person Specific Budgets are assigned to those qualifying for support, entitling them with freedom to organise and purchase their own care and support. As a consequence, there is an increased range of care services now made available by providers of care.

Source: National reports

Notwithstanding the implementation of direct payment schemes, the goal of enabling people with disabilities to choose the care arrangement that best suits their needs remains far from accomplished in the above-mentioned countries. Thus, in *Austria* there have been difficulties with the current long-term care benefit addressing the needs of people with different impairments; while in the *German* case young people with disabilities seem to have difficulty in complying with the regulations for benefits which have been tailored to older people.

Budgetary concerns have in some cases led to a freeze of benefit levels (*Austria* and *Germany*) or kept them from reflecting rising living costs (*Slovak Republic*), thus falling short of fully compensating for the costs of care. In addition, the *German* long-term care benefit has a lower value for home care services in kind and cash than for institutionalised care for people with the same assessed level of care needs.

As a relatively new approach to care provision, further research into direct payments is still needed, namely as to their impact on the State's budget or other consequences arising from these schemes (e.g. concerns that the value of personal budgets may be kept low to cut down budgetary costs). On the issue of cost-effectiveness, Hurstfield et al. (2007) reported that independent living supported by direct payments could be more cost-effective than institutionalisation for the *UK*, a finding also reported by the Institute for Applied Social Sciences for the *Netherlands*. On their recent evaluation of individual budgets in the *UK*, Glendinning et al. (2008), concluded in favor of their cost-effectiveness for social care outcomes, but not necessarily for psychological well-being, as people with learning disabilities and older people did not expressed increased psychological well-being from benefiting from individual budgets.

Some people with disabilities may find their care needs to be better addressed by relatives, friends or other informal carers.

Some of these informal carers may benefit from direct payment schemes, or similar, thus helping people with disabilities to overcome difficulties in hiring help needed to live at home (e.g. *France's* new law governing care and support). Nevertheless, there are still recognised shortages in respite care and other temporary care options which could allow carers to take some time off (*Slovak Republic, Finland, Poland, Cyprus, Latvia* and *Germany*).<sup>28</sup> In *Austria*, the activity of hired personal assistants still lacks a legal framework and definition, as well as adequate support.

In general, the medical approach to disability is receding and countries are increasingly relying on joint assessments by multidisciplinary teams in consultation with the individual concerned (*France*) or health and social services (*UK*), including the social situation in a mainstreamed assessment of people's needs (*Germany* and *UK*) or fitting care services into broader personalised 'life plans' towards independent living (*Italy* and *France*). Where they are still present, however, (*Austria, Iceland, Bulgaria, Greece* and *Cyprus*), predominantly medical approaches to disability are seen as deterrents to independent living and obstacles to the correct assessment of care needs, thus in effect hampering social inclusion.

### **Accessibility of housing and transport**

The possibility of living an independent life is dependent on accessibility issues, both within people's homes as well as in their more general living/working environment. As mentioned earlier, accessible housing and de-institutionalisation are two mutually supportive policies towards independent living. The lack of available adapted housing may have an impact on demand for other forms of care or limit people's choices. For example, in *Ireland* limited availability of mainstream housing with appropriate support or care services fuels demand for sheltered housing, which in turn would be a more suited solution for many of those currently confined to residential care (Browne, 2008). Similarly, Heywood and Turner (2006) and Mansell et al. (2007) show some evidence for the *UK* that adapting housing to the needs of PwDs is a less expensive alternative to institutionalisation or may render home care more cost-effective.

For *Finland*, Niemelä and Brandt (2008) mention that 600 flats per year should be acquired to respond to housing needs if a proposal to abolish residential care in *Finland* within the next ten years was approved. In *the Netherlands* in a recent study 25 per cent of PwDs claimed to live in houses not sufficiently adapted to their needs (Klerk and Schellingerhout, 2006). Little information is available on the accessibility of PwDs to adapted housing and while only *the UK, the Netherlands, Denmark* and *Ireland* clearly mentioned unmet needs in this area in their reports, it seems implausible that difficulties in accessing adequate housing are confined only to these countries.

Accessibility to private transport or public transportation, on which PwDs may be particularly dependent due to their economic situation, remains essential to ensure labour market participation and access to leisure activities.<sup>29</sup> However, Jolly et al. (2006) still refer to a "transport gap" between disabled and non-disabled people. Cash benefits to adapt or purchase private means of transport are present in a number of countries (*Latvia, the*

<sup>28</sup> In the German case, respite care is only covered for the highest care needs by the long-term care benefit.

<sup>29</sup> For example, PwDs in Denmark mention having less frequent contact with friends and relatives (Bengtsson, 2008).



*Slovak Republic, Denmark and Cyprus*), as well as arrangements to facilitate the use of public transport (*Latvia, the UK, Bulgaria and Cyprus*) or special grants for private transport operators to adapt their vehicles (*Czech Republic*).

However, availability of adapted public transport services may be limited as to the number of available vehicles (*Hungary*), timetables (*Iceland*), services (*Iceland and Italy*, where in the latter support for PwDs is only available at the main railway stations and only on the more expensive transport options) or demand advance notice to use them (*Iceland*), thus effectively limiting accessibility. In addition, as many of these schemes fall within the scope of local authorities this could mean that various transport schemes co-exist and that geographical differences may be considerable (Applica, CESEP and European Centre (2007)).

## **8. Barriers to accessing long-term care**

Recent research under the HealthQUEST project, financed by the European Commission, highlighted the question of existing barriers to accessing health care and how those barriers could undermine social inclusion policies (Huber et al., 2008). This was also one of the global challenges to health care and long-term care identified by the Social Protection Committee, such as in its *Review of Preliminary National Policy Statements on Health Care and Long-term Care* (European Commission, 2005). The issue of barriers to accessing long-term care services by people with disabilities is the focus of this section.

Barriers to accessing care and support that would otherwise contribute to independent living or better health conditions are still reported. For example, in *Sweden* people with disabilities have poorer health conditions, which cannot always be explained by their disability, indicating restrictions in access to health care (Welfare Commission, 2002). Barriers to accessing care may arise from discriminative legislation, views or practices, or are due to affordability of care and seem to affect more some groups of people with particular impairments, namely those with mental health conditions, learning or intellectual disabilities and complex or severe care needs.

Despite some progress towards ensuring non-discriminatory access to care and support, such as making entitlement to personal budgets a legally binding right (*Germany*, as of 2008), due to existing regulations cases of differences in access to care can still be found in Europe. For example, the Equal Treatment Act (WGBH-CZ) in *the Netherlands* has yet to be expanded to include housing and provision of goods and services. People with mental health problems in *Malta* are not entitled to the free medicine otherwise provided to people with disabilities. The recent law on disability in *Latvia* excludes people with intellectual disabilities from benefiting from personal assistant services. The same is reported for *Poland*, for people with certain disabilities. The medical procedure underlying the assessment of care needs in the *Austrian* long-term care benefit may put people with learning disabilities, hearing impairments and psychiatric disorders at a disadvantage in obtaining these services. Finally, as stated before, the *German* long-term care benefit seems to be especially aimed at dependent elderly people, leaving disabled and young people with difficulties in complying with regulations.

Access to care services is not always defined in regulation as a right, or made a legally binding entitlement, which may become a barrier in a context of greater budgetary concerns due to economic slowdown. For example, *Ireland's* Disability Act, approved in

2005, provides for an independent statutory assessment of service needs related to disability, however, access to this is dependent on budgetary constraints.

While there is considerable variation across countries regarding the possibility to choose and manage care (see 5. Independent living), there are also marked differences across different types of disabilities. In *Finland* people with intellectual and learning disabilities face restrictions in managing and choosing their care. In *Iceland* lack of empowerment in managing care and support is experienced especially by people with severe or multiple disabilities. Some groups have more limited access to instruments of empowerment, such as direct payments. For example, in the *UK* there are concerns that people with mental health conditions may not benefit as much from direct payments as those with physical disabilities and the same applies to personal budgets (Challis et al. 2007).

People with complex or severe care needs (*Finland* and *Portugal*) and those affected by dementia (*Estonia*) do not always find care and support available to meet their needs, which can also lead to unwanted institutionalisation. Being confined to an institution is more likely in the *UK* for those with learning disabilities and mental health conditions. In the process of de-institutionalisation, people with intellectual disabilities may have been left behind in institutions (*Czech Republic*). The Applica, CESEP and European Centre (2007) study also collected numbers supporting the view that those with mental health disorders make for a significant share of people with disabilities living in institutions, namely in *France, the Netherlands* and *Poland*. Institutionalisation may also be imposed, as an apparently more cost-effective solution, on people with complex or demanding care needs (*Germany*). *Austria* reports that people with learning disabilities living with their parents may have limited or no choice but to be confined to institutions once their parents die or are themselves placed in old-age institutions.

Young disabled people and children seem to be particularly in danger of being confined to institutions that are not suited to prepare them for independent living (*UK, Norway* and *Bulgaria*). In *Denmark*, budgetary concerns lead young adults born with disabilities to be much less likely to have access to adapted housing or to free adaptation than those who acquired disability during their working lives or are already in old age.

People with disabilities and their families face higher financial constraints and lack of economic resources (see 3. Social protection and poverty reduction). Financing care needs not covered by public benefits can be a significant financial burden for those faced with disability (European Commission (2005)). Thus, affordability of care remains another possible barrier (*Ireland, Latvia, the Czech Republic, Greece, Germany, Austria, Estonia, Malta* and *the Slovak Republic*), as benefits may have been kept low or constant over time or are deemed to be too low to cover the cost of care (see 5. Independent living), especially for those with more complex or demanding care needs (*Austria*). Grants provided for the purpose of adapting housing may be restricted to maximum limits which are to low or may require unaffordable co-participation from PwDs, thus limiting their choices (*Ireland*).

Thus, people with mental health conditions, learning or intellectual disabilities and those with complex or severe care needs face additional difficulties in accessing care and support, ranging from legally enshrined barriers, to unavailability of care and limited choices and empowerment. Institutionalisation seems to be a particular concern for young people with disabilities, which often results from specific barriers not linked to age itself but to the fact of being born with a disability, as opposed to acquiring disability during working life.

Besides barriers affecting particular disabilities, there are also marked differences in provision of care within countries (*Hungary, Portugal and Greece*), resulting in variations in access to care between regions. In the case of *Portugal* discrepancies in the regional availability of social services for PwDs are quite marked, with more rural municipalities at a disadvantage (GEP, 2006), and only now are these gaps beginning to be addressed through the Social Services and Equipments Network Programme (PARES), which will allocate public investment to regions in greater need. Regional variation can arise from the federal nature of some countries (*Austria*) or the relative autonomy conceded in managing benefits, especially home care, to local or regional levels of government (*the UK and Italy*, but also *Finland, Estonia, Greece, Poland and Spain* according to the Applica, CESEP and European Centre (2007)).

Rural regions may lack available care options (*Austria*), which can be particularly problematic for people with disabilities, given their mobility and financial constraints.

## 9. Involvement of disabled people in the decision-making process

Key policy measures that contribute to combating social exclusion for PwDs are those measures that provide them with the right to exercise civil rights. This also includes their direct involvement in the decision-making process of governmental programmes that are targeted at people with disabilities. Moreover, according to the OMC, it is important to involve local and regional authorities, civil society, social partners and representatives of PwDs starting from the preparation and following with the implementation and monitoring of policy measures addressing the social inclusion and social protection of PwDs.

The UN Convention on the Rights of Persons with Disabilities emphasises that PwDs “enjoy legal capacity on an equal basis with others in all aspects of life”. Article 12 of this UN Convention more specifically states that:

*“...persons with disabilities have the right to recognition everywhere as persons before the law... States Parties shall ensure that... measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person’s circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body...”<sup>30</sup>*

One of the findings from the ANED country reports is that some of the EUMSs have introduced programmes at governmental level that extend the participation and involvement of PwDs in the projection and decision-making process of policies aimed at them. Networks of PwDs have been created and actively involved to contribute to policy development, examination and evaluation of policy measures targeted at PwDs and exchange of services and experience in the implementation and monitoring of such policies.

In countries such as *the UK, Denmark, Norway, Iceland, The Slovak Republic, Estonia, Latvia and Portugal* PwDs or their representatives are part of the policy-making process and they participate in consultation and negotiations with the government prior to the approval of

<sup>30</sup> Source: Convention on the Rights of Persons with Disabilities, <http://www.un.org/disabilities/convention/conventionfull.shtml>



laws affecting PwDs. The direct involvement of PwDs offers them the possibility of contributing directly to policy measures that address their needs.

Some examples of involvement of PwDs in the decision-making process are, for example, indicated by the *UK* government, which receives policy advice from the network Equality 2025, which involves between 20 and 25 PwDs, appointed by the Minister for Disabled People. This network contributes to policy development; independent investigations of policies or services; building the capacity and awareness of disabled people; and encouraging 'shared learning' between government and disabled people. In *Denmark* organisations and representatives of PwDs now occupy half of the places on the Central Disability Council and are involved in the planning and evaluation of policy proposals. Organisations of PwDs are not directly involved in the policy-making process and the phase of implementation in *Norway*. There is, however, a State Council on Disability and by law a disability council in all municipalities / local government and organisations of PwDs are represented on these councils, both at state and local levels.

In *Portugal* since 2004 the law has ensured participation by people with disability or representative organisations, particularly in the drafting of legislation on disability and the execution and evaluation of all policies, which ensure their involvement in all situations of everyday life and society in general. The involvement of NGOs is also guaranteed through the National Council for the Rehabilitation and Integration of People with Disabilities, which provides the government with information used in deciding on matters related to defining the National Rehabilitation Policies.

In *Latvia* each legislative act or policy-planning document must be evaluated by disability NGOs. Disabled people's organisations are involved in the drafting of new policy documents and legislative acts. The National Council for Disabled People has rights and duties to comment on new legislation, policies and action plans, as the Council is the co-ordinating body for policies in the field of the integration of disabled people into society.

In *Greece* the 'Law on Social Dialogue for the Promotion of Employment and Social Protection' (2003) was created to promote dialogue with civil society on social policy issues but also, "to establish a proper administrative mechanism that would ensure the overall coordination, monitoring and assessment of the measures of the NAP".

Another finding is that, although some of the new EUMSs have established a National Disability Council, most of these councils only have an advisory role to the government and participate in the assessment process of the policies pertaining to people with disabilities. Their real involvement at a high governmental level seems currently inadequate to truly put into effect the interests of PwDs (*Hungary, Latvia and The Slovak Republic*).

Some of the EUMSs already involve PwDs and their representatives not only as passive actors, simply observing in consultations, but also as active ones in the process of decision-making in relation to policy measures targeted at them. The United Nations and international agencies ensure that the UN Convention on the Rights of People with Disabilities recognises that all PwDs have the right to make decisions on their own behalf and, where support is required to exercise that capacity, the state provide appropriate support. This approach should be extended not only to the national and governmental level but also to the local, regional and EU levels.

In *Bulgaria* an Anti-discrimination Commission was set up under the law, which is intended to quickly settle disputes regarding unequal treatment. Commissioners judge whether discrimination on a certain ground has occurred and can impose penalties. In addition, cases of discrimination may also be taken directly to court with the burden of proof reversed, meaning the accused party has to prove that there was no discrimination on any of the grounds listed in the law. NGOs on behalf of a group of people whose rights have been violated can also take action under this law.

In *Cyprus* disabled people pursue negotiations with the state, often prior to the passing of legislation. However, the different priorities set by single-impairment groups urge disabled activists to liaise with the state as separate groups, rather than as one collective group. As a result, disabled activists often manage to secure benefits or services for their impairment groups.

## 10. Best practices

In this section information on best practices provided in the national reports is presented. Best practices can range from concrete measures aimed at improving the social inclusion of people with disabilities or broader policy measures which mainstream disability (see Annex A – List of best practices). The best practices identified in the national reports arose not only as initiatives of central bodies of government, but also from local government and civil society organisations, some of which applied examples from other countries or sought to fill existing gaps in disability policies.

Although many of these best practices could potentially be applied in other countries (in fact, some resulted from examples from other countries – e.g. the system of personal assistants in Sofia was inspired by the personal assistants hired by municipalities in the Nordic countries), more information is needed before clearly asserting their transferability. In fact, lack of evaluation seems to be a feature that many of the best practices and overall policies for the disabled seem to share.

*Denmark* identifies as best practice the example of the Egmont High School which is a state high school where about half the students have disabilities. The primary goal is to develop the self-confidence and self-reliance of people with disabilities, through study, work and self-development. It functions on the same basis as other state high schools in *Denmark* and integrates young people with disabilities and non-disabled young people. It provides interesting and meaningful activities to engage in, offers the possibility for many young disabled people to make good friends and, in this way, fulfils the same function as ordinary state high schools do for non-disabled youth.

In *Cyprus* an example of good practice is the pilot programme for accessibility run by the Ministry of Communications and Works. Important public buildings were part of this pilot programme which ensured the accessibility of entire buildings.

Among countries providing PwDs with direct payments, *the UK* and *the Slovak Republic* highlighted their national schemes as examples of best practices in providing beneficiaries with increased choice, because the disabled individual selects the personal assistant him/herself and agrees on the way care is to be provided. As stated before (see 5. Independent living), this is a relatively new form of supporting people with disabilities and more information about the outcomes of these schemes would be welcomed (an evaluation of the *UK* experience was undertaken in 2008 (Glendinning *et al.*, 2008)).

Personal assistant schemes are an important tool in providing people with disabilities with support tailored to their needs. Furthermore, Kwekkeboom (2006) stresses the importance that personal assistants may have in the lives of people with psychiatric or intellectual disabilities. The municipality of Sofia (*Bulgaria*) introduced a scheme of personal assistants in which the municipality employs a personal assistant chosen by the person with disabilities to provide him/her with care. In *Poland* the personal assistant scheme was set up by an NGO, the Foundation of People with Muscular Disorders, which acts as a facilitator of social relations and of the decisions made by the beneficiary.

The *UK* mentions that the outcomes of direct payment schemes, both in increased flexibility of care arrangements and choice, were improved by the involvement of organisations for people with disabilities as partners.

The importance of involving these organisations to the apparent success of best practices is also a feature of the best practices presented by *Italy, Poland* and *Germany*, in which organisations of people with disabilities play the central role, thus acting as empowered stakeholders and contributing to the mainstreaming of disability into particular measures. The *German* 'goal agreement instrument (*Zielvereinbarung*)' is an example of particular measures (each agreement features a private or public body and an organisation of people with disabilities in relation to a specific accessibility issue) which are made in a systematic way, with 13 agreements already signed since 2005.

In *Estonia* a one-year project was launched with the aim of increasing awareness and computer skills among disabled people, increasing their level of activity and providing options for activities by arranging computer training for beginners, creating a free public internet access point and offering the experience and help of support workers, either employed or working as volunteers. This project contributed to expanding the awareness of the possibilities of finding a job, improving coping with everyday life and enhancing skills and reception of information, as well as improving the competitiveness of PwDs on the labour market.

In *Iceland* a significant rise of the ceiling for earned income was applied and people in receipt of disability benefits can now earn a much higher income before experiencing a reduction in their benefit. The earlier ceilings were much too low which removed any incentive for disability benefit recipients to seek work, as a good deal of the income they earned was taken back with benefit reductions. The ability to earn a reasonable income before having a benefit cut will not only enhance income security for disabled workers, but also potentially boost their work experience and skills.

## 11. Conclusions

Mainstreaming disability in SISP plans, according to the OMC, has experienced remarkable improvements in achieving its objectives by putting into action legislative and new policy measures. Nevertheless, attention has been addressed at the specific needs of PwDs rather than mainstreaming disability in all strands of the social inclusion and social protection strategies of EU MSs. There have been a considerable number of new laws introduced which aim to combat discrimination and improve the social inclusion of people with disabilities, in terms of education, employment, financial support, care and accessibility. In general, the objective of integrating PwDs into the labour market, combining disability benefits with earnings from work or employment training, has been addressed in new

reforms for most of the EUMSs. The medical approach has been abandoned in several EU MSs but in some other countries it still dominates.

Despite this progress, income security for PwDs against absolute poverty is still a concern for most of the EU MSs. Based on the limited research and evidence concerning social protection and poverty reduction for PwDs, we find that the absolute poverty of PwDs, especially among the elderly, is critical. The current policy measures have not been able to offer to PwDs a safety net that would bring them out of the poverty trap and enable them to lead dignified lives. Most of the EU MSs have been focusing on the situation of PwDs more from the perspective of minimal subsistence rather than the improvement and development of their potential.

EU MSs have introduced policy measures, such as mainstreaming education, to address the issues of active inclusion starting from an early phase of life. Such policies have contributed to a more inclusive education system that facilitates and increases the chances for PwDs to integrate into social life and the work environment by focusing on their abilities and optimal use of their skills rather than on their special needs.

Some EUMSs have made important steps by modernising social policies, following the principle that the best protection against poverty and exclusion is investment in education, to prepare and increase the opportunities for PwDs to work and promote independence and wellbeing and active participation in society.

Countries have taken several policy measures towards enhancing independent living for people with disabilities, namely through the promotion of de-institutionalisation and provision of direct payment schemes.

The picture of the de-institutionalisation of people with disabilities and the development of care provided in the home environment is a rather diverse one. Some countries have really pushed towards a comprehensive approach to care and support, enabling people to maintain or improve their autonomy by receiving care at home or in an almost home-like setting. For others, however, institutionalised care remains the only option for many people with disabilities. The medical approach to disability is still a factor in this segregation and social exclusion.

There are interesting and promising developments in empowering people with disabilities to choose and manage their own care, namely through the provision of direct payments or personal budgets. However, most of these schemes are still in their infancy and more independent evaluation and research is needed to fully understand the implications of these new schemes, both for independent living by the beneficiaries and for state budgets. Affordability also remains an important constraint to access to adequate quality care, and there are important regional differences in the availability of support.

There are still important barriers in accessing care, some of which result from discriminative legislation affecting particular groups of people with disabilities: those with mental health conditions, severe or complex care needs and those with learning or intellectual disabilities. These particular groups are being left behind in the de-institutionalisation process. Young disabled people are also particularly prone to being pushed into unwanted institutional care, which may arise from a more profound difficulty experienced by social and health systems in promoting social inclusion for people born with disabilities, in comparison to those who have become disabled during their working life or old age.

A common difficulty raised in all the reports is the outstanding problem concerning statistical information. There is a considerable lack of empirical evidence concerning the monitoring and evaluation of the needs of PwDs, their actual situation, policy measures, activities and practical functioning of such policies. Data collection and availability would help to concretely identify the impact in reality of policies on disabled people. The data should contain information concerning various aspects of the economic and social life of people with disabilities, such as, for example, labour market participation, income level, poverty risk, access to lifelong learning, social services etc. Moreover, the data should be disaggregated so that the specificities of PwDs can be identified and analysed accounting for gender, age, type of impairment, ethnicity etc.

## **12. Recommendations based on the national reports**

### ***Mainstreaming disability in the Open Method of Co-ordination***

There is a need to encourage or require EU MSs to routinely and effectively report on the situation of disabled people in relation to the development and evaluation of policies for social protection and social inclusion. Guidance at the European level is helpful but there may be a need for more standardisation in the consideration given to disability in the Action Plans. Both targeted and mainstreamed approaches should be evident, with evidence of data in support of policy decisions and framed within a social model approach.

### ***Fight discrimination and stigma of PwDs***

Recent actions have been taken by EUMSs to fight discrimination and improve the integration of people with disabilities. However, the implementation of anti-discrimination laws is still weak in terms of its focus and confronting the stigma attached to people with disabilities. Therefore more effort should be made to implement such laws, across the full range of policy areas (beyond employment), while specific campaigns should raise awareness in society about the risk of discrimination, thus combating the perception of a person with severe disabilities as not being capable of assuming socially included roles in life.

### ***Include PwDs in the decision-making process and increase their choices***

In terms of strategy, some EU MSs have already introduced governmental programmes that involve PwDs and their representatives not only as passive actors but also as active ones in the process of decision-making for policy measures addressed at them. All EUMSs should follow and evidence this approach because the direct involvement of PwDs allows them to implement policy measures that tackle the real needs. This approach should be extended not only to the national and governmental level but also to the local, regional levels.

### ***Capitalise on progress and good practice***

There are numerous examples of positive policies and innovative practice in European countries (as illustrated in the annex to this report). There is a need to highlight and share, more systematically, examples of good practice and policy development between states. The OMC model offer mechanisms for this, which could be developed with a specific focus on disability, involving information sharing, models of good practice, case studies and routine reporting.

### ***Focus on poverty reduction***

The study showed that, although the disability benefit system provides the basic levels of income for survival, PwDs are still among the poorest in society. Therefore, the combining of such benefits with earnings from employment would contribute to PwDs living a life in dignity and not one only just above the poverty line. Action is needed to highlight and target the poverty of disabled people within the context of social protection and social inclusion debates. EU MSs and other actors within the OMC processes should consider evidence of the situation of disabled people, as a matter of course, in reviewing, developing and evaluating policies for poverty reduction. A holistic approach is required that goes beyond targeted income benefits to include the income implications of education and employment policies.

### ***Focus on education and life-long learning***

A focus on inclusive education and lifelong learning is a priority. Mainstreaming in education would give children and young people with disabilities, in particular, the opportunity to study together with their peers at schools, colleges and universities. It is also important to combat the stigma around PwDs. People with disabilities are entitled to the same rights as other children and adults, and the education system should create a friendly and integrating environment for them. Co-ordinated research and indicators of progress in this area would be useful

### ***Focus on support for independent living***

There is a need for clearer evidence about movement from institutional care to community living, and to promote the transfer of resources from the former to the latter. Within this context a focus is required on support for independent living, where policy and implementation are rapidly changing and where knowledge of innovative examples and outcomes could hasten progress in other countries. Of particular interest here are schemes for providing user-controlled personal assistance through direct payments and personal budgets. Evidence and examples of progress, outcomes, costs and benefits would be of immediate benefit. In addition, attention is required to the problem of transferability and free movement of support for independent living within and between EU MSs.

### ***Focus on priority groups at risk of exclusion***

A clearer focus is needed on strategy and intervention to target those groups most at risk of social exclusion to avoid the tendency for inclusion of only those closest to the labour market or social inclusion in other fields. Of particular concern here are strategies targeting the poverty, educational risk, employment and independent living of people with mental health conditions, people with complex support needs, people with intellectual disabilities, and young disabled people.

### ***Improve collection and reporting of relevant data***

This report highlighted significant difficulty in accessing basic information and reliable data regarding the social situation of people with disabilities. The EU MSs should make considerable improvements in gathering and reporting such data as also required by the new UN Convention. New, and more harmonised, forms of data collection, availability and progress indicators will be required to meet these challenges. Future research should address the needs of people with different impairments, including all age categories, gender, ethnicity, people with multiple disabilities, etc. (noting the priority groups identified earlier).

### ***Conduct evaluations of policy implementation***

The national experts have identified gaps between proposed objectives in policy documents and actual implementation measures and outcomes. Little evaluation has been





carried out in many of the key focus areas of concern (particularly support for independent living). The EU may wish to stress the need for a proper evaluation of measures and policies, and countries should conduct analyses of cost and social benefit, monitoring their outcomes for beneficiaries.

***Target priorities in commissioning disability research***

The national reports have identified the need for further research and some common issues emerge in relation to the priorities identified so far: evaluation of community-based care and consequences of the de-institutionalisation process; assessment of the effects of introducing personal budgets and direct payment schemes, both for independent living and sustainability; inequality in accessing care and benefits; and usage of and demand for long-term care services. More evidence on these subjects could also contribute to raising the profile of disability within EU MSs and the EU Social Inclusion process. There is also a particular need for research adopting a life-course or longitudinal perspective to gain better knowledge about critical life transitions for people with disabilities.

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## Annex A: List of best practices

Country	Best practice	Highlighted feature
UK	Direct payment scheme	Involvement of local organisations of people with disabilities as partners
Slovak Republic	Direct payment scheme	Enhanced participation and choice over care arrangement and personal assistants
Italy	Peer consultancy: a method to promote autonomous living	Enhancement of independent living through peer review process by people with disabilities
Germany	Goal agreement instrument ( <i>Zielvereinbarung</i> )	Involvement of organisations of people with disabilities in negotiating improved accessibility with private and public bodies
Bulgaria	Personal assistants	Setting up system of personal assistants

	(Municipality of Sofia)	hired by the municipality of Sofia, but chosen by the beneficiary
Poland	Personal assistants (Foundation of People with Muscular Disorders)	Personal assistants who also act as facilitators for decisions made by people with disabilities
Norway	Reform of institutionalisation of people with disabilities	Provision of adequate care in community-based settings
Czech Republic	Sheltered housing	Promoting independent living by providing care in adapted housing facilities
Denmark	Protected workshop Hans Knudsen Institute	Help disabled people provide for themselves and feel proud of their work
Cyprus	Accessibility	Make feasible access to museums, buildings, facilitate transportation
Estonia	Computer training and access for disabled persons	Expands awareness of the possibilities of finding work, coping with everyday life
Iceland	Disability benefits: raising of the earned income ceiling	Foster accessibility to the labour market
Sweden	Support for people with certain functional impairments	Facilitate daily life and promote full participation in society
Netherlands	Talent – Care provider employment project for intellectually disabled people	Provide employment but also facilitate contacts in the community so as to enhance social inclusion.
Ireland	Workway project	Promote the employment of people with disabilities in the private sector
Portugal	Local Network of Information and Mediation Services for PwDs (SIM-PD)	Provide at local level information, orientation, follow-up services and qualified support responding to the needs of people with disabilities.
Denmark	Videnscenter for Handicapidræt (Knowledge Centre of Disability Sports) I	Assist disabled people in establishing jobs with wage support for disability benefit recipients

## Annex B: Tables and figures on disability pensions

Table 10: Numbers of disability-related benefit recipients (Applica, CESEP and European Centre

Type of benefit	2000	2001	2002	2003	2004	2005
<b>BE</b> Invalid persons (incapacity period > 1 year)	200.264	204.475	209.758	217.513	221.417	225.951
Disability allowances recipients (disabled adults)	118.921	120.228	123.945	130.347	133.739	136.742
Benef. of Allowance for Occupational disease (permanent incapacity >20%)	19.191	19.013	20.257	20.089	19.678	19.214
Invalidity war pensions	5.440	5.142	4.844	4.609	4.406	4.185
<b>CZ</b> Disability pensions	453.367	478.504	488.728	498.273	507.634	514.828
Recipients of Compensation for occupational accident (temp+perm) & disease	:	23.861	25.685	23.506	23.005	22.586
<b>DK</b> Early retirement pension (Invalidity & social cases)	257.560	254.612	258.824	258.741	257.887	246.836
Provision for disabled adults	4.746	5.665	6.048	4.293	4.677	9.851
Accidents at work giving rise to a compensation	:	:	:	:	:	9.537
<b>DE</b> Pensions due to reduced working capacity (<65)	1.908.594	1.861.542	1.809.136	1.761.646	1.694.728	1.649.767
Basic Security (Reduction of work capacity) (<65)	:	:	:	181.097	232.897	287.442
Pensions for work/commuting accidents & occupational illnesses (<65, R >20%)	383.716	371.498	360.692	348.152	332.796	316.906
Pensions for victims of war	376.372	347.979	319.914	292.644	268.760	245.141
<b>EE</b> Persons receiving pension for incapacity for work (<63)	43.394	47.140	51.339	55.480	59.174	61.921
<b>IE</b> Recipients of invalidity pensions (<65)	43.818	44.421	45.313	45.767	46.588	47.357
Recipients of Disability Allowance (<65)	53.214	50.725	55.151	59.485	71.135	77.595
Recipients of Disablement Pension (<65)	8.965	9.392	9.639	9.890	12.162	10.194
<b>EL</b> Principal (insurance) invalidity and occupational accidents pensions	328.447	320.190	323.255	318.148	316.058	:
(Principal) Subsidiary invalidity and occupational accidents pensions	29.677	32.374	34.103	35.520	37.000	:
<b>ES</b> Beneficiaries of contributory invalidity pensions	:	:	780.300	792.600	810.300	828.300
Number of non contributory invalidity pensions	244.802	207.620	206.814	207.273	206.953	204.686
Beneficiaries of LISMI benefits	108.597	97.793	87.194	77.305	69.234	60.292
<b>FR</b> Invalidity pensions (civil)	496.359	496.897	512.989	567.581	586.973	:
Persons receiving Allowance to Disabled Adult (AAH)	674.423	697.992	716.784	732.839	752.988	768.414
Occupational Accidents & Occupational diseases (recogn. invalidity, 15-64)	:	:	262.000	:	:	:
War invalids (excl widows, <65)	:	:	114.754	114.926	88.901	82.906
<b>IT</b> Benef. of incapacity/invalidity allowances & allow. for personal and contin. assistance (20-64)	399.825	369.042	342.073	321.958	440.569	424.722
Disability benefits (social assistance) (<65)	575.461	552.148	610.717	653.121	918.259	953.025
Benefits for work-related accidents or diseases (25-64) (degree: 11+)	224.594	340.631	313.217	287.824	480.304	452.973
Beneficiaries of war pensions (including survivors) (25-65)	:	21.843	20.611	19.960	38.514	:
<b>CY</b> Invalidity pensioners (16-63)	5.363	5.737	6.008	6.293	6.556	7.084
Disability allowances (social protection, 16-63)	:	:	2.982	3.236	3.547	3.958
Disablement pensioners (Accidents/Occupational, 16-65)	1.061	1.071	1.070	1.083	1.101	1.100
<b>LV</b> Invalidity pensions (25+)	83.181	80.547	77.876	75.938	74.603	73.574
State social security benefit beneficiaries with disability (generally 18-65)	10.919	11.710	12.187	12.490	13.195	13.920
Occupational Accidents & Diseases pensions	:	:	:	2.159	2.921	3.674
<b>LT</b> Persons receiving Disability pensions / Incapacity for work (all ages)	173.600	181.119	191.354	197.849	207.327	210.662
Disability assistance benefit	:	31.762	30.223	31.381	35.014	36.738
Occupational accident & disease pensions (temp+perm) (all ages)	:	:	3.292	3.355	3.514	4.599
<b>LU</b> Beneficiaries of invalidity pensions (20-64)	20.387	19.955	19.672	19.157	18.402	18.028
Beneficiaries of life annuities after a work accident	12.638	13.348	13.634	14.607	14.564	14.943
Beneficiaries of special allowances for severely handicapped people	2.160	1.837	1.630	1.493	1.291	1.174
<b>HU</b> Disability pension (<65)	447.001	453.203	467.289	462.228	465.797	454.348
Disability benefit (all ages)	247.974	246.203	249.627	250.122	250.854	243.128
Regular social assistance for reduced capacity to work (active age)	8.728	8.852	8.504	8.750	8.643	9.070
<b>MT</b> Contributory invalidity pension (19+)	6.255	6.701	7.560	8.424	8.799	8.815
Disability pensions	1.831	1.860	1.956	2.047	2.029	2.139
Disablement pension (Injury)	397	384	415	412	391	361
<b>NL</b> Invalidity benefits (WAO, WAZ, WAJONG) (16-64)	957.000	981.000	992.800	981.750	960.570	899.310
<b>AT</b> Work reduction capacity (<65)	161.999	164.352	170.026	176.686	195.569	209.537
Early old-age pensions due to reduced working capability (65/60)	89.202	82.852	73.374	60.329	42.866	26.076
Pensions accidents at work (<70)	63.200	62.497	61.984	61.883	62.042	62.360
Pensions for war victims	37.031	34.350	31.867	29.452	27.113	24.827

Type of benefit	2000	2001	2002	2003	2004	2005
<b>PL</b> Disability pensions resulting from an inability to work (duration > 1 year; 18+)	1.388.800	1.340.800	1.288.000	1.239.600	1.142.800	935.600
Compensatory allowances (duration > 1 year; 18+)	114.400	96.800	68.000	99.600	104.400	81.600
Disability pensions resulting from work accidents & prof. diseases paid by FUS	267.900	264.700	259.500	251.200	247.800	242.200
Social pensions paid by FUS (<65)	:	:	:	:	227.615	223.366
War invalidity pensions	97.300	93.700	89.400	84.800	80.400	75.900
<b>PT</b> Beneficiaries of Invalidity pension (<65)	369.561	357.344	354.556	345.603	336.215	318.022
Invalidity social pension (data already included in Invalidity pension figures)	:	:	:	45.584	45.554	46.169
Occupational permanent incapacity pensions (25-64)	12.519	:	:	:	:	:
<b>SI</b> Disability pensions (25-64) (includes work-related)	58.977	57.833	56.821	55.200	54.052	52.611
Disability benefit (independence allowance only)	7.913	6.936	6.675	6.602	6.472	6.317
<b>SK</b> Invalidity pensions receivers (includes work-related) (18-64)	:	260.000	261.000	260.000	254.000	182.856
Compensation benefit / Disabled persons allowance	:	:	:	:	:	:
<b>FI</b> Ordinary disability pensions	276.269	267.906	267.204	267.140	266.972	269.428
Disability allowance	12.020	12.300	12.476	12.468	12.453	:
<b>SE</b> Beneficiaries of Permanent Activity/Sickness Compensation (19-64)	360.494	376.035	402.153	413.071	434.137	444.950
Recipients of Work injury annuities (25-64) (degree > 6.7%)	90.132	93.760	83.635	82.408	79.024	75.454
<b>UK</b> Long-term Incapacity Benefit recipients (16-64)*	1.339.480	1.338.500	1.335.140	1.351.440	1.332.160	1.306.150
Severe Disablement Allowance (SDA) (16-65)	376.280	362.140	328.560	313.260	299.670	286.700
War disablement pensions (<65)	:	:	:	:	:	59.120
Industrial Injuries Disablement Benefit (IIDB) & Reduced Earnings Allowance (REA) (25-64)	-	-	205.030	201.045	196.600	191.510

\*: 990,590 persons only received "IB credits" in the UK in 2005.

Table 11: Definitions of disability, eligibility conditions and amounts

Countries	Definitions of disability and eligibility conditions for disability benefits	Type of disability benefits and nominal amounts
Austria	<ul style="list-style-type: none"> <li>Reduction of work capacity by 50 per cent, amount of income and the length of time insured.</li> <li>Half of the full invalidity pension is maintained while an activity income is generated.</li> </ul>	
Belgium	<ul style="list-style-type: none"> <li>Reduction of work capacity by 50 per cent, lost earnings and family situation.</li> <li>Lump-sum allowance in the event of the need for third-party assistance.</li> </ul>	



<b>Countries</b>	<b>Definitions of disability and eligibility conditions for disability benefits</b>	<b>Type of disability benefits and nominal amounts</b>
Bulgaria	<ul style="list-style-type: none"> <li>Reduction of work capacity by 50 per cent, insurance period, age, national average social insurance income and type of employment (military/non-military).</li> <li>Disabled people are 'persons with impairment certified by a Medical Labour Panel with more than 50 per cent lost ability to work'. If disability status is assessed as more than 90 per cent lost ability to work, it may, but not necessarily, be accompanied by an assistance allowance.</li> </ul>	<p>The average pension rate in 2007/2008 was BGN 149 (Euro 75) per month, taking all pension dues into account.</p> <p>The disability status of 90 per cent lost ability to work may, but not necessarily, be accompanied by an assistance allowance worth BGN 57.17 (Euro 29.00).</p> <p>The rate of the different benefits is determined in reference to the monthly subsistence cost established by the government on a year-by-year basis (BGN 55 = Euro 27.5 since 2006 and currently).</p>
Cyprus	<ul style="list-style-type: none"> <li>Reduction of work capacity by 60 per cent (for ages 60-63), earnings, number of years insured.</li> <li>Invalidity benefit may be claimed until the age of 63 (no minimum age stated) for either total or partial invalidity.</li> <li>Total invalidity is claimed when there is 100 per cent reduction in working capacity, the person receives 100 per cent invalidity pension.</li> <li>Partial invalidity is composed of three categories: 50-66.65 per cent reduced capacity (ages: 60-63) (60 per cent invalidity pension); 66.66-75 per cent reduced capacity (75 per cent invalidity pension); 76-99 per cent reduced capacity (85 per cent invalidity pension).</li> </ul>	<p>Invalidity pension amounts to 85 per cent of the full Basic Pension based on maximum Basic Insurable Earnings.</p> <p>For a single person the amount of the minimum pension is CYP 42.16 (€72) per week (85% x 60% x CYP 82.67), for a person with one dependant the amount is CYP 56.22 (€96) per week (85% x 80% x CYP 82.67), for a person with two dependants the amount is CYP 63.24 (€108) per week (85% x 90% x CYP 82.67) and for a person with three dependants the amount is CYP 70.27 (€120) per week (85% x 100% x CYP 79.90).</p> <p>The current annual rate of allowance for basic need is: for the recipient (head of household) CY£ 2,678 for every dependant aged 14+ CY£ 1,339 for every dependent aged &lt;14 CY£ 709</p>
Czech Republic	<ul style="list-style-type: none"> <li>Determining factors are: the minimum level of capacity for work at 66.66 per cent, average earnings and insurance period.</li> <li>There exists the possibility to combine the benefits with earnings from work.</li> <li>In case of full invalidity there are no limitations but in case of partial invalidity, earnings above certain thresholds (below 66 per cent of the comparable assessment base) lead to a pension reduction.</li> </ul>	<p>The average monthly full disability pension is approximately 8,000 Kč; while the average monthly partial disability pension is approximately 5,000 Kč.</p>





<b>Countries</b>	<b>Definitions of disability and eligibility conditions for disability benefits</b>	<b>Type of disability benefits and nominal amounts</b>
Denmark	<ul style="list-style-type: none"> <li>• <i>Førtidspension</i>: the criterion for <i>førtidspension</i> is not disability or any medical diagnosis, but just 'working ability'. <i>Førtidspension</i> is part of the rehabilitation system.</li> </ul>	<p><i>Førtidspension</i> amount per year is: DKK 141,720 for married / cohabitating, DKK 166,740 for single (€19,151 for married / cohabitating and €22,532 for single)</p> <p>The pension is reduced to 0 if the income is €80,000 for a married couple or €88,000 for a single person.</p>
Estonia	<ul style="list-style-type: none"> <li>• From 2000 medical assessment committees determine incapacity for work in per cent (10, 20, 30 etc up to 100) and disability in three degrees of severity (profound, severe or moderate).</li> <li>• There are nine classes of social benefits for disabled persons calculated on the basis of the rate of social benefits.</li> </ul>	<p>The amount of the Pension for Incapacity to Work (<i>töövõimetuspension</i>) is the percentage of the calculation basis corresponding to the loss of capacity for work, but not less than the National Pension Rate (<i>rahvapensioni määr</i>) of EEK 1,573 (€101) per month.</p> <p>The rate of social benefit in 2008 is EEK 400.</p>
Finland	<ul style="list-style-type: none"> <li>• The criterion is incapacity to work. People who have a permanent mobility disability or blindness always receive the full amount of this pension. The most common reason for receiving a disability pension is a mental health condition (33 per cent) and from the average age of 54 the individual can begin receiving the disability pension.</li> <li>• A special disability allowance is paid to 16-64-year-olds who are not in receipt of a pension but whose health is weakened through illness or injury to compensate for hardship, necessary services etc.</li> </ul>	<p>Disability pension: €560 per month (gross).</p> <p>Disability allowance is an alternative to disability pension and is tax free, divided into three levels based on the degree of disability. The levels are as follows: €81.83 per month, €190.94 per month and €370.24 per month.</p> <p>Dietary grant €21 per month, compensates for some of the additional costs of nutrition. Combining with earnings from work is allowed. In the case of disability pension if earnings exceed 60 per cent of the pensionable salary, the pension is withdrawn.</p>
France	<ul style="list-style-type: none"> <li>• Determining factors for the amount of benefits which applies to people with disabilities who are still able to perform some gainful activity are: average annual salary during the 10 best insurance years (or, if applicable, a shorter period), category of incapacity. It amount to SAM (<i>salaire annuel moyen</i>: average annual wage) x 30%.</li> </ul>	<p>The maximum annual amount is equal to 30 per cent of the Social Security ceiling (€9,655.20).</p>



<b>Countries</b>	<b>Definitions of disability and eligibility conditions for disability benefits</b>	<b>Type of disability benefits and nominal amounts</b>
Germany	<ul style="list-style-type: none"> <li>• Determining factors for the benefit amounts are the contributions during the entire period of insurance, voluntary contributions (contribution periods) and periods of childcare.</li> <li>• These pensions depend on the individual's degree of work capacity.</li> <li>• Recipients of the pension due to full reduction in earning capacity must have an earning capacity which is less than three hours per day, whereas recipients of the pension due to partial reduction in earning capacity are regarded as capable of working for three to six hours per day.</li> <li>• Medical expertise is required in order to tell whether and for how long a person is still able to work.</li> </ul>	<p>The amounts paid depend on the defined contributions pension formula (<i>Rentenformel</i>), which is the basis of the German pension insurance system. (Source: ANED national report)</p>
Greece	<ul style="list-style-type: none"> <li>• The pension varies according to the degree of disability (severe disability receives full pension, the pension is reduced by 25 per cent for 67 per cent incapacity and by 50 per cent in cases of 50 per cent incapacity). Fifteen years of insured employment are required.</li> <li>• Family support is only available to parents of disabled children more than 50 per cent disabled who work in the Public Telephone Organisation (OTE).</li> <li>• A new mobility benefit has been announced (30.06.2008) for people with more than 80 per cent disability in order to cover additional mobility expenses related to disability.</li> </ul>	<p>Minimum pension €445.37 per month for persons insured before 1993 and €453.71 per month for persons insured since 1993. The maximum pension is set at €2,172.25 and €2,538.28 per month respectively. In case of total disability, a pension supplement is paid for care provided by a third person which must not exceed €543.60 per month. Family support for Public Telephone Organisation (OTE) employees is €350.16 (2007). The new mobility benefit is €165 per month, in order to cover additional mobility expenses related to disability.</p>



<b>Countries</b>	<b>Definitions of disability and eligibility conditions for disability benefits</b>	<b>Type of disability benefits and nominal amounts</b>
Hungary	<ul style="list-style-type: none"> <li>• Determining factors for the level of benefit are 51 per cent disability, age, insurance period and class of invalidity.</li> <li>• Other Invalidity Annuity Benefits for persons over 18 years of age who lose 100 per cent of their working capacity before reaching the age of 25.</li> <li>• Temporary Invalidity Annuity amounts to 75 per cent of the Old Age Pension which the individual would be entitled to upon reaching retirement age.</li> <li>• Combining with earnings from work is possible if earnings do not exceed 80 per cent of the earnings obtained before the occurrence of invalidity.</li> </ul>	<p>The benefit paid by the central state budget amounts to HUF 27,180 (€108) per month. The Temporary Invalidity Annuity paid by the central state budget amounts to HUF 21,890 (€87) per month.</p>
Iceland	<ul style="list-style-type: none"> <li>• The criteria of eligibility for disability pension are age (16–67 years); residency (resident of Iceland for three years prior to the submission of an application); and a medically assessed permanent impairment.</li> <li>• There is a structured divide between those who are evaluated as ‘fully disabled’ (75 per cent) and those who are not (50–74 per cent).</li> <li>• There is a reduction in pension amount as incomes exceed a certain amount (<i>frítekjumark</i>).</li> </ul>	<p>As of June 2008, reductions are implemented when the recipient’s income exceeds ISK 195,804 or €1,603 per month. An individual is ineligible for any benefit if their income exceeds a cut-off point (<i>núllmark</i>) of ISK 302,716 or €2,478 per month.</p>
Ireland	<ul style="list-style-type: none"> <li>• The benefits are received in the case of permanent incapacity to work.</li> <li>• People who have been receiving Disability Benefit for five years or longer and who commence employment may retain 75 per cent of their Disability Benefit in the first year, 50 per cent in the second year and 25 per cent in the third year.</li> <li>• Those who become self-employed may retain 100 per cent of their Disability Benefit in the first year, 75 per cent in the second, 50 per cent in the third and 25 per cent in the fourth year.</li> </ul>	No information available



<b>Countries</b>	<b>Definitions of disability and eligibility conditions for disability benefits</b>	<b>Type of disability benefits and nominal amounts</b>
Italy	<ul style="list-style-type: none"> <li>• Conditions of entitlement to disability benefit are age, citizenship, invalidity of over 74 per cent and 99 per cent; an annual income not exceeding € 4,238.26</li> <li>• Frequency indemnity is supplied for the entire period during which an individual attends courses, school or rehabilitation cycles and it is not compatible with the accompanying indemnity.</li> <li>• Accompanying indemnity is not compatible with carrying on a job; it is provided for disability, irrespective of the individual's income and his/her age.</li> <li>• Social disability allowance: conditions of entitlement are age (18 to 65 years); being an Italian citizen; 100 per cent disability; having a personal annual income of less than € 14,466.67.</li> <li>• Social allowance: when the individual completes their 65th year the disability allowance and assistance allowance are replaced by social allowance.</li> </ul>	<ul style="list-style-type: none"> <li>• Disability benefit in 2008 amounts to: €246.73 for 13 months.</li> <li>• Frequency indemnity: €246.73 per month in 2008.</li> <li>• Accompanying indemnity: €465.09 per month and for 12 months a year in 2008.</li> <li>• Social disability allowance: €246.73 per month for 13 months in 2008.</li> <li>• Social allowance: €395.59 per month for 13 months in 2008.</li> </ul>



<b>Countries</b>	<b>Definitions of disability and eligibility conditions for disability benefits</b>	<b>Type of disability benefits and nominal amounts</b>
Latvia	<ul style="list-style-type: none"> <li>• Disability pension:               <ul style="list-style-type: none"> <li>○ Category I:1.6 x State Social Security Benefit.</li> <li>○ Category II:1.4 x State Social Security Benefit.</li> <li>○ The disability pension for category III is fixed at the level of the State Social Security Benefit.</li> </ul> </li> <li>• State Social Security Benefit – those people with disabilities from age 18 who are not eligible for disability pension.</li> <li>• Supplement to the family state benefit for disabled child under 18 years of age.</li> <li>• Disabled-child-raising allowance for people who are not employed and are raising disabled children with severe physical and functional disturbance under 18 years of age.</li> </ul>	<p>Minimum pensions are based on the State Social Security Benefit of LVL 45 (€64) per month:</p> <ul style="list-style-type: none"> <li>• Category I:1.6 x State Social Security Benefit,</li> <li>• Category II:1.4 x State Social Security Benefit.</li> <li>• The disability pension for category III is fixed at the level of the State Social Security Benefit.</li> </ul> <p>Disability pension is calculated using the 'ordinary' State Social Security Benefit (LVL 45).</p> <p>The disability pension for an individual who has been disabled from childhood: the level of State Social Security Benefit will be LVL 50 (€72) per month.</p> <p>Supplement to the family state benefit for disabled child under 18 years of age: LVL 50 (€72) per month.</p> <p>In 2008 the disabled-child-raising allowance was LVL 150.</p>
Lithuania	<ul style="list-style-type: none"> <li>• Determining factors for the level of benefit are 1/3 reduction in working capacity, social insurance period, period of time between occurrence of disability and retirement age, earnings upon which pension insurance contributions were made.</li> <li>• Compensation of care or attendance costs for disabled people with a reduction in capacity for work of at least 60 per cent or for persons of retirement age if need for permanent care or attendance is determined.</li> <li>• State Assistance Benefit: a non-contributory benefit to special groups of permanent residents who, for objective reasons, are not able to receive social insurance benefits.</li> </ul>	No information available



<b>Countries</b>	<b>Definitions of disability and eligibility conditions for disability benefits</b>	<b>Type of disability benefits and nominal amounts</b>
Luxembourg	<ul style="list-style-type: none"> <li>• Determining factors for the level of benefit are the number of insurance years, assimilated periods (flat-rate pension part) and earnings taken into account (income-related pension part).</li> <li>• Special supplements in case of early disability.</li> </ul>	No information available
Malta	<ul style="list-style-type: none"> <li>• Determining factors for the benefit amount are the number of contributions paid since age 18 and whether the claimant is in receipt of a Service Pension.</li> <li>• Other benefits are entitlement to Medical Assistance subject to a means test and to the decision of a medical panel.</li> <li>• the disability pension is given on condition that, if a disabled person is in employment, his/her weekly earnings do not exceed the amount set by the National Minimum Wage</li> <li>• Combining with earnings from work implies that invalidity pension beneficiaries are excluded from employment or self-employment.</li> <li>• The disability pension is awarded to disabled people who are Maltese citizens over the age of 18 who qualify under provisions in the Social Security Act. Unlike the invalidity pension, this pension is non-contributory.</li> </ul>	<p>The first member of the household who satisfies the determining factors for the benefit amount is entitled to MTL 8.00 (€19) per week, while any other member of the same household is entitled to MTL 5.80 (€14) per week.</p> <p>The amount of the disability pension falls in the range of €338.</p>





<b>Countries</b>	<b>Definitions of disability and eligibility conditions for disability benefits</b>	<b>Type of disability benefits and nominal amounts</b>
Netherlands	<ul style="list-style-type: none"><li>• WAO (previous scheme) with a minimum level of incapacity to work of 15 per cent.</li><li>• Initial benefit: determined by employee's last earned wage, his/her age on the starting date of benefits.</li><li>• Continuing benefit: a flat-rate basic amount plus flat-rate supplement amount depending on age.</li><li>• WIA (new scheme) with a minimum level of incapacity to work of 35 per cent is determined by employment history.</li><li>• <i>Wajong</i>: the benefits depend on the degree of disability at 25 per cent, after 104 weeks of incapacity to work, until the age of 65.</li></ul>	No information available



<b>Countries</b>	<b>Definitions of disability and eligibility conditions for disability benefits</b>	<b>Type of disability benefits and nominal amounts</b>
Norway	<ul style="list-style-type: none"> <li>• Disability benefit can be claimed by people between the age of 18 and 67 who have a loss of income potential of more than 50 per cent due to long term disease, injury or impairment. Adequate medical and vocational rehabilitation should have been tried without sufficient success.</li> <li>• Some receive a time-limited disability benefit before being granted the disability benefit, but this is now being replaced by a general temporary benefit (merged with the rehabilitation benefit).</li> <li>• Supplementary benefits are available for people with long-term disease, injury or impairment.</li> <li>• One of these ('basic benefit') is intended to cover extra costs; the other ('attendant benefit') is to compensate for private service needs (not necessarily expenses).</li> <li>• Many disabled people receive the 'basic benefit', whereas the 'attendant benefit' is more typical for children living with their family.</li> <li>• Disabled people can also receive rent support (for accommodation), technical aids, transport, etc. The calculation of the disability benefit is based on earlier income levels and years.</li> </ul>	<p>Guaranteed minimum benefit in 2008 was 173,500 NOK (€21,700) annually.</p> <p>The general minimum pension was 136,500 NOK for single person households.</p> <p>In 2005, about a third of the full (100 per cent) disability pensioners received 150 per cent of the minimum pension or more. Two thirds received more than 130 per cent of the minimum.</p> <p>The 'basic benefit' is divided into six annual rates based on needs assessment/ likely extra expenses.</p> <p>The lowest rate is 7,000 NOK (€900), the highest 35,000 NOK. There are four 'attendant benefit' rates, from NOK 12,600 to NOK 75,600. People aged 18 or over can only be granted the lowest rate.</p>



<b>Countries</b>	<b>Definitions of disability and eligibility conditions for disability benefits</b>	<b>Type of disability benefits and nominal amounts</b>
Poland	<ul style="list-style-type: none"> <li>• The incapacity level is described as either 'total' or 'partial', depending on remaining working capacity.</li> <li>• Inability to work pensions is available for insured people who are incapable of working but have at least a five-year insurance period.</li> <li>• The level of inability to work benefit depends on the number of years' insurance the individual has and on his/her level of inability to work as well as the basic amount.</li> <li>• Social pension (in Polish: <i>renta socjalna</i>) is available for every individual of certain age who is totally unable to work due to an impairment which occurred before they reached the age of 18 (or 25 years in the case of full-time students or those in the course of doctoral studies or scientific post-graduate studies).</li> <li>• Benefits from the Agricultural Social Insurance Institution (KRUS)</li> <li>• Permanent allowance if the individual meets the income criteria and is totally incapable of working due to age or disability.</li> </ul>	<ul style="list-style-type: none"> <li>• The lowest level of the total inability to work pension is PLN636 (as of 1 March 2008).</li> </ul> <p>A pension for a person who is partially incapable of work is payable at the rate of 75 per cent of the pension for a person completely incapable of work (PLN489 as of 1 March 2008).</p> <p>The nursing supplement is payable by ZUS (Social Insurance Institution) and financed by the Social Insurance Fund. As of 1 March 2008 it is payable at the monthly rate of PLN163.</p> <p>The average monthly inability to work pension was PLN 1,011 (including nursing supplements).</p> <ul style="list-style-type: none"> <li>• Social pension is fixed and set at 84 per cent of the lowest level of the inability to work pension (PLN534 gross since 1 March 2008).</li> <li>• Benefits from the Agricultural Social Insurance Institution (KRUS): The average disability pension paid out from KRUS in 2006 amounted to PLN638 (MPiPS 2007).</li> <li>• The permanent allowance is payable as of 1 October 2006 at the monthly minimum rate of PLN30 (maximum PLN 444).</li> </ul>
Portugal	<ul style="list-style-type: none"> <li>• The determining factors for the level of benefit are: 66 per cent reduction of capacity for normal occupation, the number of years covered by contributions, average monthly earnings during the entire insurance period.</li> </ul>	No information available



<b>Countries</b>	<b>Definitions of disability and eligibility conditions for disability benefits</b>	<b>Type of disability benefits and nominal amounts</b>
Romania	<ul style="list-style-type: none"><li>• The determining factors are 50 per cent of incapacity to work, previous earnings and length of service.</li><li>• The value of each benefit component must not exceed 25 per cent of the basis salary (meaning salary during the six months preceding the onset of sickness).</li><li>• Benefits are payable for a maximum period of 90 days a year.</li></ul>	<ul style="list-style-type: none"><li>• Annual Score is maximum five points. Pension Point Value may not be less than 30 per cent of the projected average gross wage, i.e. RON 381 (€122) or more than 50 per cent of the projected average gross wage, i.e. RON 635 (€204).</li><li>• Accordingly, a person with a full contribution period may obtain an Annual Average Score of five points that is 2.5 times the projected average gross wage, i.e. RON 3,175 (€1,020).<sup>31</sup></li></ul>

<sup>31</sup> for details how to calculate the Annual Score see MISSOC database  
[http://ec.europa.eu/employment\\_social/missoc/db/public/compareTables.do?lang=en](http://ec.europa.eu/employment_social/missoc/db/public/compareTables.do?lang=en)



<b>Countries</b>	<b>Definitions of disability and eligibility conditions for disability benefits</b>	<b>Type of disability benefits and nominal amounts</b>
The Slovak Republic	<ul style="list-style-type: none"> <li>• A person is considered as disabled (invalid) if his/her earning ability falls more than 40 per cent (maximum 100 per cent) due to long-term ill health. Other conditions are age and period of insurance. People over the age of 28 must have completed the employment period in the ten years prior to the occurrence of the invalidity/disability. In the case of employment injuries or occupational diseases and for a person disabled since childhood no minimum period of employment is required</li> <li>• Benefits for people with disabilities consist of financial allowances for severe disability compensation. Financial benefits can be received only by a person recognised as having a severe disability. Severely disabled is when his/her rate of functional impairment is 50 per cent (maximum 100 per cent) due to long-term disability (more than one year) - medical assessment.</li> <li>• All benefits are means-tested.</li> </ul>	<p>When the reduction in working capacity is more than 40 per cent but less than 70 per cent the amount of invalidity pension is: 4,638 Sk (€153).</p> <p>For people whose reduction in working capacity is more than 70 per cent the amount is: 8,107 Sk (€267).</p> <p>Benefits:</p> <ul style="list-style-type: none"> <li>• for personal assistance: 55 SK (€1.80)/per hour max. amount 34,100 SK (€1,124)/month</li> <li>• for purchasing disability aids: max. amount 260,000 SK (€8,065)</li> <li>• for repairing disability: maximum: 50 per cent of the price of new aid</li> <li>• for purchasing a personal motor vehicle: 250,000 SK (€7,755)</li> <li>• for adapting apartment, house or garage: 200,000 SK (€6,204)</li> <li>• for increased expenses: <ul style="list-style-type: none"> <li>○ for special diet: depends on type of diet 1,000 SK (€31), 500 SK (€15.50), 300 SK (€9.30)/month</li> <li>○ connected with hygiene or wear and tear of clothing, linen, footwear and furnishings: 500 SK (€15.50) /month</li> <li>○ connected with running a personal motor vehicle: 900 SK (€28.00) /month</li> <li>○ connected with care for specially trained dog: 1,200 SK (€37.20 EUR)/month</li> </ul> </li> <li>• for nursing: care for one person with disabilities – 6,000 SK (€186.10), care for two and more persons with disabilities 8,000 SK (€248.10)/month</li> </ul>



<b>Countries</b>	<b>Definitions of disability and eligibility conditions for disability benefits</b>	<b>Type of disability benefits and nominal amounts</b>
Slovenia	<ul style="list-style-type: none"><li>• Determining factors are causes of invalidity, previous earnings, gender of claimant, age at which invalidity occurred. Disability Allowance is awarded to those who are employed or receiving a pension.</li><li>• Occupational rehabilitation benefits are paid for the period between occupational rehabilitation and its completion. The benefit amounts to 100 per cent of the invalidity pension he/she would be entitled to on the date of the beginning of invalidity.</li></ul>	No information available
Spain	<ul style="list-style-type: none"><li>• Determining factors are the degree of incapacity at 33 per cent. Other benefits, such as pharmaceutical products, are free.</li></ul>	No information available
Sweden	<ul style="list-style-type: none"><li>• New disability regulations in force distinguish between those under 30 and those aged 30 and above. The latter receive sickness benefit and the former receive an activity benefit. The minimum level of incapacity to work is 25 per cent.</li><li>• Combining with earnings from work is possible for Assistance Allowance, Care Allowance, Care Allowance for Disabled Child and Disability Allowance.</li></ul>	No information available

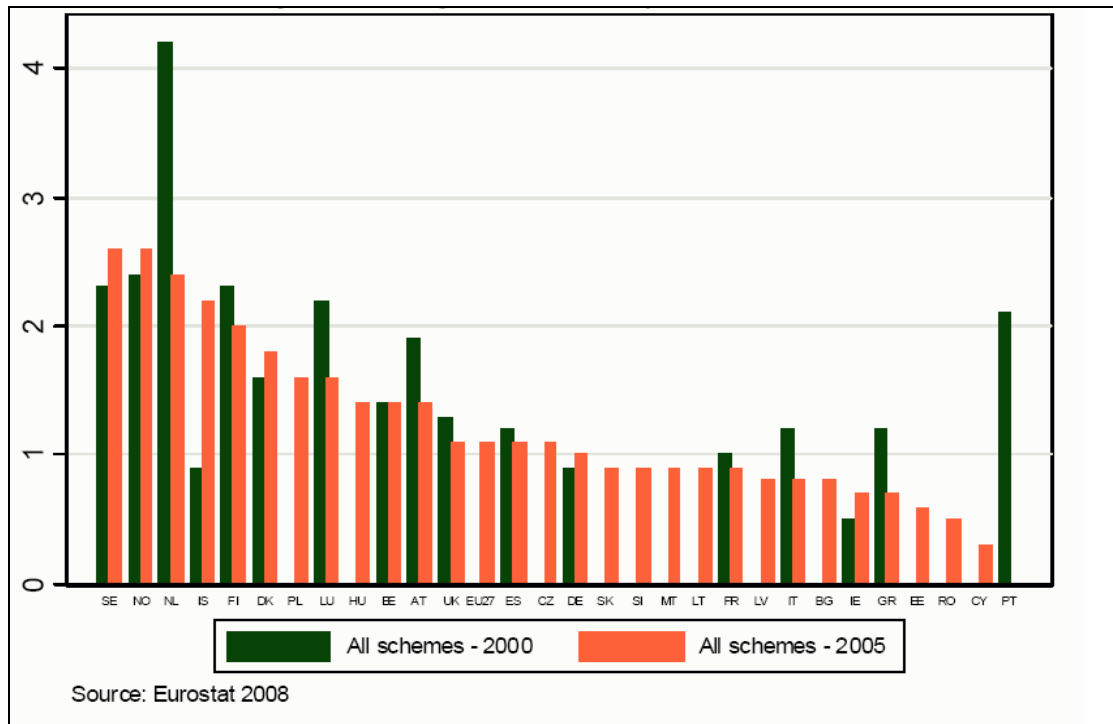




<b>Countries</b>	<b>Definitions of disability and eligibility conditions for disability benefits</b>	<b>Type of disability benefits and nominal amounts</b>
UK	<ul style="list-style-type: none"> <li>• The determining factors are personal capability assessment – a medical assessment of whether a person meets the threshold of incapacity for benefits.</li> <li>• Incapacity Benefit (IB): available for adults who cannot work because of illness or disability. IB is paid at three weekly rates.</li> <li>• Older people, over state retirement age, receive higher short-term payments but are not eligible for long-term IB (although they may get an addition if they were under 45 when they became unable to work).</li> <li>• From October 2008, however, the Welfare Reform Act 2007 will replace Incapacity Benefit with a new 'Employment and Support Allowance' and most people (of working age) will be expected to engage in some work-related activity.</li> <li>• Claims for IB can be made if a person is unable to work for at least four consecutive days or for two or more out of seven consecutive days.</li> <li>• Young people who have never worked (or recently completed education) and people out of work for more than 28 weeks may be able to claim without National Insurance contributions.</li> <li>• Disability Living Allowance: available to claimants under 65 who require some assistance and support in daily life (in or out of work). It is also available to parents of disabled children. It is an additional income benefit and there is no requirement to prove the money is spent on care.</li> </ul>	<p>IB is paid at three weekly rates: short-term lower rate (£63.70); short-term higher rate (£75.40); long-term (£84.50). Older people, over state retirement age, receive higher short-term payments (£81.10 and £84.50) but are not eligible for long-term IB (although they may get an addition if they were under 45 when they became unable to work). In February 2008 the average weekly amount received was £52.57 (£47.31 for women and £56.25 for men).</p> <p>Disability Living Allowance: DLA includes two components: the 'care' component is paid at three different rates (high £67.00; middle £44.85; low £17.75) and the 'mobility' component at two rates (higher £46.75; lower £17.75). Recipients might therefore receive payment in the range of £17.75 to £113.75 per week. In February 2008 the average weekly amount received was £64.43 (with no significant gender difference).</p>

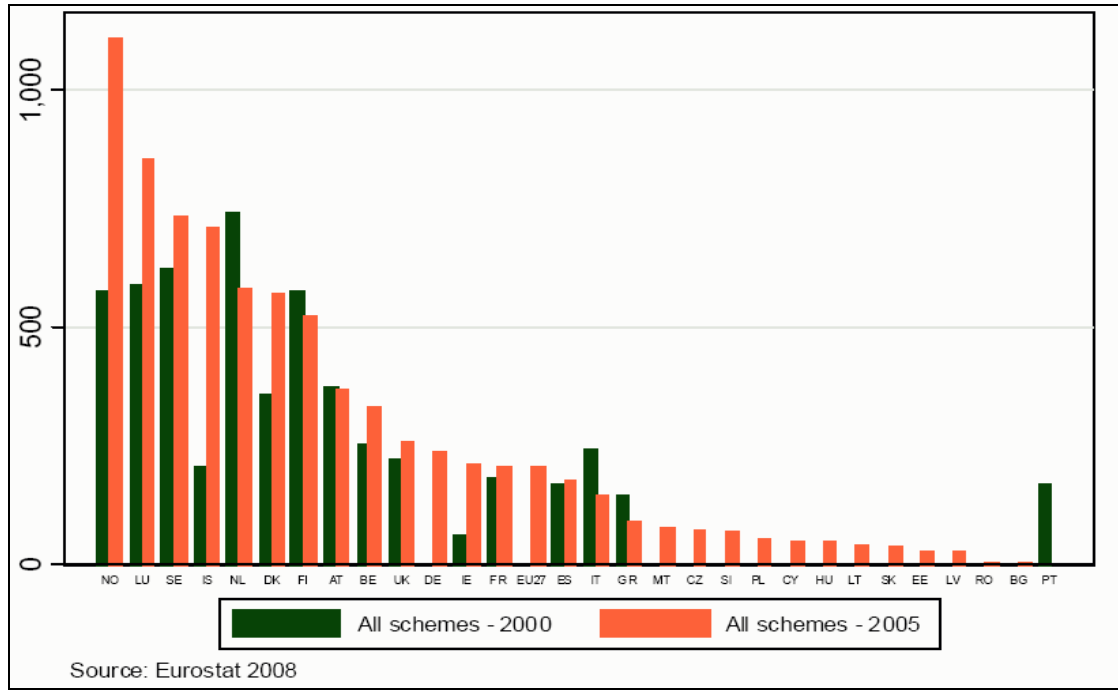


**Figure 1 The percentage of GDP spent on disability pension, all schemes**



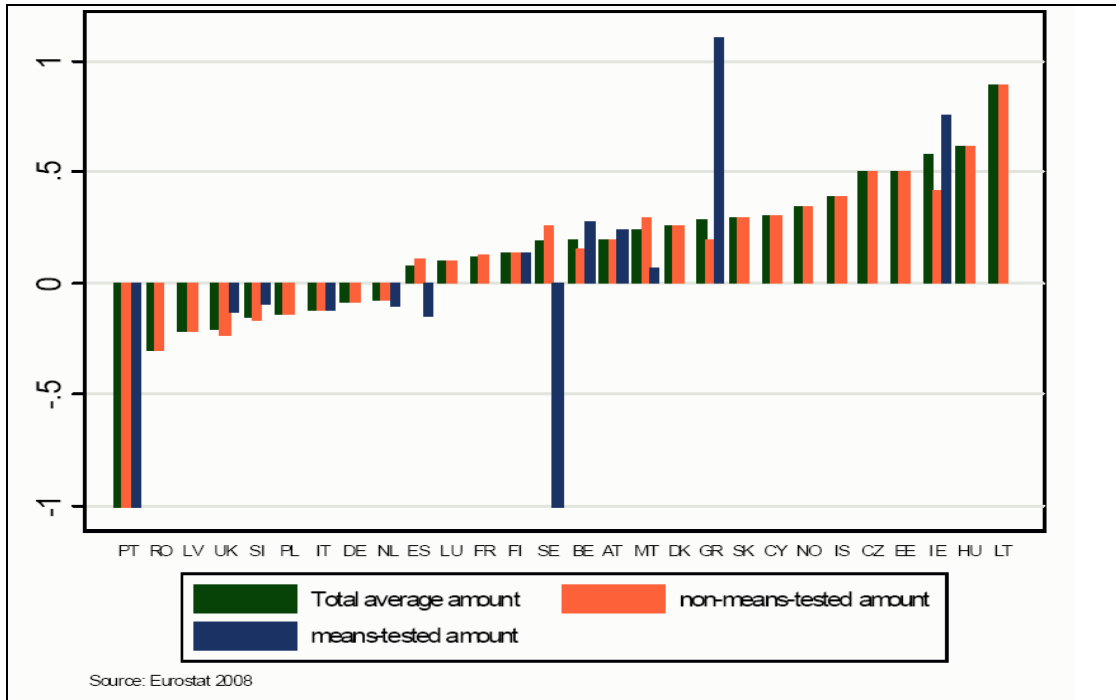


**Figure 2: Average amount of disability pension, euro per inhabitant, all schemes**





**Figure 3: Percentage change in average amount of disability pension by schemes, 2000-2005**





**Figure 4: Percentage change in the share of social expenditure on disability pension by schemes, 2000-2005**

