**Task 2017-18 Disability assessment – country report**

Country: France

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**Contents**

[Part 1 – Main forms of disability assessment 2](#_Toc536026180)

[Part 2 – Analysis and evaluation of specific assessments 9](#_Toc536026181)

[Case study 1: Admission to a general register or status of disabled person(s) or comprehensive assessment for multiple purposes. 9](#_Toc536026182)

[Case study 2: Eligibility for invalidity pension. 26](#_Toc536026183)

[Case study 3: Assessment for long-term care benefits as defined in MISSOC. 32](#_Toc536026184)

[Summary and conclusion 46](#_Toc536026185)

# Part 1 – Main forms of disability assessment

The following forms of disability assessment are currently in use in France for a variety of purposes.

Example 1: Incapacity rate assessment

Example 2: Assessment for Disability Compensation Benefit

Example 3: Assessment for Invalidity pension

Example 4: Assessment for a schooling or training course with or without support of a socio-medical service or institute

Example 5: Assessment for disabled worker recognition

Example 6: Assessment for an invalidity “mobility-inclusion” card

**Example 1: Incapacity rate assessment linked with disability**

Policy function: Assessment for multiple purposes (access to various disability benefits).

Benefit: Benefits in cash (e.g. pension). Discounts or concessions (e.g. tax allowances).

Specificity: Only persons with a previous disability assessment can apply (but this is a second stage of disability assessment designed for the specific purpose).

Responsible: The Departmental Home for Disabled Persons.

How to apply:

<http://handicap.gouv.fr/les-aides-et-les-prestations/maison-departementale-du-handicap/article/maison-departementale-des-personnes-handicapees-mdph>.

**Type of assessment: Holistic assessment (combination of impairment, functional and environmental approaches).**

Qualifying criteria: The assessment leads to a scaled calculation but it is based on the analysis of his/her impairment as well as on the one of its consequences in his/her daily life. The definition of "disability" which is used is the one of the 2005 act which defines disability as every activity limitation or restriction of participation to social life a person faces in his/her environment because of a substantial, lasting or definitive deterioration of physical, sensory, mental or psychological functions, of multiple disabilities or of an invalidating health problem. The rate which will be calculated, depending on its calculation, may enable the person to get an “mobility-inclusion” card and/or benefits in addition to the services and supports provided to disabled persons. The criteria will be the reduction of social life opportunities to establish a 50 % incapacity rate and the simultaneity of severe barriers in daily life as well as a reduction of autonomy to establish an 80 % incapacity rate. For further developments see case study 3.[[1]](#footnote-2)

Method: Combination of documentary evidence and personal interaction.

Assessor: Medical doctor, Nurse, Therapist (physical, occupational, etc.), Psychologist, Social worker, Bureaucrat / civil servant, Self-assessment.

Supporting evidence: Self-assessment (statement or structured questionnaire completed by the individual). Evidence from someone who knows the applicant’s situation (e.g. a relative, friend, neighbour or colleague). Evidence from a non-medical professional who knows the applicant. A medical note or letter from a doctor who treats the applicant.

Decision maker: The Commission for the rights and autonomy of disabled persons.

Further details of the assessment: <http://www.cnsa.fr/documentation/CNSA-Technique-eligibilites-web-2.pdf>.

Notification of outcome: A letter explaining the outcome.

Appeal possible: yes

<http://handicap.gouv.fr/les-aides-et-les-prestations/maison-departementale-du-handicap/article/maison-departementale-des-personnes-handicapees-mdph>.

**Example 2:** **Assessment for Disability Compensation Benefit**

Policy function: Help with additional costs of living associated with disability.

Benefit: Benefits in cash (e.g. disability allowance).

Specificity: The disability assessment is designed for this specific purpose.

Responsible: The departmental home for disabled persons.

How to apply:

<http://handicap.gouv.fr/les-aides-et-les-prestations/maison-departementale-du-handicap/article/maison-departementale-des-personnes-handicapees-mdph>.

**Type of assessment: Holistic assessment (combination of impairment, functional and environmental approaches).**

Qualifying criteria: The criteria which are taken into consideration are an absolute difficulty to perform a task or a severe difficulty to perform two tasks for a provisional duration of at least one year. The life project of the person is also taken into consideration.

Method: Combination of documentary evidence and personal interaction.

Assessor: Medical doctor, Nurse, Therapist (physical, occupational, etc.), Psychologist, Social worker, Bureaucrat / civil servant, Self-assessment.

Supporting evidence: Self-assessment (statement or structured questionnaire completed by the individual). Evidence from someone who knows the applicant’s situation (e.g. a relative, friend, neighbour or colleague). Evidence from a non-medical professional who knows the applicant. A medical note or letter from a doctor who treats the applicant.

Decision maker: The departmental commission for the rights and autonomy of disabled persons.

Further details of the assessment: <http://www.cnsa.fr/documentation/CNSA-Technique-eligibilites-web-2.pdf>.

Notification of outcome: A letter explaining the outcome.

Appeal possible: yes

<http://handicap.gouv.fr/les-aides-et-les-prestations/maison-departementale-du-handicap/article/maison-departementale-des-personnes-handicapees-mdph>.

**Example 3: Invalidity pension Assessment for invalidity** *(as defined in MISSOC)*

Policy function: Access to a disability pension (invalidity).

Benefit: Benefits in cash (e.g. pension). Discounts or concessions (e.g. tax allowances).

Specificity: The disability assessment is designed for this specific purpose.

Responsible: Regional Health Insurance Agency.

How to apply: <https://www.service-public.fr/particuliers/vosdroits/F672>.

**Type of assessment: Assessment of economic loss (e.g. loss of income related to disability).**

Qualifying criteria: People who worked and fulfilled the affiliation conditions for social security, are entitled to this contributory benefit (Disability pension) if their work capacity is reduced by 2/3 as a result of an accident or an illness not related to work activities, in other words if they are unable, because of this accident or this disease, to earn more than 1/3 of the salary earned by other persons having a similar job in the same region.

Method: Paper-based exercise.

Assessor: Medical doctor, Bureaucrat / civil servant.

Supporting evidence: A medical note or letter from a doctor who treats the applicant.

Decision maker: The Regional Health Insurance Agency.

Further details of the assessment: <https://www.ameli.fr/assure/droits-demarches/invalidite-handicap/invalidite>.

Notification of outcome: A certificate (e.g. proof of disability status).

Appeal possible: yes

<https://www.ameli.fr/assure/droits-demarches/reclamation-conciliation-voies-de-recours/contester-decision>.

**Example 4: Assessment for a schooling or training course with or without support of a socio-medical service or institute**

Policy function: Additional support at school or college.

Benefit: Benefits in kind (e.g. services).

Specificity: The disability assessment is designed for this specific purpose.

Responsible: Departmental Home for Disabled Persons (Maison départementale des Personnes handicapées).

How to apply: <http://handicap.gouv.fr/les-aides-et-les-prestations/maison-departementale-du-handicap/article/maison-departementale-des-personnes-handicapees-mdph>.

**Type of assessment: Assessment of need (e.g. for help / support).**

Qualifying criteria: It is based on the "life project" which is a translation of the expectations and needs regarding the child and on an evaluation of his/her needs by a multidisciplinary team. The level of impairment is taken into account in the cases of hearing and of visual impairments but is not the single criterium. The Departmental Home for Disabled Persons proposes a project of personal compensation plan which is addressed to the child's parents. The parents can make observations by mail within a 15-day period. Then the file is proposed for decision.

Method: Combination of documentary evidence and personal interaction.

Assessor: Medical doctor, Nurse, Therapist (physical, occupational, etc.). Other rehabilitation specialist, Psychologist, Social worker, Bureaucrat / civil servant.

Supporting evidence: Evidence from someone who knows the applicant’s situation (e.g. a relative, friend, neighbour or colleague). Evidence from a non-medical professional who knows the applicant. A medical note or letter from a doctor who treats the applicant.

Decision maker: The Departmental Commission for the rights and autonomy of disabled persons (CDAPH).

Further details of the assessment: -

Notification of outcome: A letter explaining the outcome.

Appeal possible: yes

<http://handicap.gouv.fr/les-aides-et-les-prestations/maison-departementale-du-handicap/article/maison-departementale-des-personnes-handicapees-mdph>.

**Example 5: Assessment for disabled worker recognition**

Policy function: Assessment for multiple purposes (access to various disability benefits).

Benefit: Benefits in kind (e.g. services). Beneficial treatment (e.g. eligibility to apply for quota jobs).

Specificity: The disability assessment is designed for this specific purpose.

Responsible: Departmental Home for Disabled People.

How to apply:

<http://handicap.gouv.fr/les-aides-et-les-prestations/maison-departementale-du-handicap/article/maison-departementale-des-personnes-handicapees-mdph>.

<https://travail-emploi.gouv.fr/emploi/emploi-et-handicap/rqth>

**Type of assessment: Holistic assessment (combination of impairment, functional and environmental approaches)**

Qualifying criteria: It is based on the "life project" of the disabled person, on the description of the health situation of the person by a doctor and on the evaluation made by a plural disciplinary team. The definition of "disability" which is used is the one of the 2005 Act which defines disability as every activity limitation or restriction of participation to social life a person faces in his/her environment because of a substantial, lasting or definitive deterioration of physical, sensory, mental or psychological functions, of multiple impairments or of an invalidating health trouble. The criterium is the reduction of the possibility to get or to keep a job because of an alteration of one or several physical, sensory, mental or physiological functions.

Method: Combination of documentary evidence and personal interaction.

Assessor: Medical doctor, Therapist (physical, occupational, etc.) Psychologist, Social worker, Bureaucrat / civil servant, Self-assessment

Supporting evidence: Self-assessment (statement or structured questionnaire completed by the individual). A medical note or letter from a doctor who treats the applicant.

Decision maker: The commission for the rights of disabled persons to independence

Further details of the assessment: <http://handicap.gouv.fr/les-aides-et-les-prestations/maison-departementale-du-handicap/article/maison-departementale-des-personnes-handicapees-mdph>.

Notification of outcome: A letter explaining the outcome.

Appeal possible: yes

<http://handicap.gouv.fr/les-aides-et-les-prestations/maison-departementale-du-handicap/article/maison-departementale-des-personnes-handicapees-mdph>.

**Example 6: Assessment for invalidity-CMI card**

Policy function: Recognition of official disability status (e.g. a general register).

Benefit: Beneficial treatment (e.g. eligibility to apply for quota jobs). Discounts or concessions (e.g. tax allowances).

Specificity: The disability assessment is designed for this specific purpose.

Responsible:

<http://handicap.gouv.fr/les-aides-et-les-prestations/maison-departementale-du-handicap/article/maison-departementale-des-personnes-handicapees-mdph>.

How to apply:

<http://handicap.gouv.fr/les-aides-et-les-prestations/maison-departementale-du-handicap/article/maison-departementale-des-personnes-handicapees-mdph>.

**Type of assessment: Barema method (% disability or scale).**

Qualifying criteria:

- either an impairment of at least 80 %;

- or the classification of the invalidity in the third category corresponding to a situation where a person is absolutely unable to work and is driven to seek the help of an outside person to make ordinary actions of daily life;

- alternatively, to be classed in Groups 1 or 2 on the Aggir scale (beneficiaries or those requesting a customised autonomy allowance).

Method: Combination of documentary evidence and personal interaction.

Assessor: Medical doctor, Nurse, Therapist (physical, occupational, etc.). Psychologist, Social worker, Bureaucrat / civil servant, Self-assessment

Supporting evidence: Self-assessment (statement or structured questionnaire completed by the individual). A medical note or letter from a doctor who treats the applicant.

Decision maker: The Commission for the rights and autonomy of disabled persons.

Further details of the assessment:

<http://handicap.gouv.fr/les-aides-et-les-prestations/maison-departementale-du-handicap/article/maison-departementale-des-personnes-handicapees-mdph>.

Notification of outcome: A personalized card (e.g. a disability identity card).

Appeal possible: yes

<http://handicap.gouv.fr/les-aides-et-les-prestations/maison-departementale-du-handicap/article/maison-departementale-des-personnes-handicapees-mdph>.

# Part 2 – Analysis and evaluation of specific assessments

This part of the report provides an in-depth analysis of three selected case studies of assessment procedure and focuses on their suitability and effectiveness.

#### Please use the EU MISSOC tables (similar to DOTCOM) providing country specific information on specific types of benefits as a starting point, <http://www.missoc.org/INFORMATIONBASE/COMPARATIVETABLES/MISSOCDATABASE/comparativeTableSearch.jsp>.

The cases are selected to enable systematic comparison between countries and to focus on areas of policy priority and development.

## Case study 1: Admission to a general register or status of disabled person(s) or comprehensive assessment for multiple purposes.

An outline of the key features of this assessment process is provided in Part 1 of this report (see **Examples 4 and 5**).

### Detailed description of the assessment process

#### The main stages of the process, from application to decision, and appeal against decision, detailing the types of professionals involved and their responsibilities. Please also describe the administrative arrangements and the roles of the different institutions involved in the process. Please indicate what role the person being assessed plays in the procedure.

French law makes a difference between disability, invalidity, incapacity and unfitness. Assessment procedures and criteria depend on disadvantages that the law intends to compensate.

By law[[2]](#footnote-3), disability is defined as any type of activity limitation or restriction of participation in society that a person faces in his/her environment because of a substantial, lasting or definitive alteration of his/her physical, sensory, mental, cognitive or psychological functions, or because of multiple impairments, or of an invalidating health problem. It is considered as the consequence of the interaction of individuals and environmental factors.[[3]](#footnote-4)

The assessment of disability needs is organised by the departmental office for disabled persons (maison départementale des personnes handicapées, MDPH). It is built upon socio-medical criteria on which a multidisciplinary team focuses to define the means needed to compensate the limitation of activity or the restriction of participation the applicant faces as regards to his/her life project and the rights he/she is entitled to.

Incapacity refers to the consequences of a disease or of an accident for a person. An incapacity can be temporary or permanent.

In the scope of the Social security system, incapacity is linked with work. Either it is due to work; in this case the analysis of the consequences will take into account the well-being of the person. Or it is not due to work, in this case the analysis will focus on the consequences on the ability to earn one’s life.

In case of temporary incapacity, the health insurance fund aims at compensating the loss of income due to the impossibility to have any activity for a limited time. It is assessed by the doctor of the insured person.[[4]](#footnote-5) There are some differences in the payments depending on whether the temporary incapacity is due to work or not.

In the Social Security code, permanent incapacity or reduction of work capacity due to work, is called, “permanent incapacity” and refers to the alteration of the state of health of the person following a disease or injury due to work and can have different degrees.

In case of a disease or accident due to work leading to a permanent reduction of one’s working capacity, the compensation focuses on the consequences of the disease or of the accident on the physical well-being of the person. The assessment of “permanent incapacity”[[5]](#footnote-6) due to such circumstances is organised by the health care insurance fund, which calculates an incapacity rate once the health state of the person has stabilised. If this rate is under 10%, a lump sum is awarded to the victim. If the rate of permanent incapacity is over 10%, an income is calculated on the basis of the former salary.[[6]](#footnote-7)

Permanent incapacity or reduction of work capacity not due to work is called “invalidity”and focuses on the reduction of income as a result of a reduction of his/her work capacity following a long lasting and stabilised health problem.[[7]](#footnote-8) The activity limitation that is considered here is linked to the work capacity and related incomes. The assessment of invalidity focuses on the consequences for the future of the person. It is organised by the health insurance fund the individual has been a member of.[[8]](#footnote-9)

A reduction of a person’s work capacity or income of at least 2/3 is considered as an invalidity. A permanent incapacity to perform his/her job is unfitness.

‘Job Unfitness’ is directly linked to the post held by the person who has been victim of an accident or a disease.[[9]](#footnote-10) It corresponds to an incapacity to fulfil a specific work contract. It is assessed by the health care insurance fund. The head of the company has to offer a new post to the person who has been declared unfit for his/her post. In case no possibility exists within the company, the person can be made redundant. An occupational health physician giving an advice of unfitness may note that any professional activity would be harmful to the person’s health or that the person’s health condition is a stumbling block to any redeployment. However, unfitness does not necessarily imply an invalidity. According to his/her health condition, without any link with a post held (except for civil servants), a person can apply for invalidity, which does not prevent him/her from working. Invalidity, incapacity and unfitness affect active adults only.

Case study 1 deals with disability. However, it is important to notice that MDPHs also use the term of incapacity in the scope of the assessment of the eligibility for some specific financial allowances that are linked with the assessment of disability. This definition is different from the one of the Social Security code.[[10]](#footnote-11) In MDPHs’ vocabulary, incapacity refers to “every reduction resulting from an incomplete or complete deficiency of the ability to perform an activity in a way or with limitations that can be considered as normal for a human being” lasting for at least one year. It corresponds to the activity limitation aspect of disability. Financial allowances awarded by MDPHs are restricted to persons whose impairment has had a disabling effect for more than one year. In this case additional criteria to the ones taken into consideration to assess disability are taken into account.

To assess the eligibility for the benefit for disabled adults (Allocation adulte handicap, AAH), or to the Education allowance for a disabled child (AEEH, Allocation éducation enfant handicap) and the related supplement (see case study 3), they calculate an incapacity rate that is different from the one calculated by the health care insurance fund and that can apply to inactive people like children. When the point at stake is the calculation of an incapacity rate, not only the severity of the activity limitation is taken into consideration by MDPHs, but also the consequences for the person’s social life. A permanent incapacity rate as defined by the Social Security code of at least 10% implies recognition as a disabled person.[[11]](#footnote-12)

As far as the process of assessment for the admission to a status of disabled person itself is concerned:

Every person corresponding to the definition of disability can apply for support enabling him/her to access his/her fundamental human rights as defined by the Law by Act of 11th of February 2005.[[12]](#footnote-13) Contrary to the invalidity pension and to the work injuries and occupational diseases benefit which aim at compensating for an alteration of a work capacity and its financial consequences, the compensation for disability tackles the general consequences of an impairment, whatever its origin, in functional (general activity related) and in social terms. It includes human, financial and technical supports for both disabled persons and institutions to implement an individuals’ rights plan.

The assessment of disability depends on “departmental offices for disabled persons” (Maisons départementales des personnes handicapées, MDPH). These are offices working as “points of single contact” in charge of the admission to a general status of disability and the support of disabled persons and of their relatives. There is one MDPH in each French department equivalent to a UK County. They are responsible for organising access to the compensation rights of disabled persons as well as **of the implementation of decisions.**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Substantial, lasting or definitive alteration of physical, sensory, mental, cognitive or psychological functions / multiple impairments / invalidating health trouble. | | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  | YES |  |  |  |  |  | NO |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| Activity limitation / restriction of participation in society in the person's environment | | | |  |  | Activity limitation / restriction of participation in society in the person's environment | | | | |
|  |  |  |  |  |  |  |  |  |  |  |
|  | YES |  |  |  | NO |  | YES |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| Link between limitation/restriction and impairment | | | |  | No disability | | | | |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  | YES |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  | Disability |  |  |  |  |  |  |  |  |  |

Process of assessment for disability and for right to compensation

First the person applies for compensation or to the admission to the status of disabled worker using an application form, which can be used to apply for any support and/or benefit intended to disabled people.[[13]](#footnote-14) [[14]](#footnote-15) He/she has to provide a medical certificate filled in by a physician[[15]](#footnote-16) informing about his/her health condition, its functional consequences and about the therapies set up. The medical certificate takes the form of a questionnaire[[16]](#footnote-17) which includes:

* the pathology the persons suffers from;
* its history (origins and circumstances in which it occurred, description and frequency of invalidating clinical signs, foreseeable changes in health condition;
* its consequences on the person’s daily life.

The latter consequences are evaluated through an assessment grid included within the questionnaire; the doctor can provide additional information. In specific circumstances (language, hearing or visual impairment), additional specific certificates concerning medical data are required.

Whatever the support, service or benefit/allowance the person applies for, or if he/she applies for an admission to a general status of disabled worker, he/she is invited to describe his/her expectations in terms of communication, health, schooling, training, employment, housing, daily life, emotional life, family life, hobbies etc in a “life project”. The family of the applicant is also invited to describe his/her situation as well as his/her needs.

A multidisciplinary team is responsible for the evaluation of the applicant’s compensation needs in respect of his/her life plans and for the process of a “personalised compensation plan” (plan personnalisé de compensation, PPC).

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  | |  |  | |  |  | |  |
|  | Needs evaluation | |  |  | | | Answers | | | | |  |
|  |  |  |  |  | |  |  | |  |  | |  |
|  | Socio-economical aspects |  |  |  | |  | course/career/medico-social care choice | | |  | |  |
|  |  | Housing |  |  | |  |  | |  |  | |  |
|  |  |  | Incapacity rate |  | | Incapacity rate |  | |  | AAH[[17]](#footnote-18), AEEH[[18]](#footnote-19), CMI[[19]](#footnote-20) | |  |
|  | Activities, functions |  |  |  | |  |  | |  |  |
| Psychological aspects |  | Training |  |  | |  |  | |  |  | |  |
|  | Existing supports |  |  |  | |  |  | |  | Financial allowances, CMI card | |  |
|  |  |  |  |  | |  |  | |  |  | |  |
|  | Medical aspects | Professional aspects |  |  | |  |  | |  |  | |  |
|  |  |  | Reference source |  | |  |  | |  |  | |  |
|  | Synthesis |  | Eligibility |  | |  |  | |  | PCH | |  |
|  |  |  |  | |  | | |  | | |  |  |
|  |  |  |  |  | |  |  | |  |  | |  |
| GEVA | | | | PPC | | | | | | | | |

Additional criteria

Role of the multidisciplinary team

Meetings of the multidisciplinary team are organised by the MDPH. It includes internal and external medical or para-medical staffs (doctors, nurses, occupational therapists), psychologists, social workers as well as stakeholders from education, employment and vocational training sectors and administrative staff. This includes partner services or organisations that can have an agreement with the MDPHs as experts in accordance with their expertise domains and the needs of the situation:

* Doctors from maternal and infant protection;
* School psychologists;
* Partner teachers;
* Professional insertion councillors;
* Professional and social actors;
* Persons in charge of medico-social institutes and services;
* Representatives of associations of disabled persons.

The corresponding organisations include the French department, the Ministry for education and research, the public employment agencies, NGOs, hospitals, medico-social institutes and services.

According to the needs of the situation, self-employed people can also take part in the multidisciplinary team.

The team is composed according to the specific situation of each applicant and to the main services the person can apply for, considering:

* Educational or medico-social care choice for children;
* Services to children;
* Social support, career choice and medico-social care choice for people aged 16 to 25;
* Benefits, employment and professional insertion regarding adults;
* The disability compensation benefit;
* Medico-social care choices for adults.

Professionals from the national education ministry represent 37% of the partnership in the assessment process in terms of time spent by external experts in multidisciplinary teams’ meetings,[[20]](#footnote-21) that is to say 37% of the time spent by experts that are not employed by the MDPHs and who have a partnership with them is spent by people employed by the Ministry for Education.

The team can visit the home of the applicant, speak with him/her as well as with the parents and/or his/her legal representative when he/she is minor or incapacitated.

There is a regulatory reference document used to collect all the elements making it possible for the multidisciplinary team to evaluate the person’s situation, GEVA (Guide d’évaluation des besoins et compensations),[[21]](#footnote-22) which makes it possible for the members of the multidisciplinary teams of the MDPHs to exchange views on the basis of a shared vocabulary, to gather elements of all the life domains (family, housing, training, professional, medical, psychological, functional, existing supports) and to build an interactive relationship with the people concerned or with their representatives by phone or on a face-to-face basis in the MDPHs’ offices or at the person’s home. Assessment is divided within several sections that describe individuals’ activity limitations and restriction of participation as defined by ICF[[22]](#footnote-23) to assess persons’ eligibility for the disability compensation benefit (prestation de compensation du handicap, PCH).[[23]](#footnote-24) The sections include:

* the human environment of the person, his/her family situation and his/her social and financial situation;
* the physical environment (housing, access to proximity services ...);
* education and employment issues;
* medical information (diagnosis enabling the description of the origin of the limitations and restrictions, treatments settled, consequences of the treatments on activity and/or participation);
* psychological assessments made before, be they based on scales or tests, or a clinical interview.

The exchanges with the applicant or his/her representatives enable the expression of the person’s expectations that are expressed in the synthesis part.

Situations are discussed during meetings of the multidisciplinary team. The disability is assessed according to 3 criteria:

* the impairment;
* the consequences of the impairment on the activity and on the social life of the person in his/her environment;
* the link between the impairment and the restrictions in her/his social life.

The needs are assessed on the basis of this multidimensional approach of disability as well as on the basis of personal factors (non-environmental) and of the life project of the person.[[24]](#footnote-25)

The needs evaluation aims at providing advice concerning course or career choices, or social-medical care, recommendations, supports and/or benefits of any nature in order to meet the needs of the person.

Within the scope of the needs assessment, disability scales, reference sources or guides (which are described later on) may be used in addition to the application form and to the medical certificates, especially to assess the eligibility for financial allowances or cards that give some financial advantages (see case study 3). The assessment of eligibility for some of these benefits require the calculation of an incapacity rate, as defined above, which is based on a scale. In any case, the criteria that are taken into account by MDPHs, even to calculate the incapacity rate, are multidimensional.

The proposals are then made by the multidisciplinary team within a PPC, which is addressed to the person. The PPC aims at communicating with the applicant as well as his/her relatives and other persons of his/her close environment like carers. The applicant has the possibility to approve or reject the proposals made by the multidisciplinary team within a 15-day period.

Then the PPC and the answers of the applicant are transmitted to the Commission for the rights and autonomy of disabled persons (Commissions pour les droits des personnes handicapées, CDAPHs),[[25]](#footnote-26) which are set up by the MDPHs. A CDAPH is constituted in every MDPH. It includes representatives of:

* the departmental administration;
* the State services and public administrations;
* social security (health insurance, family allowance office …);
* trade-unions;
* associations of pupils’ students (representatives are suggested by the associations and proposed by the regional educational officer);
* organisations in charge of the management of institutes or services intended for disabled people;
* specialised training;

as well as

* members proposed by the departmental director in charge of the social cohesion who are chosen among people suggested by associations of disabled persons and of their families;

At least one third of its members are representatives of disabled people or of their families appointed by representative associations and they also include one member of the departmental advisory council for disabled people.

Representatives of the organisations[[26]](#footnote-27) that administer medico-social institutes or offices, that is to say public or private institutions coming under social policy, sit on the board of the commission with an advisory capacity. The president of the commission is designated every two years by its members. MDPHs play the role of secretary inside the CDAPHs.

**The CDAPH makes decisions on persons’ right to:**

* a course/career choice,
* socio-medical care,
* a support or service,
* financial allowances.

The CDAPH meets in a plenary session. If needed, the MDPH’s executive commission can decide to organise the CDAPH in local or specialised sections. Depending on the situation, the commission decides to hear the person or his/her legal representative or not. If yes, the applicant may be asked to give his/her opinion upon the proposals of the multidisciplinary team. The disabled person or his/her legal representative have to be informed at least two weeks before about the date and place of the session and the possibility to be represented.

The decision is made by the commission or by the section by vote of its members on the bases of a simple majority. In case of equality of votes, the president has the casting vote, except when the decision deals with the disability compensation benefit for which the majority of the voices belong to the representatives of the departmental council.

Decisions are made for a minimum duration of one year and for a maximum duration of five years. They are notified by the president to the applicant or to a representative as well as to relevant organisations related, like schools, socio-medical institutes. A 4-month silence from the CDAPH is equivalent to a refusal.[[27]](#footnote-28)

It is possible to appeal against a decision of the commission within a 2-month period following the decision (4-months in case of an absence of response). Depending on the situation, appeal can be made before the Social security technical litigation jurisdiction or before the administrative tribunal.

Decisions that can be appealed against in before the Social security technical litigation[[28]](#footnote-29) jurisdiction are the ones about:

1. a course choice for a child or of a teenager or about measures intended to favour his/her school/professional and social insertion;
2. the designation of service providers corresponding to the needs of a child/adolescent or involved in the re-education, the education, the rehabilitation of a disabled person;
3. the assessment of the incapacity rate;
4. the assessment of the criteria leading to the Disability compensation benefit;
5. the assessment of the working capacity;
6. the support of disabled persons aged over 60 years living in institutions.

Within the procedure, every person or organisation is entitled to appeal against decisions made. The appeal procedure does not lead to the suspension of the decision, except in situations where the applicant himself/herself or his/her legal representative appeals against a decision such as described in point 2. above.[[29]](#footnote-30)

A law intended to modernise the French justice system[[30]](#footnote-31) will suppress the courts which are currently in charge ofthe technical litigation of the Social security. Such litigation will be looked after by a social hub which will be organised inside designed high Courts.[[31]](#footnote-32)

Decisions described in points 1. and 2. above can be appealed in before the administrative jurisdiction when related to the official recognition as a disabled worker or to the placement in an adapted or a sheltered workshop, or in a professional re-education centre or service.26

In case of a disagreement, the applicant or his/her legal representative may also ask the director of the MDPH to involve a qualified person to propose conciliation measures. The list of qualified persons is made by the MDPH. The designated person has access to the applicant’s file apart from the medical documents. The conciliation process may last 2 months at most. During this period, the deadline for an appeal procedure is suspended. The qualified person produces a report, which is transmitted to the applicant and to the departmental Home for disabled people. The notification puts an end to the suspension of the appeal deadline.

The observations of the qualified person cannot be used in the rest of the assessment procedure without the consent of the parties involved.

### Sources of official guidance and assessment protocols

#### Details of the guidance provided to assessors, methodology used, questionnaires, assessment scales, pro-forma used in the process, etc, with links to sources where available.

The National solidarity fund for autonomy (Caisse nationale de solidarité pour l’autonomie, CNSA), is a public organisation in charge of, among others, funding the allowances in favour of aged people losing their autonomy and in charge of disabled people. They also coordinate the network of MDPHs. The National solidarity fund for autonomy plays a central role in the diffusion of best practice in terms of enrolment, assessment of needs, organisation and follow-up of decisions and in the improvement of knowledge about the needs of disabled people. It provides tools and methods about assessment for the decisions made in the MDPHs as described later in this report.

Proforma medical certificate[[32]](#footnote-33) and guides[[33]](#footnote-34) aiming at explaining how to complete them are available on the internet site as well as on the one of the French Government.[[34]](#footnote-35)

The National solidarity fund for autonomy also offers pedagogical books aiming at supporting stakeholders in implementing accurately the planned assessment procedures. These may aim at sharing a common understanding of an issue or a topic or to clarify it. They may focus on the assessment of functional capacities that underpins the entitlement to the allocation of the disability compensation allowance (PCH)[[35]](#footnote-36) or on how to use the assessment tool GEVA.[[36]](#footnote-37)

It also provides scientific and technical guides to disseminate results of studies and research and give references and assessment tools to partners; for example: a general guide[[37]](#footnote-38) including the incapacity[[38]](#footnote-39) scale, the criteria that have to be considered as well as references for its evaluation, which make it possible to assess the eligibility for financial allowances and cards, a guide to support MDPHs in the scope of the provision of technical aids,[[39]](#footnote-40) guides supporting the assessment of the needs of people suffering from psychological problems,[[40]](#footnote-41) [[41]](#footnote-42) learning difficulties such as dyslexia, dyspraxia, etc.,[[42]](#footnote-43) personality disorders, autism problems,[[43]](#footnote-44) epilepsy,[[44]](#footnote-45) a guide about the assessment of access to human help.[[45]](#footnote-46)

### Implementation and outcomes

#### Evidence of the practical implementation, including where possible the number of persons assessed, average waiting times, and the assessment outcomes.

In 2016, 4,4 million applications were made to the MDPHs, which represents a general increase of 4.5% compared with the previous year.[[46]](#footnote-47) [[47]](#footnote-48)

Applications rose in eight departmental homes for persons with disabilities out of 10. The general increase is lower in 2015 compared with 2014.

The average duration for processing was of 4 months and 15 days for applications concerning adults and of 3 months and 17 days for applications concerning children.

There are high differences between the departments with a 1/11 ratio between the minimum (1 month) and the maximum (11 months) duration as far as adults are concerned and a 1/7 ratio as far as children are concerned (1 to 7 months).

4,53 million decisions were made by the MDPHs, which represents an increase of 6% compared with the preceding year. Yet the number of waiting applications has stabilised, which reflects an improvement in the efficiency of the process. The rate of positive answers to applications varies in accordance with the types of service or benefit and with the French departments. However, it has kept decreasing for several years both for delivering services and mainstream benefits. On average 2% of the decisions are appealed against.

### Evaluation – fitness for purpose

#### Analysis of the strengths and weaknesses of the assessment method, including where possible evidence from official or independent evaluations, studies etc. For example, the balance of medical and non-medical input, cost-effectiveness, administrative burden, claimant experience, compatibility with the CRPD. Please indicate if there is a regular evaluation of the assessment method and, if so, who carries that out. Please include references to evaluations which have been carried out.

CNSA made a synthesis of the activity reports of the MDPHs[[48]](#footnote-49) in 2016.It pointed out

* the improvement in the knowledge of assessment criteria and of the assessment processes by assessors;
* the simplification of the assessment process relating to the award of parking and invalidity cards intended for aged persons;
* an increasing diversity of health, welfare, education and career propositions made to adults;[[49]](#footnote-50)
* the difficulty to enrol disabled people in the special settings provision run by the socio-medical sector, due to the limitation of the number of opportunities in sheltered workshops but also to the lack of information about the applicants’ career histories;
* an increase in applications concerning children with language difficulties that do not meet the disability eligibility criteria;
* an improvement in the understanding by assessors of the role of teacher assistants and an improvement of the assessment of children’s schooling due to significant cooperation work between partners;
* improvement in formalising the definition and implementation of individual educational plans (plans personnalisés de scolarisation, PPS);[[50]](#footnote-51)
* a strengthening of the partnerships between the MDPHs and the organisations involved in employment and vocational training;
* difficulties in employing doctors to assess the situations of applicants;

By contrast with a bio-medical approach to disability that would relate primarily to persons’ inabilities linked to his/her impairment, the holistic assessment operated by MDPHs aims to assess the person’s needs for support in the light of the interaction of his/her impairment and his/her environment and in relationship to his/her rights. The aim of such an assessment is to compensate the disadvantages of impairment as regards social participation and human rights and to enable each (disabled) person to enjoy all human rights and fundamental freedoms, which is in compliance of the aims of the Commission for the rights of disabled people, especially with regard to articles 9 and 10.

Such an assessment aims at:

* enabling people’s social participation by compensating the disadvantages resulting from a need for support;
* connecting decisions made with individuals’ wishes, expectations and life plans;
* involving individuals and their families in the process.

The general department of social affairs (inspection générale des affaires sociales) published a report in 2012 (see case study 2) in which the assessment processes conducted by the MDPHs, especially the one related to the calculation of an incapacity rate, were compared with the ones driven by Social security funds. It noticed that the assessment criteria of MDPHs were stricter than the ones of the medical services of the health insurance funds, which is a factor a limitation of costs. Moreover, the guide and scales used by the MDPHs to assess the incapacity rate are adapted to the assessment of large volumes of applications, which is factor of efficiency.

However, operating costs of MDPHs 2.5 M € more than the receipts in 2016. They increased by 3.6%.

Many departmental homes hire their own employees. They also have partner institutions, which make professionals available and which charge or do not charge the departmental homes for the part of the corresponding salaries. The number of uncharged external contributions has decreased by 2.6% in Euros whereas the charged ones have increased by 4.23%. The decrease in uncharged contributions led to an increase of internal staff costs of 12.4% between 2014 and 2016. The global contribution of the partners keeps increasing.

Despite the increasing number of applications, the MDPHs managed to avoid delays in implementing the assessment process. However, many MDPHs express their worries about their ability to continue to be able to respect the deadlines for assessing individuals’ needs as well as to maintain a sufficient level of quality.

Financial means do not increase in accordance with the increase in the number of applications nor with a context where the MDPHs have to spend time in adapting to important changes in disability policies and in expectations from the applicants.

In 2017 the CNSA launched a self-diagnosis by the MDPHs using a questionnaire and a reference source concerning:

* admission strategy, educational and career choice opportunities and support in the definition of the “life project”;
* assessment of needs and elaboration of the PPCs;
* the management of decision-making processes both at MDPH and at the commissions for the rights of disabled people level;
* the management of disputes;
* the implementation and the follow-up of decisions;
* management and monitoring at a territorial level.

Effectiveness is compared with the one of the process of invalidity assessment in the next section (case study2).

In September 2018, a survey was launched by CNSA in order to evaluate the satisfaction of claimants.[[51]](#footnote-52) It was submitted to representatives of associations of disabled persons. It includes five “identification” variables that will be cross-tabulated: the MDPH the person applied through, the age of the claimant, the situation of the respondent as regards the claimant, if the claimant has already received a notification from the MDPH and the reason for applying. Respondents are asked to evaluate their global satisfaction and the quality of reception and to express their needs, the way they feel their rights are addressed, etc. They are also invited to express themselves about the improvements that could be made.

The results of the first survey should be available in early 2019.

### Promising practice

#### If the case study includes examples of good practice, of interest to the EU and other countries, then identify and explain the most promising elements. Please indicate if disabled peoples’ organisations have been involved in developing or evaluating the assessment method.

From the synthesis of the activity reports, the National Fund for Solidarity launched many improvements works at all the stages of the assessment and decision processes, including:

* improvement in the users’ information, use of partners’ services to improve the level of information;
* implementation of a graduated assessment (pre-assessment, assessment);
* improvements in training for front desk clerks, which translates into an improvement of their competences as well as an increased skilfulness, specific training;
* giving the opportunity to users to follow the progress of their applications online;
* harmonisation of the investigation procedures among the MDPHs;
* implementation of pre-selection in order to orientate the application in the adapted process;
* implementation of graduated processes (short process/several level process);
* progress in the quality of assessment and answers due to:
  + the standardisation of processes,
  + the improvement of the quality of information tools,
  + the monitoring of the relationships with the applicants (individualised answers built in cooperation with the partners) and with the partners,
  + the implementation of a quality management process,
  + the reinforcement of human resource management,
  + the mutualisation and training of professionals,
  + the use of externalised services,
  + the reinforcement of the territorial-level assessment processes and
  + an improvement of the admission.
* assessors’ training;
* the reduction of the number of renewal applications as a result of the extension of the duration of the validity of the services/benefits allocated;
* the possibility to increase the flexibility and efficiency of assessment procedures:
  + relocate a CDAPH at a municipal level instead of a departmental level or
  + organise it with members with specific competences and/or with limited staff, in accordance with the specificity of the applications.
* creation of tools for the development of a shared culture among stakeholders and supporting effective cooperation;
* increase the level of impartiality of decisions taken by presenting anonymously the applications to the commission;
* improvement in quality of the follow-up of the implementation of decisions made
* improvement of the quality of the information provided to the applicants concerning the decisions made by the commission;
* re-organisation of the mediation/conciliation/appeal process and formalisation of the processes;
* increase the appropriateness of the common system of information departmental homes developed at national level;
* involvement of users as experts in decision making processes.[[52]](#footnote-53)

## Case study 2: Eligibility for invalidity pension.

An outline of the key features of this assessment process is provided in Part 1 of this report (see **Example 3**).

### Detailed description of the assessment process

#### The main stages of the process, from application to decision, and appeal against decision, detailing the types of professionals involved and their responsibilities. Please also describe the administrative arrangements and the roles of the different institutions involved in the process. Please indicate what role the person being assessed plays in the procedure.

The application can be proposed by the health care insurance fund or asked for by the concerned person.

In case the fund itself notices that the insured person who has been compensated in the scope of a temporary incapacity meets the conditions to be eligible, a letter is sent to him/her to inform him/her about the decision to allocate an invalidity pension to him/her.

In other cases, the person can apply for a pension scheme.

To apply for a pension, a person has to complete a form providing administrative information, which targets his/her identity and the assessment of his/her income. He/she can also ask his/her doctor to send a medical certificate to the fund’s doctor.

The fund informs the applicant on decisions made within 2-month. In the situation where no answer is given within this period the application is supposed to be rejected.

It is possible to appeal by applying again within a 12-month time period after a refusal or through a dispute appeal in front of an Invalidity Dispute Court. The Court is taken by sending a recorded letter within a 2-month period following the contested decision. The applicant can choose a doctor to sit at the Court. He/she is asked to attend the Court by a simple mail at least 8 days before the audience. In the scope of the modernisation of the French justice system, the social hub of the high court will be competent.

The invalidity is assessed by a doctor who is an employee of the health insurance fund. The assessment focuses on the changes in the person’s health and on the consequences of this change on his/her working capacity or on his/her income opportunities. According to law, it has to take into account remaining working capacity, general state, the age and physical and mental faculties as well as his/her skills and professional skills and qualifications. The health insurance fund’s doctors combine the assessment of the health state, the age, and the capacity of the person to train.[[53]](#footnote-54) They combine medical criteria and socio-professional ones to evaluate a functional invalidity rate related to general activity limitation, and a professional invalidity linked with the possibility to perform a job in the future. There is no official scale to refer to.

### Sources of official guidance and assessment protocols

#### Details of the guidance provided to assessors, methodology used, questionnaires, assessment scales, pro-forma used in the process, etc, with links to sources where available.

As explained as an introduction to part 2, there is some confusion in the Social security code between invalidity and “permanent incapacity” and both are assessed by the doctors of the Social security system that is very complex. If the aim of the assessment between the two differs clearly (incapacity rate in one case, classification of the person in a category of invalidity in the other one), the assessment process is not clearly differentiated.

Around 10 scales exist to support the assessment of the consequences of an altered health situation, depending on the aim that is pursued: compensate a functional damage (cases of work injuries and professional diseases) or provide a replacement income (invalidity). Yet as far as invalidity as defined above[[54]](#footnote-55) is concerned, without any link to any disease or injury due to work, the general principle of assessment consists in not using any scale, be it to assess the state of health or the employability. Assessment consists of deciding on the crossing of thresholds and is based on broad categories of invalidity:

* cat. 1: for claimants still able to work: 30% of the former wage;
* cat. 2: for claimants unable to work: 50% of the former wage;
* cat. 3: for claimants unable to work and in need of a personal assistance for everyday living activities: 50% of the former wage + a 40% add-on as an attendant supplement).

The reason for this is that most of the time, invalidity is applied for after long periods of temporary incapacity and attempts to adapt the person’s work station in partnership with the fund’s doctor who has been following the evolution of the state of health of the applicant.

However, in practice, scales can be used in particular situations or for particular pathologies. For example, in some cases, the fund’s doctors of the general Social Security system use the scale that they usually use to assess “permanent incapacity”.

It is important to note that France is the unique OECD[[55]](#footnote-56) country having so many invalidity systems:

* a general system (corresponding to the general Social Security system), a system for farmers and around 10 systems for employees of the public sector (corresponding to special Social security systems), plus;
* 200 complementary systems (corresponding to professional branches) for employees of the private sector, and many individual and personal complementary insurance systems. As described in art R434-32 of the Social Security code, the assessment of the “permanent incapacity” (as defined in introduction of case study 1)[[56]](#footnote-57) following a work accident or a professional disease is based on a legal impairment scale which specifies that the doctor must consider:

1. the nature of the impairment;
2. the general health and social condition of the person;
3. the age of the person;
4. the physical and mental capacities compared to the average abilities at the same age;
5. the professional competences and qualification of the persons in the light of employment opportunities.

The “permanent incapacity” scales that are annexed to article R434-32 of the Social Security code and used to assess the consequences of work accidents[[57]](#footnote-58) and professional diseases[[58]](#footnote-59) are mainly based on medical indicators and are rather precise.

In the case of injuries, the assessment is made once they have been consolidated and is based on their side effects. These notions are explained in the related annex of R434-32 of the Social Security code. The incapacity scales included in the annexes propose average rates corresponding to the nature of impairments; the doctors are invited to modulate these rates in accordance with the other criteria: general health state, age, mental and physical capacities. The annex also explains the calculation method in case of multiple infirmities resulting from the same accident and how former infirmities should be considered.

In the case of injuries, the assessment is made once they have been consolidated and is based on their side effects. These notions are explained in the related annex of article R434-32.

For example, in the case of fingers amputation, the rate depends on whether the hand was the dominant one or not. The annex explains how to determine the dominant hand. It also explains that in the case of amputation of several fingers, the synergy between the different amputations has to be assessed as multiple infirmities but that the total of the “permanent incapacity” calculated should not exceed the one for an amputation of the whole hand. Then it provides indicative rates depending on the finger affected, on whether the hand is dominant or not and on the number of phalanxes affected.

Some work branches benefit from specific invalidity scales in the scope of their specific Social Security systems (see above), such as the one of civil servants working in hospital[[59]](#footnote-60) and in counties, which are based on medical criteria only emphasising the type and level of impairment. Otherwise, some personal individual complementary systems refer to functional scales.[[60]](#footnote-61) However, scales remain indicative.

In addition to this high level of complexity making invalidity compensation dependent on the insurance system in place (general, including specific ones, and complementary), the definition of invalidity vary as a function of the status of the applicants: the assessment for invalidity of persons of the private sector is based on a strict definition of invalidity (incapacity to have a job corresponding to one’s professional skills) whereas the one for independent workers corresponds to the incapacity to practice his/her professional activity and the one for civil servants to the incapacity to hold one’s post.[[61]](#footnote-62)

### Implementation and outcomes

#### Evidence of the practical implementation, including where possible the number of persons assessed, average waiting times and the assessment outcomes.

A survey about invalidity issues in France[[62]](#footnote-63) shows that the ratio (number of persons getting the benefit/number of active people on 1st January) rate was 0.26% of the active population in 2015.

### Evaluation – fitness for purpose

#### Analysis of the strengths and weaknesses of the assessment method, including where possible evidence from official or independent evaluations, studies etc. For example, the balance of medical and non-medical input, cost-effectiveness, administrative burden, claimant experience, compatibility with the CRPD. Please indicate if there is a regular evaluation of the assessment method and, if so, who carries that out. Please include references to evaluations which have been carried out.

The current assessment processes lead to confusion and to a significant heterogeneity of the assessment’s mechanisms and procedures. Also, the management of the invalidity compensation is expensive, as highlighted by the general department of social affairs (inspection générale des affaires sociales) in 2012.[[63]](#footnote-64) According to the latter, the methods of assessment of the incapacity rates that are currently used by the medical services of the health insurance funds lead to imprecise and diverse assessments. It also pointed out the fact that the assessment of the consequences of invalidity on the working capacity needed not only medical expertise but also additional expertise. For example, even if the doctors of the funds have been following applicants until the time they apply for an invalidity pension, they do not necessarily know all the job opportunities that might be offered by the job market to the applicants.

Also the medical scale like the ones that are used in the assessment of the incapacity rate after a professional disease or a work accident (“permanent incapacity” rate), which are based on medical and functional criteria only, that is to say on deficiencies and on the incapacities they lead to, do not correspond to the CRPD’s concerns with regard to the equality of rights, especially regarding social participation, as they do not consider the environment of the person and the consequences of his/her impairment on his/her social participation.

Improvements in the assessment of an invalidity would require a better monitoring of the implementation of existing tools within the health care insurance network. Furthermore, the report of the general department of social affairs concluded with the necessity to harmonise assessment scales in relationship to the legal definition of disability. The controller and auditor office insisted on the necessity for the Social security to develop networking, especially with stakeholders in charge of disability (MDPHs) and the services devoted to health at work.

### Promising practice

#### If the case study includes examples of good practice, of interest to the EU and other countries, then identify and explain the most promising elements. Please indicate if disabled peoples’ organisations have been involved in developing or evaluating the assessment method.

In its report on invalidity assessment, the department for social affairs proposed to harmonise the assessment process by defining common reference (scales/questionnaires) among stakeholders that articulate the assessment of functional capacities in their medical and in their social dimensions as well as the assessment of employability.

The department for social affairs pointed out the fact that the ability to work that is expected to be assessed in the scope of invalidity assessment should be connected to employability, which connects access to work with individuals’ condition and means required to enable them to access to work rather than to the opportunities offered by the job market. Assessment of invalidity should therefore take a holistic approach by taking into account the interaction between the impairment of the person and his/her environment, like the assessment of disability. The department for social affairs considers the assessment of the incapacity rate as it is carried out by MDPHs (see case study 3) as a reference. The calculation of the incapacity rate can be a second step in the evaluation of the needs of the person once he/she has been assessed as disabled by an MDPH, which may be completed with an analysis of the employability of the person (third step) in case the incapacity rate is situated between 50% and 80% (in case the incapacity rate is over 80% there is no need for any assessment of employability of the person). The calculation of an incapacity rate and the potential assessment of the employability of the person makes it possible to decide on the allocation of some financial allowances, especially the Benefit for disabled adults (AAH, Allocation pour adultes handicapés) and/or invalidity cards. The calculation of the incapacity rate is based on a global analysis of deficiencies, activity limitations and disadvantages in terms of social inclusion, which may be completed with an analysis of the employability when the incapacity rate is not severe enough to be considered as a barrier to employability itself. Actually, the Disability benefit for adults meets the same objective as an invalidity pension: compensate a loss of income or an impossibility to get incomes because of an impairment. The difference is that the invalidity pension addresses people who have financially contributed to the social security fund before; in case a person has not contributed or not enough, AAH makes it possible to be guaranteed a minimum income, which meets the engagement to ensure the right to an adequate standard of living and social protection in the scope of the CRPD (Article 28). In addition, the concept of employability has been integrated in the assessment of eligibility for AAH and the General inspection for social affairs considered the assessment process for the eligibility to AAH as an efficient process.

On the other hand, the medical scale like the ones that are used in the assessment of incapacity rate after a professional disease or a work accident, which are based on medical criteria only, are better known by the funds’ doctors. This as well as the precision of the criteria used seem to be the unique positive aspects of the practice.

Indeed, the general department for social affairs recommended using the same assessment tools as the MDPHs to assess invalidity because of the holistic aspect of the assessment and of the possibility that it offers to deal with large amounts of applications.

A promising practice would consist of the evolution of the assessment process of invalidity including a harmonisation of the tools used linked with a holistic approach like MDPHs’ one, as recommended by the General inspection of social affairs. This would be in favour of a simplification of the French system of assessment processes, making them more efficient and more compliant with the CRPD.

## Case study 3: Assessment for long-term care benefits as defined in MISSOC.

An outline of the key features of this assessment process is provided in Part 1 of this report (see **Example 2**).

### Detailed description of the assessment process

#### The main stages of the process, from application to decision, and appeal against decision, detailing the types of professionals involved and their responsibilities. Please also describe the administrative arrangements and the roles of the different institutions involved in the process. Please indicate what role the person being assessed plays in the procedure.

The processes aiming at assessing the eligibility for long-term care benefits are not managed by a unique administration. The process allowing for an access to financial resources linked to the payment for a caring person (supplement to employ a person permanently, majoration pour tierce personne, MTP) in addition to an invalidity pension or to a work injuries and occupational diseases benefits managed by the Social security system. The special education supplement for a disabled child (Supplément d’allocation d’éducation de l’enfant handicapé) and the disability compensation benefit (prestation de compensation du handicap, PCH) are managed by the MDPHs and the allowance for loss of autonomy (Allocation personalisée d’autonomie, APA) is managed by the French decentralised administration (conseils départementaux).

To ask for the **MTP**, people whose invalidity or permanent incapacity has already been assessed by the health insurance fund[[64]](#footnote-65) and who have not reached the age of retirement have to complete an application form[[65]](#footnote-66) aimed at assessing their resources, including their properties. The application form has to be sent to the health care insurance fund with all required evidence of resources. Building upon this information as well as upon the assessment of functional incapacities, the health care insurance system assesses the applicants’ eligibility. The functional incapacities necessitating the assistance of a person and the possible danger of the person for himself/herself or for others are assessed by the health care insurance fund’s doctor.

Administrative decisions can be appealed as follows:[[66]](#footnote-67)

* An amicable settlement of the litigation has to be tried first. It has to be addressed to the Health insurance fund within a 2-month deadline following the decision notification;
* After this 2-month period it is possible to go to court for Social security matters;
* Medical decisions can also be appealed in front of the court for incapacity within a 2-month period following the decision notification.

In the scope of the modernisation of the French justice system, the social hub of the high court will be relevant.

In order to apply for a **special education supplement for a disabled child**, the process is the one described in Case study 1 to assess his/her disability. In addition to the assessment of the disability situation, an incapacity rate has to be calculated and also the child’s disability has to be rated by the multidisciplinary team, taking into account the impairment, its functional consequences and its consequences in terms of social inclusion. The consequences in terms of social inclusion are assessed with regard to the autonomy in performing the tasks a person has to perform towards herself/himself in her/his daily life.

In addition, the multi-disciplinary team has to assess the necessity to get human support, and to evaluate additional medical expenses in relation with the impairment not covered by the health insurance fund. The analysis is based on the medical certificate that is provided as part of every application (see case study 1), possibly completed by other medical elements like medical exam results or/and reports on medical consultations on the one side and of a questionnaire, which is fulfilled by the child’s family with corresponding evidence, on the other.

The family allowance fund (Caisse d’Allocations familiales, CAF) controls the volume of human aid actually required, can modulate the amount of the complementary benefit which has to allocated and ask the CDAPH to re-assess a situation.

In order to apply for the **disability compensation benefit** (PCH), the process starts as the one described in the Case study 1 to assess the person’s disability. In addition to the assessment of the disability the multi-disciplinary team has to decide the difficulty to perform specific activities in relation with daily and social life and to evaluate the need for human help, for technical aids, for housing layouts as regards these difficulties. The definition of the needs takes into account the life plan of the person. They are formalised in the PPC.

To apply for an **allowance compensating for a loss of autonomy**, an older person has to ask for a form from the city council, from the administrative department or from a local information point intended for old people. Then he/she has to apply to the administrative department with documents concerning his/her identity, his/her resources and his/her property. The department services must acknowledge receipt of the application within a 10-day period. A medico-social team composed of at least one doctor evaluates the degree of loss of autonomy and supportive relatives’ needs for respite. They use existing scales depending on the nature of the needs assessed (applicant’s needs/relatives’ needs). During the instruction, the team visits the person at home; a relative or a doctor can attend the visit. If the person is assessed as being in a 1 to 4 category out of 6, an aid plan is proposed to him/her.

The categories are as follows:

* **GIR 1**- Persons staying in bed or in a chair, whose mental capacities have been **affected seriously and who need permanent personal assistance and supervision.**
* **GIR 2 - Persons staying in bed or in a chair, whose intellectual capacities have not been entirely affected and who need assistance in most ‘Activities of Daily Living’ (ADLs). Persons whose mental capacities have been altered but who can move around.**
* **GIR 3 - Persons who have kept mental autonomy, who have partly kept their locomotor autonomy but who need daily personal assistance in body hygiene.**
* **GIR 4 - Persons who are not autonomous in mobility but who can move inside home once they have stood up, who need occasional assistance to dress and undress. Persons who do not have any locomotor difficulty but who need assistance for corporal hygiene and meals.**
* **GIR 5 - Persons who need punctual assistance for corporal hygiene and meals.**
* **GIR 6 - Persons who have not lost any autonomy in ADLs.**

The plan draws up an inventory of the needs and expenses required to help the person to stay at home. The medico-social team also proposes an assessment of the needs of the aiding relatives.

The applicant accepts or asks for modifications within a 10-day deadline after the proposition. The department administration notifies its decision within a 2-month period after the reception of the application. In case no decision is made within this time, a fixed sum is allocated until the final decision.

It is possible to appeal for a decision concerning the allowance for loss of autonomy, either through a conciliation procedure or through a formal commission for social help. For a conciliation procedure, the applicant has to contact the departmental services by recorded mail within a 2-month deadline after the notification of the contested decision. The commission proposes a solution within a 1-month period and the departmental services make a decision within a 15-day period.

An appeal can be made to the departmental commission for social aid within a 2-months period after the notification of the contested decision. It is possible to be heard by the commission with the assistance of a person or of an organisation. The decision of the commission can be appealed in front of the central commission for social aid within a 2-month period after the notification of the decision of the departmental commission. It is also possible to be heard by the central commission with the assistance of a person or of an organisation.

The decision of the central commission can be appealed in front of supreme court.

**Sources of official guidance and assessment protocols**

#### Details of the guidance provided to assessors, methodology used, questionnaires, assessment scales, pro-forma used in the process, etc, with links to sources where available.

**The need for the assistance of a person** and the possible danger to the person are assessed by the health care insurance fund’s doctor. This assessment is explained by law: art D. 434-2 of the Social Security code[[67]](#footnote-68) provides a list of 10 ADLs and a circular[[68]](#footnote-69) explains that the doctor determines which ADLs the person cannot perform alone case by case, in the person’s living environment, by favouring an assessment at the applicant’s home. The circular also specifies that the inability to perform a task alone will be taken into consideration only if it is an absolute inability.

In order to assess the performance of ADLs, doctors are expected to answer the following questions:

1. Can the applicant stand and lay alone?
2. Can the applicant sit and stand from a chair alone?
3. Can the applicant move alone inside his/her home unaided by another person with or without a wheelchair?
4. Can the applicant sit and unaided stand in/from his/her wheelchair?
5. Can the applicant stand unaided in case of fall?
6. Could the applicant leave home unaided in case of danger?
7. Can the applicant dress and undress without any personal assistance?
8. Can the applicant eat and drink unaided?
9. Can the applicant go to the toilet unaided?
10. Can the applicant put on his/her orthopaedic device unaided (if any)?

In order to help the multi-disciplinary team to assess the child’s incapacity rate, which is necessary to assess the eligibility for the **supplement for disabled child** that can be awarded only to families already eligible for the AEEH, the National solidarity fund for autonomy provides a guide, which is used by MDPHs to assess the incapacity rate of any person.

Calculation of an incapacity rate (see example 1):

This represents the second step in the process, once a person has been recognised as disabled (case study 1), and before the assessment of the eligibility for the supplement. Impairments are sorted in 8 categories: intellectual and behaviour-related, psychological, hearing, language-related, visual, visceral, motor, aesthetic. The guide explains the assessment of the incapacity rate is based on the interaction between a deficiency, resulting incapacities on a functional plan and resulting social disadvantages in the person’s environment, provides ranges of incapacity rates in accordance with its severity as well as reference criteria to assess the severity of the incapacity for every type of impairment and criteria to assess in order to evaluate the range of incapacity rate corresponding to the applicant, and gives a list of ADLs whose performance is taken into account in assessing the severity of such or such incapacity. The severity is based on the severity of the impairment itself and on its consequences in the person’s life.

The ranges depend on the type of impairment, 3 to 5 categories of severity are defined for each type of impairment.

For example, for children suffering from intellectual and behavioural troubles, the guide provides 3 ranges:

* incapacity rate below 50%: moderate incapacity that not notably obstructs the daily life of the child or his/her family;
* incapacity rate between 50% and 80%: important incapacity that notably obstructs the daily life of the child and his/her family;
* incapacity rate between 80% and 100%: major incapacity that seriously obstructs the daily life of the child and his/her family.

The criteria that experts should consider are:

1. Awareness and intellectual capacities

* Self-awareness, capacity to be aware of the identity of the body.
* Body schema, space and time orientation.
* General ability to acquire knowledge and competences, clinical and psychometric test.

1. Relationship and behaviour

* With the members of his/her family.
* With other relatives.

In particular, the expert should pay attention to:

* the capacity to make relationships in playing and learning situations;
* the capacity to adapt to the usual environment and to new situations.

1. Communication

The capacity of the child to produce and give a message and to receive and understand messages is evaluated:

* Understanding the language of relatives;
* Non-verbal expression;
* Oral expression;
* Writing, reading.

1. Daily life

How far is the child autonomous in eating, in washing, if he/she controls his/her bladder, bowels, autonomy in sleeping.

1. Autonomy and socialisation

Inside the family: participation in domestic activities, in activities of the members of the family;

Apart from the family:

* capacity to get around on one’s own, use public transportation;
* capacity to stay safe in ordinary daily life situations;
* capacity to adapt to usual children’s environment: nursery, drop-in centre for young children, school, day-care centre.

Additional criteria:

The expert should also take into account the medical diagnostic which should refer to a national or international classification. He/she also should consider the age of occurrence of the deficiency, its changeability, possible therapies, set therapies, the consequences of set therapies, how often the child goes to hospital. Also, he/she has to consider other functional consequences of the deficiency if any.

Assessment of the eligibility for the supplement for disabled child:

In order to assess the need for help of a person and/or additional medical expenses not covered by the health insurance in relation to the impairment, which will determine the eligibility for the supplement for disabled child, the National solidarity fund for autonomy provides a guide.[[69]](#footnote-70) It includes:

* points of reference to compare the situation of the child with other children of the same age in terms of autonomy,
* elements to take into account in the evaluation of human help required,
* elements to take into account in the evaluation of additional medical expenses, and
* rules defining the mode of calculation of the part of the supplement that will be awarded to the family in case the child spends a part of his/her time in a residency that is fully financed by the health insurance fund.

It also provides the questionnaire that has to be completed by the family.

Experts are expected to assess:

* The link between the disability of the child and the need for personal assistance;
* The link between the disability of the child and additional expenses supported by his/her family.

This assessment is based on autonomy criteria that are assessed in the scope of the medical certificate included in the application file:

* Orientate in time (inside days) and places;
* Oral communication;
* Behave logically and appropriately;
* Stand, lie and go to bed, move from bed to armchair/armchair to bed;
* Move inside with or without a wheelchair;
* Move outside;
* Use public transportation;
* Drink and eat;
* Dress and undress;
* Wash;
* Control one’s bowel and bladder.

As far as the **disability compensation benefit** is concerned, activities are assessed in the scope of the GEVA (see Case study 1) in a specific part dedicated to the assessment of the eligibility for this support.

The National solidarity fund for autonomy provides a specific reference source to assess the access to the disability compensation benefit, which is annexed to the Social and family code.[[70]](#footnote-71) It includes a definition of the criteria that are taken into account to assess the eligibility for the fund (notions of absolute and severe difficulty, activities related to in reference to WHO’s classification) and the specification of the norms to which the team has to refer to in order to assess the severity of the disability. It also displays other criteria that must be taken into account to assess and evaluate the person’s needs.[[71]](#footnote-72)

The PCH is granted to persons whose disability generates, permanently or for a foreseeable period of one year minimum, an absolute difficulty to perform at least one basic Activity of Daily Living (ADL) or severe difficulty in performing at least two basic ADLs out of a list of 19 ADLs in the following 4 domains: personal care, mobility, communication, control and orientation. Corresponding capacities, which are part of the capacities evaluated in the scope of GEVA are the following in order to evaluate the assistance needs and their levels, are evaluated as follows, in reference with ICF:

0: no difficulty;

1: light difficulty;

2: moderate difficulty;

3: serious difficulty;

4: absolute difficulty;

9: not applicable.

Related ADLs are marked as bold in the list below.

The difficulty is considered as absolute when the activity cannot be performed at all; it is considered as serious when it is realised with difficulty and with a result which is altered in comparison with what is normally expected. The reference document specifies that the evaluation of the difficulty should be made in reference to a person of the same age without any heath problem and without taking into account any assistance. It should take into account evolving symptoms such as pain, discomfort, fatigue, etc that can exacerbate the difficulty.

The criteria assessed in order to evaluate the person’s needs are the factors that limit activities and participation or that make them easier, as well as the person’s life plans.

The activities that are analysed to assess and evaluate the assistance needs of the person are as follows:

1. General, social life:
   1. **Orient oneself in space;**
   2. **Orient oneself in time;**
   3. Pay attention;
   4. Make decisions;
   5. Take initiatives;
   6. **Manage his/her safety;**
   7. Respect norms of life;
   8. Have social relations in respect of norms of society;
   9. **Manage one’s behaviour in social relations;**
   10. Relationship with peers;
   11. Affective and sexual relationship.
2. Mobility, handling:
   1. **Stand up, go down, sit down;**
   2. **Make transfers;**
   3. Change fulcrum;
   4. Keep sitting;
   5. Keep standing;
   6. **Walk;**
   7. **Move inside the home, outside;**
   8. Use stairs;
   9. Use public transportation;
   10. Use a particular vehicle;
   11. Drive a vehicle;
   12. **Grip with the dominant hand;**
   13. **Grip with non-dominant hand;**
   14. **Have fine motor skills;**
   15. Have two-hand coordination;
   16. Raise and carry objects.
3. Self-care
   1. **Wash;**
   2. Take care of one’s body;
   3. **Evacuate the bowel and bladder and use collecting device;**
   4. **Dress and undress;**
   5. **Eat and drink;**
   6. Take care for one’s own health.
4. Communication
   1. **Speak;**
   2. **Hear and understand;**
   3. **See and identify;**
   4. **Use communication techniques and devices;**
   5. Understand a simple sentence;
   6. Steer a conversation;
   7. Produce and receive non-verbal messages.
5. Home life and daily life
   1. Make one’s shopping;
   2. Prepare a simple meal;
   3. Clean;
   4. Do laundry;
   5. Take care of one’s family;
   6. Manage one’s budget, do paper-work;
   7. Live alone in an independent home;
   8. Have informal relationships;
   9. Take part in communitarian, social and civic life;
   10. Go on holiday.
6. Knowledge and learning;
   1. Read;
   2. Write;
   3. Calculate;
   4. Acquire competences;
   5. Use competences.

Depending on whether the applicant is a child or an adult, tasks in relation with scholarship or with work are also assessed.

For each of those activities, experts have to tick a box corresponding to the effectiveness of performing the activity according to four levels of performance:

A: activity performed alone, without any personal assistance and without any difficulty;

B: activity performed partially with personal assistance and/or at a request and/or with some difficulty;

C: activity performed with repeated personal assistance and/or under continuous supervision and/or with regular difficulty;

D: activity not performed.

They also have to mention the environmental factors that favour or limit the effectiveness of their performance according to the following:

H: human environment;

T: technical environment;

L: housing;

S: services;

A: animal environment.

Experts are invited to add observations and after each of the eight parts they have to describe precisely the assistance already existing and the applicants are expected to evaluate their related satisfaction.

In order to evaluate the level of personal assistance or technical assistance required, the reference source describes:

* the purposes the service is intended to deliver and
* the expected type of service which is meant to be provided to the person (for example the maximum time normally required to help a person to dress);
* the factors that can impact the nature and/or the volume of required service and possibly;
* the part which can be funded by the benefit.

The National solidarity fund for autonomy provides a form[[72]](#footnote-73) enabling an assessment of the degree of dependence of the applicant in order to assess his/her eligibility for the **allowance for loss of autonomy** and the level of the allowance needed, as well as a guide to support the assessment. The assessment is based on the evaluation of the capacity of the person to perform 10 corporal and mental activities and 7 home and social activities as well as on the expression of the person’s needs, a short description of the person’s social and of his/her home environment and of his/her administrative and financial situation that takes the form of tick boxes. The 10 corporal and mental activities (discriminating activities) are used to place the person into a category and the 7 home and social activities (illustrative activities) give information to assess the needs of the person globally. Personal assistance already provided by relatives or professionals also has to be described. The form is part of the reference source, which enables the collection of all the information required to make an aid plan.

ADLs are evaluated using a grid called AGGIR.

The corporal and mental activities are as follows:

* transfers (standing, lying, sitting);
* inside moving (inside home, reaching the letter box);
* wash (face, torso, upper limb), shave and brush one’s hair, wash intimate parts, lower limb and feet;
* evacuate the bowel and bladder;
* dress (top, middle, bottom);
* feeding (help oneself, eat);
* give alert with appropriate tools;
* outside moving (in the street);
* orientation in space and time;
* consistency of communication and behaviour.

The home and social activities are the following ones:

* cooking;
* follow a medical treatment;
* clean;
* use transportation;
* hobbies;
* shopping;
* budget management and paper-work.

These activities are evaluated on the basis of their performance:

S: does not perform spontaneously;

T: does not perform totally (does not perform the whole components of the activity);

C: does not perform correctly;

H: does not perform usually (each time it is necessary, or the person needs it).

### Implementation and outcomes

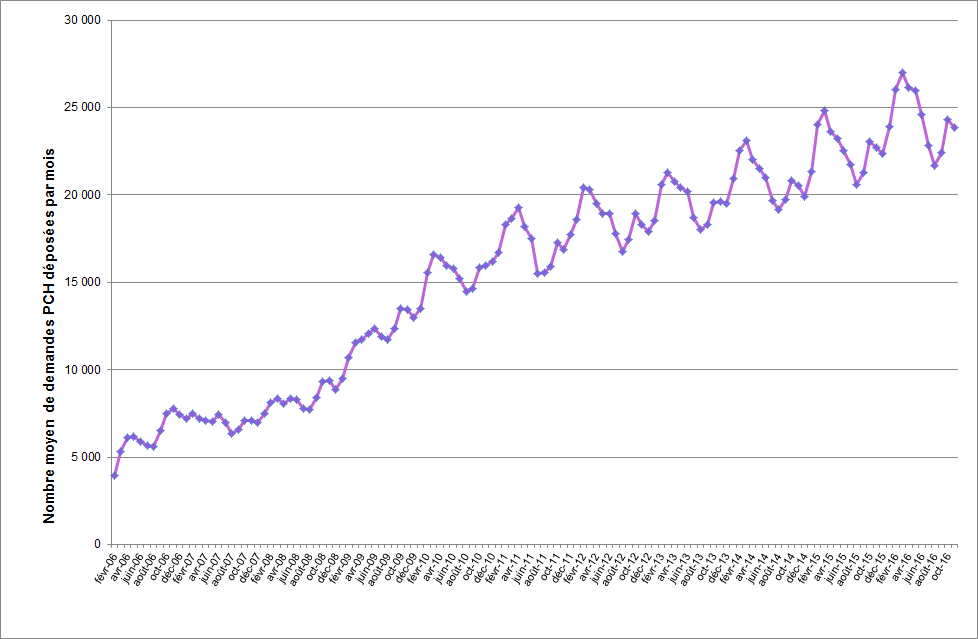
#### Evidence of the practical implementation, including where possible the number of persons assessed, average waiting times and the assessment outcomes.

In 2016, MDPHs assessed 292,700 applications for PCH, 12.5% of which related to children. 284 000 decisions were made by CDAPHs. Applicants increased by 8% in one year. In 2016, MDPHs awarded the benefit to around 128 500 applicants. The rate of positive answers has been decreasing for years.

The number of decisions related to PCH represented around 7% of the decisions made by CDPHs, which has been stable since 2010.

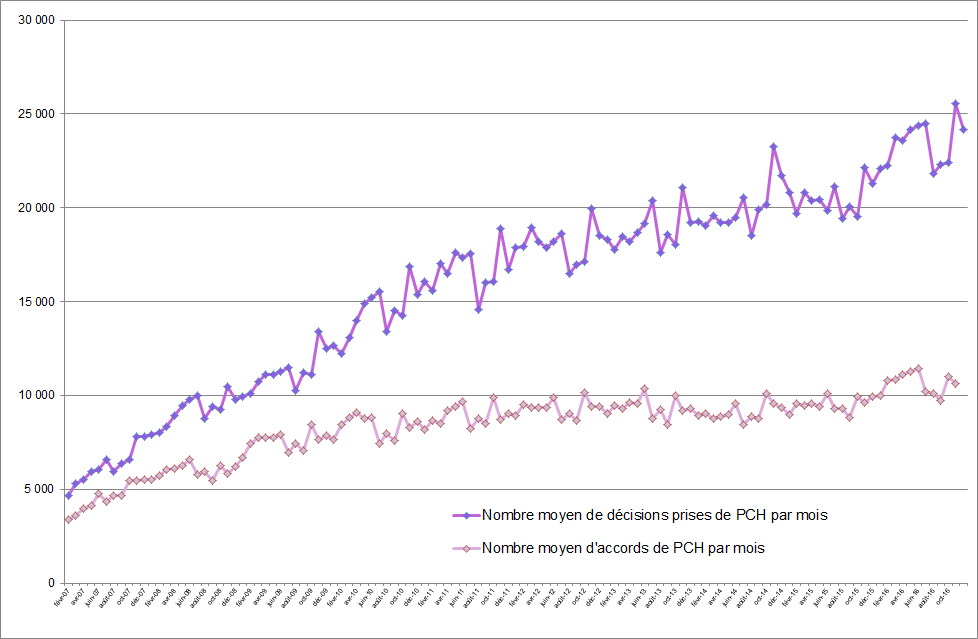
In 2015, the benefit was paid to 184 000 people (+ 6% since December 2015).

Number of monthly applications for PCH between 2006 and 2016



*Source: Monthly survey related to PCH, CNSA, estimated data.*

Number of decisions made related to PCH between 2006 and 2016



*Source: Monthly survey PCH, CNSA, estimated data.*

### Evaluation – fitness for purpose

#### Analysis of the strengths and weaknesses of the assessment method, including where possible evidence from official or independent evaluations, studies etc. For example, the balance of medical and non-medical input, cost-effectiveness, administrative burden, claimant experience, compatibility with the CRPD. Please indicate if there is a regular evaluation of the assessment method and, if so, who carries that out. Please include references to evaluations which have been carried out.

The assessment process to decide the eligibility for funding of support of a person does not include social participation concerns. Only the assessment of the eligibility for the National solidarity fund for autonomy includes social life criteria. However, the analysis is based on what is considered as a “normal” social life, in an environment that is limited to the person’s home environment; the point at issue is the possibility of the person to stay at home instead of choosing a medico-social institute, rather than the social participation. It does not take into account the life plans of the person. Moreover, the teams of the health insurance funds lack a multidisciplinarity.

The assessments that are driven by the MDPHs better meet the concerns of the CRPD, especially the equality of social participation, and ensure the multidisciplinarity of the approach of disability that is required to meet the engagements of article 9 of CRPD in particular.

In its synthesis about the MDPHs’ activity reports, the National solidarity fund for autonomy (CNSA) noticed:

* the improvement of the knowledge of the eligibility criteria by the assessors concerning the Disability Compensation benefit;
* the complexity of the Disability Compensation benefit as regards the applicant;
* the difficulty to manage cost estimates and to get information from professionals in the scope of the assessment of the eligibility for the Disability Compensation benefit.

### Promising practice

#### If the case study includes examples of good practice, of interest to the EU and other countries, then identify and explain the most promising elements. Please indicate if disabled peoples’ organisations have been involved in developing or evaluating the assessment method.

No evaluations of the assessment method related to long-term care benefits were found. The grids used provide more or less standardized tools to assess the necessity of assistance and deal with large amounts of applications. The assessment conducted by MDPHs and departments make it possible for the applicants and their relatives to express their needs. This, as well as a comprehensive analysis of the family, social and home environments of the persons, enables the evaluation of their needs in terms of nature and volume.

# Summary and conclusion

#### Taking an overview of national approaches to disability assessment and including any recommendations. Considering the range of examples identified in Part 1, and the analysis of selected cases in Part 2, please reflect on the extent to which these various assessment systems are integrated (or not). For instance, to what extent are similar application processes, similar assessment methodology, or similar administrative processes used to determine eligibility for different benefits? How could the system in your country become more integrated, cost-effective, or result in an easier applicant journey through the processes? Please also indicate any explicit references to the CRPD in the assessment procedure or whether the CRPD has been taken into account in determining the assessment procedure to be used.

The MDPHs have implemented multidisciplinary teams capable of making a holistic assessment of disability as defined by WHO. When the point at issue is the assessment of eligibility for allowances or for cards giving some financial advantages, 2 processes tend to oppose each other:

* the ones conducted by MDPHs, which do not only consider the medical and the functional (activity limitation) aspects of disability, but also the impairments’ disadvantages in terms of social participation as well as the environmental and personal context (for example, the job market and the training in case of an assessment of the work capacity);
* the ones conducted by the medical health care funds, which tend to concentrate on medical and functional aspects and may appear subjective and lead to unequal treatments in the absence of any common standardised tools (case of invalidity).

Medical indicators, as the ones used to assess the “permanent incapacity” rate are rather precise, whereas the incapacity rate criteria that are used by the MDPHs to assess the eligibility for the disability allowances are based on broader categories of disability.

It is noticeable that the MDPHs lack medical competences and that the medical health care funds lack a multidisciplinary approach. Moreover, the general Inspection for social affairs noticed the necessity to make processes more homogenous. They made a comparison between the assessment process of the eligibility for an invalidity pension as conducted by the Health insurance funds and the process of the eligibility for the Disability compensation benefit as driven by MDPHs and noticed that the processes of the MDPHs’ assessments tended to be stricter than the ones conducted by the insurance health care funds. In addition, the assessment processes undertaken by the MDPHs better meet the concerns of the CRPD; all the processes tend to keep in mind all the aspects of disability, that is to say the impairment itself, the consequences of the impairment on the activity and on the social life of the person in his/her environment and the link between the impairment and restrictions in the person’s life.

Merging the two main systems would seem to be beneficial to a more integrated system, offering a holistic assessment in all the processes as well as the multidisciplinarity required. In addition, it would reduce the complexity of the disability compensation system as well as its readability by users.[[73]](#footnote-74) Finally such an integrated system should be a factor of efficiency and of improvement of cost-effectiveness as regards operating costs.

Such a merging would require high competences in management.

|  |  |
| --- | --- |
| Services/allowances | Number of persons assessed in thousands in 2016 |
| Invalidity or priority cards | 818 |
| Benefit for disabled adults | 616 |
| Recognition as a disabled worker | 603 |
| Parking card | 563 |
| Career and training choice | 414 |
| Disability compensation benefit | 295 |
| Education allowance for a disabled child | 242 |
| Course choice | 216 |
| Additional Invalidity Allowance (supplement) | 198 |
| Choice of medico-social institute for adults | 154 |
| School assistance | 132 |
| Others | 145 |
| Transport to school | 101 |
| Total | 4,396 |

*Source: CNSA, sample : 61 MDPHs, year 2016, data calculated on the basis of the repartition of the applications given by CNSA.*

1. The calculation of an incapacity rate linked with disability is not directly connected with the processes whose description was asked for in the scope of the three case studies, but it is an intermediary step between the admission to a status of disabled person and the assessment of the eligibility for some specific allowances. It is described as such in the scope of case study 3. [↑](#footnote-ref-2)
2. Law of 11 February 2005 for equal rights and opportunities, participation and citizenship of disabled persons, article 2 which led to article 114 of the code for social action and family, <https://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006074069&idArticle=LEGIARTI000006796446&dateTexte=&categorieLien=id>. [↑](#footnote-ref-3)
3. This definition is rather similar to the one of the International Classification of Functioning, Disability and Health (ICF), which defines disability as an umbrella term for impairments, activity limitations and participation restrictions. According to ICF, Disability is the interaction between individuals with a health condition (e.g. cerebral palsy, Down syndrome and depression) and personal and environmental factors (e.g. negative attitudes, inaccessible transportation and public buildings, and limited social supports). [↑](#footnote-ref-4)
4. Article L321-1 of the Social security code <https://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006073189&idArticle=LEGIARTI000031686676&dateTexte=&categorieLien=id>. [↑](#footnote-ref-5)
5. In the current report, permanent incapacity will be put into quotation marks when it refers to the definition of the Social Security code, that is to say when it refers to a permanent reduction of working capacity linked with an accident or a disease due to work. Art. R434-32 of the Social Security Code; <https://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006073189&idArticle=LEGIARTI000006750381&dateTexte=&categorieLien=cid>. [↑](#footnote-ref-6)
6. In the Social Security code, “permanent incapacity” is also called invalidity, with a mention of disease or injury due to work. In the current report, “invalidity” will be used in reference to permanent incapacity not due to work. [↑](#footnote-ref-7)
7. Article L341-1 of the Social security code, <https://www.legifrance.gouv.fr/affichCode.do?idSectionTA=LEGISCTA000006156093&cidTexte=LEGITEXT000006073189>. [↑](#footnote-ref-8)
8. All people belong to the public system of Social Security, which is a system of regulations hedging life events and circumstances that can have financial consequences (disease, maternity, death, work accident, disease due to work, oldness, family) and a management system. The public system is divided into four systems, among which the general (Social Security) system, the social system for famers, and a group of special systems. Concretely, the Social Security public system is represented by many funds. [↑](#footnote-ref-9)
9. Articles L1226-2 and next of the Labour code, <https://www.legifrance.gouv.fr/affichCodeArticle.do?idArticle=LEGIARTI000006900966&cidTexte=LEGITEXT000006072050>. [↑](#footnote-ref-10)
10. This is a compilation of legislative and regulatory articles aiming at setting the funding, the organisation, the functioning and the general legal regime of Social security. French law is mainly based on laws and rules that are codified. [↑](#footnote-ref-11)
11. It may allow people who would get a low-level Work injuries and occupational diseases benefit to get a Disability compensation benefit in addition (see Task Social protection). [↑](#footnote-ref-12)
12. See article L114-1 of the Code for social action and family modified consequently, <https://www.legifrance.gouv.fr/affichCodeArticle.do;jsessionid=546F860B65255FD9BD2F2A5963921B28.tplgfr27s_3?idArticle=LEGIARTI000006796449&cidTexte=LEGITEXT000006074069&categorieLien=id&dateTexte>=. [↑](#footnote-ref-13)
13. <https://www.formulaires.modernisation.gouv.fr/gf/cerfa_13788.do>. [↑](#footnote-ref-14)
14. Note: 3 administrative departments (Calvados, Charente-Maritime, Meurthe-et-Moselle) offer the opportunity to apply online. [↑](#footnote-ref-15)
15. <https://www.formulaires.modernisation.gouv.fr/gf/cerfa_15695.do>. [↑](#footnote-ref-16)
16. <http://www.cnsa.fr/actualites-agenda/actualites/formulaire-et-certificat-medical-les-nouveaux-documents-de-demande-a-la-mdph>. [↑](#footnote-ref-17)
17. Allocation adulte handicapé, see case study 1 and country report on Social Protection and Article 28. [↑](#footnote-ref-18)
18. Allocation éducation enfant handicap, see case study 3 and country report on Social Protection and Article 28. [↑](#footnote-ref-19)
19. Carte mobilité inclusion (« Mobility-inclusion » card). Three different CMI exist, one is related to invalidity (CMI invalidité, Invalidity-CMI, see example 6), one is related to a priority access to public services, event and places and another one is related to parking. [↑](#footnote-ref-20)
20. Source: CNSA, synthèse des rapports d’activité des MDPH 2016, <http://www.cnsa.fr/documentation/synthesera_mdph.pdf>. [↑](#footnote-ref-21)
21. <https://www.cnsa.fr/documentation/geva_graphique-080529-2.pdf>. [↑](#footnote-ref-22)
22. Classification of Functioning, Disability and Health. [↑](#footnote-ref-23)
23. See case study 3. [↑](#footnote-ref-24)
24. The medical aspects of disability as well as their consequences on the activity of the person and his/her participation in social life, the personal factors and the environmental factors are components of the concept of “functioning, disability and health” in the WHO’s Classification of Functioning, Disability and Heath (ICF). However, the ICF is referred to by the MDPHs only to evaluate the eligibility for the Disability Compensation Benefit (see example 2 and case study 3) in general, which aims at compensating for additional living costs, and to the part intended to fund human help in particular. The rating of the different domains referred to are included in the GEVA. [↑](#footnote-ref-25)
25. Article R241-24 of the Social Security code, <https://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006074069&idArticle=LEGIARTI000022069534>. [↑](#footnote-ref-26)
26. Associations, foundations. [↑](#footnote-ref-27)
27. <http://handicap.gouv.fr/les-aides-et-les-prestations/maison-departementale-du-handicap/article/la-commission-des-droits-et-de-l-autonomie-des-personnes-handicapees>. [↑](#footnote-ref-28)
28. Article L142-2 of the Social security code <https://www.legifrance.gouv.fr/affichCodeArticle.do;jsessionid=AE40FDA413760FF5204B2CD7AC33E35C.tplgfr44s_2?idArticle=LEGIARTI000033975694&cidTexte=LEGITEXT000006073189&categorieLien=id&dateTexte=20190101>. [↑](#footnote-ref-29)
29. Article L241-9 of the Social action and family code, <https://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006074069&idArticle=LEGIARTI000006797053&dateTexte=&categorieLien=cid>. [↑](#footnote-ref-30)
30. Law **n° 2016-1547 of 18th November 2016,** <https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000033418805&categorieLien=id>**.**  [↑](#footnote-ref-31)
31. Article L211-16 of the Court organisation code,

    <https://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006071164&idArticle=LEGIARTI000033425626&dateTexte=&categorieLien=cid>. [↑](#footnote-ref-32)
32. <http://www.cnsa.fr/actualites-agenda/actualites/formulaire-et-certificat-medical-les-nouveaux-documents-de-demande-a-la-mdph>. <https://www.formulaires.modernisation.gouv.fr/gf/getAnnexe.do?cerfaAnnexe=15695-1&cerfaFormulaire=15695>.

    <https://www.formulaires.modernisation.gouv.fr/gf/getAnnexe.do?cerfaAnnexe=15695-2&cerfaFormulaire=15695>. [↑](#footnote-ref-33)
33. [https://www.formulaires.modernisation.gouv.fr/gf/getNotice.do?cerfaNotice=  
    52154&cerfaFormulaire=15695](https://www.formulaires.modernisation.gouv.fr/gf/getNotice.do?cerfaNotice=52154&cerfaFormulaire=15695). [↑](#footnote-ref-34)
34. [https://www.formulaires.modernisation.gouv.fr/gf/getNotice.do?cerfaNotice=  
    52154&cerfaFormulaire=15695](https://www.formulaires.modernisation.gouv.fr/gf/getNotice.do?cerfaNotice=52154&cerfaFormulaire=15695). [↑](#footnote-ref-35)
35. <http://www.cnsa.fr/documentation/CNSA-cahiers_pedagogiques-08-10-2013_vdef.pdf>. [↑](#footnote-ref-36)
36. <http://www.cnsa.fr/documentation/cahierpedagogique_geva_interieur-mai-2015-complet.pdf>. [↑](#footnote-ref-37)
37. <http://www.cnsa.fr/documentation/CNSA-Technique-eligibilites-web-2.pdf>. [↑](#footnote-ref-38)
38. As defined in the scope of disability. [↑](#footnote-ref-39)
39. <http://www.cnsa.fr/actualites-agenda/actualites/acces-aux-aides-techniques-le-guide-dappui-aux-pratiques-des-mdph-est-publie>. [↑](#footnote-ref-40)
40. <http://www.cnsa.fr/documentation/actes_colloque_handicaps_dorigine_psychique_2009.pdf>. [↑](#footnote-ref-41)
41. <http://www.cnsa.fr/documentation/web_cnsa-dt-troubles_psy-2016.pdf>. [↑](#footnote-ref-42)
42. <http://www.cnsa.fr/documentation/cnsa-dt-dys-web-corrige-mai_2015.pdf>. [↑](#footnote-ref-43)
43. <http://www.cnsa.fr/documentation/cnsa-dta-2016_web.pdf>. [↑](#footnote-ref-44)
44. <http://www.cnsa.fr/documentation/cnsa-dt-epilepsie-02-10-2016.pdf>. [↑](#footnote-ref-45)
45. <http://www.cnsa.fr/actualites-agenda/actualites/le-guide-sur-lacces-a-laide-humaine-de-la-pch-est-publie>. [↑](#footnote-ref-46)
46. <http://www.cnsa.fr/documentation/synthesera_mdph.pdf>. [↑](#footnote-ref-47)
47. Note: CNSA provides data about the repartition of the applications by types of support, which suggests that every application is intended to benefit from a specific support, whereas in fact an application can be intended to benefit from several applications, so that the sum of the applications by types of support should not be equal to the total number of applications. [↑](#footnote-ref-48)
48. <http://www.cnsa.fr/documentation/synthesera_mdph.pdf>. [↑](#footnote-ref-49)
49. For example, specialised teaching units have been externalised from the socio-medical sector since 2015, social life support services (services d’accompagnement à la vie sociale, SAVS) and socio-medical services (Service d’accompagnement medico-social pour adultes handicapés, [SAMSAH](http://www.unapei.org/+-SAMSAH-+.html)) have been developed. These services are defined by CDAPHs, can be provided in an ordinary or in a sheltered environment, at home or where the disabled person has social, training or professional activities, or even inside a socio-medical institute. They aim at keeping or restoring the family, social, schooling, university of professional links of disabled people. [↑](#footnote-ref-50)
50. A PPS is a document defining the needs of a disabled child or adolescent at school. It is part of PPC and the CADPH uses it as a reference document in order to make decisions concerning the schooling of the applicant. [↑](#footnote-ref-51)
51. <https://www.cnsa.fr/actualites-agenda/actualites/le-reseau-des-mdph-se-dote-dun-outil-denquete-pour-evaluer-la-satisfaction-des-usagers>;

    <http://www.mdph77.fr/library/e038cb08-e4ea-4746-baa8-251ecbdbcb86-QUESTIONNAIRE-Satisfaction-des-usagers-de-la-MDPH.pdf>. [↑](#footnote-ref-52)
52. <http://www.cnsa.fr/documentation/reponse_accompagnee_-_rapport_de_capitalisation_-juillet_17.pdf>. [↑](#footnote-ref-53)
53. Art. L. 341-3 of the Social Security code. See also Prof. Marion Del Sol, EN3S, <https://en3s.fr/articles-regards/51/DEL-SOL.pdf>, June 2017. [↑](#footnote-ref-54)
54. Case study 1. [↑](#footnote-ref-55)
55. General department of social affairs, 2012 report. [↑](#footnote-ref-56)
56. Here we develop on the criteria of “permanent incapacity” whereas it is not the same thing as invalidity as defined by MISSOC because these criteria are sometimes used by experts to assess invalidity as there is no specific scale to assess invalidity apart from the general criteria described before, aiming at crossing thresholds. [↑](#footnote-ref-57)
57. Annex I of art. R434-32, <https://www.legifrance.gouv.fr/affichCode.do?idSectionTA=LEGISCTA000006126942&cidTexte=LEGITEXT000006073189>. [↑](#footnote-ref-58)
58. Annex II of art. R434-32, <https://www.legifrance.gouv.fr/affichCode.do?idSectionTA=LEGISCTA000019325196&cidTexte=LEGITEXT000006073189>. [↑](#footnote-ref-59)
59. <https://www.cnracl.retraites.fr/sites/default/files/pdf/Baremeinvalidite_1_-2.pdf>. [↑](#footnote-ref-60)
60. <http://www.iijusticia.edu.ar/docs/Bareme.htm>. [↑](#footnote-ref-61)
61. This is legally the definition of unfitness. [↑](#footnote-ref-62)
62. Etude de l’invalidité, CNRACL 2015. [↑](#footnote-ref-63)
63. L’évaluation de l’état d’invalidité en France: réaffirmer les concepts, homogénéiser les pratiques et refondre le pilotage du risque, May 2012, <http://www.ladocumentationfrancaise.fr/var/storage/rapports-publics/124000682.pdf>. [↑](#footnote-ref-64)
64. For the process of invalidity assessment, see case study 2. [↑](#footnote-ref-65)
65. <https://www.ameli.fr/sites/default/files/formualires/97/s4151.pdf>. [↑](#footnote-ref-66)
66. <http://info-handicap.com/la-majoration-pour-tierce-personne-mtp-2018/>. [↑](#footnote-ref-67)
67. Circular DSS/2C/2013/236 of 12the 2013 relating to the input modalities of supplementary benefit for recourse to a third party: <https://www.legifrance.gouv.fr/affichCodeArticle.do?idArticle=LEGIARTI000027267037&cidTexte=LEGITEXT000006073189>. [↑](#footnote-ref-68)
68. <http://circulaire.legifrance.gouv.fr/pdf/2013/06/cir_37105.pdf>. [↑](#footnote-ref-69)
69. <http://www.cnsa.fr/documentation/CNSA-Technique-eligibilites-web-2.pdf>. [↑](#footnote-ref-70)
70. Annex 2-5, <https://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006074069&idArticle=LEGIARTI000018780363&dateTexte=&categorieLien=cid>. [↑](#footnote-ref-71)
71. These activities and factors are rated in the GEVA document. [↑](#footnote-ref-72)
72. <https://www.cnsa.fr/documentation/referentiel_apa_20_20170424.pdf>. [↑](#footnote-ref-73)
73. For example, in the current system, invalidity is assessed by Social security funds whereas invalidity “mobility-inclusion” cards are awarded by MDPHs. [↑](#footnote-ref-74)