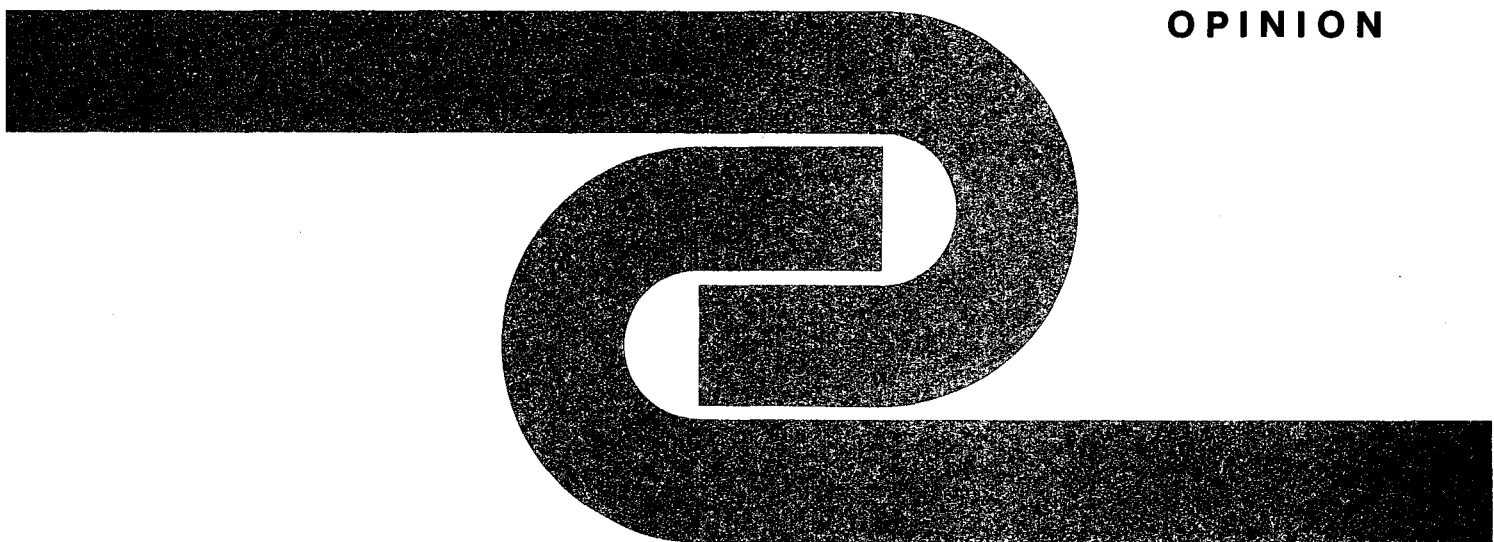


**ECONOMIC AND SOCIAL COMMITTEE
OF THE EUROPEAN COMMUNITIES**

**PROBLEMS
OF THE
HANDICAPPED**

OPINION



Brussels 1981

The European Communities' Economic and Social Committee, chaired by MrTomàs ROSEINGRAVE, approved this opinion at its 189th Plenary Session, which was held from the 1st to the 3rd July 1981.

The preliminary work was done by the Section for Social Questions, having Mr Gwilym Prys DAVIES as rapporteur.

ECONOMIC AND SOCIAL COMMITTEE
OF THE EUROPEAN COMMUNITIES

O P I N I O N

PROBLEMS
OF THE
HANDICAPPED

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C O N T E N T S

<u>PREFACE</u>	<u>Pages</u>
<u>OWN-INITIATIVE OPINION OF THE ECONOMIC AND SOCIAL</u>	
<u>COMMITTEE ON THE SITUATION AND PROBLEMS OF THE</u>	
<u>HANDICAPPED</u>	
A. INTRODUCTION	1
B. COMMENTS	6
1. Preventive Measures	6
2. Primary Prevention	7
- Children	8
- Adults	11
- Work Accidents	12
- Drugs	14
3. Secondary Prevention	15
- Children	15
- The Very Old	16
4. The Links between Poverty and Handicap	17
5. Rehabilitation	18
6. Medical Rehabilitation	20
7. Education	20
8. Vocational Rehabilitation	23
9. Obtaining Employment	25
- Subsidies and Sheltered Employment	29
- The Organisation of rehabilitation and employment measures	32
10. Community Services	32
- Identification	32
- Housing	33
- Access and Transport	35
- Domiciliary Services	35
- Day Centres	36
- Residential Care	36
11. The Financial Needs of Disabled People	37
12. Financing Community initiatives for Disabled People	39

	<u>Pages</u>
C. SUMMARY OF RECOMMENDATIONS	40
1. General	40
2. Prevention	41
3. Rehabilitation	43
4. Education	43
5. Vocational Rehabilitation.....	44
6. Employment	44
7. Community Services	47
8. The Financial Needs of Disabled People	48
9. Financing Community Initiatives for Disabled People	48
10. International	••• 48
REFERENCES	49

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PREFACE

In this International Year of Disabled People, the Economic and Social Committee of the European Communities has, on its own initiative, prepared and adopted an Opinion on the subject. In this Opinion, the Committee, which is an assembly of representatives of interest groups in the 10 Member States, makes a number of recommendations to the other institutions of the European Community as well as to the Governments of the Member States.

One of the problems that disabled people have always faced is that public bodies, whether they be national Governments or local authorities or the European Community have always tended to focus on one aspect of their handicap at a time with the result that often they find their total or overall needs ignored and the help offered, although well-intentioned, proves largely ineffective. This Opinion therefore covers the problems of disability from the cradle to the grave; indeed starting even before the cradle. For the prevention of handicap which includes proper care and advice during pregnancy is an indispensable part of any policy. At each age therefore it examines both the needs of those who are handicapped and the particular risks of those who are not handicapped today but may well be tomorrow. For the child born handicapped the prime needs may be for early assessment, adequate family support and immediate access to therapy and education. For the vast majority of children who happily are born safe and sound, the need is for inoculation against diseases about which we run the risk of becoming too complacent and as he or she grows up, protection against the dangers of modern life, both at home and on the roads, which kill and maim thousands of children every year. The same principles of provision for the handicapped and the prevention of handicap apply throughout adulthood and into old age.

When considering the employment situation of disabled people in the Community it is necessary to look at two factors and knit them together. The first factor is the general employment situation and the second is the specific problems of disabled people themselves.'

When we talk of employment in the Community today, unfortunately we talk of unemployment. Millions of our compatriots are enduring enforced idleness which we all acknowledge to be an evil- and about which we are all rightly concerned. The Community, and the Commission in particular, has expressed its worry about unemployment rates among the young and specific action has been taken. It should be pointed out that although unemployment is a misfortune for anyone it is a particular tragedy for someone who is severely disabled. This is because the opportunities for living a fulfilled life are unfortunately so much less for severely disabled than the able-bodied. The severely disabled person who is out of work may well become a prisoner of his home, stuck in front of a television day by day. So although it is natural and right for the Community to have concentrated on youth unemployment because of the social problems which we all fear, it is to be regretted that it has been unable to put a similar effort into the individual personal problems that arise when a disabled person is unemployed. This is not to imply that it has done nothing; but so far the Community has not been seen to give disabled people the degree of priority which as individuals they deserve.

One final objective of the Opinion, which was adopted unanimously, is to have an effect on attitude - the attitude of ordinary people to their disabled fellow citizens and, in particular, to their disabled fellow workers. Many of

the problems of disabled people unfortunately still arise because of the prevalence of ignorance and myths about disability. It is hoped that one of the achievements of the International Year will be to greatly reduce such ignorance and enable disabled people to be welcomed not only by employers but by fellow employees as valuable and valued members of the work force.

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OWN-INITIATIVE OPINION OF THE ECONOMIC AND SOCIAL COMMITTEE -
ON THE SITUATION AND PROBLEMS OF THE HANDICAPPED

A. Introduction

The World Health Organization estimates that throughout the world at least one person in ten is disabled by physical, mental or sensory impairment. The lives of these 500m people and their families are often characterized by poverty, frustration, isolation and dependency. In recognition of their needs in 1976 the General Assembly of the United Nations declared 1981 the International Year of Disabled People and established five principal objectives for the Year (1):

N.B. For the figures in brackets, see list of references at the end of the brochure.

- to help disabled persons in their physical and psychological adjustment to society;
- to promote efforts to provide to disabled persons proper assistance, training, care guidance, and work opportunities for full integration into society;
- to encourage studies and research projects designed to facilitate participation of disabled persons in daily life;
- to educate and inform the public of the rights of disabled persons to participate fully in economic, social and political aspects of life;
- to promote effective measures for the prevention of disability and for the rehabilitation of disabled persons.

Another objective is to further the implementations of the 1971 Declaration of the Rights of Mentally Retarded Persons (2) and the 1975 Declaration on the Rights of Disabled Persons (3), both adopted by the UN General Assembly.

In advance of the International Year Rehabilitation International has drawn up in a Charter for the 80s (4) international priorities for action during the decade. The four aims of the Charter are:

- to launch in each nation a programme to prevent as many impairments as possible, and to ensure that the necessary preventive services reach every family and every person;
- to make certain that every person with a disability, and every family which includes a member with a disability, receives whatever rehabilitation services and other support and assistance may be needed to reduce the handicapping effects of disability and to make possible for each person a full life and a constructive role in society;
- to take all necessary steps to ensure the fullest possible integration of and equal participation by people with disabilities in all aspects of the life of their communities;
- to disseminate information about people with disabilities and their potential, and about disability, its prevention and treatment, so as to¹ increase public knowledge and awareness of these problems and of their importance to every society.

The Committee fully subscribes to the aims enunciated above. The purpose of this Opinion is to draw attention of Member States and the Commission to specific actions which the Committee believes are necessary to realize these aims within the Community during 1981 and the coming years. If there is one theme running through this Opinion that theme is 'integration'. Although accepted in all Member States as an ideal (indeed in France it is enshrined in legislation) (5) the necessary practical measures have not always been forthcoming .

A change in mental attitude is necessary if the constraints and sufferings of disabled people are to be alleviated. We must not look on society as a community where the handicapped person is an exception to the rule but as one where both handicapped and non-handicapped have a place and the same rights. It is not so much a question of remedying specific situations as of ensuring that on all occasions and in all programmes, everyone - whether in the minority or the majority - is considered to be an equally full member of society. Accordingly, it is essential that disabled people should participate in working out the arrangement to meet their requirements and not just be passive recipients of services.

In this Opinion the definitions of the terms 'impairment', 'disability' and 'handicap' will be those used in the International Classification of Impairments, Disabilities and Handicaps of the World Health Organization (6), as follows

Impairment : 'Any loss or abnormality of psychological, physiological, or anatomical structure or function.'

Disability : 'Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.'

Handicap : 'A disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex and social and cultural factors) for that individual.'

Using the WHO yardstick mentioned above there would be 27m within the Community suffering some form of impairment. Such a general figure, while useful to draw attention to the size of the problem, is unhelpful in determining policy. Disabled people are not a homogeneous group and their needs vary not only from each other but also over their lifetime. Studies undertaken in individual Member States have produced similar figures which provide useful information on the structure of the disabled population in those countries but do not afford adequate information for accurate comparison between Member States because of differences in definition and methodology (7). WE THEREFORE RECOMMEND that the Commission should have discussions with Member States on harmonizing national working definitions of disability and handicap e.g. criteria for benefit payments, special employment assistance. WE ALSO RECOMMEND that the Commission should set in hand a Community-wide survey of disability in order to ascertain what the most pressing problems are in different parts of the Community which merit attention at Community level.

Certain general statements can, however, be made on the basis of available information. In the first place it is clear that throughout the Community (in contrast to developing countries) as a whole the largest category of people affected by disability are the elderly, in particular the very old. For example, a survey (8) undertaken in Great Britain in 1968/9 indicated that in the small but vitally important group described as very severely handicapped over half were over 75. The number in this age group is also expanding rapidly throughout the Community.

Balanced, however, against the number of very elderly handicapped people must be the fact that when a child is born with a severe impairment or who sustains permanent injuries he faces a lifetime of disability. Equally the effect on the individual and family when someone of working age is struck down by injury or disease may be far more complex than the problems of someone disabled later in life. To date the Community has concerned itself mainly with disabled people of working age. This Opinion, however, attempts to survey the broad needs of all age groups and in particular to recommend how the Community can intervene effectively both to prevent impairment and in the rehabilitation of those who have become disabled. It also addresses itself to the wider question of the place of disabled people in the community and the actions which need to be taken to allow them not only to influence decisions which affect their own lives but also to play a full and equal part as fellow citizens.

B. Comments

1. Preventive Measures

Prevention of handicap is usually defined in three categories :

Primary Prevention : an attempt to prevent disease or
impairment before it occurs;

Secondary Prevention : the early detection and treatment of
disease or impairment with a view to
a return to normal health;

Tertiary Prevention : the continuing treatment of the disease or disability to avoid needless progression or complications and the rehabilitation of the individual in order to minimise any consequent handicap.

Within the Community (if not in many deprived areas of the world) it is true to say that in most situations it is the individual who must take the major responsibility for his own health. To achieve this each Member State must give priority to health education, especially for school children. For some, however, especially the very young and very old., the responsibility must lie elsewhere; and in certain specific situations which we consider below the individual and social consequences of disability are so serious that legal measures to reduce the incidence of impairment are imperative.

2. Primary Prevention

Primary prevention is essential not only for humanitarian reasons but in order to release more resources for the treatment, rehabilitation and care of those whose handicaps already exist or who are unavoidably disabled in the future. The developing countries, and in particular their children, are still ravaged by malnutrition and killing and disabling diseases which are happily now little more than a memory in most Western States. Relative prosperity and the advances of

science and medicine have ironically not only produced new causes of impairment but succeeded so well in saving and prolonging life that injuries and diseases that once were fatal often now leave people to endure years, even lifetimes, of severe handicap. The imperative to seek ways of averting impairment is therefore more, not less, urgent.

Children

With victory over childhood diseases through environmental health measures as much as medical measures, congenital handicaps have assumed increasing significance as a cause of disability in children; and within this group of birth handicaps as care during pregnancy and at delivery improves, genetic disorders, at present susceptible only to genetic counselling or therapeutic abortion, are an increasing proportion. Nevertheless, on the most reliable comparative statistics, those for perinatal and infant mortality, there are marked differences between different regions and between different social classes. In the Federal Republic of Germany over 25,000 children are born annually with serious disabilities. It has been estimated that every 20th child in the Federal Republic is born in some way handicapped (9).

The Commission has already instituted a research programme on the registration of congenital abnormalities (10) and has more recently extended this to the criteria for perinatal monitoring (11). WE RECOMMEND that the Commission should expand its role in this area and fund more comparative studies in different parts of the Community. Specifically it should consider establishing a comprehensive model maternity programme in one of the highest risk areas of the Community which would include family planning, genetic counselling, ante-natal care, nutrition counselling and the best possible facilities in the maternity wards and for neo-natal care.

There is, however, no room for complacency concerning childhood diseases and there are serious dangers that a generation of parents spared, for example, the ravages of polio by vaccination in their childhood may no longer think it necessary to protect their children. WE RECOMMEND, therefore, that the Commission should monitor at intervals the take-up of vaccination and immunisation throughout the Community.

In developed countries, after the first year of life, accidents become a major cause of death and handicap. In the UK between 1967 and 1976 they claimed 27% of deaths in the age group of 1 - 4, 38% ages 5-9 and 37% ages 10 - 14 (12). For very young children the home can be highly dangerous. The Commission is already taking action in relation to the design of toys (Doc. COM(80) 369 final) and the labelling of

hazardous household products (Doc. COM(78) 403 final). Furthermore, the Committee has adopted an Opinion on the Proposal for a Council Regulation (EEC) on the Approximation of the Laws of the Member States concerning Toy Safety (Doc. COM(80) 369 final) and welcomed the Commission's decision to propose an alignment Directive designed not only to eliminate trade barriers but above all to enhance the protection of children's health and safety. WE RECOMMEND the Commission should issue guidelines, and eventually regulations, on the design of safe homes for children and, in particular, put restrictions on the use of unstrengthened glass at ground level. In the UK it is estimated that accidents in the home involving architectural glass lead to about 25,000 persons being treated in hospital departments each year and that about half of these accidents are caused by glass in doors and just over half of these occur to children (13).

For older children motor vehicles are a major hazard. A major reduction depends on a number of factors, better education of both children and adults, better environmental planning, etc. But some causes of injury are susceptible to immediate action. Car passenger accidents claimed 80 child deaths and 1,280 serious injuries in the UK in 1979 (14). In order to reduce the risk to child passengers WE RECOMMEND that all cars manufactured or imported into the Community should be fitted with rear seat belts and that the Commission should produce a directive banning children under the age of 13 from front seats except in prescribed circumstances. WE ALSO RECOMMEND that safety instruction in schools has a prominent place in the curriculum.

WE RECOMMEND that the Commission should instigate ways of developing routine collection and reporting of accidents to children and should cooperate with Member States on a coordinated child accident prevention programme. WE ALSO RECOMMEND that the Commission arrange for research to be conducted into possible different hazards both of disease and accidents faced by children in urban and rural areas which lead to handicap.

Adults

For adults, too, road accidents are a major cause of death and serious injury. In the Federal Republic of Germany about 14,000 deaths per year are caused by traffic accidents. In the UK between 1965 and 1975 one-third of deaths from injuries were attributable to road accidents although their proportion has been falling (15). Comparative figures for less serious injuries are more difficult to obtain but an estimate (16) was made that in 1973 16% of all injuries were from road accidents, whereas 34% were work-related. In 1979 (17) in Great Britain, 5,800 deaths, 66,700 serious injuries and 181,900 slight injuries were attributable to road accidents. The cost of road accidents is massive - an estimated £1,730m in 1979 (a figure which includes (18) lost output, police and administrative costs, medical costs, damage to property and pain, grief and suffering). The importance of reducing this toll lies not only in the direct reduction of human suffering but also in the freeing of health resources for the many

life-enhancing operations (e.g. joint replacement). Two measures which have proved successful in different countries in reducing injuries are strict penalties on the consumption of alcohol and the compulsory use of seat belts. In the UK (19) it is estimated that annually 1,000 deaths and 10,000 serious injuries would be prevented if seat belts were used 100% of the time. We understand that the Commission is already conducting an overview of road accidents in Member States, which includes an investigation of the causes of injury to vehicle occupants in front and side impact collisions, the development of suitable dummies for vehicle testing, and work on injuries caused to pedestrians by cars. WE RECOMMEND further comparative studies within the Community and hope that the Commission will press for harmonization in this vital matter.

Work Accidents

The Committee has already considered on a number of occasions the question of health and safety at work. In 1979 the Committee passed an Opinion on the Proposal for a Council Directive on the Approximation of Member States' Laws, Regulations and Administrative Provisions on the Protection of the Health of Workers Occupationally Exposed to Vinyl Chloride Monomer (Doc. CES 900/77).

In 1979, the Committee produced an own-initiative Study on the Health and Environmental Hazards arising from the Use of Asbestos (Doc. CES 230/79) and is at present considering the Proposal for a Second Council Directive on the Protection of Workers from the Risk Related to Exposure to

Agents at Work : Asbestos (Doc. COM(80) 518 final). Furthermore, the Committee has also passed an Opinion on the Proposal for a Council Directive on the Protection of Workers from Harmful Exposure to Chemical, Physical and Biological Agents at Work (Doc. CES 1083/79).

In 1980, the Committee adopted an Opinion on the Proposal for a Council Directive on the Protection of Workers from Harmful Exposure to Metallic Lead and its Ionic Compounds at Work (Doc. CES 884/80) and endorsed the aim of this Directive, since many dangers of lead have been recognized for a long time and have been the subject of medical and chemical research. The Committee pointed out in its Opinion that all technical means should be used to avoid or reduce to a reasonable minimum the harmful effects of lead on the health of workers.

In all of these Opinions, the Committee has made clear that life and good health are the most precious human possessions and that the risks to which workers are exposed at their work places must be controlled and eliminated wherever possible. The development of technology and of the sciences is continually leading to the discovery of new materials and substances whose effects on human health are as yet unknown.

The Committee devoted a special section to the improvement of the working and living conditions of workers in general and of the handicapped in its Opinion on the Development of the Social Situation in the Community in 1979 (Doc. CES 549/80). Already then it underlined the necessity of preventive measures. It also has not neglected to mention the cost of health and security measures. Better information about the benefits secured from preventive measures and the costs involved is needed. For this reason, "the EEC should examine the cost effectiveness of health and safety measures - perhaps by an across-Europe study, as well as implementing the proposed Community information system on accidents in which products are involved" (OJ No. C 252 of 24 October 1978). The Committee reserves itself the right to set out these principles in a study to be elaborated.

Drugs

The use and misuse of drugs, including the misuse of medicinal products, are a significant cause of disease and handicap. In the United Kingdom it is estimated that smoking-related diseases cost the NHS (National Health Service) £115 M per year (1979), cause 50,000 deaths a year and cause 50 million working days a year to be lost. Diseases attributable to alcohol consumption may cost between £36 M - £52 M a year and the cost of output ranging between £159 M - £260 M with between 2,300 - 4,900 premature deaths caused by alcohol excluding deaths resulting from traffic accidents (1977 figures). Drugs may of course be particularly dangerous during pregnancy.

While there is no possibility of a dramatic change in the habits of millions of Community citizens we are convinced that concerted Community action must be taken steadily to reduce the prevalence of drug dependence and in particular the promotion of childhood addiction. WE RECOMMEND that the Commission examine all possible methods of reducing the consumption of tobacco and alcohol and in particular urge the Member States to conduct educational campaigns and issue advice on which methods of reducing such consumption have proved most successful in the past. In particular, WE RECOMMEND the Commission should negotiate on behalf of all Member States for a significant reduction in the advertising of tobacco and alcohol products.

WE ALSO RECOMMEND that the Community, Member States and local authorities give particular attention to dependence on hard drugs.

3. Secondary Prevention

We only wish to draw attention to two areas of secondary prevention : the treatment of the very young and the very old.

Children

It is axiomatic that early detection of congenital conditions is essential for successful treatment. For example, the simple test for PKU and subsequently dietary treatment can now prevent any consequent disability. Currently methods of detecting deafness in the newborn are being developed. Equally, the earlier the recognition of cerebral palsy the sooner remedial therapy and education can commence. Ensuring that the appropriate action follows identification of impairment could be a further possibility of the regional committees we recommend below.

WE RECOMMEND that the Commission should review the procedures in Member States for the early detection of handicap (compulsory health checks, etc.) and make recommendations for a standard procedure throughout the Community. We understand that the Commission is already thinking along these lines in its preparatory work for its Third Programme.

The Very Old

We have noted in the Introduction the high incidence of severe handicap in the very old. Secondary prevention amongst the elderly by delaying or arresting where possible the progress of disabling conditions and mitigating the physical, psychological and social stress associated with ageing offers considerable scope. Intervention, both surgical and biochemical can arrest the handicapping consequences of Impairment; WE RECOMMEND more research be undertaken on the ageing process and on the causes of specific disorders such as arthritis and dementia in order to ensure that the years we are adding to our lives are as enjoyable as possible.

The services of remedial staff are particularly important for the care and rehabilitation of elderly patients; but there is still considerable shortage of remedial staff in departments of geriatric medicine. There is therefore need to encourage recruitment of more student physiotherapists, occupational therapists and speech therapists to be trained to work with the elderly.

4. The Links between Poverty and Handicap

We noted on page 8 that environmental measures have been as significant as medical in reducing disease and disability. It is unfortunately, however, still true even within comparatively affluent countries in the European Community that poverty itself is a major cause of handicap. This has already been noted in the higher incidence of perinatal and neonatal mortality and infant mortality among the poor general ill-health and deprivation also inevitably arise from inadequate nutrition and poor housing. There is also an inescapable higher risk of handicap amongst people who undertake manual employment throughout their lives.

The association between poverty and handicap can arise in a number of ways, for example :

- a) people from poor families often tend to enter unskilled manual employment which incurs a relatively higher risk of injury or disease;
- b) such manual employment, although incurring a higher risk of injury or disease or of just wearing out the worker well before retirement age, is often less well rewarded (with certain obvious exceptions) than office work;
- c) manual workers who become disabled have more difficulty in retaining their jobs or in finding alternative employment.

There is also a growing body of evidence that the health services are not fully used by most of those in greatest need of such services and that there is in particular under- utilization by them of preventive health measures (20).

We would wish to encourage Member States to introduce carefully planned health measures intended specifically to reach those in greatest need. We also stress that a prerequisite for any major inroad into the prevention of handicap is a significant redistribution of the Community's resources towards the poor, combined with special measures to bring services to groups who cannot or will not use them to best advantage themselves.

The Community has already shown its concern over the effects of lead on health and each Member State is required to carry out two screening campaigns co-ordinated throughout the Community. We understand the second campaign is just commencing. We fully support this initiative and hope that any necessary action to protect Community citizens, especially young children, from the effects of lead poisoning which is revealed by the surveys will be forthcoming.

5. Rehabilitation

'Rehabilitation' denotes both the objective, the integration of disabled people into occupational, social and cultural life, and all the medical psychological, educational,

vocational and social measures to attain this objective. Its most important precepts are that the individual should be helped to help himself, that his available capacities should be activated and that he should learn self-respect and how to develop his own particular talents.

Successful rehabilitation demands the co-ordination of all relevant phases of rehabilitation and cooperation between all the medical and para-medical professionals and, most important, the rehabilitee and his family. Indeed, understanding of members of the family and teaching within it is of paramount importance. In many cases families do not know what approach to take or how to go about assisting a member of the family who is disabled. WE RECOMMEND that the families of disabled people be supplied with information on how best they can further the rehabilitation process. For each individual a comprehensive rehabilitation plan must be agreed and one of the professionals given the task of overseeing its fulfilment. These plans should be regularly reviewed and revised. This is particularly important for mentally handicapped people since it is so easy to let matters drift until a crisis arises.

To ensure the relevance of rehabilitation to individuals and their families all institutions engaged in rehabilitation should develop procedures to permit disabled people to assist in designing and organizing the services that they and their families consider they need.

Rehabilitation is not only an economic necessity for the State but an ethical duty and as such must be financed by the public purse. The European Community has already had significant involvement in certain aspects of rehabilitation and we believe these should be strengthened and extended.

6. Medical Rehabilitation

Medical rehabilitation should commence as soon as a patient's life is out of danger or he has recovered from the effects of an operation. Too often in the past rehabilitation has been under-valued or ignored by doctors and deprived of the necessary resources. To be effective, rehabilitation must be continuous and comprehensive.

Each disabled person should have access to a comprehensive rehabilitation department with facilities for full time attendance by both in-patient and out-patient. Medical rehabilitation has hitherto been on the fringe of Community involvement although grants have been made in the past to some demonstration centres. There is, however, no equivalent network to that established for vocational rehabilitation. WE RECOMMEND that the Commission forms a parallel network of Medical Rehabilitation Centres and funds regular seminars so that personnel in Member States can learn from each other. If advanced courses of personnel in vocational rehabilitation are instituted (21) the possibility of extending them to personnel in medical rehabilitation should be considered.

7. Education

The right of handicapped children to education alongside their non-handicapped peers is generally accepted for the reason that their integration helps them to make progress (22) but the will or the resources to achieve this

ideal has often been lacking. In the past special education has, for the best of motives, usually been provided in segregated institutions which have been shown to retard children's social development. It has also led to widespread ignorance of handicap among non-disabled children which has proved a barrier to later integration in society.

The special educational needs of handicapped children vary considerably. For a child with no learning disability and who requires no special treatment not to be able to attend his local school solely because he cannot climb stairs is unacceptable. Most handicapped children, however, do require extra help of various kinds. If this is not provided it makes a misery of their lives and a mockery of integration. It is understood that the Commission are planning a programme of pilot projects in the field of special education to start next year. The Committee welcomes this initiative.

The first prerequisite is adequate teacher training. All teachers in their basic training should become acquainted with the various forms of disability and the problems they cause so that they are equipped to identify signs of special need and to appreciate the importance of early assessment of that need. The integration of certain handicapped children in ordinary schools will also necessitate an increase in the number of teachers trained in techniques of teaching children with learning and communications disorders. WE RECOMMEND that Community funds be made available for this specialist training (similar to the funds currently allotted to training instructors under the existing Social Fund) and that priority be given to the comparatively neglected areas of children with multiple handicaps (23).

The presence of severely disabled children in a classroom almost always necessitates extra staffing, whether for their education or non-educational needs (feeding, toileting, etc.). WE RECOMMEND that when resources are allocated to schools the number of disabled children and the severity of their handicap should be taken into account. Teachers of handicapped children should be remunerated appropriately according to the special qualifications in teaching children with special educational needs.

The transition from school to work is a vital period in any person's life and doubly so for the disabled child who runs the risk of being discharged from the care of one public body without being received by another. In the first place disabled children should have the absolute right to free education with no age restriction in whatever institution is most suitable for them. There is a paramount need for institutions of further education to make provisions for handicapped young people to continue their studies after they have attained the age of 18 years. Secondly before they leave school, unless their future is clear, a fresh plan should be devised with them by the relevant professionals in the education, health and careers guidance services and the most appropriate person given the duty of guiding them through the difficult transition to becoming, where possible, independent members of the community.

Because, unfortunately, so many disabled children will emerge from schools immature and lacking in social skills WE RECOMMEND that the Commission should continue to support assessment centres such as Banstead Place (24) but without the discrimination according to the home town of the disabled individual that has become necessary as a result of Article 9(2) of Council Decision 71/66/EEC (1).

8. Vocational Rehabilitation

Among all the measures designed to integrate disabled people fully into society vocational rehabilitation plays an especially important role because it is frequently the pre-condition for entry into employment which not only provides financial independence but also confers social status and is increasingly the nucleus of social contact.

It is in vocational rehabilitation that the European Community has contributed most to disabled people through the network of rehabilitation and training centres and the Social Fund. The report on the initial Community Action Programme (24a) indicates that not all the Commission's aims were achieved and that the vast increase in unemployment throughout the Community and particularly amongst young people has necessitated an urgent reappraisal of the programme. We wholly support the Commission in maintaining that there can be no let-up in the efforts to train disabled people and find them employment. Although unemployment is a misfortune for anyone it is a particular tragedy for someone who is severely disabled. A severely disabled person who is out of work can too easily become a prisoner of his home. WE THEREFORE RECOMMEND that the Commission give even greater priority to disabled people within the Social Fund with particular emphasis on the most severely disabled who, because their opportunities for open employment have been limited, have in the past been excluded.

The Social Fund Guidelines for 1981/83 are :

First priority : Demonstration actions related to employment and innovative in character involving not more than 200 persons. Total Fund intervention in these cases may not exceed three years.

Programmes for the integration of the handicapped into open employment in Greenland, the French Overseas Departments, Ireland, Northern Ireland and the Mezzogiorno.

Second priority : Operations consisting of :

- Vocational training or rehabilitation;
- Adaptation of jobs; work places or equipment ;
- The recruitment of handicapped persons in an open economy.

Although the European Parliament has increased the allocation (commitment appropriations) to the handicapped in 1981 it remains to be seen whether any second priority operations get funded since in the past applications have vastly outstripped funds. In previous years also the provisions of Article 9(2) of Council Decision 71/66/EEC (1) which requires at least 50% of the Fund's resources to be allocated within ERDF regions under Article 5 has left little or no money for demonstration projects outside these regions (25).

While we support the absolute priority given to certain regions we emphasize that disability causes similar problems everywhere and it is inappropriate for the totality of Community funding for the disabled to be bound up with regional redistribution. WE THEREFORE RECOMMEND that a separate budget be established for demonstration projects and that the Commission lift the various restrictions currently imposed (regionality, the requirement to obtain 50% funding from a public body, restriction to three years) so that the only criteria are the quality of research and development and the help afforded to disabled people.

9. Obtaining Employment

We fear that in current economic conditions, which are leading to a rising level of unemployment in all Member States and which may be of long duration, the employment opportunities for the disabled will decline more rapidly than for others.

The Report on the Community Action Programme (26) emphasizes the importance of facilitating the employment of disabled people after rehabilitation but is rather vague in specifying how it will achieve this. For example, the Commission says it :

"will direct the activities which it organizes in the appropriate manner; will ask the representatives of the Member States to coordinate more effectively the projects which receive financial aid from the Community; will, if necessary, propose activities going beyond the present framework of the action programme."

Most Member States operate a quota scheme to encourage the employment of people with disabilities, but only in the Federal Republic does it appear to obtain general acceptance. In other countries Government and employers appear to wish to be rid of it, organizations for disabled people argue for its retention for fear of being left with nothing, and disabled people themselves tend to ignore it by failing to register. The comparative success in the Federal Republic may be the result of the compensatory levies which help fund rehabilitation.

The main defect of all quota schemes is that they are a blunt instrument for dealing with the problems of a heterogeneous group of workers. The needs and problems of the severely disabled school leaver with his life ahead of him are entirely different from those of a man in his fifties or sixties who has perhaps already sacrificed his health to his work and for whom early retirement may be both desirable and just. WE THEREFORE RECOMMEND that the policies of Member States should take account of the different needs of different groups of disabled people.

For the severely disabled young person, finding a first job is often a major obstacle. WE THEREFORE RECOMMEND that, whatever the general quota system in each Member State, particular priority should be given to employing disabled school leavers, both by employers and by the relevant department of government.

WE RECOMMEND that there should be a general duty on employers towards existing employees :

a) to arrange appropriate training and re-training, career development and promotion for disabled employees (27) ;

b) when an employee is able to return to work after injury or disease :

(i) to cooperate with the relevant bodies over his continuing need (if appropriate) for rehabilitation;

(ii) to re-employ him or her where possible in his or her old job, but if not in another post which will make full use of his/her remaining abilities;

(iii) to ensure in conjunction with the relevant insurance scheme, where applicable, that the employee is at as little disadvantage as possible as a result of his disability.

Mention should be made in this context of the excellent support and rehabilitation provided for their disabled workers by certain large unions and firms. Although rehabilitation must remain the responsibility of the public authorities it can never be effective without full cooperation with the social partners. The attitude of fellow employees is critical to the successful establishment in open employment of

severely disabled people especially the mentally handicapped and those with hidden or mysterious disabilities such as epilepsy. WE RECOMMEND that (where this is not already done) trade unions should include information on disability in their training programmes for shop stewards and that for the most severely disabled new employees suitable workers should be allocated to assist their integration in the work force (28).

The nature of employment is changing as rapidly today as in the first industrial revolution and it is widely accepted that few workers can now expect to retain the same job throughout their working lives. Although the initial training and placement for a young disabled worker may be highly successful, he cannot be insulated from changes in the world around him. Historically, for obvious reasons, disabled people have been amongst the most loyal employees and unless special attention is paid to their particular problems in re-training and re-deployment, their enforced loyalty may leave them stranded when the tide of change moves on. WE RECOMMEND that all those running industrial re-training schemes should examine their suitability for disabled people. We believe that this is an area which should be urgently examined by CEDEFOP (European Centre for the Development of Vocational Training).

The brighter side of the technological revolution, however, is the opportunities it affords the most severely disabled people to undertake remunerative employment for the first time. People with minimal movement have been trained as

computer programmers and are able to work from their own homes. The Commission has already been active in the field of micro-technology and has funded research projects such as the development of a typewriter operated by light impulses at the De Hoogestraat Rehabilitation Centre in the Netherlands. It has also funded two conferences on technical aids (28a) and is currently undertaking preliminary work on the establishment of an international thesaurus and data bank. We support this initiative and RECOMMEND that the Commission continue to use all means at its disposal to publicise the ways in which modern technology can revolutionise the lives of severely disabled people. WE FURTHER RECOMMEND that the Commission examine whether there is scope in this field to integrate development efforts in the Member States to make best use of available resources in this important and growing sector of industry.

Subsidies and Sheltered Employment

The question of whether the state should subsidise either the disabled worker or his employer is a thorny one. The majority of disabled people given the right training and facilities can more than hold their own alongside their fellow workers. For a few this will never be possible. Member States therefore support sheltered workshops for a minority of severely disabled people whose capacity is at least one third of normal. Some view this as the only practicable way of providing them with worthwhile employment; others regard sheltered workshops as fundamentally segregationist and believe they should act primarily as re-integration centres. We

believe that sheltered work is a necessity for some but that greater efforts should be made to ensure workers are not isolated and that those who can graduate to open employment (and probably higher wages) are enabled to do so. WE RECOMMEND that, in order to compensate sheltered workshops for losing their best employees, a premium should be paid for every worker transferred to open employment. While a workshop may naturally wish to retain its best workers, it also may be reluctant to recruit the most severely disabled for fear that their standard of work may not be adequate. WE THEREFORE ALSO RECOMMEND that special subsidy arrangements should be made for a limited trial and training period for a minority of new recruits. In order to combat the isolation of workshops we would also wish to see the extension of sheltered industrial groups or 'enclaves' within open employment.

The major problem for sheltered workshops is obtaining enough suitable work and in selling their products and services. WE RECOMMEND the Commission should review the preferential schemes to assist workshops adopted in Member States and examine ways in which Community institutions themselves can assist by placing contracts with sheltered workshops.

Wages in sheltered workshops vary widely within as well as between Member States. In Belgium in 1977 (29) they varied between 57 BF and 166 BF per hour. In the UK the largest employer, Remploy, has yet to agree to union demands that wages should be fixed to the local authority scale for

manual workers and some employees with a family may be worse off than they would be receiving social security; but, on the other hand, some local authorities and voluntary workshops do not pay a wage at all and the worker is forced to live on social security. In France workers in 'Centre d'Aide par Travail' are guaranteed 70% of the national minimum wage and in 'Ateliers Protégés' 90%. We believe that disabled workers should receive due remuneration for their labour and RECOMMEND that the Commission shall require each Member State to guarantee a minimum income in sheltered workshops.

Assistance from the European Social Fund is not currently available for sheltered workshops. We believe many are seriously under-funded and unable to adapt to meet both changing market conditions and modern ideas about rehabilitation and appropriate employment for disabled people. WE RECOMMEND that the Social Fund Guidelines should be extended to provide for expenditure in respect of the sheltered workshops demonstration projects.

Other than for workers in 'enclaves' we do not believe that the State should permanently subsidise disabled workers in open employment since this is an admission of the failure of rehabilitation. Grants for adaptations and special equipment should, however, be provided. People who on account of their disablement can only work part time should be entitled to receive incapacity benefit for the period when their disability prevents them from working.

The Organization of rehabilitation and employment measures

As we have noted, coordination between the different professionals concerned is essential- for successful rehabilitation. Disabled people often find that there is little coherent planning between the various authorities on whom they may be dependent in different aspects of their lives. To the disabled person his medical, employment, financial, social and housing needs will often been inextricably linked, but each may be considered in isolation by different bodies. WE RECOMMEND the establishment, where they do not exist, of regional committees to oversee rehabilitation and employment measures. These committees should be composed of the relevant professionals, employers, unions, representatives of associations of disabled people themselves. The task of the committees would be to ensure the adequate provision of rehabilitation facilities and provide guidance and advice to disabled individuals. It could also have additional functions.

10. Community Services

Identification

In order to play their full part in the community, and sometimes even to continue living in their own homes, many disabled people require special provisions and special services which are usually the responsibility of local authorities, complemented in many countries by the work of voluntary

organizations. The failure of many disabled people to receive the help they require is often the consequence of total ignorance of their needs and even of their existence by the relevant authority. We believe the community has a duty to seek out people in need and not wait for them to ask for help. WE THEREFORE RECOMMEND that local authorities should seek to identify disabled people living in their area and inform them of services available to them. WE ALSO RECOMMEND that the Commission issue guidance on ways in which this should be achieved so that information assembled by local authorities in different Member States can be compared (30).

Housing

A house in which a disabled person can achieve maximum independence is an essential precondition for successful integration. This has been accepted by the Commission which produced in 1975 an excellent document on the elimination of architectural barriers (COM(75) 432 final) which established a two-tier standard : housing specially designed for people confined to wheelchairs; and housing which incorporated certain minimal features which rendered it suitable for the majority of disabled people. The document recommended that all new housing should adhere to at least the second standard but unfortunately nothing has been heard of it since. As an alternative to formulating a directive, the Commission financed a number of pilot studies in 1976 followed in 1977 by

two major projects (in the UK and Italy) involving both housing and social services, and in 1978 by a number of smaller but equally comprehensive schemes. So far, only a brief note about these projects has been published (31) but the Commission has confirmed its impression that appropriate housing is an important starting point for the social and occupational re-integration of handicapped persons, but it notes that housing alone is not enough and adaptations to the social infrastructure and vocational training institutions are also required. It also notes that whereas adaptations if planned in advance of construction may only add 5 - 10% to the cost, adaptations after construction can be nine times as costly. But it will always be necessary to make adaptations to existing houses to enable people who are struck down by disability to continue to live in the houses they are used to living in. The housing needs of mentally handicapped people should be given special consideration. Services should be available to help families to look after a mentally handicapped person at home and to enable adults to live in homes of their own if they wish.

Following the reconvened meeting of experts from Member States held in June 1981 to assess the results of these programmes, WE RECOMMEND that the Commission should either produce proposals for long-term intervention in this area or produce guidelines for implementation by Member States.

Access and Transport

Barriers to mobility, whether they are steps at the office or the local library or an inaccessible railway carriage, are a major source of frustration to people with physical handicaps. Similarly, failure to take account of the specific needs of blind and deaf people can seriously reduce their independence. We believe that Article 3(c) of the Treaty of Rome ('the abolition as between Member States of obstacles to freedom of movement for persons, services and capital') and Article 3(d) ('the adoption of a common policy in the sphere of transport') require the Commission to take a more active role in facilitating the free movement of disabled people throughout the Community. In particular WE RECOMMEND that minimum standards of accessibility should be required at all major airports and railway stations (32). The question of harmonized parking concessions for disabled people has also been under consideration for some time. We understand the Commission will be represented at the Second International Conference on Transport for Elderly and Handicapped Persons in Cambridge in 1981 and we hope concrete proposals will be forthcoming.

Domiciliary Services

Many disabled and elderly people are only able to remain living in their own homes as a result of the domestic help provided for them, the delivery of meals as well as the provision of aids and adaptations to their homes. The level of care required from a local authority depends on the informal

support available from family, voluntary agencies and local community. Some research has already been funded by the Commission as part of the Housing programme. Social structures, however, vary considerably within Member States as well as between them, and the type of support needed in a closely knit village community may be entirely different from that in a decaying inner city. We feel those providing social services in different parts of the Community should learn much from each other's experience and WE RECOMMEND that the Commission, in conjunction with the Associations of Local Authorities, should undertake a comparative study of the delivery of domiciliary services to disabled and elderly people.

Day Centres

Day Centres, where severely disabled people can maintain social contacts while receiving any care necessary and continuing to live with their families are a vital component of community care. WE RECOMMEND an increase in this type of provision where it is required.

Residential Care

Small communities in which disabled people live alongside others who are not disabled in family surroundings are in general much to be preferred to large residential institutions. It would be a matter of considerable concern if the expedient of residential care was seen as a major means of providing for those with severe mental and physical disabilities. Permanent institutional accommodation is unnecessary, expensive and undesirable for the vast majority of even very severely physically and mentally disabled people. This is not

to argue that some residential care provision is not always required and that national factors in Member States will influence the optimum number of residential places. Supreme efforts must be made not to isolate these residential institutions as has unfortunately often happened in the past. Residential care should be as intimate and as akin to a family home as is possible. Residents should be involved in the running of their homes and should be given more privacy and choice. The aim for physically or mentally handicapped residents should be to promote the maximum development and independence of which they are capable. Residence in a home should in no way affect disabled people's access to rehabilitation services. WE RECOMMEND that the regional rehabilitation committees should have a duty to satisfy themselves with the rehabilitation services provided by all residential institutions in their area.

11. The Financial Needs of Disabled People

We understand the Commission has funded a case study of the income of disabled people which is nearing completion. We would emphasize the close correlation which exists between disability and poverty which arises from two reasons :

- a) the additional costs arising from a person's disability which accrue to a disabled person and their family;
- b) the total or partial loss of earning capacity.

These consequences are independent of the cause or circumstances of the original impairment and of the institution which is responsible for compensation. Through the European Community, financial assistance is based on criteria which distinguish according to cause and circumstances and not according to need (e.g. different compensation for war disabled, industrially injured, the insured vis-à-vis the child or housewife, etc.). Often the scales used are also based on predominantly anatomical criteria and do not distinguish between additional costs and the inability to earn.

In the first place, anyone who is unable to earn a living on account of his disability should be entitled to a basic income support benefit which is sufficient to meet his normal costs of living regardless of his insured status, his or her marital status and the cause of circumstances of the original impairment.

Secondly, an allowance should be paid to help offset the extra costs of disability structured according to the severity of handicap. The assessment for the purposes of this benefit should be part and parcel of the rehabilitation process and therefore the responsibility of the regional rehabilitation committee. (It may be appropriate for a separate body, as in France, to be responsible for children).

Since in almost all Member States plans to introduce a comprehensive allowance to meet the costs of disability are still embryonic, WE RECOMMEND that the Commission should host

regular discussions between Member States on the general principles to be followed in constructing such an allowance in order to facilitate the introduction for the first time of a general benefit conceived on a European scale which will help promote equality of disabled citizens of the Community wherever they happen to live.

Participation is the principal theme of the International Year of the Disabled Persons and yet the opportunities for disabled people to help formulate Community decisions that affect them are negligible. WE THEREFORE RECOMMEND that the Commission should establish a Committee, the majority of whose membership shall consist of disabled people and representatives of organizations of and for disabled people, to advise the Commission on all matters affecting disabled people and in particular on the implementation of the proposals in this Opinion and on the Resolution of the European Parliament.

12. Financing Community initiatives for Disabled People

Enabling disabled people to become full and equal citizens of the European Community, will require substantially more finance than is available within existing Community budgets. Given that it is difficult within the European Social Fund to allocate sufficient amounts to support initiatives in favour of the handicapped, WE RECOMMEND that a "European Fund in Aid of the Handicapped" be established and administered by the Commission under the guidance of the Advisory Committee mentioned above.

This Opinion has up to this point been concerned exclusively with disabled citizens of the European Community. We cannot however ignore the fact that the problems of disability and the needs of disabled people in Europe are dwarfed by the magnitude of the problems of disability in the Third World. The Commission is already involved through the European Development Fund and, since 1976, by funding projects suggested by non-governmental organizations. WE RECOMMEND that the Commission should review its contribution to the prevention of handicap and the promotion of rehabilitation in developing countries in conjunction with WHO and Rehabilitation International.

C. SUMMARY OF RECOMMENDATIONS

1. General

The Commission should have discussions with Member States on harmonizing national working definitions of disability and handicap, e.g. criteria for benefit payments, special employment assistance, etc.

The Commission should set in hand a Community-wide survey of disability in order to ascertain what the most pressing problems are in different parts of the Community which merit attention at Community level.

2. Prevention

The Commission should expand its role in the area of perinatal mortality and handicap and fund more comparative studies in different parts of the Community. Specifically, it should consider establishing a comprehensive model maternity programme in one of the highest risk areas of the Community, which would include family planning, genetic counselling, ante-natal care and nutrition counselling, and the best possible facilities in the maternity wards and for neo-natal care.

The Commission should monitor at intervals the take-up of vaccinations throughout the Community.

The Commission should issue guidelines and eventually regulations on the design of safe homes for children, and in particular put restrictions on the use of un-strengthened glass at ground level.

All cars manufactured or imported into the Community should be fitted with rear seat belts and the Commission should produce a directive banning children under the age of thirteen from front seats except in prescribed circumstances.

Safety instruction in schools should have a prominent place in the curriculum.

The Commission should instigate ways of developing routine collection and reporting of accidents to children and should cooperate with Member States on a coordinated child accident prevention programme.

The Commission should conduct research into possible different hazards, both of disease and accidents, faced by children in urban and rural areas.

The Commission should continue its studies into injuries from road accidents and press for harmonization on all aspects of safety relating to cars.

The Commission should implement the recommendations of the Economic and Social Committee in relation to the prevention of industrial disease and accidents at work.

The Commission should examine possible methods of reducing the consumption of tobacco and alcohol and the misuse of medicinal products, and in particular should urge the Member States to conduct educational campaigns and issue advice on which methods of reducing such consumption have proved most successful in the past.

The Commission should negotiate on behalf of all Member States for a significant reduction in the advertising of tobacco and alcohol products.

The Community, Member States and local authorities should give particular attention to dependence on hard drugs.

The Commission should review the procedures in Member States for the early detection of handicap and make recommendations for a standard procedure throughout the Community.

More research should be undertaken on the ageing process and on the causes of specific disorders such as arthritis and dementia.

3. Rehabilitation

Families of disabled people should be supplied with information on how best they can further the rehabilitation process.

The Commission should form a network of medical rehabilitation centres to run in parallel with that of vocational rehabilitation centres and fund regular seminars so that personnel in Member States can learn from each other.

4. Education

Community funds should be made available for specialist training of teachers and priority should be given to the comparatively neglected areas of children with multiple handicaps.

When resources are allocated to schools the number of disabled children and the severity of their handicap, should be taken into account.

Teachers of handicapped children should be remunerated appropriately, according to their special qualifications in teaching children with special educational needs.

The Commission should continue to support assessment centres for disabled school leavers irrespective of the place of residence of the disabled adolescent.

5. Vocational Rehabilitation

The Commission should give even greater priority to disabled people within the European Social Fund with particular emphasis on the most severely disabled who, because their opportunities for open employment have been limited, have been excluded in the past.

A separate budget should be established for demonstration projects within the European Social Fund and the Commission should lift the various restrictions currently imposed.

6. Employment

The policies of Member States should take into account the different needs of different groups of disabled people, such as the severely disabled school leaver and the disabled person approaching retirement age.

Particular priority should be given to employing disabled school leavers both by employers and by the relevant department of government, whatever the general quota system in each Member State.

There should be a general duty on employers towards their existing employees :

- (a) to arrange appropriate training and retraining, career training and promotion for disabled employees;

(b) when an employee is able to return to work after injury or disease :

- (i) to cooperate with the relevant bodies over his continuing need (if appropriate) for rehabilitation;
- (ii) to re-employ him or her where possible in his or her old job, but if not in another post which will make full use of his/her remaining abilities;
- (iii) to ensure in conjunction with the relevant insurance scheme, where applicable, that the employee is at as little disadvantage as possible as a result of his disability.

Trade unions should include information on disability in their training programmes for shop stewards and for the most severely disabled employees suitable workers should be allocated to assist their integration in the workforce.

Those running industrial retraining schemes should examine their suitability for disabled people. The opportunities for disabled people in vocational training should be urgently examined by the European Centre for the Development of Vocational Training.

The Commission should continue to use all means at its disposal to publicise the ways in which modern technology can revolutionise the lives of severely disabled people.

The Commission should examine whether there is scope in the field of modern technology to integrate development efforts in the Member States to make best use of available resources in this important and growing sector of industry.

In order to compensate sheltered workshops for losing their best employees a premium should be paid for every worker transferred to open employment.

Special subsidy arrangements should be made for a limited trial and training period for a minority of the most severely disabled new recruits in sheltered workshops.

The Commission should review the preferential schemes to assist workshops adopted in Member States and examine ways in which Community institutions themselves can assist by placing contracts with sheltered workshops.

The Commission should require each Member State to determine minimum income in sheltered workshops.

European Social Fund guidelines should be extended to provide for expenditure in respect of demonstration projects in sheltered workshops.

Regional committees should be established to oversee rehabilitation and employment measures.

7. Community Services

Local authorities should seek to identify disabled people living in their area and inform them of services available to them.

The Commission should issue guidance on the ways in which identification of disabled people should be undertaken by local authorities so that information assembled by them in different Member States can be compared.

The Commission should then either produce proposals for long-term intervention concerning houses for disabled people or produce guidelines for implementation by Member States. Small communities in which disabled people live alongside others who are not disabled in family surroundings are in general much to be preferred to large residential institutions.

Minimum standards of accessibility for disabled people should be required at all major airports and railway stations.

The Commission, in conjunction with the Associations of Local Authorities, should undertake a comparative study of the delivery of domiciliary services to disabled and elderly people.

There should be an increase in the provision of day centres where they are required.

Regional rehabilitation committees should have a duty to satisfy themselves of the rehabilitation services provided by all residential institutions in their area.

8. The Financial Needs of Disabled People

The Commission should host discussions between Member States on the general principles to be followed in constructing a disablement costs allowance.

The Commission should establish a Committee, the majority of whose membership shall consist of disabled people and representatives of organizations of and for disabled people, to advise the Commission on all matters affecting disabled people and in particular on the implementation of the proposals in this Opinion and on the Resolution of the European Parliament.

9. Financing Community Initiatives for Disabled People

A "European Fund in Aid of the Handicapped" should be established and administered by the Commission under the guidance of the Advisory Committee mentioned above.

10. International

The Commission should review its contribution to the prevention of handicap and the promotion of rehabilitation in developing countries in conjunction with the World Health Organization and Rehabilitation International.

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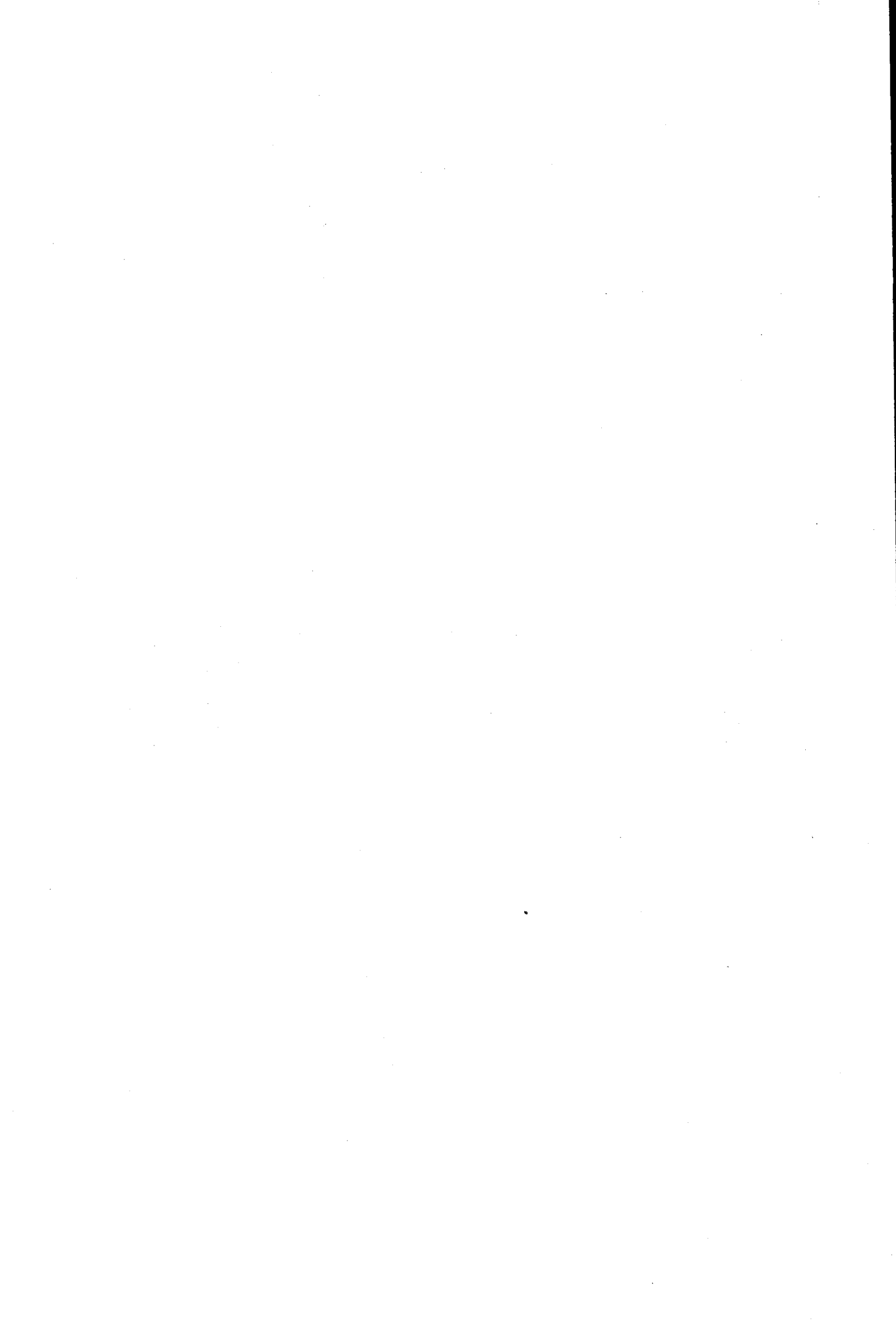
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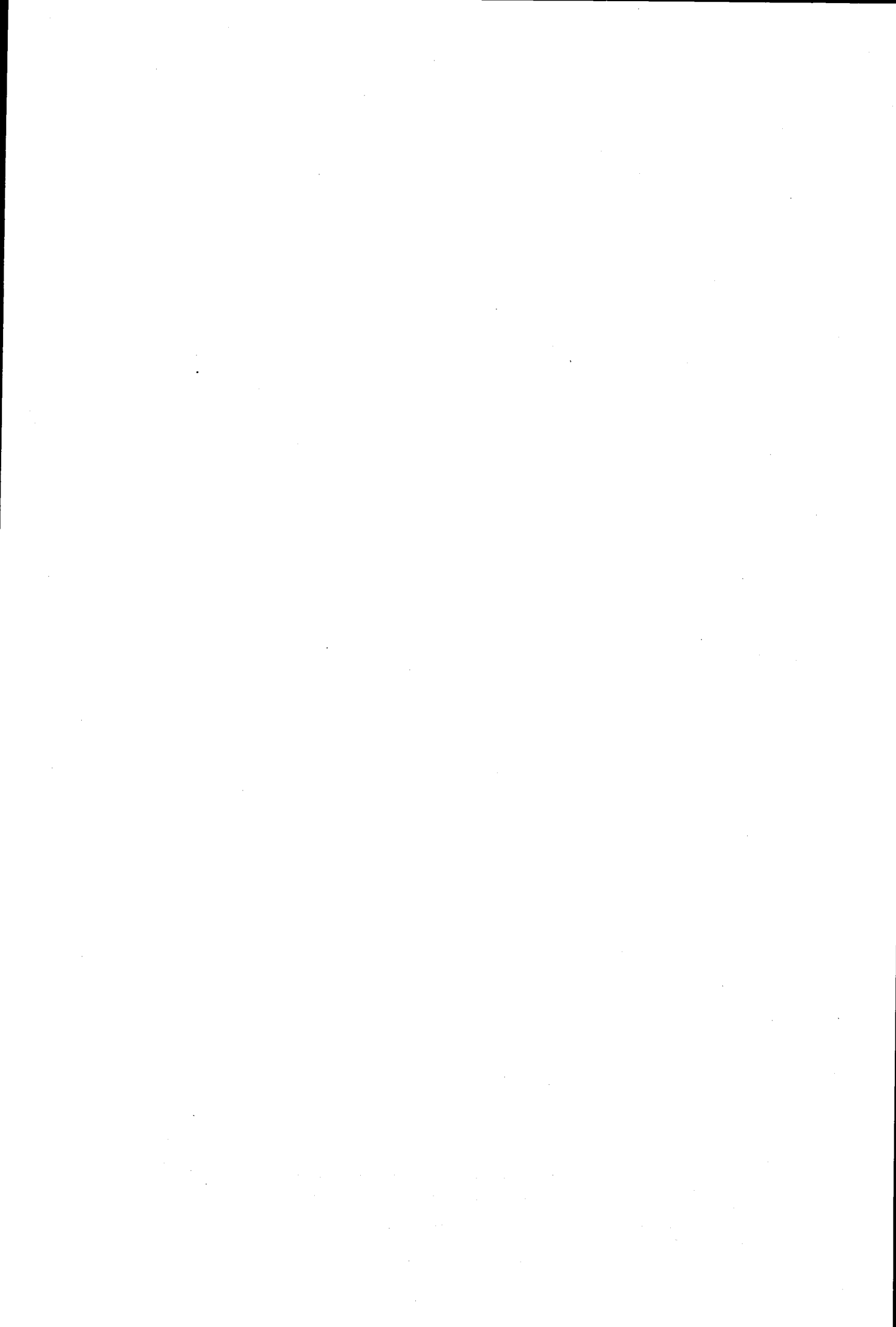
Own-Initiative Opinion of the Economic and Social Committee
Brussels: General Secretariat of the Economic and
Social' Committee

1981 - 49 pages

Dk, D, E, F, I, N, Gr.

In its Opinion the Committee emphasized that it fully supported the aims of the UN General Assembly in 1976 when it declared that 1981 would be the Interational Year of the Disabled. It also backed the declaration on the rights of the mentally defective and the 1975 declaration on the rights of disabled persons, both of which were adopted by the UN General Assembly. The Opinion contained specific and concrete recommendations to the Community authorities and the Member States.





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