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International Research Conference on

SOCIAL SECURITY DISABILITY PROGRAMMS.

organized by RI in Ass. with US Social Security Administration.

Session: Blending of Medical and Vocational Assessment of
of Disability Claimants

Paper: Abilities- and Requirements-Profiles - Aid for the Integration
of Disabled-People into Work.

Presented by Dr.-Ing. Erich Mittelsten Scheid, Fed.Rep. Germany
Tuesday April 15. 1986 - Morning Session

Mr. Chairman! Ladies and Gentlemen!

My first experience with the reintegration of impaired and disabled war-veterans dates back to the time after the first World War. We had no legislation nor experience in our efforts to find suitable job-s for them. Still - I dare saying: we did not too badly at that time.

I gathered further experience in the field of job-evaluation - and job-analysis in the early fifties - and by the task of reintegration the large number of World War II war veterans - who suffered serious impairments and were left with more or less severe disabilities. We tried as best we could to find jobs appropriate to their residual abilities - in order to enable them, to earn enough money, to pay themselves for their subsistence. Quite a few of them could be promoted into higher ranks of work-force and of management.

Based on that experience ERTOMIS - a non-profit foundation in Fed.Rep. of GERMANY - stimulated by Prof. Jochheim of Cologne - undertook as from 1973 to develop a method, intended to facilitate the search for jobs appropriate to the individual disability - regardless of the cause for the disability - so that they could be reintegrated into gainfull employment. The aim of that effort was, to minimize the handicap for a disabled-person - which may have resulted from an impairment of what-ever cause.

We analysed - as a first field study - 171 severely disabled employees as to

- 1.) Kind of job - they were doing
- 2.) normal or adjusted work place
- 3.) Rate of performance
- 4.) Level of income earned

We found the 171 disabled person to work at- almost exclusively - normal work-places, achieving a normal rate of performance, earning the same income as their undisableed colleagues. Very few only had their work place

slightly adjusted to compensate individual shortcomings. Obviously "suitable jobs" had been selected for each of them by the good old method of "trial and error"!

The next step was, to find out by another field study the circumstances disabled people find themselves in after release from hospital or rehabilitation center. This study discovered a serious obstacle on the road to an appropriate job: disabled people receive - upon release from hospital or rehabilitation-center - a certificate describing in rather general terms their "Deficits" - instead of a certificate describing their "Residual-Abilities".

All of you will know, that an employer or his personnell-department has to be informed about the applicants "Professional-Skills" - and "Elemental-Abilities" - and in case of a disabled applicant about his "Residual-Elemental-Abilities". - But normally applicants present their personal "Application for Employment" indicating their personal data plus vocational skills and rate of performance achieved at former jobs. - No evidence is presented as to his/her "Individual Elemental Abilities"!

When I speak of "Skills" - I mean the skills you learn in an apprenticeship and by experience.

On the other hand, man is born with a number of "Elemental Abilities" - more or less equal to every individual - including physical and mental abilities.

In doing a - no matter what - job, you need both abilities and skills.

No job demands all inborn abilities!

On the other hand "Disability" is caused by a reduction or loss of one or several inborn elemental abilities such as a leg, a hand, focus of vision, hearing, concentration, psychomotoric speed, tolerance of light, etc. Such reduction or loss usually is caused by an accident or disease leading to some IMPAIRMENT. The impairment will be treated in hospital - and will either be completely cured - or leave a DISABILITY behind. This disability will then be treated in a rehabilitation centre and will be fully or partly compensated. In the latter case the disabled person will have to live with his/her RESIDUAL ABILITIES. In the first case, the person can return to resume his/her old job. In the latter case a job appropriate to his/her residual abilities will have to be selected from the vacant number of jobs.

Professional skills and knowledge will normally not be reduced by accident or disease.

This search for a job suitable to the applicants "residual abilities" is the objective of the ERTOMIS Research project. It has been defined as follows:

"Develop a system for the assessment of "residual abilities" of disabled persons - by one set of criteria i.e. "elemental abilities" - so as to permit a comparison of the residual abilities with the requirements of a job. Such comparison should permit to decide on the suitability of a specific job for a specific disabled applicant."

The search for such a set of criteria took considerable time!

Three working committees were invited - each of them to select one set of "elemental abilities" as seen from their professional point of view:

- 1.) a medical committee
- 2.) a psychological committee
- 3.) a vocational trainers committee

When the three sets were presented, they were partly coinciding, partly differing from one another - and in some cases different terms had been used for the same "elemental ability" - and vice versa.

Since the system was intended to be used in industry and administration for the selection of suitable jobs for a great variety of disabled people, we felt we would overburden industry and administration if we suggested the use of three different sets for each individual case. We therefore invited the three committees - plus a committee of practitioners from industry and administration - to jointly integrate the three into one practicable set. Ultimately they came forward with that one integrated set - and with detailed definitions for each of the criteria.

The criteria had been subdivided into seven groups:

- 1.) Upper and lower limbs, coordination of their movements. head and torso movements.
- 2.) Basic postures and/or movements.
- 3.) Senses
- 4.) Psychologically oriented abilities
- 5.) Speech and writing as means of communication
- 6.) Tolerance of environmental influences at work
- 7.) Other factors - e.g. leadership ability

As you will see - on the Assessment Sheets - there are no criteria contained in the sheet related to

- family data
- vocational education and experience
- type and cause of disability

- rehabilitation treatment undergone
- etc.

These data are contained in the "Application for Employment"-sheet - respectively in the "Personell Requirement"-sheet.

The criteria selection has been achieved in close cooperation with Dr. Philip D. Wood - Chairman of the WHO Committee developing ICIDH.

Two tools have been developed for the comparison of abilities of an applicant for a job - with the requirements of a job as to such abilities:

- 1.) "Abilities Profile" sheet - grading to be entered by a X (cross) abbreviated as "AbPr" - Sheet is a transparent foil.
- 2.) "Requirement Profile" sheet - grading entered by a o (circle) abbreviated as "RqPr" - Sheet is a white paper.

The "Grading" of each of the criteria has to be assessed by sound judgement and is to be entered into the respective column on the sheet - in accordance with ICIDH - as follows:

Grade.	Ability Profile (AbPr)	Requirement Profile (RqPr) .
0	no deficit - full ability available	full requirement
1	slightly restricted ability available	slightly restricted requirement
1/2	less or more severe deficit	less or more reduced requirement
2	severely restricted ability	severely restricted requirement
3	no ability available	no requirement

You have before you one assessed case. You see the "gradings" entered into the respective columns. If you draw a line connecting the entered gradings from top to bottom of the sheet - one by one - you will see why we call this a "PROFILE".

If you want to compare the AbPr of a disabled applicant for a job - with the requirement Profile of that job, you simply overlay the AbPr over the RqPr . You then will see by a glance, whether job would suit the applicant or not - or whether the job would unduely over- or under-demand the applicant.

If the disabled applicant would be too severely overdemand - with regard to one or several of his reduced abilities - he/she might develop inferiority complexes due to constant failures in achieving an appropriate rate of performance. If she/he would be severely underdemanded he/she might develop inferiority complexes to earning less, than he/she could

earn on a fully suitable job. Both should be avoided at any rate!

Minor differences should be decided upon by the experts responsible for hiring of disabled applicants for jobs - e.g. personnel manager, company physician, disabled employee trustee, department head, foreman, etc.. They will have to decide on the spot - and in consultation with the person in question - ultimately, whether the job is suitable for the applicant - or whether additional rehabilitation treatment will qualify him/her better for the job, or whether technical aids will compensate some of the shortcomings - or ultimately whether the technical equipment could be adjusted to better suit the applicants residual abilities. The adjustment should be such, that the applicant could earn the same or nearly the same wage as his/her non-disabled colleagues. Expenses for such adjustment will be paid in Germany by the Federal Labour Exchange Administration.

The mere comparison of the two sheets cannot give final answer on the suitability - it allows for a first rough preselection of candidates for vacant jobs and vice versa.

A large number of test-runs gave evidence of the validity and reliability of the EAM-System in a number of medium sized and large industrial companies in sheltered work shop for psychiatric cases and a project is under way, to assess approx. 2.000 disabled people employed in small and medium sized factories as to their AbPr and RqPr of the job they are doing.

Who is to do the "assessment"? - The AbPr should be assessed by a well trained and experienced occupational physician. - The RqPr can be assessed by a well trained and thoroughly experienced methods engineer. The training can only be done on the basis of literature prepared by ERTOMIS both in English and German - and by a number of video-tapes - available for the various types of equipment and for both 50 and 60 cycles. The training requires the availability of "master assessments" for the jobs and the people to be assessed on the basis of the "ERTOMIS Criteria Definitions" available in both English and German.

The disabled person having his/her "AbPr" in hand - should be free, to use the AbPr wherever he/she would apply for a job. If and when the EAM-System will be practised by all relevant organizations and experts, the bearer of the AbPr should be informed though, that the AbPr might open better chances to get a job, if she/he would present the AbPr at the labour-exchange office respectively to the personnel department of an industry or administration - if vacant jobs are available and the company has RqPr for those jobs available.

The advantage of the EAM-System over other analytical systems for the disabled people consists in the fact, the job-requirements are not defined in term of e.g. 2.200 standardized "professions" - existing in Fed.Rep.Germany, but that they are assessed in terms of more basic criteria - e.g. "Elemental Abilities" - respectively "Requirements of such abilities by the job".

To clarify what I mean, I want to cite a concrete case:

"If a tool-maker would have his right hand amputated - due to a motorcycle-accident - he could no longer work in his "profession" as a "tool-maker. The deficit he suffers is just criterion Nr. 1.12 and 21.22. All other elemental abilities and professional skills did not suffer! 62 of the 64 "Elemental Abilities and his professional skills are available. He could work as a draftsman for tools or as a supervisor of the tool-making department."

The EAM-System in principle is applicable to every kind of job in industry and in administration - even to agricultural jobs. The system is flexible so as to find suitable solutions for each individual case.

It is not only suitable for hiring outside applicants for jobs - but for inplant-transfer of disabled people to another better suitable job. It so could help to avoid dismissal of an employee as the only solution in case of "no suitable job available in plant or office for that person.

Nevertheless it has to be kept in mind, that the system cannot:

- find suitable jobs if there are no jobs available in the plant
- create jobs if there are no vacancies in the open labour market
- find suitable jobs in the case of extremely severe disability

Now let me - before closing - take up a subject Reh.Int. mentioned in one of the supplementary information, attached to the invitation for this conference: the abuse of the "U.S. Work Disability Benefits" We have to deal with similar problems related to "Eligibility Criteria" for the individual adjudication of "Work Disability Benefits" in Germany. The EAM-System is under consideration as a means, to overcome such problems.

"Social Security Benefits for Disabled-people in Germany" comprise e.g.:

- Tax exemption of income tax - and other taxes
- Free public transport
- Protection against discharge from employment
- 3 additional vacation days per year with full payment

- Quota for employment of disabled persons was raised in 1974 from 2.6 % of all employees to 6.0 %

New criteria for the adjudication of the status of "severely disabled person" were introduced by the amendment of the law in 1979 - called "Minderung der Erwerbsfähigkeit" = "Reduction of earning power" Actually the new yardstick was not RoEP - but instead an outdated classification of "MdE" from 1928, which at that time was introduced for the purpose of classifying old people for the bracket of old age pension payments. The effect of that misinterpretation of the term MdE was, that the number of "severely disabled people" (status) rose from approximately 1.0 Mio to 5.6 Mio people ever since. The total benefits rose by the same ratio.

Government authorities are looking for a better "yardstick" for that eligibility for work disability benefits. There are indications that they seem to consider EAM-System as such a better yardstick. The decision process will take time though.

ERTOMIS does not claim to have the final answers to all related problems. The system is constantly under consideration for improvement by our experts. ERTOMIS is open for all criticisms and proposals for improvements. We know that there are similar efforts undertaken in other European and overseas countries. We would appreciate international cooperation in the effort to arrive at an international integration.

Now let us see the video-tape, showing how four real cases of serious disability have been dealt with by the EAM-System.

Thank you, for your attention and interest.

PUBLIC POLICY AND THE DEFINITION OF DISABILITY

by

Harlan Hahn

University of Southern California

In recent years, the definition of disability has shifted from a medical approach, which stressed functional impairments, and from an economic orientation, which emphasized vocational limitations, to a socio-political perspective, which regards disability as a product of the interaction between the individual and the environment. From the latter vantage point, the principal problems confronting persons with disabilities can be attributed primarily to a disabling environment rather than to individual defects or deficiencies.

The socio-political definition has become the foundation for a new "minority-group" paradigm for research on disability that is currently challenging the traditional "functional-limitations" model which has guided studies--and public policy--in the past. The "minority-group" perspective also is founded on three major postulates. Initially, instead of focusing on individual impairments, this approach begins with the examination of public attitudes about disability, which reveals widespread evidence of aversion and prejudice. Second, the "minority-group" model reorganizes that virtually all aspects of the environment are determined by public policy. Finally, policy is viewed as a reflection of prevalent social attitudes and values. Hence, features of the attitudinal, institutional, and built environment that have a discriminatory effect on people with disabilities cannot be viewed as

accidental or coincidental.

The "minority-group" paradigm, therefore, provides a basis not only for realizing that disabled citizens comprise a group that has been subjected to invidious discrimination within the meaning of the "equal protection" clause of the Fourteenth Amendment to the U.S. Constitution but also for formulating policies that identify bias, segregation, and discrimination as the major problems facing people with disabilities. Thus this orientation challenges the traditional premises in policy that have tended to equate disability with unemployability, or an inability to engage in "substantial gainful activity." On the contrary, the failure to provide an appropriate environment for disabled persons in employment, education, and public accommodations is regarded as an issue of discrimination; and the principal solution to their problems consists of increased efforts to enforce anti-discrimination measures such as Section 503 and 504 of the Rehabilitation Act of 1973. An exclusive emphasis on service delivery can no longer be viewed as an adequate or feasible policy response to disability. Instead, growing stress needs to be placed on the legal rights of citizens with disabilities. This focus is consistent both with emerging research on disability and with the mounting international social and political movement of disabled persons.

At the present time, disability in the United States and elsewhere is infused with inconsistent and contradictory definitions and concepts. Since the "functional-limitations" model has been the dominant paradigm in research on disability for a longer time than the "minority-group" perspective, policy has tended to reflect the former orientation. As a result, more emphasis is placed on an attempt to improve the functional capabilities of disabled

individuals than an efforts to alter the environment or to make it compatible with the needs and interests of disabled citizens. Similarly, more stress is concentrated on determining eligibility for income-support or -maintenance benefits than on securing compliance with anti-discrimination measures. This imbalance needs to be redressed by changes in research priorities, administrative organizations, the allocation of resources, and the substantive content of public policy.

DRAFT

(Subject to Change)

"NATIONAL INSTITUTE OF HANDICAPPED RESEARCH:
RESEARCH IN THE EMPLOYMENT OF DISABLED PERSONS"

Summary of Remarks
by

Alton Hodges, Dr. P.H.
Acting Director
National Institute of Handicapped Research

at the
"International Research Conference On
Social Security Disability Programs"

Baltimore, Maryland

April 14-16, 1986

THE NATIONAL INSTITUTE OF HANDICAPPED RESEARCH HAS BROADENED THE FOCUS OF ITS EMPLOYMENT-RELATED RESEARCH FROM THE MORE TRADITIONAL CONCEPTIONS OF VOCATIONAL REHABILITATION TO THE BROADER, ENCOMPASSING GOAL OF INCREASING THE FUNCTIONAL CAPACITY OF DISABLED PERSONS FOR EMPLOYMENT. IT HAS ROOTED ITS NEW APPROACHES IN BASIC CONCEPTS THAT ALL PERSONS IN THE ADULT COMMUNITY ARE INCREASINGLY SEEN AS CAPABLE OF EMPLOYMENT--EVEN THOSE "PRESUMPTIVELY ELIGIBLE" FOR INCOME PAYMENTS; THAT WE MUST AIM FOR INTEGRATED EMPLOYMENT WITH NON-DISABLED WORKERS AND "REAL WORK FOR REAL PAY"; THAT WE MUST RESEARCH AND DEMONSTRATE WAYS TO PROVIDE SUPPORT TO THOSE WORKERS WHO NEED IT; THAT WE NEED NEW MODELS OF EMPLOYMENT AND APPROACHES TO IT.

THE ORGANIZING STRUCTURE FOR THIS RESEARCH ACTIVITY FALLS INTO THREE SEGMENTS: CAREER PREPARATION, CAREER INITIATION AND CAREER ENHANCEMENT. THESE AREAS BRING WITH THEM A FULL RANGE OF CONCERNS AND ISSUES WHICH INCLUDE: ATTENTION TO EARLY INTERVENTION IN THE WORKPLACE, PREPARATION OF YOUNG PEOPLE FOR A CAREER, CAREER MOBILITY, SERVICE PROVIDER ROLES, THE IMPACT OF THE ECONOMY ON JOBS, AND ISSUES OF PUBLIC POLICY.

NIHR RESEARCH ACTIVITIES IN THESE AREAS WILL BE DESCRIBED BY DR. HODGES.

CHRONIC PAIN AND DISABILITY: INTERNATIONAL RESEARCH TRENDS

by E. Chigier, M.D.

One of the most neglected areas of rehabilitation is the rehabilitation of persons with chronic pain, especially low back pain. This condition is widespread, in the Western world, is prevalent in young adults, as well as in older persons, in persons from all walks of life, sedentary or physically active occupations, and is a prominent problem amongst people in the working age group of the population. Low back pain, or other forms of chronic pain has resulted in enormous, almost uncountable loss of work days, tremendous expenses in orthopedic, physiotherapeutic surgical and non-medical treatments, a vast amount of human misery and suffering, and a state of incapacity to function, and to earn for millions of individuals.

Yet, there are few studies on the rehabilitation approach to this condition. In Israel, Drs. Magora and Adler, at the Department of Physical Medicine and Rehabilitation, Hadassah University Hospital, Jerusalem, carried out a study in 1984, sponsored by the (then - entitled) Social and Rehabilitation Services, U.S. Department of Health, Education and Welfare, entitled "An Investigation of the Medical, Social, Economic and Vocational Problems of Individuals with Low Back Pain Syndrome".

Most important findings were as follows:

1. The highest incidence was found in heavy industry workers and nurses, the lowest in policemen.
2. The condition was more prevalent in Ashkenazim (Western hemisphere immigrants), in those with a higher level of education, in persons sitting for prolonged periods of time, or who were unable to sit at all during the working day.
3. Age and occurrence of trauma were insignificant factors, as also the feeling of strength in relation to physical occupational demands.

4. Subjects not satisfied with their present occupation, place of employment, social status, who felt that a high degree of responsibility and mental concentration was required of them, and who were nervous and fatigued after work, had a definitely higher incidence of Low Back Pain than the controls. (2)

The report on the Panel on Pain in the U.S.A. in 1979, estimated that about 75 million Americans suffer from chronic pain. According to the National Institute of Neurological and Communicative Disorders and Stroke the cost of this pain - for hospitalization, loss of income, disability payments and legal settlements is 40-50 billion dollars a year. (2)

Research by W. Fordyce at the University of Washington's Rehabilitation Research and Training Center in the Department of Rehabilitation Medicine has indicated that the disease model with regard to chronic pain i.e. that it is due to an organic or an emotional pathology is the one usually adopted by practitioners and is not a useful model. He proposed that pain be regarded as a form of behaviour, and that chronic pain should be treated like any other behaviour - that is according to the laws of learning and conditioning. For a behaviour to continue, it must be reinforced. This means it either brings about rewards or helps avoid punishment. On this basis, following a thorough evaluation, a comprehensive therapeutic strategy is worked out which has a greater chance of achieving partial or total success than the conventional methods of treatment. (3-8)

In a review of "Chronic Pain in the Medical-Legal Aspects of Workers Compensation Cases" by D.W. Florence from Minneapolis, published in 1984, chronic pain is described as a behaviour disorder and a perception illness, particularly in cases of workers' compensation, of which the greatest percentage of loss is due to minor accidents or incidents, following which the patient does not

respond to standard medical care, and does not return to his or her original employment. Medically, chronic pain is really a manifestation of stress-related situations.

Early commencement of rehabilitation at a proper center is considered as necessary to avoid time loss and mental fixation of pain. Chronic-pain treatment centers should take patients before workers compensation litigation is settled as delays tend to perpetuate rather than resolve the problem.⁽⁹⁾

A study in Australia on the "Effect of Legal Settlement on Work Disability Following Compensable Injury" by G. Mendelson (1984) showed that contrary to the beliefs of many lawyers and medical practitioners, a very significant proportion of claimants, are not "cured by verdict", and do not return to gainful employment after their cases are settled.⁽¹⁰⁾ The need for early rehabilitation intervention to avoid the fixation of chronic pain as a behaviour pattern is therefore all the more obvious.

The situation in Israel is strikingly similar to what has been mentioned above with regard to the United States and Australia. Chronic pain is a common phenomenon, treated usually by orthopedic surgeons with medication, physiotherapy, surgery, often with poor results. The National Insurance Institute programs for general disability or work-related disability pay no attention to chronic pain as such, and only provide benefits where organic signs such as limitation of movement are present. The rehabilitation department of the National Insurance Institute has little contact with the few chronic-pain treatment practitioners that function in Israel. An early promising sign has been a one-day institute organised by the Section of rehabilitation psychologists of the Israel Psychological Association together with the Ministry of Health on 16 May 1985 on Pain at the Sheba Medical Center, Tel-Hashomer.

CONCLUSION

It is strongly recommended that a policy of early referral of persons with chronic pain be made by the National Insurance Institute and its department of rehabilitation to chronic-pain treatment centers, and that a controlled study be made on the efficacy of such a rehabilitation approach, as compared to the conventional mode of treatment. In this context, a collaborative program could be set-up, in connection with the proposed plan of the Institute of Medicine, American Academy of Sciences, Washington, D.C., to organize a Work-Study group on Pain on Disability. (1)

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References

1. Magora A. and Adler E. An Investigation of the Medical, Social, Economic and Vocational Problems of Individuals with Low Back Pain Syndrome, in "Rehabilitation Research in Israel".
E. Chigier, Editor. Gomeh Publications, Tel Aviv, pp. 163-166, 1972.
2. Report on the Panel of Pain to the National Advisory Neurological and Communicative Disorders and Stroke Council, NIA Publications 79 - 1912.
June 1979.
3. Fordyce, W.E. "A Behavioral Perspective on Chronic Pain". In L.K.Y. Ng. and J.J. Bonica (eds.) Pain, Discomfort and Humanitarian Care, New York: Elsevier North Holland, Inc. 1980.
4. Fordyce, W.E. and Steger, J.C. "Behavioral Management of Chronic Pain" In J. Brady and O. Pomerleau (eds.) Behavioral Medicine: Theory and Practice, New York: Williams and Wilkins, 1978.
5. Fordyce, W.E. and Fey, S.G. "Behavioral Rehabilitation of the Chronic Pain Patient" In E. Pan, T. Backer, C. Vash and S. Newman (eds.) Annual Review of Rehabilitation, Volume 3, New York: Springer Publishing Company, in press.
6. Fordyce, W.E. "Chronic Pain" In W.C. Stolov and M.R. Clowers (eds.) Handbook of Severe Disability, Washington, D.C. U.S. Department of Education, Rehabilitation Services Administration, 1981.
7. Fordyce, W.E. "Learning Processes in Pain" In R.A. Sternback (ed.) The Psychology of Pain. New York: Raven Press, 1978.
8. Fordyce, W.E. et al. "Operant Conditioning in the Treatment of Chronic Pain" Archives of Physical Medicine and Rehabilitation, 1973, 54: 399-408.

9. Florence, D.W. "Chronic Pain in the Medical Legal Aspects of Workers' Compensation Cases" in Disability: Medical-legal Library .
A. Carmi, E. Chigier, S. Schneider (eds.) Springer-Verlag, Berlin
pp. 106-114, 1984.
 10. Medelson, G. The Effect of Legal Settlement on Work Disability
Following Compensable Injury" in Disability: Medical-legal Library
A. Carmi, E. Chigier, S. Schneider (Editors) Springer-Verlag, Berlin.
pp. 198-208, 1984.
 11. F. Solomon. Institute of Medicare; American Academy of Sciences,
Washington, D.C. - personal observation, 1985.
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Additional Notes

1. Different Forms of Chronic Pain

Most people think usually of backache or low back pain when chronic pain is mentioned. Low back pain features heavily in occupational medicine, work-related injuries, epidemiological surveys and clinical studies; but in viewing chronic pain as a disability, which calls for early rehabilitative intervention, consideration must also be given to neck pain, headache, facial pain, joint pains, pain following amputation or other forms of surgery, and menstrual pain.

2. Chronic Pain is Universal

Chronic pain is not only a Western societal phenomenon. It occurs in Philippine laborers carrying poles on their shoulders, or Javanese women carrying containers on their heads.

3. Chronic Pain Often Affects Young Adults

People in their thirties or forties often have chronic pain. The resultant disability may therefore put an end to a working career which has still 20-30 years of potential employment. (Nupin Report 1985)

4. The Vastness of the Problem

For example:

- | | |
|-------------|---|
| Finland | - 41% incidence of chronic recurrment low back pain (LBP) |
| | - 17.5% with severe LBP |
| Netherlands | - 51% positive history of LBP |
| | - 22% with LBP at time of survey |
| Spain | - LBP causes 3% of work absenteeism |
| | - Each worker lost 1.5 days in 1980 |
| Sweden | - 12% of all absenteeism/absence period 30 days average |
| England | - LBP causes 11 sickness absence periods per 1000 women |
| | - 22.6 sickness absence periods per 1000 men |

U.S.A. - 12-20% of population

Philippines - 10% of population

5. Time Factor and Patho-physiology

A report from London, England describes four different modifying pain mechanisms:

- 1) With a latency of milliseconds - rapid powerful gate control.
- 2) With a latency of minutes - impulses in C fibers change excitability of peripheral endings and of spinal cord circuits.
- 3) With a latency of days - chemical transport in C fibers from areas of damage, further modifies cord connectivity with a disappearance of inhibition and an expansion of receptive fields.
- 4) With a latency of weeks or months - anatomical degeneration produces secondary changes in differentiated cells, with atrophy, sprouting and abnormal firing patterns.

Time, therefore, and early active intervention is of the essence.

6. Circadian Rythmn

A study in England reported most pain in the morning (60%) and afternoon (30%) i.e. essentially in working hours.

7. Relationship to Psychosocial Factors

Sweden - amongst other factors (of ergonomic nature) significant relationship to other psychosomatic symptoms (headache, digestive or sleep disturbances) fatigue after work, dissatisfaction with salary and a more serious attitude towards symptoms.

Sweden - correlation with work monotony, dissatisfaction.

England - after 6 months chronic pain - a progressive iatrogenic influence on presentation of psychological features in chronic LBP.

Finland - LBP patients with chronic pain surveyed by psychiatrists:

31% had a clinical disorder. Others often had associated neuroses or mild neurotic traits.

USA - a) the "Hassle Test" in the Nupin Report indicated that high stress is more commonly associated with chronic pain and for longer periods.

b) Chronic facial pain often leading to severe depression.

c) Pain of a chronic type may run in families - early awareness or orientation to pain, psychosomatic or tension factors, possibly genetic.

d) Cultural factors relate to the threshold of pain (Zobrowski)

8. Psychodynamics of Chronic Pain (Fordyce)

a) Awareness of hurt and harm.

b) Impact of injury, surgery, disuse, superstitious overguarding and illness convictions.

c) Realization of defects in ability to be well.

d) Progression from acute to chronic pain - interaction of 2 set of forces:

1) patient characteristics: particularly readiness to convey to others that he or she is sick; "pain plumage" leading to a sick role.

2) early management methods which unintentionally promote persistence of the problem.

e) The value of a situation inventory.

9. Pain Test

Dr. M. Cousins - Flinders Medical Center, Australia

insertion of tube into epidural space through which a placebo, pain relieving opiate (which is effective when given epidurally) which affects receptors in spinal cord, and followed by an opiate antagonist. Patient uses a pain sheet

to record pain and its severity. Will differentiate between organic and functional pain. Inexpensive, easy to carry out, takes 3-4 hours.

10. Active Intervention

Finland - outcome of comprehensive rehabilitation program with chronic LBP - less pain, less functional disability but no improvement in work capacity at 4 week and 4 month follow-up.

Netherlands - pain control courses (to avoid opposition to psychotherapy) included multi-disciplinary education, group session and self-hypnosis training led to significant improvement in some aspects. Sometimes it is better to learn to live with the pain, appeal to sense of personal mastery, develop individual coping strategies, rather than aim for unrealistic cure and relief from all pain.

USA - recommendation to ignore pain behavior and respond to remaining elements of positive behavior.

11. Conclusion

To have any chance of return to working capacity comprehensive rehabilitation approach is called for at the earliest possible stage, i.e. 3-6 months following onset of chronic pain.

DRAFT

Computerized Synthesis of Responses to Questionnaire
on Social Security Disability Programs:

Austria, Canada, Federal Republic of Germany,
Finland, Israel, Netherlands,
Sweden, U.K. and U.S.A.

Prepared by:

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International Research Conference on
Social Security Disability Programs

April 1986

FOREWORD

The following is a synthesis of responses to the questionnaire developed for the Rehabilitation International project on social security disability programs in eight countries, contracted by the U.S. Social Security Administration in 1985. The questionnaire was developed for the project by a small group of consultants from the countries studied.

This draft is being submitted to the International Research Conference on Social Security Disability Programs, the concluding activity of this project. Some corrections and additions are still being made by the country experts and a final version of this synthesis will be issued following the conference.

We invite your comments, reactions, corrections and criticisms.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section I Part I

Provide a brief description of the Social Security Disability Benefit program, including stated objectives and the scope of population coverage. Include the overall definition of disability used for this program.

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
In Austria the complex social security system is subdivided in 3 branches-health insurance, accident insurance & pensions insurance. SS benefits for the disabled are most often found in the invalidity incapacity to work and incapacity for gainful occupation pensions from the pensions insurance program. In Austria social insurance is obligatory for nearly all self-employed & employed persons. Its benefits are to the greatest part financed by tax contributions, while the state grants subsidies for certain specific areas. There is not really one specific definition of disability applied by the social security system. In the health insurance, the term "incapacity to work due to illness", is found, in the accident insurance is cited "reduction of earning capacity" & in the pensions insurance the terms "invalidity", "incapacity to work", & a "permanent incapacity for gainful occupation" are found.	The Canada Pension Plan (CPP) & Quebec Pension Plan (QPP), as of 1/66 are compulsory contributory social insurance plans to protect workers and their families against loss of income from retirement, disability or death. Most working Canadians are eligible since contribution is compulsory for everyone employed between 18 and 65 yrs. Provided that contributions were made for a minimum of 5 out of the last 10 years and for 1/3 of the contributory period, a disability pension is payable to a person with a severe and prolonged mental or physical disability. A person is eligible if "he or she is incapable of pursuing any substantially gainful occupation due to a disability which is likely to be of long or indefinite duration or is likely to result in death." The QPP & CPP are somewhat alike in terms of eligibility criteria, benefits and financing.	In Finland there are four programs which provide disability benefits. The Social Insurance Institute (SII) has responsibility for administration of the National Invalidity Pension (NIP). This program provides a minimum flat rate income to the insured. This benefit is payable to insured men & women between 16-65 who, because of an illness, defect, or injury, are unable to maintain themselves by their usual work or any other kind of work which, considering their age, occupation, education & place of residence, would be suitable for them. The other private insurance programs are Employment earnings-related Pension & Disability Pension programs which are referred as EPDP. The programs are nationally administered by private pension insurance companies, pension funds and foundations, semi-public and public pension institutions. There is also Employment Accident Insurance (EAI) and Motor Liability Insurance (MLI). The programs are nationally administered by private insurance companies and one semi public and one public institution. The compulsory programs provide benefits for persons who have become disabled for work in employment or traffic accident or have an occupational disease.	The UK equivalent of SSDI is Invalidity Benefit. It is an insurance benefit for employees or the self employed who have been incapable of work for 28 weeks. It provides income for people unable to work due to a specific disease or bodily or mental disablement. Most people of working age are covered, including those insured unemployed persons who are available for work. Main exclusions are those who have never worked, or worked too briefly to pay sufficient contributions, very low earners and people not available for work-mainly married women caring for children. Some married women in work still choose to pay reduced contributions which do not entitle them to sickness or invalidity benefits. (This option was abolished in 1977 for newly married women) People are also deemed incapable of work if they are suspected of carrying or being in contact with an infectious disease or if they are only performing therapeutic tasks recommended by a physician.	The general disability benefit program is administered by the National Insurance Institute. While the Institute has been responsible for providing VR services for many years it only began to pay benefits with the commencement of collection of insurance contributions in 1970. Payments of pensions to disabled persons, which included only newly disabled persons began in 1974. Disability benefits were extended to include the disabled housewife in 1977, the disabled person from abroad in 1979, & the disabled child in 1981. Mobility allowance for certain categories of disabled persons became functional in 1975, with various extensions of benefits during 76&77. Attendance Allowances were introduced in 1979. In 1981 amendments to the General Disability Law came into effect, the most important being the abolition of the distinction between a "previously disabled" & a "newly disabled" person.		The SS system-except for unemployment insurance-are administered centrally by the National Social Insurance Board, which is an independent government authority under the jurisdiction of the Ministry of Health & Social Affairs. Locally they are administered by 26 regional social insurance offices & by local tax offices (460 totally). The social insurance offices are independent corporations with their own financial structure. They are neither state nor municipal authorities. Each office is managed by a board with a chairman appointed by the Government. They are supervised by the National Social Insurance Board. The local tax offices determine pensionable income for supplementary pension purposes & contributions from employers & self-employed persons.		The SSA has national responsibility for the administration of the Social Security Disability Benefit (SSDI) program which provides cash benefits for disabled workers & their dependents who have contributed to the SS trust fund thru FICA tax on their earnings. It defines disability as "inability to engage in any substantial gainful activity by reason of a medically determinable physical/mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months".

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section I Part I.A.1

What agency administers the SSOD program at: the national level?
the regional level?
the local level?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
There are two insurance institutes administering social security on a national level: (1)Pensions Insurance Institute for Employees (2)Pensions Insurance Institute for Workers, even though there are several social insurance institutes administering the social insurance benefits for disabled persons based on occupational and/or territorial structures. At the regional level, the Pensions Insurance Institute for Employees has offices in the provinces, that do not have any decision power (centrally organized). The Pensions Insurance Institute for Workers has regional offices with decision power (decentrally organized).	The CPP except in Quebec. That province has established a comparable provincial plan in lieu of CPP. Info is available from offices located at the local level, including Income Security Programs offices of the Dept of National Health & Welfare, regional offices and Client Service Centers, both full- and part-time. These offices are often in contact in applying for benefits. Claims can be submitted at local or national level. There are no provincial offices. Itinerant offices are set up periodically in areas too small to warrant a permanent operation. A field officer is sent to provide info, collect forms and help clients fill out forms if necessary.	SII administers NIP & its disability benefit program on a national level. EPDP programs are administered on a national level by private pension insurance companies, pension funds and foundations, semi-public and public pension institutions. EAI and MLI programs are administered on a national level by private insurance companies and by 1 public institution. The SII has 5 regional offices which has oversight over the 206 district offices and 244 district sub-offices. At the local level: EPDP - private pension insurance companies have local branch offices in major cities and in addition local agents. Pension funds & foundations are locally operated in connection to larger enterprises. Semi-public and public pension institutions have head-offices only. EAI & MLI - Private insurance companies have head-offices & branch offices in major cities as well as agents in rural areas.	A national office handles data on contributions. Regional offices are responsible for conducting (but not initiating) medical reviews. The Dept of Health and Social Security (DHSS) administers the program thru local offices in England, Scotland & Wales. The DHSS in Northern Ireland administers a separate but identical program.	The General Disability Benefit Program is administered by the National Insurance Institute which has its central national office in Jerusalem. The work of the Institute is carried out thru 17 branches located throughout the country. There are also several sub-branches, so that in all there are 30 branches & sub-branches. Each one has a unit dealing with the general disability benefit program, as well as a rehab service unit, which deals with referrals from the general disability benefit unit work-injury unit and other units who refer clients from rehab. There is also a medical unit at the branch level.	The implementation of the SS acts is the responsibility of the semi-public trade associations at both the national and regional levels. The 25 trade associations have, in turn, set up the Joint Medical Service (JMS) to act as advisor in the evaluation of labor disability and in the provision of facilities to compensate for functional disabilities. Before a decision can be made by a trade association concerning social/medical matters, the JMS must first be consulted. The implementation of the most important social insurance programs for the disabled therefore consists of the combined action of the JMS and the trade assoc. Both the JMS & the trade assoc., to the extent that they committed their record-keeping to the Joint Administration Office (JAO), maintain regional offices and 1 national headquarters in Amsterdam.	The disability benefit system is administered centrally by the National Social Insurance Board, which is an independent government authority under the jurisdiction of the Ministry of Health and Social Affairs.	Pension insurance administrations (1) for salaried employees: (Federal Insurance Institute for Salaried Employees), (2) for workers in the mining industries: (Federal Miners' Insurance Institute), (3) for maritime workers: (Maritime Insurance Fund), (4) for Federal Railways workers: (Federal Railways Insurance Institute). Regional Insurance institutes administer the wage earners pension insurance. The regional competence of the 18 regional insurance institutes administering wage earners' pension insurance is not always identical with lander boundaries.	The Social Security Administration (SSA) operates the disability program at the national level. There are 10 federal regions at state and local offices. On the state level the program is administered by the Disability Determination Services (DDS), a state agency w/ state employees & federally funded. There are 1300 district SS offices staffed by federal employees. Area directors supervise local operations.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section I Part I.B

What are the communication and procedural links between the different levels of the agency?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
***** The links between the social insurance institutes & the social assistance are set forth in the General Social Insurance Act. The 28 independent social insurance institutes are linked together in the Federation of Austrian Social Insurance Institutes. The Federation is acting as a coordinating institution, where the rehab measures are concerned.	***** A number of federal agencies have input to CPP, e.g. the Dept of Nat'l Health & Welfare has primary administrative job; the Canada Employment and Immigration Commission administers the Social Insurance & system used for ID purposes; Revenue Canada, Taxation deals w/ coverage and contributions; the Dept of Supply & Services assists in electronic data processing. The CPP Act is administered by the Quebec Pension Board, while contributions and contributory status are the responsibility of the Quebec Ministry of Revenue. Applications are forwarded from local offices to the national office. Contributory records (Record of Earnings) are computer checked to confirm eligibility & the medical review process begins. Operational bulletins inform field officers of changes in procedure etc. Staff training programs and revisions to the operational manual ensure that current info is available to local offices.	***** See above.	***** Not applicable.	***** Each branch has a director who is in direct contact & under supervision of the national office. The rehab service unit is integrated directly into the local branch, with direct referrals, continuing contacts & collaboration. Each unit director, also has a direct contact at the national office & the heads of the dept., thus ensuring supervision & continued communication. The Bureau of Research & Planning which is headed by a deputy-director general, of the MII, maintains contacts with the various depts., provides statistics and carries out various evaluations and analyses. The communication & procedural links are a) Horizontal between units at the branch level or between dept. at the national office level, b) Vertical between units of local branch & their respective dept. at the national office. Since the country is very small in size & population, there is no regional level in operation.	***** The regional offices of the JAO and the JMS are always located in the same building, which successfully eliminates all geographical hindrances to communication. The activities of the JAO & JMS are coordinated at all levels: at the national level via supervisory councils, management & staff, & at the regional level via peripheral management. Guarantees of the greatest possible uniformity in advice concerning benefits or facilities & services are ensured within the JAO, JMS & the autonomous trade assoc. by the use of manuals and the standard "Rules & Directives". Tasks required of the JMS: a) the reintegration of the handicapped with regard to employment & society, b) investigating the nature & degree of labor disability, c) advising concerning the degree of labor disability, d) investigating the need for facilities or services, e) advising concerning facilities for living or work, f) the setting up & managing of certain categories of facilities, g) monitoring the process and result of treatment or facilities, h) researching the quality of reintegration possibilities.	***** See above.	***** The various pension insurance administrations are members of the (Federation of German Pensions Insurance Institutes) who co-ordinates all matters of common interest.	***** 10 Regional SSA Offices oversee state & local ones. Area Directors supervise local offices, independent of the state (DSS).

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section I Part I.C

How is the program funded in terms of benefit payments to the beneficiaries?
Contributions by insured workers? General tax revenues? Contributions
or taxes paid by employers? Other?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
There are obligatory contributions by insured workers and employees, except with accident insurance where there are no contributions by employed insured persons. In addition, there are contributions of the state from general tax revenues. There are also contributions by employers. Further, there are contributions of persons who are voluntarily insured either as a continuation of insurance after employment has ceased or as a self-insurance and/or from other income (from property, interests on arrears, extra charges, etc.)	There are equal contributions by the employee and the employer. There is also interest on the Canada Pension Plan Account contributed to the program.	There are employee contributions to the SII and employer contributions for SII, EPDP & EAI. In addition, contributions are made by: For SII-state & municipalities. For EPDP-some programs by the state. For MLI-contributions by owners & holders of motor vehicles.	91% of the benefits are paid out from the national insurance fund and 9% are from general taxes. Employees pay 9% of their weekly salary up to 265 pounds. The SS Act-1985 reduced contributions for people earning less than 90 pounds. No contributions are payable if weekly earnings are less than 35.5 pounds. Employers pay 10.5% of employees weekly salary up to 265 pounds. The SS Act-1985 abolished upper limit.	There are employee contributions with a level set at .75% of wages up to a ceiling of three times the average wage. Employee contributions also comprise .75% of wages up to a ceiling of 3% the average wage. Insured (self-employed & other non-employed) comprise 1.5% of income up to a ceiling. Note: a housewife is exempt, & does not pay insurance, while she is entitled to receive benefits from the general disability benefit program. There are no contributions from general tax revenue except for those to the mobility allowances.	The GDBA & DIA are financed by means of premiums paid by employees. All funds collected in this way by the trade associations are put into 2 funds: The General Disabling Benefit Fund (GDBF/AAF) or The Disabling Insurance Fund (DIF/ADF). In addition there are also premiums paid by employers.	There are contributions by self-employed persons but employer contributions make up about 65% of the total expenses. In addition there are State subsidies (about 17% of the total expenses). Also by interest & contributions paid by the municipalities.	There are equal amounts contributed by both employers and employees. Additionally a federal subsidy is granted. There is no special earmarking of funds used for rehabilitation or incapacity pensions. Insured workers' & employers' contributions amounted to 83%, the federal subsidy to 15.6% of the 1984 revenues. The remainder (1.4%) came from interest & miscellaneous other sources.	There are equal contributions by employers and employees.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section I Part I.D,E,I,E.2

How is the agency which administers the program funded?
What are the annual expenditures of the agency?
What percentage of these expenditures are direct benefit payments?
What % is spent on agency staff? Appeals procedures? Other agency?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
See above.	CPP Account. No direct federal government funding.	See above.	Mainly from general taxation, but administration costs are met from the National Insurance Fund.	The NII, which administers the program is an autonomous agency which receives its funds thru collection of contributions from employees employers and other insured for the various categories of benefits provided.	The operational structures of the trade associations and the JMS are financed from the GLDF & the LDF on the basis of the declaration of costs incurred for benefits, facilities & services, administration, etc.	See above.	Administrative expenditures, too, are financed from the above contributions and federal subsidy.	SS Trust Fund.
Data from 1983 in 1000 Austrian Shillings: Pensions insurance for workers & employees = 107,968,794 (100%), Pensions insurance for self-employed = 21,376,060 (100%), & Accident insurance = 7,386,412 (100%).	\$3,745,815,000 (1984). 11.9% on disability pension payments; 1.4% on disabled contributor's child benefits.	Due to the different structures of the described systems figures are not comparable.	40 billion pounds. (22 billion pounds are paid from the National Insurance Fund at an administrative cost of 770 pounds.	1983 total was 197,064 000 dollars=15,108,160 000 shekels. 1984 is likely to be at the same level.	GDIF spent 9,661,171,000 f in 1982, and the DIF spent 9,159,597,000 f.		In 1984, total expenditures under the wage earners' and salaried employees' pension insurance scheme amounted to approximately 160,000 million Deutschmarks.	Relevant figures will be supplied by SSA.
Pensions insurance for workers & employees = 104,175,480 (96.49%), Pensions insurance for self-employed = 20,522,053 (96.05%), & Accident insurance =	Because staff of different agencies are involved it is impossible to provide this.	All the systems are using about 80% for benefit payments.	The expenditure on Invalidity Benefits is 2280 million pounds. Of the 40 billion pounds, 38.5 billion pounds is for benefit payments.	For 1983-5.4 % of budget was spent on administration expenses, the rest being for payment of disability pensions.	GDIF & DIF-approximately 95% are used for direct benefits & facilities.		86.5% were spent on pension benefits, 8.1% on pensioners' health insurance, 2.4% on rehabilitation benefits.	
Agency staff, appeals procedures & other agency administration: Pensions insurance for workers & employees = 3,793,314 (3.51%), Pensions insurance for self-employed = 845,007 (3.95%), & Accident insurance = 1,353,566 (18.33%).	Less than 1%. 2.4%.	Administration costs are about 20-23% of benefit expenditures.	1.5 billion pounds for administration of which 50% represents staff costs.	N/A.	The direct administration costs account for about 5% of the costs withdrawn from the GDIF. The direct administration costs amounted to circ. 3% of the DIF's costs.		1.8% on administrative and processing costs.	
		These figures are not separately available.	Not separately identifiable.	N/A.				

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section I Part I.F.

Who administers the agency at the highest level?
(e.g. government officials, board representing interest groups.)

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
..... The social insurance institutes are legal entities under civil law. As for any legal entity, they are governed by the organs of self-administration & are subject to controls by the Federal Ministry for Social Administration. The public-law institutions of employers & employed persons nominate delegates for the administrative bodies of the social insurance institutes.	 Minister of Health and Welfare, an official responsible directly to the Prime Minister.	 SII-Director General Commissioners appointed by the Parliament, Enlarged Board, Board of Directors. EPDP-Managing Directors, Boards of Directors. EAI & MLI-Managing Directors, Boards of Directors. All are supervised by the Ministry of Health and Social Affairs.	 The DHSS is headed by the Secretary of State for Social Services, a Member of Parliament & Cabinet Minister, assisted by 4 other Ministers in the House of Commons and 1 in the House of Lords.	 The agency is administered by the director of the General Disability Benefit Dept at the national office & his staff. The Council the NIL, which comprises representatives of the government, employers & employees associations, & acts as an advisory body to the NIL, has various committees, including a committee for the general Disability Benefit Program which is also comprised of representatives from government, employers & employees associations & has an advisory capacity.	 At their highest levels, the trade associations are managed by a board of management consisting of 3 representatives from the central employers' organizations, 3 members appointed by the central workers' organizations, 4 members appointed by the trade associations, of which 2 come from employers and 2 from trade unions. In addition, the JMS board also includes 2 other members, appointed by the Minister of Social Affairs and Employment from the ranks of the handicapped.	 The National Social Insurance Board which is managed by a board. The chairman of the board is the Director General. Besides the Director General & his deputy, at least five other members should be elected to the board. These members are appointed by the government & represent for instance the parties on the labor market.	 Top-level responsibility of the pension insurance administration is placed with the administration's self-governing bodies, which combine employers' & insured workers' representatives. Responsibility for current administrative business lies with employed executive directors.	 The Commissioner of the SSA who is an employee of the Dept. of Health & Human Services.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section I Part II.A
Agency Staffing

What type of personnel in the agency are involved in the benefit decision-making process.
At the local level?
At the regional/state level?
At the national level?
What non-agency personnel are involved in the process?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
From the legal point of view: senior clerks/ social workers & controllers, From the medical point of view: medical specialists & head physicians, and from both: self-administration (pensions board, rehab board). This decision making process applies at the regional & at the national level.	Staff are facilitators only; they can make recommendations, but no decisions. Physicians are involved at the national level. Non-agency personnel serve to provide data only.	At the local level there is no SSI & EPDP staff. There is staff for EAI & MLI-Head Offices Dept Heads, normally with legal training, with help of physicians. At both the regional and national levels: SSI & EPDP-Physician & legally trained adjudicator. Non-agency personnel: physicians and members of interest groups connected to Pension Boards.	At the local level Adjudication Officers are based in DHSS offices. At the regional level medical evidence is provided initially by the claimant's own doctor. Further advice may be sought from the DHSS Regional Medical Service or sometimes from independent specialists. Nationally, there is a Chief Adjudication Officer at this level.	Claims Officers are involved at the local level. No decisions are made at the regional level. There are no decisions at the national level except in special cases. Non-agency personnel are rarely involved.	The JMS acts, on the peripheral level where decisions are made, as advisor to the trade associations in the form of teams involved in drafting of advisory reports. These teams consist of: A national insurance practitioner, who is a graduated Medical Dr. A vocational rehabilitation expert, a legal assessor and a team secretary who monitors the progress of the process. When specialized knowledge must be recruited a team can call in experts. The advisory report must have the unanimous approval of the team.		Benefit claim decision making occurs at the relevant insurance administration's head office at the local or regional level. Where necessary in the individual case, appropriate non-agency experts are asked to give their professional opinion.	The claims representative operates at the local level. There is a disability doctor at the state level. Nationally, there are QA reviewers, claims authorizers, disability doctors/examiners. Non-agency personnel are physician, psychiatrists, psychologists on contract to the SSA.

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QUESTIONNAIRE RESPONSES

Section I Part II.B

What percentage of claims are decided at each level?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
As the Pensions Insurance Institute for Employees is centrally organized, the decisions on claims are exclusively made by the central administration. In the Pensions Insurance Institute for Workers, the decisions on claims are exclusively made by the provincial offices & the central administration only has a coordinating function.	100% of claims are decided at the national level, excluding applications to the CPP. In 1984, 48,613 new applications for disability pensions and 7,904 new applications for disabled contributor's children's benefits were received.	SSI-all decisions are made on control level. BPP, EAI & ALI-all decisions are made by the head offices.	All claims are decided by the local adjudication officer.	All claims are decided at the local level, except very special cases.	The body of the advisory reports are drafted at the 33 peripheral offices. These reports are then sent to the trade associations, which make decisions at the central level, and, for some difficult cases, the reports may also be sent to a special administrative committee (the so-called 'little commission').		Since the subdivisions do not exist between levels this section is not applicable.	2,000,000 filed/yr. 1,100,000 for SSI. 900,000 for SSI-See VII 1,414,000 of these cases will be decided on disability and the balance denied for reasons unrelated to disability. 467,000 initially OK'D 949,000 denied at the initial level. 1985 SSA projections: 70% initial approvals 9% reconsidered 20% at ALJ hearings 1% by Appeals Council and the Federal Courts

REHABILITATION INTERNATIONAL
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Section I Part II.C

What are the qualifications of the claims processors or adjudicators?
Academic (school years, degrees)
Training (special training, on the job training)

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
When the decision making process requires a specific academic training, persons with academic qualifications are used (jurists,economists, psychologists,specialized physicians, etc.) Otherwise lay persons who have been adequately trained by the in-house training dept are used. A great importance is attached to continuation and refresher courses.	Claims processors:High school graduation or equivalent,plus training. Adjudicators:RMs, some with BS degrees. All staff members receive special training.	Academic (often legal education) or college graduates or have advanced through the ranks. All personnel receive continuous training on the job.	Adjudication officers do not need to possess any academic qualifications beyond those required for entry to the lay civil service. Additional training is provided at the place of work & on specialist training courses. Courses include a 1 wk. basic course available after 3 wks on duty. Follow up training moduls are also available as required if applicable to particular benefits.Adjudication officers on appeals work have a correspondence course & attend a 3-day course on appeals presentation.	Matriculation certificates are required for processors. There is no training beforehand. A two month training course as well as on the job training is provided. There is a period of initial supervision of 3-12 mths followed by regular periodic supervision.Lectures & training sessions are organized intermittently.	The vocational expert must have completed higher technical school education,with emphasis on technical or social matters. The national insurance practitioner must have completed medical training. The legal assessor must have completed higher (professional) education. The vocational expert must have at least 5 yrs of extensive and varied labor experience. The national insurance practitioner must have experience as practitioner or, preferably, as industrial practitioner. The legal assessor must have a diploma in social insurances (internal training). The employment experts & national insurance practitioners also receive internal training from the JMS, & an information system concerning the operational functions of a peripheral office is also at their disposal. (The Employment Structures Documentation system-ESDS).The legal assessor receives training from the Joint Administration Office in the form of the JAO's own social insurance course.	The administrative decision is usually made by staff holding university degrees (law degrees). Claims-processing matters for preparation of the final decision are as a rule incumbent on specifically trained personnel.The required specific knowledge is ensured through in-service training.	The administrative decision is usually made by staff holding university degrees (law degrees). Claims-processing matters for preparation of the final decision are as a rule incumbent on specifically trained personnel.The required specific knowledge is ensured through in-service training.	Local, national and BA reviews-college grad/BA or advanced thru ranks State requirements vary but usually require a college degree. All personnel receive formal training,on-the job training & 1st yr. are closely reviewed. Claims reps get up to 13 wk classroom classes. Disability examiners up to 8 weeks.

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Section I Part II.D.

What job aids are used by the adjudicators?
(e.g. regulations, guide books, etc.)

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
..... The relevant official law bulletins and decrees, information circulars, service instructions, decisions of the special arbitration courts for social insurance and the high courts, specialized literature.	 Operational manuals provide guidelines.	 Relevant legislation, rulings of the relevant boards, appeal decisions, manuals, handbooks, program circulars and desk aids.	 All up-to-date legislation relating to social security. A Guide on all appropriate matters issued by the Chief Adjudication Officer, who advises on performance of statutory functions. Model decisions for use in drafting decisions. Reported decisions of the SS Commissioners & a Digest thereof. Access to advice on individual cases from the office of the Chief Adjudication Officer.	 Regulations of the general disability benefit program are published in book form, putting all the laws & amendments under one cover. The last issue was published 1/1/85. In addition, various documents relating to claims procedure are available. Claim officers, especially in the early stages of their work, consult with the claims unit director. Also, over 60% of claim decisions are made by the claim officer after consultation or assessment by the rehab officer of the branch. In other cases the medical officer writes in his report that medical disability is clear-cut & opinion of rehab officer isn't required for decision of claim officer.	 Everyone has access to service manuals which include both factual information in the various areas & directives for the implementation of case methods & procedures for dealing with cases. These manuals are comprised of those policy guidelines which have been approved by the JHS board & management, usually after consultation with the trade associations.		 The claims processors primarily rely on administrative instructions setting forth the relevant legal provisions & regulations. Handbooks, commentaries and other professional literature is also available to insurance administration staff.	 Law, regulations, SSA published rulings, Program Operations Manual System (POMS), physician handbook, program circulars desk aids, guidelines.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
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Section I Part III.A

How is the accuracy of the decision making computed, monitored or improved within the agency?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
..... The factual & arithmetic correctness of the decision making is monitored by special controlling depts. and controllers in each case. Legal decisions are controlled by controlling panels, the heads of the specialized depts. and the employees of the auditing unit. Medical decisions are controlled by the head physician on the basis of the evaluation of the main medical expert(specialized physician).	 Decision-making is centrally located at the national level. There is a quality control procedure whereby a senior medical officer audits a % of files every day. Also appeals force the original decision to be re-examined.	 SSI-thru control decision making procedures EPDP-thru control decision making & use of relevant Pension Board EAI & MLI-thru advisory boards of medical drs. & insurance experts & lawyers as well as laymen. Disability pension matters have to be taken to the relevant board before decision of benefit is made.	 Monitored by adjudication officers immediately senior to them in their local office who are required to select cases to examine at random & who are also available to provide adjudication advice. The standard of performance at both levels is in turn monitored from regional offices & the office of the Chief Adjudication Officer. Also each region arranges regular adjudication meetings. This monitoring, visits to local offices, case-work exams & information gained from group meetings form the basis of an annual report produced for publication by the Chief Adjudication Officer by law.	 By use of above-mentioned consultation procedures, with medical officer, director of the claims unit, and/or with the rehab officer a final signature of approval of decision of claims officer is provided by a senior claims officer of the branch. If no consensus can be reached at unit level by dr., rehab officer & claims officer, the claim is sent to national office for decision.	 The JHS tries to monitor & maintain the accuracy of its decision-making by a very thorough systematization of case handling & by dividing this handling into 7 phases (1) Administrative preparation, (2) intake, (3) information gathering, (4) decision making, (5) implementation of treatment plan, (6) follow-up care, (7) administrative follow up. By means of the arrangements for handling complaints, the management can also keep an eye on the provision of services by the JHS.		 Monitoring by senior officers, verifications thru within agency reviews, verification thru computerized "law-finding" programs.	 3 levels: GA in state agency, federal GA at regional level; central (headquarters) GA checks accuracy of the regional level.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section 1 Part III.B

Describe review procedures for local, regional and state decisions.

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
***** In the Pensions Insurance Institute for Employers, the review is done by special controlling depts. of the central administration also for claims from the different provinces. In the Pensions Insurance Institute for Workers, the review is only done on a regional level.	***** No local or regional decisions are made. All claims are channeled to the national office.	***** See above.	***** Any person may apply to have a decision reviewed by an adjudication officer. Application must be made in writing & show grounds. Decisions may also be reviewed by an adjudication officer of his own accord. A SS appeal tribunal may review a decision on reference to it by an adjudication officer. Reviews must meet criteria: (1) the original decision was given in ignorance of, or was based on a mistake as to, some material fact, or fresh evidence, (2) There has been a relevant change of circumstances, (3) The decision was based on the decision of another authority which has been revised, (4) The decision was erroneous in point of law. There is no separate system of local, regional & state decisions.	***** In the beginning, all decisions were reviewed by national office, but this proved impractical due to large volume of claims. At present, spot checks are done periodically to review local decision procedures.	***** The correction/re-evaluation procedure actually runs parallel to the normal working methods.	*****	***** Not Applicable.	***** 65% of all allowances reviewed on the central level; common deficiency lack of documentation/ evidence - sent back for corrections.

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QUESTIONNAIRE RESPONSES

Section I Part III.C

How is uniformity of decision in similar cases achieved?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
Through service in- structions & the central decision making by the bodies of the self- administration.	As there are no bene- fits awarded for par- tial disability, incon- sistency isn't a major problem. Uniformity is maintained when most claims go to the same doctors for adjudica- tion. Geographical lo- cation and local un- employment rates are not used to evaluate, so there is no problem to ensure consistency in this respect.	See above.	The SS Commissioners interpret statute law in their decisions on appeals submitted to them. Important decisions are published and form case-law which can be used in similar cases by other adjudication authorities. The Guide & model decisions pro- vided by the Chief Ad- judication Officer, the regular monitoring of adjudication and exams of casework, the pub- lication of the annual report, and assessment standards of adjudica- tion in detail all pro- vide a safeguard as to the uniformity of de- cision-making. Also there is training avail- able to adjudication officers.	Thru simple diffusion of knowledge, accumu- lated experience, and consultation procedures.	The manuals & direc- tives provide the basis for a rather uniform approach on the part of the JMS. In addition, the pronouncements of the appeals court also provide footholds for a uniform approach.		By joint consideration and decision-making in the relevant bodies of the Federation of Ger- man Pension Insurance Institutes.	Central office reviews 10 regions. Policy people clarify issues of great differences among the regions.

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Section I Part IV.A

How is the record keeping handled?(e.g. where are the files stored?)

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
The files are stored in the archives of the different depts. respectively in central archives (files).	For each case, a file is opened for the application form and the record of earnings verification form.	Each agency has its own databank & record of folders. SII keeps a record from everyone from birth to death. For the private EPDP programs there is one central databank at the Central Pension Security Institute, keeping record of a person's entire working life and under which program he is. There is a complete population register of the country kept partially by the registered churches in Finland & partially by the population registration authority.	Records of most SS benefits are maintained in a local network of some 550 BHSS offices, including invalidity benefit, severe disablement allowance & industrial disablement benefit. Records of claims & payments of war pensions, & attendance, mobility & invalid care allowances are kept at a central office at North Fylde.	The files are stored at the local branch.	All incoming material from 1 person is filed under a single registration number. The individual data from the district (peripheral) offices is then fed into the JMS' computerized registration system. This system contains personal, procedural & advisory info. The files themselves remain at the peripheral offices, with few exceptions.		By means of (1) file storage in the records room, (2) microfilming, (3) electronic data storage.	7 Program Centers nationwide for payment related activities where moves monitored, deaths recorded, etc. One of 7 is headquarters. The headquarters program center stores records of all GSDI recipients to age 59. Then info goes to other centers which also keep widow records.

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Section I Part IV.B

Is medical evidence stored in the same folder with technical
evidence or in a different folder?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
Same folder.	Same folder.	Same folder.	Varies according to the benefit in question, but mostly there is a sep- arate folder for med- ical information.	Same. The file consists of 3 parts: basic data & documentation, medical evidence, & documenta- tion regarding claims & benefits.	Medical information is included in the same file as other data.		As a rule only single file is kept.	Same folder.

REHABILITATION INTERNATIONAL
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QUESTIONNAIRE RESPONSES

Section I Part IV.C

What, if anything, is stored on the computer?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
Only data on the pension assessment & a statement of substantiation & data concerning the payment of pensions, but not medical data.	Contributor Application Records; CPP contributors' "Records of Earnings"; summary of data for each beneficiary with age, sex & benefit level; status of claim and where file is located, e.g. at a field office. Info about the nature of the disability is not recorded.	Technical data including diagnosis but not medical evidence.	A "Database" computer system is being built up at North Fylde which will contain details of claims, the decision on a claim & details of payments made in respect of attendance, mobility & invalid care allowances. Industrial disablement benefit & severe disablement allowance are not yet computerized, except for production of order books.	Until now, only basic data & financial aspects of benefits to beneficiaries were stored in the computer. Now, the agency is changing the set-up so as to enable all data to be stored in the computer.	In principle, no distinction is made between electronically stored and other forms of registration system.		Personal data, pertinent insurance data, as well as data relative to payments and/or rehabilitation measures provided.	Technical data, including diagnosis, but not medical evidence.

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QUESTIONNAIRE RESPONSES

Section I Part IV.D

How are data on contributions stored?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
..... The data processing of obligatory contributions is done by the Federation of Austrian Social Insurance Institutes. The different social insurance institutes can ask for the data. The social insurance institutes themselves only store data on voluntary insurance & later acquiring of insurance periods.	 Records on each person contributing to the CPP are stored on a central computer; there are 16 billion records spanning 47 years.	 Data on contributions, rather existence of insurance, are on the computer at the relevant head office.	 On a computer at a central office at Newcastle.	 In the central computer service at the national office.	 See above.		 On the computer.	 On the computer at headquarters.

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QUESTIONNAIRE RESPONSES

Section I Part IV.E

Are these data recalled when claim is made?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
Yes.	Yes.	At the time a claim is presented these data on contributions are retrieved in NLI only.	The local office is able to check computer records using a "Data-link" system. The computer is interrogated each night to give a 36 hr reply service.	Yes.	Info is stored in the file for the duration of the benefit. When the benefit expires or is terminated, the JMS keeps the data for 5 yrs before destroying it. If a request for benefits is rejected, the info is destroyed after 2 yrs. The trade associations keep the info for the same period of time as the JMS.		Yes.	Yes.

REHABILITATION INTERNATIONAL
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QUESTIONNAIRE RESPONSES

Section I Part IV.F

How are benefits computed and initiated?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
One has to distinguish between benefits in kind & compensation payments. The calculation of the compensation payments is set forth in the law. The payment of the benefits is affected by mail or thru wiring the benefits to a bank in Austria.	Benefits are composed of a flat rate and an earnings related portion, with a specified monthly amount.	Benefits are computed according to a formula relevant to each program. Various agencies may have slightly different formulas. Payments are initiated by entry on the computer which goes to the treasury which starts payments.	Invalidity benefit, severe disablement allowance & industrial disablement benefit are computed manually at the local office. At North Fyde the initial payment of attendance allowance & mobility allowance is manually computed; thereafter payments are made by a selection of methods including payment by Automated Credit Transfer, by order book or by combining payment with another benefit.	Benefits are computed according to the formula described in statute. Payments are initiated by entry on the computer thru which payments are sent to the disabled persons' bank account.	After the claimant has been disabled for 1 yr the JMS presents an official report to the trade association which then makes a decision. If the claimant wishes to request a facility or service, he or she must do so through the trade association dealing with his/her case. The application form is available at any post office. The trade association then begins its own file and asks the JMS for advice.		By means of the statutory pension formula; benefit payment is usually made thru the mail pensions service of Deutsche Bundespost.	Computed according to a statute formula. Payment initiated by computer entry to the treasury.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section 1 Part IV.B

Is loss of claimant information or claimant folders a problem?
If so, what are safeguarding measures?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
Fundamentally, the loss of claimant folders or parts of them does not represent a problem. The claimant folder only contains copies or transcripts of original documents (stored by other depts). The individual data cards on employment that have been lost can normally be re-established by most of the health insurance institutes on the basis of the employment lists sent to them by the employers. The loss of a medical expertise would make necessary a new medical check of the claimant. Should it not be possible to re-establish data (such as original data cards, etc.), the decisions are based on other documents - (certificates, wage tax cards, declarations of witnesses, etc.).	No, although occasionally a file will be temporarily misplaced as it makes its way thru the system. Once info is computerized, backup tapes are stored in 3 locations for safe-keeping.	Due to relatively small organizations there very seldom occur losses of claimant information. Original documentation very seldom leaves the premises, only thru photocopies.	The DMS maintain this is a small problem. Records of claims are kept at Newcastle Central Office so that on receipt of a new claim, transfer action of previous claim papers is initiated. Similarly at North Fylde previous claims are recorded & on receipt of a new claim the original papers are called for. Phone inquiry response is a problem with papers moving between so many offices.	No. This is because files are not removed from the local office.	Info concerning the claimant is stored in part by the JMS & in part by the trade association. Loss of this info could therefore result in a partial re-investigation and the repetition of the case procedure. Yet actual loss of this sort seldom occurs.		No; data safe-guarding measures are in place.	Yes. Card monitoring movement of folder through system is the only safe-guard.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section 1 Part V.A

Is information regarding benefits provided regularly by administering agency:
1 Through TV ads & radio?
2 Through other mass media such as newspapers, magazines, etc.?
3 Through agency publications available through employers, community, etc.?
4 If none of the above, how do most people find out about the benefits?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
Changes in the regulations or specific problems on radio & TV.	Each year an information dissemination plan is formulated. Local offices are responsible for implementation. Staff members participate in interviews and hotline shows on both radio and TV.	Info is provided in TV & radio in programs concerning social security.	There are no tv or radio ads.	There are no tv, radio or other mass media ads.	The Dutch government has regular radio programs which answer listeners' questions concerning social security.		There is dissemination thru TV ads, radio & other mass media.	There is dissemination thru TV ads, radio, newspapers and magazines.
Important changes of benefits are made known in the newspapers, in specialized papers respectively in publications of statal organs.	Information copy is also provided to newspapers.	There are articles and ads concerning social security.	Generally, newspapers and magazines are the media thru which info is disseminated.	There is a publication available at the local office describing the program, its benefits & procedures required. There is also a phone information service provided by the agency at the local office.	Newspapers also run regular question-and-answer columns dealing with the law & social security.		In addition, info is given by means of brochures, newsletters & leaflets, relative to benefits & services in general, and, more specifically, concerning new legislation. Individual information and counselling is ensured through special advisory services.	Furthermore, there are agency publications widely distributed via government and non-government channels.
The different types of benefits are basically known to the population thru different publications. For the benefits of the pensions insurance, there are brochures that are at the disposal of the insured persons, the shop stewards, the unions, the workers' reps., respectively are distributed at exhibitions or trade fairs.	Meetings are arranged with employers & local groups; radio talk shows and seminars are also offered. Publications include "Basic Facts on SS programs"; "Inventory of Income Security Programs in Canada."	Agency publications are widely distributed thru employers and other channels. The private EPDP programs have a joint central databank, Central Pension Security Institute, which sends to everyone under these programs an extract of his personal record 11 year or after a change of employment. All the insurance institutions have magazines for their customer service. In EPDP programs the insured may send an inquiry card free of charge at any time.	There are no specific programs of advertising Invalidity Benefit since it is a follow on from Sickness Benefit. There are many leaflets distributed thru DHSS offices and advice agencies, etc. It is not believed to have take-up problems. Even if people are unaware of benefit they may receive it automatically after 28 weeks of sickness benefit.	People find out thru community social workers, associations for disabled persons, employment officers, & word-of-mouth.	The executorial bodies have set up a Social Insurance Information Center. They publish information material, which is then distributed thru legal advice and assistance centers, employers, lawyers & others. Easy access info hours are held in neighborhood centers & led by residents or social workers. The JMS has recently taken on its own social counselors & established info counselling hrs.			In addition there is a toll-free 800 # listed in most phone books.
Consultations are held regularly in companies & offices of the public-law institutions. The Pensions Insurance Institute for Employees furthermore has a special information bus that is used throughout Austria.	Info is distributed periodically thru the Contributory Information Project, which involves surveying people who have contributed to the CPP at any time.	People are welcome to phone all the agencies for information. There are special clerks on duty.						

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Section 1 Part V.B

Do you as a regular practice:

1 Make information available in more than one language?

2 Communicate with claimant in language of preference?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
In certain cases, circulars or information leaflets are published or handed out in the language of the claimant. The communication, especially where the claim is concerned, is in German.	All written info is in English and French. Where international agreements exist, info on the provision of the agreement is available in other languages. Efforts are made to hire field staff who speak a variety of languages as required by the community in which the office is located.	All the written info is available in Finnish & in Swedish. The claimant may use his mother tongue of Finnish or Swedish.	The basic leaflet, "Which Benefit" has recently been translated into Chinese, Hindi, Gujarati, Punjabi, Bengali and Urdu. All written communications from the DHSS are in English. Interpreters are provided at the local office where possible. However, school children often interpret for their parents.	A Publication in Arabic is available in Jerusalem. Areas where Arab speaking population is more concentrated, opportunities to communicate with claimant in Arabic are very high. Since Israel is a country of immigrants, arrangements will be made, whenever possible, to find an official or a translator to assist in order to communicate with claimant in his home language if he can't manage Hebrew.	Not applicable.		Not applicable.	Yes, Spanish & others. Interpreter efforts are made.

REHABILITATION INTERNATIONAL
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QUESTIONNAIRE RESPONSES

Section I Part V.C

Are notices to claimants written in
language easily understood by the
majority of claimants?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
..... The letters & information are formulated in an easily understandable way.	 In 1982 it was determined that the forms should use a more simplified language. This is still a problem due to difficulty of losing precision in meaning when simplifying terminology.	 All notices to claimants are written in language as understandable and simple as possible.	 Many of the standard letters are phrased in difficult legalistic language. One frequent source of misunderstanding is the instructions relating to additions for a partner. Many claim incorrectly when their partner is already receiving a personal benefit. Resulting overpayments are always reclaimed by DHSS. Claimants also often don't understand why their benefit has been refused/cut off, or make their doctors understand the complex procedures for appeal.	 Yes.	 Improvement has lately been seen in the simplification of the written language used by administrators regarding decisions made on claims. However, the social security system as a whole remains difficult for the insured to understand.		 Yes.	 Notice Simplification Task Force improves language of agency communications all the time.

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QUESTIONNAIRE RESPONSES

Section I Part V.B

Is information for claimants available through special communication modes such as Braille for the blind and telecommunication devices for the deaf?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
There currently are trials with videotext.	Braille and taped info were made available at one time, but there was little demand. A large print booklet is available and some field offices have TDDs.	Some information material is available on recordings.	No plans at present to produce leaflet in Braille as the % of people able to read it is extremely low. Facilities for blind or hearing impaired people vary among offices and there are no special provisions for those with more severe communication disorders.	No.	There are no specific modes of communication for the visually or sensorily handicapped. There are, however, interpreting/translation facilities for communication with foreigners.		No.	Some pamphlets are available in braille and on recordings.

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Section I Part VI.A,B,C

Are payments periods made: weekly? Fortnightly? Monthly? Other?
Is timing of payments made at the beginning or end of the period?
Are payment transfers made by: mail? By voucher or order book? By credit transfer?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
Monthly.	Monthly.	Monthly.	Payments are made 1 week in arrears and 1 week in advance.	Monthly.	Monthly.		Pension due to occupational or earning incapacity paid monthly.	Monthly.
Beginning of each month.	End of period.	Generally at the beginning of the period.		Payments are made on the 28th of the month.	Payments by the individual trade associations do not always take place on the same date, as every trade association has its own system.		It is paid at the beginning of the month.	Payment is made at the end of the period.
Any way insured chooses.	By post and direct deposits to the bank.	Through the banking systems.	By Girocheque; particularly if medical evidence held is for less than 6 wks payment. Also available are a book of weekly orders covering a period of up to 26 wks which the recipient can cash each wk at a post office of his choice.	Payments are by credit transfer.		Payment is made via transfer to bank or postal-savings account (by voucher) or thru the mailing of a personalized check.	Payment is made either by postal cash delivery service or is transferred to a bank account.	Payment transfers are made by post or by credit transfer.

Definition

of the criteria and degrees of abilities and requirements for the
ERTOMIS employment referral sheets

Evaluators please note:

Abilities and requirements should be evaluated exclusively in terms of the degree of ability (function) currently available to the handicapped person or required by the job (including those abilities attainable through the use of compensating health aids such as eyeglasses, prostheses, hearing aids, etc.)

The cause of origin of a handicap or functional disturbance should not be considered in this evaluation.

Criteria requiring the differentiation between "one side" and "both sides" should be evaluated as follows:

if "one side", left or right: under "one side" 0 and/or 1/2
"both sides" 3

if "both sides", left or right: " "one side" 0 and/or 1/2
"both sides" 0 and/or 1/2.

Frequently occurring "explanations" will only be given with numbers - explanations related to specific functions will be listed under the criteria in question.

Explanation 1: The degree of availability of function and/or functional requirement of limbs or other parts should be evaluated in terms of the functionality of the joints and/or the related musculature and both the central and peripheral nervous support.

Explanation 2: Full functionality means the intact interplay of the related joints, the musculature and the central and peripheral nervous system supply. In assessing full functionality, other central nervous system functions such as intact coordination and sense of balance should also be considered. Normal cardiovascular conditions should also be present.

Unless otherwise noted - abilities and requirements should be graded according to the following system:

Ability Profile (APr)	Requirement Profile (RPr)	Grade
..... available	 required	
full and constant function	full and constant function	0
limited and/or temporary function	limited and/or temporary function	1/2
no function	no function	3

Definitions

1.11 finger movement - one side 1.12 finger movement - both sides

The subject

APr: can

RPr: must

work with his fingers - as the most important "work tools" of the human body.

1.21 hand movement - one side 1.22 hand movement - both sides

including wrist joint

The subject

APr: can

RPr: must

work with his hands - as bearers of the fingers.

Explanation 1.

1.31 lower arm movement, one side 1.32 lower arm movement, both sides

including elbow joint

The subject

APr: can

RPr: must

work with his lower arm - as bearer of the hand.

Explanation 1.

1.41 upper arm movement, one side 1.42 upper arm movement, both sides

including shoulder joint

The subject

APr: can

RPr: must

work with his upper arm - as bearer of the lower arm.

Explanation 1.

1.51 foot movement, one side 1.52 foot movement, both sides

including ankle joint

The subject

APr: can

RPr: must

use his feet - as the most important locomotion devices

Explanation 1.

1.61 lower leg movement, one side 1.62 lower leg movement, both sides

including knee joint

The subject

APr: can

RPr: must

work with his lower legs - as bearers of the feet.

Explanation 1.

1.71 thigh movement, one side 1.72 thigh movement, both sides

including hip joint

The subject

APr: can

RPr: must

work with his thighs - as bearer of the lower legs.

Explanation 1.

1.80 head movement (including cervical vertebrae)

The subject

APr: can

RPr: must

carry out work-related turning and bending motions of the head.

Explanation 1.

1.81 trunk movement (especially movement of the spine)

The subject

APr: can

RPr: must

carry out work-related turning and bending motions of the trunk.

Explanation 1.

1.82 coordination of upper body
limb movements

1.83 coordination of lower body
limb movements

The subject

APr: can

RPr: must

coordinate the movements of fingers, hands, lower and upper arms, lower legs and thighs.

Explanation: Coordination is a result of a conscious interplay of different limbs and/or parts of the body as a complex function of the central nervous system. Paralytic symptoms can be easily confused with coordination impairments.

2.01 sitting

The subject

APr: can

RPr: must

work in a sitting posture.

Explanation: Sitting without functional limitation means an intact interplay of one part of the spinal joints and the lower leg including the intact central and peripheral nervous system supply, making possible free sitting without the aid of technical devices. This ability might possibly be limited by impediments (impaired function) in the area of the spine, the hip joints and the related musculature and nervous system supply.

2.02 standing

The subject

APr: can

RPr: must

work in a standing posture.

Explanation 2.

2.03 crouching, kneeling

The subject

APr: can

RPr: must

work in a crouching or kneeling posture.

Explanation: Neither of these positions is possible without a coordinated interplay of the lower limb, trunk and head movements, constrained posture ability, good sense of balance and normal cardiovascular condition.

2.04 constrained posture

The subject

APr: can

RPr: must

work in a position in which certain individual parts of the body must be tensed up while other parts of the body will simultaneously have to carry out controlled movement relative to the job, and without loss of balance.

Explanation 2.

2.05 walking

The subject

APr: can

RPr: must

in the exercise of his work walk on flat ground or on slightly uneven ground.

Explanation 2. as a rule, work activities do not involve running.

2.06 climbing, traversing

The subject

APr: can

RPr: must

in the exercise of his work climb on stairs or ladders and/or walk on sloping ground.

Explanation 2.

2.07 lifting

Here we must evaluate the weight of the load, the height of the lift and the time required for all work-related lifting within an eight-hour shift - according to the following grading table, which is based on a lift height up to 1.2 metres and a carrying distance of 2 metres per activity:

Weight in kilogrammes male/female	time required for activity			
	up to 1 hr. per shift	up to 4 hrs. per shift	up to 6 hrs. per shift	over 6 hrs. per shift
M > 25 f > 12	0	-	-	-
m < 25 f = 12	1	0	-	-
m < 12 f = 6	2	1	0	-
m < 6 f < 2	3	2	1	0

Explanation 2. The evaluations on the table refer to full and constant functionality. In cases of limited ability, the evaluation should be "3" - these grades should be entered into the RPr in accordance with the table. Handling a load of 1 kilogramme is not to be evaluated as "lifting".

2.08 carrying

Here we must evaluate the load which is to be transported by walking and the aggregate elapsed real time of transport (lifting up, transporting, setting down) of all carrying activities in an 8-hour shift. The following grading table is based on a carrying distance between 2 and 50 metres.

weights in kilogrammes male female	time required for activity			
	up to 1/2 hr. per shift	up to 2 hrs. per shift	up to 4 hrs. per shift	over 4 hrs. per shift
m > 22 f > 11	0	-	-	-
m < 22 f = 11	1	0	-	-
m < 12 f = 7	2	1	0	-
m < 4 f < 2	3	2	1	0

Explanation 2. Transporting a load of less than 1 kilogramme is not to be evaluated as "carrying".

2.09 continuous physical strain - see page 12

3.01 focus of vision

The subject

APr: can

RPr: must

focus his vision sufficiently well to meet work requirements.

Explanation: This includes the ability/requirement to focus vision at varying distances and under different light conditions.

3.02 spatial vision

The subject

APr: can

RPr: must

recognise and estimate different work-related distances and/or elongation of objects and/or the relative speeds of different vehicles (as in overtaking another car).

Explanation: Spatial vision with one eye is, as a rule, first attainable after receiving special training.

3.03 colour vision

The subject

APr: can

RPr: must

recognise and distinguish different colours (especially red and green) and nuances of colour.

3.04 field of vision

The subject

APr: can

RPr: must

without moving his head - use his eyes to see a field of vision with an angle of 35° in clear focus.

3.05 hearing

The subject

APr: can

RPr: must

perceive and judge work-related sounds, words, tones (informational) in terms of pitch and volume.

Explanation: The hearing of different persons may perceive various pitches and volumes differently or have different sensitivity to these factors on the left and right sides.

3.06 directional hearing

The subject

APr: can

RPr: must

hear and recognise from which direction various work-related sounds and tones are coming.

3.07 smell

The subject

APr: can

RPr: must

perceive the nature and intensity of work-related smells.

3.08 taste

The subject

APr: can

RPr: must

perceive the difference between the nature and intensity of various work-related flavours.

3.11 feel, one side

3.12 feel, both sides

The subject

APr: can

RPr: must

using the tips of the fingers and/or the back of the hand differentiate and evaluate various

- 1) shapes
- 2) surface structures
- 3) material structures (fibre material, graininess, etc.)
- 4) temperatures
- 5) vibrations.

Explanation: Indicate under "Remarks" what kind of feeling is being considered - differentiate between one side and both sides.

3.13 sense of balance

The subject

APr: can

RPr: must

maintain the balance of the body, both at rest and in motion, under the influence of powers within his own body and outside it.

4.01 drive

The subject

APr: can

RPr: must

take this fundamental condition of his inner dynamic behaviour structure - which has the potential of serving him in the completion of his work or can lead to uncontrolled behaviour patterns - and use it purposefully toward the completion of his job responsibilities.

4.02 motivation

The subject

APr: can

RPr: must

place his personal performance capacity at the service of the effective performance of his work.

4.03 attention

The subject

APr: can

RPr: must

keep his senses (see criteria group no. 3) directed on the entire job process, take in relevant observations, signals and items of information and subject his own performance to conscious controls.

4.04 perception

The subject

APr: can

RPr: must

quickly take in and understand work-related observations, processes and signals and/or the content and significance of read information.

4.05 concentration

The subject

APr: can

RPr: must

maintain alert attention on job-related tasks and persons, even in cases of constant change.

4.06 learning/ remembering

The subject

APr: can

RPr: must

keep acquired and understood information, instructions and signals - simple or complex - available in his memory for shorter or longer periods of time.

4.07 imagination

The subject

APr: can

RPr: must

realistically imagine job-related figures, sizes, surface and cubic areas, shapes and sizes - and concretely visualise interrelationships, organisational structures and functionoriented processes.

4.08 independence

The subject

APr: can

RPr: must

draw from his vocational training and on-the-job experience to make job-oriented decisions of all kinds and carry them out without outside assistance.

4.09 inspiration/ problem solving

The subject

APr: can

RPr: must

independently recognise the special problems in novel, work-related situations and find his own solutions for these situations or assignments based on known possibilities, which decisions can then be practically carried out.

4.10 teamwork

The subject

APr: can

RPr: must

work together with fellow-workers (superiors, colleagues and subordinates), in mutual respect of the special qualities and abilities of all parties concerned, to find and apply practical solutions to human and work problems.

4.11 critical control

The subject

APr: can

RPr: must

subject all the results of work and behaviour - his own and that of others - to a critical control of both human and work factors, and deal with criticism of his own work by others.

4.12 responsibility

The subject

APr: can

RPr: must

carefully and precisely perform all jobs in keeping with the rules and/or the instructions of the persons involved, and -

- keep promises and appointments made to others in conjunction with his job (as punctuality is the basis of mutual reliability),
- take good care of the material and tools he uses,
- observe all safety rules and regulations.

Explanation: Responsibility requires a personal identification with norms, values, moral principles and expectations and manifests itself in relations with persons and objects in the form of an attitude of obligation recognition. Such qualities as care, precision, circumspection, conscientiousness and consideration are all closely identified with the concept of "responsibility".

4.13 stress resistance

The subject

APr: can

RPr: must

endure physical, mental and emotional stress in his own activity and in relations with co-workers (superiors, colleagues and subordinates), visitors, customers, etc. over long periods of time.

4.14 perseverance

The subject

APr: can

RPr: must

remain completely and unrestrictedly concentrated on his work assignment - even if success is not always at hand.

4.15 psychomotoric speed

The subject

APr: can

RPr: must

quickly react to sudden and unexpected changes in the work situation.

Explanation: Reaction speed is the time required to react psychomotorically to a more or less complicated stimulus.

4.16 work tempo

The subject

APr: can

RPr: must

perform the phases of his job (in terms of intensity and effectiveness) at a speed which will permit the emergence of agreed work results (productivity and wages) within the agreed time frame.

5.01 speech

The subject

APr: can

RPr: must

speak clearly and understandably, in terms of grammar and vocabulary, on work-related subjects.

Explanation: Speech impediments may have a wide variety of causes. When they occur in the area of the central nervous system, they are known as neuropsychological disorders, in the sense of so-called "aphasias". Here we can differentiate in a general sense between word comprehension on the one hand, and, on the other, the inability, once work

comprehension has been achieved, to put the psychomotoric tools to work to speak words distinctly. Needless to say, disorders in the peripheral area may have been caused by paralysis of the musculature or by anatomical deformities or injuries to the organs of articulation. The person filling out the ability profile thus has the option to "remarks" column to make specific clarifications in this regard.

5.02 writing

The subject

APr: can

RPr: must

write legibly and comprehensibly, in terms of grammar and spelling, with respect to work-related matters.

Explanation: Writing is a complex ability, which requires both mental capabilities as well as an intact control on the part of the central nervous system and intact organs of mobility.

6.01 light/ illumination

The subject

APr: can

RPr: must

work under available, work-related light conditions (in which surface reflections and extreme changes in light conditions - welding glow, glowing glass or iron - may increase the difficulty).

Explanation: An ability to work under changing light conditions fundamentally involves both a peripheral and a central function. With peripheral function, we mean the optical organ, the central function of the central nervous system including the vegetative nervous system. Possible limitations in the central area may occur in cases of brain damage.

6.02 climate

The subject

APr: can

RPr: must

do his job under given temperature, humidity, stressful air speed, and heat radiation conditions.

Explanation: An endurance evaluation for specific climatic conditions which exceed normal conditions also requires a consideration of cardiovascular conditions and central nervous system, particularly vegetative nervous system, functions.

6.03 noise

The subject

APr: can

RPr: must

do his job in the presence of noises, sounds or tones which could be considered disturbing or damaging.

Evaluation: Grade 0 above 85 dB (A)
Grade 1/2 above 55 - 85 dB (A)
Grade 3 up to 55 dB (A).

Explanation: The ability to endure specific noise stress may be influenced by disturbances both in the central nervous system and the acoustical organs.

6.04 gases/ vapours/ dust

The subject

APr: can

RPr: must

inhale work-related gases, vapours and/or dust.

Explanation: These work places must be equipped according to the rules for the handling and use of dangerous substances. The maximum permissible work-place concentrations are all defined by law. The type of gases, vapours and dust should be indicated in the "remarks" column. The ability may be affected by metabolic disorders (cirrhosis of the liver - solvents!) Various allergies may also bring about certain limitations.

6.05 liquids/ moisture

The subject

APr: can

RPr: must

do a job which involves touching or working in certain work-related liquids or moisture.

Explanation: The work places must be equipped according to the appropriate regulations for the use of dangerous substances.
If work places are organised according to these regulations, this ability can only be limited by specific functional disorders, such as metabolic disorders of the liver in constant contact with solvents, allergies, as well as hypersensitivity because of disorders of the central nervous system. As with other criteria, we would recommend consulting the appropriate insurance regulations for industrial medical examination.

The nature of the liquids should be indicated in the "remarks" column.

6.06 mechanical vibrations

The subject

APr: can

RPr: must

do his job under the influence of mechanical vibrations which have a direct effect on the body (tractors, pneumatic hammers, etc.)

6.07 changes in atmospheric pressure

The subject

APr: can

RPr: must

do his job in the presence of constant changes in atmospheric pressure.

Explanation: This includes mining, deep sea diving, etc. Please refer to the appropriate work regulations for your area.

7.01 leadership

This includes the following qualities required of a supervisor:

- 1) overview and decisiveness
- 2) planning and scheduling
- 3) giving instructions and making assignments
- 4) controlling work, making corrections and giving recognition
- 5) securing cooperation in group situations, including the maintenance of good co-worker relations and motivating fellow employees.

Explanation: Because of the complexity of the qualities and characteristics required, this ability is extremely difficult to evaluate. This leadership ability should really only be evaluated in cases where the subject's training and abilities would suggest that such an evaluation would be in his special interest.

As a result of a discussion held on August 28, 1964, the following definition was added:

2.09 continuous physical strain

The subject

APr: can

RPr: must

stand physical strain of varying duration and intensity.

Explanation: Handicaps do by no means exclude the ability to stand continuous physical strain in all areas. If limitations are present, they should be recognizable from the assessment of the other criteria. If this is not possible, a more detailed description should be given under "Remarks".

THE BLENDING OF MEDICAL AND VOCATIONAL ASSESSMENTS OF
DISABILITY CLAIMANTS

For

International Research Conference
Social Security Disability Programmes
Baltimore, Maryland, April 14-16, 1986

By

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In this paper I intend to review the approach used in the Rehabilitation Centre in Kingston, where a co-operative comprehensive approach to the assessment of disability claims has been taken since the establishment of the centre 20 years ago. From the outset a blending of medical and vocational elements of these assessments has been one of the guiding principles. Another has been to use a rehabilitation approach to determine what hope there is of returning the applicant to employment and a state of financial independence.

A vocational department was established within the Regional Rehabilitation Centre, which is funded by the Ministry of Health, in co-operation with and funded by the Ministry of Community and Social Services (COMSOC). The latter Ministry is responsible for the operation of the Vocational Rehabilitation of Disabled Persons Act, a programme jointly funded by the Federal Government (Dept. of Health & Welfare) and by the Provincial Government (COMSOC). A full range of vocational evaluation and rehabilitation services have been developed with clients receiving only those, which are appropriate to their individual needs.

Another guiding principle, which we followed was not to duplicate services already available in the community, and for this reason, an Area Rehabilitation Council, was established to promote co-operation between existing agencies and understanding of each other's role and programmes. This Area Rehabilitation Council also identified gaps in service, for which new programmes were needed.

A fourth principle adopted was the involvement of the community in the vocational rehabilitation process, wherever possible and appropriate.

A specific component of the vocational programme in the Regional Rehabilitation Centre was established to assess and assist individuals, who were considered to be unemployable, but who wanted to work, and for whom no existing services were appropriate. This particular project was entitled our "Pre-vocational Programme". During the years the results and cost-benefits of this programme have been the subject of two studies.⁽¹⁾⁽²⁾⁽³⁾. Consistently this programme returns 50% of those, who enter to competitive employment, while another 10% achieve sheltered employment or progress to educational upgrading and/or vocational training for a specific occupation. These figures are based on a minimum 2 year follow-up of the participants. The total cost of this programme for both successful and unsuccessful clients is recouped within two years and in the long haul a ten-fold recovery of the initial investment is believed to be a conservative estimate of the long term economic benefit.

Clients are referred by physicians and vocational services, and a variety of sponsors, including the Workers' Compensation Board, COMSOC, Canada Employment, insurance companies, lawyers, and municipal welfare departments. A small number of people are also seen as part of the appeal process, when they are denied a Canada Pension.

The vocational rehabilitation team in addition to providing this range of services, has offered a number of seminars, ranging in length from one half day to one week and directed towards members of the insurance industry. Members of the team have engaged also in a number of research projects. Some of those, which have a bearing on the topic of this seminar include a - "A Study of Medical Eligibility Requirements for the Provincial Disability Plan of the Ministry of Community and Social Services"⁽⁴⁾; "An Assessment of the Medical Rehabilitation Provisions in the Long Term Disability Plan For Employees of the Canadian Broadcasting Corporation"⁽⁵⁾ a "Study of the Need for University Level of Education of Vocational Personnel in Canada",⁽⁶⁾ and another on "Return to Employment After Myocardial Infarction."⁽⁷⁾

Two cases will now be presented to illustrate in a practical way how the the blending of the medical and vocational assessments is achieved.

CASE PRESENTATION I

Gerry was 51 years of age, when first seen in 1971. He was a married man with a grown family, who had been employed in the Alcan Aluminum Plant, as a machine operator, for 31 years. His problems were hypertension, controlled by medication, and a flail left leg due to poliomyelitis, for which he wore a long leg brace. He also had some weakness in his back and in his right leg. He was having problems with his brace and back and leg pain when first seen. He was talking about taking early retirement, because his job required him to be on his feet 90% of the time and he was having increasing problems coping. At this time, adjustments were made to his brace.

In February of 1974, he was seen again complaining of back and leg pain and of difficulty keeping up with the pressures of work, where increased productivity was being demanded. He found the three rotating shifts difficult to cope with. He had increasing difficulty getting from the far end of the parking lot into the plant through the ice and snow in the winter months. Again, he was considering retirement and asked advice on this.

One month off work was prescribed. This consisted of one week of rest, followed by three weeks of therapy. Thereafter, he returned to work and was encouraged to start a regular keep fit programme. Swimming was specifically recommended, but because of his disability he had never learned to swim and so he was referred to the handicapped swimming programme. Through the works doctor, his employer was asked to provide special parking privileges close to the plant entrance and to assign him to a regular day shift.

He was also counselled to look into his pension situation, should he retire in the near future, so that he would know exactly what his financial situation would be. He was further advised to consider the likely effects of inflation on his standard of living, since the works' pension was not indexed. He was also advised to look into the Canada Pension benefits. It transpired that his pension income at that time would be inadequate for his needs.

Life after retirement was also discussed. He had no plans and was reluctant to quit work, as he had no hobbies and was afraid that being at home all day, he would be difficult to live with.

Subsequently, he was able to cope better at work, but required further therapy from time to time, especially in the winter months. After a year or so, he was granted a special parking privilege and assigned to different work on a regular day shift.

He learned to swim and swam regularly and became convinced that his previously poor state of fitness had contributed to his back pain and difficulties on the job. He was encouraged by his swimming instructor to enter the Ontario Games for the Physically Disabled, which he did, beginning in 1976, winning a medal for swimming.

Subsequently, he entered into track and field events competing at the Games every year, winning at least one medal each year. His interest in sports for the disabled expanded and he became involved with the local wheelchair basketball team. He assisted in repairing and modifying their wheelchairs; and at one time considered the possibility of part time work repairing wheelchairs after his retirement.

He continued at work with difficulty and each winter it seemed more difficult, and each winter he would consider retiring. He kept going, however, and it was not until February, 1984, that he finally quit, taking his regular retirement at the age of 65 years.

After his retirement, he continued his active participation in the sports for the disabled programme for one year. In 1985, he switched from being a participant to coaching. He became, over the last 10 years the most prominent and active promoter of

sports for the disabled in Kingston, giving great encouragement, leadership and assistance to many other disabled people.

He no longer had any doubts about what he wanted to do with his retirement and was very active until a short time before his death in February of 1986.

This case history illustrates how difficult it can be to determine whether or not a given individual is unemployable, the many facets of the situation which need to be assessed, and the variety of rehabilitation methods required to achieve optimal vocational performance.

Let us briefly review the elements important to the assessment, using a mnemonic, which I have found useful in this situation. The letters of the word SEMAPHORE provide a useful aid to remembering the key elements in this type of rehabilitation assessment.

- S - SOCIAL ELEMENTS - in this case this man was married. Had a stable marriage. Lived with his wife in their own home and this aspect of his situation was a very positive one.
- E - EMOTIONAL PROBLEMS - often very important. Gerry was at times anxious and depressed and these problems were helped considerably by discussion of the practical problems confronting him. This helped to relieve both his anxiety and his depression, but more than counselling was required, in that intervention through the works doctor was instrumental in relieving some of

the stresses, which induced his anxiety and depression and which were adding to his vocational handicap. It was fortunate, that he was a valued, conscientious and capable employee whose skill and experience made it much easier to obtain the concessions necessary to keep him employed.

- M - THE MENTAL OR INTELLECTUAL FUNCTIONING OF THE INDIVIDUAL. It was not necessary to evaluate this aspect in any detail in this case.
- A - AGE - Certainly, in a man past 50 the possibility of retraining him for other work, while not out of the question, is more difficult and his age was certainly a determining factor, together with his length of tenure with his present employer in making every effort to keep him at his former job with his former employer.
- P - PHYSICAL DISABILITY & ABILITY - Every effort was made to minimize the disability by improving the strength, where this was possible, namely in the right leg and in his back and to some extent in the left thigh. The disability was compensated for by trying to keep his leg braced in an optimal fashion. His general fitness was developed, as a means of improving his overall physical ability. Treatment of the disability and development of his ability were both important in keeping him at his job.
- H - GENERAL HEALTH - In addition to the hypertension, already mentioned this man developed celiac sprue in 1978, which was controlled by diet. He also was treated, at one point, for a supraspinatus tendonitis and for recurring problems in the left knee, because of the profound instability in that joint.

- O - OCCUPATIONAL-EDUCATIONAL BACKGROUND - This man had been with his present employer from the age of 20. He was a valued employee and as mentioned previously, in these circumstances, it was felt that every effort should be made to keep him with his former employer and his former job or related work.
- E - ECONOMICS OF THE SITUATION - It was very important to discuss with this man the amount of pension to which he was entitled and to help spell out the combined effect of his long term disability pension from his plant, the possible benefits of a disability pension from his plant, and his Canada Pension benefits. It is my experience that most people seldom go into this before actually deciding to retire and that they frequently need the help of people knowledgeable about the various systems. Communication between the physician, the works doctor and the Human Resources Department contributed to the outcome in Gerry's case.

In this man's situation, it would have been relatively easy to express the opinion, that he was eligible for a disability pension at any time from 1974 onwards. I venture to say, that in the majority of cases, comparable to this one, the individual would have been pensioned off. I am in no doubt that the granting of a pension would have resulted in a much less favourable outcome. I have discussed this with his widow and she is in strong agreement.

It is important, however, to recognize that most physicians have little or no exposure to this type of comprehensive assessment; that little time in the medical curriculum is devoted to

rehabilitation, and even in our medical school (where teaching in rehabilitation is above the average across Canada), only one to two hours of exposure to vocational rehabilitation is guaranteed.

It is my strong belief, that the physician has a key role in determining eligibility for disability pensions, but is poorly prepared to discharge that responsibility. If we wish to harness the physician's potential in the future we will have to either expand education of general physicians in this area or alternatively conduct these assessments using physicians specially trained at the postgraduate level. While the specialist in Physical Medicine & Rehabilitation has special training in this field, experience is generally limited to individuals with physical disability.

Frequently, the physician is not able alone to work with an occupational health physician, as illustrated in the first case and is required to work closely with vocational rehabilitation staff. I would now like to present a second case illustrating how we operate in these circumstances.

CASE PRESENTATION II

Mr. S.W. sustained head injuries in a motor vehicle accident in June of 1980 at the age of 16 years. At the time of the accident, he was living with his parents and four siblings in the family home. His parents were in good health, but there were marital problems prior to the accident, which became aggravated by subsequent events and resulted in a period of temporary separation of both parents and disruption of the family. Shawn was attending highschool and performing poorly, prior to the accident and there had been talk of some minor drug problem. He had no regular work experience before sustaining these injuries.

One month after admission to the hospital, he was transferred to the Rehabilitation Ward, where he remained for about seven weeks before being discharged to his home. His disability comprised:-

- 1) Impaired co-ordination of movement in all 4 extremities, but worse in the right arm and leg. In addition a mild spastic paralysis of the right arm and leg.
- 2) Speech impairment due primarily to inco-ordination of the speech muscles, resulting in unclear dysarthric speech.
- 3) Intellectual impairment consisting primarily of impaired memory, decreased general intellectual functioning and some perceptual difficulties.

A vocational counsellor was assigned at the time of his initial admission to the rehabilitation ward and continued to follow him and is still involved. Serial intellectual assessments in August of 1980 and 1981 revealed a general improvement in intellectual

and memory function, between these two examinations. He continued to have difficulty with tests requiring verbal ability. Incoordination handicapped him in the performance of tasks requiring motor function. Tests of memory revealed performance within the normal range, but his parents continued to report, that he had difficulty with his memory at home and at school. Testing of his capacity to learn suggested that this was quite good, but despite this he continued to have difficulties in the school setting. Guidance was provided through the special education services with the local school board. He, himself, denied having any problems and was quite unrealistic in terms of his general ability to progress in school and had quite unrealistic vocational goals.

Formal vocational testing was carried out in March of 1982, at which time his stated vocational objective was to complete Grade XII and attend a sound technicians's course at the community college level. He gave as his reason for this choice, the fact, that he was a "music freak."

Tests administered at this time included the:

Wechsler Adult Intelligence Scale

The Peter Circular Mazes

The Bender-Gestalt

The Vocational Questionnaire

The Strong Campbell Vocational Interest Inventory

While his intellectual functioning was within the average range, the profile generally was that of a young man, who could be considered as an under-achiever. The testing also suggested, that he had not benefitted much from his schooling. He did reasonably well in the practical problem solving situation of the Mazes. His quality of work was good and he seemed able to plan ahead, to make decisions and follow through on them appropriately. The Bender-Gestalt was administered to assess perceptual acuity and visual memory. His responses to the Vocational Questionnaire reflected concern about getting a job. He did not want to work week-ends or at a fast pace. He preferred a physically active job and one that was outdoors. The Strong-Vocational Interest Inventory pattern was typical of the late teenage group. His interests were not well developed or specific. His basic orientation was towards adventure and art. His attitude towards school was thought to be improved, since the accident, but testing suggested that his interests were not compatible with those of a good student.

Counselling, career exploration and definition were recommended. Job exposure, either through summer employment or part time work, while attending school or alternatively through involvement in a pre-vocational assessment programme was recommended.

After successfully completing Grade XI in highschool, he left school and elected to try and find work, because of financial problems at home. He was unsuccessful.

To improve his chances of finding employment, during the summer of 1982, he was enrolled in the pre-vocational programme at the Kingston General Hospital for eight weeks. This began with a two-week assessment in the occupational therapy department, followed by work experience in three job stations. His lawyer encouraged this and arranged financing by the insurance company representing the defendant in an action for damages.

He worked at the Queen's University greenhouse, the City Parks and Recreation Department and Eastern Generator. At the Queen's greenhouse, his duties were potting, general cleaning and painting. At the City greenhouse, he was responsible for planting, potting, washing pots, mixing soil and digging. At Eastern Generator he was responsible for general cleaning, painting new parts of cars, and tearing down used parts.

At the Queen's greenhouse, there were no problems with his work habits. He attended regularly and was on time. In the last two job stations, he slacked off. He missed work several times and did not call in. Sometimes, he would disappear early without notifying his employer. Finally, he asked for three days off in the last week of this experience, but when told by his counsellor, that he couldn't do this, he attended for two of the final three days. Shawn's work attitude varied with how well he liked the job and/or the supervisor.

His vocational limitations were summarized, as follows:-

1. Poor attention to detail
2. Slow production, particularly in a job which he does not like.
3. Slow at performing cognitive tasks
4. Difficulty with tasks requiring problem solving
5. Difficulty with written instruction
6. Some shaking of the arms and legs with job requiring exertion.
7. Difficulty with tasks requiring fine motor skills
8. Poor attitude in a job he does not like, or when problems with supervision arise
9. Difficulty with close authoritarian supervision
10. Unrealistic attitude about vocational goals.

His counsellor concluded that his performance on this experience varied according to his like or dislike of the job and his supervisor. He still seemed to have an immature attitude towards work in general.

He continued in a fruitless search for employment and in September of 1983 returned for an educational upgrading programme at St. Lawrence College. He also expressed an interest in underwater construction work, such as welding. While this was thought to be unrealistic, his fitness for scuba diving was checked out and after examination by an experienced physician, he was passed fit to take a scuba diving course. This was paid for in part by the insurance company and in part by his grandparents. He successfully learned to scuba dive and having done so, accepted that he would not be able to work as an underwater

welder. Over a fairly lengthy period of time, he began to accept more realistic vocational goals.

A medical examiner for the defendant in the action concluded that he would probably never persist in menial work, which was the only type for which he was competent and, therefore, considered him permanently unemployable or employable for only brief periods in very simple jobs.

He subsequently found part time work in a local pub performing unskilled janitorial services and he was also dismissed from a number of other jobs for unsatisfactory work.

Prior to the settlement of his case, early this year, he found employment in a sporting goods store. A position, which he has held successfully now for several months and one from which he derives considerable satisfaction.

His legal settlement, provides him with a monthly income for life, but he continues working and it is my personal hope, that he will continue to do so. I believe, that if he is not employed, he is liable to drift into bad company and get re-involved with alcohol and drugs.

Prior to his accident, his greatest interests were water skiing, soccer and other sports and he socialized with a great many young people. Since his accident, he has lost most of his friends and had lost much of his self-confidence, because of his rather drunken gait and drunken speech. The scuba diving course has opened new recreational possibilities and through this and his job, he is rebuilding his social life.

Despite the use of virtually all of the vocational assessment resources available to us, his future continues to be uncertain. We have described his vocational prognosis in terms of four scenarios. The most probable one being that he will either continue in part time employment or episodic full time employment, providing him with sufficient satisfaction and occupation to distract him from self-destructive complications, such as alcohol, drugs, etc.

Throughout the last six years, the physician and vocational staff have worked closely together with this patient and his family. The lead role has shifted back and forward from medical to vocational and frequently each has needed the complementary support of the other. This blending is facilitated by the fact, that the medical and vocational offices are a few steps apart.

We have been fortunate, also, to work with a lawyer, who appreciated that his client required more than a simple financial settlement to rebuild his life, and by an insurer, who appreciated the mutual benefit of the rehabilitation approach.

Other members of the rehabilitation team have made important contributions and ease of communication between them and with the patient and family, and a willingness to devote time to this was a very factor.

As I conclude this paper, I feel compelled, once more, to return to the question -"what are the goals of the social security system?" I hope that these case histories will have provided you with some new insights and an appreciation of the need to

broaden the existing goals of economic support, to include the more humanitarian requirements illustrated in this paper. I suggest to you, that what we must do, is find ways to offer as many handicapped people, as possible, "a hand-up, rather than a hand-out".

Thank you.

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REFERENCES

- 1) A Review and Cost Benefit Analysis of a Hospital and University Based Pre-Vocational Programme: Symington, D.C.; Lewis, M.; Archives of Physical Medicine, Vo.54,p.341,Aug/73.
- 2) Vocational Rehabilitation of Unemployed Persons with Complex Handicaps: An analysis of three years experience, 1968-71: Symington: D.C., Lewis, M.: unpublished study.
- 3) Vocational Rehabilitation of Persons with Complex Problems-The Pre-Vocational Programme, 1976-1977: An analysis of three years experience: unpublished study.
- 4) A Study of the Medical Eligibility Plan of the Ministry of Community and Social Services, Ontario, Canada(The Family Benefits & Vocational Rehabilitation Services Programs), October, 1982
- 5) A Report for the Canadian Broadcasting Corporation on their Long Term Disability Plan: A Study of the Rehabilitation Option: Prepared by Symington, D.C., August, 1983
- 6) The Need for University Level Education in Rehabilitation Counselling in Canada: Symington, D.C.; Lewis, M., June,1982
- 7) Return to Work after Myocardial Infarction; Wigle,R.,Symington,D.C.,Lewis,M., Connell, F., Parker,J.: Canadian Medical Association journal, Vol. 104,February, 1971.

DRAFT

Computerized Synthesis of Responses to Questionnaire
on Social Security Disability Programs:

Austria, Canada, Federal Republic of Germany,
Finland, Israel, Netherlands,
Sweden, U.K. and U.S.A.

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Social Security Disability Programs

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FOREWORD

The following is a synthesis of responses to the questionnaire developed for the Rehabilitation International project on social security disability programs in eight countries, contracted by the U.S. Social Security Administration in 1985. The questionnaire was developed for the project by a small group of consultants from the countries studied.

This draft is being submitted to the International Research Conference on Social Security Disability Programs, the concluding activity of this project. Some corrections and additions are still being made by the country experts and a final version of this synthesis will be issued following the conference.

We invite your comments, reactions, corrections and criticisms.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section I Part I

Provide a brief description of the Social Security Disability Benefit program, including stated objectives and the scope of population coverage. Include the overall definition of disability used for this program.

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
In Austria the complex social security system is subdivided in 3 branches-health insurance, accident insurance & pensions insurance. SS benefits for the disabled are most often found in the invalidity incapacity to work and incapacity for gainful occupation pensions from the pensions insurance program. In Austria social insurance is obligatory for nearly all self-employed & employed persons. Its benefits are to the greatest part financed by tax contributions, while the state grants subsidies for certain specific areas. There is not really one specific definition of disability applied by the social security system. In the health insurance, the term "incapacity to work due to illness", is found, in the accident insurance is cited "reduction of earning capacity" & in the pensions insurance the term "invalidity", incapacity to work", & a "permanent incapacity for gainful occupation" are found.	The Canada Pension Plan (CPP) & Quebec Pension Plan (QPP), as of 1/66 are compulsory contributory social insurance plans to protect workers and their families against loss of income from retirement, disability or death. Most working Canadians are eligible since contribution is compulsory for everyone employed between 18 and 65 yrs. Provided that contributions were made for a minimum of 5 out of the last 10 years and for 1/3 of the contributory period, a disability pension is payable to a person with a severe and prolonged mental or physical disability. A person is eligible if "he or she is incapable of pursuing any substantially gainful occupation due to a disability which is likely to be of long or indefinite duration or is likely to result in death." The QPP & CPP are somewhat alike in terms of eligibility criteria, benefits and financing.	In Finland there are four programs which provide disability benefits. The Social Insurance Institute (SII) has responsibility for administration of the National Invalidity Pension (NIP). This program provides a minimum flat rate income to the insured. This benefit is payable to insured men & women between 16-65 who, because of an illness, defect, or injury, are unable to maintain themselves by their usual work or any other kind of work which, considering their age, occupation, education & place of residence, would be suitable for them. The other private insurance programs are related Pension & Disability Pension programs which are referred as EPDP. The programs are nationally administered by private pension insurance companies, pension funds and foundations, semi-public and public pension institutions. There is also Employment Accident Insurance (EAI) and Motor Liability Insurance (MLI). The programs are nationally administered by private insurance companies and one semi public and one public institution. The compulsory programs provide benefits for persons who have become disabled for work in employment or traffic accident or have an occupational disease.	The UK equivalent of SSDI is Invalidity Benefit. It is an insurance benefit for employees or the self employed who have been incapable of work for 28 weeks. It provides income for people unable to work due to a specific disease or bodily or mental disablement. Most people of working age are covered, including those insured unemployed persons who are available for work. Main exclusions are those who have never worked, or worked too briefly to pay sufficient contributions, very low earners and people not available for work-mainly married women caring for children. Some married women in work still choose to pay reduced contributions which do not entitle them to sickness or invalidity benefits. (This option was abolished in 1977 for newly married women) People are also deemed incapable of work if they are suspected of carrying or being in contact with an infectious disease or if they are only performing therapeutic tasks recommended by a physician.	The general disability benefit program is administered by the the National Insurance Institute. While the Institute has been responsible for providing VR services for many years it only began to pay benefits with the commencement of collection of insurance contributions in 1970. Payments of pensions to disabled persons, which included only newly disabled persons began in 1974. Disability benefits were extended to include the disabled housewife in 1977, the disabled person from abroad in 1979, & the disabled child in 1981. Mobility allowance for certain categories of disabled persons became functional in 1975, with various extensions of benefits during 76&77. Attendance Allowances were introduced in 1979. In 1984 amendments to the General Disability Law came into effect, the most important being the abolition of the distinction between a "previously disabled" & a "newly disabled" person.		The SS system-except for unemployment insurance-are administered centrally by the National Social Insurance Board, which is an independent government authority under the jurisdiction of the Ministry of Health & Social Affairs. Locally they are administered by 26 regional social insurance offices & by local tax offices (460 totally). The social insurance offices are independent corporations with their own financial structure. They are neither state nor municipal authorities. Each office is managed by a board with a chairman appointed by the Government. They are supervised by the National Social Insurance Board. The local tax offices determine pensionable income for supplementary pension purposes & contributions from employers & self-employed persons.		The SSA has national responsibility for the administration of the Social Security Disability Benefit (SSDI) program which provides cash benefits for disabled workers & their dependents who have contributed to the SS trust fund thru FICA tax on their earnings. It defines disability as "inability to engage in any substantial gainful activity by reason of a medically determinable physical/mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months".

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section I Part I.A.1

What agency administers the SSDB program at: the national level?
the regional level?
the local level?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
There are two insurance institutes administering social security on a national level: (1)Pensions Insurance Institute for Employees (2)Pensions Insurance Institute for Workers, even though there are several social insurance institutes administering the social insurance benefits for disabled persons based on occupational and/or territorial structures. At the regional level, the Pensions Insurance Institute for Employees has offices in the provinces, that do not have any decision power (centrally organized). The Pensions Insurance Institute for Workers has regional offices with decision power (decentrally organized).	The CPP except in Quebec. That province has established a comparable provincial plan in lieu of CPP. Info is available from offices located at the local level, including Income Security Programs offices of the Dept of National Health & Welfare, regional offices and Client Service Centers, both full- and part-time. These offices are often 1st contact in applying for benefits. Claims can be submitted at local or national level. There are no provincial offices. Itinerant offices are set up periodically in areas too small to warrant a permanent operation. A field officer is sent to provide info, collect forms and help clients fill out forms if necessary.	SII administers NIP & its disability benefit program on a national level.EPDP program are administered on a national level by private pension insurance companies, pension funds and foundations, semi-public and public pension institutions. EAI and MLI programs are administered on a national level by private insurance companies and by 1 public institution. The SII has 5 regional offices which has overall office has oversight over the 206 district offices and 244 district sub-offices. At the local level: EPDP - private pension insurance companies have local branch offices in major cities and in addition local agents.Pension funds & foundations are locally operated in connection to larger enterprises. Semi-public and public pension institutions have head-offices only. EAI & MLI - Private insurance companies have head-offices & branch offices in major cities as well as agents in rural areas.	A national office handles data on contributions. Regional offices are responsible for conducting (but not initiating) medical reviews. The Dept of Health and Social Security (DHSS) administers the program thru local offices in England, Scotland & Wales.The DHSS in Northern Ireland administers a separate but identical program.	The General Disability Benefit Program is administered by the National Insurance Institute which has its central national office in Jerusalem. The work of the Institute is carried out thru 17 branches located throughout the country. There are also several sub-branches, so that in all there are 30 branches & sub-branches. Each one has a unit dealing with the general disability benefit program, as well as a rehab service unit, which deals with referrals from the general disability benefit unit work-injury unit and other units who refer clients from rehab.There is also a medical unit at the branch level.	The implementation of the SS acts is the responsibility of the semi-public trade associations at both the national and regional levels. The 25 trade associations have, in turn, set up the Joint Medical Service (JMS) to act as advisor in the evaluation of labor disability and in the provision of facilities to compensate for functional disabilities. Before a decision can be made by a trade association concerning social/medical matters, the JMS must first be consulted.The implementation of the most important social insurance programs for the disabled therefore consists of the combined action of the JMS and the trade assoc. Both the JMS & the trade assoc., to the extent that they committed their record-keeping to the Joint Administration Office (JAO), maintain regional offices and 1 national headquarters in Amsterdam.	The disability benefit system is administered centrally by the National Social Insurance Board, which is an independent government authority under the jurisdiction of the Ministry of Health and Social Affairs.	Pension insurance administrations (1) for salaried employees (Federal Insurance Institute for Salaried Employees), (2) for workers in the mining industries (Federal Miners' Insurance Institute), (3) for maritime workers (Maritime Insurance Fund), (4) for Federal Railways workers (Federal Railways Insurance Institute). Regional insurance institutes administer the wage earners pension insurance. The regional competence of the 18 regional insurance institutes administering wage earners' pension insurance is not always identical with Länder boundaries.	The Social Security Administration(SSA) operates the disability program at the national level. There are 10 federal regions at state and local offices.On the state level the program is administered by the Disability Determination Services(DDS),a state agency w/ state employees & federally funded. There are 1300 district SS offices staffed by federal employees.Area directors supervise local operations.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section I Part I.B

What are the communication and procedural links between the different levels of the agency?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
***** The links between the social insurance institutes & the social assistance are set forth in the General Social Insurance Act. The 28 independent social insurance institutes are linked together in the Federation of Austrian Social Insurance Institutes. The Federation is acting as a coordinating institution, where the rehab measures are concerned.	***** A number of federal agencies have input to CPP, e.g. the Dept of Nat'l Health & Welfare has primary administrative job; the Canada Employment and Immigration Commission administers the Social Insurance 8 system used for ID purposes; Revenue Canada, Taxation deals w/ coverage and contributions; the Dept of Supply & Services assists in electronic data processing. The QPP Act is administered by the Quebec Pension Board, while contributions and contributory status are the responsibility of the Quebec Ministry of Revenue. Applications are forwarded from local offices to the national office. Contributory records (Record of Earnings) are computer checked to confirm eligibility & the medical review process begins. Operational bulletins inform field officers of changes in procedure etc. Staff training programs and revisions to the operational manual ensure that current info is available to local offices.	***** See above.	***** Not applicable.	***** Each branch has a director who is in direct contact & under supervision of the national office. The rehab service unit is integrated directly into the local branch, with direct referrals, continuing contacts & collaboration. Each unit director, also has a direct contact at the national office & the heads of the dept., thus ensuring supervision & continued communication. The Bureau of Research & Planning which is headed by a deputy-director general, of the NII, maintains contacts with the various depts., provides statistics and carries out various evaluations and analyses. The communication & procedural links are a) Horizontal between units at the branch level or between dept. at the national office level, b) Vertical between units of local branch & their respective dept. at the national office. Since the country is very small in size & population, there is no regional level in operation.	***** The regional offices of the JAO and the JMS are always located in the same building, which successfully eliminates all geographical hindrances to communication. The activities of the JAO & JMS are coordinated at all levels: at the national level via supervisory councils, management & staff, & at the regional level via peripheral management. Guarantees of the greatest possible uniformity in advice concerning benefits or facilities & services are ensured within the JAO, JMS & the autonomous trade assoc. by the use of manuals and the standard "Rules & Directives". Tasks required of the JMS: a) the reintegration of the handicapped with regard to employment & society, b) investigating the nature & degree of labor disability, c) advising concerning the degree of labor disability, d) investigating the need for facilities or services, e) advising concerning facilities for living or work, f) the setting up & managing of certain categories of facilities, g) monitoring the process and result of treatment or facilities, h) researching the quality of reintegration possibilities.	***** See above.	***** The various pension insurance administrations are members of the (Federation of German Pensions Insurance Institutes) who co-ordinates all matters of common interest.	***** 10 Regional SSA Offices oversee state & local ones. Area Directors supervise local offices, independent of the state (BOS).

REHABILITATION INTERNATIONAL
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QUESTIONNAIRE RESPONSES

Section 1 Part I.C

How is the program funded in terms of benefit payments to the beneficiaries?
Contributions by insured workers? General tax revenues? Contributions
or taxes paid by employers? Other?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
There are obligatory contributions by insured workers and employees, except with accident insurance where there are no contributions by employed insured persons. In addition, there are contributions of the state from general tax revenues. There are also contributions by employers. Further, there are contributions of persons who are voluntarily insured either as a continuation of insurance after employment has ceased or as a self-insurance and/or from other income (from property, interests on arrears, extra charges, etc.)	There are equal contributions by the employee and the employer. There is also interest on the Canada Pension Plan Account contributed to the program.	There are employee contributions to the SII and employer contributions for SII, EPBP & EAI. In addition, contributions are made by: For SII-state & municipalities. For EPBP-some programs by the state. For MLI-contributions by owners & holders of motor vehicles.	91% of the benefits are paid out from the national insurance fund and 9% are from general taxes. Employees pay 9% of their weekly salary up to 265 pounds. The SS Act-1983 reduced contributions for people earning less than 90 pounds. No contributions are payable if weekly earnings are less than 35.5 pounds. Employers pay 10.5% of employees weekly salary up to 265 pounds. The SS Act-1983 abolished upper limit.	There are employee contributions with a level set at .75% of wages up to a ceiling of three times the average wage. Employee contributions also comprise .75% of wages up to a ceiling of 3% the average wage. Insured (self-employed & other non-employed) comprise 1.5% of income up to a ceiling. Note: a housewife is exempt, & does not pay insurance, while she is entitled to receive benefits from the general disability benefit program. There are no contributions from general tax revenue except for those to the mobility allowances.	The GDBA & DIA are financed by means of premiums paid by employees. All funds collected in this way by the trade associations are put into 2 funds: The General Disabling Benefit Fund (GDBF/ANF) or The Disabling Insurance Fund (DIF/ADF). In addition there are also premiums paid by employers.	There are contributions by self-employed persons but employer contributions make up about 65% of the total expenses. In addition there are State subsidies (about 17% of the total expenses). Also by interest & contributions paid by the municipalities.	There are equal amounts contributed by both employers and employees. Additionally a federal subsidy is granted. There is no special earmarking of funds used for rehabilitation or incapacity pensions. Insured workers' & employers' contributions amounted to 83%, the federal subsidy to 15.6% of the 1984 revenues. The remainder (1.4%) came from interest & miscellaneous other sources.	There are equal contributions by employers and employees.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section I Part I.D,E,I,E.2

How is the agency which administers the program funded?
What are the annual expenditures of the agency?
What percentage of these expenditures are direct benefit payments?
What % is spent on agency staff? Appeals procedures? Other agency?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
See above.	EPP Account. No direct federal government funding.	See above.	Mainly from general taxation, but administration costs are met from the National Insurance Fund.	The MII, which administers the program is an autonomous agency which receives its funds thru collection of contributions from employees employers and other insured for the various categories of benefits provided.	The operational structures of the trade associations and the JMS are financed from the GLDF & the LDF on the basis of the declaration of costs incurred for benefits, facilities & services, administration, etc.	See above.	Administrative expenditures, too, are financed from the above contributions and federal subsidy.	SS Trust Fund.
Data from 1983 in 1000 Austrian Shillings: Pensions insurance for workers & employees = 107,968,794 (100%), Pensions insurance for self-employed = 21,376,060 (100%), & Accident insurance = 7,386,412 (100%).	63,745,815,000 (1984). 11.9% on disability pension payments; 1.4% on disabled contributor's child benefits. Because staff of different agencies are involved it is impossible to provide this.	Due to the different structures of the described systems figures are not comparable. All the systems are using about 80% for benefit payments. Administration costs are about 20-23% of benefit expenditures. These figures are not separately available.	40 billion pounds. 122 billion pounds are paid from the National Insurance Fund at an administrative cost of 770 pounds. The expenditure on Invalidity Benefits is 2280 million pounds. Of the 40 billion pounds, 38.5 billion pounds is for benefit payments. 1.5 billion pounds for administration of which 50% represents staff costs. Not separately identifiable.	1983 total was 197,064 000 dollars=15,108,160 000 shekels. 1984 is likely to be at the same level. For 1983-5.4 % of budget was spent on administration expenses, the rest being for payment of disability pensions. N/A. N/A. N/A.	GDIF spent 9,661,171,000 f in 1982, and the DIF spent 9,159,597,000 f. GDIF & DIF-approximately 95% are used for direct benefits & facilities. The direct administration costs account for about 5% of the costs withdrawn from the GDIF. The direct administration costs amounted to circ. 3% of the DIF's costs.	See above.	In 1984, total expenditures under the wage earners' and salaried employees' pension insurance scheme amounted to approximately 160,000 million Deutschmarks. 86.5% were spent on pension benefits, 8.1% on pensioners' health insurance, 2.4% on rehabilitation benefits. 1.8% on administrative and processing costs.	Relevant figures will be supplied by SSA.
Pensions insurance for workers & employees = 104,175,480 (96.49%), Pensions insurance for self-employed = 20,522,053 (96.05%), & Accident insurance =	Less than 1%.							
Agency staff, appeals procedures & other agency administration: Pensions insurance for workers & employees = 3,793,314 (3.51%), Pensions insurance for self-employed = 845,007 (3.95%), & Accident insurance = 1,353,566 (18.33%).	2.4%.							

REHABILITATION INTERNATIONAL
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QUESTIONNAIRE RESPONSES

Section I Part I.F.

Who administers the agency at the highest level?
(e.g. government officials, board representing interest groups.)

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
..... The social insurance institutes are legal entities under civil law. As for any legal entity, they are governed by the organs of self-administration & are subject to controls by the Federal Ministry for Social Administration. The public-law institutions of employers & employed persons nominate delegates for the administrative bodies of the social insurance institutes.	 Minister of Health and Welfare, an official responsible directly to the Prime Minister.	 SII-Director General Commissioners appointed by the Parliament, Enlarged Board, Board of Directors. EPBP-Managing Directors, Boards of Directors. EAI & MLI-Managing Directors, Boards of Directors. All are supervised by the Ministry of Health and Social Affairs.	 The DMSS is headed by the Secretary of State for Social Services, a Member of Parliament & Cabinet Minister, assisted by 4 other Ministers in the House of Commons and 1 in the House of Lords.	 The agency is administered by the director of the General Disability Benefit Dept at the national office & his staff. The Council the NII, which comprises representatives of the government, employers & employees associations, & acts as an advisory body to the NII, has various committees, including a committee for the general Disability Benefit Program which is also comprised of representatives from government, employers & employees associations & has an advisory capacity.	 At their highest levels, the trade associations are managed by a board of management consisting of 3 representatives from the central employers' organizations, 3 members appointed by the central workers' organizations, 4 members appointed by the trade associations, of which 2 come from employers and 2 from trade unions. In addition, the JMS board also includes 2 other members, appointed by the Minister of Social Affairs and Employment from the ranks of the handicapped.	 The National Social Insurance Board which is managed by a board. The chairman of the board is the Director General. Besides the Director General & his deputy, at least five other members should be elected to the board. These members are appointed by the government & represent for instance the parties on the labor market.	 Top-level responsibility of the pension insurance administration is placed with the administration's self-government bodies, which combines employers' & insured workers' representatives. Responsibility for current administrative business lies with employed executive directors.	 The Commissioner of the SSA who is an employee of the Dept. of Health & Human Services.

REHABILITATION INTERNATIONAL
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Section I Part II.A
Agency Staffing

What type of personnel in the agency are involved in the benefit decision-making process.
At the local level?
At the regional/state level?
At the national level?
What non-agency personnel are involved in the process?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
From the legal point of view:senior clerks/ social workers & controllers. From the medical point of view:medical specialists & head physicians, and from both:self-administration (pensions board, rehab board). This decision making process applies at the regional & at the national level.	Staff are facilitators only;they can make recommendations, but no decisions. Physicians are involved at the national level. Non-agency personnel serve to provide data only.	At the local level there is no SSI & EPDP staff. There is staff for EAI & MLI-Head Offices Dept Heads, normally with legal training, with help of physicians. At both the regional and national levels: SSI & EPDP-Physician & legally trained adjudicator. Non-agency personnel: physicians and members of interest groups connected to Pension Boards.	At the local level Adjudication Officers are based in DHSS offices. At the regional level medical evidence is provided initially by the claimant's own doctor.Further advice may be sought from the DHSS Regional Medical Service or sometimes from independent specialists. Nationally, there is a Chief Adjudication Officer at this level.	Claims Officers are involved at the local level. No decisions are made at the regional level. There are no decisions at the national level except in special cases. Non-agency personnel are rarely involved.	The JMS acts, on the peripheral level where decisions are made, as advisor to the trade associations in the form of teams involved in drafting of advisory reports. These teams consist of: A national insurance practitioner, who is a graduated Medical Dr. A vocational rehabilitation expert,a legal assessor and a team secretary who monitors the progress of the process. When specialized knowledge must be recruited a team can call in experts.The advisory report must have the unanimous approval of the team.	Benefit claim decision making occurs at the relevant insurance administration's head office at the local or regional level. Where necessary in the individual case, appropriate non-agency experts are asked to give their professional opinion.	The claims representative operates at the local level. There is a disability doctor at the state level. Nationally, there are BA reviewers, claims authorizers,disability doctors/examiners. Non-agency personnel are physician,psychiatrists, psychologists on contract to the SSA.	

REHABILITATION INTERNATIONAL
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QUESTIONNAIRE RESPONSES

Section I Part II.B

What percentage of claims are decided at each level?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
As the Pensions Insurance Institute for Employees is centrally organized, the decisions on claims are exclusively made by the central administration. In the Pensions Insurance Institute for Workers, the decisions on claims are exclusively made by the provincial offices & the central administration only has a coordinating function.	100% of claims are decided at the national level, excluding applications to the OPP. In 1984, 48,613 new applications for disability pensions and 7,904 new applications for disabled contributor's children's benefits were received.	SSI-all decisions are made on control level. BPBP, EAL & MLI-all decisions are made by the head offices.	All claims are decided by the local adjudication officer.	All claims are decided at the local level, except very special cases.	The body of the advisory reports are drafted at the 33 peripheral offices. These reports are then sent to the trade associations, which make decisions at the central level, and, for more difficult cases, the reports may also be sent to a special administrative committee (the so-called 'little commission').	Since the subdivisions do not exist between levels this section is not applicable.	Since the subdivisions do not exist between levels this section is not applicable.	2,000,000 filed/yr. 1,100,000 for SSDI. 900,000 for SSI-See VII 1,416,000 of these cases will be decided on disability and the balance denied for reasons unrelated to disability. 467,000 initially OK'D 949,000 denied at the initial level. 1985 SSA projections: 70% initial approvals 9% reconsidered 20% at ALJ hearings 12 by Appeals Council and the Federal Courts

REHABILITATION INTERNATIONAL
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Section I Part II.C

What are the qualifications of the claims processors or adjudicators?
Academic (school years, degrees)
Training (special training, on the job training)

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
When the decision making process requires a specific academic training, persons with academic qualifications are used (jurists, economists, psychologists, specialized physicians, etc.) Otherwise lay persons who have been adequately trained by the in-house training dept are used. A great importance is attached to continuation and refresher courses.	Claims processors: High school graduation or equivalent, plus training. Adjudicators: RNs, some with BS degrees. All staff members receive special training.	Academic (often legal education) or college graduates or have advanced through the ranks. All personnel receive continuous training on the job.	Adjudication officers do not need to possess any academic qualifications beyond those required for entry to the lay civil service. Additional training is provided at the place of work & on specialist training courses. Courses include a 1 wk. basic course available after 3 wks on duty. Follow up training modules are also available as required if applicable to particular benefits. Adjudication officers on appeals work have a correspondence course & attend a 3-day course on appeals presentation.	Matriculation certificates are required for processors. There is no training beforehand. A two month training course as well as on the job training is provided. There is a period of initial supervision of 3-12 mths followed by regular periodic supervision. Lectures & training sessions are organized intermittently.	The vocational expert must have completed higher technical school education, with emphasis on technical or social matters. The national insurance practitioner must have completed medical training. The legal assessor must have completed higher (professional) education. The vocational expert must have at least 5 yrs of extensive and varied labor experience. The national insurance practitioner must have experience as practitioner or, preferably, as industrial practitioner. The legal assessor must have a diploma in social insurances (internal training). The employment experts & national insurance practitioners also receive internal training from the JMS, & an information system concerning the operational functions of a peripheral office is also at their disposal. (The Employment Structures Documentation system-ESDS). The legal assessor receives training from the Joint Administration Office in the form of the JAO's own social insurance course.	The administrative decision is usually made by staff holding university degrees (law degrees). Claims-processing matters for preparation of the final decision are as a rule incumbent on specifically trained personnel. The required specific knowledge is ensured through in-service training.	The administrative decision is usually made by staff holding university degrees (law degrees). Claims-processing matters for preparation of the final decision are as a rule incumbent on specifically trained personnel. The required specific knowledge is ensured through in-service training.	Local, national and BA reviews-college grad/BA or advanced thru ranks. State requirements vary but usually require a college degree. All personnel receive formal training, on-the-job training & 1st yr. are closely reviewed. Claims reps get up to 13 wk classroom classes. Disability examiners up to 8 weeks.

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Section I Part II.D.

What job aids are used by the adjudicators?
(e.g. regulations, guide books, etc.)

**Austria
Response**
The relevant official law bulletins and decrees, information circulars, service instructions, decisions of the special arbitration courts for social insurance and the high courts, specialized literature.

**Canada
Response**
Operational manuals provide guidelines.

**Finland
Response**
Relevant legislation, rulings of the relevant boards, appeal decisions, manuals, handbooks, program circulars and desk aids.

**Great Britain
Response**
All up-to-date legislation relating to social security. A Guide on all appropriate matters issued by the Chief Adjudication Officer, who advises on performance of statutory functions. Model decisions for use in drafting decisions. Reported decisions of the SS Commissioners & a Digest thereof. Access to advice on individual cases from the office of the Chief Adjudication Officer.

**Israel
Response**
Regulations of the general disability benefit program are published in book form, putting all the laws & amendments under one cover. The last issue was published 1/1/85. In addition, various documents relating to claims procedure are available. Claim officers, especially in the early stages of their work, consult with the claims unit director. Also, over 60% of claim decisions are made by the claims officer after consultation or assessment by the rehab officer of the branch. In other cases the medical officer writes in his report that medical disability is clear-cut & opinion of rehab officer isn't required for decision of claims officer.

**The Netherlands
Response**
Everyone has access to service manuals which include both factual information in the various areas & directives for the implementation of case methods & procedures for dealing with cases. These manuals are comprised of those policy guidelines which have been approved by the JHS board & management, usually after consultation with the trade associations.

**Sweden
Response**

**West Germany
Response**
The claims processors primarily rely on administrative instructions setting forth the relevant legal provisions & regulations. Handbooks, commentaries and other professional literature is also available to insurance administration staff.

**USA
Response**
Law, regulations, SSA published rulings, Program Operations Manual System (POMS), physician handbook, program circulars desk aids, guidelines.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section I Part III.A

How is the accuracy of the decision making computed, monitored or improved within the agency?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
..... The factual & arithmetic correctness of the decision making is monitored by special controlling depts. and controllers in each case. Legal decisions are controlled by controlling panels, the heads of the specialized depts. and the employees of the auditing unit. Medical decisions are controlled by the head physician on the basis of the evaluation of the main medical expert(specialized physician).	 Decision-making is centrally located at the national level. There is a quality control procedure whereby a senior medical officer audits a 0 of files every day. Also appeals force the original decision to be re-examined.	 SSI-thru control decision making procedures EPDP-thru control decision making & use of relevant Pension Board EAI & MLI-thru advisory boards of medical drs. & insurance experts & lawyers as well as laymen. Disability pension matters have to be taken to the relevant board before decision of benefit is made.	 Monitored by adjudication officers immediately senior to them in their local office who are required to select cases to examine at random & who are also available to provide adjudication advice. The standard of performance at both levels is in turn monitored from regional offices & the office of the Chief Adjudication Officer. Also each region arranges regular adjudication meetings. This monitoring, visits to local offices, case-work exams & information gained from group meetings form the basis of an annual report produced for publication by the Chief Adjudication Officer by law.	 By use of above-mentioned consultation procedures, with medical officer, director of the claims unit, and/or with the rehab officer a final signature of approval of decision of claims officer is provided by a senior claims officer of the branch. If no consensus can be reached at unit level by dr., rehab officer & claims officer, the claim is sent to national office for decision.	 The JHS tries to monitor & maintain the accuracy of its decision-making by a very thorough systematization of case handling & by dividing this handling into 7 phases (1) Administrative preparation, (2) intake, (3) information gathering, (4) decision making, (5) implementation of treatment plan, (6) follow-up care, (7) administrative follow up. By means of the arrangements for handling complaints, the management can also keep an eye on the provision of services by the JHS.		 Monitoring by senior officers, verifications thru within agency reviews, verification thru computerized "flow-finding" programs.	 3 levels: GA in state agency, federal GA at regional level; central (headquarters) GA checks accuracy of the regional level.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section 1 Part III.D

Describe review procedures for local, regional and state decisions.

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
In the Pensions Insurance Institute for Employees, the review is done by special controlling depts. of the central administration also for claims from the different provinces. In the Pensions Insurance Institute for Workers, the review is only done on a regional level.	No local or regional decisions are made. All claims are channelled to the national office.	See above.	Any person may apply to have a decision reviewed by an adjudication officer. Application must be made in writing & show grounds. Decisions may also be reviewed by an adjudication officer of his own accord. A SS appeal tribunal may review a decision on reference to it by an adjudication officer. Reviews must meet criteria: (1) the original decision was given in ignorance of, or was based on a mistake as to, some material fact, or fresh evidence, (2) There has been a relevant change of circumstances, (3) The decision was based on the decision of another authority which has been revised, (4) The decision was erroneous in point of law. There is no separate system of local, regional & state decisions.	In the beginning, all decisions were reviewed by national office, but this proved impractical due to large volume of claims. At present, spot checks are done periodically to review local decision procedures.	The correction/re-evaluation procedure actually runs parallel to the normal working methods.		Not Applicable.	65% of all allowances reviewed on the central level; common deficiency lack of documentation/ evidence - sent back for corrections.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section I Part III.C

How is uniformity of decision in similar cases achieved?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
Through service instructions & the central decision making by the bodies of the self-administration.	As there are no benefits awarded for partial disability, inconsistency isn't a major problem. Uniformity is maintained when most claims go to the same doctors for adjudication. Geographical location and local unemployment rates are not used to evaluate, so there is no problem to ensure consistency in this respect.	See above.	The SS Commissioners interpret statute law in their decisions on appeals submitted to them. Important decisions are published and form case-law which can be used in similar cases by other adjudication authorities. The Guide & model decisions provided by the Chief Adjudication Officer, the regular monitoring of adjudication and exams of casework, the publication of the annual report, and assessment standards of adjudication in detail all provide a safeguard as to the uniformity of decision-making. Also there is training available to adjudication officers.	Thru simple diffusion of knowledge, accumulated experience, and consultation procedures.	The manuals & directives provide the basis for a rather uniform approach on the part of the JMS. In addition, the pronouncements of the appeals court also provide footholds for a uniform approach.		By joint consideration and decision-making in the relevant bodies of the Federation of German Pension Insurance Institutes.	Central office reviews 10 regions. Policy people clarify issues of great differences among the regions.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section 1 Part IV.A

How is the record keeping handled?(e.g. where are the files stored?)

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
The files are stored in the archives of the different depts. respectively in central archives (files).	For each case, a file is opened for the application form and the record of earnings verification form.	Each agency has its own databank & record of folders. SII keeps a record from everyone from birth to death. For the private EPDP programs there is one central databank at the Central Pension Security Institute, keeping record of a person's entire working life and under which program he is. There is a complete population register of the country kept partially by the registered churches in Finland & partially by the population registration authority.	Records of most SS benefits are maintained in a local network of some 550 DHSS offices, including invalidity benefit, severe disablement allowance & industrial disablement benefit. Records of claims & payments of war pensions, & attendance, mobility & invalid care allowances are kept at a central office at North Fylde.	The files are stored at the local branch.	All incoming material from 1 person is filed under a single registration number. The individual data from the district (peripheral) offices is then fed into the JMS' computerized registration system. This system contains personal, procedural & advisory info. The files themselves remain at the peripheral offices, with few exceptions.		By means of (1) file storage in the records room, (2) microfilming, (3) electronic data storage.	7 Program Centers nationwide for payment related activities where moves monitored, deaths recorded, etc. One of 7 is headquarters. The headquarters program center stores records of all SSDI recipients to age 59. Then info goes to other centers which also keep widow records.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section 1 Part IV.D

Is medical evidence stored in the same folder with technical evidence or in a different folder?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
Same folder.	Same folder.	Same folder.	Varies according to the benefit in question, but mostly there is a separate folder for medical information.	Same. The file consists of 3 parts: basic data & documentation, medical evidence, & documentation regarding claims & benefits.	Medical information is included in the same file as other data.		As a rule only single file is kept.	Same folder.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section 1 Part IV.C

What, if anything, is stored on the computer?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
Only data on the pension assessment & a statement of substantiation & data concerning the payment of pensions, but not medical data.	Contributor Application Records; CPP contributors' Records of Earnings; summary of data for each beneficiary with age, sex & benefit level; status of claim and where file is located, e.g. at a field office. Info about the nature of the disability is not recorded.	Technical data including diagnosis but not medical evidence.	A "Database" computer system is being built up at North Fylde which will contain details of claims, the decision on a claim & details of payments made in respect of attendance, mobility & invalid care allowances. Industrial disablement benefit & severe disablement allowance are not yet computerized, except for production of order books.	Until now, only basic data & financial aspects of benefits to beneficiaries were stored in the computer. Now, the agency is changing the set-up so as to enable all data to be stored in the computer.	In principle, no distinction is made between electronically stored and other forms of registration system.		Personal data, pertinent insurance data, as well as data relative to payments and/or rehabilitation measures provided.	Technical data, including diagnosis, but not medical evidence.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section 1 Part IV.B

How are data on contributions stored?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
===== The data processing of obligatory contributions is done by the Federation of Austrian Social Insurance Institutes. The different social insurance institutes can ask for the data. The social insurance institutes themselves only store data on voluntary insurance & later acquiring of insurance periods.	===== Records on each person contributing to the CPP are stored on a central computer; there are 16 million records spanning 47 years.	===== Data on contributions, rather existence of insurance, are on the computer at the relevant head office.	===== On a computer at a central office at Newcastle.	===== In the central computer service at the national office.	===== See above.	=====	===== On the computer.	===== On the computer at headquarters.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section 1 Part IV.E

Are these data recalled when claim is made?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
Yes.	Yes.	At the time a claim is presented these data on contributions are retrieved in RLI only.	The local office is able to check computer records using a "Data-link" system. The computer is interrogated each night to give a 36 hr reply service.	Yes.	Info is stored in the file for the duration of the benefit. When the benefit expires or is terminated, the JMS keeps the data for 5 yrs before destroying it. If a request for benefits is rejected, the info is destroyed after 2 yrs. The trade associations keep the info for the same period of time as the JMS.		Yes.	Yes.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section I Part IV.F

How are benefits computed and initiated?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
One has to distinguish between benefits in kind & compensation payments. The calculation of the compensation payments is set forth in the law. The payment of the benefits is affected by mail or thru wiring the benefits to a bank in Austria.	Benefits are composed of a flat rate and an earnings related portion, with a specified monthly amount.	Benefits are computed according to a formula relevant to each program. Various agencies may have slightly different formulas. Payments are initiated by entry on the computer which goes to the treasury which starts payments.	Invalidity benefit, severe disablement allowance & industrial disablement benefit are computed manually at the local office. At North Flyde the initial payment of attendance allowance & mobility allowance is manually computed; thereafter payments are made by a selection of methods including payment by Automated Credit Transfer, by order book or by combining payment with another benefit.	Benefits are computed according to the formula described in statute. Payments are initiated by entry on the computer thru which payments are sent to the disabled persons' bank account.	After the claimant has been disabled for 1 yr the JMS presents an official report to the trade association which then makes a decision. If the claimant wishes to request a facility or service, he or she must do so through the trade association dealing with his/her case. The application form is available at any post office. The trade association then begins its own file and asks the JMS for advice.		By means of the statutory pension formula; benefit payment is usually made thru the mail pensions service of Deutsche Bundespost.	Computed according to a statute formula. Payment initiated by computer entry to the treasury.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section 1 Part IV.B

Is loss of claimant information or claimant folders a problem?
If so, what are safeguarding measures?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
Fundamentally, the loss of claimant folders or parts of them does not represent a problem. The claimant folder only contains copies or transcripts of original documents stored by other depts). The individual data cards on employment that have been lost can normally be re-established by most of the health insurance institutes on the basis of the employment lists sent to them by the employers. The loss of a medical expertise would make necessary a new medical check of the claimant. Should it not be possible to re-establish data (such as original data cards, etc.), the decisions are based on other documents - (certificates, wage tax cards, declarations of witnesses, etc.).	No, although occasionally a file will be temporarily misplaced as it makes its way thru the system. Once info is computerized, backup tapes are stored in 3 locations for safe-keeping.	Due to relatively small organizations there very seldom occur losses of claimant information. Original documentation very seldom leaves the premises, only thru photocopies.	The DHSS maintain this is a small problem. Records of claims are kept at Newcastle Central Office so that on receipt of a new claim, transfer action of previous claim papers is initiated. Similarly at North Fylde previous claims are recorded & on receipt of a new claim the original papers are called for. Phone inquiry response is a problem with papers moving between so many offices.	No. This is because files are not removed from the local office.	Info concerning the claimant is stored in part by the JHS & in part by the trade association. Loss of this info could therefore result in a partial re-investigation and the repetition of the case procedure. Yet actual loss of this sort seldom occurs.		No; data safe-guarding measures are in place.	Yes. Card monitoring movement of folder through system is the only safe-guard.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section I Part V.A

Is information regarding benefits provided regularly by administering agency:
1 Through TV ads & radio?
2 Through other mass media such as newspapers, magazines, etc.?
3 Through agency publications available through employers, community, etc.?
4 If none of the above, how do most people find out about the benefits?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
Changes in the regulations or specific problems on radio & TV.	Each year an information dissemination plan is formulated. Local offices are responsible for implementation. Staff members participate in interviews and hotline shows on both radio and TV.	Info is provided in TV & radio in programs concerning social security.	There are no tv or radio ads.	There are no tv, radio or other mass media ads.	The Dutch government has regular radio programs which answer listeners' questions concerning social security.	There is dissemination thru TV ads, radio & other mass media.	There is dissemination thru TV ads, radio, newspapers and magazines.	There is dissemination thru TV ads, radio, newspapers and magazines.
Important changes of benefits are made known in the newspapers, in specialized papers respectively in publications of statal organs.	Information copy is also provided to newspapers.	There are articles and ads concerning social security.	Generally, newspapers and magazines are the media thru which info is disseminated.	There is a publication available at the local office describing the program, its benefits & procedures required. There is also a phone information service provided by the agency at the local office.	Newspapers also run regular question-and-answer columns dealing with the law & social security.	In addition, info is given by means of brochures, newsletters & leaflets, relative to benefits & services in general, and, more specifically, concerning new legislation. Individual information and counselling is ensured through special advisory services.	Furthermore, there are agency publications widely distributed via government and non-government channels.	Furthermore, there are agency publications widely distributed via government and non-government channels.
The different types of benefits are basically known to the population thru different publications. For the benefits of the pensions insurance, there are brochures that are at the disposal of the insured persons, the shop stewards, the unions, the workers' reps., respectively are distributed at exhibitions or trade fairs.	Meetings are arranged with employers & local groups; radio talk shows and seminars are also offered. Publications include "Basic Facts on SS programs"; "Inventory of Income Security Programs in Canada."	Agency publications are widely distributed thru employers and other channels. The private EPDP programs have a joint central databank, Central Pension Security Institute, which sends to everyone under these programs an extract of his personal record 11 year or after a change of employment. All the insurance institutions have magazines for their customer service. In EPDP programs the insured may send an inquiry card free of charge at any time.	There are no specific programs of advertising invalidity benefit since it is a follow on from Sickness Benefit. There are many leaflets distributed thru DHSS offices and advice agencies, etc. It is not believed to have take-up problems. Even if people are unaware of benefit they may receive it automatically after 28 weeks of sickness benefit.	People find out thru community social workers, associations for disabled persons, employment officers, & word-of-mouth.	The executorial bodies have set up a Social Insurance Information Center. They publish information material, which is then distributed thru legal advice and assistance centers, employers, lawyers & others. Easy access info hours are held in neighborhood centers & led by residents or social workers. The JMS has recently taken on its own social counselors & established info counselling hrs.		In addition there is a toll-free 800 8 listed in most phone books.	
Consultations are held regularly in companies & offices of the public-law institutions. The Pensions Insurance Institute for Employees furthermore has a special information bus that is used throughout Austria.	Info is distributed periodically thru the Contributory Information Project, which involves surveying people who have contributed to the CPP at any time.							
		People are welcome to phone all the agencies for information. There are special clerks on duty.						

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section 1 Part V.D

Do you as a regular practice:

1 Make information available in more than one language?

2 Communicate with claimant in language of preference?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
***** In certain cases, circulars or information leaflets are published or handed out in the language of the claimant. The communication, especially where the claim is concerned, is in German.	***** All written info is in English and French. Where international agreements exist, info on the provision of the agreement is available in other languages. Efforts are made to hire field staff who speak a variety of languages as required by the community in which the office is located.	***** All the written info is available in Finnish & in Swedish. The claimant may use his mother tongue of Finnish or Swedish.	***** The basic leaflet, "Which Benefit" has recently been translated into Chinese, Hindi, Gujarati, Punjabi, Bengali and Urdu. All written communications from the DHSS are in English. Interpreters are provided at the local office where possible. However, school children often interpret for their parents.	***** A Publication in Arabic is available in Jerusalem. Areas where Arab speaking population is more concentrated, opportunities to communicate with claimant in Arabic are very high. Since Israel is a country of immigrants, arrangements will be made, whenever possible, to find an official or a translator to assist in order to communicate with claimant in his home language if he can't manage Hebrew.	***** Not applicable.	*****	***** Not applicable.	***** Yes, Spanish & others. Interpreter efforts are made.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section 1 Part V.C

Are notices to claimants written in
language easily understood by the
majority of claimants?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
***** The letters & information are formulated in an easily understandable way.	***** In 1982 it was determined that the forms should use a more simplified language. This is still a problem due to difficulty of losing precision in meaning when simplifying terminology.	***** All notices to claimants are written in language as understandable and simple as possible.	***** Many of the standard letters are phrased in difficult legalistic language. One frequent source of misunderstanding is the instructions relating to additions for a partner. Many claim incorrectly when their partner is already receiving a personal benefit. Resulting overpayments are always reclaimed by DHSS. Claimants also often don't understand why their benefit has been refused/cut off, or make their doctors understand the complex procedures for appeal.	***** Yes.	***** Improvement has lately been seen in the simplification of the written language used by administrators regarding decisions made on claims. However, the social security system as a whole remains difficult for the insured to understand.	*****	***** Yes.	***** Notice Simplification Task Force improves language of agency communications all the time.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section 1 Part V.D

Is information for claimants available through special communication modes such as Braille for the blind and telecommunication devices for the deaf?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sueden Response	West Germany Response	USA Response
There currently are trials with videotext.	Braille and taped info were made available at one time, but there was little demand. A large print booklet is available and some field offices have TDDs.	Some information material is available on recordings.	No plans at present to produce leaflet in Braille as the % of people able to read it is extremely low. Facilities for blind or hearing impaired people vary among offices and there are no special provisions for those with more severe communication disorders.	No.	There are no specific modes of communication for the visually or sensorily handicapped. There are, however, interpreting/translating facilities for communication with foreigners.		No.	Some pamphlets are available in Braille and on recordings.

REHABILITATION INTERNATIONAL
CROSS-NATIONAL STUDY OF DISABILITY BENEFITS
QUESTIONNAIRE RESPONSES

Section I Part VI.A,B,C

Are payments periods made: weekly? Fortnightly? Monthly? Other?
Is timing of payments made at the beginning or end of the period?
Are payment transfers made by: mail? By voucher or order book? By credit transfer?

Austria Response	Canada Response	Finland Response	Great Britain Response	Israel Response	The Netherlands Response	Sweden Response	West Germany Response	USA Response
Monthly.	Monthly.	Monthly.	Payments are made 1 week in arrears and 1 week in advance.	Monthly.	Monthly.		Pension due to occupational or earning incapacity paid monthly.	Monthly.
Beginning of each month.	End of period.	Generally at the beginning of the period.	By Girocheque; particularly if medical evidence held is for less than 6 wks payment. Also available are a book of weekly orders covering a period of up to 26 wks which the recipient can cash each wk at a post office of his choice.	Payments are made on the 28th of the month.	Payments by the individual trade associations do not always take place on the same date, as every trade association has its own system.		It is paid at the beginning of the month.	Payment is made at the end of the period.
Any way insured chooses.	By post and direct deposits to the bank.	Through the banking system.		Payments are by credit transfer.	Payment is made via transfer to bank or postal-giral account (by voucher) or thru the mailing of a personalized check.		Payment is made either by postal cash delivery service or is transferred to a bank account.	Payment transfers are made by post or by credit transfer.

DEFINITIONS OF DISABILITY AND THEIR PROGRAMME IMPLICATIONS

For

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By

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I believe, that the definitions of impairment, disability and handicap provided in the World Health Organization Classification system are a most important step towards a clearer understanding of disability and handicap as a social problem. The WHO definitions of these terms have gained widespread and general acceptance unlike the classification system, which is a source of controversy. Previously these terms were frequently used interchangeably reflecting our confusion of the three separate facets of this social problem, which they now so clearly delineate.

I would like to review each of these definitions in turn, exploring with you the concepts which flow from them, and their application in the field of income support systems for individuals with impairment, disability and handicap.

The World Health Organization's publication International Classification of Impairment, Disability and Handicap⁽¹⁾ presents the following definitions of these terms:-

IMPAIRMENT is defined in the context of health experience as

"ANY LOSS OR ABNORMALITY OF PSYCHOLOGICAL,
PHYSIOLOGICAL OR ANATOMICAL STRUCTURE OR FUNCTION".

Impairment represents deviation from some norm in the individual's biomedical status. It is characterized by losses that may be temporary or permanent and it includes the existence or occurrence of an anomaly, defect or loss in a limb, organ, tissue or other structure of the body. It also includes a defect in a functional system or mechanism of the body, including the systems of mental function.

Impairment is not contingent upon etiology.

It does not necessarily indicate that the individual should be regarded as sick.

It does not need to be perceived by the impaired individual.

Impairment only ensues when there is a reaction by the body, so that a pathological process or processes develop. The concept of a latent impairment is a contradiction in terms.

CLASSIFICATION OF IMPAIRMENTS: (List of two-digit categories)

- | | |
|------------------------------------|---|
| 1. Intellectual impairments | 6. Visceral impairments |
| 2. Other psychological impairments | 7. Skeletal impairments |
| 3. Language impairments | 8. Disfiguring impairments |
| 4. Aural impairments | 9. Generalized, sensory & other impairments |
| 5. Ocular impairments | |

DISABILITY is defined as -

"ANY RESTRICTION OR LACK OF ABILITY TO PERFORM AN ACTIVITY IN A MANNER OR WITHIN THE RANGE WHICH IS CONSIDERED NORMAL".

Disability is concerned with compound or integrated activities expected of the person or of the body, as a whole, such as tasks, skills and behaviours.

Disability represents a departure from the norm in terms of performance of the individual, as opposed to that of the organ or mechanism.

The concept of disability is that of a functional limitation which expresses itself as a reality in every day life. By concentrating on activities disability is concerned with what happens - the practical results of an impairment.

CLASSIFICATION OF DISABILITIES:

1. Behaviour disabilities
2. Communication disabilities
3. Personal care disabilities
4. Locomotor disabilities
5. Body disposition disabilities
6. Dexterity disabilities
7. Situational disabilities
8. Particular skill disabilities
9. Other activity restrictions

HANDICAP is defined as -

"A DISADVANTAGE FOR A GIVEN INDIVIDUAL, RESULTING FROM AN IMPAIRMENT OR A DISABILITY THAT LIMITS OR PREVENTS THE FULFILLMENT OF A ROLE THAT IS NORMAL FOR THAT INDIVIDUAL (DEPENDING ON AGE,SEX,SOCIAL & CULTURAL FACTORS)"

Handicap is thus a social phenomenon representing the social and environmental consequences for the individual stemming from the presence of impairments and disabilities.

The state of being handicapped is relative to other people, hence the importance of existing societal values, which in turn are influenced by the institutional arrangements of society.

CLASSIFICATION OF HANDICAP(List of Dimensions)

1. Orientation handicap
2. Physical independence handicap
3. Mobility handicap
4. Occupational handicap
5. Social integration handicap
6. Economic self-sufficiency handicap
7. Other handicap

By way of illustration, an adult diabetic, successfully controlled by diet and drugs, has an impairment but may be neither disabled nor handicapped. If in addition to diet and drugs there is a need to restrict heavy exercise, or lead a regular life style in order to achieve adequate control, the individual qualifies as a disabled person, because there is now a restriction of ability to perform activities in a manner or within the range which is considered normal. When such an individual is employed in sedentary work and has regular hours of employment there is no vocational handicap. A similar impairment in a person, who is employed in a physically demanding occupation, where shift work is required qualifies as a vocationally handicapped person.

Note that in a group of 10 individuals with this impairment, 5 might qualify as disabled and of those, who are disabled only one might be vocationally handicapped.

Let me draw your attention to several concepts implicit in these definitions: -

- 1) First, the concept that impairment need not necessarily result in a disability or handicap.

- 2) Second, handicap is not a function of impairment and disability alone, but depends upon the interplay of various other factors. In the illustrations given the vocational handicap results from the demands of the job and the existence and degree of the handicap may depend upon the attitude of the employer and the range of vocational options open to the individual, which in turn are dependent upon such considerations as age, intelligence, emotional stability, education, past work experience, etc.

In the event that the labouring shift worker is laid off the potential vocational handicap becomes a real disadvantage and this healthy appearing reasonably active individual may be unable to find work despite what we may consider to be a trivial disability. The more important handicapping factors may be age, education, etc.

- 3) This illustrates a third concept, namely that the severity of the disability does not necessarily equate with the severity of the handicap. Lets look at two more examples. Mild arthritis of the hand may terminate the career of a concert violinist, while a computer programmer may continue at work despite a high level quadriplegia.

When we consider this we can see that a scale which measures the severity of disabilities will not serve also to measure the severity of handicap.

IMPAIRMENT PENSIONS

In Canada the Workers' Compensation Board's pension system is based upon an assessment of impairment. The loss of a digit, hand or foot, or an impairment of back function results in a pension, which is based upon the percentage loss of body structure or function without regard to the degree of disability or vocational handicap. This system makes medical evaluation

relatively easy, but creates much hardship and bitterness in those vocationally handicapped workers, who are unemployable because of a relatively minor impairment.

For example a 58 year old labourer, who following a knee injury is left with a stiff painful knee and is unable to perform his former duties. He has no other marketable skills and is rendered unemployable. His impairment is assessed at 20% and the amount of pension set accordingly. He fails to understand, how he can be expected to live on such a small pension and is bitter and angry. Because of political pressure on appeal, some individuals in this situation may now be granted a supplementary pension, which in my view, is basically a hardship allowance.

This approach is also utilized by many insurance companies underwriting accidental death and dismemberment policies, where fixed amounts are paid for the loss of one limb, one eye, etc.

From my perspective in the public domain, a logical application of an impairment pension scheme might include the provision of funds to prevent impairment from causing a disability. For example the provision of medication to an individual with marginal income, who has epilepsy, diabetes, or hemophilia, where the cost of treatment is a deterrent to compliance with treatment, which would prevent progression to disability and handicap.

DISABILITY PENSIONS

The mobility pension in the United Kingdom comes to mind as an obvious example of a pension, which sets out to compensate the individual for a restriction of specific activity. In Canada the

approach is to provide at the Federal level an income tax exemption to those with restricted mobility impairment. This, of course, fails to assist those, who are unemployed and renders them vocationally handicapped, since they are disadvantaged in searching for employment and in getting to and from work. This type of disability pension, as I perceive it, seeks to place the disabled person on a more equal footing with the abled bodied population in competing for work and in participating in education, social and recreational activities.

In the Canadian Workers' Compensation Board system a quadriplegic beneficiary has been automatically granted a 100% pension in accordance with their impairment rating system. With the advent of high level quadriplegics residing at home and requiring personal care assistance, an attendant care supplement has been created. Using the WHO definition this would be defined as a disability(personal care) pension. Of course, the provision of technical aids, such as a communication device, adaptations to the workplace would also fall under this heading.

An obvious question arises. Surely these disabled individuals are also socially disadvantaged and, therefore, handicapped? Why, therefore, is this not called a handicap pension?

The distinction from my standpoint is, that the determination of eligibility would be based on the mere presence of the disability and would not be contingent upon proving the presence of a social disadvantage. In other words, the high level quadriplegic person would receive the attendant care disability pension irrespective of his or her social, vocational or economic status.

I view the measurement or certification of the degree of disability as more complex than the simple certification of an impairment. It may require the involvement of a wider range of health care professions, particularly, in defining the level of severity of the various categories of disability.

I see two distinct approaches to determining eligibility for disability pensions. One is financial compensation based on the severity of the disability and the other is in the form of providing technical aids, rehabilitation and other specific assistance to compensate for the restricted activity. Some combination of these two approaches provides a third alternative.

HANDICAPPED PENSIONS

As defined by WHO, a handicap pension would, in my view, be provided on the basis of an existing social disadvantage resulting from an impairment or disability.

- e.g. disadvantaged in obtaining employment -

The Canadian Disability Pension Plan falls under this category, as, in order to be eligible, the individual must suffer from "a severe and prolonged mental or physical disability and be incapable of pursuing substantially gainful occupation".

Eligibility here hinges on two conditions. First, the presence of a severe and prolonged mental or physical disability. This calls for a medical determination, which does not pose a great deal of difficulty for a physician in most instances. The second condition, namely certification of incapacity to pursue any substantially gainful occupation is commonly required from a physician and this, in my opinion, is inappropriate and a source of a great deal of difficulty. It is particularly difficult, when

the physician being asked to make this certification is the family physician, and is aware of his patient's financial difficulties and believes (often mistakenly) that the granting of a handicap pension is in his patient's best interest. There is a clear conflict of interest here, which makes objective evaluation difficult.

In my work, as a Senior Consultant in Rehabilitation to the Ministry of Community and Social Services in Ontario, I have in consultation with another colleague, a psychiatrist and two staff of the local Ministry, examined a consecutive series of 150 files where the individuals were granted handicap pensions on the basis that they were considered unemployable by a physician. The four reviewers unanimously agreed that in 75% of these cases there was insufficient information provided to make a determination of unemployability caused by an impairment or disability. It is my firm opinion, that in Ontario, Canada, there is a problem in determining unemployability and that this problem results in the inappropriate granting of pensions, almost as frequently as it results in the inappropriate denial of pensions. As this subject will be discussed in a later panel, I do not propose to pursue the question of determining unemployability at this time.

I would like to leave off consideration of the World Health Organization definitions now and turn to some other aspects of defining disability for the purpose of determining eligibility, which are extremely important in terms of the physician's role in this process.

First, a few words about the descriptive wording surrounding the definitions. Take this example relating to a definition of unemployability "the individual must be totally and permanently

unfit to perform any and all occupations, for which his/her education and past work experience equips him/her".

This wording defies the physician to say, that the applicant can not handle one of those rare plum jobs that some companies have available for long service employees. The job of indoor car park attendant, the weigh scale operator. The wording implies, that it doesn't matter that there may be a waiting list a yard long for these jobs or that the chance of the applicant actually being able to obtain work is remote.

The decision called for is black and white. There is no provision for another alternative. No equivocation is tolerated. Frequently, the correct answer, which the physician should give is "I don't know". To say that may be viewed as an admission of incompetence or as an aggravation of the patient's problems, by adding uncertainty and anxiety to the patient's existing difficulties. The physician is torn between his obligation to help the patient and his desire to answer the question truthfully.

I wish to make a strong plea for recognition of the difficulties, which a physician faces in this situation, particularly, when he/she is the family physician. I wish to recommend that the definitions of eligibility make provision for the uncertainty, which exists in many of these situations, the degree of difficulty, which is often involved in arriving at a proper opinion, the often enormous financial implications of these decisions, the conflict of interest situation and the need for physicians to be aware of the consequences of their actions. This leads to another consideration, namely, that eligibility be defined on the basis of a rehabilitation assessment, which

measures residual ability and vocational potential rather than residual disability.

Since the blending of medical and vocational assessment of disability claimants is the subject of a later panel, I will not pursue this topic further at this time. I would, however, like to emphasize that this raises a most important issue and that is what is the goal of these disability pension programmes. Is the goal simply one of identifying individuals with a certain level of disability and providing them with a pension, or is the goal to assist as many of these individuals as possible to return to employment and to total or partial self sufficiency.

In my view, a definition of the goals and objectives of these programmes should be made before definitions of eligibility are attempted.

In Canada recently, it has been proposed that we adopt a National Goal of reducing unemployment among employable disabled persons to the national level of unemployment within the next decade. (2)(3)

If such a National Goal was adopted and applied to the policies and programmes of our Canada Pension Plan, the assessment of eligibility, the whole thrust of the assessment process would turn away from establishing proof of an existing disability, as defined by the Canada Pension Act, towards a process which first attempts through a process of medical and vocational rehabilitation to return the individual to the work force. Only after this process has been attempted is eligibility determined, based largely on the outcome of that process.

The Vocational Rehabilitation of Disabled Person's Programme in

Canada, which is funded jointly by the Federal and Provincial Governments does utilize this approach, but the majority of income support programmes for individuals, who are vocationally disadvantaged do not.

Personally, as a physician, who has worked for over 30 years with disabled people, I believe, that this is the route that the majority of individuals with these problems would prefer to follow. This view was also strongly supported by the many disabled people, who gave evidence before our Special Parliamentary Committee on the Needs of the Disabled and the Handicapped in the years 1981-1983. They wanted work not pensions.⁽⁴⁾

The programme implications, of course, are obvious today in an era of high unemployment. Politically, it is very difficult to visualize adding hundreds of thousands of handicapped Canadians to the unemployment statistics. The growing voice of the human rights movement, however, argues that surely vocationally handicapped Canadians deserve an equal opportunity to compete for employment and the increased standard of living and dignity, which goes with it.

In my view, this is one of the major challenges facing society at this time and it is one, which the disability pension system alone cannot solve, but in which it will have an important part to play.

As I see it our Governments are faced with the difficulty of financing the escalating costs of disability pensions on one side and a need to reduce the present unacceptably high level of general unemployment on the other.

I am confident that an efficient vocational rehabilitation programme approach has the potential to reduce the escalating cost of income support systems for the disabled and handicapped, but to be fully effective, it will also be necessary to reduce the present high level of unemployment

Thank you

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REFERENCES

1. World Health Organization: International classification of impairments, disabilities, and handicaps. Geneva, World Health Organization, 1980
2. Symington, D.C.: Integration: Are We Ready?: An address prepared for the First Canadian Congress of Rehabilitation, Ottawa, Canada, March 1983.
3. Symington, D.C.: The Goals of Rehabilitation: The 33rd John Stanley Coulter Memorial Lecture, Presented at the 60th Annual Session of the American Congress of Rehabilitation Medicine, Los Angeles, November, 1983: Arch. Phys. Med. Rehabil. Vol. 65, August, 1984
4. Obstacles: Report of the Special Committee on the Disabled and the Handicapped, Government of Canada, Ottawa, Canada, 1981.