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Rochelle V. Habeck, Ph.D.
Assistant Professor

Rehabilitation
- Research
- Service
- Education

6.8.87.

Dear Lex,

We missed you in Michigan!

I thought you might enjoy seeing the program and adding these resources to your files. The conference and climate in Michigan public and private sector is exciting... we need to move people to action now.

Thanks for facilitating my visit to the disability policy meeting. I thought your comments were strong and highly relevant. Sorry to miss talking with you personally.

Hope your summer allows some respite.

Best regards,

Rochelle

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IMPLEMENTING DISABILITY MANAGEMENT
A MICHIGAN STRATEGY

June 1 - 2, 1987
Kellogg Center
Michigan State University

The Disability Management and
Rehabilitation Research Project

School of Health Education,
Counseling Psychology and Human Performance

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IMPLEMENTING DISABILITY MANAGEMENT: A MICHIGAN STRATEGY

June 1 - 2, 1987

Kellogg Center

Michigan State University

The Disability Management and Rehabilitation Project is a three year research study on the topic of disability management and rehabilitation within the business and industrial environment. The Project is funded by the National Institute of Disability and Rehabilitation Research (NIDRR), U.S. Department of Education and sponsored by the School of Health Educaton, Counseling Psychology and Human Performance at Michigan State University. The School is an interdisciplinary unit of the College of Education, the College of Osteopathic Medicine, and the College of Human Medicine.

IMPLEMENTING DISABILITY MANAGEMENT: A MICHIGAN STRATEGY
June 1-2, 1987

ACKNOWLEDGEMENTS

Project Advisory Committee

The Advisory Council has provided valuable contributions and support to the research project throughout the three year grant period. We would like to express our appreciation for their continued guidance and their involvement in the development of the conference.

Annette Abrams, Deputy Director, Bureau of Intergovernmental Relations and Human Resources, Michigan Department of Mental Health

Irving Bluestone, Professor, Labor Studies, Wayne State University

Dr. Eugenia Carpenter, President, GINI and Associates

Dr. Carl Frost, Management Consultant, Frost, Greenwood and Associates

Peter Griswold, State Director, Michigan Rehabilitation Services, Michigan Department of Education

Dr. Cecil Williams, Director of Health and Wellness, Herman Miller, Inc.

Dr. H. Allan Hunt, Manager of Research, W.E. Upjohn Institute for Employment Research

Douglas Langham, Administrator, Vocational Rehabilitation Division, Bureau of Workers' Disability Compensation, Michigan Department of Labor

Dr. Michael Moore, Professor, School of Labor and Industrial Relations, Michigan State University

James Richards, Manager, Personnel Services, Buick-Oldsmobile-Cadillac Lansing Product Team, General Motors

Dr. Donald Shrey, Associate Director, International Center for Industry, Labor and Rehabilitation

Governor James J. Blanchard's Office

A special acknowledgement is given to Governor James J. Blanchard for his continued support of the research project and in particular to his office for their ongoing involvement and commitment to the development of the project.

Libby Richards, Human Services Advisor
Susan Arnaud, Assistant Human Services Advisor

Employer Participants

We wish to express our particular gratitude to the three employer organizations who have participated as partners in this research, generously sharing their time and resources and demonstrating their commitment and responsibility to their employees and the community.

Buick-Oldsmobile-Cadillac Group Lansing Product Team
Division of General Motors

Herman Miller, Inc.
Zeeland, Michigan

Department of Mental Health
State of Michigan

IMPLEMENTING DISABILITY MANAGEMENT: A MICHIGAN STRATEGY

June 1-2, 1987

Agenda

Monday, June 1, 1987

12:00 noon **REGISTRATION** (Conference Desk)

1:00 **WELCOME AND OPENING REMARKS** (Lincoln Room)

Rochelle V. Habeck, Ph.D.
Director, Disability Management Project

Dean Judith Lanier
College of Education

President John DiBiaggio
Michigan State University

1:30 **KEYNOTE ADDRESS** (Lincoln Room)

Robert Naftaly, Director
Michigan Department of Management and Budget

Donald Galvin, Ph.D.
Washington Business Group on Health/
National Rehabilitation Hospital

2:30-2:40 **BREAK**

2:40 **MICHIGAN LEADERSHIP PANEL: HEALTH AND DISABILITY ISSUES IN THE WORKPLACE** (Lincoln Room)

The economic and human costs associated with health and disability have become a major private and public sector concern. Management and labor have begun to focus on prevention and early intervention and are becoming more active in responding to the health concerns of the workforce. The purpose of the session is to raise awareness and increase understanding as to the significance of health and disability problems as faced by representatives of private and public organizations that impact and are impacted by these problems. The general theme will be the impact of health and disability costs on Michigan business and labor and how public policy, regulation, labor and management commitment, education and research, and qualified service providers can contribute solutions to address these costs.

Moderators:

Donald Galvin, Ph.D.
National Rehabilitation Hospital/
Washington Business Group on Health

Carl Frost, Ph.D.
Frost, Greenwood and Associates

Participants:

William Sederberg
State Senator, 24th District

Edward Welch
Director, Bureau of Workers
Disability Compensation
Michigan Department of Labor

Richard Ruch
Chief Financial Officer
Herman Miller, Inc.

Lynn Meyers
Assistant Director
Human Resource Development Institute
AFL-CIO

David Scott, Provost
Michigan State University

Peter Griswold
State Director
Michigan Rehabilitation Services
Department of Education

4:30 **AUDIENCE AND PANEL INTERCHANGE**

5:00 **RECEPTION: SUNKEN GARDEN**

Reception Host

Dr. William Hinds
Director, School of Health Education, Counseling
Psychology and Human Performance

Tuesday, June 2, 1987

8:00 a.m. **REGISTRATION** (Conference Desk)
Continental Breakfast Available (Lincoln Room)

8:30 **WELCOME AND MORNING ADDRESS**

Introduction: **Denise Tate, Ph.D.**
Department of Physical Medicine
and Rehabilitation
University of Michigan

Keynote Address: **Michael Scofield, Ph.D.**
Manager, Health Promotion
Program Development and Evaluation
AT&T

9:20-10:35 **SESSION 1 Identifying the Problem: Organizational Analysis**
(Lincoln Room)

A system to identify and track information relating to the incidence of injury/disability, health care costs, absenteeism and placement is a necessary element for disability management. An effective system provides organizational capacity to evaluate the effectiveness of current human resource programs to guide the development of a comprehensive plan for disability management. The focus of the session is on different approaches for the initial identification of this information along with factors to consider when developing a data collection system.

Moderator:

Don Galvin, Ph.D.
National Rehabilitation Hospital
Washington Business Group on Health

Participants:

Marlene Begelman, M.D.
Senior Scientist, Health Data Institute

Sally Carlson, Consultant to
GM/UAW Disability Management Project

James Kasprzak, Assistant to the Director
Michigan Department of Management and Budget

9:20-10:35 **SESSION 2 Prevention at the Worksite**
(Room 104)

Reducing the occurrence of injury and disability at the worksite through preventive strategies is a major factor in an industrialized approach to cost containment and human resource development. This requires attention to ergonomic factors in the design of the workplace, teaching supervisory personnel to consider the job and worker interface and the use of athletic trainers at the worksite to enhance individual capacity. The session will focus on each of these areas as strategies to reduce the incidence or impact of disability and to encourage a preventive approach to human resource management.

Moderator:

Len Sawisch, Ph.D.
Economic Development Unit
Michigan Rehabilitation Services
Michigan Department of Education

Participants:

Don Bronson
Industrial Environmental Specialist
Contract Interiors

Al Qualman
Ergonomics Coordinator
GM/UAW Ergonomics
Human Factors Team
Hydra-Matic
Willow Run Plant

Robert Hubbard, Ph.D.
Associate Professor of Biomechanics
Michigan State University

Herbert Reynolds, Ph.D.
Associate Professor of
Biomechanics, Michigan
State University

Don Tonti
Corporate Director of Human Resources
Walbro Corporation

10:40-11:50 **SESSION 3 Strategies to Manage the Costs of Disability**
(Lincoln Room)

Health care cost containment requires not only the development of a comprehensive data base but also consideration of personnel policies and benefit systems, rehabilitation service utilization and evaluation mechanisms. The focus of the session will be on specific approaches taken by organizations to effectively manage the costs of long term disability and workers compensation.

Moderator:

Denise Tate, Ph.D.
Assistant Professor, Department of
Physical Medicine and Rehabilitation
University of Michigan

Participants:

Dee Yeater, Regional Manager
Thomas L. Jacobs and Associates, Inc.

Stephen Johnson, President
Hi Tech Machine and Tool, Inc.

10:40-11:50 **SESSION 4** **Return to Work**
(Room 104)

Commitment to developing a return to work program is good business sense and demonstrates concern as to the importance of employee welfare. These programs may take many forms; however the basic components are organization commitment, return to work policy, and a placement process that uses the capacities of recovering workers by identifying productive work opportunities within the organization. The session will consider approaches that certain organizations have taken including a policy approach for reasonable accommodation and alternative duty, an organizational program for transitional placements throughout the company, and a specific center of internally contracted work for recovering employees.

Moderator:

Douglas Langham, Administrator
Vocational Rehabilitation Division
Bureau of Workers Disability Compensation
Michigan Department of Labor

Participants:

Mary Pollock, Office of
Intergovernmental Relations,
Michigan Department of Mental Health

Marlene Sal, Director
Transitional Work Center
Herman Miller, Inc.

Michael Gall, Supervisor
Employee Services, Steelcase, Inc.

12:00 **LUNCHEON** (Centennial Room)

Introduction: **Len Sawisch, Ph.D.**
Economic Development Unit
Michigan Rehabilitation Services
Michigan Department of Education

Luncheon Address: **Jay Rochlin**
Acting Executive Director
President's Committee on Employment
of the Handicapped
(Executive on loan from AT&T)

1:30-2:40 **SESSION 5 Building Management and Labor Consensus for Program Development** (Lincoln Room)

Building a comprehensive approach to disability management requires an atmosphere of cooperation to encourage exchange of ideas, consensus on outcomes, and commitment to the concept of joint initiatives. Issues and barriers to be considered in the development of an organizational approach are identified. The session will consider formal and informal ways to build labor and management commitment to joint initiatives for disability and human resource management.

Moderator:

Rochelle Habeck, Ph.D.
Director, Disability Management Project
Michigan State University

Participants:

Annette Abrams, Deputy Director
Bureau of Intergovernmental Relations
and Human Resources, Michigan Department
of Mental Health

James Richards, Manager, Personnel Services
Buick-Oldsmobile-Cadillac Lansing Group
Division of General Motors

Cecil Williams, Ph.D., Director of
Health & Wellness, People Division
Herman Miller, Inc.

Lynn Meyers, Assistant Director
Human Resource Development Institute
AFL-CIO

1:30-2:40 **SESSION 6 Selection and Evaluation of Service Programs** (Room 104)

Ensuring quality care for employees in a cost efficient manner is essential for effective management of disability. The session will focus on principles for achieving effective relationships with medical practitioners, guidelines for selecting and monitoring private vocational rehabilitation providers, and methods for evaluating the costs, outcomes and effectiveness of an organization's providers and service programs.

Moderator:

Michael Leahy, Ph.D.
Assistant Professor
School of Health Education,
Counseling Psychology and
Human Performance
Michigan State University

Participants:

Donald Stanton, D.O., Professor
and Chief, Division of Rehabilitation Medicine
College of Osteopathic Medicine
Michigan State University

Stephen O'Connor, Rehabilitation Consultant
Michigan Hospital Association

Donald Rigo, Workers Compensation
and Rehabilitation Coordinator
Ford Motor Company

William Frey, Ph.D., Director
Disability Research Systems, Inc.

2:50-4:00 **SESSION 7 New Approaches to Workers Compensation**
(Lincoln Room)

Workers compensation as a cost can be controlled. As awareness of the factors affecting the incidence and outcomes of injury claims have become better understood there is an opportunity to develop new and innovative ways to positively influence the economic, legal, and vocational outcomes of work injuries. The session will identify and focus on a number of new approaches to enhance cooperation and cost containment, including the use of research to identify policy, organizational and demographic factors that affect incidence and outcome, mediation efforts to achieve conciliation, and education to encourage the adoption of proactive approaches to work injury.

Moderator:

Diane Munrowd, M.A., C.R.C.
Project Coordinator
Disability Management Project

Participants:

Edward Welch, Director
Bureau of Workers' Disability Compensation
Michigan Department of Labor

H. Allan Hunt, Ph.D.
Manager of Research
W.E. Upjohn Institute
for Employment Research

Ervin Vahratian, Deputy Director
Bureau of Workers Disability Compensation
Michigan Department of Labor

2:50-4:00 **SESSION 8 New LTD Challenges: Stress-Related Disability and AIDS** (Room 104)

Costs associated with long term disability occur at many levels. Disability affects the individual, the employer, insurer and the community. Unaddressed, these disabilities result in loss of human potential and economic profitability. This session will consider two emerging health problems that pose new challenges of long term disability management for the employer. The discussion will emphasize the issues that arise when these health problems occur in the course of employment with respect to legal responsibility, benefit cost containment, and human resource management.

Moderator:

Eugenia Carpenter, Ph.D.
President, GINI and Associates

Participants:

Rodney Lowman, Ph.D.
Director, Corporate Mental Health Programs
Occupational Medicine Division
Duke University Medical Center

William Burian, Ph.D.
Dean, College of Health and Human Services
Western Michigan University

Gwynee Winsberg, Ph.D.
Vice President
Efficient Health Systems, Inc.

4:15 **FINAL ASSEMBLY** (Lincoln Room)

4:45 **CASH BAR** (Lincoln Room)

CONFERENCE FACULTY

Special thanks to the organizations and businesses who assisted the conference by supporting the participation of the following individuals as conference faculty:

Annette Abrams, Michigan Department of Mental Health
Lansing, Michigan

Marlene Begelman, M.D., Health Data Institute
Lexington, Massachusetts

Donald Bronson, Contract Interiors
Southfield, Michigan

William Burian, Ph.D., College of Health
and Human Services
Western Michigan University

Sally Carlson, GM/UAW Disability Management Project
Lansing, Michigan

Eugenia Carpenter, Ph.D., GINI & Associates
Ann Arbor, Michigan

John DiBiaggio, Michigan State University
East Lansing, Michigan

William Frey, Ph.D., Disability Research Systems, Inc.
East Lansing, Michigan

Carl Frost, Ph.D., Frost, Greenwood and Associates
Lansing, Michigan

Michael Gall, Steelcase, Inc.
Grand Rapids, Michigan

Donald Galvin, Ph.D., National Rehabilitation
Hospital/Washington Business Group on Health
Washington, D.C.

Peter Griswold, Michigan Department of Education
Lansing, Michigan

Robert Hubbard, Ph.D., Michigan State University
East Lansing, Michigan

H. Allan Hunt, Ph.D., W.E. Upjohn Institute
for Employment Research
Kalamazoo, Michigan

Stephen Johnson, Hi Tech Machine & Tool, Inc.
Grandville, Michigan

James Kasprzak, Michigan Department of
Management and Budget
Lansing, Michigan

Douglas Langham, Michigan Department of Labor
Lansing, Michigan

Rodney Lowman, Ph.D.
Duke University Medical Center
Durham, North Carolina

Lynn Meyers, Human Resource Development Institute
AFL-CIO
Washington, D.C.

Robert Naftaly, Michigan Department of
Management and Budget
Lansing, Michigan

Stephen O'Connor, Michigan Hospital Association
Lansing, Michigan

Mary Pollock, Michigan Department of Mental Health
Lansing, Michigan

Al Qualman, Hydra-matic, Willow Run Plant
Division of General Motors
Ypsilanti, Michigan

James Richards, Buick-Oldsmobile Cadillac
Lansing Group, Division of General Motors
Lansing, Michigan

Donald Rigo, Ford Motor Company
Lansing, Michigan

Jay Rochlin, Presidents Committee on Employment
of the Handicapped
Washington, D.C.

Richard Ruch, Herman Miller, Inc.
Zeeland, Michigan

Marlene Sal, Herman Miller, Inc.
Zeeland, Michigan

Len Sawisch, Ph.D., Michigan Department of Education
Lansing, Michigan

Michael Scofield, Ph.D., AT&T
Morristown, New Jersey

David Scott, Michigan State University
East Lansing, Michigan

Senator William Sederberg, 24th District
Lansing, Michigan

Donald Stanton, D.O., Michigan State University
East Lansing, Michigan

Denise Tate, Ph.D., University of Michigan
Ann Arbor, Michigan

Don Tonti, Walbro Corporation
Cass City, Michigan

Ervin Vahratian, Michigan Department of Labor
Detroit, Michigan

Edward Welch, Bureau of Workers Disability
Compensation, Michigan Department of Labor
Lansing, Michigan

Cecil Williams, Ph.D., Herman Miller, Inc.
Zeeland, Michigan

Gwynne Winsberg, Ph.D., Efficient Health Systems, Inc.
Skokie, Illinois

Dee Yeater, Thomas L. Jacobs & Associates, Inc.
Conohohocken, Pennsylvania

DISABILITY MANAGEMENT PROJECT

Michigan State University
513 Erickson Hall
East Lansing, Michigan 48824-1034

DISABILITY MANAGEMENT AND REHABILITATION

Disability management and rehabilitation involves the identification of employees who are showing signs of chronic illness or disability and the provision of intervention via in-house or contracted public and private rehabilitation services. The objective is to retain the disabled worker in employment.

Three factors reinforce the rising concern over disability in the workplace.

- the growing costs of health care and disability to business and industry;
- personal loss of economic security, independence and self esteem; and
- income maintenance which may inadvertently serve as a disincentive to return to work

Employers have come to realize that healthy employees represent an investment, an asset, and a resource to the firm. Research has demonstrated the work place as particularly well suited to effective and wide spread health promotion and intervention programs. It is the site where programs will have the greatest impact on the present adult population. Disability management is an active process of minimizing the impact limited abilities may have on the social and vocational roles of the individual. The process is cohesive, systematic, goal oriented and organized within an employer base.

Research Study

Michigan State University has received funds from the National Institute for Handicapped Research to conduct a three-year research project on disability management. The purpose of the project is to study incidence and experience of disability costs and outcomes, and service strategies operational in three major Michigan employers. The study proposes to investigate the impact of disability management and rehabilitation as offered through these employers upon such factors as disability payments, time off the job, continued employment and the efficacy of private and public rehabilitation.

Three sets of data will be investigated:

- macroeconomic factors (e.g. general economic trends, the extent of demand for labor in the economy, the amount of labor force ejection)
- organizational factors (e.g. employer policies, service strategies and costs)
- employee outcomes (e.g. health/disability status, job performance, time off work)

The aim of disability management and rehabilitation is to prevent an employee's passing from productive activity to dependence on disability benefits (or to reduce the amount of time one is receiving disability benefits and worker's compensation) by maintaining his or her working capacity and adjusting work to his or her capabilities. If proven successful, this investment may prevent the disability process and thus limit the growth of cost to employers, the social support system and, most importantly, the chronically ill, injured or disabled worker.

The study will also conduct a systems analysis of specific processes within the workplace of each employer participant. Based on factors identified as influential to costs and outcomes the study will proffer a set of recommendations to improve the efficiency and effectiveness of each employer's disability management and rehabilitation programs and policies.

The analysis is intended to produce information that will be useful in guiding these and other employers in the design and development of more effective disability management and rehabilitation programs.

Resources Available to Employers, Researchers and Educators

- Access and referral to bibliographic sources and publications
- Referral to other organizations or employers conducting similar programs
- Technical assistance and consultation in the development and implementation of disability management and rehabilitation programs.

Project Staff

- Donald E. Galvin, Ph.D., Professor, Michigan State University and former Associate Superintendent for Rehabilitation, Michigan Department of Education. Currently he is the Principal Investigator of this study and is directing the rehabilitation counseling program at MSU.
- Denise G. Tate, Ph.D., Associate Professor, Michigan State University and Director of the disability management study. She has had extensive consulting experience with respect to program design and evaluation.
- Rochelle V. Habeck, Ph.D., Assistant Professor, Michigan State University and Research Associate with the project. Dr. Habeck has clinical and research experience in psychosocial aspects of cancer and other physical disabilities.

For further information please contact any of the individuals listed above at (517) 355-1824.

Treating the industrial athlete

Most athletic teams, from high school to professional, have sports trainers to help prevent injuries and to treat minor injuries when they occur.

And, while athletic trainers have been a part of team sports for years, their expertise has recently attracted the attention of the nation's manufacturing executives and many have been employed to treat the "industrial athlete".

Year after year, statistics compiled by the Michigan Department of Labor's MIOSHA information division show that sprains and strains account for the majority of reported workplace injuries.

"Preventing sprains and strains and treating them when they do occur is precisely what athletic trainers are trained to do," said Ken Kopke, president of Athletic Training Services, Inc., of Mt. Pleasant.

Kopke was head athletic trainer at Central Michigan University for about 15 years and while in that position was called into the General Motors Saginaw Steering Gear plant to study workplace injuries and determine if physical training and conditioning could reduce them.

He evaluated each job from an ergonomic standpoint and recommended ways to change work operation that caused repeated stress on the same body parts and helped the plant set up a training room and employ an athletic trainer.

Shortly thereafter the plant began realizing a direct dollar saving in its workers' compensation costs, he said.

After experiencing success at Steering Gear, Kopke began thinking about beginning a consulting business that would offer the same services to any company.

While he was still head trainer at CMU and a member of the sports medicine staff, Kopke began consulting on a part-time basis.

CMU has the only school in Michigan and one of 63 in the United States which offers a four-year degree sports medicine major and an athletic trainer minor — two separate undergraduate programs through its Physical Education department in the School of Health.

The CMU course was the first to be fully approved and recognized by the National Athletic Trainers Association which certifies athletic trainers.

Kopke began his company, Athletic Training Services in 1983 and incorporated in 1984. In addition to offering consulting services, ATS is the Athletic Trainer National Registry — a placement service for athletic trainers.

"We really knew we were on to something when, during the 1984 GM

(Continued on page 102)

Don Tonti, left, discusses equipment with trainer, Martin Daniel.

Fitness center, trainers, save money for Walbro

Don Tonti is sold on the benefits of having an athletic trainer on the Walbro Corporation staff.

But, he had to be convinced.

When Walbro was planning a new building addition, employees suggested a fitness center, but Tonti, Walbro's Human Resources director was not ready to rush out and spend a lot of money on what might be a passing fad.

He was, however, willing to study the suggestion to see how a fitness center would benefit both the company and its workers.

He found by talking to others and, ultimately from Walbro's experience, that instead of costing the company money, a fitness center actually saves money.

Tonti had heard about the program at G.M.'s Saginaw Steering Gear (see related story) and after looking it over and learning the results, he began talking to Athletic Training Services, (ATS) Inc., in Mt. Pleasant.

While Ken Kopke, president of ATS, had done some consulting while head trainer at Central Michigan University, the Walbro Corporation was the first ATS customer.

ATS came in, studied all workers' compensation injuries and illnesses, studied all work operations and made recommendations as to what type of training program and equipment Walbro needed.

(Continued on page 101)

Walbro . . .

In October of 1985, Martin Daniel, certified athletic trainer was recruited by ATS and hired by Walbro, to supervise its rehabilitation and general fitness program.

The results have been phenomenal, far exceeding Tonti's expectations. The demand on Daniel's time has been so great that a second full-time trainer, Tanya Katschanow who was an intern, has been recently hired.

"We were told the payback would be five years," Tonti said. "Instead, the payback of all equipment and two salaries will occur in one year."

In the first six months occupational time off because of injury and illness was reduced by 79 percent.

During the first quarter there was a 36 percent reduction in absenteeism and the company realized a savings of 7.6 cents an hour per employee in all medical costs, including workers' compensation. During the first three months of 1986, there were no workers' compensation claims filed by Walbro employees.

"We found that people who were sore from weekend activities came in on Monday to work with the trainer and then perform some of their work duties, whereas before they probably would have stayed home," Tonti said.

Viewing workers as industrial athletes is a concept. Tonti not only believes in, but one he now strongly advocates.

The Walbro Corporation has nearly 800 employees at three locations: its corporate headquarters in Cass City, its automotive products group division in Caro, and the ARJAY Plastics division in Bad Axe.

Walbro manufactures fuel systems for 75 to 80 percent of small engines manufactured in the world. The company's growth came in the early 70s when the energy crisis resulted in a massive increase in chain saw sales.

Another boost in the company's sales came when the automotive industry began using more fuel injection engines, for which Walbro manufactures throttle bodies. In addition the company developed an "in the tank" fuel pump for the automotive industry.

Walbro's rehabilitation and fitness program is much more than working with employees who suffer strain and sprain injuries on the job and during weekend activities.

The fitness center is open from 5:30 a.m. to 9 p.m. for any employees who want to strengthen the muscles they use on the job and improve their overall fitness.

Walbro employee Ann Milligan discusses her injury with trainer Daniel while receiving a whirlpool treatment.

Since Daniel has been at Walbro, in addition to working with injured employees, he has organized aerobics groups and observed work practices.

One of the maintenance workers was experiencing back pain. Daniel took a look at the way he did his job and observed that he carried his tools on his belt. The trainer suggested that he carry the tools on a hand cart and the worker has had no further problems.

There are seven aerobic classes, taught by four instructors and attended by 10 percent of the employees; 19 percent are working out on their own and 3 percent are participating in a diet program because they want to lose weight.

At the ARJAY plant 75 employees work out three nights a week and 25 additional employees are in aerobics. The company rents a room in school buildings in Bad Axe and Caro for aerobic classes.

Since hired, Daniel has established communication with the area's physicians.

"Whenever he is treating someone who has been injured, Daniel is in constant contact with that employee's personal physician," Tonti said. "By the same token, the physicians are also referring people back to the fitness center for treatment."

When Walbro opened its employee rehabilitation center, the physicians in the area were invited in to look it over and talk with the trainer.

The dependents of Walbro employees are eligible to participate in the fitness and rehabilitation programs, and many do, according to Tonti.

What Daniel has not had time to do is serve the athletic teams at the area high schools.

"When we first hired him, we thought we could offer his services to the high schools, but working with Walbro employees and their families has kept him too busy," Tonti said. He added with the hiring of an additional trainer, the company hoped to be able to serve the high schools next year.

Tonti, who now works out regularly himself, said the nice thing about the fitness center is that it not only serves a useful and productive function, but that everyone likes it.

"The Detroit Tigers have a training staff to keep their athletes in the game, so why shouldn't a manufacturing community have the same thing to keep their athletes on the job?" Tonti asks.

Employment Research and Training Center

CONTACT: Amnon Tishler
(516) 747-5400
or
Diane Woods
(212) 679-2934

FOR IMMEDIATE RELEASE

NEW MONOGRAPH ON DISABILITY ISSUES

The Changing Nature of Work, Society and Disability: The Impact on Rehabilitation Policy

Edited by David Vandergoot, Human Resources Center
and
Diane Woods, World Rehabilitation Fund

A new monograph that outlines the need to reassess the changing nature of work and society, and the resultant impact on disability issues and policies, is now available.

Published jointly by the Human Resources Center's Research and Training Institute and the World Rehabilitation Fund's International Exchange of Experts and Information in Rehabilitation, this publication is based on papers presented at a conference sponsored by the WRF centering around a previous monograph by Paul Cornes on "The Future of Work for People with Disabilities: The View From Great Britain." The papers presented in the new monograph are the results of discussions at the conference.

While many experts on rehabilitation are comfortable only with discussing traditional issues, such as the definition of disability, funding and data collection, these papers reflect the beginning of a paradigm shift in rehabilitation. They assume that rehabilitation is affected by social, economic and political events influenced by time and place. They discuss such vital issues as labor market supply and demand, structural unemployment and the value of work in future societies.

In his forward to the new monograph, Dr. Frank Bowe says the current "ideology (of rehabilitation) may no longer suffice to permit the field to grow. Rehabilitation is ignoring its greatest potential stimulants to expansion--a growing population of people with disabilities, an urgent cry from business for help, an emerging capacity of technology to provide much of that help."

This new monograph should stimulate some hard thinking among rehabilitation experts, which may lead to a more flexible field, one with a world-view that permits it to react to changing climates and thus be more effective and relevant in its ability to respond to people with disabilities.

Price per paperback copy is $5.00, including postage and handling. Orders of 25 or more are discounted 20 percent.

For further information, contact: Amnon Tishler, Human Resources Center, I.U. Willets Road, Albertson, NY 11507 or Diane Woods, World Rehabilitation Fund, Inc., 400 E. 34th Street, New York, NY 10016.

Book Review Editors: Complimentary copies will be provided upon receipt of a request on your letterhead.

Your Right to Federal Records

Questions and Answers on the Freedom of Information Act and the Privacy Act

United States Department of Justice
OFFICE OF INFORMATION LAW AND POLICY
WASHINGTON, D.C. 20530

Dear Reader:

This is a simple brochure about complicated subjects—the Freedom of Information Act and the Privacy Act of the U.S. Government.

Enacted by Congress in 1966, the Freedom of Information Act (FOIA) is rooted in the belief that Government records should be open to the people. Most of the time Federal agencies will respond to public inquiries, and there is no need to use the FOIA to have your questions answered. However, before enactment of the FOIA, individuals occasionally had to prove their right to look at Government records. The FOIA changes this. It shifts the burden of proof from the citizen to the Government. You no longer have to prove your need to see Government records. Now, by law you have the right to access—unless the Government can prove that the records you wish to see are "exempt" by law from that right (more about the exemptions later).

FOIA was intended for use by everyone. Yet today, the extensive use of the FOIA by lawyers and organizations has led to a growing mass of court decisions, regulations, articles, and other literature about FOIA. These materials are now too vast for even full-time specialists in FOIA work to read and digest completely. Thus, most people can certainly use practical help in exercising their rights under this law—help this booklet is designed to offer.

Closely related to the Freedom of Information Act is the Privacy Act, another Federal law regarding Government records. The Privacy Act gives individuals some control over how the Federal Government gathers, maintains, and disseminates personal information. The Privacy Act pertains only to records the Federal Government keeps on individual citizens and lawfully admitted resident aliens. The FOIA, on the other hand, pertains to all records of Federal agencies.

The questions answered in this brochure are those most frequently asked by persons who contact the Federal Information Centers (FIC's) throughout the country for information on the FOIA and Privacy Act. The answers were compiled by the staffs of the FIC and Consumer Information Center (CIC) of the General Services Administration. They were reviewed by the Department of Justice, the agency responsible for coordinating administration of the FOIA and encouraging agency compliance. The Office of Management and Budget, which has a similar responsibility for the Privacy Act, reviewed the answers to related questions on the Privacy Act.

We believe the brochure will give you accurate and useful information about the FOIA and Privacy Act in a clear, simple form. We hope you will find it helpful.

Sincerely,

Robert L. Saloschin

Robert L. Saloschin
Director, Office of Information Law and Policy
U.S. Department of Justice

Your Right to Federal Records

Page

The Freedom of Information Act
What the Freedom of Information Act is and how to use it 1

The Privacy Act
What the Privacy Act is and how to use it 5

A Comparison of the Freedom of Information Act and the Privacy Act
Relationship between the two acts and deciding which to use 7

Other Sources of Information 8

Text of the Freedom of Information Act 10

Federal Information Centers
Addresses and telephone numbers 15

The Freedom of Information Act

What does the Freedom of Information Act (FOIA) do?

It guarantees any person the right, enforceable in court, to look at all Federal agency records except for those specifically exempted in the Act. FOIA applies only to records of the executive branch of the Federal Government, not to those of the Congress or the Federal courts. It also does not apply to records of any State or local government or any private entity.

There are nine exemptions to the Act, or reasons an agency can withhold records from the public. They cover such material as (1) classified defense and foreign relations information, (2) internal agency personnel rules and practices, (3) material exempted by another statute from disclosure, (4) trade secrets and other confidential business information, (5) certain inter-agency or intra-agency communications, (6) personnel, medical, and other files involving personal privacy, (7) investigatory records compiled for law enforcement purposes, (8) matters relating to the supervision of financial institutions, and (9) geological information on oil wells. Although not required to do so, agencies often voluntarily release information that falls under an exemption unless they believe that disclosure is likely to cause harm. Interpretation of the Act—particularly of the exemptions—has raised many complex questions and disputes. Ultimately the courts decide whether an agency is properly withholding records under an exemption of the FOIA.

The Freedom of Information Act is printed in its entirety beginning on page 10.

What information may I request under FOIA?

Under FOIA, you may request and receive any record that is in Federal files and not covered by one of the exemptions. For example, suppose you have heard that a certain toy is being investigated as a safety hazard and want to know the details. In this case, the Consumer Product Safety Commission probably could help you. Or perhaps you want to read the latest inspection report on conditions at a nursing home certified for Medicare. Your local Social Security office keeps these records on file. Possibly you want to know if the Federal Bureau of Investigation has a file on you. In all these examples, you may use the FOIA to request information from the appropriate Federal agency (more later on how to find the right agency and address).

When you make an FOIA request, you must describe the material you want. If the agency cannot identify what you've requested with a reasonable amount of effort, it is under no obligation to you. It is not required to do research for you or to compile or analyze data.

What if I want information from a private business or a State or local government?

The FOIA does not apply to records that belong to a private business. Nor does it apply to the records of State or local government. However, nearly all State governments have their own FOIA's. You may request information about a State's act by writing the attorney general of the State.

Although FOIA does not cover private business records, many private

firms submit reports and other information to Federal agencies. This is often necessary to do business with the Government, to receive subsidies or licenses, or to engage in certain kinds of activity. Agencies usually withhold confidential commercial material that is contained in such reports. However, if the private firm has no objections, most agencies will provide such material to you. In addition, Federal agencies may release some information from business firms even if the firm objects; *i.e.*, if the information cannot be legally withheld. The FOIA does not require a private firm to release any information or records directly to you.

Whom do I contact in the Federal Government with my request? How do I get the right address?

No one office handles all FOIA requests. Each request for information must be made to the appropriate agency. For example, if you want to know about an investigation of motor vehicle defects, write to the Department of Transportation. Or, if you want information about a work-related accident at a nearby job site or manufacturing plant, write to the Department of Labor (at the office in the region where the accident occurred). Some of the larger departments and agencies have several Freedom of Information offices. Some have one for each major bureau or other component; others have one for each region of the country.

You may have to do a little research to find the proper office to handle your inquiry, but you will save time in the long run if you send your request directly to the appropriate office. For assistance you can contact the nearest Federal Information Center (FIC). Located throughout the country, the FIC's are specially prepared to help you find the right agency, the right office, and the right address. These centers are operated by the General Services Administration. A list of FIC addresses and telephone numbers begins on page 15. Also, a booklet called the *Consumer's Resource Handbook* tells what Federal agencies are responsible for specific consumer problems and where to write for assistance. (The *Handbook* is available free of charge; see page 8 for ordering instructions.) The *U.S. Government Manual,* the official handbook of the Federal Government, may also be useful. It describes the programs within each Federal agency and lists the names of top personnel and agency addresses. The *Manual* is available at most public libraries or can be purchased from the Superintendent of Documents (ordering instructions on page 8).

How do I request information under FOIA?

When you get the agency's name and address, write a letter of request to the agency's Freedom of Information Office. (Note on the envelope and at the top of the letter "Freedom of Information Request.") Identify the records you want as accurately as possible. Although you do not have to give the document's name or title, your request must reasonably describe the records sought. Any facts or clues which you can furnish about the time, place, persons, events, subjects, or other details of the information or records you seek will be helpful to agency personnel in deciding where to search and in determining which records pertain to your request. This may save you and the Government time and money and also improve your prospects of getting what you want.

A sample request letter is shown below. Keep a copy of your request. You may need it in the event of an appeal or if your original request is not answered.

If you are not sure whether the information you want falls under one of the nine exemptions, you may request it anyway. It might help your case to state your reasons for such a request, even though the FOIA does not require you to do so. Agencies usually have discretion to release material that falls under these exemptions. Stating your reasons for a request may persuade an agency to give you access to records they might otherwise deny as legally exempt. In addition, giving reasons for a request may help the agency locate information which is useful to you.

What about costs for getting records under FOIA?

An agency may charge only for the cost of searching for the material and the cost of copying. Searching fees usually run from $4 to $10 per hour; the rates generally reflect salary levels of the personnel needed for the search. The charge for copying letter-size and legal-size pages can run up to 25 cents apiece, but 10 cents per page is common in most agencies. If you wish to avoid

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Freedom of Information Act Request

Date

Agency Head or FOIA Officer
Name of agency or agency component
Address (see discussion above on whom to contact)

Dear --- :

Under the Freedom of Information Act, 5 U.S.C. 552, I am requesting access to or copies of (identify the records as clearly as possible).

If there are any fees for copying or searching for the records, please let me know before you fill my request. (Or . . . please supply the records without informing me of the cost if the fees do not exceed $ _____.)

[Optional] I am requesting this information because (state the reason if you think it will help you obtain the information).

If you deny all or any part of this request, please cite the specific exemption you think justifies your refusal to release the information and notify me of appeal procedures available under the law.

[Optional] If you have any questions about handling this request, you may telephone me at _____(home phone) or at _____(office phone).

Sincerely,

Name
Address

copying charges, you may request to visit the agency in person to see the records.

Some agencies waive charges if the total cost is minimal. You may receive a waiver or reduction in fees if you request it and can show the information you are seeking will, when released, primarily benefit the general public. There is no requirement for uniform fees among the agencies.

How long will it take to answer my request?

Federal agencies are required to answer your request for information within 10 working days of receipt (excluding Saturdays, Sundays, and holidays). If you have not received a reply by the end of that time (be sure to allow for mailing time), write a followup letter or telephone the agency to ask about the delay.

Sometimes, an agency may need more than 10 working days to find the records, examine them, possibly consult other persons or agencies, and decide whether it will disclose the records requested. If so, the agency is required to inform you in writing before the deadline. They have the right to extend up to 10 more working days.

A few agencies sometimes receive unexpectedly large numbers of requests. If an agency has a backlog of requests that were received before yours and has assigned a reasonable portion of its staff to work on the backlog, the agency usually will handle requests on a first-come, first-served basis.

What happens if the agency refuses to give me the information?

An agency normally will deny an FOIA request only if it has a serious practical problem with granting it, supported by a legal reason for denial (an exemption). If an agency denies your request, it must be able to prove that the information is covered by one of the nine exemptions listed in the Act. The agency must give you the reason (exemption) for denial in writing and inform you of your right to appeal the decision.

How do I appeal a denial?

You should promptly send a letter notifying the agency that you want to appeal. Most agencies require that appeals be made within 30 to 45 days after you get a notification of denial. The denial letter should tell you to whom your appeal letter should be addressed. Simply ask the agency to review your FOIA request and change its decision. It is a good idea also to give your reasons for believing the denial was wrong. Be sure you refer to all communications you have had on the matter. It will save time in acting on your appeal if you include copies of the original request for information and the agency's letter of denial.

The agency has 20 working days after it receives your appeal letter to respond. Under certain circumstances, it may take an extension of up to 10 working days. If, however, an agency took 10 extra days to deny your initial request, it would not be entitled to an extension on the appeal.

What can I do if my appeal is rejected?

If you are willing to invest the time and money, you may take the case to court. You can file suit in the U.S. District Court where you live, where you have your principal place of business, where the documents are kept, or in the District of Columbia. The agency will have to prove that the withheld records, or the deleted parts of them, are covered by one of the exemptions listed in the Act. If you win a substantial portion of your case, the court may require the Government to pay court costs and reasonable attorney's fees for you.

What does the Privacy Act do?

The Federal Government often compiles information on individuals. For example, if you were ever in the military service or employed by a Federal agency, there are records of your service. If you have ever applied for a Federal grant or received a student loan certified by the Government, there is a file. There are records on every individual who has ever paid income taxes or received a check from Social Security or Medicare.

The Privacy Act, passed by Congress in 1974, gives citizens some control over what personal information is collected by the Federal Government and how it is used. The Act guarantees two basic rights: the right to see files about yourself, and the right to sue the Government for permitting others to see your files without your permission or knowledge. Both of these rights are subject to a number of exceptions.

What information may I request under the Privacy Act?

The Act applies only to documents about individuals maintained by agencies in the executive branch of the Federal Government. It applies to such records only if they are in a "system" of records, which means they can be retrieved by name, social security number, or other identifier. In other words, the Act does not apply to information about individuals in records that are filed under other subjects, such as organizations or events, unless the agency routinely retrieves them by name, etc. Also, the Act does not apply to records held by local governments or private organizations.

There are seven exemptions to the Privacy Act under which an agency can withhold certain kinds of information from you. Examples of exempt records are those containing highly sensitive information on national security or ongoing criminal investigations. Another exemption often used by agencies is that which protects information that would identify a confidential source. For example, if an investigator questions a person about your qualifications for Federal employment and that person agrees to answer only if his identity is protected, then his name or any information that would identify him could be withheld. The seven exemptions are listed in the Act. If you are interested in more details, you may read the Privacy Act in its entirety. It is printed in both the *U.S. Government Manual* and the *U.S. Code* (Section 552a of Title 5), which are available in most public and school libraries. You may also order a copy of the Privacy Act, Public Law 93-579, from the Superintendent of Documents (ordering instructions on page 8), since it is too lengthy to publish as part of this brochure.

Whom do I contact in the Federal Government with my request? How do I get the right address?

As with the FOIA, no one office handles all Privacy Act requests. To locate the proper agency to handle your request, follow the same guidelines as for the Freedom of Information Act. (See page 2.)

How do I request information under the Privacy Act?

Write a letter to the agency that has your file. Address your request to the Privacy Act Officer or head of the agency, such as "Secretary, Department of Health and Human Services." Be sure to write "Privacy Act Request" clearly on both the letter and the envelope.

Most agencies require some proof of identity before they will give you your records. So, it is a good idea to enclose proof of identity (such as a copy of your driver's license) with your full name and

address. **Do not send the original documents.** Remember to sign your request for information, since your signature is a form of identification. (A notarized signature is even better.) If an agency needs more proof of identity before releasing your files, it will let you know.

What about costs for getting records under the Privacy Act?

An agency can charge only for the cost of copying personal records about you, not for time spent locating them. You may avoid copying charges by requesting to visit the agency in person to see the records.

How long will it take to answer my request?

Under the terms of the Privacy Act, the agency is not required to reply to such a request within a given period of time, although some agencies have adopted time limits similar to the FOIA 10-day response time, by regulation. If you do not receive any response within 2 weeks, write again, enclosing a copy of your original request.

How do I know if an agency has a file on me?

If you think a particular agency has your file, you should write to the Privacy Act Officer or head of the agency. Agencies are generally required to inform you upon request whether or not they have files on you. In addition, agencies are required to report publicly the existence of all records systems they keep on individuals. The Office of the Federal Register annually compiles and publishes (or updates) a list of systems and any exemptions that apply to each. This multi-volume work, called the *Privacy Act Issuances Compilation,* is available at most large reference and university libraries or can be purchased from the Superintendent of Documents (ordering instructions on page 8).

Most agencies require that you specify the systems of records you wish to have searched. If you do not know which systems to specify, give as much information as possible as to why you believe the agency has records about you. The agency should process your request or contact you for additional information.

What if I find that a Federal agency has incorrect information about me in the files?

The Privacy Act requires agencies that keep records containing personal information about individuals to maintain complete, accurate, and relevant files. If, after seeing your file, you believe facts are incorrect and should be amended, write to the agency official who released the record to you. Include any documentation for the changes you are requesting. The agency will let you know if further proof is needed. The Act requires an agency to respond to such a request within 10 working days of receipt and to tell you precisely what will be done to amend the records. You may appeal any denial. Even if an agency also denies your appeal, you have the right to submit a statement explaining why you think the record is wrong. The agency will attach your statement to the record involved.

What recourse do I have if I am denied information requested under the Privacy Act?

There is no standard procedure for Privacy Act appeals, but the agency should advise you of its own appeal procedure when it makes the denial. Should the agency deny your appeal, you may take the matter to court. If you win your case, you may be awarded attorney's fees.

A Comparison of the Freedom of Information Act and the Privacy Act

What is the relationship between the FOIA and the Privacy Act?

Although the two laws were enacted for different purposes, there is some similarity in their provisions. Both the FOIA and the Privacy Act give people the right of access to records held by agencies of the Federal Government. FOIA's access rights are given to "any person," but the Privacy Act's access rights are only for the individual who is the subject of the records sought. FOIA applies to all records of Federal agencies; the Privacy Act applies only to a majority of those Federal agency records which contain information about individuals. Each act has a somewhat different set of fees charged, time limits, and exemptions from its rights of access. If you request records about yourself, Federal agencies may withhold them from you only to the extent the records are exempt under both acts.

Which act should I use to get access to records?

If the information you want concerns activities of Federal agencies or another person, make your request under the FOIA, which covers all agency records. If the information you want is about yourself and you wish to avoid possible search fees, make the request under the Privacy Act, which covers most records of agencies that pertain to individuals. To maximize the chances of getting all the available information about yourself, getting it quickly, and with only a slight possibility of incurring a search fee, make the request under both acts. Sometimes you can use the FOIA to help you get records about yourself that are not in a Privacy Act "system." However, if the records you seek are covered only by the FOIA, you must be able to "reasonably describe" them and you may be charged search fees. If you are in doubt about which act applies or would better suit your needs, you should probably base your request letter on both acts.

The FOIA contains one very important provision concerning privacy—Exemption 6. It may protect you from others seeking information about you, but may block you if you seek information about others. FOIA Exemption 6 permits an agency to withhold information about individuals if disclosing it would be a "clearly unwarranted invasion of personal privacy." This includes, for example, most of the information in medical and personnel files.

Exemption 6 cannot be used to deny you access to information about yourself, only to deny you information about other persons. To be covered by Exemption 6, the information requested must be (a) about an identifiable individual, (b) an invasion of the individual's privacy if disclosed to others, and (c) "clearly unwarranted" to disclose. Release of information about an individual is considered an invasion of privacy if he could reasonably object because of its intimacy or its possible adverse effects upon himself or his family. But such information is not protected by Exemption 6 if the injury to the individual is counterbalanced by a public interest favoring the release. For example, home addresses are exempt from release for unspecified or random uses such as commercial solicitation, but are not exempt from release to State income tax authorities for State law enforcement. If you were seeking information about a Federal employee's working status, an agency usually will disclose his or her name, grade, salary, job title, and permanent work location, but an agency will not usually disclose similar informa-

tion about an employee of a private business. Even Federal employees, however, receive some privacy protection. For example, if you want to see the details of an investigative report which led to an employee's demotion, an agency might decide that disclosure of these details is not justified on public interest grounds.

Other Sources of Information

Consumer's Resource Handbook

Published by the U.S. Office of Consumer Affairs, this comprehensive booklet tells consumers how to complain and get results. It lists the Federal agencies which are responsible for resolving particular consumer problems and tells where help is available in State and local governments and private organizations. Single copies are free and may be obtained by writing the Consumer Information Center, Dept. 619J, Pueblo, CO 81009.

U.S. Government Manual

This is the official handbook of the Federal Government. Published by the U.S. General Services Administration, it describes the programs in each Federal agency, lists the names of top personnel, the mailing address, and a general information telephone number. It is available in most public libraries or can be purchased for $8.50 by sending a check or money order to the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402. Please specify stock number 022-003-01052-1.

Privacy Act

This Act gives citizens the right to see files about themselves and the right to sue the Government for permitting others to see their files without their knowledge and permission. A complete copy of the Privacy Act can be found in the back of the *U.S. Government Manual.* It can also be found as Section 552a of Title 5 of the *U.S. Code.* Or you may order a copy of the Privacy Act, Public Law 93-579, from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402, for 35 cents. Specify stock number 022-003-90866-8.

Privacy Act Issuances Compilation

Annually each Federal agency publishes descriptions of its systems of records that contain information on individuals. These descriptions are collected from all the agencies in a publication entitled *Privacy Act Issuances Compilation,* which shows the data covered in each system and lists the categories of people to whom the information pertains. The 1979 *Compilation* consists of four volumes, which are for sale separately. (Price per volume is $9 50 to

$10.) A fifth volume of research aids is available for $4. The entire set may be purchased for $43 from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402. The Superintendent of Documents will help you identify the volumes you need if you indicate the agencies in which you are interested. Or, you may find a complete set of the *Compilation* available as a reference at all Federal Information Centers (addresses on page 15) and in most reference and university libraries.

A Citizen's Guide on How To Use the Freedom of Information Act and the Privacy Act in Requesting Government Documents

This booklet, written by the Committee on Government Operations, U.S. House of Representatives, is a much more detailed explanation of the Freedom of Information Act and the Privacy Act than this brochure. It may be purchased for $3 from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402. Please specify stock number 052-071-00540-4.

A Short Guide to the Freedom of Information Act

This was written by three Government lawyers with extensive experience in the field and revised in 1979 and again in 1980. Especially useful to attorneys, it is a comprehensive summary of the law, including a discussion of the nine FOIA exemptions. It is included in the *Freedom of Information Case List, September 1980 Edition,* which may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402, for $5. Please specify stock number 027-000-01057-1.

Text of the Freedom of Information Act

§ 552. Public information; agency rules, opinions, orders, records, and proceedings.

(a) Each agency shall make available to the public information as follows:

(1) Each agency shall separately state and currently publish in the Federal Register for the guidance of the public—

(A) descriptions of its central and field organization and the established places at which, the employees (and in the case of a uniformed service, the members) from whom, and the methods whereby, the public may obtain information, make submittals or requests, or obtain decisions;

(B) statements of the general course and method by which its functions are channeled and determined, including the nature and requirements of all formal and informal procedures available;

(C) rules of procedure, descriptions of forms available or the places at which the forms may be obtained, and instructions as to the scope and contents of all papers, reports, or examinations;

(D) substantive rules of general applicability adopted as authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency; and

(E) each amendment, revision, or repeal of the foregoing.

Except to the extent that a person has actual and timely notice of the terms thereof, a person may not in any manner be required to resort to, or be adversely affected by, a matter required to be published in the Federal Register and not so published. For the purpose of this paragraph, matter reasonably available to the class of persons affected thereby is deemed published in the Federal Register when incorporated by reference therein with the approval of the Director of the Federal Register.

(2) Each agency, in accordance with published rules, shall make available for public inspection and copying—

(A) final opinions, including concurring and dissenting opinions, as well as orders, made in the adjudication of cases;

(B) those statements of policy and interpretations have been adopted by the agency and are not published in the Federal Register; and

(C) administrative staff manuals and instructions to staff that affect a member of the public;

unless the materials are promptly published and copies offered for sale. To the extent required to prevent a clearly unwarranted invasion of personal privacy, an agency may delete identifying details when it makes available or publishes an opinion, statement of policy, interpretation, or staff manual or instruction. However, in each case the justification for the deletion shall be explained fully in writing. Each agency shall also maintain and make available for public inspection and copying current indexes providing identifying information for the public as to any matter issued, adopted, or promulgated after July 4, 1967, and required by this paragraph to be made available or published. Each agency shall promptly publish, quarterly or more frequently, and distribute (by sale or otherwise) copies of each index or supplements thereto unless it determines

by order published in the Federal Register that the publication would be unnecessary and impracticable, in which case the agency shall nonetheless provide copies of such index on request at a cost not to exceed the direct cost of duplication. A final order, opinion, statement of policy, interpretation, or staff manual or instruction that affects a member of the public may be relied on, used, or cited as precedent by an agency against a party other than an agency only if—

(i) it has been indexed and either made available or published as provided by this paragraph; or

(ii) the party has actual and timely notice of the terms thereof.

(3) Except with respect to the records made available under paragraphs (1) and (2) of this subsection, each agency, upon any request for records which (A) reasonably describes such records and (B) is made in accordance with published rules stating the time, place, fees (if any), and procedures to be followed, shall make the records promptly available to any person.

(4) (A) In order to carry out the provisions of this section, each agency shall promulgate regulations, pursuant to notice and receipt of public comment, specifying a uniform schedule of fees applicable to all constituent units of such agency. Such fees shall be limited to reasonable standard charges for document search and duplication and provide for recovery of only the direct costs of such search and duplication. Documents shall be furnished without charge or at a reduced charge where the agency determines that waiver or reduction of the fee is in the public interest because furnishing the information can be considered as primarily benefiting the general public.

(B) On complaint, the district court of the United States in the district in which the complainant resides, or has his principal place of business, or in which the agency records are situated, or in the District of Columbia, has jurisdiction to enjoin the agency from withholding agency records and to order the production of any agency records improperly withheld from the complainant. In such a case the court shall determine the matter do novo, and may examine the contents of such agency records in camera to determine whether such records or any part thereof shall be withheld under any of the exemptions set forth in subsection (b) of this section, and the burden is on the agency to sustain its action.

(C) Notwithstanding any other provision of law, the defendant shall serve an answer or otherwise plead to any complaint made under this subsection within thirty days after service upon the defendant of the pleading in which such complaint is made, unless the court otherwise directs for good cause shown.

(D) Except as to cases the court considers of greater importance, proceedings before the district court, as authorized by this subsection, and appeals therefrom, take precedence on the docket over all cases and shall be assigned for hearing and trial or for argument at the earliest practicable date and expedited in every way.

(E) The court may assess against the United States reasonable attorney fees and other litigation costs reasonably incurred in any case under this section in which the complainant has substantially prevailed.

(F) Whenever the court orders the production of any agency records improperly withheld from the complainant and assesses against the United States reasonable attorney fees and other litigation costs, and the court additionally issues a written finding that the circumstances surrounding the withholding raise questions whether agency personnel acted arbitrarily or capriciously with

respect to the withholding, the Special Counsel shall promptly initiate a proceeding to determine whether disciplinary action is warranted against the officer or employee who was primarily responsible for the withholding. The Special Counsel, after investigation and consideration of the evidence submitted shall submit his findings and recommendations to the administrative authority of the agency concerned and shall send copies of the findings and recommendations to the officer or employee or his representative. The administrative authority shall take the corrective action that the Special Counsel recommends.

(G) In the event of noncompliance with the order of the court, the district court may punish for contempt the responsible employee, and in the case of a uniformed service, the responsible member.

(5) Each agency having more than one member shall maintain and make available for public inspection a record of the final votes of each member in every agency proceeding.

(6) (A) Each agency, upon any request for records made under paragraph (1), (2), or (3) of this subsection, shall—

(i) determine within ten days (excepting Saturdays, Sundays, and legal public holidays) after the receipt of any such request whether to comply with such request and shall immediately notify the person making such request of such determination and the reasons therefor, and of the right of such person to appeal to the head of the agency any adverse determination; and

(ii) make a determination with respect to any appeal within twenty days (excepting Saturdays, Sundays, and legal public holidays) after the receipt of such appeal. If on appeal the denial of the request for records is in whole or in part upheld, the agency shall notify the person making such request of the provisions for judicial review of that determination under paragraph (4) of this subsection.

(B) In unusual circumstances as specified in this subparagraph, the time limits prescribed in either clause (i) or clause (ii) of subparagraph (A) may be extended by written notice to the person making such request setting forth the reasons for such extension and the date on which a determination is expected to be dispatched. No such notice shall specify a date that would result in an extension for more than ten working days. As used in this subparagraph, "unusual circumstances" means, but only to the extent reasonably necessary to the proper processing of the particular request—

(i) the need to search for and collect the requested records from field facilities or other establishments that are separate from the office processing the request;

(ii) the need to search for, collect, and appropriately examine a voluminous amount of separate and distinct records which are demanded in a single request; or

(iii) the need for consultation, which shall be conducted with all practicable speed, with another agency having a substantial interest in the determination of the request or among two or more components of the agency having substantial subject-matter interest therein.

(C) Any person making a request to any agency for records under paragraph (1), (2), or (3) of this subsection shall be deemed to have exhausted his administrative remedies with respect to such request if the agency fails to comply with the applicable time limit provisions of this paragraph. If the Government can show exceptional circumstances exist and that the agency is exercising due diligence in responding to the request, the court may retain jurisdiction and

allow the agency additional time to complete its review of the records. Upon any determination by an agency to comply with a request for records, the records shall be made promptly available to such person making such request. Any notification of denial of any request for records under this subsection shall set forth the names and titles or positions of each person responsible for the denial of such request.

(b) This section does not apply to matters that are—

(1) (A) specifically authorized under criteria established by an Executive order to be kept secret in the interest of national defense or foreign policy and (B) are in fact properly classified pursuant to such Executive order;

(2) related solely to the internal personnel rules and practices of an agency;

(3) specifically exempted from disclosure by statute (other than section 552b of this title), provided that such statute (A) requires that the matters be withheld from the public in such a manner as to leave no discretion on the issue, or (B) establishes particular criteria for withholding or refers to particular types of matters to be withheld;

(4) trade secrets and commercial or financial information obtained from a person and privileged or confidential;

(5) inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency;

(6) personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy;

(7) investigatory records compiled for law enforcement purposes, but only to the extent that the production of such records would (A) interfere with enforcement proceedings, (B) deprive a person of a right to a fair trial or an impartial adjudication, (C) constitute an unwarranted invasion of personal privacy, (D) disclose the identity of a confidential source and, in the case of a record compiled by a criminal law enforcement authority in the course of a criminal investigation, or by an agency conducting a lawful national security intelligence investigation, confidential information furnished only by the confidential source, (E) disclose investigative techniques and procedures, or (F) endanger the life or physical safety of law enforcement personnel;

(8) contained in or related to examination, operating, or condition reports prepared by, on behalf of, or for the use of an agency responsible for the regulation or supervision of financial institutions; or

(9) geological and geophysical information and data, including maps, concerning wells.

Any reasonably segregable portion of a record shall be provided to any person requesting such record after deletion of the portions which are exempt under this subsection.

(c) This section does not authorize withholding of information or limit the availability of records to the public, except as specifically stated in this section. This section is not authority to withhold information from Congress.

(d) On or before March 1 of each calendar year, each agency shall submit a report covering the preceding calendar year to the Speaker of the House of Representatives and President of the Senate for referral to the appropriate committees of the Congress. The report shall include—

(1) the number of determinations made by such agency not to comply with requests for records made to such agency under subsection (a) and the reasons for each such determination;

(2) the number of appeals made by persons under subsection (a)(6), the result of such appeals, and the reason for the action upon each appeal that results in a denial of information;

(3) the names and titles or positions of each person responsible for the denial of records requested under this section, and the number of instances of participation for each;

(4) the results of each proceeding conducted pursuant to subsection (a)(4)(F), including a report of the disciplinary action taken against the officer or employee who was primarily responsible for improperly withholding records or an explanation of why disciplinary action was not taken;

(5) a copy of every rule made by such agency regarding this section;

(6) a copy of the fee schedule and the total amount of fees collected by the agency for making records available under this section; and

(7) such other information as indicates efforts to administer fully this section.

The Attorney General shall submit an annual report on or before March 1 of each calendar year which shall include for the prior calendar year a listing of the number of cases arising under this section, the exemption involved in each case, the disposition of such case, and the cost, fees, and penalties assessed under subsections (a)(4)(E), (F), and (G). Such report shall also include a description of the efforts undertaken by the Department of Justice to encourage agency compliance with this section.

(e) For purposes of this section, the term "agency" as defined in section 551(1) of this title includes any executive department, military department, Government corporation, Government controlled corporation, or other establishment in the executive branch of the Government (including the Executive Office of the President), or any independent regulatory agency.

(Pub. L. 89–554, Sept. 6, 1966, 80 Stat. 383; Pub. L. 90–23, § 1, June 5, 1967, 81 Stat. 54; Pub. L. 93–502, §§ 1–3, Nov. 21, 1974, 88 Stat. 1561–1564; Pub. L. 94–409, § 5(b), Sept. 13, 1976, 90 Stat. 1247; Pub. L. 95–454, § 906(a)(10), Oct. 13, 1978, 92 Stat. 1225.)

Federal Information Centers

Federal Information Centers are in 41 metropolitan areas across the country. You may call or write any of them for aid in contacting the proper Federal agency with your Freedom of Information Act or Privacy Act request.

If you write, address your letter to the Federal Information Center at the closest of the mailing addresses listed below.

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Disability Management: *Origins, Concepts and Principles for Practice*

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Abstract

Disability management is an emerging concept in the field of rehabilitation practice. Several factors have led to the growth of disability management programs at the workplace, including the increasing costs of health care and disability payments for employers. Many large employers have begun to view disability management both as a way to manage costs and to assume more direct involvement in providing human services to their disabled/injured workers. This article reviews the many factors that have contributed to the development of worksite programs, the evolution of the disability management concept, the aims and objectives of such programs and basic components for implementation. In addition, the authors present a discussion of the obstacles and barriers that impede these aims as well as of the implications for rehabilitation counseling practice.

In its "pursuit of excellence," corporate America is becoming increasingly aware of the value of investing in its human as well as its capital resources. In effect, employers are treating employees less like "hired hands" and more like full-fledged members of the organization (Zager & Rosow, 1982). Most corporate leaders see a well-trained and well-educated workforce as a means for achieving a competitive advantage. Increasingly, they also see a healthy workforce as an important factor in their quest for commercial success. Thus, economic factors and human resource costs have required businesses to address health and disability issues in order to maintain profitability in a period of increased international competition.

Concurrently, there has been a shift in public policy which tends to foster more private-sector solutions to problems of health and human welfare. Further, persons with disabilities have increased their advocacy efforts for more effective strategies to achieve employment and related benefits in the primary labor market. At the same time, traditional programs of vocational rehabilitation have shifted toward a private-sector model of service that emphasizes the economic benefits of vocational rehabilitation to third-party sponsors. These diverse yet related factors have contributed to the development of employer-based initiatives as a rehabilitation strategy.

Disability management is an evolving concept that is becoming more defined as it is applied in rehabilitation practice. Disability management combines the clinical and case management practices of vocational rehabilitation counseling, the multidisciplinary team approach of rehabilitation, and principles of organization development and program administration into a comprehensive framework that is managed and coordinated within the firm. Based on current trends, it appears that as employers become more aware of the need and potential for managing health and disability-related costs through the provisions of such programs, and as advocates for disabled persons argue for early intervention to prevent the unnecessary loss of employment after illness or injury, worksite programs will become an important sector for the practice of rehabilitation counseling.

The purpose of this article is to provide the reader with a comprehensive introduction to the area of disability management including a) factors that have contributed to the development of worksite programs, b) the evolution of the concept, c) the aims and objectives of such programs and basic components for implementation, d) obstacles and barriers that impede these aims, and e) implications for rehabilitation counseling practice.

A Favorable Climate for Change

Several factors have led to the development of disability management programs at the workplace. As Naisbitt and Aburdene (1985) point out, health care and disability costs are becoming a significant cost of doing business.

Alarmed with these costs, employers began to document them in several ways. Goodyear, for example, estimated that health care accounts for $2 of the cost of a $57 tire (Naisbitt and Aburdene, 1985). At Chrysler, health care costs came to $600 million or about $600 per car (Iacocca & Novak, 1984). In 1979, General Motors documented these costs to be $175 per automobile produced (Parkinson, 1982). In 1980, Ford estimated its expenses to be $290 per car (Parkinson, 1982).

Disability costs represent a sizable portion of the payroll. Although such expenses vary from company to company depending on the state, type of industry, and insurance arrangement, some figures can be easily estimated. For example, short-term disability (STD) costs frequently run from 2-4% of total payroll while long-term disability (LTD) benefits can add another ½-1% of payroll to this amount. Often, for every million dollars of payroll, $50,000 is spent on disability benefits alone (Lundell, 1985).

In society at large, disability and health care costs are enormous. In 1981, the cost of disability income payments and health care services totaled $184.6 billion. Of this amount, $114 billion went for health care and the remaining $70.6 billion was spent on wage replacement programs for disabled individuals who could no longer work (Schwartz, 1984). In a more recent study, Berkowitz (1985) reports the following disability expenditures for 1982:

Cash Disability Transfers (Social Security Disability, long-term disability, private disability insurance, supplemental security income, veterans' pensions)	$67.4 Billion
Medical Care Costs (Medicare, Medicaid, private and employer provided insurance, indemnity)	51.2 Billion
Direct Services (Vocational rehabilitation, vocational education, veterans' programs, employment assistance, general federal programs, i.e., food stamps, social services, services for specific disabled populations)	3.0 Billion
TOTAL	121.6 Billion

In examining these figures one can easily see that only a very small portion of disability expenditures are allocated for rehabilitation and other direct services as compared to costs allocated for cash benefits and medical care. These figures also illustrate how disabled persons are provided with cash disability transfers instead of provisions to help them into the labor market. In this respect, the cost of promoting dependency vastly exceeds the costs of spending to make the disabled persons independent (Bowe, 1982).

The costs of disability-induced unemployment, when compared to the positive outcomes of return-to-work among disabled persons, emphasize further the importance and need for programs geared toward prevention, early intervention, and disability management at the workplace. There is convincing evidence that disabled persons do not have good opportunities for employment in the current labor market (National Council on the Handicapped, 1986). In his study of demography and disability, Bowe (1982) found that the "average" working age disabled American does not hold a full or part-time job and has an income of about $5,000. These figures are much worse for disabled persons who are also women and/or minorities. The rate of unemployment also is higher among younger, working age disabled people than older persons. However, disabled persons who do work full-time earn almost as much as their non-disabled peers. Therefore, disability management efforts that retain persons in viable employment after the onset of disability can be one critical solution in rectifying the economic and employment status among disabled persons.

For those who become disabled at the workplace, the key to continued labor force paticipation, according to Levitan and Taggart (1982), is the ability to remain in the same job after the onset of the disabling condition. This principle is clearly affected by whether the employer is hiring or laying off and whether the disabled employee is considered valuable to the firm. Once the attachment to the labor force is broken, the tendency is for the employee to settle into the income transfer system making it difficult, if not insurmountable, to return the person to employment. When the employee's work orientation is maintained, it is well established that new job procurement for applicants with a history of injury or disability is far more difficult than persuading an employer to return a disabled employee to his/her previous job.

The exact figures for the costs of disability at the workplace are very difficult to obtain. For employers, a large portion of disability costs arises from factors such as the loss of productivity imposed by illness and disability as well as the costs of rehiring and retraining a new employee. Fielding (1984) estimates losses in productivity to average about 20% of the disabled worker's salary. But these estimates have to be taken with great caution, since they vary immensely from industry to industry.

Other costs, seldom accounted for, involve the nonmonetary costs of illness and disability. These represent indirect costs to employers and direct costs to the individual him/herself, and they include a loss of self-esteem derived from work and interaction with one's peers, emotional and psychological distress affecting the disabled worker's family and friends, and a sense of worthlessness and of being deprived of one's occupational role in society (Tate, 1984).

Many disability conditions are associated with characteristics of acute as well as progressive illness. These include conditions such as cancer and cardiac disease. Acute conditions often are associated, initially, with significant amounts of lost work time for diagnostic and treatment purposes. In those conditions where both acute and progressive symptomology are present, however, work absences may last longer, and the person's successful return to work will depend on the severity of the disease.

Preventing a worker's passage to unemployment requires the adoption of early intervention practices and disability management. For example, individuals with chronic disease often have symptoms that appear years earlier. Intervention prior to permanent disability may lessen the impact of the disability (Karjula, 1985). Similarly, in work-related injuries, studies have shown that the shorter the length of time between the injury and the referral to rehabilitation services, the more likely the worker will return to work (Jarvikoski & Lahelma, 1980; O'Brien, 1983).

Lastly, an additional factor having contributed to the growth of disability management programs both as a response to the human needs of disabled workers and as a way for employers to manage costs is the growing trend for the private sector to assume more direct involvement in providing human services and responding to health and disability problems. From the viewpoint of public policy, Reich (1983) points out

that the workplace is becoming the center of social services for a large portion of America's population. Many large employers have begun to use their own in-house rehabilitation team efforts to manage most of their disability cases, adding to these efforts the use of private rehabilitation vendors or state programs when appropriate and necessary. Public sector rehabilitation and human services are often viewed by employers more as social welfare programs for those who are not employed, whose disability is too severe, and/or who live in poverty.

Public sponsored partnerships involving rehabilitation and business (e.g., projects with industry, programs for supported employment) have resulted in greater opportunities for disabled persons to enter employment. Companies that have learned to accommodate their own disabled workers may be more likely to try to accommodate the newly hired disabled worker and vice-versa. At the very least, the public policy of the 1970s and early 1980s has fostered a greater awareness, of and receptivity to, business becoming involved in rehabilitation.

In a recent article, Pati (1985) attempted to summarize the many factors that contributed to the adoption of rehabilitation policies and programs at the workplace. These include, among others, anti-discrimination laws and regulations and incentives, cost-containment in health care, disability payments and worker's compensation, the low costs of accommodation, the increased number of qualified disabled persons entering the labor market, the expansion of social consciousness, the attention to corporate citizenship, and image in the community.

Rehabilitation may be viewed as a part of the changing "corporate culture," that is, as a tool to manage people based in the philosophy that human beings are an asset who must be cared for and properly nurtured. Rehabilitation in industry represents the unique conjunction of humanitarian and utilitarian virtues of social and economic benefits (Galvin, in press).

Evolution of a Concept

Since the 1970s both business and labor have experimented in a piece-meal fashion with a variety of intervention strategies such as employee assistance programs, referrals to public and private rehabilitation, job accommodation, and job modification techniques. These excellent efforts, however, have only indicated a small portion of the full context and potential for comprehensive, industry-based rehabilitation approaches. As Galvin (in press) points out, the conceptual foundation for effective industry-based disability management and rehabilitation was not fully understood among rehabilitation professionals in the United States until 1980, when the World Rehabilitation Fund sponsored a lecture tour by Aila Jarvikoski of the Rehabilitation Foundation of Helsinki, Finland.

The City of Helsinki project had as its purpose to develop and test an early rehabilitation program for two major city employers, the Port Authority and the Water Works. The program was set up to devise an appropriate method for screening those in need of early rehabilitation and to develop rehabilitation measures to be applied at the workplace (Galvin, 1983). The program provided client assessment, guidance and counseling, job reassignment, changes in work tasks, and ergonomic changes. Group activities included exercise, relaxation sessions, and educational programs addressing low back pain, stress, and cardiac rehabilitation.

Parallel developments took place in Sweden, Australia, and other countries. In Sweden, Volvo and other industrial firms established "adjustment groups" to adjust jobs to handicapped persons. The Swedish government paid up to half of the costs for job modifications and special devices. The Volvo automobile firm was particularly progressive in adapting the work environment to keep productivity at a high level while protecting its employee from undue physical or mental stress.

In Australia, most large employers have assumed the responsibility for the rehabilitation of injured workers through in-house programs (Galvin, 1983). The Victorian Railway Company (Vic Rail) has a particularly comprehensive rehabilitation program that benefits from the positive support of management and labor. The company rehabilitation specialist is responsible for hiring disabled workers and for monitoring all rehabilitation services provided to injured employees.

In the United States, initial efforts in disability management began with a pilot program at Burlington Industries in North Carolina (Mitchell & Winfield, 1980). The program represented a pioneering industry-based effort to identify and manage osteoarthritis and rheumatoid arthritis at the workplace. The purpose was to initiate rehabilitation services for those individuals with arthritis prior to their becoming too disabled to work. Services offered by this program included an educational program for supervisors and employees, medical screening by a board certified rheumatologist and an occupational health nurse, disability counseling and career guidance, occupational therapy, functional assessment, job analysis, and worksite modifications.

Since these initial efforts, other U.S. companies have become increasingly involved in developing and conducting disability management approaches. Private-sector efforts include those of Xerox, Control Data Corporation, Kodak, 3M Corporation, Herman Miller, Inc., Steelcase, Inc., General Motors, and others. Public-sector efforts have begun to flourish more recently and include programs of the Tennessee Valley Authority, Social Security Administration, U.S. Postal Service, and Michigan's Department of Mental Health. Some of these efforts are discussed in separate articles to follow.

Defining Disability Management

Jarvikowski and Lahelma (1980) defined disability management as a coordinated activity with the following aims:

> [It] is directed towards an individual with a chronic or permanent functional limitation or disability, or an individual with symptoms indicating a risk of chronic functional limitation or disability.... [It] is intended to restore an individual's working or functional capacity, or to prevent deterioration. [And, it] includes measures aimed at developing an individual's own resources or removing obstacles imposed by the environment. (p.10)

Other authors have conceptualized disability management beyond the idea of providing vocational rehabilitation services to disabled and/or injured workers. From a systems

perspective, disability management is more broadly conceptualized as an organizational approach, one that involves many issues besides rehabilitation services. Mitchell and Winfield (1980), for example, introduced the concept of disability management as a philosophical and technical approach developed to assist an individual with a chronic disease to return to work. The process of disability management is viewed as a systematic, cohesive, and goal-oriented program of organizing the industry's response to disability. Mitchell (1982) further defined disability management as the process of reducing the impact of injury on the person's ability to function within a vocational role.

A slightly different emphasis is provided by Schwartz (1984) who defines disability management as a continuum of actions aimed not only at minimizing the impact of disability, but also as an important prevention strategy to maintain a healthy workforce. As the author explains, by developing the capacity to quickly identify work-related problems and prevent chronic disability, one can better maintain a healthy workforce and help employees continue to work to the extent of their ability. The disability management process begins when an employee is first hired by the company and includes screening to identify health risks as well as providing appropriate measures and guidance on how the employee might proceed in reducing these risks. Often these preventive measures include a combination of approaches such as health promotion and wellness programs and employee assistance programs.

In general, disability management as defined throughout the rehabilitation literature includes both the concepts of prevention and early identification of the initial signs of disease or injury. However, the concept goes beyond individuals at risk and also addresses various methods for reducing the negative consequences on the vocational capacity of persons with existing functional limitations.

Disability management adds to the existing traditional vocational rehabilitation process in several ways. The strategy of disability management, as shown in the definitions above, includes preparatory education and policy development activities, prevention, and early identification at the workplace with a focus on the total impact of disabling events. This approach also requires collaboration between industry management, labor and the individual worker. And, this intervention strategy incorporates an early recognition of disability signs, a corporate policy to deal with impairments and disability before they permanently disable the worker, with a structured service program to return the worker to employment.

Principles for Practice

When discussing the disability management concept, the emphasis should be on the word ***management*** and all it connotes: organization, coordination, evaluation. Information is an essential component of any management system. Disability management, as such a system, also requires adequate and appropriate information regarding the company's experience and incidence with disability. Data gathering and analysis share a co-equal spot with the provision of disability management services and the coordination of employee benefits and services.

Mitchell (1982), Galvin (in press), and others have described the essential steps in setting up a disability management program. These include:

1. Formulate a corporate or organizational policy that reflects a commitment to rehabilitation and that takes into account the nature and extent of the illness/injury/disability characteristics of the organization.

Disability management is an employer-based effort and as such it reflects critical elements of the organization's climate such as the business orientation, the management attitude and style, management structure (e.g., communication style), productivity control, criteria for performance evaluation, and the work orientation with respect to its effect on employee morale and motivation (Pati, 1985).

The company's support and endorsement of this concept can be best described by an attitude of concern about the health and well-being of the work force. In this respect, the objectives of a disability management program should also reflect this particular management concern. Galvin (in press) outlines the objectives of a program as: maintaining optimal work performance within the employee's functional limitations; fostering maximum independence for those individuals unable to work due to chronic illness, injury, or disability; and increasing the continuity and coordination of community-based rehabilitation services.

The disability management policy also needs to ensure that data are collected about the types of injury and illness and the nature of claims made and the effects of such factors in work productivity. These are discussed further by Shrey and Mitchell later in this issue.

2. Offer an educational program to employers and employees defining the disability management concept and outlining the duties of each party.

As a new concept, the successful application of disability management to industry or any other type of organization lies in the manner in which it is defined and introduced to key personnel in a position to implement new concepts (Overton, 1984). Thus, effective communication and coordination among those responsible for disability management at the workplace is very important. To be effective, disability management practices need to result from a coordination of efforts of all units and/or departments in the organization that, in some degree or another, interface their activities with the areas of health and disability.

Representatives from the following departments are especially important as members of a multidisciplinary team whose aim is disability prevention and management: medicine and psychology, vocational rehabilitation, benefits, safety and ergonomics, education and training, organization development, labor relations, and industrial engineering, as well as upper, middle and line management supervisors. Each department needs to have a clear understanding of its role and responsibilities in the overall process and of the impact that it may have in contributing to the organization's goals in managing the health and disability among the workforce. In-

dividual budget accountability is also important in this respect.

This effort should involve labor union officials as well; they play an important role in the disability management process. Many unionized companies have established labor-management committees that examine the causes of health cost inflation as they affect the company and workforce, explore and recommend appropriate cost-containment measures, and participate in local coalitions (Klett, 1984).

3. Identify the critical decision points regarding medical care, disability benefits, return-to-work outcomes, and disability retirement.

A comprehensive knowledge of all the possible disability benefits, incentives, and disincentives comes into play here as does the continued importance of information gathering.

4. Establish comprehensive and systematic rehabilitation services.

The disability management process requires on-going medical monitoring and management of each individual case. The organization must strive to develop likages between the employer, health care providers, and other facilities or community resources providing appropriate treatment to employees.

5. Develop a systematic return-to-work plan involving job analysis, job assignment, job modification, and other placement services so that rehabilitation services in fact do result in return to employment to achieve the economic and humanitarian objectives of the program.

6. Develop an evaluation system for program review and improvements.

It is important that, in reviewing the program, one takes into consideration efforts made by each representative of the company involved in the disability management process. In addition, this evaluation system should be designed so that it provides constant feedback and improvements to the program.

Cost containment is clearly one objective of disability management; Lundell (1985) has suggested four steps to obtain it: a) create a disability management committee to oversee the administration of these benefits, b) conduct an audit of disability claims, including a review of plan provisions and experience data, c) consider plan design changes and the reformulation of plan contract language to allow for cost containment measures, and d) improve the acquisition and use of information by key managers via coordinated reporting.

So far this section has reviewed the internal elements necessary for successful implementation of disability management programs. Pati (1985) underlines the importance of external components related to the organization's linkages and outreach capabilities. Among these are necessary rehabilitation services from private and public rehabilitation agencies and providers and other necessary community services and resources such as public and private employment agencies and medical centers. In addition, organizations can benefit from participation in Projects with Industry (P.W.I.) and networking with other employers implementing similar practices. Likewise, cooperative relationships with organizations specializing in services to various disabilities, advocacy groups, and professional rehabilitation associations and educational institutions can provide valuable colleagues. These are important resources to employers and their employees since they enhance internal resources and provide further means to achieve the end goal of return to work.

Obstacles and Barriers

Despite the strongest corporate commitment and service strategies, there are several obstacles to successful disability management. Of course, failure to achieve the principles of practice as outlined above constitutes a major barrier to success. Others equally significant are: the psychosocial impact of disability on individuals and their responses to the disability process, the inadequate or inappropriate use of disability support systems, disincentives to return-to-work, a lack of understanding of rehabilitation services on the part of the major players in the process, and union and employer policies for hiring and providing placement and job accommodations for disabled and injured workers.

A worker's psychological and emotional status is an important factor in rehabilitation. In describing the "accident process," Herschfield and Behan (1963) explain that in some cases a worker's injury may provide a solution to some of life's problems. According to these authors, such a worker is "an accident waiting to happen," because the injury provides relief from responsibilities and conflicts. This type of behavior or response acts as an obstacle to the success of rehabilitation. Furthermore, an extended period of medical treatment in the absence of a rehabilitation focus can foster a dependent attitude in the injured worker and undermine his/her desire to return to work. The worker may quickly grow accustomed to an inactive lifestyle and come to feel entitled to disability benefits. In fact, such employees may view an opportunity for an early return to work as an attempt to deprive them of benefits that they believe themselves entitled to receive (Galvin & Schwartz, in press). At the same time, once the worker has accumulated a history of prior injury or illness, employers may become more likely to question the employee's future performance and motivation, which, thus, becomes a significant barrier to employment.

Work incentives in the form of accommodations also are important components of successful disability management. For example, some large U.S. employers will pay for an employee's relocation expenses when a job is found in the company at a different geographical site. Other employers offer bonuses for employees to participate in health promotion programs, wellness programs and opportunities for retraining. On the other hand, disability benefits can function as powerful disincentives, when disabled workers who do not return to work receive cash compensation. Designing work incentives while reducing disincentives is a major challenge to disability management. The issue of work incentives versus disincentives is a delicate one. It poses both practical and ethical questions to policy makers, employers, and rehabilitation counselors in terms of how to encourage workers to return to work without undue coercion or depriving those who cannot work of adequate benefits.

Review and coordination of benefits are critical principles for an effective disability management program since they

control exit and entry from the disability support system and employment. In this instance, obstacles can result from the peculiarities and lack of linkages among the various elements of the system. The disability support system is further complicated by the great number and variety of public and private disability-related benefits. In fact, the Health Insurance Association of America (1979) has identified 38 other disability support systems.

In many cases, workers who are disabled are eligible for benefits from several sources. For example, as Hester and Decelles (1985) point out, a person may have worked for sufficient time to qualify for Social Security Disability Insurance (SSDI). In addition, if the person's injury is work-related, he/she may qualify for workers compensation, and, further still, he/she may carry an individual Long-Term Disability (LTD) policy. For employers, benefit cost shifts often occur when some portion of the disabled worker's support is allocated to a different source. For example, in accordance with benefit coordination policies, some employers require that LTD beneficiaries apply for SSDI benefits. In encouraging or requiring employees to utilize benefits that shift costs to various sources, employers may inadvertently promote disincentives to employment and reduce employee and organizational accountability for return to work.

A thorough understanding of the disability benefit system and programs available to injured/ill workers is an important and necessary step for employers who are concerned about cost management, and who want to maintain a healthy workforce. Knowledge of the system is also important to rehabilitation counselors in their role of helping disabled employees and employers.

In many states, vocational rehabilitation is an integral part of the worker's compensation system. Yet, overall, vocational rehabilitation remains an underutilized resource in solving problems of work-related disability. As Carpenter (1985) stated factors that contribute to underutilization include a lack of understanding or support for rehabilitation services on the part of most employers, insurance carriers, and injured workers; the litigious nature of the worker's compensation system; the quality and costs of services currently provided by the public and private sectors; and the lack of adequate program evaluation. On the other hand, employers have not only recognized the benefit of vocational rehabilitation services for work-related injuries, but have extended the provision of these services to workers with non-work related injuries, illness and disability.

A final barrier to be discussed includes employers and labor union policies and regulations (e.g., job seniority rules) that obstruct return to work by functionally impaired employees who can only work with restrictions and/or accommodations. Often employers are afraid of law-suits or reinjury and of establishing precedents and privileges that cannot be extended to able-bodied employees. Similarly, labor unions have been consistent in providing access to jobs according to levels of seniority. The concern is that any party (i.e., worker, union or employer) may use these rules and regulations to their own advantage. Thus, if an employer is not satisfied with the worker's past performance or views a disability absence as an opportunity to eliminate certain jobs for cost reasons, the employer is less likely to adopt a policy that supports return to work alternatives.

Unfortunately, the need to provide special job accommodations or to restructure jobs for a disabled employee may convince employers that workers with disabilities are an obstacle to necessary adaptations during a time when business methods and processes require rapid change (Galvin, 1983). Under such conditions, employers may resist rehiring employees with restrictions and, for workers already on the job, may accept the pension/disability benefits solution rather than undertake retraining and/or reassignment.

Implications for Rehabilitation Counselors

The basic tenets of the disability management concept can be applied at three different levels of intervention. These include: clinical (i.e., direct employee service), educational (i.e., training and assisting service providers), and consultative (i.e., facilitating the interdisciplinary process among the different players in the disability management process, designing programs and models of service).

As rehabilitation counselors become involved in employer-based efforts in disability management and rehabilitation, several issues emerge.

1. *Limitations of the Clinical Model*

The provision of competent services alone is not sufficient to impact an organization's disability-related costs and employee outcomes. Counselors venturing into this arena also need to adopt a systems perspective or an organizational approach to intervention. This requires an understanding of management concepts and organization structures, as well as familiarity with policy and benefit administration. More importantly, this systems approach requires skills in negotiating cross-department cooperation, facilitating a team approach with internal and external parties, and developing and maintaining corporate commitment to the program.

2. *Importance of a Caring Response*

Rehabilitation counselors often anticipate that humanitarian motives must be abandoned or disguised in order to be effective in a business environment. On the contrary, those corporations that have been most successful in the management of disability costs and return-to-work outcomes typically emphasize the importance of a genuine, caring response and a trusting relationship. In order for these programs to be successful, the primary objective must be to help the injured or ill worker to achieve recovery and retain economic security and personal well-being. Programs that attempt to reduce costs through manipulation of employees are not successful.

3. *Importance of Clinical Skills*

Rehabilitation counselors must be skilled providers of service in order to effectively address the psychosocial impact of illness and injury, to mediate the disincentives and barriers to rehabilitation, and to coordinate the participation of various parties with conflicting interests. Workers who encounter difficulty in returning to work have often had personal and work adjustment problems in the past. "Early retirement" through disability has been a convenient alter-

native for the employee and supervisor, although an expensive solution for the organization and benefit programs. Overcoming the resistance of employers and supervisors is a challenging task that requires well-developed human relations skills.

4. ***Importance of Cost-Benefit***

While humanitarian concerns of social conscience may be important motivators for business interest in disability management, these efforts must prove to be at least self-supporting if not profitable in order to sustain their long-term viability in the organization. Consequently, effective information systems must be adopted for monitoring company costs and outcomes and the consequences of program expenditures in managing these factors.

5. ***The Values of Tradition and Innovation***

Although there are many common elements that are found in effective corporate programs, there is no single approach that is appropriate for all organizations. As with any organizational innovation, programs must be developed with participant input at all levels of the organization and be responsive to the particular environmental context and needs. On the other hand, the fundamental elements of traditional vocational rehabilitation provide the building blocks for the service program once it is established. Individualized plans of service that involve the disabled employee as an active participant are no less important here. A timely response and adaptation of the rehabilitation process for an efficient return-to-work strategy are particularly important to successful outcomes. Strategies that emphasize job and worker assessment and matching job modifications, accommodations, and supervisor education are recommended in these programs.

6. ***Considerations for the Future***

As Reich (1983) pointed out, employer-based programs are growing more rapidly than traditional government-sponsored programs as providers of human services. These employee-based benefits are constituting an ever larger portion of employment compensation. Rehabilitation counselors can learn from the experiences of social workers, for example, who have entered these programs as service providers through the growth of employee assistance programs. In order to become recognized as a valuable component of these disability management and rehabilitation programs at the workplace, it will be important for rehabilitation counselors to adapt and expand their professional skills and models of service to meet the needs of this environment and its participants.

Summary

Throughout this article, disability management has been described as an emerging concept in the rehabilitation field that is addressing the many needs of employers and persons with disabilities at the workplace. Mainly, disability management serves as an intervention for both large and small employers in protecting the health of their workforce, as well as a cost-management strategy for controlling high expenditures in health care and disability payments. With an emphasis on return-to-work, disability management assists in preventing the severence of ties between employers and their injured/disabled employees.

It should be noted that this article discusses mostly large employers and their experience with innovative initiatives in disability management. Further studies need to be conducted to investigate the special needs, strategies, and resources of smaller employers in managing disability, since they constitute the majority of U.S. employers and employment openings.

The articles to follow cover a variety of models currently being adopted at the workplace. Also discussed are implications of clinical practice, research and policy, and education and training.

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Special Article

Disability Management: A Comprehensive Framework for Prevention and Rehabilitation in the Workplace

DENISE G. TATE, Ph.D., ROCHELLE V. HABECK, Ph.D., and GAIL SCHWARTZ

ABSTRACT: As employers began to realize that healthy employees represent an investment and a resource to the organization, preventing and managing disability have become a more central concern. This concern led to the fast expansion of health promotion disability management programs, employee assistance programs, and transitional work programs to meet the challenge of effective cost management. This article defines these programs, presents an example of a U.S. company that is currently adopting these approaches, and discusses implications vis-à-vis future trends and current concerns.

IT HAS BEEN ESTIMATED that American industry spends $46 billion annually for people who are out of work on disability. Such figures represent a serious concern especially for employers whose labor force is relatively younger.[13] It has been documented elsewhere that at age 32 a long-term disability is 6.5 times more likely to occur than death; that between 35 and 65, seven out of ten workers will be disabled for three months or more; and that before retirement age, one out of seven workers will be disabled for two years or more.[5]

Thus, employers are increasingly interested in finding ways to reduce the costs of workers' compensation, illness, and long-term disability at the workplace. The actual expenditures accrued by employers go beyond the medical and benefit areas. Additional dollars are associated with the loss of work time and productivity, the costs of rehiring, retraining, and replacing employees.

As employers began to realize that healthy employees represent an investment and a resource to the organization, preventing and managing disability has become a more central concern. This concern has led to the rapid expansion of health promotion and disability management programs, as well as employee assistance programs and transitional work programs to meet the challenge of effective cost management. Current research indicates that the workplace is particularly well suited for effective and wide spread health promotion and disability management programs.[6] It is the site where programs will have the greatest impact on the present adult working population.

This article has three purposes: (1) to define disability management, health promotion and other programmatic strategies, such as employee assistance programs (EAPs) and transitional work programs; (2) to present an example that illustrates this approach as adopted by a major U.S. employer; and (3) to discuss the implications of this conceptual framework vis-à-vis future trends and current concerns.

Disability Management

Disability management involves the identification of employees who are showing signs of chronic illness or disability and the provision of intervention via in-house or contracted public and private rehabilitation services. The objective is to retain the disabled worker in productive employment. Disability management is an active process of minimizing the impact that limited abilities may have on the social and vocational roles of the individual. The process is cohesive, systematic, goal-oriented, and organized within an employer base.

Further, disability management is a strategy which can be used to maximize the health of an employee population and their dependents. Disability management has been defined as:

(a) directed toward an individual with chronic or permanent functional limitation or disability, or an individual with symptoms indicating a risk of disability;
(b) intended to restore an individual's working or functional capacity, or to prevent deterioration; and
(c) including measures aimed at developing an individual's own resources or removing obstacles imposed by the environment.[7]

The first step in the establishment of a disability management program is the creation of a policy by the company that reflects the actual status of the illness/injury and endorses a commitment to rehabilitation.[11] To succeed, the program must be built upon a solid philosophical commitment. Second, an educational effort must be offered to employers and employees. Time must be invested in explaining the process to a variety of corporate officials, union representatives, supervisors, and the workers themselves. Third, disability management requires the identification of critical decision points in the process. Such decisions

often involve benefit approval, medical and vocational rehabilitation services, and return-to-work options. Fourth, disability management emphasizes the establishment of ongoing medical monitoring and management. Finally, disability management requires the adoption of a systematic return to work plan which may involve job analysis, job modification and accommodation, and temporary assignments to transitional work activities.

A disability management program within business and industry emphasizes the early identification of individuals at risk for job/disability related problems, the management of physical symptoms, a willingness to modify jobs, and the establishment of personnel policies that facilitate work return. If the firm adopts a corporate value toward the management of disability problems rather than a solution based on wage compensation benefits, there will be greater acknowledgement and utilization of rehabilitation techniques designed to maintain appropriate levels of employment for individuals with functional limitations.[4]

The employer actively implements disability management by such means as providing work incentives into disability benefit design, by educating managers about disability benefit plans, by assigning one corporate representative with overall responsibility for coordinating disability benefit programs, and by facilitating communication among varying divisions which are involved in disability policy within the corporation. The essential ingredient is in promulgating communication among those persons administering health and disability benefits. This may span a range of departments such as human resources, personnel, benefits (income maintenance and long-term disability), workmen's compensation, group insurance, corporate medical department, risk management, government affairs, corporate contributions, legal counsel, EAP, health promotion, finance, labor relations, safety, and so forth.

Thus, a successful program for disability management requires a varied combination of both philosophical and operational components for effective implementation. To summarize, the major elements in our view include the explicit commitment of senior management, employee involvement, supervisor involvement, clearly delineated program objectives, confidentiality of employee-related information, coordination among corporate departments in different facets of disability, coordination with employee's family and physician where appropriate, and assignment of program responsibility to a specific manager.

Disability management is only one of a multitude of approaches instituted by employers to maximize the health of their employee population. In fact, other forms of worksite wellness programs have gained even wider attention. A large number of medium and large companies have developed employee assistance programs (EAPs). An abundance of health promotion programs have also proliferated within small, medium, and large companies. We view both of these approaches as compatible partners in a broader disability management scheme.

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Health Promotion

Health promotion programs emphasize a critical piece of disability management—that is, prevention of chronic illness and associated disability. Preventing disability requires:

- reducing the incidence of degenerative diseases such as heart disease, arthritis, diabetes, stroke, and many cancers;
- reducing the incidence of injuries, both on and off the job, and the potential causes of traumatic injury;
- a comprehensive approach to minimizing the number and severity of occupational illnesses;
- creating an environment where stress is not a major contributor to disease;
- assisting troubled employees, including those with alcoholism and other substance abuse problems; and
- minimizing the effect of specific limitations and impairments on employees' perception of their

ability to work and on their ability to perform in an appropriate job.[2]

Health promotion and wellness efforts are similar to disability management efforts in that they are proactive, systematic, and aimed at an at-risk group. Most health promotion programs have been established since 1975.[14] Their aims are much broader than prevention alone. In fact, these programs are tailored to respond to the needs, corporate philosophies, and goals of each employer. Examples of corporate goals for these programs include enhancing the corporate image (Pepsico), improving recruitment (Kimberly-Clark), tackling the high incidence of health problems in the working population (New York Telephone) or high-risk populations (Campbell Soup), providing an executive benefit (Chase Manhattan Bank), and facilitating individual responsibility for health (IBM).

Specific wellness and health promotion programs can include exercise and fitness, nutrition, smoking cessation, low back pain control, cancer education, chronic care management, stress management, alcohol and drug abuse, and employee assistance. In fact, employee assistance programs have been described among the fastest growing components of wellness.[8]

Employee Assistance Programs (EAPs)

Initially, employee assistance programs in industry were developed to deal with the problems of the alcoholic worker. As alcoholism programs became more successful the goals of EAPs broadened to include other substance abuse problems and other emotional, social, family, and financial problems. EAPs often operate by referring individuals with problems to the appropriate community resources (e.g., clinics, hospitals) or by providing direct psychological support, counseling, and in-depth treatment. A survey of 64 large corporations found that 60 percent of the corporations had adopted a comprehensive EAP program.[9] Forty-one percent provided a stress management program while 62 percent extended EAP services to disabled employees.

When we compare employee assistance with disability management programs, it becomes apparent that both share much of the same philosophy, being aimed at high-risk populations, and are methods of proactively dealing with worker problems using systematic, structured approaches.[12]

Although in the past EAPs and traditional rehabilitation programs were developed independently to address different populations (i.e., alcohol abusers and disabled veterans, respectively), the overlap of the problems and solutions that are now addressed in these programs provide a situation that emphasizes their similarities. In preventive rehabilitation, for example, measures are taken to avoid the need for rehabilitation services.[15] Similarly, EAPs provide preventive services that are solidly grounded in the occupational setting and are closely aligned conceptually with the rehabilitation notion of reducing functional limitations and improving job performance. Both programs have experienced accelerated growth due to reforms within the insurance industry. EAPs have expanded as a direct result of medical insurance coverage for emotional, mental, and behavioral maladies.[10] Likewise, rehabilitation services (especially in the private sector) have grown in states that require rehabilitation for workmen's compensation recipients. Furthermore, both programs are responsive to the needs of employers in that they pay close attention to the maintenance of employee productivity, the conservation of costs associated with turnover, absenteeism, tardiness, and poor performance.

Transitional Work Programs

In transitional work programs, disabled or injured workers are kept close to the work environment and active in the workplace. Typically, workers are assured that they will have employment in the company, regardless of the severity of their functional limitations. Workers whose conditions are stable enough to endure some work activity are assigned to specific jobs in the company (i.e., light duties, modified or other job activities) that can be performed by a worker with physical or emotional restrictions. Often these are temporary assignments with duration determined on by the employee's recovery process. Medical and vocational rehabilitation case management assess when the worker is ready to return to work on a permanent basis.

An example of a company that has adopted the transitional work concept is Herman Miller, Inc. At Herman Miller, ill or injured employees are encouraged to return to work that is suited to whatever restrictions apply as soon as they are medically able. During their stay in the program, workers may be given lighter tasks or modified work schedules as needed, but within the actual jobs and work environment of the company. If the employee cannot eventually return to his/her old job due to permanent restrictions, the company finds a new position for the worker that is within medical restrictions and without any salary reduction. Job training assistance is provided when necessary.

A Unifying Framework

All strategies defined thus far represent a variety of ways adopted by employers to protect the health and well-being of their workers. In contrast with the traditional medical model, which focuses on treatment of acute illness, these strategies are geared toward pre-

vention of chronic illness and the management of disability.

In this perspective, employers are using preventive health promotion, wellness programs, and employee assistance programs to reduce the risk of illness and injury among their workers. Once injury/illness occurs, the focus of efforts shifts to minimize the impact of illness on the employee's work productivity and personal lifestyle. Such post-impairment efforts include early intervention strategies in the workplace, return-to-work programs, transitional work programs, or simply job accommodation programs.

Thus, interventions for illness and injury include preventative and rehabilitation strategies that can be viewed as related ends in a comprehensive conceptual framework of disability management.

Traditionally, occupational health, ergonomics, and safety programs have been used on a preventive basis; while job modification, accommodation, and environmental accessibility have been used on post-injury/illness basis. Similarly, employee assistance programs have been commonly adopted as early intervention strategies. In fact, each of these strategies are applicable in the prevention, early intervention and rehabilitation of health-related problems.

Likewise, health promotion and wellness programs in corporate settings have been primarily designed for able-bodied workers. However, health promotion and wellness programs can be applicable to disabled people with special emphasis on self-responsibility, nutritional awareness, physical fitness, and stress management.[1] Each of these areas can affect the physical, psychological, and social dimensions of health before and after the onset of injury or disability, thus making wellness and health promotion programs applicable to the full continuum of intervention.

We have attempted so far to reflect in this article some of the different organizational strategies commonly used by employers to prevent and manage illness and disability and to identify their similarities and differences. The implementation of a unified disability management program strategy can be better understood in the context of an example of an employer who adopts the prevention/rehabilitation continuum approach as explained earlier. A number of companies have been successful in implementing these strategies to manage illness and disability. These include 3M, Burlington Industries, Xerox, and others.

An Example of the Prevention-Rehabilitation Continuum in Operation

The particular example used to illustrate one employer's implementation of a unified disability management approach is the Wellness and Rehabilitation Program of the Adolph Coors Company.[16] This program was selected for the 1985 President's Award by the National Rehabilitation Association as a major contribution to the rehabilitation field.

The Adolph Coors Company is a brewery located in Golden, Colorado, that has 10,000 employees. The company is self-insured and nonunionized. The historical forces that shaped the program's development are similar to many other employers. In the 1960s, the company opened a medical center to meet the immediate needs of employees with occupational injuries or illnesses. This was followed by the implementation of an employee assistance program provided through contractual agreement with an external provider for counseling services. Based on his personal experience with illness, Bill Coors recognized the inadequacy and underutilization of the existing traditional services and led the development of the Wellness Program and a redefinition of the medical program to include rehabilitation with a vocational emphasis.

In 1980, the EAP arrangements were modified to expand the range of providers and services utilized by employees and their dependents. At the same time, an in-house psychological, diagnostic, and referral service was added, as well as policy changes to increase the mental health care benefits provided. The medical program began expanding its approaches to wellness, including stress management, fitness, and nutrition. These developments have been identified as the initial steps in redefining Coors' approach to mental and physical health.

Cost savings are not viewed as the primary motive of the program. Company managers emphasize a commitment to employee wellness as a corporate value. However, the company recognizes that the potential needs of its aging workforce will provide significant financial challenges to the company in the future. Likewise, the mandatory rehabilitation provision with the state's workers compensation law created the need to control resulting costs through an organized approach.

Components of the program include: the *medical and rehabilitation service* that consists of primary and acute medical care, physical medicine and rehabilitation, medical management, and prevention; the *counseling service* that consists of employee and family counseling and vocational rehabilitation counseling; and the *wellness program* that consists of programs to help people stop, start, and stay in the cessation of unhealthy habits, the initiation of healthy lifestyle behaviors, and the maintenance of lifestyle changes.

The focus of medical management is managing work- and nonwork-related medical situations, relating to community providers, conducting preplacement health screening for selective placement, providing early intervention with employees for return to work, and resulting in a referral at the end of the process to the Wellness Center.

Vocational rehabilitation counseling focuses on retention of work identity and maintenance of employment. The objective of the program is to fully utilize or develop the disabled employee's skills and abilities so that the employee may be placed in a meaningful job. The process utilizes referral, medical and vocational evaluation, vocational counseling and guidance, development of vocational options, and follow-up. The first strategy used is to accommodate the individual back into the company using task analysis and job accommodation. A rehabilitation plan is formulated for each referred individual. In some cases formal training programs are utilized for training in marketable skill areas. In other cases private companies are used for out-placement of individuals who cannot return to the company. Referrals are made by vocational rehabilitation to other programs within the overall health and wellness program. There is also a light duty leave of absence coordinator in the company. This individual monitors the status of individuals absent from work and encourages their return into light duty work. The coordinator has identified all light duty work that is meaningful and available in the company and utilizes these placements in order to maintain work behavior and work identification. When permanent restrictions are identified, the coordinator refers these individuals to vocational rehabilitation.

The wellness programs include physical fitness, smoking cessation, slimness, nutrition, alcohol awareness and decision making, and stress management. The physical fitness program offers health screening, individual and group exercise, a healthy back program, and a cardiac rehabilitation program. Eighty-five percent of the back problems in the company are now handled within the program without outside referrals. The cardiac rehabilitation program has resulted in decreased time off work after the cardiac incident.

Conclusion

There is no doubt that cost management is a clear objective for employers adopting these preventive and rehabilitation strategies. However, successful programs at the workplace have not been justified solely on a cost containment basis. Rather, these programs also emphasize corporate commitment toward caring for and assisting employee well-being. Many interventions may be viewed as costly by the company when measured against short-term gains, but the actual benefits of such provisions can only be fully appreciated on a long-term basis. Short-term approaches (e.g., specific health behavior change programs) are often adopted to achieve readily available results and assure immediate credit or merit to its initiators.

Statistics for the working population in the future indicate a trend of increasing numbers of older workers accompanied by functional limitations from chronic health conditions that will interfere with their job activities. More and more employers will be faced with the challenge of accommodating persons with disabilities in order to protect their investment in valuable human resources.

In responding to this challenge, unifying strategies of disability management as discussed here can be very helpful to employers. The integration of these strategies as part of a coordinated and comprehensive policy toward employee health and disability becomes very important to achieving all aspects of effective business management.

As companies follow the tendencies for simplified management structures, a movement toward the coordination of disability policies and programs and direct participation in disability-related decisions by all the relevant parties will occur. Furthermore, existing intervention strategies will be expanded to accommodate the needs of persons with disabilities. Health promotion and wellness programs can be modified to address the needs of persons with permanent disabilities as well as those of able-bodied employees.

Employee assistance programs can incorporate the expertise of a rehabilitation specialist in order to address unique needs of disabled workers with potential to maintain or return to employment. Rehabilitation specialists have the background and experience to assess and counsel both psychologically and physically disabled employees and the knowledge and skills to recommend accommodation strategies to the organization, which can allow the successful retention of valuable employees where appropriate.[4] Early intervention and vocational rehabilitation programs can be also increasingly adopted for employees who are on an extended sick-leave or receiving long-term disability benefits. Currently, most companies only offer rehabilitation to employees receiving workmen's compensation benefits.

Most important, the growing pressures on business for profitability and economic survival have dictated the need for both management and labor representatives to partake in an equitable dialogue, thus achieving a balance between the goals of doing business and of protecting the quality of life of injured and disabled workers. In many companies, the strategies discussed here are already being implemented as a result of such dialogue.

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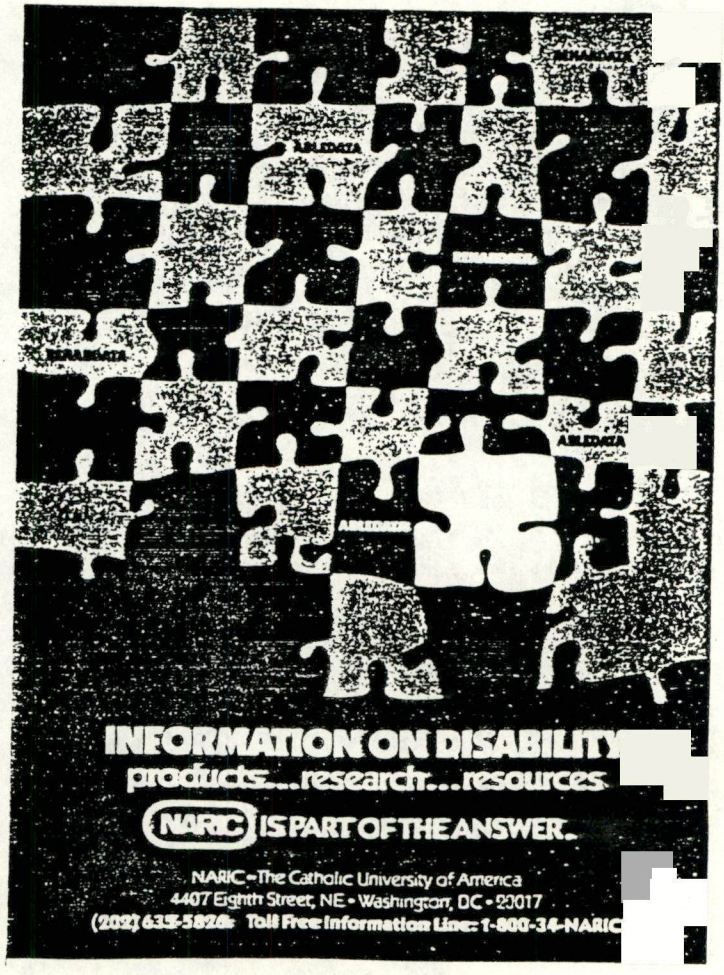

Disability Management Research:

Current Status, Needs and Implications For Study

By Donald E. Galvin
Denise G. Tate
and Gail E. Schwartz

Abstract

Disability management is a new field of knowledge in rehabilitation. Consequently research efforts in this area are also quite recent. This article reviews current disability management research, focusing on research in progress funded by the National Institute of Handicapped Research and a few corporate foundations. The authors discuss several implications of the current research and recommended areas for future study. Strategies for dissemination and utilization are presented as well as a discussion of the relevance of the research to selected policy concerns.

During recent years social science research has made a substantial contribution to the public policy making process. Basic and applied social science research offers an extensive reservoir of knowledge that, if effectively utilized, may contribute to the resolution of many societal problems. An excellent example of the impact of relevant research of policy is provided by the development of Title VII ("Comprehensive Services for Independent Living") of the Rehabilitation Act of 1973. In 1974 the U.S. Congress commissioned the Urban Institute of Washington, D.C. to conduct a large-scale study of the comprehensive needs of severely disabled individuals. The study, entitled ***Report of the Comprehensive Needs Study*** (1975), had a significant role in shaping Title VII (amended to the Act in 1978), which was a pioneering piece of legislation that enhanced the quality of life of the disabled and improved their opportunity to receive rehabilitation services.

As we continue to assess the varied needs of disabled persons in society, other dimensions of rehabilitation become appropriate targets for further policy oriented research. One such new area is disabled management.

The purpose of this article is to provide the reader with a better understanding of current and future disability management concerns by focusing on relevant research and its policy implications. Specifically, the article will address research in progress that is funded by the National Institute of Handicapped Research and a few corporate foundations. In the first section notation is made of recently completed literature reviews, and current disability management research is described. In the second section, the authors discuss some limitations and implications of the current research and recommend areas for future study. The third section is a brief treatment of dissemination and utilization problems unique to research on disability management. The closing section is a discussion of the relevance of the research to selected policy concerns.

Current Disability Management Research

Current research in disability management has been sustained by two primary sponsors: the National Institute of Handicapped Research (NIHR) which supports of specific projects directly related to employer-based disability management efforts. NIHR support has included grants awarded to universities and private organizations, under the field-initiated research and fellowship categories, and a larger grant for a research and training center dedicated to preventing disability dependence, awarded to a foundation.

Research projects in disability management that are currently funded by NIHR propose to:

1. Analyze public and private employers' policies and practices in disability management and their relation to incidence and experience with disability, disability payments, time off the job, and continued employment (Michigan State University).

2. Revise and update national statistics on the costs of disability and rehabilitation services (Rutgers University).

3. Explore, develop, and disseminate a unified body of knowledge which enhances the prevention and/or elimination of disability dependence via strategies such as early intervention, worksite modification, and job placement (Menninger Foundation).

4. Identify employee assistance programs (EAPs) that focus on the needs of disabled workers and disseminate effective EAP models to new work settings; also identify the role of unions in facilitating the disability management process (both projects are being conducted at Columbia University).

5. Study a range of factors, patterns, and characteristics of older workers which influence their likelihood of returning to work; and examine the incidence and resolution of performance problems associated with physical and mental impairments among Social Security Administration employees (both projects are being conducted by the International Center for Labor, Industry and Rehabilitation).

6. Determine the extent to which seriously injured workers in the State of Washington have been rehabilitated and returned to their preinjury employment (Washington State University).

7. Survey disability management practices among major U.S. employers regarding short- and long-term disability policies, workers' compensation, rehabilitation, return-to-work, job accommodation, health care, and reimbursement for rehabilitation services (Institute for Rehabilitation and Disability Management).

In addition to these specific efforts, NIHR supports a variety of large scale research projects that also impinge upon the employment of persons with disabilities. These projects include, for example, studies in the areas of psychiatric and cardiac rehabilitation, chronic pain management, vocational aspects of disability, and transition from school to work.

Corporate foundations sponsoring disability management research include AT&T, General Electric, Eastman Kodak, ARCO and Kimberly-Clark. AT&T's corporation foundation awarded funds to the Institute for Rehabilitation and Disability Management for research on the development of selection criteria and performance standards for employers to use in selecting and contracting with private rehabilitation vendors. General Electric, Eastman Kodak, ARCO, and the Kimberly-Clark Foundation are currently funding a project to develop policy options for improved management of convalescent and early return-to-work. This study, conducted by the Health Policy Institute of Boston University, focuses on identifying differences in patterns of return-to-work, and describes policies and procedures that employers utilize in managing short-term disabilities.

Literature Reviews

Recently, a few researchers have conducted comprehensive reviews of the disability management literature. For example, Tate, Hockett, and Starkman (1985) published a review containing approximately 80 citations on such topics as disability management, health promotion, workers' compensation, employee assistance programs, innovative vocational rehabilitation programs, and the costs of disability.

Galvin and Schwarts (in press) recently completed a Rehabilitation Research Review about disability management on behalf of the National Rehabilitation Information Center (NARIC). This publication attempts to conceptually organize the expanding literature in the area, and includes 142 bibliographic citations and 41 annotated references. The review addresses topics such as the economic impact of disability; responses to the problem such as prevention, disability management, and rehabilitation; examples of employer-based disability management and rehabilitation initiatives; and the "confounding obstacles" in the system (e.g., labor-market factors, psycho-social factors, and employer policies and practices).

Hood and Downs (1985) produced a literature review emphasizing return-to-work among chronically ill, injured and disabled employees. The review covers: (a) the emergence of the return-to-work philosophy; (b) the importance of early intervention; (c) return-to-work incentivies and disincentives; and (d) a description of programs promoting return-to-work.

Implications and Limitations of Research

Most research conducted in the field of disability management has been of a descriptive nature. The implications and limitations of existing studies may be grouped in two categories: those with respect to the method of investigation; and those with respect to the object of the study.

Methodological Implications and Limitations

Research and evaluation studies oftens stand or fall on the basis of how well they measure up to established scientific standards of excellence. Pitfalls, sources of confusion, and invalidating factors abound, challenging the findings and interpretation of any given study. Several methodological issues compound the difficulties of research in the area of disability management. First, one is faced with the difficulties of operationally determining and consistently applying the definitions for the objects of study. Disability definitions abound and vary according to the characteristics of a specific population (e.g., back injuries, carpal tunnel syndrom, chronic pain, cancer); according to the medical and financial criteria for entitlement to benefits under differenct programs (e.g., Social Security Disability Insurance, Workers' Compensation, Long-Term Disability Insurance (LTD); and according to eligibility for services (i.e., vocational rehabilitation services, civil rights protection, employee assistance services, and veteran's rehabilitation services).

One also confronts methodological difficulties in assessing the outcomes of disability programs and in measuring direct and indirect benefits resulting from a program. As Carpenter (1983) points out, information on costs and program outcomes is often unavailable. For example, most private employers do not systematically collect employee-related or intervention-related data that would enable them to evaluate the costs and efficacy of rehabilitating injured workers. Yet without such data, no utilization review program can be instituted or administered, nor can any effective cost monitoring and cost containment efforts be mounted.

The lack of comprehensive data bases from federal and state regulatory agencies, public and private employers, and other agencies, i.e. workers' compensation, has often forced researchers to rely on secondary sources of information for analysis. Even in this case, however, comprehensive studies addressing specific objectives and methods are often not available. While helpful data bases do exist in the general areas of health and safety (Harunian, Smart and Thompson, 1981), efforts are just now underway to utilize computers for systematically classifying and tracking characteristics, patterns, and costs associated with those who become injured and/or ill at the workplace.

Cost analysis evaluation is a popular research technique for aiding policy makers, managers, and administrative personnel in implementing decisions. With respect to adopting a cost analysis approach, however, several methodological as well as data-related limitations need to be considered. Johnson and Dietrich (1971), for example, recognize the following problems:

1. Costs are infrequently linear, that is, increases and/or decreases in costs may not directly relate to equal increases or decreases in the object of cost. Many program expenses are fixed over narrow ranges, whereas

the expenses of others are dependent upon enrollment or use, the cost of materials, and other factors thus making it very difficult for the administrator to ascertain a constant figure for costs over a longer period of time.

2. Costs records and data are usually incomplete or otherwise inadequate. For the majority of organizations, costs categories are not sufficiently detailed to afford accurate costs accounting for research purposes.
3. Data on legitimate and relevant costs are often unavailable. For example, organizations may only report cost data that reflect well on their existing rehabilitation practices and other employee services.
4. Cost data on projects may be unreliable. The methods of collecting data on program functions and costs are as varied as the definitions of those functions.

Implications Regarding the Object of Study

Davidson (1985), Carpenter (1985), and Mitchell (1982) report that few studies have specifically investigated the impact, or costs and benefits, of disability management and rehabilitation programs. Indeed, Galvin and Schwartz (in press) conclude:

> *While one may propose that early rehabilitation initiatives, particularly employer-based programs that respond immediately and humanely, may reduce disability costs, prevent further functional deteriorations, avoid adverse psychosocial sequalae, the disincentive dilemma, dependence upon benefit payments, and help to avoid the creation of a disabled population excluded from the workforce -- all this has yet to be proved through data-based scientific study.*

Employers, public policy makers, labor and insurance officials, administrators, rehabilitation practitioners, disabled workers, and others have a vital interest in the systematic study of disability management and the rehabilitation of chronically ill, injured, and disabled workers. In large measure, however, we have just begun to frame the appropriate questions for study.

Based on an extensive review of the literature augmented by participation in several state and national conferences, and interviews with knowledgeable persons including employers, government officials, and employees, the authors suggest several lines of study that appear both timely and necessary. These are discussed in the following paragraphs.

Most disability management research currently focuses on employer efforts to manage disability costs and return disabled employees to work. Generally, however, this research does not address the specific and long-term impact of disability management strategies on participating employees. Long-term, controlled studies of employees who have received disability management services would make an important contribution to research and policy making.

One of the most important barriers to the development of corporate disability management strategies is the lack of data substantiating the economic value of such practices. To justify the establishment of a disability management approach, managers must often convince corporate officers that the start-up costs (e.g., feasibility studies, analysis of employee demographics, and the collection of disability related data) and the additional costs (e.g., personnel, work site modifications) required for maintaining the program will evenutally prove cost effective. Employers also need information on the relative cost-effectiveness of different programs or approaches in order to make proper operational decisions. Comparative data, including data derived from the use of control groups, would be most helpful. Furthermore, the need for information on the costs and impact of disability management strategies is on-going. Established programs must continually justify their costs and prove their benefits, or these programs remain in constant jeopardy.

With respect to comparing different approaches, research is needed on how and why some employers choose to develop internal workplace programs, while others choose to contract with outside service providers. To date, disability management research has focused mostly upon large corporations (i.e., Xerox, 3M, IBM). These large employers seem to prefer their own in-house rehabilitation programs. On the other hand, there is a large number of other employers who continue to use contractural arrangements with outside service providers for such programs as health promotion, employee assistance counseling, and disability management. Thus, employers need information if they are to evaluate the advantages and disadvantages of each strategy.

Similiarly, there is also an urgent need for further research on small and medium-sized companies and their approaches to managing disability benefits, retaining employees who become disabled, assisting employees in their search for appropriate services, and utilizing available community resources in the management of disability problems. Specific questions to be researched include: (a) Are there distinguishable strategies or practices which are most appropriate for small employers? (b) How can such strategies be implemented? and (c) Are there particular obstacles that are specific to small employers?

Recently a few public employers have initiated disability management programs. They include the Social Security Administration, the United States Postal Service, the U.S. Department of Labor, the Michigan Department of Mental Health, and the Tennessee Valley Authority. Cost-benefits studies of these approaches to disability management as well as information on methods of implementing these strategies within the public sector would be useful to public decision-makers and administrators.

The role of labor unions in returning disabled workers to work is an important factor for many private and public employers. Employers who have worked jointly with their affiliated labor unions in developing disability management programs have experienced substantial success. In fact, certain employers who responded to a 1986 survey conducted by IRDM identified union support and participation as the key to successful disability management programs. Additional research is needed to understand how to foster labor-management cooperation in order to facilitate job-retention.

Also, little research effort has been directed at relating disability management to wellness, prevention, and/or the health maintenance of persons with disabilities. Research into the impact of corporate health promotion programs on the health of persons with disabilities could significantly advance the emerging field of disability management. Topics to be

studied include (a) corporate strategies for preventing both short- and long-term disabilities; (b) the use of mental health and employee assistance services to maintain a healthy workforce; and (c) the role and the impact of health promotion programs on persons with disabilities.

Containing health care costs, including appropriate health benefit design, is the immediate and primary concern of most employers. Not only are employers concerned about controlling the costs of disability compensation, but they are also concerned about medical and vocational rehabilitation costs. In this respect, employers need information on the costs of inpatient versus outpatient rehabilitation, the average length of stay in rehabilitation facilities, and the return-to-work probabilities associated with medical and vocational rehabilitation (Eckenhoff, 1984).

Finally, the attitudes and expectations of employers is another area that is relevant to the development and performance of disability management programs. As reported by Carpenter (1985), many employers are skeptical of disability management and rehabilitation efforts. Research may help us to better understand employer attitudes and may be utilized to better inform/educate employers and others.

Dissemination and Utilization Of Disability Management Research

To assure the relevance and proper dissemination and utilization of knowledge about disability management, it is important that potential users of this knowledge (i.e., employers, employees, educators, administrators) participate actively in all phases of the research process. Participation alone, however, is not sufficient to guarantee the dissemination and utilization of research-based information. The dissemination and utilization of research results is often problematic under the most favorable circumstances. Several factors complicate the process. As noted above, social scientists often find it difficult to conduct research, in both the private and public sectors, that meets the standards of scientific inquiry. The issues of employee confidentiality, labor/management relations, the need for secrecy in the competitive world of business, company concerns regarding image and reputation, the lack of necessary information systems and data, and fragmented or dispersed responsibility/activity all add to the researcher's difficulty in disseminating valuable information obtained from research in a manner that is acceptable for potential users.

In fact, the very language, concepts and values of social science research and business practice may impede the dissemination, interpretation and utilization of research results. As Backer (1986) notes, "The endless qualifications, complex terminology, and lack of immediate connection with reality (i.e., day-to-day operating problems, budget) that characterize much scientific research and writing often gets in the way on convincing people to adopt innovations."

Problems also exist with respect to the specific channels used for research dissemination. The vast majority of literature on disability management practices is not reported in the literature typically read by business people. In order to influence the development of disability policies and practices, employers need to be aware of the programs established by other leading employers and unions. Thus, current and future research findings should be publicized in magazines and journals that are more likely to be reviewed by corporate decision-makers, benefit managers, risk managers, and corporate medical physicians. Those publications that have the most significant impact on employers, for example, ***The Wall Street Journal, Harvard Business Review,*** and ***Business Week,*** are not typical vehicles for reports on social science research in fields such as disability management and rehabilitation. Editors of such publications do not traditionally seek such information while most social science researchers look to a totally different set of publications for dissemination of research results.

Personal contracts between social science researchers and business people are rare. Only on a few occasions are such contacts facilitated through conferences, seminars, and committee assignments. As a consequence, all too often the social scientist who conducts rehabilitation research has little or no idea as to which specific office or individual within a given major firm is the appropriate target for disseminated information.

Unfortunately, there are too few organizations or individuals who efficiently and effectively serve as linkage agents and/or "translators" between social science researchers and the business community. The Washington Business Group on Health, the President's Committee on Employment of the Handicapped, the Labor-Industry Council and the Projects With Industry program are examples of rehabilitation relevant organizations that, in part, perform this vital function of information broker to the business community.

The development and implementation of employer-based disability management programs is usually a substantial innovation for the majority of business firms. Backer (1986) reminds us that the utilization of research results to promote and serve organizational innovation presents four major challenges, namely:

1. Implementation of innovative practices requires changes at the workplace and change is hard. The adoption of disability management policies and practices may require very substantial change, in attitude and practice, among a wide variety of individuals or units in the private firm or public agency.
2. Utilization of information disseminated requires resources. As noted earlier, while disability management may eventually contain or reduce employer costs, the initial adoption and implementation of this innovation requires start-up costs for such items as additional personnel, worksite modifications or accommodations, equipment, and medical and rehabilitation services (e.g., independent medical reviews, job placement services) which in the past had not been provided. Thus, some employers may feel that expected benefits in the form of eventual cost reduction would be substantially eroded by the initial costs of implementing the innovative program.
3. Innovation adopters need to believe that the innovation will work in the organization. Innovators must not only be aware of the innovation but must have sound reasons or evidence to support and further the adoption of the innovation in their firm. In our ex-

perience, we have repeatedly been exposed to a curious attitude or perception among potential employer innovators or adopters. Specifically, most employers are eager to learn about the experiences other employers have had in adopting the disability management innovation. Indeed, they seem more influenced (positively and negatively) by the reported personal experience of peers, even those from other firms, than by information gained through more scientific reports. However, while many potential adopters are eager to learn about the experience of others, they often remain doubtful that the innovation could be successfully applied to the perceived uniqueness of their firm.

4. Innovative adopters must be aware of innovative programs being adopted by other organizations. This is the most basic and evident utilization requirement. In other words, when innovations are not adopted, it is usually simply because potential users have no knowledge of the available technique. Employers, administrators, policy makers, trainers, and rehabilitation counselors are just becoming aware of the costs of unmanaged disability. They are just now becoming aware of alternative approaches and open to "solution messages." For the most part, however, these individuals do not yet possess complete, sufficient experience or evidence to evaluate, sort, select, advocate, and endorse specific disability management strategies.

Relevance of Research to Selected Policy Concerns

In the area of disability management and the rehabilitation of chronically ill, injured, and disabled workers, one steps into a maelstrom of public and private sector policies, as well as the policy preferences of organized groups (i.e., the business community, labor organizations, professional associations, and disability consumer groups). The number and nature of policy concerns is complicated by the number of interests of such groups or viewpoints involved. Specific group or individual values, ideologies, and images frequently define social problems and the policies and programs which are to serve as solutions. As Howards, Breham, and Nagi (1980) observe, the problem of the disabled worker can be addressed: (a) from the perspective of restoring individual work capacity (i.e., change the person); (b) from the perspective of restructuring the work environment or performance demands to compensate for capacity limitations (i.e., change the job); (c) from the perspective of simply replacing earnings through programs of private or public income maintenance (i.e., retirement pension); or (d) by some combination of all three. Thus, a disability management and rehabilitation program established by an employer as a response to the costs and personal consequences of employee illness, injury or disability is preceded by an explicit or implicit definition of the problem and decisions as to how one is to be guided in addressing the problem.

Perhaps one of the oldest and most frustrating policy issues in the field of rehabilitation and disability management is the difficulty in defining and assessing whether and to what extent someone is actually disabled. Research findings on how to measure the relationship between functional capacity and the ability to work should be incorporated into both public and private disability compensation programs.

Public policy research is also needed to explore and clarify the role of state vocational rehabilitation agencies vis-a-vis employer-based disability management programs. State vocational rehabilitation agencies in New York, Georgia, Michigan, Minnesota, and Virginia have worked closely with the business community to implement special programs to enhance the return to work of chronically ill, injured, and disabled workers. These public and private sector initiatives deserve the attention of researchers, since they might serve as instructive models for such cooperation elsewhere.

A further public policy issue involves the lack of physician expertise in the area of rehabilitation and return-to-work. The lack of such knowledge can perpetuate the problem of disability dependence. For example, all too often, physicians conservatively prescribe unnecessarily lengthy periods of recuperation and are not sufficiently aware of job requirements. A related issue involves the fact that persons with disabilities frequently do not have access to primary health care and/or local physicians who are knowledgeable about disabling conditions and related health concerns. Therefore, more medical education and training should be directed at physicians to familiarize them with the special health and employment needs of persons with disabilities.

A further area requiring public policy attention is the development and implementation of innovative work incentives. The lack of adequate work incentives creates tremendous barriers to successful return-to-work programs. Several leading disability experts state that the risk of losing one's health insurance while unemployed may be the most crucial work disincentive. Policy issues such as the most appropriate wage replacement ratio needed to encourage return-to-work, and the impact of work disincentives in the public disability insurance programs on the chances for return-to-work can be further clarified by effective studies in these areas.

Summary and Conclusions

Robert B. Reich (1983) in his book ***The Next American Frontier*** advocates that the private employment sector, in collaboration with the public sector, is investing substantial resources in the human capital represented by their employees. Such investment takes the form of training and education, skill development, and a variety of traditional human services. Reich asserts that the private sector's investment in such services now equals about twenty percent of all government expenditures on social services. Further, such employer-based benefits and services are growing far more rapidly than traditional government sponsored social services, as they are coming to represent an even larger proportion of employee compensation.

Reich concludes that despite America's relative slowness in integrating its economic development and human development strategies, social services are to a substantial extent delivered via one's employment. It may be predicted that in the near future much of traditional "social service" will be provided by private and public employers to their own workers. The development and extension of employer-based disability management and rehabilitation as a service delivery

scheme is certainly consistent with this corporate policy trend.

Participation in research on disability management, as well as an awareness of related research and of the literature in the field, leads the authors to several conclusions. First, more empirical research is needed to supplement the many descriptive studies which currently dominate the literature. As mentioned earlier, there is a specific need for these studies to incorporate comparative data, including data derived from the use of control groups. Second, policy oriented research as well as experimental or quasi-experimental demonstration projects should be supported. Third, to enhance the relevance of current research in this area and its utilization it is essential that all user groups interested in disability management participate actively in the design, application, and dissemination of such research. Fourth, while the research sponsored by the federal government will no doubt contribute to the accumulation of knowledge in this area, the private sector, which has much to gain from disability management innovations, has a companion responsibility and should be urged to sponsor systematic, empirical research in the field. And finally, efforts need to be made to relate the results of disability management research to the improvement and relevance of both counselor education and professional in-service training.

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Managing Benefit Costs With Disability Claims Audits

BY RICHARD LEWIS

Disability costs are climbing and are ripe for improved control strategies.

DISABILITY REPORT

The problem of disability in the U.S. is great both in terms of cost and lost human potential. Social Security Administration (SSA) statistics indicate about 165 of every 1,000 working age adults are disabled. In 1981, the government and employers spent more than $70 billion in wage replacement programs for disabled workers and more than $100 billion in health care expenditures for them.

The majority of the disabled population falls into the 55 to 64 age bracket, a statistic which is important to employers with aging work forces. It also means that employers with high disability rates among predominantly younger work forces might examine more closely their disability administrative policies and management for possible problems. This also underscores the need employers have for detailed experience and trend information about their disability claims.

Clearly, disability costs are an area ripe for improved cost management and control strategies. Claims auditing is one technique that can be employed to evaluate all types of disability income programs, including sick leave, short- and long-term disability, disability retirement and workers' compensation programs, and to identify administrative and plan design opportunities for controlling costs. Although this approach has been used widely in cost management strategies for medical benefits, its application to disability cost monitoring is relatively new.

Ingredients of an Audit

Essentially, an audit of a selected group of disability claims involves an evaluation of benefit entitlement and initial adjudication, Social Security assistance, cost control and case management practices, management reports and calculation accuracy.

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An examination of benefit entitlement and initial adjudication determines whether a disability claims administrator promptly, efficiently and correctly developed specific cases so that accurate initial benefits determinations were made, candidates for rehabilitation identified and appropriate follow-up steps scheduled.

It is important in the audit to identify cases that were approved with incomplete or vague medical reports, cases in which rehabilitation opportunities were overlooked, and those where no specific follow-up actions were scheduled. Also, it is valuable to find out what the overall approval rate is from the administrator. If it is above 95 percent for initial approvals, and above 80 percent for cases over two years old, this may indicate that case development and follow-up are weak.

An administrator also is reponsible for informing claimants of their rights and benefits with respect to Social Security Disability Insurance (SSDI), and compliance with this duty should be checked. The auditor should determine if the administrator provides effective assistance to claimants seeking these benefits initially, and in instances where claimants decide to appeal denial of Social Security payments.

In the area of cost control, it should be ascertained that the administrator has effective procedures and controls for minimizing overpayments of disability benefits. The auditors should review how case durations are established, and on what basis independent medical examinations and investigations are arranged and scheduled. Also, it is very important to analyze how carefully plan limitations and exclusions are being administered.

For example, if a plan has a pre-existing condition clause, is the administrator properly investigating claims for disabilities which may have been incurred before the claimant was covered? Finally, the audits should determine if rehabilitation is used when possible, and that cases selected for rehabilitation are monitored regularly to make

sure positive results are being achieved.

Management reports also should be provided that effectively identify the costs of a disability benefits plan, both in total and by company subsidiary or division, if appropriate. Such reports must be flexible and responsive to an employer's information requirements for planning purposes.

For instance, an employer may be concerned about the incidence of cardiac related disabilities, in order to evaluate the need for a hypertension screening program. The reporting system of the administrator should be able to provide such a report by diagnosis, class of employee, age and company location on an as-needed basis.

Another important issue to be evaluated in the audit is benefit calculation accuracy, which involves accounting for individual claimants' offsetting benefits from other sources such as Social Security and workers' compensation, taxes and rehabilitation earnings, as well as any retroactive benefit awards and other adjustments.

Error rates in benefit calculations are highest where the administrator does not have an automated calculation system, and relies on disability adjusters to manually calculate benefits. Perhaps the biggest problem in this area is Social Security overpayments. This can happen when a claimant is denied benefits by Social Security, paid a full benefit by the administrator, then receives a retroactive Social Security award on appeal and does not notify the administrator. The audit should determine the types of controls the administrator has in place to minimize this, and also what the administrator's policies are on reimbursement.

The largest benefit accuracy study conducted recently was at the U.S. Railroad Retirement Board where a study of disability recipients revealed a computation determination error rate of over 25 percent. While many of these errors were minor, it indicates the seriousness of this aspect of a claims audit.

Disability Audit: The Basics

A disability audit contains three basic parts:

- A review of disability plan provisions, and the procedures and materials used in plan administration;
- A detailed audit of selected representative claims;
- Data tabulation and analysis.

The first part involves a review of manuals, forms

A Disability Audit Case Study

The following is an actual case study of how a claims audit was conducted for a major U.S. manufacturer of its long-term disability program. The employer was dissatisfied with the quality of service rendered by the insurance company which administered the program, as well as with increases in administrative costs and reserve requirements which had tripled over a three-year period. Thus, the employer decided to both self-fund, and self-administer all its long-term disability claims.

An independent review was requested to audit cases previously adjudicated by the insurance company. Specifically, the audit was to assess the accuracy of claim processing by the previous administrator and to provide technical assistance and develop procedures for the transition to in-house claim processing. Auditors also were to identify specific cases which represented high potential for obtaining Social Security assistance or for termination of benefits.

A detailed audit of approximately 500 long-term disability claims administered by the insurance company was undertaken, with emphasis being placed on benefits eligibility, medical and vocational documentation of disability, follow-up controls to verify employees' continued disability, Social Security status and rehabilitation potential. A list of major findings follows.

- The majority of files audited lacked regular, aggressive follow-up for updated medical substantiation of continued disability.
- No Social Security follow-up had been done after initial approval of Social Security Disability Income benefits. This is important, since the employer's plan language and the recent changes in the law provide for regular review of active claims by SSA.
- Files reflected very little use of on-site interviews with disabled employees and activity investigations.
- Rehabilitation referral and evaluation appeared sporadic and inconsistent.
- Files lacked organization and were not in chronological order, thereby creating confusion and potential claim handling errors.
- The insurance company did not provide assistance to claimants in obtaining Social Security benefits.
- Calculation errors identified had resulted in almost $9,700 in overpayments for disability.
- Numerous claims represented disability cases with potential for termination of benefits.

Disability case management improved as a result of the problems identified in the claims audit, and the employer's decision to self-administer the disability program. A reserve reduction led to savings in excess of $750,000, while the audit cost approximately $20,000. A variety of new controls were established including: use of specialized and diagnostic medical questionnaires that give more detailed information on which to base disability judgments; more rigorous and regular follow-ups of disabled employees; and development of a Social Security assistance package for claimants that includes instructions on how to apply for disability benefits, how to appeal Social Security decisions not to award benefits, and requirements for notifying the employer when retroactive Social Security payments or adjustments are received.

and policy statements used by the administrator. This informs the audit team of how the administrator intends to apply disability benefits, and also allows the auditors to evaluate whether or not the basic forms and procedures are adequate. For example, if the auditors find that there is no procedure for assisting claimants with SSDI, or that claimants are not required to sign an agreement to reimburse the employer for SSDI retroactive awards, this may indicate a generic rather than a case specific problem.

Once the background and materials review has been completed, and a sample of claims has been selected, the next part of the audit involves a detailed claim review. This process requires the audit team to essentially read-judicate the sample claims and note errors and exceptions. Since disability claims can be quite complex and open to judgment, it is important for the auditors to use a structured audit guide for consistency and documentation of their findings.

In the final portion of the audit, the data gathered is tabulated and analyzed. It is usually a sound practice to review specific case findings with the administrator. This gives the administrator an opportunity to respond to criticisms and also to gain insight concerning where there may be problems. Once this review has taken place, the final report is prepared, with tabulations and specific recommendations.

A detailed description of the specific steps in a disability claim audit follows. Such audits can be conducted by either in-house staff or specialized contractors, or a combination of both. The value of using in-house staff is one of cost and continuity; the value of using a contractor is one of expertise and independence. Average costs of using outside auditors vary by sample size, although the range is generally between $10,000 and $25,000. Average savings resulting from a disability claims audit exceed $1 million, including reserve savings. Regardless of whether the audit is done in-house or by an outsider, the audit team should be familiar with the mechanics of disability claims adjudication, and should have the medical and vocational expertise necessary to evaluate the claim administrators' methods, materials and decisions.

The audit itself, which is normally conducted at the administrators' location, includes seven steps.

Step 1: Review initial claim submittal procedures. The first step in the disability claim process is claim submittal. The auditor will check each sample claim to make sure that eligibility was properly verified, that claim forms were completed, and that required job information was provided. Each exception or error will be noted and documented. Problems in initial claims submittal, such as payments made to ineligible employees, can create delays in payment which cause employee hardship.

Step 2: Analysis of initial adjudication. In this step, the claims examiner has reviewed the evidence submitted, and has made a decision to approve or deny the claim. The auditor must determine whether the decision was correct, incorrect or questionable. This will require an analysis of the data provided on the claim form, the supporting medical and vocational documentation, and the steps taken by the claims examiner to develop a complete case file. In addition, the auditor will evaluate factors such as processing turnaround time, response to claimant inquiries, and handling of denials and appeals. This step of the audit is critical, since it will provide a strong indicator of how accurately claims are being initially adjudicated. Weaknesses here will significantly affect long-term costs, and usually indicate overall problems in procedures, control and policy.

Step 3: Calculation of Benefits. During the review of the sample files, calculations of benefits will be reviewed and recalculated. The auditor will check to see if benefit offsets were properly determined and applied, if overpayments were noted and proper adjustments made, and if accurate earnings data have been provided by the employer. This step provides the employer with a good indication of the adequacy of the administrators' internal financial and quality controls.

"Error rates in benefit calculations are highest where the administrator does not have an automated calculation system, and relies on disability adjusters to manually calculate benefits. Perhaps the biggest problem in this area is Social Security overpayments."

Step 4: Social Security Disability Benefits. Almost all long-term disability benefit plans offset payments for SSDI benefits. Thus, it is extremely important in controlling costs that the administrator help claimants obtain SSDI benefits. In this step of the audit, the auditor will review what initial assistance has been provided to the claimant in filing for benefits and what follow-up assistance and support has been provided in appealing denials. The auditor will also evaluate the administrator's knowledge and awareness of Social Security standards and practices. If the audit reveals weak Social Security knowledge and claimant assistance, it is almost certain that the benefit plans costs are higher than they need be, both in terms of ongoing payments and reserves.

Step 5: Administration of Plan Provisions. Before the onsight audit, the audit team will familiarize itself with the provisions of the employer's plan. In the audit, it will analyze how rigorously these provisions are being applied. Examples of key provisions that should be checked include pre-existing conditions, and exclusions or limitations for mental and nervous conditions, and for self-inflicted injuries. In addition, the auditor will review benefit terminations and denials, to make sure these are being handled in accordance with the plan. The importance of this part of the audit is twofold. Improper administration

of plan provisions increase benefit costs; improper or inconsistent administration can expose the employer to litigation.

"It is . . . sound practice to review specific case findings with the administrator. This gives the administrator an opportunity to respond to criticisms and also to gain insight concerning where there may be problems. Once this review has taken place, the final report is prepared . . . ."

Step 6: Follow-up and Ongoing Claim Verification. Even if a claim is initially adjudicated properly, it requires ongoing review and verification. The audit team will analyze a sample of claims to determine if there is medical documentation in the file to support the continuance of disability payments, that the employee is under the regular care of a qualified physician, and that the employee has not returned to work. Also, the audit will evaluate the administrator's use of independent medical examiners and investigators, particularly in continuing to approve cases which are for "soft" conditions, or if the plan changes from an "own occupation" to an "any occupation" definition of disability. Good follow-up and case management help reduce long-term costs and can also be a positive factor in employee relations.

Step 7: Rehabilitation. The final step in the audit process will be to review cases in which rehabilitation has been, or could have been used. This technique can be very useful in helping employees return to productive employment, although it must be used very selectively because of its expense. The audit team will also analyze how well the administrator controls rehabilitation cases, to insure that the administrator is achieving plan results that are cost-effective.

Uses of Audit Information

The information gathered in disability claim audits can be used to evaluate both short- and long-term disability benefit or disability retirement programs. The structure and elements of such programs are similar and require comparable analytic approaches. In many cases, given the interrelationship between short- and long-term disability programs, it is helpful to audit both simultaneously to make sure that an employer's entire disability process is being properly controlled.

One of the essential tools in conducting an audit is a structured and detailed audit guide. A good example is a standard form with a check list for essential information such as physician statements, Social Security awards and findings of overpayments. Using this type of format ensures that auditors will be consistent in their program evaluation and will provide clear documentation of any exceptions noted in their review. A structured audit also provides for consistency of auditing practices over time.

Another key element to a successful rigorous audit is sample selection. Normally, a single employer's volume of disability cases is relatively small compared to the volume of medical or dental benefit claims. Thus, the best approach might be to select a structured sample of disability claims which represent situations with high potential for benefit miscalculations and possible cost savings. Claims falling into this category include: those filed by younger employees (under age 40); large claims, either in terms of total exposure or monthly benefits; claims involving "soft" or subjective diagnoses, such as back pain, or mental-nervous conditions; and disability cases in which Social Security benefits have not been approved.

For long-term disability plans, it is usually most effective to audit all such cases initially then to select additional cases for a second audit based on these findings. For short-term disability plans, a statistical sample of cases at the ±5 percent error rate factor is usually adequate.

"One of the essential tools in conducting an audit is a structured and detailed audit guide. A good example is a standard form with a check list for essential information such as physician statements, Social Security awards and findings of overpayments. Using this type of format ensures that auditors will be consistent in their program evaluation and will provide clear documentation of any exceptions noted in their review."

A disability claims audit illustrates in a very practical way how specific data can lead to improved cost and administrative controls for employers (see box). An audit not only helps reduce benefit abuse, but also can lead to an improved use of tools such as rehabilitation and limited duty programs. The key is for employers not to relinquish control of these programs to their disability claims administrator. This will inevitably lead to higher and higher costs. Employers must use tools such as the claim audit to enforce quality performance by their administrators. ■

The Quest to Manage Mental Health Costs

BY SEAN SULLIVAN, THERESA J. FLYNN AND MARION EIN LEWIN

Providing care will save employers money, but review, other controls must be in place.

MENTAL HEALTH REPORT

Mental health problems, along with alcohol and drug abuse, represent a significant share of employees' use of medical services. These problems are getting more attention as employers consider how they affect productivity as well as health care costs.

Although estimates of the costs of treating mental illness and chemical dependency vary with the scope of coverage and the way such costs are measured, they may reach 25 percent of total health care outlays. Concern about these costs is prompting companies to consider how they might redesign mental health benefits to promote more cost-effective and appropriate delivery of needed services. Thus, corporate managers and mental health providers have begun to discuss new ways to organize and finance mental health care.

Corporate and provider perspectives are being shared in forums such as a recent symposium at the American Enterprise Institute's Center for Health Policy Research. There, corporate health care managers and providers of mental health services met for the purpose of framing the critical issues facing both parties and for considering possible approaches to resolving them. Analysis of data on their employees' utilization is starting to give employers the same knowledge about the costs and efficacy of mental health services that they have for medical and surgical services.

Compared with general medical and surgical care, mental health services traditionally have been less well insured because employers have been skeptical of their effectiveness. The costs and benefits of mental health care are more difficult to measure than those of medical and surgical interventions largely because the definitions of mental illness and the goals of treatment programs are considerably more subjective. Lacking good data on the cost-effectiveness of mental health care, companies have tended to avoid offering liberal benefits for fear of creating a demand for services of questionable value.

Moreover, a recent American Psychiatric Association survey of major private employers found an erosion of mental health benefits between 1981 and 1984. Fewer plans had inpatient coverage equivalent to that for general medical conditions (48 percent vs. 58 percent earlier), fewer had the same dollar maximum for mental health care (31 percent vs. 39 percent) and fewer covered psychologists (29 percent vs. 36 percent). Interestingly, though, more plans covered treatment of alcoholism (61 percent vs. 38 percent) in 1984 than in 1981.

Supply and Demand for Services

Historically, mental health has been outside the mainstream of medical care in both its financing and delivery. Services traditionally have been provided in psychiatrists' offices or special hospitals, thereby identifying the recipients as mental patients. Now, corporate employee assistance plans provide for mental health care, as do health maintenance organizations (HMOs) and general hospitals. Mental health is thus beginning to lose some of the stigma attached to it. The general movement toward holistic health care should further increase its acceptance into the mainstream of medical practice, which, in turn, should give mental health providers the chance to prove their effectiveness.

The lessening stigma attached to mental illness is one factor making people more willing to seek mental health care. Moreover, stress brought on by work, family breakdowns and economic pressures has contributed to employees' seeking professional help. Alcohol and drug abuse, in particular, are increasingly serious problems among employees. A study done by the Research Triangle Institute for the Alcohol, Drug Abuse and Mental Health Administration concluded that 10 percent of the nation's work force is impaired by alcohol abuse, accounting for costs equal to nearly

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2 percent of the gross national product in 1980.

Effective demand also has increased as a result of the proliferation of mandated benefit laws. Twenty-nine states now require insurance companies to offer certain minimum benefits covering the treatment of mental illness. Thirty-six states require that insurance plans either include coverage for treatment of alcohol and substance abuse or offer it as an option.

Important changes also have been occurring on the supply side of mental health care. Twenty years ago the state mental hospital was the primary treatment setting. The number of beds in these institutions has been reduced substantially, and more of this inpatient care now is being delivered in general purpose hospitals with or without special psychiatric units. This is becoming even more common because the exemption of psychiatric care from Medicare's prospective payment system (PPS) is prompting acute care hospitals to convert empty medical and surgical beds to psychiatric or alcohol and drug rehabilitation beds. This practice is increasing, moreover, as expiration of certificate-of-need laws in many states is removing a large impediment to bed expansion.

At the same time, the number of private psychiatric hospitals has risen from 180 in 1970 to nearly 250 in 1985. As psychiatric care facilities and units remain exempt from diagnosis related groups (DRGs) under Medicare, the field is attracting attention within the health care industry as a potential profit making venture. The number of psychiatric beds owned and operated by investor owned hospital chains, for example, increased by about 15 percent in 1984.

Facilities that traditionally offered only inpatient care are expanding to include outpatient services, such as home care and community based treatment. Moreover, the number of providers that offer outpatient care are growing dramatically. These include psychologists and social workers who are competing with psychiatrists for limited mental health care dollars.

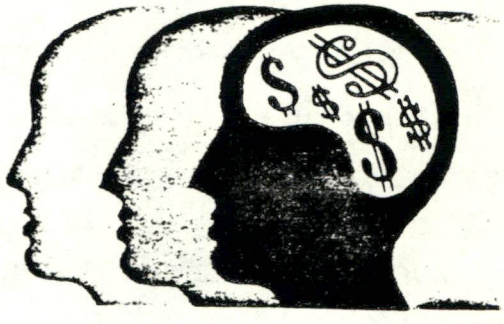
Opening up the system by adding coverage for supposedly lower cost alternative providers, however, does not necessarily drive down the cost of care. The experience at the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), for example, showed that payments to psychiatric social workers tended to rise to, or even above, parity with those of psychiatrists and psychologists. A better strategy for promoting cost-effective care through the use of alternative providers may be to negotiate a price with selected or preferred ones.

Since employers want to improve their employees' productivity as well as cut their medical care costs, they have a built-in incentive for developing a more cost-effective way to finance and deliver mental health care. Corporate managers are seeing a potential for mental health care to reduce time lost from work because of disability, as well as to make individuals more productive when they are on the job.

Importance of Data

Employers need data to tell them where their mental health dollars are being spent and what results they are getting from those expenditures. Data analysis is a promising tool for identifying opportunities to redesign benefits and, thereby, to improve the allocation of resources to mental health treatments.

By hiring health data experts to analyze their extensive claims files, employers are opening up new avenues for improving their management of mental health benefits. Mental health problems develop over time and do not fit neatly into discrete episodes in the way that many medical or surgical problems do. Employers need longitudinal data that can give a more accurate picture of most psychiatric disorders. For example, the Health Data Institute (HDI) in Lexington, Mass., used longitudinal claims files from a major auto company to develop criteria to classify employees as definite, probable or possible alcoholics. HDI then was able to estimate the total costs of alcoholism, which turned out to be four-to-six times greater than the reported costs of treating alcoholism itself, when medical as well as mental health costs were considered. Further, the data showed that it was costlier not to treat workers with alcohol abuse problems. Alcoholics who were not being treated cost their company 50 percent more for medical care than those who were.



HDI's analysis also revealed enormous differences in rates of recidivism experienced by treatment programs. Some providers treating severe alcoholics had much lower readmission rates than others taking care of less serious cases. Thus, longitudinal data analysis not only helps measure true costs, but also can help identify differences in providers' performance for certain conditions and treatments.

Availability of data is raising anew the basic questions of what kinds of and how much mental health care employers should buy. Coverage of inpatient care historically has been more generous than that of outpatient care, which tends to encourage costlier hospital care even when it is inappropriate. Outpatient care often is more effective as well as less costly, but the recognition that too much is being spent on inpatient care has not yet caused much of a shift to outpatient settings. As employers increasingly offer incentives for outpatient use, more of a shift from outpatient care can be expected.

Ways to Provide, Manage Care

Employers face a challenge in finding the best ways to provide mental health care, given the variety of delivery settings and the need to guard against excessive or inappropriate use of services. A company should start by defining what it hopes to achieve in providing mental health benefits to its employees. Similarly, providers can help employers choose the best ways to cover their employees' mental health care by becoming more aware of corporate objectives and working to help meet them. Companies want to buy smart;

providers must understand and respond to this newly expressed desire.

At the same time, many employers are just becoming aware of their new role as active purchasers of care. They need to be educated about the issues in delivery of mental health services so they can ask the right questions when purchasing them.

Employers should maintain a continuous interaction with providers to better understand their services and oversee the provision of those services to employees. A few companies are starting to link in-house case management with changes in benefit design to control employees' use of mental health services. Studies of employers' data show that a relatively few individuals usually account for most of a company's mental health care costs. Case management can be used to target these high cost users and control unnecessary use.

Honeywell Inc., for example, is implementing a managed care pilot program this year at four company test sites around the country. The company is giving fixed budgets to managers of its employee assistance plans (EAPS) at these sites. Each manager has a trust account, out of which the costs of all mental health services must be met. The case managers are free to decide how to allocate the funds to medical and nonmedical outpatient services and for chemical dependency treatments in freestanding facilities. Honeywell believes this approach is more appropriate and effective than putting arbitrary limits on coverage, and preferable to giving a third party control over the cost and duration of services.

"A few companies are starting to link in-house case management with changes in benefit design to control employees' use of mental health services. . . . Case management can be used to target . . . high cost users. . . ."

The way in which a company conceives of case management will depend on its particular objectives in providing mental health benefits and on its corporate values. For example, FMC Corporation assigns a psychiatric case manager to every patient who has a mental health related disability. The overall purpose is to return the employee to productive work by encouraging compliance with treatment regimens, building family supports and informing psychiatrists about the patient's home and work environments.

Providers can encourage employers to become involved in an employee's care along with the employee's immediate supervisor and family. Ameritrust's absenteeism control protocol, for example, specifies that the supervisor call the employee's home the first day of an unauthorized absence to find out if a personal or family problem needs to be addressed. The company wants to get the employee back on the job or the family member taken care of. It actively seeks to identify potential problems through its EAP, its front line supervisors or employees, themselves. When a problem becomes disciplinary, the employee is required to see an EAP counselor.

Corporate health care managers want providers to help develop criteria to evaluate outside case management organizations. Professional case management services can be judged by their intensity (frequency and specificity) and their comprehensiveness.

The case manager can have several roles. The first is managing health care use, which requires understanding the services that are medically and psychologically necessary as well as knowing trends in use of services by the mentally ill. Another role is that of patient or family advocate, a broker who can help organize care and actively intervene when the system is breaking down. A third role is to facilitate relationships with the patient's employer. Finally, the case manager can act as a consultant to the providers rendering care.

Providers have begun to adopt widely such techniques as preadmission screening and concurrent review of hospital stays to ensure both cost-effectiveness and quality. Mental health presents special problems to designers of review mechanisms because the benefits from treatments are more difficult to measure. But improved methods of data analysis are helping to create standards for judging the necessity of hospitalization and appropriateness of alternative treatments for psychiatric disorders. One day there may be generally accepted definitions of necessary and unnecessary care, especially for those patients who are not severely ill but whose ability to function is impaired.

Mental health providers, because of questions about the legitimacy of mental health treatments in the first place, are acutely aware of the need to establish their accountability. Both the American Psychiatric Association and American Psychological Association have developed peer review programs. The former also conducts peer review for private insurance carriers. Despite providers' efforts to develop better measures of appropriateness, though, some employers remain skeptical about peer review, which they see as almost invariably ratifying practices that themselves may be unnecessarily costly or even inappropriate.

Employers are looking for a set of objective measures to determine whether a provider is medically effective as well as cost-effective. On the other hand, providers are concerned that what employers consider to be cost-effective treatment may not yield quality care. How quality is defined will affect what both employers and providers are trying to achieve. At a minimum, it might mean the avoidance of negative outcomes from treatment, which is the concern of most current quality assurance activities. Going a step further, quality can be defined more positively as reducing disability by alleviating the problem being treated. Beyond this, it can consist of improving the quality of the patient's life.

Historically, the decision of what constitutes quality has been made by providers. Given the trends that have led to a buyers' market for health care, however, the decision increasingly will be purchasers' to make. It is important that purchasers and providers together reach a working agree-

ment on what constitutes effective care.

Quality assurance and efforts to review use of services may not always lower mental health costs. In fact, they can increase employers' expenditures for mental health care. Still, companies may want to spend more on psychiatric counseling and treatment for drug abuse because such care can reduce the need for costly medical and surgical services.

Prospective Payment of Mental Health Care

Several issues surround the inclusion of psychiatric hospitals and alcohol and drug abuse treatment centers and units in Medicare's PPS. These issues are relevant to private insurers and employers as they consider prepayment for inpatient psychiatric care and chemical dependency treatments.

Studies commissioned by the National Association of Private Psychiatric Hospitals (NAPPH) and the American Psychiatric Association both found that DRGs are not an appropriate payment mechanism for psychiatric hospitals. The NAPPH study recommends that some hospital specific costs be included in a prospective payment system to account for variations in patient populations and treatment modalities.

"Employers are looking for . . . objective measures to determine whether a provider is medically- . . . as well as cost-effective. . . . Providers are concerned that what employers consider to be cost-effective treatment may not yield quality care."

Data from these studies also suggest that applying DRGs to psychiatric units in general hospitals will cause costly patients to be shifted to state mental hospitals.

Although these studies underscore the difficulty of establishing an acceptable basis for a prospective payment system, the current exemption of psychiatric care from Medicare's PPS has sharpened the focus of attention on the financing of mental health care. As a result, providers are being challenged to justify their allocation of resources for treating mental illness. Ultimately, they ought to help develop a pricing system that accommodates the wide range of methods for diagnosing and treating psychiatric problems. Failure to develop such a system may lead to increasing regulatory pressure on providers to standardize their practice patterns.

The first step in trying to move to a prospective payment system is to define the product, as DRGs have done for inpatient surgical procedures under Medicare. Prospective payment has forced providers to get into the product costing business. In mental health they have yet to define the product, although they are beginning to make some progress in this regard.

Efforts also are being made to develop objective instruments for assessing a patient's need. Researchers are experimenting with a clinically based system of classification that could provide a standardized gauge of the level of care required. Such a tool would help both providers and payers place patients in categories based on their health status and resource needs, thereby facilitating case management of services. Criteria that predict the kinds of patients likely to respond to particular treatments also are being tested and refined. By establishing standards that providers can use to predict the care that patients will require, these techniques may enable them to assume some degree of financial risk for providing mental health services.

The Challenge for Employers

Some of the concerns about prospective payment for mental health services — specifically, that it creates incentives to underserve — already are evident with respect to HMOs. Ameritrust surveyed its employees and found that many of those enrolled in HMOs perceived a lag in the provision of mental health care. The company decided to get more involved in mental health through its EAP, and persuaded the largest HMO serving its employees to expand benefits for occupational rehabilitation and alcohol detoxification. Ameritrust also is seeking to establish preferred provider arrangements for delivery of mental health services.

As employers encourage their employees to seek help for drug and alcohol abuse problems, HMOs are experiencing increased demand for chemical dependency services and for psychiatric care generally. In the past, HMOs let enrollees obtain care from outside providers who then billed the HMO on a fee-for-service basis. Now, in response to this increased demand, HMOs are trying to control costs by paying groups of providers flat fees for taking care of their enrollees' mental health needs.

Some providers are showing enthusiasm for prepaid capitation because it offers a framework for negotiating with purchasers that current insurance models, with their specific limits and caps, do not allow. Capitation models offer providers and employers flexibility in designing appropriate delivery systems for mental health services. The example cited of a company negotiating with an HMO for expanded benefits shows the kind of opportunity available for interaction between employers and providers.

More employers are realizing that it can be very costly not to offer their employees adequate mental health benefits. Given the need to provide some level of coverage, employers must decide which services to reimburse and the extent to which they should be covered. The diversity of the delivery system for mental health care makes this decision difficult. Mental health services include long-term care for chronic illness, short-term therapy for milder emotional problems, and detoxification and rehabilitation programs for chemical dependency cases. Each type of care now is being delivered in a variety of inpatient and outpatient settings and by a growing array of alternative providers. The challenge for employers is to design a better fit between the delivery and financing of mental health care, considering these alternative providers and treatment settings. ■

WASHINGTON FILE

Disability payment reforms in public, private sectors focus on return to work.

By Cathy Amkraut

The quiet reform taking place regarding disability policy and work is resulting in rational, incremental change. This reform is happening in both the public and private sectors and as usual the interplay between the two is critical.

Of the multitude of disability programs, two federal programs swept up in this metamorphosis are Social Security Disability Income (SSDI) and Supplemental Security Income (SSI).

SSDI is a Social Security Administration (SSA) program established to provide income and, after a period of 24 months, medical benefits to those determined to be unable to work. In 1980, this $17 billion per year program was providing benefits to 4.7 million disabled workers and dependents. At that time, the cases of some 150,000 beneficiaries were reviewed annually. Congress mandated SSA to do a more rigorous review process in 1980, and between 1981 and March 1984 more than 1.1 million cases were reviewed and 485,000 initial notices of termination were sent out. National attention was drawn to the plight of hundreds of thousands of disabled individuals who were told that their major and in some cases only source of income was about to end. After a lengthy and costly appeals process, about one-half were reinstated.

Return-to-Work Incentives

These determinations had direct cost implications for employers who use SSDI to offset long-term disability benefits. If an employee receives long-term disability and is denied or cut off from SSDI, the employer must absorb the total disability benefit cost. For example, if SSDI provides $500 a month, a long-term disability plan would save $60,000 over a 10-year period with an offset. Given this, some employers provide assistance to disabled employees in applying and/or appealing SSDI determinations.

Congress got into the act and passed the Social Security Disability Reform Act in October 1984 to set new standards for disability benefits determination and the termination process. The following year, the SSA developed new guidelines for the assessment of medical improvement, mental disability and chronic pain impairment. These guidelines broke new ground particularly in the area of mental health where functional issues such as the ability to work were included as part of the evaluation.

Continuing on this reform track are efforts by Rep. Steve Bartlett (R.-Tex.), ranking minority member of the House Education and Labor Subcommittee on Select Education, to address work disincentives built into the SSDI system. Currently, beneficiaries often have more to lose financially from going back to work than continuing with their benefits.

Bartletts' motivation comes from his success in SSI reform. SSI, or title XVI of the Social Security program, provides income maintenance payments to aged, blind and disabled persons who never worked. Section 1619 of the program was authorized in 1980 as a demonstration to allow SSI recipients who could work to do so by securing their health benefits through Medicaid and reducing but not terminating their income benefits. Last year, legislation was passed making Section 1619 a permanent part of the SSI program.

Also advancing the cause of the disabled at work, the 1986 Tax Reform Act allows employers to take a tax credit for a percentage of wages paid to special groups, including the disabled, and makes permanent a deduction of up to $35,000 to employers for expenses incurred to make facilities accessible to the elderly and disabled.

On the state level, many workers' compensation reforms are aimed at return to work for injured beneficiaries. More than 30 states have established second-injury funds to pay for the difference in liability between hiring an already injured worker and a disabled one. Rehabilitation benefits are provided in all states but are mandatory in relatively few. In some states and the District of Columbia, benefits to the injured party are contingent on "reasonable cooperation" with rehabilitation efforts provided by employers. Several states, including Florida, Louisiana, Michigan, New York and Pennsylvania, have enacted wage-loss systems under workers' compensation in which benefits are awarded based on actual loss of wages rather than degree of impairment. Such an approach encourages employer rehabilitation efforts and dissuades overcompensation for those partially disabled who can work.

Private Sector Response

Expensive long-term disability claims are attracting increasing scrutiny by employers. In a recent survey of 400 corporations, the Institute of Rehabilitation and Disability Management (IRDM) of the Washington Business Group on Health and the National Rehabilitation Hospital found that 68 percent of the companies track these high cost health claims. The cost of a chronically ill or disabled employee shows up not only on the health budget but also in absenteeism, lost productivity, training, retraining and increased turnover. Other findings show that the majority of large employers provide reimbursement for rehabilitation.

However, only 28 percent cover vocational rehabilitation and only 15 percent have mandatory rehabilitation in their long-term disability policies. Disability research clearly shows that the sooner rehabilitation begins after a traumatic injury or illness, the more likely a person is to return to work. The disability leave portion — up to 26 weeks — of the recently reintroduced Parental and Medical Leave Act may inhibit the ultimate goal of disability advocates and employers to create incentives for early return to work even if only in a modified capacity.

Whether it is in the public or private sectors, the goals of employment are driving U.S. disability policy toward a reform that recognizes the inherent attributes of all persons, regardless of disability, to remain in the work force. ■

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Work Place Safety: Present Costs, Future Trends

BY RICHARD B. VICTOR

Employers can stem cost of worker injury through prevention, claims validation.

OCCUPATIONAL HEALTH REPORT

More than eight million U.S. workers will be injured on the job this year, with a consequent loss of more than 62 million work days. Fortunately, most injuries are minor, causing little time off the job. However, a substantial number result in some permanent disability, and a small number are fatal.

The economic consequences of the occupational health and safety problem in the U.S. are significant. Employers lose the services of valued workers and may incur the substantial costs of recruiting and training replacements. In addition, productivity is lost when the work place is disrupted by an accident, and repair costs are incurred from expensive equipment damaged as part of that accident.

As for employees, disabled workers lose wages and their employers provide them with medical treatment, rehabilitation and partial wage replacement under workers' compensation laws. Workers' compensation alone will cost employers over $30 billion in 1985, and the aggregate cost to employers of work place injuries will surpass $100 billion.

Injury Facts and Figures

The risk of injury and the consequent costs vary widely across industries. Jobs in manufacturing and construction are the most hazardous, while those in the service industries are typically safest (see Table 1).

Over the past decade, the risk of injury has declined noticeably from 11.0 to 7.6 injuries per 100 workers. Some of the decline is the result of a secular trend — greater efforts on the part of employers and their insurers, the advent of the Occupational Health and Safety Administration (OSHA), a shift from the older factories of the Snowbelt to the newer factories of the Sunbelt, and the rapid growth of the relatively safe service sector accompanied by the slower growth or decline of more hazardous manufacturing industries. Preliminary analysis shows that these trends have combined to reduce the aggregate injury rate by about 2.3 injuries per 100 workers, or over two million injuries in 1985 as compared to conditions in 1973.[1]

Much of the rest of the decline has to do with how injury rates fluctuate over the business cycle (see Figure I). When business is booming, injury rates rise. Inexperienced workers are hired and "rusty" employees recalled from layoff. Others are transferred into new jobs. And increasing numbers of employees work overtime. In such cases, workers are more injury prone. For example, 40 percent of all injuries occur during a worker's first year on the job.[2] Also, as business activity expands, older, less efficient plants and equipment are recalled into use, which may contribute to the increase in injuries.

The reverse occurs as business activity slumps in a recession. Less experienced workers are laid off, overtime is reduced, fewer new workers are hired, fewer job changes are made, and older plants and equipment are shut down. Moreover, with jobs relatively scarce, workers may be more careful so as not to have their employment interrupted and their security threatened. All of these factors combine to reduce injury rates during an economic downturn.

More than half of all injuries are minor, necessitating no lost work time apart from the day of the injury. Nevertheless, the average lost time from injury lasts from about 15 to 17 days. This has not changed significantly over the past decade, except over the course of the business cycle. Evidence suggests that during the growth phase of the cycle, average disability duration declines, while during the contraction phase of the cycle, average duration lengthens. This results from an increase in minor injuries during the expansion phase.

The most frequent types of injuries involve strains

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and sprains, cuts, contusions and fractures. Collectively, these account for more than 80 percent of all injuries. Of conditions requiring hospitalization, back problems are by far the most frequent accounting for nearly one-third of all hospitalizations. Together with back injuries, hernias, knee and hand surgery account for more than half of all hospitalization for work related injuries (see Table II).

The Role of Workers' Compensation

Looming large among the costs to employers are statutorily mandated workers' compensation costs. Workers' compensation systems are the disabled workers' social safety net. These systems have their historic roots in Bismarck's Germany and came into existence in this country during the first quarter of the 20th century. They are principally creatures of state law, although the federal government has singled out certain groups, for example, longshoremen and federal employees, for federal workers' compensation programs.

TABLE I
Injury Rates, By Industry
1983

Industry	Total Cases	Lost Work-Day Cases	Average Duration of Disability
All Industries	7.6	3.4	17.2
Mining	8.4	4.5	27.8
Construction	14.8	6.3	18.7
Manufacturing	10.0	4.3	17.0
Wholesale/Retail	7.2	3.1	15.4
Service	5.1	2.4	15.4

Source: Bureau of Labor Statistics

These safety nets typically provide workers who suffer job related injuries with all necessary medical treatment — with no deductible or copayment — and two-thirds of the workers' wage loss. Since this income replacement is tax free, workers' compensation systems replace 80 to 100 percent of a disabled worker's take-home pay for most disabilities.[3]

Workers' compensation costs will exceed $30 billion this year, skyrocketing more than 600 percent from less than $5 billion in 1970 (see Figure II). This rapid escalation can be explained, in part, by general inflation and the growth in employment during the period. However, a significant contributor to this surge in costs has been major changes in benefits, the legal structure and administrative practices of workers' compensation systems in most states. Enhancement in benefits alone, which occurred as part of major reform efforts in most states during the 1970s, resulted in cost increases (as a percentage of payroll, thus controlling for inflation and employment growth) of 71 percent during the decade as compared to a 17 percent increase during the prior decade.

Medical costs soaring above the general rate of inflation also have contributed to the growth in workers' compensation costs. Medical costs are typically 30 percent to 40 percent of all benefit payments. Rising rates of litigation have driven costs further upward. The California Workers' Compensation Institute reports that annual litigation costs in the state exceeded $500 million in 1983.

Cost Containment Strategies

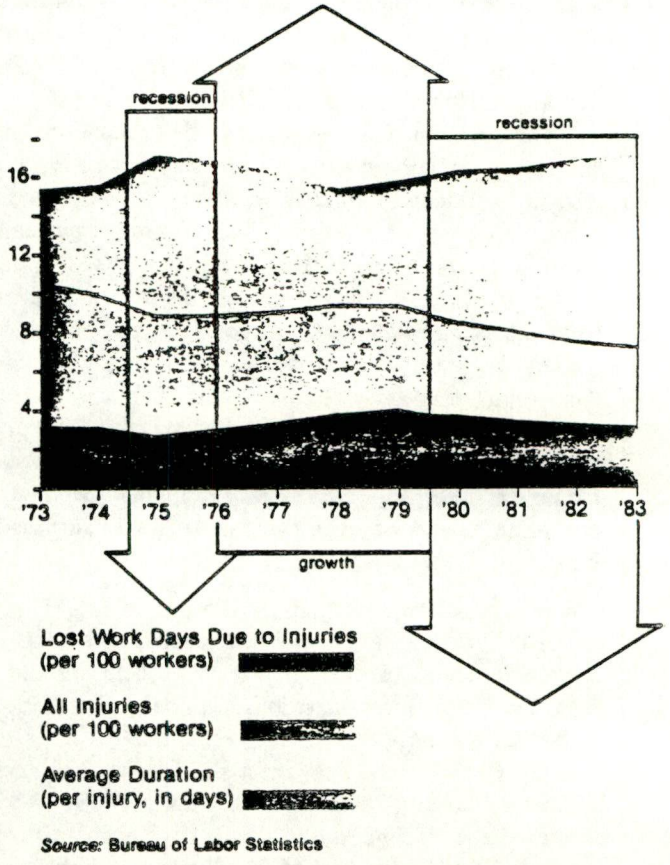
Three general strategies are available to employers to stem the significant growth of injury and workers' compensation costs: prevention; improved claim administration; and legislative and administrative reform to improve workers' compensation systems. An effective cost containment strategy should employ each in an appropriate balance.

Prevention, particularly through regular worksite inspections, is the first line of defense in a cost containment strategy. This can be done by trained safety professionals employed by the company, by consultants or by the company's insurer. Typically, a large insurer conducts more inspections annually than does OSHA. Senior level supervisors also can be trained to conduct basic safety audits.

Education is another key to a successful prevention program. Employees should be instructed and periodically reminded how to do their job safely, for example, by using proper lifting techniques or the importance of wearing hearing protection or safety goggles.

Figure I

Cyclical Variation in Injury Rates 1973 to 1983



Source: Bureau of Labor Statistics

Testing and screening also can be important. Preemployment identification of employees who are vulnerable to certain work place hazards, such as heavy lifting, dusts or chemicals, may spare the worker an injury or illness, and the employer the consequent costs. And regular testing of workers exposed to certain chemicals, dusts or high

levels of noise can help detect a problem in its early stages.

Once an injury has occurred and a workers' compensation claim filed, effective claims administration can help to control the ultimate cost of the injury. Early and accurate determination of the validity of a worker's claim as well as payment of first benefits is the best cost containment device available. It assures fair treatment of the worker, provides for appropriate medical care and rehabilitation, and reduces the likelihood the worker will seek legal assistance, which could escalate the dispute and increase litigation and other costs of the claim.

TABLE II

Hospitalizations for Work Related Injuries, Most Common Medical Problems Massachusetts, 1982 to 1983

Medical Problem	Number	Percent of Cases	Percent of Days Hospitalized
Hernias	1,247	8.8	6.2
Back (surgery)	1,170	8.3	14.4
Back (medical)	3,499	24.8	26.1
Knee (surgery)	1,039	7.4	5.5
Hand (surgery)	580	4.1	1.9
Total	7,535	53.4	54.1

Source: Massachusetts Health Data Consortium

Timely return to work can be facilitated by making available light or limited duty jobs to employees who would like to return to work, but presently are unable to perform the more demanding duties of their previous positions. Unfortunately, timely return to work can be obstructed by the lack of coordination among the various benefit programs provided by the employer or purchased by the employee. The most significant in this regard is disability insurance. Most employer paid disability insurance policies acknowledge that workers' compensation benefits takes precedence in covering work related disabilities. They provide dollar-for-dollar offsets against the workers' compensation payments. But in some cases, employer paid disability insurance and workers' compensation are not coordinated in this manner. One large Boston bank, for example, generously provided their employees with disability insurance with no offset. When a junior accountant slipped on a stairway and injured his back, the bank's workers' compensation insurer found the accountant was eligible to receive benefits under both policies that, in combination, replaced 175 percent of his take-home pay. An improved coordination of the benefit package could have provided stronger incentives to return to work.

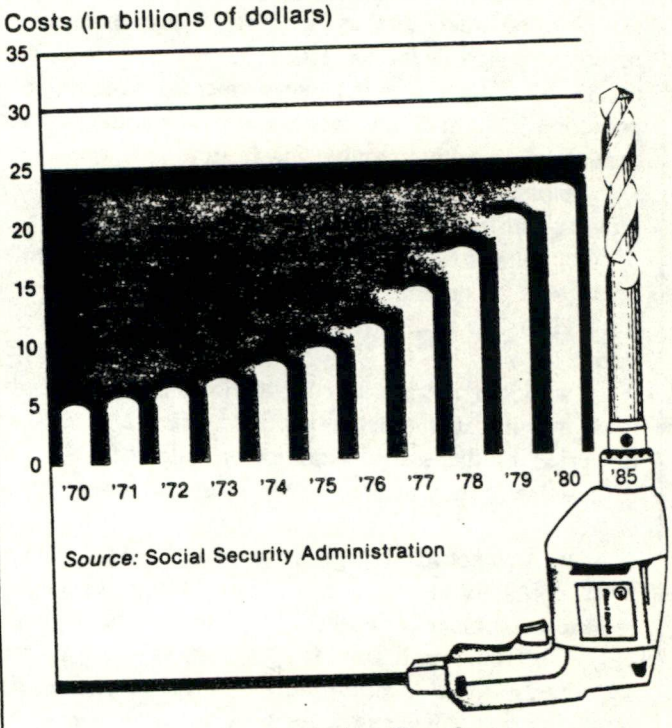
Disability insurance policies purchased by employees outside of their employment typically do not provide for workers' compensation offsets. If such a policy replaces half of a worker's gross pay, the combination of workers' compensation benefits and the disability benefits would replace more than 150 percent of the take-home pay for most full-time employees. Employers cannot control the purchase of private insurance by employees, but clearly the uncoordinated feature of these policies dilutes the incentive to return promptly to work.

Even an effective claims administration program can only do so much because it must take as given the legal rules and administrative practices of the workers' compensation system. Each year, more than a dozen states establish study commissions to recommend major reforms of their systems. Yet absent good information as the basis for improving the system, policy makers too often are left to rely on anecdote, emotion, raw political forces and conflicting information presented by adversaries in the political process.

Thinking about the three pillars of a cost containment strategy as a whole, employers invest substantial sums in prevention and claims administration programs, but little or nothing in research to provide policy makers with the information needed to improve the system. Yet the decisions about the rules of the system have a direct impact on their costs. To help address this oversight, the Workers' Compensation Research Institute was established last year by employers and insurers to provide objective information about the major public policy issues facing workers' compensation systems.

Figure II

Growth of Workers' Compensation Costs 1970 to 1985



The Coming Decade

The costs of industrial injuries and workers' compensation systems during the next decade will be shaped by current and future legal developments, trends in medical costs, and several key socioeconomic and demographic trends. Much has been written about the related legal and cost containment issues. The following discussion, based in part on a 1982 Rand Corporation study, focuses on the consequences that socioeconomic and demographic trends are having and will have on injury rates and

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workers' compensation systems.[4]

The postwar baby boom is a dominant force that has shaped many of the features of the social, political and economic scene in the U.S. during the past 35 years. Much like a snake swallowing a large mouse, as the baby boom generation ages, and the society and economy tries to digest it, the oversized cohort spawns major changes in social and economic institutions. The subsequent baby bust will have a major impact, as well.

What does this mean for future injury rates and workers' compensation costs?

First, as the large baby boom generation ages and is replaced in the labor force by a smaller, younger cohort, it means that the labor force is aging relatively rapidly. Twenty years ago, 1 in 10 workers was between 50 and 65 years old. In less than 20 years from now, 1 in 6 will be in that age group.

Older workers have fewer but more severe injuries, allegedly due to slower reaction times and longer healing periods. And with a larger proportion of the labor force nearing the end of their working lives, more cumulative injury claims are likely. Such workers' compensation claims typically allege a disability resulting from repeated small traumas incurred over a long period of time. It is often difficult to distinguish the contribution of the work place in these claims from the ordinary aging process or off-the-job events. Because of this, these cases usually are litigated, and tend to be difficult and expensive to resolve. A significant escalation in the number of these claims could have a noticeable impact on workers' compensation costs and also could overburden the workers' compensation administrative machinery.

Second, while the baby boomers have provided employers with a plentiful supply of labor for a wide range of jobs, the subsequent and smaller baby bust cohort presages a labor shortage that will begin to be felt by the end of this decade and will continue for at least 15 years.

Two important and countervailing consequences spring from this impending labor shortage. Like any shortage, the price of the scarce commodity will rise — in this case wages. This means higher workers' compensation benefits.

On the other hand, high wages will induce employers, where possible, to substitute labor saving devices and reduce the number of workers they employ. For example, banks will use more automated tellers in place of teller windows. With production processes less labor intensive, fewer injuries will result. The net effect on costs — with higher benefits but fewer injuries — will vary from firm to firm and industry to industry.

The exodus from large northeast and midwest cities is a third population trend with implications for future injury rates and workers' compensation costs. These migrants tend to relocate to the Sunbelt and to western states. There is also movement from large urban centers of the Snowbelt to the smaller cities and towns.

Both migration trends have noteworthy consequences for injury rates and workers' compensation costs. As people and jobs exit, older urban plants are closed or operations are contracted. Experience shows that the permanent layoffs that result often lead to the filing of large numbers of workers' compensation claims — many of them alleging cumulative injuries resulting from a lifetime of work.

Yet, the new facilities built in the Sunbelt and smaller cities tend to be more modern, more capital intensive and, hence, safer. In the short run, the process of geographic readjustment will continue to be accompanied by difficult and expensive cumulative injury claims, but in the longer run, there will be safer work places and lower injury rates.

A fourth trend — the declining international competitiveness of certain basic U.S. industries, such as autos and steel — is related to and reinforces the migration of industry away from the large Snowbelt urban areas, with their older, less efficient plants, higher cost labor and high taxes.

And a final related trend is the shifting composition of U.S. industry, with the relatively rapid growth of the service sector and the slow growth or decline in many traditional manufacturing industries. To illustrate this, during the 1970's, employment in service industries grew 56 percent, while manufacturing employment did not even increase 4 percent. Since the service sector tends to be safer than manufacturing, injury rates will continue to decline.

A Call for Cost-Effective Resolutions

What is the net assessment of these various trends? In combination, they suggest lower injury rates, but growing numbers of cumulative injury claims, which are difficult and expensive to resolve. A lesson from an analogous problem, asbestos tort cases, shows that for each $1 paid out by defendants, only 37 cents reached asbestos victims. The remaining 63 cents went for litigation costs. Is a compensation system like this affordable?

It is imperative that such a development be avoided in the worksite injury arena by putting into place administrative dispute resolution institutions and procedures that are cost-effective, predictable and fair. A central component of a plan like this is to make certain that the best available medical and scientific evidence is used in a credible, objective and nonadversarial manner to decide cumulative injury cases. This would reduce the frequency, intensity and costs of litigation. Absent such procedures and institutions, the litigation costs could dwarf the actual benefit payments made by employers. ■

Notes

1. John Gardner and Richard Victor, *Injury Rates: Secular and Cyclical Trends* (Cambridge, Mass.: Workers' Compensation Research Institute, forthcoming).
2. Norman Root and Michael Hoefer, "Research Summaries," *Monthly Labor Review* 102(1):176-180, January 1979.
3. Karen DeVol, *Income Replacement for Short-Term Disability* (Cambridge, Mass.: Workers' Compensation Research Institute, forthcoming).
4. William Butz et al., *Demographic Challenges in America's Future* (Santa Monica, Calif.: The Rand Corporation, 1982).

The Labor Factor

By Suzanne Viau Klett

Unions' unique role can influence the extent to which health care reforms take root.

LABOR REPORT

For St. Louis machinist Fred Speckmann, the era of rationing by health care costs is here. Faced with a financially strapped health and welfare fund, his local, District 9 of the International Association of Machinists and Aerospace Workers, has given up first dollar coverage for hospitalizations, adding both front end deductibles and cost sharing. However, the Machinists' plan now pays fully for outpatient care as a financial incentive and has incorporated preadmission testing and other cost containment features.

"Our liabilities got ahead of our income," explains Speckmann, a former tool and die maker and now directing business representative of Machinists District 9. Elsewhere across the nation, the story is similar. Whether bargaining individually for health care coverage for a few hundred workers or collectively for benefits for thousands, unions are hearing from employers, insurers and health care providers that generous health plans and consumer overutilization are part and parcel of the health spending problem.

While they do not dispute that economic times have changed and that consumer expectations about limitless health care resources need to be tempered, labor leaders say they are not about to accept, if they can help it, so-called solutions that whittle away at workers' hard won health benefits. An alternative is for unions to participate in the search for mutually acceptable solutions.

Unions, in fact, are mobilizing to do that in a variety of ways. Approaches range from lobbying at the national level for major regulatory reform to working with employers at the company level to sort out the causes of out-of-control health costs.

Back in St. Louis, for example, machinist Speckmann chairs a newly formed all labor coalition of area unions which have joined forces to do something about the high costs threatening their health benefits. "When you see the cost of medical services going up 15 to 20 percent a year, and you have to settle a contract for a fixed amount, you can't settle for three years [worth] without knowing what the [health care] costs will be," observes Speckmann.

So the labor coalition, called the Mississippi Valley Health Care Committee, Inc., is exploring ways it can collaborate with a local business-health coalition on common concerns such as identifying and better budgeting for workers' health care needs.

More and more unions — especially at the local level — are expressing a willingness to work with the business community, when they can, to bring about health care delivery reforms. But on issues where they do not see eye to eye, such as cost sharing, unions are coming up with their own alternatives, some of which go beyond the gamut of prehospitalization certification and second opinion programs.

Nevertheless, labor representatives at all levels say they continue to believe the real solution to the health spending problem lies in broad reform of the current fee-for-service health care system.

"We are still working for national health insurance (NHI) as an overall goal. But we recognize that it will be difficult to achieve that goal unless we get costs under control," contends Karen M. Ignagni, assistant director of the AFL-CIO's Occupational Safety, Health and Social Security Department.

In their unique role as representatives of large numbers of public and private sector employees, unions' perspectives on the health cost problem and potential solutions bear closer examination. The manner in which unions now and in the future may influence workers' expectations could have considerable impact on the pace and extent to which health care reforms take root.

Suzanne Viau Klett is associate editor of BUSINESS AND HEALTH.

What is Organized Labor?

Like the business community, the component organized labor — unions — are diverse. Moreover, approaches different unions take to benefits bargaining as well as to specific health care issues, varies markedly depending on factors such as the type of industry or occupational groups they represent, their size and geographic location.

Most importantly, the positions a particular union espouses at the national level may or may not be echoed by its local constituents who, faced with different economic and political circumstances, may take alternative stances. Such discrepancies tend to occur more in industries like construction where workers' benefits generally are provided through Taft-Hartley jointly administered trust funds, than industries such as auto manufacturing where collective bargaining is predominant.

The term "organized labor" typically conjures up an image of blue-collar workers in basic industries such as manufacturing, construction, transportation and public utilities. But the labor front, over the years, has become increasingly broad. Unionization continues to occur over a wide spectrum of the work force from lawyers to hospital workers.

Nonetheless, the Bureau of Labor Statistics shows nearly a quarter (23 percent) of the 87.5 million public and private, wage and salaried workers in the U.S. are unionized, and better than half are blue-collar workers in basic industries. About 38 percent are white-collar workers and another 10 percent are service workers.

The union impact can be substantial not only on wages but health benefit expenditures as well, a 1981 U.S. Chamber of Commerce survey of health insurance costs by industry indicates. It shows that in the heavily labor represented public utilities, the average health insurance cost per employee per year is $1,055. However, in banking and finance, where less than 11 percent of employees are represented, chamber data show the average annual health insurance cost per employee is about $680 (see chart).

Staying the Course

This mixed bag of statistics and trends prompts such questions as whether the movement toward unionization of primarily nonindustrial, often lower paying and female dominated service occupations suggests major changes in workers health care needs. Also, is there likely to be more trading off of health care benefits to ensure job security in declining industries?

The answer to the first question, at least, is an emphatic "no," contends Melvin A. Glasser, director of the Health Security Action Council, the lobbying arm of the Committee for National Health Insurance. "If we need comprehensive health care services today, we will need them in the future. Women have less access [to health care] now than men do; that access will have to be improved as they are independent, functioning members in work and society in a way that they weren't 10 years ago," says Glasser.

There are trade offs being made between management and labor over health benefits, Glasser acknowledges, but he contends but they are occurring mostly out of ignorance at the local level among workers with little clout.

In certain industries, however, trade-offs are necessary due to circumstances working against unions. Admittedly, some unions have had difficulty responding to new pressure for cost sharing, notes Ignagni. Aside from large, collectively bargained agreements, most union negotiations have centered around how many cents per hour to devote to health benefits.

HEALTH INSURANCE COSTS BY INDUSTRY (1981)

Industrial Group	Cents Per Payroll Hour	Average Health Insurance Cost As A Percentage Of Payroll	Average Cost Per Employee Per Year
Food/Beverage/ Tobacco	41.8	5.4	$ 858.88
Textiles/Apparel	29.5	5.1	$ 599.71
Pulp/Paper/Lumber	45.66	5.5	$ 955.86
Printing/Publishing	39.66	4.3	$ 798.79
Chemicals	55.83	6.3	$1,150.20
Petroleum	61.63	5.0	$1,305.06
Rubber/Leather/ Plastic	49.55	5.8	$1,006.72
Stone/Clay/Glass	57.74	6.8	$1,128.47
Primary Metals	66.92	7.8	$1,375.82
Fabricated Metals	52.98	6.6	$1,103.82
Machinery	58.06	6.5	$1,217.37
Electric Machinery	54.60	6.3	$1,125.82
Transportation Equipment	68.38	7.0	$1,409.60
Instruments/Misc. Manufacturing	48.04	5.7	$ 992.39
Public Utilities	50.27	4.9	$1,055.07
Trade	27.63	4.0	$ 565.39
Banks/Finance Co.'s/ Trust Co.'s	33.73	4.5	$ 679.40
Insurance	35.77	4.4	$ 711.37
Hospitals	28.51	4.1	$ 591.43
Misc. Non-Manufacture	36.72	4.2	$ 754.18

Source: Business Council of Pennsylvania based on data from the U.S. Chamber of Commerce, *Employee Benefits 1981.*

The "Mini-Fiefdoms" Problem

Although unions may share the same goal of comprehensive basic health coverage, the specific needs of their constituencies dictate that some unions take different approaches, Gerry Shea of the Service Employees International Union asserts.

Shea, who is SEIU's health care division coordinator, describes the 850,000-member union as "a federation of mini-fiefdoms." SEIU's constituency ranges from predominantly black, female nursing home workers in the

deep south to mainly white state employees in Massachusetts. Few of the union's members are covered by master agreements. Instead, the union must keep track of 5,000 contracts, says Shea.

There are many instances in which a union local has made settlements not consistent with what the SEIU espouses at the national level, but it had no choice, he adds. SEIU members in some areas still are battling to obtain any health insurance. In New York City, for example, the SEIU, two years ago, won health insurance coverage for some of its 15,000 unionized home health workers.

Aside from its diverse membership, the trend toward prospective payment and state rate-setting for health care could put the SEIU in a tough spot because of its 175,000 members who are hospital workers. Although the union has come out in favor of state rate-setting, "it's a political issue we're watching closely," says Shea, because of the job security implications for workers who could be laid off by hospitals feeling the pinch from cost controls. However, SEIU feels there are plenty of savings to be captured by establishing appropriate payment levels for hospital care that provide for adequate reimbursement to the hospitals to cover union members' wages.

In a major legislative reform effort, SEIU is capitalizing on what appears to be an increasing shift in the locus of power from the federal to state level. The union is sponsoring legislation in eight states to tie group premium rate increases and administrative cost allowances for Blue Cross-Blue Shield and commercial insurers to their progress in introducing cost containment programs. The legislation also calls for a freeze on physicians fees "until negotiations produce fair rates to be charged under all private insurance plans in those states," asserts SEIU president John J. Sweeney. The states involved are Michigan, New York, Illinois, Ohio, Missouri, Pennsylvania, Oregon and Texas.

A similarly diverse union that has taken a different tactic in addressing health cost and benefit issues is the International Brotherhood of Electrical Workers.

The one million-member union covers four major industries — construction, telephone, manufacturing and utilities — and divides the country into 11 geographic regions, each with its own vice president. Health benefits for about a quarter of the union's membership — primarily those in construction — are provided through Taft-Hartley health and welfare funds, while the rest of the membership is covered under employer administered health plans, says Roy W. Dickinson, IBEW assistant director for research and education and an electrician, himself.

Union members, for the most part, have "above normal" health benefits, that is, coverage of all inpatient costs and major medical benefits, says Dickinson, especially if they are in major metropolitan areas. "Where we've had problems is in import sensitive industries. Those are the ones that have adopted copayment and cost sharing approaches which we feel are doing nothing to overcome the problem of constraining costs." Automotive supplies is one such industry forced by competition from foreign imports to cut expenses in the benefit area.

"The biggest problem has come where everyone has just sat around and waited for negotiations, leaving it up to management to do [its] thing." The IBEW is trying to change that by bringing trust funds administrators together, for example, to trade notes on problems and potential solutions, says Dickinson.

The main point administrators have learned from such meetings, he adds, is that "everything doesn't work for everyone." For instance, if a particular local does not have a problem with extraneous surgery, a second surgical would produce few savings. The union's leadership is urging local IBEW officials to start collecting the data that will tell them this and other vital information that will better prepare them for labor-management negotiations.

The IBEW also is bringing together, by industry, labor representatives for employer administered plans to participate in mock bargaining sessions. At these conferences, union officials are briefed on cost containment strategies, then divided into groups and told to come up with counterproposals to hypothetical management offers. The drill teaches union negotiators about requesting information from management on employee health care costs and utilization, proposing changes in health plan administration, making equitable plan design changes and incorporating alternative delivery modes such as HMOs and preferred provider organizations (PPOs).

Labor-Management Committees

The Communication Workers of America, whose 650,000-member constituency overlaps with the IBEW mostly in the telephone industry, also favors closer scrutiny of factors influencing health care costs at the company level. A 15-day strike by unionized AT&T workers last year, prior to the company's divestiture, led to an agreement that joint labor-management committees be subsequently set up in each Bell operating company and within AT&T.

The committees are to examine the causes of health cost inflation as they affect the company and work force, explore and recommend appropriate cost containment measures (including cost sharing if potentially viable), and participate in local coalitions spearheading efforts like development of alternative delivery systems. The committees also must report periodically to company and union leaders on their work.

The agreement has "teeth," in that labor contracts can be reopened by mutual consent to incorporate health plan changes recommended by the joint committees, such as including wellness programs, hospice coverage or precertification for certain inpatient procedures. However, any changes first must be approved by the CWA and company leadership, says John Abraham, CWA associate director for research.

AT&T contract talks last year marked "the first time the company has made health benefits a priority topic of discussion in negotiations, and the issue is to remain in the forefront...unless costs are brought under control," says Abraham. In 1983, AT&T's health care bill totaled $2 billion for 3 million beneficiaries — employees and their dependents — and would have increased to $3 billion

by 1986 if provider practice pattern and fee schedule trends were to remain the same, according to Abraham.

That is why union negotiators balked at AT&T proposals such as an employee flexible benefits plan and new deductibles and copayments. The union felt the proposals were designed primarily to limit management's liability for health care cost increases by leaving workers to pay the balance.

Communication Workers of America

"... Union negotiators [have] balked at AT&T proposals such as employee flexible benefit plans.... The union [feels] the proposals were designed ...to limit management's liability for health care cost increases...."

Instead, CWA's new contract is built around incentive for providers to alter their behavior and cut costs. For example, if a list of 22 surgical procedures are done on an outpatient basis, the surgeon receives 100 percent of reasonable and customary charges, whereas reimbursement is at 95 percent if the surgery is done on an inpatient basis. The same concept applies for a list of 28 inpatient procedures, where the surgeon receives more if the surgery was confirmed first through a voluntary second surgical opinion program.

The United Steelworkers of America also has rejected, in national level bargaining, management proposals to take away health benefits. In the last round of collective bargaining negotiations, the recession and competition plagued steel industry was given "substantial economic relief" under the labor agreement. But the union held fast to first dollar health benefits through nine months of negotiations ending in 1983, observes Thomas Dusak, former director of insurance, pensions, unemployment and health benefits for the Steelworkers.

Instead, the Steelworkers' contract, covering workers in basic industries such as steel, aluminum, copper and container manufacturing, calls for joint labor-management committees like CWA's to identify and institute appropriate cost containment strategies. In effect, the agreement formalizes what already was happening in a few companies, says Dusak, now with U.S. Administrators, a California based claims processing firm. For example, at Jones & Laughlin Steel Corp., management and labor have collaborated successfully on a health fair and other health promotion and education activities to make workers aware of the cost of health care.

Pros and Cons of Flexible Benefits

The Steelworkers, however, opposed the medical reimbursement account for workers at the Aluminum Company of America (ALCOA), which members of the Aluminum, Brick and Glass Workers International Union have accepted.

The plan, also adopted for aluminum workers at Reynolds Metals, sets up a $700 reimbursement account for each worker per year in lieu of first dollar health care coverage. The account can be used to cover deductibles and copayments under the health plan, as well as for benefits such as routine physical examinations and cosmetic surgery which are not otherwise covered. Unused funds from the account can be paid to employees at the end of each year as taxable income or can be placed, for example, in a tax deferred individual retirement account.

The Internal Revenue Service has challenged what it sees as the tax avoidance aspect of flexible benefits such as this. But employers with existing plans have won a reprieve until June 30, 1985, which will allow Congress to hold hearings investigating the impact of these plans on revenues and make possible legislative changes.

"As far as we are concerned, we are $700 ahead of the game if we do not use (the account) at all," says Gilbert Wolf, director of research and education for the Aluminum Workers. Wolf admits the big selling point for the plan was company data showing that based on past experience about 80 percent of workers would have some unused funds at the end of each year.

Still, there is strong opposition by many labor groups to flexible benefit type programs such as the Aluminum Workers'. The AFL-CIO, for one, has criticized this strategy, fearing it will encourage employees to deprive themselves and their families of less costly preventive medical care, which could lead later to health problems requiring hospialization.

Coalition Fever

Some labor officials feel a better way to get at the root of high hospitalization costs than resorting to a benefits overhaul is by joining forces with other unions and employers to form health care coalitions.

In Knoxville, Tenn., for example, local health planning efforts have failed to deter unnecessary capital expenditures by hospitals for high technology items. This has led to increasing cost shifting to private payers, according to ALCOA steelworker Harold Woods. So Woods, president of the AFL-CIO affiliated Knoxville Central Labor Council, brought his company and other large area employers with heavily unionized work forces together last summer to form a strictly labor-management coalition to address these problems.

Woods stressed the importance of having employers and unions collaborating on solutions to health cost problems so that "when we get to [making] contract changes that bring costs down, we won't just be shifting costs around the company. Having a community level joint coalition behind them also can reinforce the reform efforts of individual unions, says Woods.

The coalition spirit is spreading through labor as it is the business community. The number of health care coalitions involving labor has grown from 15 last year to 42 this year, according to the AFL-CIO's Ignagni. The

federation, itself, is a member of the "Group of S. a high level coalition formed six years ago to encou. community coalition development. Other members group are the American Hospital Association, the Am. Medical Association, the Health Insurance Associat. America, Blue Cross and Blue Shield Association and The Business Roundtable.

A leading coalition model that both business and labor point to as having had a substantive influence is the Economic Alliance for Michigan. Established two years ago, the alliance is a statewide business-labor coalition formed to revitalize Michigan's economy by focusing on troublesome issues from unemployment compensation to health care costs.

Last summer, the alliance produced three primary recommendations for health care reforms which have received state level support. One recommendation to encourage expanded enrollment in HMOs led to a special conference attracting 800 health and welfare fund trustees and company benefits personnel last spring, which was coordinated through the alliance, the Michigan governor's office and the state HMO association.

Two other recommendations that resulted in legislation pending in the Michigan legislature would remove regulatory obstacles in state laws to clear the way for development of prudent purchaser arrangements (also known as PPOs) by insurers, and strengthen the state's certificate-of-need process by establishing an annual budgetary limit on hospital expenditures approved.

One reason the alliance has accomplished so much is because it sticks to resolving specific issues within the context of the state. In addition, the group's 50-50 representation from business and labor at the onset ruled out getting involved in collective bargaining issues such as cost sharing. "Almost by definition we have precluded a range war," alliance president Robert Wack explains.

The Promise of Regulatory Reform

Labor leaders feel that by encouraging union locals to take the offensive in contract negotiations, organize and participate in coalitions, and educate workers about appropriate use of health benefits they will be staking their concerns amid the current wave of reforms. Yet, from the national level on down, union officials echo the same criticism — that none of these approaches offers a long-term solution to the health cost problem, and none assures access to basic, comprehensive health care.

Major gaps in health care coverage continue to remain for most of the U.S. work force, they contend. Although there has been much criticism, for example, about the thousands of dollars spent annually on the health care coverage of individual UAW employees of the Big Three auto manufacturers, one important basic benefit — physician office visits — remains uncovered. "That's a big deductible, in effect," observes Patrick F. Killeen, senior health care consultant with the UAW's social security department.

Susan Adelman, past president of the Wayne County, Mich., Medical Society and a vocal critic of the UAW, agrees with Killeen, however, on that point. The auto workers' coverage is skewed so as to eliminate the major cost savings that preventive health care can provide, notes Adelman, a Detroit pediatric surgeon.

But there are alternatives for the short-term that labor supports. A major one is legislation sponsored by Sen. Edward M. Kennedy (D.-Mass.) and Rep. Richard A. Gephardt (D.-Mo.) that would encourage states to adopt prospective hospital rate-setting systems for public as well as private payers, and provide a federal fall back system for states failing to do so. The Kennedy-Gephardt bill, introduced in Congress last spring, is viewed by labor as the kind of regulatory reform needed to start the ball rolling toward systemic change. However, there are some competitive features of the bill — like the requirement that employers contribute equally to competitive and higher priced medical plans — that labor does not favor.

Despite the support within labor for across-the-board prospective budgeting, however, unions such as the American Federation of State, County and Municipal Employees (AFSCME), fear an all-payer system based, for example, on Medicare's diagnosis related groups (DRGs) approach could lead to massive layoffs of hospital support personnel as a cost cutting measure. That would seriously affect quality of care, AFSCME contends.

The Looming Retiree Problem

Labor is closely tracking other developments in Medicare policy as well for their implications on the steadily rising cost of retiree health benefits in the private sector. Declining industries and a growing aged population, combined with reforms that would decrease Medicare support, threaten to place a considerably greater burden on elderly patients to pay for health care.

An indication of the pressure building in the private sector over this issue was when retired steelworkers sued Colt Industries last winter to force the company to continue to pay for their medical benefits. The retirees had worked for the company's Midland, Pa., factory which was closed in 1982 and sold to Jones & Laughlin Steel Corp. Neither Colt nor J&L wanted to assume liability for the health benefits of 4,200 Colt retirees and their dependents which reportedly totaled $5 million in 1983. Colt now is continuing to pay modified benefits to the retirees while a long-term solution is being worked out with the assistance of the United Steelworkers who are supporting the retirees.

For the rest of the labor force, as well, retiree health care costs will become an increasing concern if, for example, the Financial Accounting Standards Board (FASB) goes with their proposed changes in budgeting for these expenditures. The FASB is considering requiring employees to account, in advance, for retiree health costs, which could affect bargaining for these benefits, thus placing further strain on labor-management relations.

As Glasser puts it, "The U.S. is one of the last industrial societies to provide for continuing needs on retirement....We continue to believe that they will be met by the private sector....[Yet], nowhere in the world, except in the U.S. do unions worry about their health care." ■

Labor's Role in Job Placement of the Disabled

BY LAWRENCE T. SMEDLEY

Preserving access to jobs is the key to self-reliance among handicapped workers.

LABOR REPORT

Organized labor from its earliest days has supported the right of disabled workers to secure employment and to earn a decent living. The trade union movement took the lead more than 50 years ago in securing the enactment of the first industrial injury laws to protect workers hurt on the job. But labor leaders soon realized that only a small portion of the disability burden of union members arose from on-the-job causes. Many more disabilities are non-industrial in origin, resulting from accidents outside the work place, disease and a host of chronic conditions.

In this broader context of disability, the focus of labor's concern has not been just narrowly focused on the individual union member and his or her job, but has been extended to the family unit as a whole. This has stimulated unions to play a leading role in the development of social insurance programs as well as collectively bargained health and welfare plans, the aim of which are to alleviate the burden of disability regardless of how it might arise.

Labor leaders also acknowledge the experience showing that cash benefit programs, although vital and worthwhile, are not as satisfactory to the individual, his or her family or society as a means of restoring the disabled employee to the self-reliance of a productive worker. Thus, labor recognizes the importance of rehabilitation and employment programs for the handicapped and has joined with management, public and private groups to promote these efforts.

Picking Up Where Medicine Leaves Off

It is a paradox that modern medicine in some ways magnifies the problem of disability. Individuals who in the past would have had brief life expectancies now are living to old age with chronic disabling and handicapping conditions. It seems certain that, as rehabilitation programs expand in hopes of reducing the pool of handicapped individuals needing employment, medical science will be adding to that backlog by prolonging human life.

Handicapped individuals are doomed to a lifetime of dependency unless they can be made productive. Not only is it necessary to remove an economic burden from a financially hard pressed society, but also for moral reasons, a society that provides medical rehabilitation enabling an individual to live longer has an obligation to complete the rehabilitation process by ensuring these individuals the opportunity to be self-reliant.

Because income is based almost entirely on small monthly membership dues, unions lack the resources to undertake vocational or training programs, unless largely funded by government or other sources. Thus, unions concentrate on those efforts they do best, that is, using the collective bargaining agreement to fight for disabled workers' right to remain at work, and to give advice and to refer disabled workers to those public and private agencies best able to help them.

Organized labor has been equally concerned about preventing disability and has given priority to safeguarding the health and safety of workers. Congress, largely as a result of pressure applied by organized labor, passed an occupational health and safety law 15 years ago to provide for greater protection of workers at the worksite. Labor's strenuous efforts since to rectify inadequate enforcement of this law reflects the importance labor attributes to the prevention of injury and disability. For example, a local of the Oil, Atomic and Chemical Workers' Union was the first to notice the adverse effects of the chemical dibromochloropropane (DBCP) on workers. Through the efforts of this union, the U.S. Department of Labor issued standards for DBCP use and the Environmental Protection Agency prohibited its use as an insecticide.

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Similarly, labor leaders have been concerned about the fragmentation of health services in the U.S., and that health programs are not more directly concerned with the prevention of illness. In the final analysis, the health of the total person is what really counts, and prevention and treatment must be coordinated and combined with rehabilitation in a comprehensive health package. Based on its experience in trying to better meet the health needs of its members, organized labor feels comprehensive programs not only better serve workers and their families, but are more economical. The Amalgamated Clothing and Textile Workers Union, for instance, provides services to members with a broad range of disabilities under its Health Assistance Program. Among the services that are especially useful are referral to appropriate medical help including mental health practitioners and provision of necessary information between a practitioner and a worker's supervisor with the permission of the workers involved.

Experience also has shown that failure to integrate a disabled worker into the labor force is not, in most cases, due primarily to the disability; rather, there are a variety of causes. A major obstacle, for example, has been persistent, high unemployment rates. Thus, the emphasis need not be on making special provisions for workers' disabilities, but on integrating them into programs that secure employment for workers in general.

Ensuring Job Security

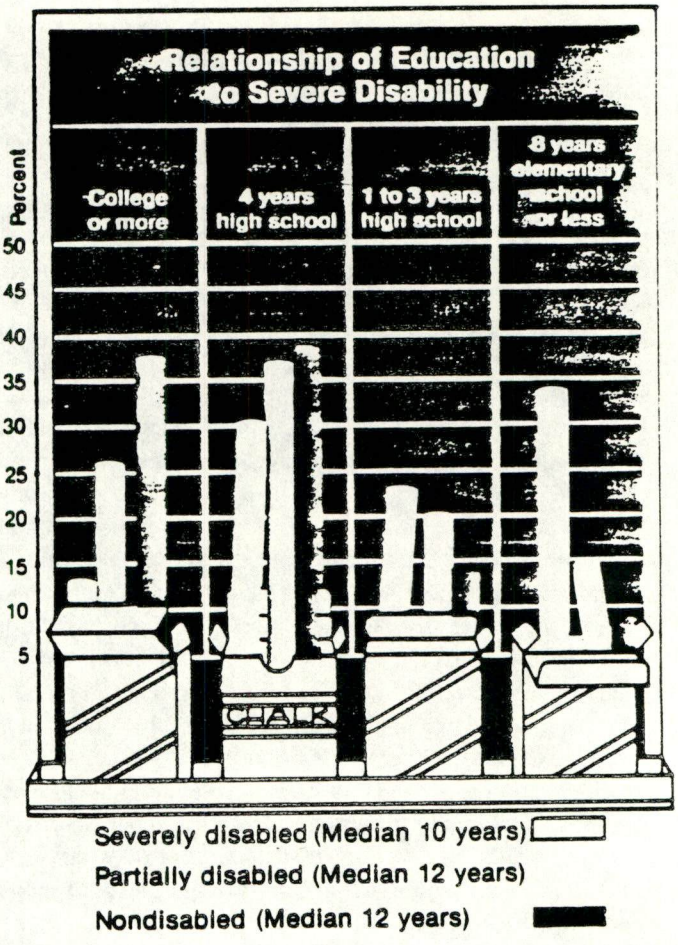
There are a number of ways organized labor has contributed to increased employment of the handicapped worker. The first is in the area of collective bargaining. Unions have attempted through provisions of collective bargaining agreements to ensure that disabled employees will be able to return to their old jobs or, where that is not possible, to some other job with the same employer.

The collective bargaining agreement between a union and an employer typically provides that disputes over the interpretation of various provisions are subject to a grievance procedure, with unresolved disputes decided by final and binding arbitration by a third party. Thus, under such conditions, an employer may not capriciously deny disabled employees the right to return to their jobs, since the question of whether the disability prevents them from handling their old jobs is subject to the grievance procedure. Most workers who incur a disability do return to their old jobs and/or the same employer.

Of course, there are some disabled workers who cannot return to work or continue on their regular job. Many collective bargaining agreements also specify that certain job classifications are reserved for disabled workers so they can be placed in these positions without regard to seniority. Seniority is a major consideration in worker placements. A disabled employee who cannot return to his or her old job could be barred from continued employment because he or she lacked the seniority to compete for other jobs.

The charge is often made that the seniority system is a barrier to employment of handicapped people. However, seniority does not discriminate since it is neutral with regard to disability, race, religion or sex.

The problem arises most frequently in the case of entry level jobs. If a handicapped worker does not qualify for the normal entry level job and could qualify for the next higher level, the employer should not be faulted for not hiring the handicapped individual at the higher level because the job normally would be given to an employee on the basis of seniority pursuant to a union agreement. To do otherwise would result in discrimination against the nonhandicapped. In any event, if an employer is sincerely interested in hiring the handicapped, the personnel office can always locate workers whose disabilities will not affect their performance in the entry level job.



Source: Social Security Administration

Efforts to return disabled workers to their old jobs are of crucial importance. The best indicator of a successful return to the labor market by a disabled worker is if he or she can resume work with the same employer, in the same job if possible. Research, such as that by Sar Levitan in "Jobs for the Disabled," indicates that if a disabled worker returns to the same occupation and/or employer, the worker is much more likely to have a good job in future years. On the other hand, if the worker changes employers and/or occupation, he or she is more likely to have a less satisfactory job or no job in the future.

The reason for this discrepancy is that for most disabled workers, returning to the same employer means resuming their former occupation and wage rate, with the likelihood of higher wages in the future. Workers who

AFL-CIO Institute Promotes Job Placement of the Disabled

The eight-year-old AFL-CIO Human Resources Development Institute's (HRDI) handicapped placement program works on behalf of the organized labor movement to expand job opportunities for handicapped and disabled persons.

Through local projects in Baltimore, Md., Houston, Tex., St. Louis, Mo., and St. Paul, Minn., the HRDI program provides counseling, job development, placement and follow-up services. These are supported by grants from the U.S. Department of Education Rehabilitation Services Administration's Projects with Industry program and by matching funds from the national labor federation.

Every HRDI project is staffed by a handicapped placement specialist and a clerical assistant, and operates under a cooperative agreement with the state vocational rehabilitation agency that spells out arrangements for it to serve persons referred by the state agency. Its participants have a wide range of physical and mental disabilities. Many are blind, deaf or hearing impaired, or are amputees. Others have a history of mental disorders or disabled conditions such as cancer and epilepsy.

Links to Employers in St. Paul

How does HRDI link these seriously disabled persons with suitable jobs? The St. Paul program provides a good example. To secure employment for her project's participants, placement specialist Jenny Kron has developed productive relationships with a number of area employers, such as an ongoing arrangement with the St. Paul post office to recruit and screen hearing impaired workers for its jobs. Kron also calls and visits employers regularly, checks with new and expanding businesses and follows up job information supplied by the project's advisory council representing business, labor and rehabilitation.

Often, she has to convince employers that it is good business to hire handicapped workers. To do so, Kron spends time educating employers about the abilities, as well as the disabilities, of her clients. In dispelling unrealistic fears about safety and other problems, she often refers employers to others who have hired her clients and are pleased with their performance. To help participants secure the jobs she develops, Kron arranges for any needed modifications to accommodate their disabilities and for special services at job interviews such as sign language interpreters and readers for the blind.

Through these activities, the St. Paul project has placed more than 150 seriously disabled workers over the past year and a half. They are employed as construction workers, letter carriers, mail handlers, health care workers and in many other jobs paying an average entry wage of $5.55 per hour.

Assisting Local Unions

While every handicapped placement project serves all disabled persons referred by the state rehabilitation agency, HRDI, as labor's employment and training arm, devotes special attention to the reemployment of disabled union members. Currently, it is planning to expand this assistance by working with local unions to identify their members on disability rolls and providing early intervention services to help them return to the work place.

Building on its handicapped placement project in Houston, HRDI is now operating a disabled worker program in cooperation with the Texas Employment Commission. Through the new program, it is providing additional services and assisting persons not served in the traditional vocational rehabilitation process, including many dislocated workers who are disabled. In the coming months, the institute plans to extend these activities to other parts of the country, opening up job opportunities for many more handicapped and disabled workers.

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do not return, usually find new jobs at lower wages or fail to find steady employment. This pattern of lower wages and marginal labor force attachment tends to be maintained in future years.

Generally, disabled workers who do not make a fully successful return to work resemble nondisabled, unemployed workers. They are older, less well educated and lacking in skills (see graph). Conversely, those who make a successful return to work resemble the successfully employed, that is, they are younger, better educated and more skilled.

In short, the problem of disabled workers is a part of the general problem of unemployment, and disability, itself, appears to be of secondary importance in determining future work success when measured against such factors as age, education, skills and ethnic group. The disabled worker loses a job and seniority rights, and is forced to compete for a job in a labor market characterized by unemployment and employer criteria for selecting new employees that emphasize youth, education and skills. Obviously, these circumstances do not apply in all cases; severely disabled workers confined to beds or wheelchairs, or those afflicted with mental retardation, mental illness, alcohol and drug abuse problems are exceptions. Everything else being equal, an accountant with a disabled leg will not encounter the employment difficulties faced by an accountant with a record of alcoholism or mental illness.

Training, Job Placement Options Key

From these observations, organized labor has drawn some obvious inferences. Since a disabled worker's future employment success is so closely related to whether or not he or she returns to work for the same employer, unions, employers and government should make special efforts to ensure that these workers have a maximum opportunity to do so. Clearly, organized labor has an obligation to emphasize and negotiate for broader job security provisions in collective bargaining agreements for when disability strikes.

Contract language should state that when a worker becomes unable to perform his or her job for reasons of physical or mental disability incurred on the job, the employer would be required to make every effort to place

the employee on another job and to train the person on that job. During the training period, the worker should maintain full seniority rights and wages.

Rehabilitation efforts should be concentrated to a greater extent on those disabled individuals who are likely to experience the most difficulty in a satisfactory return to the labor market — the older, unskilled, less educated worker. Since having a skill is such a major factor in determining whether the disabled worker — in fact any worker — is employed, emphasis should be on training disabled people. The handicapped, with few exceptions, can be trained, and there is a need for trained and skilled workers.

The hiring of new employees with handicapping conditions is primarily the responsibility of management. Unions are seldom involved in the hiring of these individuals. There are some exceptions to this general rule, such as the maritime and construction industries that have union hiring halls, but these constitute only a minute fraction of employment opportunities.

To say this, however, is not to play down the important role organized labor can and should play in new hiring of the disabled. Organized labor, working through national, state and local organizations, helps both public and voluntary agencies to develop resources necessary to do a good job of rehabilitation and job placement of these individuals. Unions also inform and educate their own leaders and members through publications and conferences about programs to rehabilitate and employ handicapped workers. In addition, organized labor has a responsibility for encouraging employer acceptance of such programs, and particularly for securing acceptance of handicapped persons by their fellow workers.

Through such programs as the AFL-CIO Human Resources Development Institute's Projects with Industry Program, and the International Association of Machinists' Disabled Workers Program, organized labor directly provides job placement as well as a range of other services to enhance work opportunities for disabled persons. These kinds of projects, often funded by government grants from the Projects with Industry (PWI) program of the U.S. Department of Health and Human Services, reflect a growing awareness and concern on the part of labor for the specific needs of workers with handicapping conditions.

American employers hire handicapped employees for reasons of self-interest as well as the public interest; they have found it pays to hire the handicapped. Studies by E.I. Du Pont of its physically handicapped employees indicated that their job performance and attendance are better than average, their safety records are outstanding, and some of the most productive workers are those with the most severe disabilities.

The labor movement, through political and legislative action, has helped pass, improve and utilize legislation related to the rehabilitation of disabled persons. Through AFL-CIO local community services committees and union counselors, members who need rehabilitation services have been detected and referred to the proper agencies for services, often including a follow-up to see that they are placed in jobs. The AFL-CIO also has worked closely with the President's Committee on Employment of the Handicapped as well as with governor's committees in most states.

Breaking Down Barriers

Still there are many unintended barriers that limit employment of disabled persons. They do not deny job opportunity but prevent access to it, or pose health problems in connection with it. The step or steps it takes to enter a building, for example, may bar the person in a wheelchair. Narrow doors, inadequate toilet facilities and a dozen of other seemingly unimportant conditions in and around a place of employment may keep the most capable person from reaching or doing his or her job. Major progress has been made in eliminating these barriers in recent years, largely through the impact of labor supported legislation that requires employers to make reasonable accommodations for handicapped workers.

Organized labor has used considerable political and legislative influence on all levels, federal and state, to help obtain grants, subsidies and adequate appropriations for rehabilitation purposes, as well as to improve existing laws and to pass new rehabilitation legislation. The AFL-CIO supported successful efforts in October 1984 to have Congress set standards for the Social Security disability program to ensure that disabled citizens receive the benefits to which they are entitled. Because as necessary as voluntary and collective bargaining efforts are, organized labor realizes that fully successful rehabilitation programs will require national efforts and resources. This can only be done by government; therefore, rehabilitation of the handicapped must be largely a public responsibility.

Another example of legislation supported by organized labor was rehabilitation legislation passed by the U.S. Congress in 1973 that represented a major breakthrough in the fight to employ the handicapped. This legislation requires that government contractors and subcontractors take affirmative action to employ and advance in employment qualified handicapped individuals. These employers must not discriminate against handicapped individuals and must actively recruit, consider and employ qualified handicapped applicants.

Affirmative action not only applies to hiring but also to job assignments, promotions, training, transfer, termination, accessibility and working conditions. Unfortunately, this statute is becoming a victim of budget cuts and the Reagan Administration's general reluctance to enforce antidiscrimination legislation.

Such legislation has opened broad avenues for joint efforts ranging from the work of the Industry-Labor Council, which grew out of the White House Conference on the Handicapped, to the continuing efforts of the labor and employer committees of the President's Committee on Employment of the Handicapped. But as the trade union movement supports rehabilitation programs, it does not lose sight of the fact that without jobs for everyone, the problems of rehabilitation will not be fully solved and only a part of the solution will be provided. ■

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The Merits of Hiring Disabled Persons

BY NINA HILL, THOMAS MEHNERT AND ELISA LEDERER

Surveys show impaired persons have a strong desire to work, reap payoffs for employers.

DISABILITY REPORT

Every summer, the television networks recycle the previous year's stories about high unemployment among various groups including teenagers, unskilled workers and young blacks. Little such attention is paid to a demographic group with the highest level of unemployment — disabled Americans. According to a 1986 International Center for the Disabled (ICD) survey, two-thirds of disabled persons between the ages of 16 and 64 are not working. Of these 12.4 million people, 8 million want to work. The survey was conducted by Louis Harris and Associates in cooperation with the National Council on the Handicapped.

Employment of disabled Americans long has been a major objective of rehabilitation, one that has met with some success. Progress in rehabilitation and the forging of links with the business community has resulted in the employment of some 6.2 million disabled people. Many nondisability related barriers to the employment of disabled people — primarily ignorance and misinformation — remain, however. What better source of information is there to help break down these barriers than the group of disabled Americans who have found jobs?

To some extent, information about the on-the-job experience of people with disabilities already has been collected by state and private rehabilitation organizations through post-placement status checks. However, these follow-up efforts rarely exceed three months. They usually elicit little information other than whether the client is still employed. Consequently, little long-term information exists about the job experience of working age disabled Americans, particularly concerning their job satisfaction, their longevity and their upward mobility. It is precisely this kind of information that prospective employers most need.

ICD is a comprehensive, outpatient rehabilitation facility in New York City that specializes in meeting the needs of disabled persons through its medical, psychosocial and vocational services. Job placement assistance includes preparation, job counseling and help with job searches using established contacts in the business community. For the past two years, ICD also has conducted follow-up surveys of clients placed in competitive employment for up to 16 months after placement. The results of the most recent ICD survey this past summer as well as relevant findings from the 1986 ICD-Harris survey follow.

Characteristics of Disabled Employees

In June 1986, a survey questionnaire was mailed to all of the 113 ICD clients placed in competitive employment in 1984. Telephone follow-up for nonrespondents yielded a total return rate of 60 percent (63 persons) for the 105 people who actually could be reached. The respondents were considered quite representative of the target sample, according to ICD investigator Mary Boyd.

Fifty-seven percent of the respondents were male and 43 percent female, and they ranged in age from 18 to 59 with the average age being about 34. Two-thirds had single disabilities, one-third multiple disabilities. The single disabilities were classified as: physical, 57 percent; mental disturbance, 21 percent; sensory impairment, 10 percent; and other serious health impairment, 12 percent. Of the one-third of respondents with multiple disabilities, 8, or 38 percent, had a mental or emotional disability. Overall, 27 percent of respondents had a mental or emotional disability. The respondents were placed in a variety of jobs, primarily clerical and managerial, in a broad range of industries (see Tables I and II).

One myth about disabled people, particularly those who have been psychiatrically disabled, is that they cannot hold down a job. However, the ICD survey showed that as of June 1986, 50 of 63 respondents still were employed with the same or a different employer, and had been employed

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without a break for an average of 16.2 months. The 13 persons who no longer were employed had stayed on the job for an average of 9 months. Moreover, of these 13 people, 3 were laid off temporarily and 2 had gone back to school. Subtracting these 5 people from the 63 in the sample yields an employment rate of 86 percent. What is remarkable about this figure is that 43 of the 50 still employed previously had been unemployed for up to 20 years — the average was 3.5 years — and the remaining 7 had never had a job before being placed by ICD. Nineteen of the 50 had a disability with a developmental or psychiatric component, meaning cognitive or behavioral disabilities do not necessarily make an individual unemployable.

Table I

Placement of Disabled Respondents by Job Category

Job Category	Numbers	Percent
Clerical	29	47%
Managerial-Professional	16	26
Human Service Aide-Paraprofessional	4	6
Service	2	3
Sales	2	3
Technical	1	1
Other	9	14

Of those still employed, 10 had gone on to better jobs. Six of them left because they were offered more challenging jobs by other employers, and four were promoted within the same company. For instance, one 24-year-old male with a hearing impairment was hired as a data entry operator and now is a supervisor at the same advertising agency having been promoted three times in a year and a half. The concerns felt by a nondisabled person offered a promotion also surfaced among these respondents, but with an added dimension. As a 32-year-old man with an amputated right leg said, he was afraid when he was offered a promotion about how his co-workers would respond to a disabled supervisor. But once he proved his abilities as a manager, things moved smoothly.

Clearly, these two disabled men are considered assets by their companies. Moreover, if salary data are any indication, the employers of the 48 other respondents who remain employed are pleased as well. The starting salary for these 50 individuals, which ranged from $7,000 to $40,000 and averaged $12,000, increased over a 16-month period by 21 percent to an average of $14,700. Admittedly, first hires usually get a salary increase after a probationary period, but given that the salary increase nationally for the same period only averaged 4.3 percent, the increase for these respondents can be interpreted as recognition of a job well done. Thus, many disabled persons enjoy upward mobility on the job once they are given the opportunity to work. However, the myths about disabled people among potential employers and society-at-large are so pervasive that for them to be hired at all is considered upward mobility.

The Value of Employment

A question one person often asks another when they first meet is, "What do you do for a living?" The salience of one's job in American society was attested to by a 1972 survey by the W. E. Upjohn Institute for Employment Research, which found that 80 percent of people in the United States would continue to work even if they were to inherit enough money to live comfortably without having to work again. This, despite the fact that only 9 percent would do so because they enjoy their work.

Given the importance Americans place on their jobs, it was not surprising to learn from the ICD-Harris survey that only 26 percent of employed disabled persons consider themselves disabled, as opposed to 59 percent of those disabled who are unemployed. In addition, 80 percent of those working vs. 62 percent of those not working said they are satisfied with life. Forty-seven percent of the workers believe that their disability has prevented them from realizing their abilities, as opposed to 60 percent of the unemployed who feel this way. And 83 percent of those who work are satisfied with their jobs, while the same percentage of those who are unemployed feel that if they did not have a disability, they would have the kind of job they would like. Still, 39 percent of those who do have a job feel they would have a better one if they did not have a disability. Fifty percent of disabled Americans over age 16 had a household income in 1984 of $15,000 or less; only 29 percent of nondisabled persons are at that income level.

A ICD-Harris survey finding that was surprising is that relatively few — 25 percent — of the working age disabled respondents report having encountered job discrimination. However, three out of every four disabled persons believe that civil rights laws that protect minorities against discrimination should also apply to them. The Rehabilitation Act of 1973 affords some protection for disabled citizens but it is not nearly as broad as laws prohibiting discrimination on the basis of race, color, sex, religion or national origin.

Table II

Placement of Disabled Respondents by Industry

Industry Category	Number	Percent
Service	11	18%
Nonprofit	10	16
Banking	7	11
Government	5	8
Finance	5	8
Manufacturing	4	6
Real Estate	3	5
Retail	3	5
Insurance	3	5
Publishing	3	5
Communications	3	5
Import-Export	2	3
Printing	2	3
Advertising	2	3

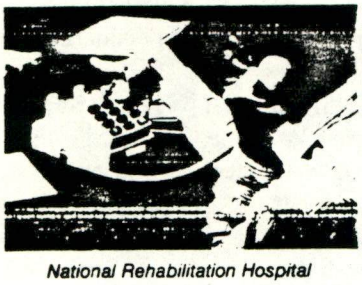
In the latest ICD follow-up survey, 55 respondents to a question about what positive changes had occurred in their lives since they began working cited the following: increased self-esteem, 18 percent; increased purchasing power, 18 percent; a feeling of independence, 15 percent; increased confidence, 13 percent; a positive outlook, 11 percent; and a feeling of responsibility, 11 percent. Many also noted a feeling of security and pride in being able to care for themselves and their family. Clearly, having a job is at least as

important for those with disabilities as for those who are not disabled.

In the words of a 33-year-old man with renal failure who was unemployed for four years before being placed as a special projects technician at an annual salary of $18,000, "I have a much better outlook and sense of worth. I also get more respect from friends and family . . . because they saw me go to school and make it pay off." Indeed, half of the employed members of the sample felt they were calling on their full talents and abilities in their jobs. A 36-year-old woman with an orthopedic disability who now is earning $18,800 a year as a social worker, said, "Since I started working, my physical handicap no longer is a factor in my intellectual, social and personal development." The income that a job, even a part-time one, brings is very important as well to those with disabilities.

What Employers Can Do to Help

One factor cited by potential employers to justify their reluctance to hire disabled persons is that they must spend a lot of company time and money to accommodate those that they do hire. This, too, is a myth. The ICD-Harris survey discovered that 35 percent of disabled workers had employers who made some sort of accommodation for their disability. Moreover, as Berkeley Planning Associates, a California based consulting firm, stated in a 1982 report for the U.S. Department of Labor, most job accommodations for handicapped employees involve little or no expense to the employers. Specifically, of 51 percent of accommodations made by the U.S. firms interviewed, 30 percent cost less than $50 and 8 percent cost more than $2,000.



National Rehabilitation Hospital

"...The myths about disabled people among potential employers and society-at-large are so pervasive that for them to be hired at all is considered upward mobility."

In some cases little more is needed than some imagination and flexibility. The hearing impaired data entry supervisor mentioned earlier, for instance, was accommodated by a form of job sharing. His telephone work was allocated to a co-worker or subordinate. In fact, his disability has been accommodated in three positions at his advertising agency.

Only 15 of the 50 still employed respondents in the ICD follow-up survey claimed that employers needed to make accommodations for them. These accommodations can be categorized as minor: equipment modifications, such as raising tables, providing footstools and making supplies more accessible; job sharing, such as through reallocating tasks; and flexible scheduling. In one ICD case, for example, a kidney patient's employer merely allowed him to change his work schedule to accommodate his dialysis requirements.

Potential employers apprehensive about finding substitutes for disabled employees who may have to leave their jobs for extended periods because of their disability should know that the ICD-Harris survey showed that 58 percent of disabled full-time workers have worked for at least 5 years, with interruptions totaling no more than one month for the entire period. Seventy-five percent have worked without major interruptions for two or more years.

Employers, however, should consult with state and private rehabilitation agencies to insure appropriate pre- and post-placement training and support. The remarkably high retention rate mentioned above is due to the care with which ICD matched the person to the job and the continuing availability of rehabilitation staff to both employers and employees after placement.

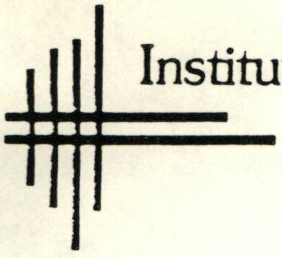
Potential Payoffs Substantial

In every state, there is a mechanism already in place through the local vocational rehabilitation office to lend assistance if and when the need arises. The ICD-Harris survey found that better than 9 out of 10 disabled persons think that the government and private sector should increase efforts to educate, train and rehabilitate disabled persons. Moreover, 8 out of 10 disabled persons feel that less government money should be spent for disabled persons who can, but will not, work. What better sign of motivation and commitment can an employer look for? The relatively minor accommodations that employers need to make can have some impressive payoffs, not the least of which is the knowledge that they have hired good workers and also are helping the American economy.

Previous studies at ICD have shown that a 1,200 percent return on investment can be expected over 25 years for every $1 invested in rehabilitation that results in successful job placement. In the short-term, combining the wages earned with the benefits relinquished, the yield in one year is $1.42 for every $1 invested in rehabilitation. This is due partly to the saving of tax dollars that otherwise would be used for government transfer payments and partly to the multiplier effect of employment. People who are unemployed merely consume. People who are employed both consume and produce. They produce goods and services, contribute to the tax base and create jobs for other people.

Take the example of a 40-year-old woman who had not worked because of childhood polio, which left her with limited mobility. With her medical condition and lack of marketable skills, the woman's attempts at competitive employment were unsuccessful and she supported herself on government disability income of $4,117 per year. To maintain this income for 25 years through age 65 would cost the taxpayer $80,400 in current dollars. After rehabilitation, the woman began work as a clerk typist with a first year income of $12,265. Projected over the next 25 years, her income would total $306,625, which, taxed at 20 percent, would yield the government a net gain of $141,700 in taxes plus savings on transfer payments.

Why, then, are so many disabled Americans unemployed? The answer is that employers need to make what may be the most difficult accommodation of all — abandoning the stereotype of the disabled person. ■



Institute For Rehabilitation & Disability Management

A Partnership of the Washington Business Group on Health and National Rehabilitation Hospital

SELECTION CRITERIA AND PERFORMANCE STANDARDS FOR EMPLOYERS TO USE IN CONTRACTING WITH PRIVATE SECTOR REHABILITATION FIRMS

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Table of Contents

I.	EXECUTIVE SUMMARY	1
II.	RECOMMENDATIONS	3
III.	BACKGROUND	11
IV.	CASE EXAMPLES	16
V.	LESSONS FROM EAP	35
VI.	RESEARCH	39
VII.	SELECTION AND PERFORMANCE REVIEW FORM	44
VIII.	BIBLIOGRAPHY	
IX.	APPENDICES	

Appendix A. Business and Health reprint. Schwartz, Gail and Beggelman, Marlene. "Assessing the Need for Rehabilitation Providers," May 1986.

Appendix B. Letters from rehabilitation providers who requested information about this study.

Appendix C. Memo to WBGH home office and Washington Representatives announcing a contribution from AT&T's Foundation to develop guidelines.

Appendix D. Resource Directory

Appendix E. Copies of two National Rehabilitation Hospital Newsletters that discuss this study.

Appendix F. "State of the Art: Corporate Behavior in Disability Management," Survey Results of 400 major employers.

Appendix G. Galvin, Don and Schwartz, Gail. "Literature Review of Corporate-Based Rehabilitation and Disability Management Programs."

II. RECOMMENDATIONS

Recommendations for facilitating the appropriate usage of private rehabilitation firms are provided below. The recommendations address organizational concerns related to the employer, as well as the selection and management of private rehabilitation firms.

ORGANIZATIONAL PRINCIPLES

o **Rehabilitation and Disability Management Strategies**

Prior to selecting and contracting with private rehabilitation firms, it is important to determine your company's general approach toward disability issues. For example, what is your corporate disability policy? Does your company offer disability benefits? Does your company hire and/or retain disabled persons? Has your company ever contracted with private rehabilitation firms? If so, what has been your company's experience? Better results can be achieved if both the vendor and the employer clearly understand the company's philosophy and practices related to disabled employees.

o **Needs Assessment**

In order to maximize an employers investment with a private rehabilitation firm, employers should first conduct an internal assessment to determine their needs and goals. Does the employer want to use the vendor for the medical case management function or for job placement? Are the goals of job placement to return the individual to a former job or place them within a new company? What does the employer usually do when an employee becomes disabled? What is the vendor's track record in returning disabled persons to work? If the company is unionized, what does the union need and how can the employer and union collaborate to effectively contract with private rehabilitation firms? In summary, what is the employer's ultimate goal?.

o Early Intervention

The success of rehabilitation depends on the timeliness of referrals. Do not delay in assessing employees for referral. The degree of rehabilitation success drops drastically when referral is delayed. A private firm has a much greater likelihood of success when the referral is received promptly following the onset of the injury or disability. Also, it is important to remember that all disabled individuals are not appropriate candidates for rehabilitation. The following factors should be considered when determining who should be referred for rehabilitation services: age, diagnosis, skills, family support, and employee motivation.

o Employee Assistance Programs (EAP)

If your company contracts with an EAP provider, consult with your corporate EAP supervisor. How did they select their EAP provider and how are they held accountable? The role of employers in contracting with EAP providers is similar to their role in selecting and utilizing private rehabilitation firms. Most employers have more experience in using EAPs. Many employers and EAP providers have developed selection criteria and performance standards to use in contracting with EAP providers.

o Corporate Culture

Understand the impact of your corporate culture on the rehabilitation process. Does the corporate culture support return-to-work efforts? Does your company employ people with disabilities? Is there a strong commitment to human resource development?

o Senior Management

It is essential to have the support of senior management. Management will be more committed and helpful if they understand the cost-effectiveness of rehabilitation and return-to-work efforts.

o Consult with Other Employers

Other employers in your geographic region may have developed rehabilitation efforts. Talk to them and learn about their positive and negative experiences in implementing and/or contracting for services. Employer-based health care coalitions such as the Washington Business Group on Health, the New York Business Group on Health, the Midwest Business Group on Health, and others may be particularly helpful.

o Talk to Your Insurance Company

If your company uses an insurer, find out whether the insurer provides rehabilitation benefits. What are the rehabilitation benefits offered to your employees?

o Communicate with Employees

Develop a communications campaign that explains rehabilitation as a positive employee benefit. Communicate with employees about the economic, social and family benefits of re-employment.

o Case Control

If the employer contracts with a private rehabilitation firm, the employer can maximize its success by maintaining close contact and control. A close relationship enables the employer and the rehabilitation firm to support each other's efforts and achievements.

o Communicate with the Provider

It is important for the provider to understand your company's needs and corporate culture. Take the time to get to know potential vendors and give them sufficient time to get to know your firm.

o Selecting the Vendor is Not Enough

Identify whether the vendor refers clients to other specialists for rehabilitation services. For example, if employees with back pain are routinely referred to pain clinics, find out whether the clinic is reputable. Also, find out whether clients obtain positive results in a timely manner. Does the vendor have access to reputable psychiatrists, nurses, physical and occupational therapists, speech pathologists, and other related providers?

o Costs

Most private rehabilitation firms in the same area or state utilize similar fee scales. However, ask about their hourly fee and daily fees so you can compare vendors costs. Some employers ask the vendor to identify the cost of a three-point contact which involves communication with the employee, the employer, and the employee's physician. It would be useful to compare these costs.

o Location and Hours

Where is the vendor located? Be sure that the location is convenient and accessible to your employees. What are the vendor's hours of operation? Does the vendor maintain flexible hours?

o **Privacy and Confidentiality**

Be sure that the proposed vendor has a policy for maintaining privacy and confidentiality. Find out how they protect client privacy. How do they communicate with the employee's family physician, attorney, and former supervisor? Be sure that vendors consult the employer before making contact with third-parties.

o **Request for Proposals**

Consider writing an RFP to recruit a pool of potential vendors. This will help you compare and select providers.

o **Face-to-Face Interviews**

It is best to meet potential rehabilitation vendors prior to making a selection. Request to meet the actual counselors who will be working with your employees. It is not enough to meet the vendor's marketing representative. Get to know the counselors.

o **Professional and Educational Background**

Obtain background information on the staff's academic degrees, educational background, and experience. What criteria does the firm use in hiring staff? In what states are their counselors licensed? Are counselors certified by the Commission on Rehabilitation Counselor Certification? What is the rate of employee turnover?

o **Specialization**

What kind of services does the firm provide? What are their strengths and weaknesses? How long does it take to place a typical client? Does the vendor have a record of previous successes? Does it have the expertise required to handle the particular mix of cases you can anticipate? What is the firms area of specialization (i.e. pain, head injury, mental health)?

o **Employee Contact**

Upon referral, how soon does the vendor contact the client? Does the vendor contact the employee's family?

o **Average Caseload**

What are the counselor's job responsibilities? What is the size of the average caseload? Find out how much time the counselors spend working with clients and how much of their time is spent on administrative matters. Are they making marketing contacts or substantially engaged in non-client relevant activities?

o **Liability Insurance**

It is critical that your vendors carry liability insurance. Find out the type and extent of their liability coverage.

o **Financial Viability**

Find out how long the company has been in existence. How financially secure is the company? Is the firm a member of a state or national chain, or are they a sole proprietor? How are counselors paid -- salary, bonuses, or percent of billable hours?

o **References**

Insist that you be given the names of at least three other firms or insurance companies that have recently utilized the provider's services.

o **Unlikely Rehabilitation Candidates**

What does the vendor do when they determine that an individual is an unlikely rehabilitation candidate?

ASSURING THE PERFORMANCE OF PRIVATE REHABILITATION FIRMS

o Hospital Accreditation

When utilizing the services of a rehabilitation hospital, it is advisable that the hospital be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and/or the Joint Commission on Accreditation of Hospitals (JCAH).

o Written Documentation

The rehabilitation vendor should provide the employer with the following written documentation:

1. Initial Client Assessment Report
   (medical, vocational, psychosocial, family, educational information and status)

2. Rehabilitation and Return-to-Work Plan
   (delineates the vendor's strategy and the specific services to achieve stated objectives, including estimated duration and cost of services)

3. Periodic Progress Reports
   (the customary practice is to require timely written progress reports at least every 30 days)

4. Closure Reports
   (a summary statement with emphasis on reasons for closure and employee's status at closure)

5. Invoices
   (invoices should identify all charges in detail)

o Managing Reports

Decide what the vendor's report should contain. How frequently should reports be submitted? How soon following referral should the report be submitted?

o Charges

Determine what charges are reimbursable. Are you willing to reimburse for travel, phone calls, and waiting time in physician offices? Develop a written policy which addresses allowable charges. This will help avoid future problems.

Assessing the Need for Rehabilitation Providers

BY GAIL E. SCHWARTZ AND MARLENE BEGGELMAN

Employers can contract with providers who offer cost management, return-to-work programs.

DISABILITY REPORT

The provider rehabilitation sector is expanding rapidly. In 1982, private sector rehabilitation costs to third party payers were approximately $450 million and at that time were growing at a rate of 30 percent a year, according to a 1985 U.S. Department of Education study. Changes in worker compensation and casualty insurance laws, coupled with an increasing awareness of disability costs on the part of employers, have contributed to this marked growth. As a result, many employers are interested in getting their disabled employees back to work.

According to the National Association of Rehabilitation Professionals in the Private Sector (NARPPS), there are approximately 1,500 private rehabilitation companies in the U.S. employing over 8,000 individual rehabilitation practitioners. A recent survey conducted by the Washington Business Group on Health's Institute for Rehabilitation and Disability Management found that only 8 percent of the 400 companies contacted have in-house physical or vocational rehabilitation programs while one-third, or 34 percent, contract with private rehabilitation providers for medical or vocational services.

Rehabilitation providers can be for-profit or nonprofit operations and can consist of one- to two-person operations or may be large multistate vendors. They usually provide some combination of medical, psychosocial, vocational and/or case management services, with a goal to stabilize the employee's medical condition, maximize his or her capacity and return the individual to work. Health problems that are commonly addressed include trauma, such as spinal cord injury, burns, stroke, brain injury, falls and low back pain, and cardiac related difficulties, such as heart attack, angina and congestive heart failure. Frequently used rehabilitation services include occupational and physical therapy, pain control programs, spinal cord and head injury centers, cardiac rehabilitation, mental health vocational counseling and job placement skills training. In addition, rehabilitation oriented services such as employee assistance programs (EAPs) and community services such as Alcoholics Anonymous (AA) may be used.

These services are identified as medical management and/or expedient return-to-work programs. Where feasible, the two kinds of programs should be carried out simultaneously. Numerous studies support the finding that intervention and vocational rehabilitation efforts are most successful when conducted early on.

Weighing Outside vs. In-house Programs

The corporate decision to develop an in-house program or contract with a rehabilitation provider must take into consideration the following factors.

- How many disabled employees does a company have in a given geographic location? If a company has an extremely decentralized labor force, it may be more cost-effective to contract for services because few employees would be participating in an in-house program.

- What is the company's primary industry type? For example, by their very nature, industries such as manufacturing and trucking are more prone to disability cases than the retail industry. Therefore, if a company has a large number of employees on its disability rolls, it is more cost-effective to develop an in-house program. A Tennessee Valley Authority (TVA) cost analysis showed that the in-house TVA rehabilitation service was more cost-effective than similar services that could be contracted from the private sector. In 1984, 49 percent of the employees who were referred to the in-house program were rehabilitated and returned to work. However, only 36

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percent of employees that were referred to outside providers returned to the work place.

• What rehabilitation services exist at the local and community level? If there are sufficient community services available, the employer may want to assess whether they are sufficient to meet the needs of employees. In addition, an employer may want to decide what gaps exist and determine whether the gaps can be best filled through a provider or an in-house program.

• What is the company's current level of involvement in health care management and/or delivery? A company with an EAP, for instance, may want to expand that service to include disabled employees.

• What is the company's previous experience, if any, in returning disabled employees to work? Last year, FMC Corporation returned two severely disabled employees back to work within six months of the onset of disability. Both cases were referred for outside rehabilitation services during the first week of injury. Had no attempt been made to return these employees back to the work place, FMC would have incurred costs for incapacitated and nonproductive workers until retirement.

Employee Health Profile Key

Fundamental to a rehabilitation program is to establish a plan for service selection rather than to respond exclusively to the first provider who knocks on the door. The service selection should match the employee health profile. The most frequent, costly and serious employee health problems will vary depending on characteristics such as age, sex, socioeconomics, geography, as well as work and work exposure. Reasonable success depends on planning a range of services that address the most problematic areas that also are amenable to intervention. For example, a population of heavy laborers usually will have increased rates of low back pain problems. Furthermore, motor vehicle accidents can be a serious disability issue in a young male population, whereas cardiovascular problems are more prevalent among older workers.

Defining appropriate targets for intervention usually requires a team effort drawing on many sources of expertise, clinical and nonclinical. Because this selection often involves much uncertainty and difference of opinion among rehabilitation staff, input from knowledgeable individuals in rehabilitation insurance, medical benefits and clinical specialities is invaluable.

An efficient way for an employer to organize these efforts is to appoint a capable in-house coordinator responsible for program development. The coordinator should play a key role in integrating complicated, differing opinions, developing a working plan and following performance over a set period of time. This will help the employer prevent the rehabilitation provider from developing plans that are incongruent with the company's return-to-work efforts.

Employers also need to ask providers whether cases are handled in a timely manner and what is the average caseload. The employer should ask if the provider has an internal evaluation system and how previous clients have evaluated the provider's services. Another consideration is how supervision is structured.

An important part of the selection process involves interviewing the rehabilitation staff who will handle the cases. Employers must try to observe staff counseling skills and whether they evoke enough trust for patients and family for optimal rehabilitation. Of course staff within the same organization will differ markedly in these types of skills, yet establishing a relationship with specific individuals and requesting consistent assignment of cases to their care can be a point of contract negotiation with the provider.

Parameters of Evaluation Design

Even before services are provided, an evaluation plan should be in place. A common problem in evaluation design is the lack of adequate control groups. For example, 80 percent to 90 percent of people with low back pain get better without any treatment. It is easy, therefore, to make a low back pain program look successful by selecting people who would have recovered in any case. However, establishing a well-matched control group with comparable age, sex and work exposure, for example, could be used to evaluate more accurately the effect the rehabilitation intervention had on recovery.

Another problem with evaluation design is failure to consider any biased and confounding factors affecting recovery. For example, an EAP for alcoholism might appear inaccurately successful when the real effect stems from concurrent enrollment in an AA program. Employer funds invested in evaluating the effectiveness of rehabilitation programs, especially those that are expensive, can be cost-effective and can result in employee satisfaction as well.

One point of caution is to be wary of providers who maximize short-term results at the expense of long-term well-being and expenses. Saving money by denying necessary rehabilitation services eventually will alienate employees and ultimately increase long-term costs to the company.

An effective rehabilitation program should foster employee enthusiasm and support by focusing heavily on interventions that will save money by improving health care and well-being. Furthermore, the success of the rehabilitation process involves the employer's acceptance of and cooperation with provider efforts. The process of improving employee function and bringing him or her back to work requires upper and middle level management to be receptive to such a program. It also places responsibility on the employer to refer cases in a timely manner and assure that the rehabilitation provider is held accountable for its services. Once these developments take place, rehabilitation providers can provide the employer with services that enhance employee job opportunities, flexibility and modifications, all of which are essential in returning employees to work. ■

AIDS: Employers' Rights And Responsibilities

By Elizabeth Younger and Linda Harris

Acquired Immune Deficiency Syndrome (AIDS) has now been recorded in every state in the United States. It is estimated that approximately 1.5 million people have been infected with the AIDS virus in this country. Scientists predict that between 20 and 30 percent of those 1.5 million infected people will develop AIDS within five years. (As of November 1986, 26,878 people have been diagnosed as having full-blown AIDS; approximately half of them have died.) Another 100,000 to 200,000 may develop AIDS-related complex (ARC), according to the Surgeon General's recent report on AIDS. The report warns that all of the 1.5 million people already infected "are assumed to be capable of spreading the virus sexually (heterosexually or homosexually) or by sharing needles and syringes or other implements for intravenous drug use."[1]

Like it or not, almost every employer in the United States will eventually have to deal with AIDS, either in a preventive or a crisis manner. Among the complex issues this new disease raises:

- What is the employer's legal responsibility to an employee with AIDS?
- Can individuals with AIDS be fired or forced to take a medical leave?
- Is it safe to work with someone who has AIDS?
- How can an AIDS patient best be cared for?
- How much will that care cost? Will it be covered by insurance?

Ultimately, AIDS can be effectively and humanely addressed in the workplace if employers consider all these issues in light of their own rights, responsibilities, and opportunities.

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Almost every employer in the United States will eventually have to deal with AIDS, either in a preventive or a crisis manner.

One of the principal concerns for the workplace is whether AIDS can be transmitted to fellow employees or other people the individual with AIDS deals with on the job. All of the scientific evidence thus far indicates that transmission is not possible through casual personal contact:

- In a study of more than 300 households in which a person with AIDS lived, not a single case of transmission was recorded, except from sexual contact or from infected mother to newborn. Many of those tested were children who shared beds, bottles, toothbrushes, and eating utensils with an infected sibling.[2-4]
- In studies of 1,750 health care workers with intense exposure to AIDS patients, no individuals were found to be infected who did not otherwise belong to a high-risk group. (High-risk groups include sexually active homosexual and bisexual men with multiple partners; present or past abusers of intravenous drugs; patients who have received transfusions of blood or blood products; hemophiliacs or those with other coagulation disorders; those who have had sexual relations with someone who has AIDS or who is at risk for AIDS; infants born to infected mothers.)
- In another important study, 660 health care workers who accidentally stuck themselves with contaminated needles did not become infected. In fact, there has only been one documented case of such contamination thus far. That occurred when a nurse received a microinjection of contaminated blood after an arterial puncture.[5,6]

The consensus among medical professionals—that AIDS cannot be transmitted through casual contact—is expected to shape many of the legal rights and responsibilities of employers.

Medical Update

The virus that causes AIDS is alternately called HTLV-III or LAV. Transmission has been demonstrated to take place through:

- Intimate sexual contact, involving the exchange of body fluids with an infected person
- Sharing needles contaminated with the virus
- Exposure to blood or blood products from infected persons
- Infected women to their newborns.[7-12]

AIDS suppresses the immune system, leaving the body vulnerable to life-threatening infection.[13] Two infections that commonly attack individuals with AIDS are:

- *Pneumocystis carinii* pneumonia, a lung infection
- Kaposi's sarcoma, a rare form of cancer.[14]

During the incubation period, there may be no tell-tale signs of AIDS. As the illness progresses, some of the following symptoms develop, either recurrently or persistently:

The Surgeon General on AIDS

This fall, U.S. Surgeon General C. Everett Koop issued a report on the latest scientific evidence about AIDS (Acquired Immune Deficiency Syndrome). The report makes it clear that this deadly, frightening disease is not transmitted through the kind of casual social contact that takes place at work. Working with someone who has AIDS will not put you at risk. Having sexual relations or sharing illicit drug injections with someone exposed to the AIDS virus will.

Following are excerpts from *Surgeon General's Report on Acquired Immune Deficiency Syndrome*:

"Casual *social* contact such as shaking hands, hugging, social kissing, crying, coughing or sneezing, will not transmit the AIDS virus. Nor has AIDS been contracted from swimming in pools or bathing in hot tubs or from eating in restaurants (even if a restaurant worker has AIDS or carries the AIDS virus.). . . "The most certain way to avoid getting the AIDS virus and to control the AIDS epidemic in the United States is for individuals to avoid promiscuous sexual practices, to maintain mutually faithful monogamous sexual relationships and to avoid injecting illicit drugs. . . .

"It is estimated that in 1991 54,000 people will die from AIDS. At this moment, many of them are not infected with the AIDS virus. With proper information and education, as many as 12,000 to 14,000 people could be saved in 1991 from death by AIDS."

- Fever, including night sweats
- Rapid weight loss for no apparent reason
- Swollen lymph nodes in the neck, underarm, and groin
- Constant fatigue
- Unexplained diarrhea
- White spots or blemishes in the mouth.

These are also symptoms of many other diseases. In the case of AIDS, however, the symptoms are not explained by any other illness and persist for unusually long periods of time.[15] In later stages of the disease, the immune system of those with AIDS becomes severely weakened, turning normally mild, harmless infections into potentially fatal conditions.[16]

ARC is a closely related but usually less severe illness that may vary from one extreme to the other. Some infected persons may be relatively healthy; others may be very ill

One of the principal concerns for the workplace is whether AIDS can be transmitted to fellow employees or other people the individual with AIDS deals with on the job. All of the scientific evidence thus far indicates that transmission is not possible through casual personal contact.

but not have the exact symptoms necessary to fit the Centers for Disease Control (CDC) definition of AIDS.

As of this time, there is no known cure for AIDS. But a new drug, AZT (azidothymidine), has been shown in clinical trials to prolong the life of people with AIDS. It is still not known, however, whether the benefits of the drug are only temporary or whether serious side effects will ultimately be found with longer administration of the drug.[17]

A Protected Class?

One of the big unanswered questions is whether those with AIDS should be protected from employment discrimination under the Federal Vocational Rehabilitation Act of 1973, which protects handicapped and disabled workers from discrimination because of their handicap. (The act only applies to contractors, grantees, and employers of the federal government. But many states have similar laws.)

There have been several court opinions extending employment and education protections to those with other contagious diseases: Among those rulings:

- The U.S. Court of Appeals concluded that tuberculosis, another contagious disease, qualifies as a protected handicap under the Rehabilitation Act. The U.S. Supreme Court is expected to review this ruling during its 1986–87 term.
- A similar Federal District Court decision held that it is a violation of the Rehabilitation Act to restrict handicapped children with hepatitis B, a contagious disease, to certain classes.

Thus, if individuals with AIDS are qualified and can carry out the essential duties of an employee, they are probably protected and cannot be fired by virtue of testing positive for the AIDS virus.[18]

The U.S. Justice Department issued a memorandum on AIDS in June 1986 agreeing with the above interpretation. However, the memorandum stated that fear of contamination would be a legitimate reason for firing or refusing to hire someone with AIDS. It noted that the individual's potential (whether real or imagined by the employer) to transmit the disease is not a handicap and, therefore, not protected under the Rehabilitation Act.[19] It is unclear at this point what impact the Justice Department ruling will have on future judicial interpretations of the AIDS issue.

State Laws

Many legal experts believe that state laws protecting the handicapped and disabled from discrimination will apply to those with AIDS. Some jurisdictions have explicitly spelled out those protections. The New York Division of Human Rights Policy has ruled that AIDS is a protected handicap under state law.[20]

Other states have declared AIDS to be a handicap under their own laws prohibiting discrimination against the handicapped.[21] Among them:

- Connecticut
- Florida
- Illinois
- Maine
- Massachusetts
- Michigan
- Minnesota
- Missouri
- New Jersey
- New Mexico
- Oregon
- Washington
- Wisconsin.

Rights and Responsibilities

Assuming then, as many legal commentators do, that AIDS will eventually be classified as a protected disability or handicap, what are the employer's rights and responsibilities?[22]

Q. *May an employer take adverse action against an employee with AIDS because of fear of contagion?*

A. The medical opinion is essentially unanimous that AIDS cannot be spread through casual social contact. Segregation without solid medical justification would probably violate statutory prohibitions against discrimination on the basis of disability. However, according to the Justice Department ruling, organizations that receive federal funding (those subject to the Rehabilitation Act of 1973) can dismiss individuals with AIDS or exclude them from employment if the employer believes that the action will prevent the spread of the disease. But the Justice Department ruling does not apply to state laws that protect the handicapped from employment discrimination. Although federal agencies generally follow the statutory interpretations of the Justice Department, it is unclear yet how much—if any—weight the courts will place on the ruling.

Nevertheless, the ruling is likely to contribute to the perception that if the employer believes that AIDS can be transmitted in the workplace, the employee may be fired—even though current medical opinion is that AIDS cannot be spread through casual contact.

Many legal experts believe that state laws protecting the handicapped and disabled from discrimination will apply to those with AIDS.

Q. *May an employer fire someone with AIDS because of economic concerns that the employee may soon be incapacitated?*

A. No. Case law interpreting disability statutes generally rejects "future risk" arguments.

Q. *May an employer force a person with AIDS to take a medical leave of absence?*

A. No, unless the employee is physically unable to perform his or her normal work duties.

Q. *What job accommodations are employers obliged to make for persons with AIDS?*

A. Employers are legally bound either to provide reasonable accommodations or to change the job of a disabled or handicapped person. Such accommodations should not cause unreasonable disruption to business.[23]

Q. *May an employer deny employment to an otherwise qualified applicant with AIDS?*

A. No, unless the disease is so advanced that the employee is incapable of performing the duties the job requires.

Q. *May an employer ask job applicants whether they have AIDS or whether they have been exposed to the AIDS virus?*

A. No. Disability statutes generally prohibit overly broad pre-employment inquiries that are not job-related.

Q. *May an employer require job applicants to take a blood test for AIDS?*

A. Yes, *if* the test is part of a broad pre-employment physical required for all potential employees. It would be considered discriminatory to require only selected individuals to submit to a physical.[24] If the employer decides not to hire someone who tested positive for exposure to the AIDS virus, it could be difficult to prove that the applicant was not discriminated against because of the test results.

Q. *Is the employer obligated to tell employees if one of their co-workers tested positive for the AIDS virus?*

A. No. The employer is not bound to disclose this information to other employees or anyone else. In fact, disclosure may compound the employer's legal and personnel problems. Employees may erroneously believe that their work environment has become unsafe and try to invoke federal labor relations acts that grant them the right to refuse to work in a perceived unsafe environment.[25]

Q. *What if employees refuse to work with someone who has AIDS?*

A. Even though federal laws require employers to provide a safe working environment, it clearly would be discriminatory to resolve the conflict by isolating the individual with AIDS.[26] Since all the available medical data indicate that AIDS is not contagious through casual contact, it is likely that the courts would uphold the rights of the person with AIDS. The employer should educate protesting employees about the minimal risk. If they still refuse to work with their infected co-worker, the employer may threaten discipline and eventually replace them permanently.[27]

Testing for AIDS

The current HTLV-III blood test, which detects the presence of antibodies to the AIDS virus, cannot actually determine whether a person has or will later contract the disease. All it can tell is that someone has been exposed to the virus. There is no way of knowing from the test whether the virus is still present or currently active. Many people who have antibodies to AIDS will never come down with the disease.

Employee Education

Employers should address the issue of AIDS before the first case is reported since the employees' level of receptivity will be much higher. General hysteria accompanying the first case of AIDS can often lead to the suspicion that management is not providing all of the information available. In that atmosphere, employees may distrust the validity of the medical evidence employers give them about the safety of working with someone who has AIDS.

Perhaps the best approach is to incorporate an AIDS information campaign into existing employee benefits communication programs to educate employees about AIDS and the corporate policy on dealing with the disease. This approach allows employers to assure workers that AIDS will be treated like any other catastrophic illness under the company's group health insurance policy.

At the Cutting Edge

Taking the lead in employer efforts to educate themselves and their staffs about AIDS is the Business Leadership Task Force, comprised of 15 major Northern California employers. Among the innovators:

Levi Strauss. This company offers such programs as lectures for managers by experts on AIDS; resource and support classes for persons with AIDS, as well as for relatives and associates; a video presentation that can be checked out for home viewing; and regular updates on AIDS in the company newsletter.

Pacific Bell. This utility company provides AIDS seminars in connection with the San Francisco AIDS Foundation and publishes in company newsletters sensitive information about sexual activity related to AIDS.

Bank of America. This corporation has made a commitment to "reasonable accommodations" for persons with AIDS and other illnesses, recognizing that continued employment of someone with a life-threatening illness may be therapeutically important to the remission or recovery process and perhaps even prolong that person's life.[28]

Insurance Coverage

Large employer-sponsored group health insurance plans, covering more than 25 employees, generally treat AIDS as any other catastrophic illness. Approximately 85 percent of insured workers are covered by such plans. The group plans typically do not involve individual underwriting; therefore, employees are not subjected to medical questions or testing in order to qualify for coverage.[29]

However, individuals with AIDS or who have a lifestyle associated with an AIDS high-risk group may find it difficult to get health insurance coverage through an individual or small-group policy. Insurance companies have historically utilized medical questions and testing to determine insurability under such plans. The insurance industry is using blood tests for individual or small-group applicants, where not prohibited by state law.

Some states that have restricted the use of tests for AIDS include:

- California, which prohibits the use of the HTLV-III antibody test results by insurers and business.
- Wisconsin, which requires that such testing first receive approval from the state health department.[30]

The District of Columbia has also passed a law that prohibits health and life insurers from denying coverage to persons who test positive for exposure to the AIDS virus. The law also specifies that such persons may not be charged a higher rate during the first five years of coverage. The law is intended to prevent insurers from discriminating

Employers should address the issue of AIDS before the first case is reported since the employees' level of receptivity will be much higher.

against those who show signs of having been exposed to AIDS. However, it does not extend protections to those actually diagnosed as having the disease.

Case Management

The typical health care plan for AIDS patients is hospital based. However, employers and insurers are beginning to recognize that health care costs can be substantially reduced by encouraging alternatives to hospital care.

The U.S. Centers for Disease Control has estimated the cost of hospital care for the first 10,000 AIDS cases to be $1.47 billion, with the average cost per case at about $147,000.[31] However, the average cost per case in San Francisco is considerably lower—between $25,000 and $32,000. A major reason for this large discrepancy is the implementation of individual case management programs among West Coast health care purchasers.[32]

In San Francisco, where a full array of community support systems exists and are supported by employers, AIDS patients typically stay in the hospital for only 11.4 days, compared with 31 to 50 days in many other cities. In addition, only 10 percent of AIDS patients in San Francisco spend time in the intensive care unit. Many are cared for at home, with friends, or at hospices and nursing homes. They and their loved ones receive practical, emotional, and spiritual support from a variety of community organizations.[33]

In San Francisco, where a full array of community support systems exists and are supported by employers, AIDS patients typically stay in the hospital for only 11.4 days, compared with 31 to 50 days in many other cities.

Case management, a relatively new concept, is designed to customize care for individual patients with catastrophic illnesses. The process requires cost analysis and coordination by an individual case manager, often a nurse. The case manager compares the costs and quality of care provided by health care programs within the community with those of inpatient hospital care, then discusses the options with the patient, family, and health care professionals. (For more information on case management, see pages 38 to 43 in this issue.)

Finally, the case manager presents a cost-effective and humane plan to the purchaser. The plan goes far beyond mere medical care for the disease. Emotional support and training are also extended to family and friends, who typically assume a great deal of responsibility for the patient's care. Following are three case examples:

- *After spending nine days in intensive care, Joe, a 32-year-old AIDS patient, was too sick to go home alone. But he no longer needed to stay in an intensive-care facility. His employer's case manager arranged for a visiting nurse to care for him at home. This arrangement was not originally covered under Joe's health insurance plan. But the case manager negotiated with the insurer to include all costs for his home care.*

- *A 28-year-old West Virginia man with AIDS was struck down by an opportunistic disease while he was visiting his mother in a retirement community in Texas. His case manager determined that with training, his mother could care for him during this period. Her training for home care was paid for under his amended insurance plan.*
- *Sally was working as an upper-level manager in a software company when she was stricken with AIDS. She was determined to finish a major project but was becoming too weak to commute to her office every day. Her managed care included a job accommodation allowing her to work at home.*

In each case, a comprehensive, individualized health care plan called for the creative coordination of employer, family, and community resources. Each of these alternatives to institutional care cost significantly less than care in the intensive care unit of a hospital. And such an individualized approach is often preferred by the patient.

Taking the Lead

Although most businesses are not in the business of health care or health education, it is to their advantage and to their credit to take the lead in this national health crisis. Employers may feel awkward dealing with the taboo subject of AIDS and with employees who have the disease. Nevertheless, they are legally and ethically bound to treat employers with AIDS the same way they must treat those with other catastrophic and disabling conditions.

Some companies have already demonstrated courage and innovation in their educational and health policies. These employers, along with those who follow their lead, will help eliminate the fear and discrimination that plague individuals with AIDS.

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Company Responses to the AIDS Threat

Despite widespread public concern about the growing AIDS epidemic, few American companies appear to be taking concrete steps to deal with the problem at the workplace. The American Management Association (AMA) reports that only about four percent of the 124 respondents to a 1985 survey have established formal policies to deal with AIDS. The AMA polled human resources managers and readers of its *Personnel* magazine.

Employee Education

Only 15 percent of respondents said their company was attempting to educate employees about AIDS. Most of those with education programs attempt to reach all employees through a variety of means—from articles in employee publications, to health fairs, and videocassettes. A few companies limit their educational efforts to such groups as managers or personnel officers.

Only 10 of the 101 respondents without educational programs said their company planned to establish one soon. Lack of legal guidelines and of employee concern were two of the main reasons given for not setting up an educational program.

Co-Worker Reactions

For many companies, the AIDS epidemic is still of only theoretical concern. Just seven of the 124 respondents said they knew of employees with AIDS or ARC (AIDS-related complex). One other organization said a former employee had died of AIDS.

Employees in five of the seven organizations knew that a co-worker suffered from the disease, while those in the other two companies did not. Employee reactions to the news were mixed. One large communications firm said the information caused "no problem" at its California subsidiary, while employees at its Texas office refused to work if the AIDS victim returned to the job.

In a number of cases, education seems to make a difference. Nine of the 19 organizations with education programs said they thought the programs had allayed employee fears. A representative of a large Western financial firm with an AIDS employee said that without education, employee reactions were fearful; with education, they were positive and supportive.

Health Care and Support

A surprisingly high number of organizations—49 percent—reported that AIDS victims are covered by their medical insurance for such alternative long-term care as home or hospice care or case management. In addition, 69 percent of those with such medical coverage reported that it had cut the long-term costs of such illnesses as AIDS and cancer.

However, only 23 percent of the respondents said their organizations offer employee assistance programs or counseling services to help AIDS victims and their families cope with the disease. And only one of those organizations reported that the counselor was specifically trained to work with AIDS patients.

30 EMPLOYER INITIATIVES IN THE EMPLOYMENT OR RE-EMPLOYMENT OF PEOPLE WITH DISABILITIES: VIEWS FROM ABROAD

World Rehabilitation Fund
International Exchange of Information in Rehabilitation

MONOGRAPH NUMBER THIRTY

EMPLOYER INITIATIVES IN THE EMPLOYMENT OR RE-EMPLOYMENT OF PEOPLE WITH DISABILITIES: VIEWS FROM ABROAD

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TABLE OF CONTENTS

PREFACE 4

AUTHORS' AFFILIATIONS 6

OVERVIEW
Sheila Akabas 7

I PROGRAMS OPERATED BY INDIVIDUAL FIRMS

- The Employment of Disabled People in Scottish Gas
by Douglas Walker 13
- Integration of Primarily Physically Disabled Persons in a Manufacturing Company
by Manfred Schulz 29
- People with Disabilities in the Workforce, the Experience of VAUXHALL Motors Limited
by P.F. McDonald 34
- The Toronto Transit Commission and Canada's Human Rights Code
by W.G. Frost 40

II PARTNERSHIP PROGRAMS IN WHICH GOVERNMENT MAY OR MAY NOT BE INVOLVED

- On the Development of Early Rehabilitation Programs in Finland
by Kirsti Tuunainen 43
- Japan's New Model of Employment of Severely Disabled Persons through the "Third Sector" Companies
by Yoko Kojima 56
- The Jewelry Technical Center of Israel: A U.S./Israeli Partnership
by Gail A. Magaliff and Brian Newman 71
- Employment for Disabled in France through a Tripartite Program: GIRPEH
by Annick Mallet 78

III PARTNERSHIP ARRANGEMENTS IN WHICH GOVERNMENT IS A KEY FACTOR

- Rehabilitation in Australia—A Program Involving Unions and Employers
by Doug Limbrick 83
- Alternative Programs for Employment and Job-Seeking Strategies in Israel
by Yecheskel Taler 88
- Employment for the Handicapped in the Netherlands
by John Franquinet, Jelle Jan Klinkert, and Jan Vlaanderen 99
- The Shaw Trust's Experience with Supported Employment
by Ron Whitehouse 105

IV TWO NATIONAL OVERVIEWS OF POLICIES AND PROGRAMS

- Utilizing the Labor Potential of Disabled Persons: Disability Policies in the Soviet System
by Aliki Coudroglou 111
- Retention of Workers: A Challenge for American Business and Industry
by Jay Rochlin 123

Preface and Acknowledgements

Over the past six years the World Rehabilitation Fund has published twenty-nine monographs in its International Exchange of Experts and Information in Rehabilitation series. This has been possible through a grant from the National Institute of Handicapped Research which encourages the international exchange of ideas.

The International Exchange of Experts and Information in Rehabilitation project's raison d'etre is to "import" knowledge and new ideas from abroad which have the potential of enhancing the knowledge base in the U.S.

In the 1985 monograph series five new monographs have been prepared by foreign authors. They are:

Monograph #30—Employer Initiatives In The Employment Or Re-Employment Of People With Disabilities: Perspectives From Several Countries

Monograph #31—The More We Do Together: Adapting The Environment For Children With Disabilities (The Nordic Committee on Disability)

Monograph #32—Life Transitions Of Learning Disabled Adults: Perspectives From Several Countries

Monograph #33—Evaluation And Information In The Field Of Technical Aids For Motor-Impaired Persons: A European Perspective, by Profs. Antonio Pedotti and Renzo Andrich (S.I.V.A., Italy)

Monograph #34—Bridges From School To Working Life, by Trevor Parmenter (MacQuarie University—Australia)

Two of these monographs, #30 and #31, have been prepared using the contributions of several authors selected through an extensive network of contacts which the IEEIR has developed over the years.

We are most grateful to Sheila Akabas, Director of the *Columbia University School of Social Work's Center for Social Policy and Practice at the Workplace* for her expert assistance with the IEEIR in developing the topic for this monograph as well as the selection of authors. Dr. Akabas has been involved throughout in the process of pulling together the various articles which were submitted as well as reviewing them and tackling the problem of integrating them into her commentary.

It is important, we feel, not only to present ideas and information about programs, practices and policies from abroad, but also to provide a U.S. context. This is what both Sheila Akabas and Jay Rochlin were asked to do. We greatly appreciate their efforts in relation to that task.

When we learned that Aliki Coudroglou, a former WRF fellow, was taking her second professional trip to the U.S.S.R. in May 1985, we asked her if she would be willing to provide us with a "late entry" for this monograph

which would contrast the Soviet system with what we have called "employer initiatives." Her article, "Cooperative Enterprises and the State of the Soviet Disabled Worker," provides an interesting contrast to the other articles.

We want to thank all of the authors who made a commitment and contributions to this monograph. Without them, of course, we would not have been able to have such a rich array of ideas and approaches to share with you, the reader.

And last, but perhaps most important, we want to thank you the reader for your interest in this international exchange of ideas in rehabilitation. The hope is, of course, that through this exchange of ideas in the field of rehabilitation the lives of disabled persons throughout the world will be affected positively.

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OVERVIEW

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Ever since Adam Smith legitimated self interest by identifying that it and competition are the invisible hands leading to the greatest welfare of the greatest number under a capitalist economy, program planners have sought to sell programs based on making the connection between beneficent behavior and self-interest. Feeding recent fuel to this flame of "every man for himself," the authors of *Doing Good: The Limits of Benevolence* suggest that public beneficence is far from harmless. In fact, under its guise much damage is done. Experience in rehabilitation has, in part, confirmed this conclusion—i.e. assuring *long* recuperative periods following illness or accident, and providing long-term *disability pension* for the disabled, may not be in the best interest of the recipient of such "generosity." Such "munificence" severely reduces potential lifetime income of the person with a disability, endangers his or her self-esteem, sense of accomplishment and social opportunities, and removes, from daily life, the key organizing theme that active employment provides.

But until early retirement schemes for persons with disabilities were identified as contrary to the self-interest of the employing organization, alternative options received limited attention. Now, however, a combination of forces has aroused employers to define maintenance at work for disabled employees as a matter of self-interest. This offers new hope to the disabled because where once employers viewed their self-interest as allied to early retirement of workers, the new information suggests the converse—that maintenance of disabled workers on their jobs, or accommodation to some other function in the same workplace, may offer a superior cost/benefit outcome for the employing organization. This new evaluation is the result, in part, of the computerization of information that has allowed company benefit managers to take a more comprehensive look at the high cost of those who have been retired early on disability, and, in part, of a realization that the aging of the American labor force, aided by a medical technology that improves the life expectancy of chronically ill persons, has vastly increased the number and proportion of those of working age who are limited in their ability to work. Fully 25% of the 55-64 age group, for example, a group with significant ties to the workplace, are functionally disabled to some degree.

Thus, the ongoing costs incurred by retiring someone early, coupled with the loss of skilled, dependable workers that such early retirements foster, have made employing organizations take a new look at the possibility of maintaining disabled workers at the workplace. The emerging trend, job maintenance of disabled workers is, therefore, that win-win situation where

the pursuit of self-interest results in the best of benevolence.

In the search for a programmatic response to this new set of ideas—for all new objectives require new programs—we need not rediscover what is already available. This monograph, which culls private initiatives in the maintenance and return to work of persons with disabilities throughout the world, provides readers with a chance to review best practice from around the industrialized world. It is not our purpose to review what has been written here, but rather to offer a context for thinking about the ideas that are presented, and to whet the readers' appetite concerning the various options. There are at least three reasons why readers of this volume will find something of value here:

—*First,* the diversity of different national solutions suggests a rich array of options, and these options are responsive to a variety of industrial as well as national conditions. Faced with making choices, American management can look into the menu offered here—if Column A has nothing appetizing, try Column B!

—*Second,* to the degree that the variety of solutions here are typical of, or fostered by, particular aspects of the national culture in which they are derived, our own national melting pot may offer a comparable group in need of a similar, culturally derived solution.

—*Third,* the many American firms that are multinationals indeed may welcome a chance to adopt policies that are characteristic of responses from a diversity of nations.

The articles presented cover a great variety of programs and practices. They confirm the industrialized world's universal recognition of the significance of work to general well-being. Although the words may differ depending on the article, each author appears to agree with the same underlying assumption that is expressed by Ron Whitehouse, writing about the Shaw Trust: "...the work ethic is a necessary stimulus in progressive human development and the dignity of earning one's living can be the springboard for an independent and self-reliant lifestyle." This belief is quite ancient, as Yecheskel Taler, writing from Israel helps us recall. The concept has its origins in the Old Testament, which accords to persons with disabilities the same status as any others. Taler reminds us as well that the greatest help one individual can give another, according to the revered Jewish sage, Maimonides, was to give a person work "...in order to strengthen him until he no longer needs to ask for help."

The translation of these fundamental principles to the actual employment situation appears, in these articles, to fall into two general arenas, and they have been used to organize the content that follows:

—those programs developed and promoted by individual firms, and

—those programs which reflect cooperation among several parties, often involving rather unique partnership arrangements.

These later, in turn, break down into two subsets, namely

- **those in which government may or may not be involved, and**
- **those in which government's involvement makes it the key actor.**

A final section of this monograph provides a national overview of policy and program in the United States and the Soviet Union.

Programs Operated by Individual Firms

The magnitude of the programs reported by individual firms is impressive, ranging from active job maintenance efforts to in-house rehabilitation programs that could match the components in many community facilities. Each demonstrates the coalescence of self-interest and benevolence. The reports suggest situations that are probably comparable to what American industry is experiencing. For example, Walker notes that over 7% of the labor force at Scottish Gas has some disability, and that two thirds of these, often the most severe, have developed since the individual was employed. In recognition of this, and of the faltering work ability of the aging members of their labor force, BMW reports the use of ergonomics to accommodate the needs of special populations of workers, and identifies that by studying the demands of the jobs filled by employees who become disabled, they are able to humanize work life for everybody.

Another side benefit is detailed by McDonald of Vauxhall who claims that safety consciousness increases when a company focuses on disability and provides the kind of in-plant rehabilitation service offered at Vauxhall. McDonald also calls attention to the connection between company policy and community welfare that is apparent when the company is the major local employer. He concludes that such dominant employers are well served by a rehabilitation program that helps create a community image of a caring employer. This is confirmed by Frost of Tbronto Transit who notes that not only its employment policy but its product is the subject of community attention in relation to the needs of persons with disabilities. In one way or another, the authors of these individual company reports mirror Frost's conclusion that, "Looking at existing employees, those who have become disabled but are fit for some form of work, every effort is made to match that employee to a suitable job. As a result, these employees can continue to live a fruitful life and at the same time make a meaningful contribution to the organization."

Partnership Programs in Which Government May or May Not Be Involved

Many observers question whether individual companies can or will undertake major rehabilitation efforts. They point to the mobility of the American labor force and wonder whether the company that makes an

expenditure on its labor force is necessarily rewarded for its investment, or whether that reward accrues to another employer (negating the desired balance between self-interest and benevolence). As well, they note that large employers account for only a small portion of the employment opportunities, and wonder, if only large employers offer job maintenance, what happens to the employees of the numerous small and medium sized worksites that are less likely to offer an extensive rehabilitation effort. For such doubters, the descriptions of the many partnership arrangements provide important ideas. Creative elements dominate these cooperative arrangements.

The model which comes closest to a private employer while still incorporating a partnership arrangement is detailed in the Finnish contribution. Recognizing the natural inertia of an employing organization concerning the development and maintenance of a rehabilitation outlook, Tuunainen describes a model that compensates by introducing into the system an objective third party, in this case the Rehabilitation Foundation, to initiate, facilitate, prod and reward effective efforts at early rehabilitation. Discouraged innovators at home would do well to note the patience required, the need for attention to process, and the importance of in-depth training of all organizational personnel on the road to establishing early rehabilitation as a routine workplace activity. The article offers an informed account of organizational change.

In Japan, leading corporations serve as parents for "third sector companies." The parent company becomes the source of orders, providing a safe and stable demand for the output of the third sector firm which, in turn, employs disabled persons who have difficulty securing jobs with mainstream employers. Third sector companies have proven economically viable, requiring no subsidization beyond the status of preferred contractor. Standing somewhere between sheltered and totally competitive employment these companies have helped measurably in reducing the unemployment rate among disabled persons. Because Japanese workers may draw salaries from these companies and still receive their social security income, "... workers in these third sector companies keep their average standard of living close to the standard in their local communities." The success of this model supports those who advocate for partial disability payments for workers with disabilities in the United States.

A very different partnership accounts for the success of the Jewelry Technical Center of Israel in which organizations from the United States and Israel have combined forces. The program joins the needs for training and employment for disabled persons with the modern technical labor needs of a fast growing industry and the economic development needs of a severely disadvantaged neighborhood. One might expect such combined agendas to assure chaos and failure, but in this case they have been a source of strength and reinforcement of the goals of each. Perhaps new alliances would benefit

rehabilitation efforts in the United States as well.

Yet another cooperative approach is represented by GIRPEH, a French non-profit organization initiated by businessmen who perceived a need for expert advice on the intricacies of successful integration of workers with disabilities. Although tripartite in its structure, including management, labor and handicapped consumers, the dominant role played by representatives of employers apparently affords GIRPEH credibility in the corporate world, and introduces a note of realism, an ingredient rehabilitation specialists are sometimes accused of lacking. Many corporations in the United States provide executives with release time, and place retired employees in positions, to assist with community programs. Utilizing such personnel in a nationally organized corporate effort of the kind described by Mallet might serve a valuable role here as well.

Partnership Arrangements in Which Government Is A Key Actor

The role played by government can be an important nudge to the promotion of rehabilitation. The articles from Australia, Israel, the Netherlands and the report of the Shaw Trust in the United Kingdom all validate the potential significance of government as the key partner. Yet each also describes an innovative arrangement between government and other actors. For those who, without appreciating the sanctity with which trade unions regard the provisions of the collectively bargained contract, complain that organized labor sometimes impedes the placement of workers with disabilities, the Australian model has an interesting prescription. It requires the relevant trade union to sign off on all on-the-job training opportunities before they will be financed by the government. The government's recognition makes the union a partner rather than a barrier. Surely there is a lesson here for American practice.

Government initiative in Israel led to the establishment of Ha 'Meshakem Company, Ltd. which provides employment to disabled persons under conditions of pay and other fringe benefits, including vacation allowances, that replicate those available in competitive industry. Although Taler expresses concern about the tendency of those working in Ha 'Meshakem to lose the incentive to seek, or return to, mainstream employment, it is impossible not to applaud a national, government-sponsored, vertically integrated setting that offers services from rehabilitation treatment through long-term employment.

An even more pervasive system of government encouragement concerning employment of the disabled is reported extant in the Netherlands, based on work performed by a government sponsored team that includes a "medical insurance officer," a "labor expert" (probably a placement specialist) and a "legal assessor." The full force and credibility of the government, it would appear, stands behind this team as it negotiates with the private sector for maintenance at employment of persons with disability because,

"Employers can also be liable to redress if they do not give a handicapped person who is unable to perform his job the opportunity to carry out suitable work which is performed elsewhere in the company." This might well constitute an appropriate amendment to the affirmative action provisions of the Vocational Rehabilitation Act of 1973.

The catalyst role played by the Shaw Trust in a way empowers government to accomplish its goals. We are all too familiar with enabling legislation that is finally enacted only to wallow in disuse. The Trust acts to preclude this from occuring in the United Kingdom in relation to the provisions for Sheltered Placement under which a competitive employer may serve as "host" to a worker with a disability. The Trust has assumed responsibility for developing such placements, and for making up the difference between the payment the worker receives, based on his or her productivity, and the pay for the job to a person without handicap. The government then repays the Shaw Trust, another testimonial to the unlimited possibilities that occur when creative partnerships are evolved.

Conclusions and Afterthoughts

This overview, like the articles in this monograph, provides an optimistic view of what is possible when best practice becomes the framework for program development. A few simple guidelines encourage private sector initiatives in the employment and maintenance at work of persons with disability:

—A philosophy that dignifies work as a human right

—A method of work that promotes interdisciplinary collaboration and cooperative partnerships

—Persistence and creativity as necessary ingredients of organizational change

—Risk-taking professionals armed with knowledge and new technology

There are, of course, problems as well as possibilities. Many of the initiatives described throughout this monograph are available to limited numbers of people, are less than equal in the opportunities they offer, depend on expanding economies for their support, and lack the promise of upward mobility. As Taler points out, the jobs frequently held by disabled persons are "marked for extinction." Yet, we are encouraged by the array of options and the potential of new technology and developing methodologies such as ergonomics. Variety is not only the spice of life but the source of hope for expanded opportunities for disabled persons. What follows provides just that.

SECTION ONE
PROGRAMS OPERATED BY INDIVIDUAL FIRMS

THE EMPLOYMENT OF DISABLED PEOPLE IN SCOTTISH GAS
by Douglas Walker, Senior Medical Consultant, Scottish Gas, U.K.

The British Gas Corporation, consists of twelve Regions throughout England, Wales and Scotland with its headquarters in London. Each Region has its own Occupational Health Service directed by its Medical Officer. The range of service provided varies between Regions and while there is broad agreement in policies, the comments made in this paper do not necessarily reflect the situation throughout the Gas Industry.

Scottish Gas covers the whole of Scotland, an area of about 30,000 sq. miles having approximately 6,500 employees engaged in a wide variety of jobs including the production, transmission, and distribution of gas, sales, service, transport, stores and offices. Although its employees are located throughout Scotland in many widely scattered locations, the majority are to be found in the central belt between and around Edinburgh and Glasgow. Many employees, while based at offices and depots, spend a substantial proportion of their working day out of their working base.

The management of Scottish Gas has always had a positive attitude to the employment of persons with disability and the Region follows the broad policy issued by the Gas Corporation in 1979 (see appendix).

Scottish Gas already carries out almost all the advise contained in the recently published "Code of Good Practice on the Employment of Disabled People," published by the Manpower Services Commission in 1984.

This Code of Practice is designed to advise Directors and Senior Managers on Company Policy for disabled people and to advise personnel and other managers on aspects of recruitment, induction, health and safety, integration into the work force, training and promotion. It is concerned not only with the recruitment of disabled people but also with the management of those who develop disability while in employment.

Legislation in the United Kingdom

Before discussing the situation in Scottish Gas it is important to consider the main legislation regarding the employment of disabled persons in the United Kingdom.

Not long ago, disablement was regarded mainly as a medical and social problem. Its relation to employment was only highlighted during World War II, when, owing to the shortage of manpower, a scheme was launched to bring the disabled into the war effort. It was discovered that the vast majority of them were capable of working alongside their fit colleagues, provided that they were properly selected for the job.

This and many other similar lessons were embodied in the Tomlinson Report of 1943. The Disabled Persons (Employment) Act of 1944 gave effect to the recommendations of that Report related to employment.

This Act remains the principal legislation regarding the employment of disabled persons in the United Kingdom. The Act made provision for disabled persons in a number of ways. It produced a Disabled Persons Register for the substantially handicapped in order to enable them better to obtain (and retain) employment. The Act obliges employers to employ Registered Disabled Persons in numbers equivalent to 3% of their total workforce, the so called "Quota Scheme."

It also reserves certain occupations as being "Designated Employment" for Registered Disabled Persons and, authorizes the provision of "Sheltered Employment" for those capable of employment but not fit to work in the normal industrial situation. It provides for courses of occupational rehabilitation to be given in Industrial Rehabilitation Units, now known as Employment Rehabilitation Centres (E.R.C.'s) and arranges for vocational training for those requiring to learn new skills, in Skill Centres. Skill Centres and Employment Rehabilitation Centres are located throughout the United Kingdom.

The other main provision of the Act was to appoint special individuals based at Employment Centres, to find suitable work for the disabled—the Disablement Resettlement Officers (D.R.O's). More recently changes in the Disablement Resettlement Officers' Service have been suggested (Manpower Services Commission 1982).

There are many criticisms of some of the provisions of the 1944 Act, particularly with regard to the Quota Scheme and the Manpower Services Commission in their "Review of the Quota Scheme for the Employment of Disabled People" in 1981, summarised the various opinions and suggested alternatives.

Of the many provisions of the Act, the services of the Disablement Resettlement Officers and the facilities of the Employment Rehabilitation Centres are probably of most help to the majority of disabled. The Employment Rehabilitation Centres offer occupational rehabilitation as opposed to

the medical rehabilitation available in hospitals and specialized units. Individuals attend daily for about 6-8 weeks during which they become attuned to the working environment and have the opportunity of discovering new aptitudes as they rotate through a variety of different tasks. Where an aptitude is discovered which requires further training the individual may be referred to the neighbouring Skill Centre.

Industries such as the National Coal Board in the early 40's, The Austin Motor Company in 1943 and Vauxhall Motors of Luton in 1946, set a splendid example in showing what could be achieved within industry to assist employees with disability.

Many other industries have followed suit and have shown how effective in-house rehabilitation services can be in retaining disabled persons in employment.

Other important legislation requires Companies which employ more than 250 employees to include in the Annual Report of their Directors a statement describing their policies for the employment of disabled people—The Companies (*Directors Report*) (*Employment of Disabled Persons*) Regulations, 1980.

Pre-Employment Assessment of Disabled Persons in Scottish Gas

It is normal practice within Scottish Gas for employees to have a health assessment before commencing work. This is carried out to assess fitness for the job in question, and to assess any possible future effects of the job on any existing disability.

The examination is carried out by a nursing officer and consists of a detailed health questionnaire followed by a brief physical assessment including measurement of height and weight, lung function, blood pressure, vision and urine. Should no abnormality be detected the candidate is classified fit for employment.

In the event of any abnormality being detected or a significant past history of ill health, the case is referred to the Regional Medical Officer who may carry out a more detailed examination following which additional information may be obtained from other sources such as the individual's family Doctor or hospital consultant.

Subsequently, the Regional Medical Officer, with the knowledge of the requirement of the job in question, is able to advise on fitness for employment.

The assesment of physical disability is generally easier than for mental disability. In the case of the former, physical examination and supplementary information is usually detailed and accurate and, where required, a practical assessment of the job can be made quickly.

On the other hand the assessment of a potential employee with a mental disability presents greater problems. It is very difficult for the Regional Medical Officer to assess an individual in the brief period available to him and the accuracy and helpfulness of any additional information obtained from the

hospital consultant or family doctor is generally poor.

While a number of people who apply for jobs with Scottish Gas, are known to have a disability at the time of employment, the disabilities tend to be relatively minor and seldom affect fitness to carry out the job for which they have applied.

Disability in Employment

The greater problem arises when disability develops while in employment, as it may well effect fitness to carry out the full requirements of the job. The identification of such a disability may be due to observation by management either because of frequent sickness absence, or a reduction in the quality and out-put of the individual's work. It may also be as a result of information received from the family doctor or more commonly from information on sickness absence received by the industry's Occupational Health Service. In this respect in the United Kingdom, a family doctor's certificate is required for all employees who are absent from work for more than seven days.

The action carried out by the Occupational Health Service on receipt of such a certificate depends to some extent on the significance of the problem. For a relatively minor condition which is likely to be short-lived and result in no residual disability, no specific measures may be taken.

On the other hand action is taken in the case of more serious conditions, particularly where there might be a possibility of the individual not being able to resume full duties on return to work, or where an individual is hospitalized or likely to be off work for a prolonged period. In these situations the Nursing Officer visits the individual.

The hospital visit is partly a welfare visit to express the industry's concern about one of its employees but principally to get some idea of the significance of the condition and possible effect on work. Generally it is possible to reassure the individual with regard to employment. Home visits are invariably welcomed, and it is very unusual for an employee to decline a visit.

During the course of these visits, particular attention is paid in reassuring the individual that the visit is not to check on the genuineness of the health problem but to assess the nature, and prognosis of the condition with special regard to any problems which may be encountered on return to work. The opportunity is also taken to identify those employees who might benefit from rehabilitation.

As a result of these visits disabilities which may effect work capacity are identified at the earliest possible state so that efforts can be made to promote maximum recovery and, to modify work or reassign the individual as early as possible where required.

Assessment of an individual's disability is made initially by the Occupational Health Nurse and if any problems with regard to employment are

anticipated, the individual is examined by the Regional Medical Officer. Again with the help of additional information from the family doctor or hospital consultant and in the light of specialized knowledge of the requirements of the individual's job, a clear assessment of a person's capabilities can be made.

Management of Employees with Disability Developing in Employment

In considering the management of disabled employees, it is important to appreciate that the basic objectives of the Occupational Health Service is to get the employee back to work as quickly as possible, preferably to his usual job. To achieve this, the Occupational Health Service may communicate with the individual's family doctor to arrange treatment from local rehabilitation services where none is currently being carried out, or it may assist in arranging for attendance at specialized rehabilitation units with the approval of the individual and the family doctor.

There are several residential and day medical rehabilitation units in Scotland some of which specialize in various conditions such as cardiac problems or strokes. Encouragement is given to the individual to attend these units by reimbursing travelling expenses involved.

At the end of the period of rehabilitation, or when it is considered that the maximum progress has been made, management is advised on the fitness of the disabled employee. The advice may be that the individual is fit to resume his usual job without any restrictions, or with some modification of the working environment or some aspects of the job. The advice may be to attempt to reassign the individual to another job within the individual's limitations. The emphasis, however, is always placed on the person's capabilities rather than his limitations.

Management may occasionally be advised that the individual should be retired on health grounds but this advice is only given when an employee is considered to be permanently unfit for his usual job and, where there is no suitable alternative available.

Disability Developing in Employment— The Size of the Problem in Scottish Gas

In considering employment and disability in the United Kingdom the main emphasis has always been on obtaining employment for disabled persons and in industries achieving the quota of 3% disabled in their workforce, as required under the Disabled Persons (Employment) Act of 1944. Little attention has been paid in the past to the disabled in employment although the Manpower Services Commission review of the quota scheme for the employment of Disabled People (1981), and their Code of Good Practice on the Employment of Disabled People (1984), places considerable emphasis on this aspect. The M.S.C. review recognizes that the Quota

Scheme does not accurately reflect the numbers of disabled persons in employment.

It was decided to assess the extent of disability in employees of Scottish Gas and, in particular to identify those who developed their disability while in employment. As Scottish Gas employees are broadly classified into staff and manual grades, the opportunity was taken to compare and contrast the levels of disability in these groups and the requirements for modification of work or job reassignment in those who developed disability while in employment.

In view of the greater significance in terms of management, of disability among manual grades as compared to staff grades (equivalent to "blue collar" and "white collar" jobs) the broad causes of disability noted at the date of starting employment, was compared with those developing while in employment.

The numbers of staff and manual grades who required to be retired on medical grounds, were also examined together with causes of such retirements.

Medical records are kept for all Scottish Gas employees. In December, 1982 six Nursing Officers examined the medical records of all employees for disabilities which were known to be present in 1982, and were considered likely to last twelve months or more. The disability had to be sufficiently serious for the Nursing Officers to consider that it would have substantially handicapped the person in obtaining employment appropriate to his qualifications or experience, compared with someone of the same age and sex without such a disability. In other words, the disability was such that the individual could have become a Registered Disabled Person, if he/she had so wished.

Five of the six nurses examined approximately equal numbers of staff and manual records.

The prevalence of disability in male and female staff grades is shown in *Table 1*. The manual grades are virtually exclusively male. In the staff grades, there are more disabled male employees than female (9% compared with 6.2%) and when the sexes are combined the prevalence is 7.9% compared with 6.3% among manual grades. The overall prevalence for staff and manual grades combined, is 7.2%.

When the prevalence of disability is examined in relation to its presence before or after joining the industry *(Table 2)*, it is seen that 118 out of 318 disabled staff (37%) were known to have their condition on starting work, compared with 48 out of 187 (25%) of the manual grades. It is not surprising that it is easier to place disabled employees in non-manual jobs.

The main finding however, was that the majority of disability developed in employment; 63% of the disabled staff, and 75% of the disabled manual workers developed their health problems while in employment.

With regard to the requirement for modification of work, *Table 3* shows

that 7.5% disabled staff (15/200) and 15% of disabled manual workers (21/139) required temporary modification of their work, while 8% of the former group (16) and 21% of the latter group (29) required to have their jobs permanently modified in some way.

The numbers of staff and manual workers who required reassignment on the basis of disability, is shown in *Table 4*. Only 8 out or 200 (4%) staff had to be reassigned compared with 16 out of 139 (11.5%) of the manual grades.

The broad causes of disability in manual workers, noted before and after joining the industry, are shown in *Table 5*. The main causes of disability noted before commencing employment were due to visual defects (almost exclusively monocular vision), and these accounted for 41% (20/48) of the defects noted. When disability arising after joining the industry is considered, the major causes are locomotor (including back conditions) which account for 41% of the disabilities (57/139) and cardiac conditions, 25% (35/139).

The number of retirements on health grounds for staff and manual groups, over a three year period, according to the age which retirement took place are shown in *Table 6*. The number of retirements of male and female staff (a total of 21), can be compared with 23 retirals among the manual workers' group. The majority (54%) of retirements (staff and manual grades combined) took place in the 50-59 age group, (24/44), and 34% took place in the 60+ age group (15/44).

The ratio of retirements to average population at risk (x1,000) shows that more male staff retire than female staff, while manual workers are only slightly more likely to retire on health grounds, compared with male staff.

The broad causes of retirement on health grounds, for staff and manual grades, are shown in *Table 7*. The main causes of retirements of staff were cardiovascular conditions, which accounted for 43% (9/21) of all retirements, while these accounted for 47% of the main causes of retirement in manual grades (11/23). Cardiovascular disease is particularly prevalent in Scotland.

The study confirmed that the number of Registered Disabled Persons is not an accurate reflection of the number of persons with disability in an industry. Although only about 1% of the workforce of Scottish Gas are officially registered as disabled persons, the overall prevalence of disability in all employees is very much higher (7.5%).

Approximately one third of these employees were known to have a disability on joining the industry, which reflects the progressive approach the industry adopts to employing the disabled.

However, that two-thirds of the disabled group developed disability while in employment, emphasizes the importance of considering this aspect.

While the majority who developed disability were able to resume their normal occupations, the proportion who required permanent modification of their work was not inconsiderable, and this was particularly the case for the manual grades (21% compared with 8% of the staff disabled). The greater

problem which disability presents to manual grades is also reflected in the proportion who needed to be reassigned. Almost three times as many manual disabled needed to be reassigned, compared with staff disabled (11.5% compared with 4%).

In considering the causes of disabilities noted before and after joining the industry, the conditions known beforehand were, relatively speaking, less severe than those which developed after employment. That this causes problems is apparent by the proportion who require permanent modification of their jobs, or reassignment to other jobs.

In manual workers, cardiac and locomotor problems (including back trouble) are the main causes of disability developing while in employment.

The study did not attempt to assess the contribution of age, occupation, social class etc., to the development of these conditions. That so few of the Scottish Gas employees with disability required to be retired on health grounds, over the period 1980-82 inclusive, is gratifying as is the fact that manual workers were only at a slight disadvantage in this respect compared to their staff colleagues. Those who were retired on health grounds were almost exclusively in the oldest age group, and almost all were considered unfit for alternative employment.

The few retirements reflect the willingness of the industry to try to modify work or redeploy to alternative work where disability prevents an employee from working normally.

Problems in the Management of Disabled Employees

Management of the disabled at work may present problems not only to the employer but also to the disabled employee. For the employer it may be extremely difficult to modify an individual's work in view of the increasing requirement in industry for flexibility and the limit to the number of employees who can have work modified or restricted in the light of increasing demands to improve efficiency.

For the employee modification or restriction at work may result in loss of earnings and antagonism from colleagues who may have to carry out the heavier aspects of the work their disabled fellows are unable to do.

Job reassignment presents even greater problems. While it is relatively easy to assess medical fitness for alternative work, it is not so easy to assess the individuals capability for such work particularly if it is of a very different nature to the type of work he is normally accustomed to. What is required is a means of assessing personal ability and the demands of different jobs in order to be able to identify suitable work for a particular individual.

In this respect specialized units outside industry such as the Employment Rehabilitation Centres have outstanding facilities for assessing a persons capabilities and potential. However, the type of work for which the individual is suited may not be readily available and even if it is, there may be understandable reluctance for a department to accept someone who has

probably been off work for a very long time. Even where such alternative employment is available, it invariably means a loss of earnings to the individual concerned and the type of work offered may conflict with his expectations.

It is therefore, not uncommon for the Occupational Health Service and management to go to considerable efforts to reassign a person only for the offer to be rejected albeit for very understandable reasons. Although this occurs from time to time, it does not discourage attempts to seek suitable alternative work for those needing it.

It goes without saying that the efforts made to retain an individual in employment should reflect his work performance prior to the development of the disability. Age too, is another important factor in considering redeployment, as generally it is more difficult for the older age groups to adapt to change.

Job reassignment, if advised, can more readily be obtained on a temporary basis because the receiving department is aware of the brief duration of the arrangements. Permanent reassignment tends to present greater difficulties for reasons already outlined.

Where reassignment is not possible medical retirement has to be considered but this approach is only taken as a last resort.

Supervision of Disabled Employees

It is one of the many functions of an Occupational Health Service to supervise employees with disability. Frequency of review depends on the nature and extent of disability and the type of work the person carries out.

In Scottish Gas, employees with disabilities who could become Registered Disabled Persons, are designated "potential" Registered Disabled Persons. Each individual in this category is seen at least once a year in order to assess the progress of his disability and any possible harmful effects of his employment on it. If it is considered the disability is likely to last for another twelve months the individual is reviewed subsequently. In addition other employees who develop significant disabilities are identified and monitored at regular intervals. Apart from regular supervision of employees with disability, regular visits to work places are made by the nursing officers in order to assess any possible adverse effects of work on the health of the employee or in their ability to carry out the duties of the job.

Liaison with Outside Agencies

It is important that Occupational Health Services develop a close relationship with those outside industry, who are concerned with helping the disabled gain maximum fitness and return to work.

Reference has already been made to the liaison Scottish Gas has with the Employment Rehabilitation Centres. An excellent relationship has also been developed with the Specialized medical rehabilitation units throughout Scot-

land and the Rehabilitation Studies Unit at the University of Edinburgh.

Liaison with local Disablement Resettlement Officers of the Department of Health and Social Security is also important. Through the industry's policies for the management of disabled employees and its liaison with outside bodies, including voluntary agencies, a good relationship with the community is fostered.

Future Prospects

Cornes, in his comprehensive review on work for disabled people in the United Kingdom, 1984 outlines some areas of concern for the future.

There is no doubt that the prospects of employing disabled people in Scottish Gas, as for other industries, will depend to a great extent on general levels of unemployment through out the country. Also, the smaller the work force the more emphasis industry is likely to place on having a fit work-force having the flexibility to adapt to changes in technology as they occur. However, technological changes, with their tendency to reduce the heavier and more physical components of work, could benefit the disabled who generally retain their mental functions, so the future need not be regarded with undue pessimism.

Problems may still occur, however, in those who develop disability while in employment and a detailed assessment of a person's capabilities both medically and occupationally will still be required. In this respect greater use could be made of existing specialized medical rehabilitation units, and the facilities of the Employment Rehabilitation Centres. The latter are at present almost exclusively involved in the assessment of disabled people who are currently unemployed.

If *greater use of these facilities was made for employed persons, the chances of retaining them in employment would improve.*

More could be done by industries themselves, by utilizing the expertise and facilities of their education and training departments and, by relocating those not able to perform usual jobs, for a trial period, to allow the receiving departments the opportunity of assessing the person's work performance and attendance. This facility would encourage departments to receive employees with disability in the knowledge that if it did not work out they would not be saddled with a problem.

It is also highly desirable that a particular individual within the Personnel function takes on special responsibilities for the disabled, to co-ordinate the arrangements for assessment, retraining and redeployment.

The employment of disabled persons often presents difficulties, but the various problems can be overcome, and the outcome can be rewarding not only to the employee, but to industry as well. Cooperation is required between the employee and management and the various health and rehabilitation services which care for the disabled, if a successful outcome is to be achieved.

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APPENDIX

BRITISH GAS CORPORATION
EMPLOYMENT OF DISABLED PERSONS POLICY STATEMENT

British Gas acknowledges the importance of continuing to provide employment opportunities for disabled persons. To foster this objective, British Gas will:—

1. Retain the services of an employee who is or becomes disabled, whenever practical;
2. Try, initially, to retain the services of such an employee in his/her existing job. If this does not prove possible, suitable alternative opportunities will be sought for the employee within the Industry. Failing this, the Industry will, if the employee wishes, assist in seeking alternative outside employment for the employee. At each stage, consideration will be given to drawing upon the services of the Disablement Resettlement Service;
3. Provide, if appropriate, special training for an employee who has disability, to enable him/her to compete on an equal basis with other employees for career development and promotion;
4. Encourage disabled employees who are eligible, to register officially;
5. When recruitment from outside the Industry is required, taking account of job requirements, consider applications for employment from disabled persons, on an equal basis, as far as this is practical;
6. Review the progress of the Policy annually at the Personnel Committee.

This Policy, should be seen as complementary to British Gas' efforts in the field of accident prevention and the promotion of the good health of its employees.

TABLE 1
Prevalence of Employees with Disability in Male/Female Staff/Manual Grades in Scottish Gas

Grade	Males			Females			Males and Females Combined	
	No. Disabled	No. at Risk	% Disabled	No. Disabled	No. at Risk	% Disabled	No.	%
Staff	220	2446	9.0	98	1572	6.2	318	7.9
Manual	187	2959	6.3	—	—	—	187	6.3
All Grades							505	7.2

TABLE 2
Prevalence of Disabled Employees Who Developed Disability Before or After Joining Scottish Gas

Grade	Disability Before Joining Gas Industry		Disability After Joining Gas Industry		Ratio Of
	Nos.	% of total disabled	Nos.	% of total disabled	After/Before
Staff (318)	118	37	200	63	1.7 (200/118)
Manual (187)	48	25.6	139	74.4	2.9 (139/48)
All (505)	166	32.9	339	67.1	2.0 (339/166)

TABLE 3
Number of Employees Who Developed Disability After Joining the Gas Industry Who Required Temporary or Permanent Modification of Their Job

Grade	Nos. of Disabled	Temporary Modification		Permanent Modification	
		No.	%	No.	%
Staff	200	15	(7.5)	16	(8.0)
Manual	139	21	(15.1)	29	(20.8)
All	339	36	(10.6)	45	(13.3)

TABLE 4
Number of Employees Who Developed Disability After Joining Scottish Gas Who Required to be Redeployed

Grade	Nos. of Disabled	Nos. Redeployed No.	%
Staff	200	8	(4.0)
Manual	139	16	(11.5)
All	339	24	(7.0)

TABLE 5
Causes of Disability in Manual Workers Before and After Joining Gas Industry

Disability	Noted Before Joining Industry	Noted After Joining Industry	Total
Heart & Circulatory Disorders	0	35	35
Chest	8	11	19
Epilepsy	1	11	12
Gastro Intestinal	0	10	10
Locomotor Excluding Back	8	33	41
Back	0	24	24
Visual/Monocular Vision	1/19	0/1	1/20
Deafness/Other E.N.T.	6/0	0/0	6/0
Psychiatric	0	3	3
Other	5	11	16
Totals	48	139	187

TABLE 6
Retirals on Health Grounds Among Scottish Gas Employees Over Period 1980-1982 Inclusive by Grade, Age and Sex

Grade	Sex (Average An.) (Nos. at risk)	Age Group					Total	No. Retirals (Av. pop. at risk) (x 1000)
		21-30	30-39	40-49	50-59	60 +		
Staff	(2446) M	—	—	—	10	5	15	6.1
	(1572) F	—	—	2	4	—	6	3.8
Manual	(2959) M	—	2	1	9*	10*	22	7.1
	(23) F	—	—	—	1	—	1	
All Grades	(7000)	—	2	3	24	15	44	6.2

***includes two employees who were considered fit for alternative employment but no suitable work was available**

TABLE 7
Causes for Retiral on Health Grounds Among Scottish Gas Employees Over Period 1980-1982 Inclusive

Cause	Staff	Manual	All
Cardiac/Vascular	9	11	20
Chest	2	1	3
Neurological	5	3	8
Locomotor ex. back	—	2	2
Back	—	1	1
Visual	1	2	3
Nervous	—	1	1
Cancer	3	2	5
Other	1	—	1
Total	21	23	44

INTEGRATION OF PRIMARILY PHYSICALLY DISABLED PERSONS IN A MANUFACTURING COMPANY

by Manfred Schulz
Bavarian Motor Works (BMW AG)

Background

From mid-1979 to the beginning of 1983 the research project: Integration of primarily physically disabled persons in a manufacturing company was carried out at BMW AG in Munich. This project was supported by the Federal Ministry for Research and Technology as part of the program "Humanization of work life".

This project was designed to improve the integration of disabled persons and persons with reduced work abilities who require jobs that take into account their reduction in capacity.

In addition to various departments of BMW AG, the Labour Research Institute (awfi) in Berlin participated in the project.

BMW is an automobile and motorcycle company with more than 40,000 employees in six locations with primarily assembly-line work on one product with little flexibility.

More than 5,000 employees are disabled or are persons with reduced abilities but only half of this group of employees is officially identified as disabled. The other half are those with reduced abilities as certified by the company physician.

The integration of disabled employees on the job has always been an important company task, not only from a social point of view but also from the stand point of economic considerations.

Personnel assignments in accordance with the abilities and skills of the individual is an essential personnel objective. This objective is not always easy to reach.

Apart from the officially recognized disabled employees there is a group of persons with "reduced work abilities". This term refers to employees who as a result of health problems are faced with certain work-related restrictions for which allowances must be made in the work assignment.

In regard to the measures taken to provide adequate employment possibilities for disabled persons and persons with reduced abilities there is, from the point of view of the company, very little difference between these two groups—apart from the legal protection to which disabled persons are entitled.

Objectives of the Project

In the mid-70s the Bavarian Motor Works became aware of a development which, at the time, did not receive much attention. Many companies have only in recent years become aware of the need to match the residual

abilities of disabled persons (and persons with reduced work capacity) to job requirements.

There was agreement about the fact that various coordinated measures were required to improve the integration possibilities for disabled persons and persons with reduced work abilities in the company on a wider basis. Based on an analysis of the company situation, there was evidence that:

- the integration of disabled persons into the system of a manufacturing company is possible and advisable for all parties concerned.
- there is an adequate number of suitable jobs available or ones that can be created through job-site adaptation measures.
- development and use of technical work aids make it possible for disabled employees to do jobs that they would otherwise not be able to do.
- development and investigation of a procedure designed to ensure better cooperation of the different company bodies (such as personnel manager, works council, company physician, safety engineer, job designer, trusted agent or advocate) in regard to placing and assisting disabled persons and persons with reduced work abilities is desirable.

The Project

The first aim of the project was to obtain detailed information about the group of disabled persons and those with reduced abilities. For this purpose a secondary statistical analysis of the anonymous personnel data of about 2,100 disabled employees was carried out. This analysis was informative regarding for example: the age structure, the average period of employment, the persent areas of activity of the disabled and of those with reduced abilities.

A written survey of 2,572 disabled and non-disabled persons (response rate: about 54% = 1,385) revealed the work situation of the disabled persons and of those with reduced abilities as seen by themselves and also as seen by their colleagues. Many of respondents were persons with responsibilities in the production departments, the planning departments, the personnel departments, the company's medical service as well as the works' council and the advocates of the disabled workers. In addition a sample of 41 persons: the disabled themselves or those with reduced abilities and their superiors were interviewed with regard to individual aspects of their situation within the company.

To obtain detailed information on the physical problems of the disabled and of those with reduced abilities, about 220 employees were thoroughly queried according to the criteria of industrial medicine by using the instrument developed within the scope of this project for the "Analysis of demand and ability."

This ability/demand profile which has been developed to put the disabled person into industry consists of thirty items which are comparable to the World Health Organization's International Classification of impairment,

Disability and Handicap (ICIDH).

Parallel to this, comprehensive job site analyses (a sample of about 350 representative for about 7,500 job sites) were carried out with this instrument, in order to obtain a survey of the requirements and demands occuring at the job sites of the company.

With regard to the target group of the project, there was both an extension as well as a shift during the realization of the project. While at the beginning of the project the working conditions of the physically disabled *with an officially recognized reduction of work capacity* were made the center point of the research, it became apparent during the actual analysis

- that the "classical disabled," that is the person confined to a wheelchair, the blind or the employee with amputations, represents only an infinitely small part of the group of the disabled in a company and that this group of disabled did not present problems for either the personnel department or the superiors, since considerable attention is already focussed on this group and difficulties can frequently be solved by simple—often conventional—technical and organizational aids;
- that operational problems arise particularly in cases where physical impairments of the employees are *not* "visible" for superiors, colleagues and personnel departments, especially where new employees are concerned;
- that included in the group with certified *reduced abilities* there were people with *unspecific* impairments of health (this represented in terms of numbers a similarly large group). It was decided that preventive aspects had to be considered in the project; *impairments of health can lead to disability if prevention, as such, is not considered;*
- that frequently the older employees had to be included in the group of the persons with reduced abilities; and
- quite often all "disabled persons" are blamed for the problems which in reality arise in connection with poor working conditions.

Some Results

This expansion of subjects in the study and the realization that many more employees were disabled or potentially disabled resulted in a systematic and possibly preventitive application of ergonomical designs in the workplace at BMW.

Improvements on a large-scale basis of shop conditions have resulted in changes throughout the factory such as different heights in floors and chairs to accomodate the actual work activity of the individual, computerized lifts and pulleys which eliminate heavy lifting and reaching, choices regarding sitting or standing for a particular worker at a particular worksite. The kind of structural changes made at BMW have the potential of affecting all workers and thus on a long term basis of preventing disabling conditions which would be related to poor working conditions.

The system engineer and his staff have changed more than 24 work systems: each one is individual and this requires individual solutions. However, his team has become specialized and adept in recognizing problems and reaching solutions. They have concluded that to be most effective industry must search for solutions that will benefit the greatest number of workers.

Now, after completion of the project the objectives for the redesign of new job sites are consequently realized taking into consideration unfavorable economic conditions.

- The main function of the instrument used for the "analysis of demand and ability" is to provide for better problem-oriented communication and cooperation between the responsible departments, especially between the physician, personnel department and superiors, in matters concerning personnel assignment or resettlement measures.
- This instrument also allows one to check the ergonomic level of existing and future job sites.
- In-company training courses treating the subjects "problems of employing disabled persons and persons with reduced abilities and "the principles of job design" have become a firm part of the in-company training program.
- A detailed analysis of the experiences gained in connection with the assignment of disabled persons and persons with reduced abilities reesulted in a very important decision which was to create a special central division charged with the assignment of disabled persons; the activities of this department include initiation and coordination, giving expert advice and attending to questions of:
  - — job design meeting the requirements of disabled employees
  - — advising and assisting the different departments of the company in individual cases and
  - — organizing the employment of disabled persons or persons with reduced abilities.

As a result of the findings, training seminars are held for the 170 supervisors in the Munich plant. Topics and discussion are directed toward a better understanding of the disabled worker and disability characteristics and residuals. Seminars are held for personnel managers, for physicians and for work site designers and engineers. The latter two groups are briefed in the use of Ability/Demand Profile and the engineer is trained in job analysis techniques. Training materials for the seminars were developed and are contained in a "green book." The materials include:

1. Evaluation forms used by the 3 groups: physicians, engineers, supervisors
2. The Ability/Demand Profile
3. Manual for physicians, compiled by Heidelberg Vocational Training Center consultants.
4. Ideas and possibilities to explore in searching for job modifications by systems engineers

5. Pictures and solutions for changes in work sites.
6. Seminar training materials
7. All the questionaires and inventories used in the project.

Appendix

Further questions regarding course and contents of the project, can be addressed to the following contacts:

- Bundesministerium für Forschung und Technologie
  -Projektträger Humanisierung des Arbeitslebens-,
  Südstraße 24, 5300 Bonn 2
- BMW AG, Zentrales Personal- und Sozialwesen, Petuelring 130, 8000 München 40
- awfi GmbH, Bayreuther Straße 3,1000 Berlin 30

Material for this article came from:

Volume I– Integration of primarily physically disabled persons in a manufacturing company

Additional volumes are available which provide details and instruments on specific subjects:

Volume II– Analysis of demand and ability; an instrument for company physicians, personnel manager, factory superiors and job designers

Volume III– Disabilities, illnesses and their effects on the work situation; a manual particulary for company physicians

Volume IV– Guideline for a preventive and corrective workplace layout; 12 selected characteristics

Volume V– Examples for workplace adaptations; a picture documentation

Volume VI– Seminar guidelines; for the information of factory superiors, planning personnel and personnel managers

In each volume a brief summary of the subject as a whole is given so that the volumes can be used independently.

Furthermore a collection of the study instruments is available:

Volume VII– Project study instruments

We wish to thank Patricia Dvonch, Phd. New York University for her assistance.In 1984 she carried out a WRF-IEEIR fellowship in the Federal Republic of Germany. One of her site-visit interviews was with Herr Schulz at BMW.
(Editor's note)

PEOPLE WITH DISABILITIES IN THE WORKFORCE, THE EXPERIENCE OF VAUXHALL MOTORS LIMITED

by P.F. McDonald, Rehabilitation Superintendent, Vauxhall Motors Limited

Review of Vauxhall's Program

Vauxhall Motors management has always been enlightened in the field of rehabilitation and retention of disabled employees. It employs so many people, the Company feels an obligation towards those of the workforce who are, or become, temporarily or permanently disabled. It has no wish to lose a good employee who, after retraining or regrading, can carry out a useful function for the Company.

We feel that as a caring Company we can make valuable contributions to the community by having a deliberate policy to employ and retain disabled people and use their abilities to the full. Our rehabilitation programme was developed in conjunction with the local hospital, and orthopaedic surgeons make frequent visits to the factory, carrying out follow-up clinics and checking on patients in the Rehabilitation Centre. This co-operation enables employees to consult specialists at work which saves time and money for both the employee and the Company.

Our workforce is so large and spread across a wide range of ages, we have people becoming disabled to various degrees, regularly. We feel it is as much to our advantage as to the employees' to do all we can to ensure that any of them becoming unable to do their job due to a disability is given every opportunity to exploit their abilities, and we make every effort to find a suitable job for them.

First, an assessment is made of the disabled person by our Medical Officer who, along with the Rehabilitation Superintendent, will also look at the current occupation of the patient and will decide if he can continue with his normal job with, or without, modification or special aids. Where outside agencies can be of assistance (Manpower Services Commission, Royal National Institute for the Blind etc.), they are called in at the earliest opportunity. Whatever special aids we can provide, sometimes with government assistance, will be obtained.

After any rehabilitation and retraining has been given, a list of the employee's restrictions are made out on a preprinted form. A copy of this form is provided for the management in the part of the factory in which the patient is employed. Based on these working ability recommendations, a suitable position is usually found for the person concerned. It would be wrong to suggest that a place is always found, but, as far as possible, restricted employees will be accommodated.

When we are not able to place an employee in his normal type of work,

we have a sheltered workshop known as the Protected Work Centre, where disabled employees are given suitable work, and where they will stay permanently.

We have a very firmly established system through which employees can take advantage of our facilities and this is open to all who need it. If an individual feels he has a problem which is preventing him from doing his normal job, our Company doctor will see him in the clinic which is held every morning. There are two doctors in the plant, the Chief Medical Officer, who is the department head, and the Plant Medical Officer. It is the Plant Medical Officer who holds daily clinics, although the Chief Medical Officer will do this in his absence.

If it is decided an employee needs to go to the Rehabilitation Centre, the Plant Medical Officer will send the individual to the Rehabilitation Superintendent with a brief outline of the problem. The patient is then given therapeutic work and any physiotherapy which may be necessary. He will be seen on a regular basis by the Plant Medical Officer. The patients stay in the Rehabilitation Centre until they have made the best recovery possible.

Consultants at the local hospital Orthopaedic Department, and in some cases the Plastic Surgeon, have direct admission facilities to the Centre. This allows any patient who is referred to them and works for the Company to be sent directly to the Rehabilitation Centre. Patients admitted in this manner are under the care of our Chief Medical Officer and will be followed-up in the Consultant's Clinic, which is held at the factory.

The Casualty Department at the hospital is also able to refer patients direct to the Rehabilitation Centre, or to a special clinic held at the hospital on Friday mornings. This clinic is attended by the Rehabilitation Superintendent and the Physiotherapist, and they, in conjunction with the Orthopaedic Surgeon, will plan a patient's return to work, either through rehabilitation or modified work. We also allow other hospitals and local GP's limited access to the Rehabilitation Centre, and any hospital or GP may refer patients to our Physiotherapist for treatment without necessarily being in the Rehabilitation Centre.

Once in the Centre, the employees are treated the same as if they were at work, that is to say, they receive their normal wages and bonus, work the same number of hours (no overtime) and start and finish work at normal times. The Centre itself is equipped to carry out all production sub-assembly operations, has a substantial machine shop for the manufacture of tools and jigs etc. and a variety of special machines used to aid recovery. It is staffed by the Rehabilitation Superintendent, reporting directly to the Chief Medical Officer, two chargehands, who are also toolmakers, who help with the day-to-day running of the workshop and setting of machinery, and an inspector who is responsible for quality control.

Geographically, the Centre is situated within easy reach of the canteen

facilities, in the same building as the Employment Department and Welfare offices and next to the Medical centre. It is also close to the bus stops into the town centre. The only concession made to patients is a five minute allowance at the end of each shift to enable patients to get away from the factory area before the rush of other employees leaving work.

The Protected Work Centre, while not under the control of the Medical Department, is close by and is run on a similar basis to the Rehabilitation Centre. Placement in the Protected Work Centre is based on length of service, age and the degree of disability. Patients are placed on a waiting list, and, when a place becomes available, all employees on the list will be considered on the above criteria. The placement is made by the Chief Medical Officer.

The Company's interest in the disabled, particularly the retention of newly disabled employees, was recognized two years ago by the Manpower Services Commission. This is a government body attached to the Department of Employment, which has the responsibility for the employment, rehabilitation and retraining of the nation's disabled workforce. The Manpower Services Commission also provides aids to employment and some financial incentives to companies who take on disabled workers.

The Commission makes awards each year to companies in recognition of their outstanding achievements in the employment of disabled people. This is known as a "Fit for Work Award." Vauxhall Motors and Bedford Commercial Vehicles were recipients of this award in 1983.

Current Legislation

Vauxhall Motors has been engaged in rehabilitation and employment of disabled people since 1946, so current legislation has served to vindicate rather than influence the Company's policies. Nevertheless, there are laws concerning this matter, of which the Company is aware, and this legislation is taken into consideration when we formulate policies and when deciding on individual cases. First, any company employing more than 20 people must employ at least 3% registered disabled people. This is very difficult to invoke, as there are not 3% of the British working population who are registered disabled. The Disabled Persons Register is a voluntary register of people who are substantially handicapped by any kind of disability in obtaining or keeping employment. Severely disabled people who are registered can be given help with fares to work and provision of special aids to employment. Any vacancies for car park attendants must be filled by registered disabled people.

There are, of course, laws against discrimination. Disability itself should not be regarded as a reason not to employ an individual, nor is the fact that a company already has its quota an absolute bar on taking on a disabled employee. Also, each company must produce a code of practice which outlines its policies on the employment and retention of disabled people.

There are laws covering unfair dismissal and these apply to disabled employees as much as anyone else, and are dealt with on an individual basis.

The foregoing is a basic outline of the laws of the country and are not intended to be a detailed account of all legislation appertaining to disabled people; the general environment in Great Britain for the employment and retention of disabled people is reasonably good. Of course there are those of us in the profession who believe more could and should be done, but there are many initiatives taken by the government in this field. There are establishments set up by the government around the country for the purpose of retraining disabled people called Employment Rehabilitation Centres. These Centres are of various designs and serve several purposes; in general they take in people who are unable to carry on with their normal job by reason of a disability and retrain them for other types of work. The particular problem with this scheme is the difficulty of the individual securing a job on completion of his/her retraining.

Remploy

One of the most innovative ideas is a government-funded organization called Remploy. This is a company with 91 production units throughout Great Britain dealing in industries as wide ranging as book binding and the manufacture of ice-cream. They also carry out packaging operations and are one of the country's largest furniture manufacturers. In addition, the Manpower Service Commission has Disablement Resettlement Officers in every town. Their function is to assist disabled people in finding employment and to advise companies of the incentives available to them for employing or retraining disabled employees. There is also a Disablement Advisory Service who liaise with local firms on the subject of vacancies which could be filled by disabled people and advise disabled job seekers about suitable opportunities. All in all, the general environment in this country for employment and retention of disabled people is good, and there are numerous private agencies to supplement activities in the area of retraining and sheltered workshops, including hospitals, large and small charities.

Case Examples

In our own organization we have had some interesting results, particularly in the field of retaining newly disabled employees. One case concerned a trainee accountant who lost his eyesight due to an hereditary disease. He was not able to continue with his training so he had to be found some alternative work if possible. He was admitted into the Rehabilitation Centre for an assessment and help with coping with his problem, and, while he was in there, the local Blind Persons Resettlement Officer sent along one of her staff to teach the lad braille. He was also helped to get around by the Mobility Officer (both of whom work for Manpower Services Commission); he was taught how to use a white cane and how to use the small amount of sight he

had left to his best advantage. The next step was to send him on a course at the Royal National Institute for the Blind Rehabilitation Centre in the South West of England, where he could not only learn daily living skills but also a variety of skills connected with computer programming/operating. This proved very successful. After his return, and a period of training in our own computer centre, he now works with the aid of a "Talking Terminal" as a programmer in our Data Centre. We are now going through the same process with another employee with similar eyesight problems. We have many day-to-day successes with our programme by virtue of the fact that, as the biggest engineering employer in Luton, our facilities are open to a great many people.

These facilities are intended to supplement and not replace the National Health Service. We do not interfere with treatment given by employees' own doctors. Our Physiotherapy Department is open to any employee who is at work (we do not treat people if they are off sick), providing he is referred by his own doctor or one of our Works' Medical Officers. The outcome of this system is that many people who would normally be off work are, in fact, doing their job and having treatment on the premises. When patients are admitted to the Rehabilitation Centre, they are back at work in every sense, as they work a full day and get their normal pay. The results are a shorter recuperation period, particularly in the case of accidents such as fractured bones, and an early return to full wages for the employee. *Our programme ensures that employees who are off work and unable to do normal job can, provided they can make their way to work, return to some modified work in the Rehabilitation Centre until they are ready to resume normal duties, or, if they can manage their normal job, return to work and have any treatment required at the factory.*

Future Developments

As for the future, it is difficult to lay firm plans owing to the volatile nature of the industry, but we certainly have a few forward plans in mind. The general concepts of the Rehabilitation Centre and the Protected Work Centre do not need any fundamental changes. However, it is intended to establish closer links between the Rehabilitation Centre and the Protected Work Centre, with the intention of bringing them both under the control of the Medical Department. Another matter receiving attention is the development of more therapeutic machinery for the Rehabilitation Centre, enabling us to deal with a greater range of problems which will be helped by doing production work.

Community Relations

The effect on community relations is considerable. As a very large employer in Luton, it is well known that Vauxhall Motors is prepared to employ and retain disabled people. This is reflected in the fact that I, as the

Rehabilitation Superintendent, am in touch constantly with Manpower Services Commission Officers, and most of the local self-help groups for particular ailments are fully aware of the facilities the Company provides. I have also given many talks to local bodies such as the Red Cross and local charities; this can only serve to enhance the Company's relations with the local community.

Conclusion

Records have been kept, and below are some figures which reflect the size of the Vauxhall experience:

1. From 1946 to 1983 12,707 patients have been admitted to the Rehabilitation Centre, of these 60% have been through our own system and 40% direct from the local hospital.
2. We distinguish between a personal condition and a works' accident, but any accident occurring outside of the factory is recorded as a personal condition. Works' accidents over this period accounted for 28% of all cases, but it must be realized that the total workforce has gradually declined and safety standards vastly improved since 1946.
3. To illustrate this point, in 1954 15,000 employees were on the Company's books, and 311 patients were admitted to the Rehabilitation Centre, this represented 2% of the workforce, of these 40% were the result of works' accidents. In 1982 there were 14,000 employees, and 203 patients were admitted to the Rehabilitation Centre, this represented 1.45% of the workforce, of these only 22% were as a result of works' accidents. At the peak, in 1964, there were 28,000 employees, and 508 patients were admitted to the Rehabilitation Centre, this represented 1.8% of the workforce, of these 35% were due to works' accidents.

These figures reflect the efforts made to increase safety over the last 40 years. They also indicate that the percentage of the workforce using the facilities has not declined very much, a sign it would appear, of the increasing range of conditions which can be helped by industrial rehabilitation. The length of stay over this 40 year period has increased from an average of 6 weeks to an average of 8 weeks.

The follow-up clinics held by the orthopaedic surgeons at the factory have dealt with 82,075 patient visits.

To conclude, Vauxhall has a genuine concern for the employment and retention of disabled workers which means that it does far more than is legally required of it. Because of this it can be said that the programme has been successful and will continue to be successful in the employment and re-employment of workers with disabilities.

THE TORONTO TRANSIT COMMISSION AND CANADA'S HUMAN RIGHTS CODE
by. W.G. Frost, Personnel Manager, Toronto Transit Commission

The Toronto Transit Commission operates public transit services within the 243 square mile boundary of the Municipality of Metropolitan Toronto in the Province of Ontario, Canada. Toronto, with a population of just over two million, is the seat of our Provincial Government. The city is known for its cleanliness, its burgeoning art and theatrical community, the relative absence of street crime and for its transit system. The Toronto Transit Commission (TTC) is the second largest transit system in North America carrying over 405 million passengers a year.

The Toronto Transit Commission is highly visible in the Metro Toronto community, not only as a provider of service but also as an employer. *The TTC is one of Metropolitan Toronto's largest employers.* In 1984, almost 10,000 people were employed by the Commission.

In terms of legislated labour and employment standards the Commission operates in a very progressive environment.

The first human rights statute of the modern era was the Ontario Racial Discrimination Act of 1944. In 1950, the Ontario Labour Relations Act was amended to ban discriminatory clauses in collective agreements. In 1951, Ontario enacted the first Fair Employment Practices Act and the Female Employees Fair Remuneration Act. The Ontario Anti-Discrimination Commission was created in 1958 and, in 1962, Ontario took the initiative of consolidating various anti-discrimination provisions into a comprehensive human rights code, providing full-time staff to administer it.

The pioneering Ontario Human Rights Code of 1962 prohibited discrimination on the grounds of race, creed, colour, nationality, ancestry or place of origin in signs and notices; public accommodation; services and facilities; housing with more than six self-contained dwelling units; employment; and trade union membership.

In 1966, the Age Discrimination Act was passed, followed in 1970 by the Women's Equal Opportunity Act. In 1972, the provisions of these acts were consolidated into an amended Human Rights Code. On June 15, 1982, as a result of a comprehensive legislative review, a new Human Rights Code became law in the Province of Ontario.

The Human Rights Code provides that every person in the Province of Ontario has a right to freedom from discrimination:

In the areas of:

- services, goods and facilities
- the occupancy of accommodation
- contracts
- employment
- membership in vocational associations & trade unions

On the grounds of:

- race
- ancestry
- place of origin
- colour
- ethnic origin
- citizenship
- creed
- sex
- handicap
- age (18-65 years in employment; 18 years and over in other areas)
- marital status (includes cohabitation, widowhood, separation)
- family status (parent-child relationship)
- the receipt of public assistance (in accommodation only)
- record of offenses (Provincial offenses, pardoned Federal offenses—in employment only).

The new Code is more far-reaching than previous legislation and more powerful. Its provisions supercede all other legislation.

As a major employer and as a major provider of service in the community, the Toronto Transit Commission is sensitive to the legislative environment. The Commission has been and continues to be a leader in effecting changes in its policies, standards and practices which comply with or exceed the provisions of human rights legislation.

While the Toronto Transit Commission has not adopted formal programs with respect to the employment or re-employment of people with disabilities, it has succeeded in *creating an environment which does not artificially limit opportunities.*

The Commission routinely reviews and assesses hiring procedures, employment policies and practices to ensure that standards, tests and selection or other criteria are non-discriminatory. In addition, employment practices are monitored to ensure that the objectives of the Code are being met.

The Commission's hiring policies are based solely on the requirements of the job and not on factors unrelated to the job such as age, marital or family status, race, religion or handicap. Our job application forms do not ask for irrelevant information. When a job has physical requirements associated with it, applicants are asked to perform those functions if there is any doubt as to their physical abilities. At one time, certain occupations, like that of a vehicle operator, had height and weight restrictions which can result in systematic discrimination with respect to sex and race.

In addition to reviewing and assessing employment policies, standards, practices and procedures, the Commission has undertaken a major initiative to acquaint not only those involved in recruitment, but all managerial and supervisory personnel with the provisions of the Code and its objectives. During 1984, over 800 supervisory personnel participated in a full day seminar on human rights.

Awareness and knowledge combat discrimination.

In reviewing the transit system itself, the Commission realized that it

was not accessible to all members of the Metropolitan Toronto community. As a result, in the mid-1970's, the Commission formed "Wheel-Trans," a publicly-funded, door-to-door transit service for Metro Toronto's disabled community. This parallel service is designed to provide mobility for non-ambulatory disabled persons who could not use the conventional transit system.

The progressive legislative environment in which the Commission operates and its equal opportunity practices, combined with its efforts to improve service to the disabled community, have made management aware of the abilities of the handicapped population.

We were also concerned for people who could use the system, but only with great difficulty. Therefore, in 1979, the Commission formed the Technical Advisory Committee on Improved Accessibility (TACIA). TACIA was charged with the task of identifying and implementing changes to the system to make it more easily accessible. This was done based on extensive consultation with the handicapped community.

As part of this program, the Commission produced a sensitivity awareness film for its employees. The film, entitled "Touchdown," illustrates some of the problems encountered by the elderly and disabled in using the transit system. The film not only exposed and sensitized the Commission's employees to the needs and problems of these groups, but because of its high calibre and resulting wide distribution, it is being used by Metro schools, the Metro police force and has been shown in many communities throughout North America.

Another potential area of discrimination was in medical examinations. Many organizations did, and still do, have a standard medical with a standard level of fitness. Thus for instance, a wheelchair-using applicant would be automatically ruled out for a position even though that particular job does not require full mobility. TTC medical examinations have always been job-specific. As a result, a formal affirmative action program, aimed at hiring the disabled, is not required and our most recent statistics show that *eighty-three individuals with various handicaps were hired in a one year period.* Their disabilities ranged from quadraplegia, heart and psychiatric diseases to various degrees of vision and hearing impairment. These individuals were not hired because they were handicapped, but rather because of their ability to do the jobs for which they applied.

Looking at existing employees, those who have become disabled but are fit for some form of work, every effort is made to match that employee to a suitable job. As a result, these employees can continue to live a fruitful life and at the same time, make a meaningful contribution to the organization.

In summary, the Toronto Transit Commission considers itself sensitive to the needs of everyone in the community, both in its role as an employer and as a provider of service within Metropolitan Toronto.

SECTION TWO
PARTNERSHIP PROGRAMS IN WHICH GOVERNMENT MAY OR MAY NOT BE INVOLVED

ON THE DEVELOPMENT OF EARLY REHABILITATION PROGRAMS IN FINLAND

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BACKGROUND

Since the 70's research on disability prevention and the development and assessment of early rehabilitation programs have attained greater actuality in the Finnish public health policy. Selection of the topics focused on and the emphasis given to treatment programs in some disease groups have been mainly based on the prevalence of disability according to the number of disability pensions.

This problem has been viewed according to two paradigms prevailing in the medical sciences. According to the bio-individual approach health is seen as the proper functioning of the body and the causes of illness are primarily thought to stem from a biological origin. In the social-epidemiological approach illness is thought to stem from the environment and living habits of the individual (e.g., diet, smoking habits, risk factors and hazards at work). The basic aim in both approaches is disease prevention, and other related problems are either neglected or are thought to be a direct consequence of the disease, i.e. removable after the disease itself has been mitigated. (Purola 1979, 1980.)

Though, according to some health indicators, an improvement in the population's health in general could be seen during the 70's, similar favourable trends could not be found in the working capacity and quality of life of the working-age population. (Raunio 1983, Valkonen 1983, Statistical Yearbook of Finland 1983, Karisto 1984, Klaukka 1982.)

Prevention of disability has been biased: it has mainly focused on disease prevention. Even the statistics reflect this tendency. In statistical figures only the main disease is presented which is the legitimate cause for the positive

pension decision. Information on crucial factors affecting the disability process, i.e. individual developmental factors and societal factors affecting the individual's life situation, is not available. The statistics only present the outlines of disability and more detailed information of the phenomenon stays concealed. The figures do not reveal hidden disability or early phases of the disability process.

Disability has been dealt with as a problem for health care and social insurance and factors affecting work and working conditions and their regulation have received less attention. This has led to a situation where procedures carried out at the work place and aimed at eliminating or preventing a threatening disability in a positive, work-related way, have not been possible.

Rehabilitation has traditionally been restorative and timed after a sudden handicapping illness or accident or after a long process that has already led to a long-term occupational disability (as a result of a chronic degenerative disease, or the cumulative effects of a stressful life situation, exhaustion and inability to cope with the situation). Rehabilitation practitioners have become more aware of the need for a more holistic approach that would be applicable to the early phases of the disability process. At the same time there has arisen a growing need for more versatility in the activity and better cooperation between the social welfare and health care sectors.

At present there seems to be possibilities for the development and implementation of early rehabilitation activity as a means for the prevention of disability. Economic aspects also sustain the need for developing the activity into a new direction. In evaluating the health care activity more emphasis has been given to how well the goals of the activity have been reached, as opposed to how many measures have been carried out.

Experiences in rehabilitation programs at the workplace

Early rehabilitation activity in Finland was started in the mid 70's, when the first study on the need for rehabilitation among the working-age population was carried out (Järvikoski & Tuunainen 1978, Järvikoski & Lahelma 1980, Tuunainen et al. 1981.) Since then studies on the outcome of rehabilitation with various employee groups suffering from, e.g. low-back pain and cardiac heart disease, have been carried out. (cf. Härkäpää et al. 1984, Piikivi 1983, Rinne & Kallio 1983.)

Some of the larger places of employment have organizations taking care of job changes and replacements (cf. Järvikoski & Lahelma 1980) and many of them also offer medical rehabilitation services as a part of their occupational health care activity.

The following deals only with those programs and projects which have been carried out in those places of employment in which the employees' need for rehabilitation has been assessed and where follow-up on the activity has been included in the program.

Assessing the need for early rehabilitation and planning of measures by an external specialist team

A study on the need for rehabilitation was carried out by the Rehabilitation Foundation in cooperation with the City of Helsinki (cf. Järvikoski & Tuunainen, 1975, 1978, Järvikoski 1977). The need for rehabilitation was assessed by a mailed questionnaire on the basis of which the City employees were asked to attend a semi-structured interview carried out at the Rehabilitation Foundation. On the basis of the screening questionnaire and the interview a rehabilitation team (consisting of specialists outside the workplace) made recommendations which were forwarded to the occupational health physicians in the places of employment.

The results and experiences of the study led to the following conclusions:

1. The most common diseases and symptoms causing disability or connected to it in a working population were musculoskeletal diseases and mental disorders which included psychosomatic stress symptoms. These disorders and symptoms seem to demand new, more holistic methods of treatment.
2. The easiest screening method available, using the number of sick leaves, was unsatisfactory. The difference between subjective need and the evaluated need for rehabilitation indicated that multiple screening methods are necessary.
3. The attempt to realize recommended rehabilitation measures, especially the vocational ones, turned out to be the most difficult problem in this project. That, and some other problems as well, are no doubt related to the fact that rehabilitation was not integrated into the organizations at the work place.

Realization of the rehabilitation model at the work place in collaboration with external specialists

From this empirical background a program aimed at developing an early rehabilitation model was carried out at two authorities of the City of Helsinki (1300 employees). The general objectives, organization, rehabilitation process, etc., have been presented elsewhere (Järvikoski & Lahelma 1980, Karjula 1985).

In this project the rehabilitation activity was implemented at the work place, as a part of the personnel administration, labor protection and occupational health care organizations. The members of the rehabilitation team (rehabilitation physician, counsellor, physiotherapist and psychologist) were experts from the Rehabilitation Foundation, i.e. outside the work place.

Results and conclusions

1. The screening method based on self-determined searches reached 13-15 percent of the personnel during two and a half years. However, some of the potential need for rehabilitation still remained undisclosed. Only 20

percent of the employees with frequent or prolonged sick-leaves (11 percent of the personnel) sought rehabilitation.

2. Assessment of the adequate direction of early rehabilitation measures presupposes the use of a screening questionnaire that covers all employees at the work place.
3. Even though the activity was carried out at the work place, this system could not guarantee that the activity would continue after the experimental phase and without ongoing aid from the external specialists.

Early rehabilitation activity in collaboration with Social Insurance Institution and three large enterprises

Both the National Pensions Act and the National Sickness Insurance Act can be used for early rehabilitation activity: both those on disability pension and those still at work can receive rehabilitation according to these acts.

In 1983 the Social Insurance Institution (SII) started an early rehabilitation project in collaboration with three industrial places of employment. The aims of the project are:

- to ascertain the quality and quantity of the need for rehabilitation,
- to assess the outcome of rehabilitation,
- to assess the possibilities of implementing early rehabilitation activity in the occupational health care organizations,
- clarify questions of cooperation.

The study comprises 7500 employees. Potential rehabilitees were selected according to the following criteria:

- threatening risk of disability
- age between 25 and 54 years
- absenteeism.

Rehabilitation teams at the work place assessed the need for rehabilitation among the employees. The teams had as their members representatives from personnel administration, occupational health care and labor protection organization and were supplemented by experts from the SII. If the rehabilitation recommended by the team required measures to be carried out outside the work place, the client was referred by the local SII unit to rehabilitation assessment and planning of further measures at the SII Rehabilitation and Research Center. According to preliminary results the share of those in need of rehabilitation was 6 percent of all the employees. Information on the feasibility of the model is not yet available.

EARLY REHABILITATION ACTIVITY AS A PART OF THE PERSONNEL ADMINISTRATION OF THE STATE EMPLOYEES

Introduction

Approximately 10 percent (200,000 persons) of Finland's working-age population is employed by the state. The State Treasury and the Ministry of

Finance which are responsible for the personnel administration of the state employees made the decision to start a 3-year early rehabilitation program among 10,000 civil servants and other state employees. The reasons for this experiment were varied. Among the most prominent were economic considerations. In 1976 the costs of disability pensions were 202 million FIM and in 1980 already 354 million FIM. The State Pensions Scheme presupposes that the costs of the occupational disability pensions are subsidized directly from the National Budget: the pensions scheme is not based on social insurance services. The employer, the State, pays all the costs of the disability pensions. Additionally, the pensions scheme does not include possibilities for partial pensions or rehabilitation.

Another reason for the program was the observation that the traditional measures carried out by the personnel administration were not useful when trying to tackle the problem of the growing share of occupational disability among the state employees. The problem had become even more difficult because of increasing changes in job demands, and the challenges they place upon the employees.

Economic and technological growth brings about problems on the individual level. The individual worker may not be able to anticipate or adjust to the emerging changes or make adequate decisions. All this can lead to hidden disability the costs of which are included in salary expenses, though they are, in fact, hidden social security costs. An ever growing problem has become the maintenance of the working capacity of those middle-aged or older employees with low educational level, multiple health problems, and a stressful life situation.

Responsibility for dealing with a threatening decrease in working capacity is not clearly defined as a task for any definite part of the organization. The problem's mere existence is easily denied and it is often referred to another section of the organization since coping with the problem is preceived too difficult and complicated. Because of it's intricacy solving the problem requires cooperation between several units in the organization.

The Aims of the Study

The Ministry of Finance formulated the main aim of the program as the assessment of the feasibility of arranging rehabilitation activity in all places of employment. The task was to develop early rehabilitation activity so that the goals, values and methods could be approved by the employer as well as the employees and so that the methods could be fitted to the already existing organizations at the work place.

In sum, the aims of the project were the following:

Developing rehabilitation activity

The aim was to produce such knowledge, know-how and experience that could be used as a basis for rehabilitation activity and its development in all places of employment. The program was carried out as an action research

in which the activity is evaluated during its implementation and emerging problems are solved and methods changed, if needed, while the program is in progress. This fact was regarded as important because it gives opportunity to take into account, in the final analysis of the program's feasibility, those difficulties affecting the outcome which can be eliminated through practice, training, information or by improving the cooperation between the members of the team.

The special aim was to produce information on factors affecting the outcome of rehabilitation, e.g.

- information gaps evident in different levels of the rehabilitation organization
- factors hindering the implementation of rehabilitation activity
- factors affecting their employee's search for rehabilitation
- flexibility of the decision making process.

Evaluation of the outcomes of rehabilitation activity

Information on the outcome of early rehabilitation at the work place, on the relevance of the measures and the duration of their effects is still inadequate. The aim is to bring about information on the outcome of the activity and make recommendations feasible for further work. The aims can be individualized as follows:

- to bring about knowledge on the relevance and appropriateness of the activity
- to gather information on the outcomes of the activity, especially from the viewpoint of maintaining working capacity and alleviating the risks of disability
- to evaluate the costs and benefits of the activity.

Prevalence of disability and its risk factors

On account of the obscurity of factors affecting occupational disability, it was obvious that the problem could not be mastered by using one unambiguous means-ends hierarchy. The task expanded, therefore, to encompass research on the phenomenon itself, i.e. disability and its subcategory occupational disability. Therefore, the study aims at testing hypotheses on the nature of the process leading to disability and inability to work, and trying to decipher a suitable theoretical framework for describing these phenomena.

The aims of the theoretical part of the study are to ascertain

- the quantity and quality of disability, decrease in working capacity and need for rehabilitation
- what kind of environmental (social, physical) and especially work-related and occupational factors are connected to disability, decrease in working capacity and need for rehabilitation
- what kind of factors in the individual's work and his life are likely to inrease his proneness to disability and the risks of occupational disability.

The design of the study is presented in *Figure 1.*

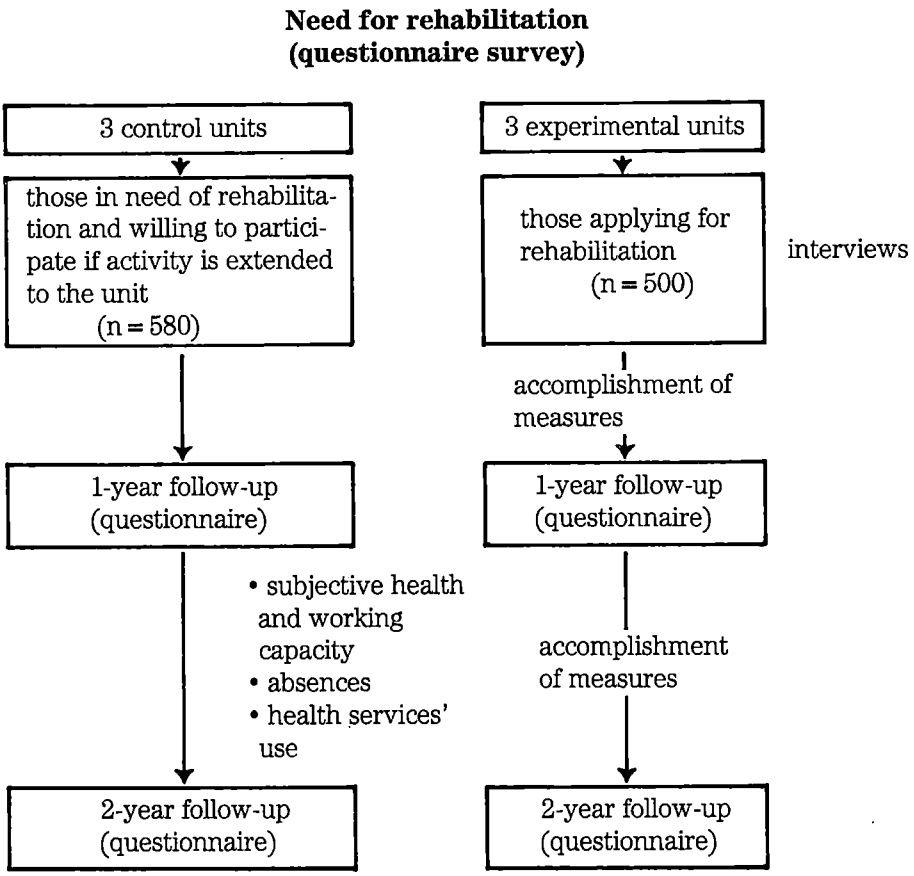

FIGURE 1.
The design of the study.

THE IMPLEMENTATION PHASE

Background

In 1981 a grant for the early rehabilitation program was included in the National Budget. The program is supervised by the Ministry of Finance and carried out by the State Treasury in collaboration with the State rehabilitation commission which has representatives from the Ministry of Finance, the trade unions and the State Treasury. A rehabilitation unit with three rehabilitation specialists was established in the State Treasury. Rehabilitation orga-

nizations in the local units were based on their already existing resources. The planning and realization of the program was carried out in cooperation with the Rehabilitation Foundation. The program includes, at the moment, the employees from three state institutes, i.e. The University of Helsinki, the Customs Administration and a local unit of the Post and Tele Establishment. In addition to these experimental units the program includes three control units. The program covers 10,000 of the total of 200,000 civil servants and other state employees.

Negotiations with the state institutes taking part in the program began in May 1981. These included, for example, giving information on rehabilitation in general as well as more detailed information about the arrangements, and organization and economic details which the program's initiation would require.

In the local units the rehabilitation organization was planned in cooperation with the rehabilitation experts of the State Treasury. Further planning of the local rehabilitation organizations was done during a two-day training course arranged at the work place.

The rehabilitation unit in the State Treasury has had an active part in starting the program. It has taken part in the meetings of the several local rehabilitation teams, and has provided guidance and counseling to both the team and clients. It has also arranged several training courses for the local rehabilitation teams.

The rehabilitation process

The self-determined search for rehabilitation and the process in general follow the guidelines observed as feasible in the City of Helsinki program (cf. Järvikoski & Lahelma 1980, Karjula 1985). The organizational scheme and the tasks of the rehabilitation organization are presented in *Figure 2.*

In the following some special features of the process are presented:

(1) All the costs of the rehabilitation measures were covered by the employer.

(2) All financial decisions were made at the State Treasury after the rehabilitation commission had given its opinion on them. This meant that the rehabilitation unit received information on the details of every rehabilitation plan and, thus, could give guidance and counseling to the local occupational health care units and institutes. This also made it possible to assess training needs in a centralized way.

(3) The activity was deliberately planned in such a way that cooperation between different organizational units was unavoidable. Previous experience had proved that rehabilitation activity is easily restricted to the occupational health care unit and to include only medical measures. Special efforts were taken in order to ensure that also work-related measures and occupational rehabilitation methods would be included in the activity.

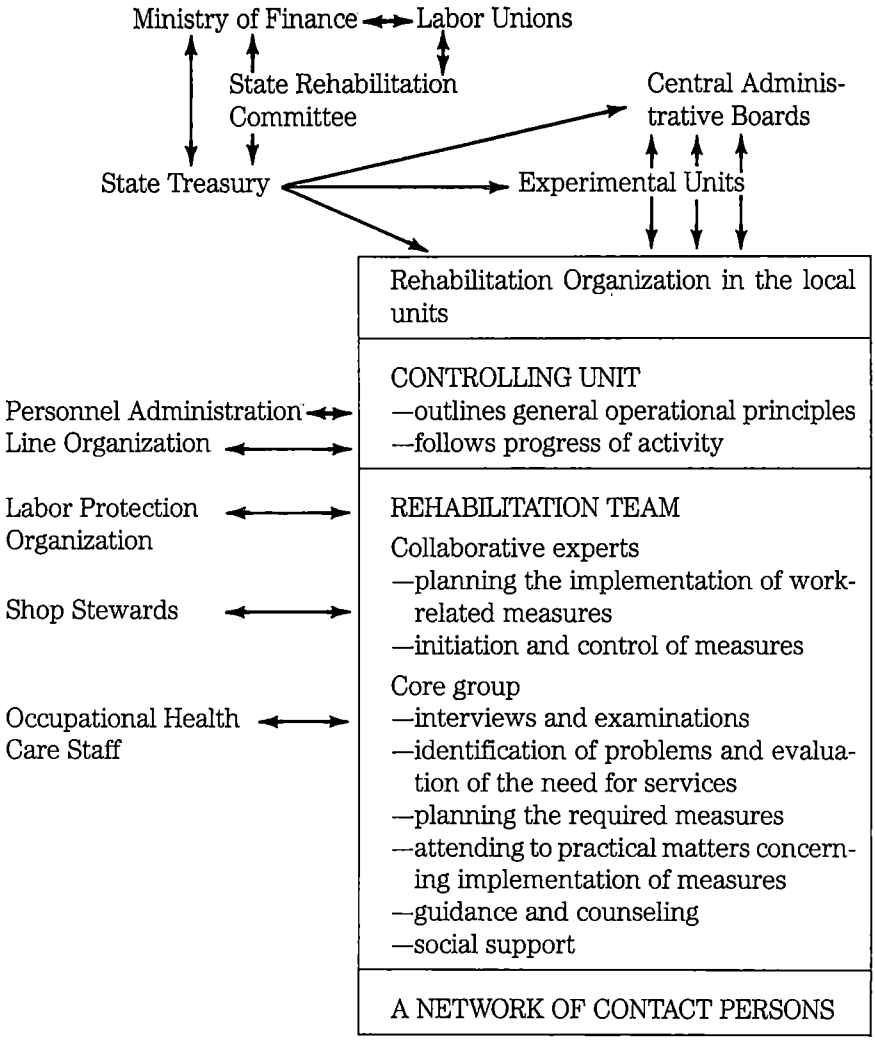

FIGURE 2
General scheme of the organization and tasks of the rehabilitation organizations.

(4) The principle of centralizing the financial decisions to the State Treasury had some educational aspects, too. In large organizations higher-level decision makers often have difficulties in perceiving the consequences of their decisions on the individual. In contrast, rehabilitation plans are always made on an individual basis and familiarizing himself with the details of the case the decision maker can receive valuable information for further use.

(5) The quality of the measures were not restricted beforehand in any way, i.e. all measures that were thought to assure the working capacity of the individual employee could be used. In reality the measures ranged from physical therapy to occupational re-education.
(6) Because the central aim of the project was to implement early rehabilitation activity as a permanent part of personnel administration, special emphasis was given to the guidance, counseling and training of the occupational health care and other personnel. In this kind of situation, the initiation of the program is quite hard and the goals are reached slowly, but in the long run the activity can prove to be more profitable.

Some preliminary results

The need for rehabilitation

The questionnaire survey (n = 4000) showed that with 15 percent of the employees a decrease in working capacity was evident. The share of those who regarded themselves as occupationally disabled was 1.7 percent. Approximately 2 percent reported that their working capacity had decreased to such degree that they would not be able to continue in their work for two years, and 7 percent reported difficulties in continuing in their present jobs. The share of those reporting occupational disability was quite similar to the figures representing annual disability pension applications.

Twenty three percent of the respondents reported some need for rehabilitation. Approximately half of them can be categorized as "possible need for rehabilitation" cases. Even in this group work performance was affected to some degree, so that from the employer's point of view this group also seems to need some rehabilitative measures. The need for rehabilitation seemed to increase with age; the increase was most noticeable in physically strenuous work and in working conditions which included physio-chemical risk factors or hazards. (Karjula & Järvikoski 1985.)

The self-determined search and the relevance of the activity

The relevance of the self determined search as a referral method was evaluated on the basis of the reported need for rehabilitation in the questionnaire survey and the self-determined searches for rehabilitation. The searches were strongly dependent on the reported degree of the need for rehabilitation, though half of those having reported the need did not, in fact, search for rehabilitation. Approximately 8 percent of those who had not reported need for rehabilitation did search for the services. The fit between the reported need and the use of rehabilitation services was *76.3 percent.*

The group that sought rehabilitation differed from the other employees according to characteristics presented in *Table 1.*

The costs of the activity (to the employer) have been approximately 550,000 FIM annually, i.e. 55 FIM per one employee, or approximately 3000 FIM per one rehabilitee.

TABLE 1
Some preliminary results on the characteristics of those applying for rehabilitation.

	rehabilitees	all employees
Mean age	45.0	40.4
Days of absence ($\bar{x}$)	22.4	11.3
Subjective working capacity (range 0-100, $\bar{x}$)	6.7	85.6
Subjective state of health moderate or bad (%)	66.5	45.7
Physical strenousness of work moderate or very strenuous (%)	15.4	12.7
Mental strenuousness of work moderate or very stressful (%)	32.0	22.9

The follow-up and report phases of the project are still in progress and reports on the relevance of the activity and the need for rehabilitation as well as preliminary follow-up results are to be published in 1985.

Conclusions

The state program is the first one in which implementation of early rehabilitation as a part of the normal activity at the work place, without outside experts, has been tried. The program makes use of and continues the research and development work started at the Rehabilitation Foundation in the beginning of the 70's.

The realization of the program has brought forth new demands to change some of the general principles in work-life, attitudes and the rigidity of prevailing policies.

Maintenance of working capacity is a multifaceted task and requires cooperation between several organizational units. In order to become accepted as a routine activity at the work place the implementation of rehabilitation activity necessitates a gradual process during which external specialists are used for dealing with the resistance, prejudices, denial and conflicts possibly emerging during the initiation phase.

Difficulties in recognizing factors that are connected to the disability

process are reflected in problems of defining and dividing tasks and responsibilities in an adequate way.

Effecting an action model requires extensive training (skills, attitudes, knowledge) of the personnel in the organization's key positions so that they can and will take into account factors connected to disability and its prevention, and so that they can serve as experts in the local rehabilitation teams.

Early rehabilitation is a new activity which requires the combining of information coming from personnel administration, labor protection and occupational health care, and also information on job demands and the capabilities of individual employees, in order to maintain the working capacity of those employees who are at risk of disability. This means that the activity cannot be restricted to those measures that are typical of preventive work in general, i.e. elimination of risk factors and assessing the degree of the lowering in working capacity. It is similarly important to augment supportive factors in maintaining ability to work and increasing working capacity, and to foster hidden or unrevealed resources of the individual employee.

This kind of activity presupposes measures and agreements which give possibilities for adapting the job to the employee's capacities. Adapting the work, rearrangement of work tasks, career planning, replacement and development of cooperation and division of work all belong to the tasks of administrative units. In the preparation and planning of measures outside experts can be used, but agreements on the rules and the implementation of the activity depend on the knowledge of the staff and belong to its tasks.

Many measures of vocational rehabilitation, which are only possible if the work place and outside rehabilitation systems work closely together, have remained unused. An example is a sufficiently long work try-out period in cases where another work unit or another employer can offer work tasks which are more suitable for the disabled employee. Work try-outs can give more opportunities for occupational mobility. Their arrangement give realistic information on the capabilities of the employee to the possible new employer and offer a chance to assess the rehabilitee's work performance in authentic circumstances before the realization of a replacement is considered.

As mentioned previously, the first task is to identify the factors that may impose a risk to the individual's working capacity. It is a striking feature that somatic factors only are usually seen as causes for the lowering of working capacity, while other important problems are often neglected. This may lead to unnecessary medicalization of the concept of working capacity and thus restrict the practical measures to somatic treatment. Disease prevention is not the solution to the problem. One factor leading to these problems is the common practice of defining diseases as the only legitimate causes for problems in working capacity. As a consequence, the employees are unwilling and even unable to identify and express the most critical barriers to their work performance. To generalize, it seems as if variability can only be seen

in the amount and quality of the diseases, and as if the employees themselves were homogenous as to their mental structure, abilities, social background, social relations, work experience and skills, and the demands of their work, etc.

Another critical problem in this context is the narrow expertise of the occupational health care staff. The training of both occupational nurses and occupational physicians is based on the causal thinking of the natural sciences, with the result that understanding other than medical factors affecting individual's working capacity is difficult. As a result of this medicalization, occupational health care is often found as the only unit responsible for disability prevention and management, and other units in the line organization never become aware of disability related problems which actually are part of their responsibility.

Measures aimed at disability prevention have to be implemented at the very places where the first symptoms of the process are to be seen, i.e. at the work site. Prevention of occupational disability should, as far as possible, become a routine activity at the work place.

The needs for further development revealed by the project have received serious consideration in the state administration. The issue at the moment is what kind of strategies and policies should be applied in further development of disability prevention.

JAPAN'S NEW MODEL OF EMPLOYMENT OF SEVERELY DISABLED PERSONS THROUGH "THIRD" SECTOR COMPANIES

by Yoko Kojima, Ph.D.
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Development of Japanese Employment Policy for the Disabled and Its Obstacles

Under the revised Physically Handicapped Persons' Employment Promotion Law (1976), more working opportunities in the common open labor market have opened for Japanese disabled people who have work capacity. According to this employment promotion law, all governmental and private firms with more than 300 employees must follow the quota system for employment of disabled workers.

The quota rates set by the law are 1.9% for non-physical labor agencies of national and local governments, 1.8% for physical labor governmental agencies, and 1.5% for private firms with more than 300 employees *(see Table 1 and Table 2.)* The law also introduced the levy and grant system to equalize the financial burden between firms with large numbers of disabled employees and firms with little acceptance of handicapped workers. If a company does not meet the quota rate, it must pay 40,000 yen a month for vacant slots which should have been filled by disabled workers. The levy is pooled and administered by the National Association for Employment of the Handicapped. On the other hand, firms which employ disabled workers beyond the quota requirement are able to receive employment grants of 10,000 to 20,000 yen per month from the pool.

In addition to the employment grants the firms which employ disabled workers beyond the quota rate and provide innovative services to disabled workers benefit from various grants categorized as follows:

- construction grants to employers who develop barrier free factories for disabled workers.
- work adjustment grants to enable employers to help severely disabled workers adjust to employment in their firms.
- special employment grants for severely disabled workers.
- construction grants for firms with high employment of disabled workers.
- ability promotion grants to employers who provide special training for severely handicapped people.

This system of levies and grants is administered through the National Association for Employment of the Handicapped and is thoroughly supervised by the Ministry of Labor. Under these incentive to employment strategies for employers, employment of the disabled has gradually increased. However, the private sector, especially in large size industries and firms with face to face customer service such as retail and finance, still has difficulty in

meeting the quota rate, as the data in Tables 3 and 4 indicate.

Although promotion of employment of disabled workers is one of the priority tasks of the Labor Ministry of Japan, employment of the disabled has shown a very modest advance in the 1980's due partly to slow economic growth of the Japanese economy. The labor ministry analyzed what part of the disabled population remains as the hard core of unemployment in 1979. As of 1980, the employment rate of the disabled as a whole was 48.8% and yet the rate for the severely disabled was still 27.8%.

The Ministry of Labor considered employment of the hard core unemployed group very seriously in the late 1970's, under the impact of the pressure groups' appeal for establishment of a company such as the British Remploy Ltd., a type of semigovernmental firm to employ disabled workers. However, the large general government deficit which existed in the 1980's created strong pressure for control of government spending and resistance to dependency on governmental funds to make up the deficit produced by a government sponsored special company.

The Ministry of Labor did not reject the appeal from the pressure group directly even in this situation. Instead the Ministry in March 1980 organized a research group to survey employment policies throughout the world and discover which method would be most desirable for the Japanese economic and political situation of this decade. The research group, of which the author is a member, was titled the *Task Force to Survey Special Policies to Employ Severely Disabled Workers.* (In the remainder of this paper this group will be called *the Task Force.*) The Task Force surveyed all possible employment policies in the world with much attention on Projects-With-Industry of U.S.A, Remploy of U.K., sheltered and semi-sheltered employment of Sweden, and social employment of the Netherlands as well as Japanese examples. And it discussed strengths and weaknesses of each policy as well as the adjustability for adoption in the Japanese current employment situation and needs.

Emergence of the Third Sector Companies in Early 1980

While the research and discussion of the Task Force was underway, in October 1980, a company named "Kibi-Matsushita Company" was established in the Kibi Highland Welfeare Community in Okayama Prefecture. The Kibi-Matsushita Company's work is the assembly of video cassette machines by employing disabled workers. It is a branch of the Matsushita Electric Company, which has a very positive attitude to employment of disabled workers. Matsushita Electric was invited by the Okayama Prefecture to join in developing the new and specially planned human service community in the remote highland area of Okayama Prefecture.

The Okayama Prefectural Government wanted to invite a firm which has a high priority policy for employment of the disabled. The negotiation between the prefectural government as a first sector and the Matsushita

Electric Company as a second sector resulted in establishment of a separate company in the third sector with the function of employment of the disabled. The newly born company was named the Kibi-Matsushita Company with an initial capitalization of 50,000,000 yen*. The funding was shared by Matshushita (51.0%), Okayama Prefectural Government (40.0%), town of Kamogawa (4.5%), and town of Kayo (4.5%) (in which two towns the new plant is located.)

The newly established third sector company started by employing 32 disabled workers, (mostly men and women in wheelchairs) and 51 non-disabled workers the majority of whom are local housewives.

The physical plant of the Company is entirely barrier free and has a dormitory for the disabled workers who have difficulty in commuting. The company received 200 million yen as a construction grant for mass employment of disabled workers from the National Association for Employment of the Handicapped. Since the business began, disabled workers have worked integrally with non-disabled workers and the company has paid normal salaries to the disabled workers.

Since the management of the company strictly follows the normal procedures of Japanese companies, the government has never had to pay for any deficit or provide any subsidy to the company except for the initial fund.

Following the Kibi-Matsushita Company other third sector companies were established by the matching of Osaka Prefectural Government and Matsushita Electric Company to form Katano-Matsushita Company in November 1981 and the matching of Hyogo Prefectural Government and Sanyo Electric Company to form Harima-Sanyo Company in April 1982.

These three prioneering third sector companies have been developing their business significantly since their operations started. People who participated in creating these employment measures did not have any knowledge about P.W.I. in the U.S.A. But as a result, this Japanese model in which employers took the initiative for employment and training of the disabled reached a similar philosophy to the P.W.I. model in the United States.

Looking at these three examples in which companies in a competitive industry successfully took positive initiative for management of disabled labor, the Task Force recommended to the Ministry of Labor that the third sector model of employment of the disabled would be a more desirable model for Japan than the case of Remploy Ltd., or any other examples in European sheltered workshops. The third sector company is viewed as a more normal working situation for the disabled workers and as more economically efficient than the sheltered workshop model.

After receiving the recommendation of the Task Force, in 1983 the Ministry of Labor took the third sector model as the new employment strategy for severely disabled workers who are difficult to place individually in the open labor market.

* (U.S. $1.00 = approx. 250 yen)

Operation of the Third Sector Companies

There are three third sector companies having a primary interest in employing disabled workers with the following characteristics:

Type of work and source of orders.

Kibi-Matsushita in Okayama Prefecture assembles video machines, Katano-Matsushita in Osaka does micro cassette production, and Harima Sanyo in Kasai City near Kobe assembles nagnetrons for microwave ovens.

Since these companies are branches of Matsushita and Sanyo, which are major electric companies, the source of their orders is entirely through contracts with their parent company. This arrangement gives these third sector companies a stable source of orders.

System of Management.

Even though these three third sector companies are independent companies having their own presidents and stock holders meetings separately from the parent companies, top managerial staff and chief technical staff are all transferred staff from the parent company. As a result the production management and quality control methods are identical to those of the parent company. The only unique aspect of the third sector companies is the existence of a vice presidential level personnel manager who is well qualified for this particular type of employment. Personnel managers in each company take the role of vocational counselor and social worker to the disabled employees by handling their social security matters, family relations, career advice, and other matters. Since the third sector companies were established by the initiative of local governments and the parent companies, the personnel managers are sent by the local government while the production managers and foremen are supplied by the parent company. The managerial staff are very limited in number and manage both the disabled and non-disabled workers in these companies (see Table 5).

The Process of Employing Disabled Workers.

Each of these companies have some criteria for employment:

Kibi-Matsushita states that those who are eligible are those who (1) are profoundly physically handicapped with full ability for self care, (2) have able upper extremeties, (3) are not color blind and have good vision, (4) have good finger dexterity, and (5) are younger than age 35.

Katano-Matsushita, which handles light weight material for production of micro cassette tapes states, in addition, their willingness to accept wheelchair users.

Harima-Sanyo states that those who are eligible are those who (1) are willing to work equally with non-disabled workers, (2) are able to do self care (3) are normal in hand and eye coordination, (4) have serious disability in the Japanese disability classification at grade 1 or 2.

These criteria mean these companies want to accept severely disabled but not vocationally handicapped workers. More than 60% of the total

employees in the third sector companies are high school graduates and half of the disabled workers became disabled after birth either through accident or disease. Before these workers came to work with the third sector companies, 55% of them had experience in various trades such as printing, laundry, carpentry, dress-making, clerical work, etc. These working experiences generally preceeded their disabilities. After workers became disabled and before they found jobs in the third sector companies, most of them lived on unstable jobs for many years. In order to upgrade their vocational status, more than 50% of the disabled workers were introduced to the companies by the public employment security offices of social welfare agencies.

The most significant reasons for the employees to come to the companies were found to be familiarity of the name of the parent company and the reputation of the parent company as a first class company in Japan.

Characteristics of the Disabled Employees.

1. Physical disability:

The disabled workers in these third sector companies were screened by the companies so that they were not vocationally handicapped. However, they have a variety of physical handicaps.

Wheelchair users as a result of paralyzed lower extremities are the most common at Kibi-Matsushita (71.0%) and Katano-Matsushita (88.0%). On the other hand Harima-Sanyo employs a higher proportion of deaf people (52.2%). It encourages staff and co-workers to master sign language in work and leisure time. (*See Table* 6.)

As *Table 7* shows, roughly 70% of the disabled workers suffered various types of diseases such as cerebral palsy, polio, and auditory illness at birth or in early childhood. Traffic accidents caused 30% of the disabilities of these workers. The reason why the labor accident cases (2.5%) are so rare in this worker population is probably that those who were injured on the job are still employed by their previous company or a closely related company.

2. Economic Status of Disabled Employees:

All employees including the disabled workers are employed as regular, full time workers and life long employment is also applied unless workers wish to leave the job.

Each third sector company has its own pay scale which is not the same as the parent company's.

Starting salary of Kibi-Matsushita is a flat rate regardless of age but the salary goes up according to the attendance record and degree of contribution to the company.

Katano-Matsushita considers age in deciding starting salaries and salaries go up according to productivity and number of years employed.

The basic salary policy of Harima-Sanyo is equal salary for equal jobs. In spite of this principle, the starting salary of disabled workers is 90% of the salary of non-disabled workers in the same age group. Salary increases are

based on age and productivity.

The income of the disabled workers consist of their earnings and their social security income.

A survey conducted by the author at the three companies found that as of 1984, 100,000 yen was the average amount of income from work. *(See Table 8 and Table 9.)* Besides their salaries, roughly 73% of the disabled workers received social security, workers compensation benefits, etc. *(See Table 10.)*

Their salary is not as high as among Japanese non-disabled workers in general. Also the amount of social security varies depending on how much the worker earned before having an accident or a disease, how long the worker contributed to insurance funds, the worker's age and marital status.

If one adds everything, however, the disabled workers in these third sector companies keep their average standard of living close to the standard in their local communities.

3. Marital Status and Family Responsibilities:

Single workers are more common in the three third sector companies. Disabled workers with family responsibilities are 32.3% in Kibi-Matsushita, 36.0% in Katano-Matsushita, and 9.0% in Harima-Sanyo where the employees tend to be relatively young disabled high school graduates. Most of these single workers live in dormitories of the companies.

Even though they are securely employed, disabled workers with dependent families are rare (26.9% of the total) and most of them became disabled after marriage. The fact that more than 70% of the workers remain single shows that disabled people have difficulty in finding marriage partners. *(See Table 11.)* This is the area where psycho-social investigation in depth is needed.

4. Leisure Activities of the Disabled Employees:

The leisure of disabled workers still seemed not to be rich and active. It is because the companies were built in rather isolated places with rather scarce public transportation that disabled workers integrate mainly with non-disabled within the company and do not have much community life. *(See Table 12.)* The only group of workers who had a rather active social life were those who had a driving license for their remodeled car (77%).

The ways the disabled workers spend their weekends are as follows:

Shopping and seeing the town	27.2%
Resting in the room of a dormitory	26.3%
Recreation	18.4%
Household activities	11.4%
Returning home from dormitory	8.8%
Other	7.9%

Among the recreational programs, sports activities are most popular. Women workers are more in favor of aesthetic activities such as flower arranging and caligraphy lessons, just as most Japanese women are.

Effect Produced by Emergence of Third Sector Companies

Among 250,000 in the disabled workforce in Japan, the share of employees in the newly started third sector companies seems to be negligible and they are quite passive in their social life. And yet the experiment with this new type of employment practice had a great impact in the world of employment of the severely disabled.

The most obvious changes observed are first that a majority of the disabled in these firms were for the first time able to find a stable status and to live as productive citizens.

Secondly, the able bodied co-workers, who are mostly local female workers in rural non-industrial areas, found their first renumerative jobs in these companies. Beyond these financial benefits, 85% of non-disabled workers in the third sector companies stated that they learned many important lessons of life through their integral work experiences with the disabled workers. Through their experience, these co-workers even though lacking any professional training became more aware and provided thoughtful comments on creating desirable working conditions for disabled people.

Also, the experience with third sector employment brought several positive effects in the local communities. The prefectural governments which introduced the third sector companies evaluate the influence of this type of employment effort in these aspects:

- Acceptance and understanding toward the disabled people by the community has been enhanced through a marriage between the disabled workers and the women in the neighborhood, and workers participation in the village festival is the most significant community action.
- Group living of the disabled workers in the community had the result of creating a more extensive barrier free environment. The influence of the disabled workers could be seen in curb cuts and parking, and improved doors and approaches to shops and offices.
- After the third sector companies were launched, other companies which had been apathetic to employment of the disabled became more interested in employing them, especially since the example was offered by prestigious companies like Matsushita and Sanyo.

The municipal governments also comment on the advantage of the third sector employment in such aspects.

- Since the third sector companies are interested in employing both disabled and nondisabled, women's employment in these remote communities have been greatly improved.
- As a result of being a stock holder of a unique company having both

humanitarian and economic value, the reputation of the mayor of the village has been much improved in the national mayors' association.

- On the negative side, village people voiced concern about the destruction of the natural surroundings by construction of factories.

Future National Plan to Develop the Third Sector Company Model

Advantages and limitations of the third sector companies:

The three third sector companies have started by the initiative of local government and the positive response of employers without any guidelines provided by the national government or by scholars.

These were experimental efforts but the employment practices of the third sector companies certainly opens the avenue to the disabled worker to be employed by a branch of first class companies in Japan.

There are, however, several problems and limitations revealed in our research on the three existing third sector companies.

The first three problems reflect the nature of the branch of a parent company and the last problem identified was a specific problem which arose from the company's management policy.

1. Because the disabled people are mass employed by third sector companies, they must be employed on a separate pay scale. There is no direct avenue for promotion from these companies to their parent companies. It is ironic that the dual structure of the Japanese industry management inevitably creates low level employment practices in the third sector model even though it is higher than the workers' status in many sheltered work welfare institutions.
2. In order to keep the separate finance between parent companies and the third sector companies, the third sector companies tend to prefer to employ the vocationally successful severely disabled person. The vocationally less successful people would still be left out of employment even if this kind of new model emerged further.
3. No matter how small the companies are, Japanese rules of life long employment are applied. Although 30% of the disabled employees found that their jobs are not suitable, there are no positive measures to guide these employees to a better vocational life style.
4. Each third sector company has a dormitory for the disabled. Japanese companies normally provide housing for their employees. The rooms are shared by two employees in all dormitories because employers think it will be the better system for providing security in case of illness, fire, or earthquakes. But 60% of disabled employees complain that there is no privacy when they are involved in many years of dormitory living.

If the model is to be followed nationally these problems must be given consideration.

Plan for future.

Learning from the existing examples and accepting the proposal of the Task Force, the Ministry of Labor set out the policy of establishing third sector factories in all prefectures in Japan starting from 1983. It will assist about three prefectures each year through providing construction grants for firms with mass employment of disabled workers.

In 1983, the following three prefectures were chosen.

1. Tokyo Metropolitan Government planned to establish a set of small community-based third sector companies in data processing by establishing partnership with a computer company in Tokyo.

Another project of the Tokyo Metropolitan Government is to establish a third sector company to work with an aerial photography company.

2. In cooperation with Nada Co-op Company, Hyogo Prefecture will start to establish another third sector company in the tertiary industry area of retail cooperative stores.
3. Kyoto Prefectural government started an investigation to build a third sector company.

In 1984, three additional prefectures appear to have started preparations to establish third sector companies. These are:

1. With a group of local companies as partners, Yamagata Prefectural Government started preparations to have a set of third sector companies in electric mechanics, food preparation and textile manufacturing.
2. Aichi Prefectural Government has started to look for appropriate companies to go into partnership with.
3. Kumamoto Prefectural Government in a newly developed community plan has started the process of inviting a company in seconday industry to establish a third sector plant.

Since the third sector companies develop training as well as employment, for the disabled workers one pioneering company, Kibi CN Ability Promotion Center was established in 1982 as a training company for the disabled in the area of precision tool making through a partnership of Okayama Prefecture and JAPAX Ltd.

Following this sample operation, two third sector companies for training the disabled are to be developed in two prefectures. They are a training program for the mentally retarded in Kanagawa Prefecture and a training program for the mentally retarded in a primary industry, such as horticulture, in Nagasaki Prefecture.

In this manner, the third sector companies for both employment (three cases) and training (one case) became the pilot models in new employment and training measures to be applied all over Japan today and in the future.

Implications For the Future

For the further development of employment through third sector companies, several suggestions have come out of the evaluative survey conducted by the author in 1984.

1. Since the key element for successful employment of disabled persons is effective business and personnel management, local governments must find companies which have a humanitarian attitude toward disabled persons and a wide range of productive activities from which appropriate activities for the disabled can be appropriately selected. They must also have financial soundness so that they can invest capital for employing disabled persons.
2. The payment and fringe benefits to disabled workers must be the same as for non-disabled workers wherever possible.
3. The large companies which sponsor the third sector companies also should stress the employment of disabled persons in the parent companies, otherwise the third sector companies become merely show windows and little progress will occur in the parent companies concerning employment of people with disabilities.
4. Making full use of counselors in the local vocational rehabilitation centers, reasonable turnover of the disabled manpower must be promoted (in spite of a general commitment to lifetime employment) so that those who have other vocational preferences may express them.
5. The experimental pilot companies had a pattern of matching local authorities with one company. But in the future, different versions with plural companies can be tried out so that the companies will be able to serve the vocational needs of all disability groups.
6. All pilot companies started to employ the physically handicapped (especially favoring wheelchair users and deaf people) but in future the third sector companies must serve other types of disabilities too such as mentally retarded, mentally handicapped and groups with mixed disabilities.
7. Something like a management council should be organized using local representatives from companies, labor department, groups of disabled, academics and labor associations. This would guide the company to a balance between profit making and human welfare of the disabled workers.

This paper has focused on employment of the disabled in the third sector companies as a type of *enclave system* for employment of the disabled. This is important because it can enhance the vocational integration of the severely disabled. Nevertheless the ideal method is to incorporate disabled workers in the mainstream of employment. Third sector employment can be considered one step to reaching this goal.

	Number of agencies	Number of the disabled employed	Actual employment rate
Non physical labor governmental firms to which a 1.9% quota rate is to be applied	3,842	38,607	% 1.89
Physical labor governmental firms to which a 1.8% quota rate is to be applied	272	12,226	1.90

Source: Japanese Ministry of Labor

TABLE 1. Employment Situation of the Disabled by the National and Local Government (as of June 1, 1984)

	Number of firms	Number of the disabled employed	Employment rate of the disabled	Rate of the firms achieved quota rate
Private firms to which a 1.5% quota rate is to be applied	38,358	159,909	% 1.25	% 53.6
Special judicial body to which a 1.8% quota rate is to be applied	97	1,348	1.79	76.3

Source: Japanese Ministry of Labor

TABLE 2. Employment Situation of the Disabled by the Private Enterprises (as of June 1, 1984)

Size of firms (persons)	Number of firms	Number of the disabled workers	Employment rate	Rate of the firms fulfilled quota rate
67-99	9,184	13,215	1.76 %	61.6 %
100-299	20,774	45,471	1.43	59.6
300-499	3,848	15,726	1.20	41.8
500-999	2,605	17,239	1.09	33.2
Over 1,000	1,947	69,258	1.14	23.3

Source: Japanese Ministry of Labor

TABLE 3. Employment Rate of the Disabled in Private Firms with Size Categories (as of June 1, 1984)

Trades	Number of firms	Number of the disabled employees	Employment rate of the disabled	Rate of the firms achieved the quota rate
Agriculture, forestry and fishery	81	240	% 1.35	% 60.5
Mining	65	634	2.59	75.4
Construction	1,517	6,322	1.18	56.2
Manufacture	16,665	87,276	1.43	65.8
Wholesale and retail	8,621	17,452	0.73	32.7
Finance, insurance and real estate	1,861	13,784	1.04	31.0
Transportation and Communication	2,128	9,036	1.38	63.4
Electric, gas and water supply	103	2,231	1.22	35.9
Service	7,317	22,934	1.42	52.4

Source: Japanese Ministry of Labor

TABLE 4. Employment Rate of the Disabled in Private Firms by Trade Classifications (as of June 1, 1984)

Companies / Disabilities	Kibi-Matsushita	Katano-Matsushita	Harima-Sanyo	Average
Quadraplegic	22.6 %	8.0 %	0 %	10.2 %
Paralyzed lower extremities	71.0	88.0	43.5	67.5
Paralyzed upper extremities	0	0	0	0
Paralyzed lower extremities and right hand	0	4	0	1.3
Paraplegic	3.2	0	0	1.1
One leg	3.2	0	0	1.1
One hand	0	0	4.3	1.4
Hearing and speech	0	0	52.2	17.4
Total	100.0	100.0	100.0	100.0

TABLE 6. Types of Disability of the Disabled Workers (as of 1984)

Companies		Kibi-Matsushita	Katano-Matsushita	Harima-Sanyo
Disabled workers	male	23 (74.2) %	20 (80) %	14 (63.6) %
	female	8 (25.8)	5 (20)	8 (36.4)
	sub total	31 (100.0)	25 (100)	22 (100.0)
Non-disabled worker		54	8	52
Total		85	33	74

TABLE 5. Number of Employees of 3 Third Sector Companies (as of 1984)

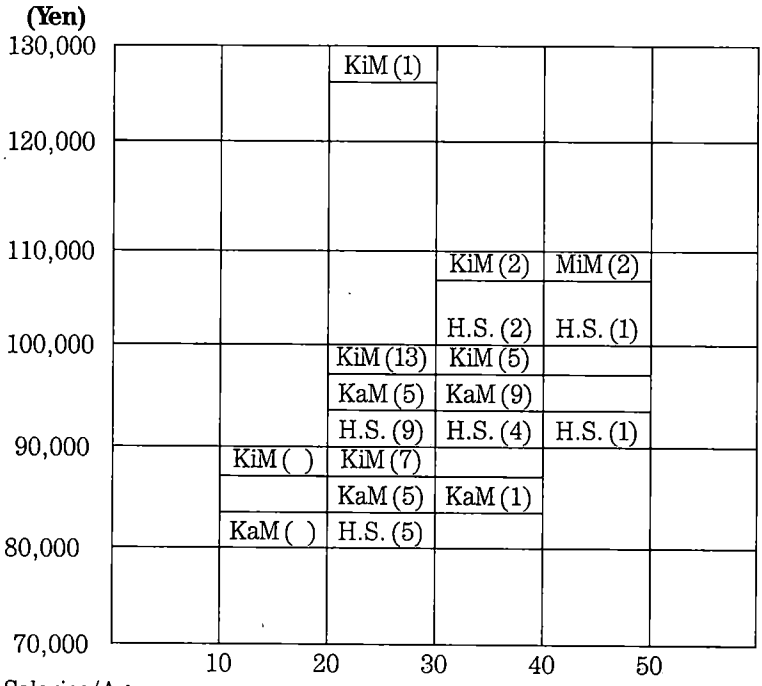
Company / Causes of disability		Kibi-Matsushita		Katano-Matsushita		Harima-Sanyo		Total	
		Number of persons	%	Number of persons	%	Number of persons	%	Number of persons	%
Diseases	Cerebral palsy	8	25.8	4	16.0	5	21.8	17	21.5
	Polio	5	16.1	3	12.0	1	4.3	8	10.1
	Congenital dislocation of hip bone	1	3.2	1	4.0	2	8.7	4	5.1
	Deaf and mute	0	0	0	0	9	39.2	9	11.4
	Spina bifida	0	0	2	8.0	0	0	2	2.5
	Malformation of spine	0	0	2	8.0	0	0	2	2.5
	Bone malformation	0	0	1	4.0	2	8.7	3	3.8
	Spinal caries	0	0	1	4.0	0	0	1	1.3
	Muscular dystrophy	0	0	0	0	0	0	1	1.3
	Weak hearing	0	0	0	0	1	4.3	1	1.3
	Malformation of hip bone	1	3.2	0	0	0	0	1	1.3
	Hemophilia	1	3.2	0	0	0	0	1	1.3
	Others	2	6.5	0	0	0	0	2	2.5
Accidents	Traffic accident	5	16.1	8	32	3	13	16	20.3
	Labor accident	2	6.5	0	0	0	0	2	2.5
	Other accident	6	19.4	3	12	0	0	9	11.4
	Total	31	100.0	25	100.0	23	100.0	79	100.0

TABLE 7. Causes of Disabilities (as of 1984)

Companies / Salary ranks (Yen)	Kibi-Matsushita		Katano-Matsushita		Harima-Sanyo		Average	
	Number of persons	%	Number of persons	%	Number of persons	%	Number of persons	%
Under 80,000	0	0	0	0	0	0	0	0
80,000—89,999	7	23.3	9	36.0	5	22.7	21	27.3
90,000—99,999	18	60.1	15	60.0	13	59.1	46	59.7
100,000—109,999	4	13.3	1	4.0	4	18.2	9	11.7
110,000—119,999	0	0	0	0	0	0	0	0
Over 120,000	1	3.3	0	0	0	0	1	1.3
Total	30	100.0	25	100.0	22	100.0	77	100.0

(As of April 1985, one (1) US Dollar = 250.9 Yen)

TABLE 8. Basic Payment of Disabled Employees (as of February 1982)



( ) show the number of persons in the category
KiM = Kibi-Matsushita
KaM = Katano-Matsushita
H.S. = Harima-Sanyo

TABLE 9. Distribution of Income by Age

Company / Type of Social security	Kibi-Matsushita		Katano-Matsushita		Harima-Sanyo		Total	
	persons	%	persons	%	persons	%	persons	%
non-contributory disability pension	13	31.0	10	36.0	19	86.5	42	45.5
contributory disability pension	11	26.2	7	25.0	1	4.5	19	20.7
disability allowance	15	35.6	8	27.0	0	0	23	25.0
Workers Compensation benefit	2	4.8	0	0	1	4.5	3	3.3
others	1	2.4	1	3.0	0	0	2	2.2
none	0	0	0	0	1	4.5	1	1.1
unknown	0	0	2	7.0	0	0	2	2.2
Total	42	100.0	28	100.0	22	100.0	92	100.0

TABLE 10. Type of Social Security Benefit

Companies / Living arrangement		Kibi-Matsushita		Katano-Matsushita		Harima-Sanyo		Total	
		persons	%	persons	%	persons	%	persons	%
Single living		18	58.0	13	52.0	19	86.5	50	64.2
With family MEMBERS	With spouse	6	19.3	4	16.0	1	4.5	11	14.1
	With spouse with one child	0	0	1	4.0	0	0	1	1.3
	Single worker with parents	3	9.7	3	12.0	1	4.5	7	8.9
Others		4	13.0	4	16.0	1	4.5	9	11.5
Total		31	100.0	25	100.0	22	100.0	78	100.0

TABLE 11. Living Arrangement of Disabled Workers

THE JEWELRY TECHNICAL CENTER OF ISRAEL: A U.S./ISRAELI PARTNERSHIP

by Gail A. Magaliff, Associate Executive Vice President, FEGS
Mr. Bryan Newman, President, Ne'eman Industries Ltd. Israel

In October 1985 in Hatikvah, Tel-Aviv, the Jewelry Technical Center of Israel is scheduled to open its doors. What has transpired over these past few years to create the Center is an endeavour between an industry, a government, a voluntary organization, a neighborhood, a philanthropic community, and individuals, who, working thousands of miles apart, will together be creating new jobs, a better economy, and a future for many of Israel's unemployed. Yet, the Jewelry Technical Center of Israel is much more than a new endeavour to create jobs.

- It represents a model which does not rely on public or philanthropic support;
- It represents a program which is designed to be self supporting;
- It demonstrates what an industry can do to assure its place in the world of high technology; and
- It demonstrates what every nation must be concerned with—the economic development of its industries and the future employment of its citizens.

The Jewelry Technical School of Israel is a joint endeavour of the Israel Jewelry Manufacturers Association, Tel Aviv Educational & Cultural Corporation, Project Renewal NY, Federation Employment & Guidance Service NY, Ministry of Labor & Social Affairs, Israel and FEGS Israel, with the cooperation of the Ministry of Commerce & Industry, Israel, Tel Aviv Municipality and Hatikvah Neighborhood Committee.

What is the Jewelry Technical Center of Israel? How did it evolve and how can other nations use this model for its own industries?

The Jewelry Technical Center of Israel has been established to meet the modern technical labor needs of one of Israel's fastest growing industries. The Jewelry Technical Center of Israel will:

- Provide technical training in all areas of the manufacturing process including: setting, polishing/lapping/stripping, casting, finishing, soldering, chain making, and other areas.
- Create an information center and library for the jewelry industry.
- Upgrade skills of current industry workers by providing advanced courses.
- Provide specialized seminars for the industry demonstrating new equipment and jewelry techniques.

Graduates of the Center will be highly trained in all of the manufacturing techniques needed in the industry today.

The Center will provide training to the unemployed, new immigrants, war veterans, the disabled, and others, as well as offer advanced courses to people already working in the industry to upgrade their skills. By providing the Israel Jewelry Manufacturing Industry with jewelers and production line workers the Center will also make a significant contribution to the economy of Israel and will substantially increase Israel's jewelry export trade.

How did it happen?

A Voluntary Organization

Since 1934, Federation Employment & Guidance Service, the largest non-profit human services agency in the US has been serving the New York community through the provision of a comprehensive array of rehabilitation, training, employment, home care, treatment services, and corporate services. Currently serving over 50,000 individuals a year in facilities located throughout Metropolitan New York, the organization's $27M budget is funded through federal, state, and city government, private foundations, and through its membership in the Federation of Jewish Philanthropies of New York.

Since the inception of FEGS, it has provided services which help enable individuals achieve economic, personal, and community independence. Today the agency's Treatment Services Division, Educational and Vocational Division, Home Care Division, and Corporate Services and Economic Development Division, provide direct services to almost 2,000 individuals a day and target its diversified programs to New Yorkers who need help.

- FEGS works with youth, the adult, the elderly, the new immigrant, the high school dropout, the disabled, the unemployed, the criminal justice offender, the recent college graduate, single parent families, and others in need of services to enable them to become economically independent and personally self-sufficient.
- FEGS operates employment centers, career counseling programs, trades and business schools, residential facilities, treatment centers, home attendant care services, dropout prevention programs, sheltered workshops, and mobile job and career centers.
- FEGS offers advanced training to human resource professionals and works with universities and corporations to train their students and their personnel.
- FEGS works with business and industry to create programs to meet their immediate needs and their economic needs.
- FEGS has served as consultant to the governments of Puerto Rico and Israel to assist these nations in enhancing their services and training their personnel. *In 1984 the Agency incorporated an affiliate organization, FEGS Israel.*

FEGS' Jewelry Institute of New York

For almost two decades, through its Vocational Services Division, FEGS has operated Business and Trades Schools designed to meet the needs of industry and the needs of the disabled, the disadvantaged, and others unemployed and in need of training, counseling and rehabilitation. FEGS's Jewelry Institute of New York (JINY) working directly with the Manufacturing Jewelers & Silversmiths of America and the entire jewelry industry, each year places over 100 individuals in a variety of manufacturing occupations, in the jewelry industry primarily in the greater New York area. Licensed by the State Education Department of New York, the ongoing success of the program is its everchanging ability to meet the needs of industry, provide quality vocational education, and offer specialized and individualized services to its students. In the US the program is primarily supported by a variety of government grants and contracts and the majority of students receive vocational training at no cost to themselves or their families.

Over the years this funding approach has enabled diverse groups of individuals to receive training, including the physically/emotionally disabled, developmentally disabled, the deaf, the economically disadvantaged, the new immigrant, the school dropout, the learning disabled, the veteran, etc. While hundreds of individuals have successfully completed these vocational courses, the system of funding in the US usually relies on a specific government agency which funds such programs and individuals in need of training who are eligible to receive government support.

Historically FEGS' Jewelry Institute of New York shows high success rates. Well over 75 percent of its graduates obtain jobs in competitive industry. The jewelry industry is also a vocation which can accommodate many individuals, as the primary skills needed for this occupation are fine finger dexterity, spatial perception, and the ability to engage in a sedentary occupation. Thus, men and women with physical, educational or language barriers are able to successfully learn this trade, enter industry with competitive skills, and advance in the jewelry field.

An Industry

As part of the ongoing business and professional activities of the Institute, FEGS regularly participates in jewelry trade shows. Of prime importance at these trade shows is the exchange with the manufacturers who hire FEGS graduates, as well as with businesses which produce jewelry equipment and develop new methods to enhance manufacturing capability. Business contacts with local, national, and international jewelers has been vital in assuring that FEGS maintains up-to-date modern facilities to train individuals to meet the needs of the jewelry industry.

Several years ago, at a trade show held in New York City, members of the Israeli jewelry industry were invited to visit FEGS' Jewelry Institute of New York. The initial meeting resulted in a strong request from the Israeli jewelers

to implement in Israel a school modelled after the FEGS program. The rationale was simple: Israel is a small country which relies on many industries, to employ its population and to export materials and products. The export capability of the Israeli jewelry industry has increased substantially over the years, however, most manufacturers employ few people, are scattered throughout the country, and have limited capability to regularly train new workers.

While the country has design schools, it needs a central vocational school to train people for the manufacturing industry. The connection between FEGS and the jewelry manufacturers is perfect. FEGS has over a decade of experience in operating a New York State licensed jewelry school and also of working with students in need of vocational and rehabilitation services: the physically disabled, the deaf, the emotionally disabled, the developmentally disabled, the new immigrant, the school dropout.

The Israel Jewelry Manufacturers Association, like many professional and business associations, is composed of business colleagues whose purpose is to work together to share ideas, create new markets for their product, develop new technologies, keep abreast of the latest export trends, and work together to solve problems and improve business.

A Government

At the initiation of the Israel Jewelry Manufacturers who fully supported the concept of creating a school in Israel, FEGS' first interest was to be sure that it could be of assistance in helping to develop a school to meet their needs. FEGS knew that many in Israel could become jewelers—not only do many of Israel's immigrants come from nations which have long been well-known for their hand-craft skills, but the jewelry industry is also one which can accommodate the physically disabled as well as individuals who have language problems.

Israel is a country of many war veterans, that is, many who need sedentary jobs, and it is also a country of new immigrants, many of whom have difficulty developing technical expertise in their new language. FEGS is also committed to help Israel, not only as a nation which is an ally of the U.S. but also as a member agency of the Federation of Jewish Philanthropies of New York. FEGS has long worked with programs to develop and assure Israel's strong growth and survival.

The Agency has, for many years, been training carefully selected Israeli professionals and assisting them in developing management skills which in turn help Israel develop new programs for the disabled.

The Ministry of Labor and Social Affairs in Israel is the government agency responsible for rehabilitation services to the disabled as well as vocational services to individuals who are unemployed. The Ministry, through its Manpower Training and Development Bureau, operates vocational centers around the country and, through its Bureau of Rehabilitation,

also operates sheltered workshops throughout Israel.

In creating the Jewelry Center in Israel, FEGS acknowledged that it had to operate with the support and under the auspices of respected and recognized Israel government organizations who would ensure that the Center met all the appropriate legal, curricula, and programmatic requirements of the country. The Ministry has not only become an active partner in this joint effort but is instrumental in participating in the design of the program and in funding it for its' initial five years. Potential students who are unemployed, disadvantaged, and disabled, will all be able to receive training at the Center at no cost to them and will likewise receive the full support of services from the Ministry.

The Israel Jewelry Manufacturers Association, recognizing the strength of initiating a Center with support from the U.S., as well as support from the Israel government, also recognized the importance of assuring ongoing funding for the Center.

Under the auspices of the Ministry of Industry and Commerce in Israel, in August, 1983, emergency legislation through bills submitted to the Knesset was passed which will ensure the funding of the Jewelry Center. The legislation, often referred to as the "mil tax," enables industries which export products to impose a tax upon those manufacturers who export at a certain level and directs this tax to be used for the purpose of vocational training and/or research for new technology. The Israel Jewelry Manufacturers Association, by joint agreement, voted to impose upon themselves a 0.1% tax on those exports above 5 million shekels (5 million shekels as per August, 1983: Level of shekel changed based on inflation rate).

In summary, the Jewelry Industry of Israel, with the support of the Ministry of Industry and Commerce, is now instrumental in upgrading its manufacturing capability, training Israel's future jewelers, and providing this training through its own funds as opposed to government or philanthropic efforts.

FEGS Israel

FEGS Israel, an affiliate agency of FEGS, was established in 1984 as a non profit corporation in Israel to be a partner with the Ministry of Labor and Social Affairs, the Israel Jewelry Manufacturers Association, and the Tel-Aviv Educational and Cultural Corporation (the Israeli arm of Project Renewal) to initiate the Center. The establishment of FEGS-Israel working with FEGS-New York will be FEGS' arm in Israel to help implement the project. Both FEGS-Israel and FEGS are also involved in other endeavors to develop human services in Israel. In 1984, under agreement with the U.S. Department of Health and Human Services and the State of Israel, a joint Memorandum of Understanding (MOU) was established to implement projects between the U.S. and Israel to help develop the social service network of both countries.

FEGS plays an active role in this program which is also working with the Federation of Jewish Philanthropies and other organizations in the U.S. to create these endeavors.

A Philanthropic Community—A Neighborhood Project Renewal Hatikvah/New York

"Project Renewal is people helping to renew the lives of people. It is a partnership between the people of Israel and world Jewry; a large-scale, imaginative plan to improve the lives of 300,000 Jews in 160 distressed neighborhoods in Israel.

Project Renewal began in 1979. It is a comprehensive social and physical rehabilitation program which links Jewish communities abroad with these neighborhoods. The people of the neighborhood and the twinned community work as a team with the Jewish Agency, the Israeli government and the local municipality to revitalize the neighborhood. The cost of the entire program is $1.2 billion, shared equally by Israel and world Jewry.

The New York Jewish community, through the UJA-Federation Campaign, is twinned with Hatikvah, Tel Aviv, the largest distressed neighborhood in Israel. The Campaign's commitment is $20 million. New Yorkers do more than raise money. They are active partners in Hatikvah's renewal. They give their skills and time to help residents plan and carry out rehabilitation projects. They provide training in self-government to develop local leadership and self-esteem.

The majority of Hatikvah's 15,000 residents are immigrants and children of immigrants from Arab and North African countries who fled to Israel just after the 1948 War of Independence. Many were left on the fringes of Israeli society, isolated by language, inadequate education, and negligible job skills. They became heirs to many ills that poverty breeds: decayed and overcrowded housing, low education levels.

A high percentage of Hatikvah's people work at menial jobs. Many families are on welfare. Juvenile delinquency, teenage prostitution, drug addiction, and alcoholism in Hatikvah are the highest in the country. Hatikvah's people became part of "the other Israel," the product of a social gap dividing Israel into haves and have nots.

Project renewal set out to eliminate "the other Israel," to bring the people of Hatikvah into the mainstream of Israeli life. Its programs attacked Hatikvah's worst problems: housing, education, community facilities, social services.

Project Renewal has generated far-reaching changes in Hatikvah. Its effects can be seen in new apartment houses, renovated streets and schools, new parks, playgrounds, swimming pools, club houses, basketball courts and day care centers. There are youth programs to keep children off the streets. There are adult education classes, family counseling services, vocational training, tutoring and career training for youth, services for the aged,

scholarships for university students.

The crime rate is down. Thousands of children are enrolled in after-school education programs. Arithmetic scores of elementary school children have improved. Hundreds of children are enrolled in scouting programs, and more than a thousand kids take part in basketball and soccer leagues.

There is a new pride and leadership in the community. Hatikvah's negative view of itself is being eliminated. Residents take an active part in determining community needs at the grass roots level, and work to solve their own problems."

(Abstracted from "People Helping People—A Partnership"—Project Renewal, Hatikvah/New York)

Today...The Future

The Jewelry Technical Center of Israel is scheduled to open in October, 1985. The partners have selected a Director who has just completed an extensive six week training program at the FEG's Jewelry Institute of New York. The Municipality of Tel-Aviv is providing the building in Hatikvah, which is now undergoing renovation.

Student recruitment will include the unemployed residents of Hatikvah, the disabled, war veterans, the educationally disadvantaged, the newly arrived Ethiopians, and any other individual in need of training or retraining. The Center will also recruit individuals already working in industry and develop special courses to upgrade their skills. Manufacturers will take an active role in an advisory committee and will also provide their expertise by offering short-term courses, lectures, seminars, field visits, and, of course, job placement.

It is the hope of FEGS that the Jewelry Technical Center of Israel will serve as a model for other industries not only in Israel but in other nations. A model between government, voluntary, and private sectors, who together can create new ways, new funding, and new resources to help people in need and to improve our nations.

EMPLOYMENT FOR DISABLED IN FRANCE THROUGH A TRIPARTITE PROGRAM: GIRPEH by Annick Mallet, Déléguée Générale, G.I.R.P.E.H.: (Intraprofessional Regionalized Groups for Promotion of Employment of Disabled Persons)

Overview of GIRPEH

In society, work is an essential part of life, and the handicapped attach a particular importance to the possibility of obtaining a job that will permit them to work among others, like the rest of the world. However, of all the problems handicapped people must confront, employment still remains the most poorly handled. The corporate world has not been truly involved in any of the phases of the integration of the handicapped. And yet, there will be no solution without its active participation.

What happens when a business, large or small, finds itself faced with the problem of integrating a handicapped person? First it will try to resolve the problem with its own personnel department. However the complexity these situations usually represent requires the help of experts. This is where GIRPEH comes in.

GIRPEH is a non-profit organization, which represents a cross-section of the professional world. It was created in 1977, expressly to promote employment of the handicapped in normal working environments.

Conceived by businessmen confronted daily with the most intricate aspects of personnel management, GIRPEH provides a meeting place for all those concerned with hiring policies (corporations, private businesses, organizations for the handicapped, training specialists, government agencies).
Three objectives were established:

- to help firms integrate and manage their handicapped employees;
- to promote the integration of handicapped persons seeking employment;
- to develop ties between businesses and organizations which create sheltered work areas for the handicapped.

The aims of GIRPEH go beyond the placement and maintaining of jobs for the handicapped: the ultimate goal is the accessability of professional integration and successful careers, as often as is possible, in normal working environments. GIRPEH attempts to give the handicapped an equal chance at job opportunities, without undo economic burdens on the businesses involved.

How GIRPEH Is Organized

GIRPEH functions as a service organization with its headquarters in Paris.

For maximum efficiency, its structure is tripartite, interprofessional and regionalized:

Tripartite: the national authorities as well as the regional groups comprise three bodies sharing an equal voice:

1. the body of employers, made up of private and public companies, business associations, chambers of commerce, agricultural and craft guilds.
2. the body of employees, made up of representatives from national labor unions.
3. the body of qualified personnel for the handicapped, made up of the handicapped themselves and of people specializing in their concerns.

Interprofessional: this group addresses itself to all professions, all areas of activity: factories, banking and insurance, service industries, commerce, crafts, agriculture and professional people.

Regionalized: regional groups throughout France allow for action as close to the job as possible, in direct contact with those concerned. Eight groups have been either already established or are in the process of being formed.

Regional groups are an intermediary step, necessary from an administrative point of view; but the goal of the regional GIRPEH bureau is to open channels within important industrial/employment areas.

Funding for these groups is by:

- the contributions of member firms, who may also have a personal representative as a permanent part of the group;
- payments made by businesses, which are deductible from:
  - apprenticeship taxes, or
  - financial obligations concerning the continued education/training of employees,
- government subsidies (very few)
- lastly, since 1983, in the form of honorarium.

This last source of funding becomes vital since GIRPEH, like any other organization dependent on funds received from private companies which are scarcely aided by public funding, must find new funding sources through their own efforts.

GIRPEH functions with a small permanent staff, made up of employees and executives sent by member firms. About forty volunteer counselors, generally executives, pre-retired or retired from personnel departments, work closely with the permanent staff members.

Thus the team possesses an excellent knowledge of the businesses involved, and the problems that the professional integration of the handicapped can present. This competence contributes to the group's credibility and efficiency.

GIRPEH'S Role, Activities, Services:

GIRPEH's role is essentially to permit businesses, administrations, and handicapped persons in specialized training centers and in sheltered work areas, the possibility of knowing each other, understanding each other, and

working together; and as a result, to collectively promote the employment of the handicapped.

A compliment to the Ministry of Labor's specialized services, GIRPEH has become the "meeting place" of all those who privately or publicly must participate in the professional integration of the handicapped.

GIRPEH plays a double role:

- within the professional corporate world, it creates awareness and coordinates activities concerning employment of the handicapped;
- it acts as a liaison among business circles, government agencies, the training/placement institutions, and the handicapped themselves.

GIRPEH seeks to enhance awareness of:

- ways the business world can help facilitate integration of people with disabilities,
- the existing methods of orientation, training, and employment of the handicapped,
- and finally, the way to accomplish these goals within the specific businesses concerned.

GIRPEH gathers, processes and facilitates the exchange of information, through various means:

1. by the research and analysis of documentation
2. by direct, individual contacts
3. by participation in existing study groups
4. by formation of permanent study or work-shop groups.

This collaboration has allowed for the development of six important tools for businesses, the handicapped, the rehabilitation/training centers, and sheltered work areas:

1. Creating awareness of the special problems involved in the professional integration of handicapped persons;
2. Techniques on how to welcome and integrate the handicapped into the working situation;
3. "Ergonomics and the handicapping situation";
4. "How the company can deal with official rules and restrictions"
5. Professional orientation of handicapped workers;
   and
6. "Techniques for job-seeking" for handicapped workers.

As was mentioned previously when a company encounters an integration situation, they usually try to solve it through their own personnel department. More often than not, the situation is too complex for them to handle alone. GIRPEH's experts are called upon to make an analysis of the situation, help formulate a policy decision, and help to resolve or avoid similar future problems.

The services provided for the handicapped consist of group or individual professional guidance for those seeking employment. GIRPEH helps the handicapped to analyze the work they seek, to examine their professional

desires, and to discover a realistic goal. GIRPEH then advises these handicapped persons as to the most efficient means for them to accomplish their goal.

Furthermore, GIRPEH seeks to develop the rapport between the specialized training centers and the professional world. Their representatives are also available to participate in the formation of these training centers and their staffs, and to help them define programs appropriate to the needs of the job market.

Lastly, GIRPEH facilitates contacts between the sheltered work centers and the companies which could help them by providing them with work. And when possible, helping them with the transfer of handicapped persons from a sheltered work center to the normal working environment.

As one can see, these actions have immediate as well as long-term ramifications. Assessing the time element involved in GIRPEH planning is fundamental; at stake is not only the solving of an economic problem of employment, often complicated and delicate for those concerned, but also the proposing of structural modifications which could not be considered without a slow and meaningful change in societal attitudes. Dealing with handicapped employment is first of all linked to cultural traditions which have led to certain welfare practices concerning the methods of integration, rather than to a realistic management of the handicapped person's capacities. The handicapped themselves very often unconsciously reinforce these types of attitudes and practices.

Refusing an apriori welfare approach to assisting the handicapped who can prove their skills and their capacity to enter the working world, the GIRPEH alternative offers a much more positive approach for the objectives of the person and those of the firms. In a realistic search for mutual solutions, GIRPEH is in a position to render mutual service.

The goals and methods of GIRPEH are now recognized as playing an important part in changing attitudes regarding handicapped persons in working environments. This is due not only to the fact that GIRPEH answers a real need, but as a result of our operating principles, based on *realism, openmindedness and independence.*

Realistic, how?

GIRPEH's realistic approach is based on a thorough analysis of the problems which arise with integration into the normal working world. We work as closely as possible on the job site, and take into account the conditions particular to each firm, and its immediate environment. This step is implemented through the means of regional and local structures. We have always looked for the most direct solutions, using past experience as examples. This pragmatic approach has helped to avoid the complications of over-theorizing and over-generalizing, and has permitted us to perfect our methodology for professional integration.

The principal phases of integration can be summarized as follows:

- convincing and involving the management of the firm;
- defining the policy of the firm and installing methods to achieve this policy;
- then, treating each case individually by taking into account the person involved, the position (specifically the precise definition of possible positions) along with their possibilities for handicap adaptation (the work conditions, environment, etc...), plus the career potential of the job.
- involving all those taking part in the integration, without neglecting the employee concerned who is given the maximum opportunity to assume his responsibilities himself.
- lastly, sensitizing and preparing superiors and fellow workers, concerning technical and relational problems that the disabled person integrated into the workforce might encounter.

Open-minded, how?

GIRPEH must remain open to all viewpoints expressed by all parties concerned. Our tripartite structure facilitates and in fact, imposes an open-minded availability at all times. Our activities are conducted in constant contact with government bodies, the companies, welfare institutions, and all other public and private authorities participating in the process. This open-mindedness gives GIRPEH the multidisciplinary dimension that is indispensable to a smooth and efficient operation.

Independent, how?

GIRPEH is not a part of any official authority. A decision resulting from a tripartite vote does not oblige compliance from any of the local subscribers; yet our national guidelines are for the most part followed. The reason for this is the total autonomy our three way partnership allows us with regard to the before-mentioned groups whose viewpoints we must hear: government, welfare associations, unions, individual companies.

Despite current economic difficulties, GIRPEH possesses many assets to insure the continuity of our mission. More than half of the regional member companies are part of nationalized industries. If government encourages an affirmative policy on employment of the handicapped within the nationalized area, private businesses will follow suit.

By virtue of its structure and autonomy, GIRPEH has been able to act as a catalysing element in the professional corporate world; we have raised consciousness concerning societal attitudes toward the handicapped. More important however, we have provided for the capable handicapped person and the company desirous of giving him a job, the means to find one another and work together toward a common goal.

From a speech given at Michigan State University on May 1, 1984 at an International Conference on Employment Policies for People with Disabilities sponsored by the University Center for International Rehabilitation (UCIR).

SECTION THREE
PARTNERSHIP ARRANGEMENTS IN WHICH GOVERNMENT IS A KEY FACTOR

REHABILITATION IN AUSTRALIA—A PROGRAM INVOLVING UNIONS AND EMPLOYERS
by Doug Limbrick, Australian Department of Social Services

The Commonwealth Rehabilitation Service

In Australia the Federal Government is directly involved in provision of rehabilitation services to people with disabilities through the operation of the Commonwealth Rehabilitation Service (CRS). The CRS is fully funded by the Federal Government and the management and the professional staff employed by the Service are government employees. The services are delivered to clients through a range of different facilities and mobile casework teams dispersed throughout the country. Some of the CRS facilities offer specialized services while others provide a broad range of rehabilitation assistance. A small number of facilities are operated jointly with other agencies. All CRS programs are arranged on the basis of meeting the needs of each individual client, utilizing interdisciplinary casework practice and individual program planning.

The CRS was established in 1948 as the basis for a community rehabilitation scheme but was largely confined to assisting recipients of government pensions, benefits and allowances until 1977 when the eligiblity criteria were considerably expanded. The free services of the CRS are now available to any disabled person within the broad working age group (16-60 for women and 16-64 for men) who could benefit from a rehabilitation program. Prior to the 1977 legislative amendment the CRS was confined to providing only vocational rehabilitation. However, since 1977 clients of the Serivce may have a much wider range of rehabilitation goals.

Trade Union Movement

The CRS has recently completed renegotiation of a special arrangement for CRS clients with the Australian Council of Trade Unions (ACTU). The arrangement is for the continuation of a "work therapy" scheme which is

essentially a scheme to provide on-the-job training and experience for CRS vocational clients.

The ACTU, which was formed in 1927, is a national confederation of some 160 trade unions. It represents the union movement through presentation of submissions at the National Wage Case and to the Federal Government on economic, legal and industrial issues. Delegates from member unions, attending the ACTU Congress, which meets every second year, decide trade union movement policy on major issues including wages, conditions, legislation, health and safety, etc.

The work therapy scheme grew out of post-war training schemes for ex-service personnel. The informal arrangements which existed with various unions and employers lead to union reservations about the legitimacy of the arrangements as a rehabilitation measure and concern about the effect on union members. This lead to the establishment of a Rehabilitation Advisory Committee on which the then president of the ACTU was a member.

In 1958 the ACTU accepted the proposition by the CRS that work therapy was a special rehabilitation measure. This was to form the basis of a formal agreement with the ACTU which operated with the continuing co-operation of the unions from 1958 until reviewed in 1984 and was subsequently reaffirmed with a new formal agreement in early 1985. This was confirmed by the ACTU with a set of guidelines to all affiliated unions.

The development of the original work therapy arrangement arose for two main reasons:

1. the need for short term practical job experience; and
2. the need for the CRS to have a training measure which could be used quickly and flexibly.

The major objective from the ACTU perspective in reviewing the arrangement was to clarify certain aspects of the scheme. There was particular concern about clarification of goals and objectives of placements and the role of all parties, the rights of disabled participants and the rights of other employees (particularly as instructors). The main method of overcoming these concerns was through a redevelopment of the written training agreement and a restatement of the roles of all parties involved in the program. There was initially some problem over the use of non-union shops but this was resolved satisfactorily by agreement to inform the ACTU of any such placements.

In short work therapy may be described as an arrangement to provide a disabled person with work experience in a real work environment. It involves an agreement between the disabled person, an employer, the CRS and the appropriate trade union.

Aims and Objectives

The aims of the work therapy scheme have been variously described as:

- placement in a work environment;
- on the job training;
- job practice;
- work trial;
- a furthering of the rehabilitation process;
- an opportunity for assessment of the success of rehabilitation and/or work potential;
- refresher training; and
- transition from a sheltered environment as part of a rehabilitation program.

While these aims of the program are not in conflict, it is clear that the program has a number of facets which are possible because of the flexibility of the scheme.

The stated goals for the scheme are:

1. for the CRS;
   - to assess the work potential of the rehabilitee,
   - to facilitate employment
2. for the rehabilitee:
   - to gain employment, but also to regain confidence,
   - to become adjusted to industrial discipline and working conditions,
   - to become adjusted gradually to employment through job practice,
   - to learn to use tools and equipment and acquire skill and experience.

Eligiblity

To be eligible for work therapy a disabled person must be a client of the CRS. Eligibility for CRS assistance is provided for in Part VIII of the Social Security Act 1947. As indicated earlier in this paper any disabled person in the broad working age range, who can derive substantial benefit from rehabilitation, has prima facie eligibility for the free services of the CRS.

Process for Arranging Work Therapy

Once a placement has been arranged with an employer it is the responsibility of the CRS to notify the federal secretary of the relevant union. Placement is not put into effect until the permission of the union secretary has been obtained. Where an employer agrees to a work therapy placement, but claims to be a non-union establishment the secretary of the State Branch of the ACTU is informed (with the agreement of the employer).

Before a client is placed in training on the job, it is necessary for him/her to sign a formal training agreement. This agreement describes the nature of the training provided and, in the event of any legal proceedings (for example, as a result of accident during training) it would provide substantial evidence concerning the conditions under which the training was being

provided. One copy of the agreement is given to the trainee and another is attached to a letter to the employer indicating his role as "instructor" in the training agreement.

The role of each of the four participants (the employer, the client, the CRS, the union) in the program is summarised below:

The employer

1. The employer undertakes to provide on the job instruction in the use of tools and equipment and to assist the client acquire skills and experience and to become accustomed to normal work routine.
2. The employer should have similar expectations of the client as for any other employee regarding behaviour and discipline.
3. The employer does not pay the client any wage nor does he guarantee to provide permanent employment for the client.
4. The employer should discuss any problems with the rehabilitation counselor and may request that the work therapy be terminated at any time.
5. The employer undertakes to give the client regular feedback on how he/she is performing on the job.

The Client

1. The client undertakes to attend the employers' premises as instructed by the employer and undertakes the work required to the best of his/her ability.
2. The client has access to his/her rehabilitation counselor at any time (with the employer's permission during working hours).
3. The client may terminate the work therapy after discussion with the rehabilitation counselor.

The Commonwealth Rehabilitation Service

1. The CRS pays the client a training allowance for the duration of the work therapy program.
2. If eligible the client will also be paid a Rehabilitation Allowance and also a Living-Away-From-Home Allowance.
3. The client will be reimbursed by the CRS for transportation fares to and from the employer's premises.
4. The CRS provides the client with protective clothing and any items regarded as essential by the employer and normally provided by employees for their own use.
5. The CRS will arrange any modifications to the work place and provide any technical aids or appliances required by the client.
6. The CRS undertakes to obtain approval of the appropriate union before a work therapy program commences.
   Where non-union establishments are used the state branch of the ACTU is to be notified of the placement.
7. The client is covered for workers' compensation under the provision of

the Compensation (Commonwealth Government Employees) Act 1971, in the same manner as government employees.

8. The CRS undertakes to pay for any additional cost of premiums paid by employers for workers' compensation or public risk cover incurred as a result of agreeing to have CRS clients in his work place.

The Union

1. The relevant union must approve of the work therapy before it commences.

Work therapy, which would generally be completed within three months, may cover a wide range of occupations although it is primarily intended for semi-skilled occupations.

Training for skilled occupations will normally involve the CRS in the use of formal training courses provided through colleges and universities.

The Value of Work Therapy

Work therapy is a valuable tool in the rehabilitation process. It provides a unique opportunity for work potential to be observed and assessed by CRS multi-disciplinary casework teams and individual casework staff particularly the rehabilitation counselor. It is regarded by caseworkers as an integral part of rehabilitation treatment and assessment procedures that have taken place through CRS centres, facilities and programs.

It is particularly valuable in facilitating the placement in employment of those persons:

a) who have been unable to work for a long period of time or who have never worked;

b) whose confidence in their ability to perform satisfactorily has to be restored or established; and

c) whose ability to cope with the requirements of the job must be tested and proved.

Only a relatively small proportion (approximately 10%) of total CRS cases undergo work therapy as a part of their rehabilitation program. However, for these individuals this activity is considered to be invaluable in the process of enabling a severely disabled person to make the transition from the relatively sheltered environment of the rehabilitation program to open competitive employment.

Although the employer is not under any obligation to provide the trainee with employment at the end of the work training the normal expectation is that, provided the trainee performs satisfactorily. the employer will engage him/her as an employee under the relevant award conditions at the conclusion of the training. Most work therapy placements, in fact, ultimately lead to open employment for the disabled person, this is largely the result of the work of the rehabilitation counselor in negotiating the right placement, in the right job, at the right time for the disabled client.

ALTERNATIVE PROGRAMS FOR EMPLOYMENT AND JOB-SEEKING STRATEGIES IN ISRAEL

by Yecheskel Taler Ph.D.
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Background

Israel is a young country which is undergoing a continuous process of absorption of new immigrants. It is being formed from a variety of groups, societies and cultures. It is a meeting ground for immigrants of different classes and cultural backgrounds, from developed and industrialized countries as well as from those which are neither developed nor industrialized.

This fact calls for a process of integration, as well as the adaptation of large groups to modern technology and the development of new mechanisms for absorbing individuals with vocational handicaps.

For populations with such handicaps, it is extremely difficult to adjust to a new technological and physical situation. Thus, the rehabilitation services in Israel have played a central role in the area of vocational training.

Jewish religious culture—the Bible—does not deal at all with the problem of individuals who have handicaps. In comparison with other cultures, religions and peoples of the ancient world, the Jews had an advanced conception, one which accorded the handicapped person the same status as any other. This ancient conception is valid to this day.

Maimonides, the greatest interpreter of Jewish law, stated that there were 8 ranks of charity; the highest consisted in "...giving a gift or a loan or forming a partnership with a person or giving him work in order to strengthen him until he no longer needs to ask for help." In other words, the highest charity is to help a needy individual to stand on his own two feet, so he will not have to be dependent on others. (Maimonides, "Laws Concerning Gifts to the Poor," Chapter 10, Verse 7). This is in fact the purpose of rehabilitation, and this is why Jewish law and culture assign high priority to the subject of employment and job seeking.

A job is more than a means of making a living; it is the normal daily activity of the adult in our society; in order to be a part of the mainstream of life, one must be part of the work force. Freud considered the ability to work one of the two most important constituents of the functioning of a healthy adult. The National Institute of Mental Health views work as a means of preserving sanity; as such, it is of utmost importance. (Taler, 1984). From this we can see that the purpose of rehabilitation is integration into the world of work (Ben-Zvi, 1982).

The subject of employment of handicapped persons includes various dimensions, some of which are universal and others which vary from place to place—for example, the population in question, the legal situation, the

current policy, the system in charge of rehabilitation, the special projects developed, and the attitude of society as a whole, including employers, rehabilitation personnel, and the handicapped persons themselves.

In the following, I will discuss each of these points with specific reference to Israel.

The Handicapped Population in Israel

For the purpose of this discussion, it is possible to differentiate among three large groups:

- Persons handicapped from birth, or who became handicapped sometime during their lives through illness or accident.
- Persons handicapped in work accidents which left them with physical or mental disabilities.
- War injured—persons who incurred physical or mental injury in the course of military service—whether regular service or reserve duty.

These differences are important, as the law distinguishes between the three groups, and current policy makes significant distinctions between the first two groups and the third.

The Employment of Handicapped Persons—
The Legal Aspect and the Handicapped Population

According to the General Handicap Law, a "handicapped" person is defined by his inability to earn a living, or the diminishing of this ability by 50% or more as a result of a biological deficiency, including birth defects (Miller, 1981). For this we can conclude that an individual with a disability who works and earns a living is not considered handicapped.

The National Insurance Law defines a person handicapped through work injury as a "person who is unable to do the work that a person of his/her age or sex is normally able to do." This definition covers both biological handicap and what can be termed "general handicap": it refers to the economic effects of the injury, or, to be more precise, its effect on the ability of the individual to earn a living (Miller, 1980).

Thus, the law treats the economic factor as the primary one which determines whether the person is handicapped or not. At the same time, what is conspicuous in its absence in the legal status of various groups of handicapped persons, *(with the exception of war injured)* is the right to work (Miller, 1980). No advantage is conferred by law on handicapped persons, and employers have no obligation to hire them; apparently, the onus is on the Employment Service or rehabilitation workers administering to handicapped persons to persuade employers to hire them.

Still, as early as 1954, the National Insurance Institute recognized the importance of returning to work, when it conferred first on work injured and later also on other categories—war injured (at the beginning of the 1970's), widows (1970), and general handicapped (1974)—the right to occupational rehabilitation, along with the right to income maintenance.

The war injured, however, are the responsibility of another body—the Rehabilitation Department of the Ministry of Defense. This population has numerous special benefits: for example, exemption from sales taxes on home installations and appliances and reduced fees (their offspring pay lower tuition at all institutes of higher learning). Moreover, the law states that 5% of those hired by every employer must be persons defined as war injured.

The law therefore does differentiate between war injured and the rest of the population of handicapped persons.

Rehabilitation personnel are divided in their opinions with regard to what constitutes desirable law. Some recommend passing a law that would require employers to hire handicapped persons at the rate of 5%, while others oppose such legislation, arguing that employers may refuse to hire additional handicapped persons once they have employed their *quota.* The result will be that handicapped persons will not have the option of approaching employers as ordinary people, but will have to go through the placement agencies labeled as handicapped.

The System of Civilian Rehabilitation Services in Israel

In Israel, the rehabilitation system operates in different organizational frameworks which supply a wide variety of rehabilitation services to the population of handicapped and disabled. The number of organizational frameworks and the differences in their policies has resulted in a lack of uniformity in the rehabilitation services offered, overlapping of services, and lack of coordination among the different organizations. This situation undoubtedly has an adverse effect on the efficiency of the rehabilitation services in the country.

The directors and workers of the various rehabilitation services are aware of the problems involved, and this makes it possible for all those engaged in rehabilitation to work together for the benefit of the individual who needs such services.

An Overview of Rehabilitation Services in Israel

There are several bodies which deal with the rehabilitation of the handicapped population in Israel.

The Rehabilitation Department of the National Insurance Institute

The National Insurance Institute has an extensive system of pensions and allowances for the handicapped. One of the basic ideas of the National Insurance Law, which came into effect 1954, together with the idea of income maintenance, was *the ideology of returning to work through the right to vocational rehabilitation.* The Institute has 17 main branch offices and additional smaller offices located throughout the country. The system of rehabilitation services is an integral part of all divisions of the Institute and its extensions, which include some 30 locations. The aims and purposes of the

Department can be described as covering the following areas: diagnosis, referral, welfare, sheltered work, employment on the free market, and community work.

The National Insurance Institute has Rehabilitation Centers in Branch Offices throughout the country. These deal directly with handicapped persons, who come to them or are sought out by them. Each Center is under the direction of a senior coordinator, and has at least one team. A team consists of six rehabilitation workers and a liaison worker (who provides administrative assistance), supervised by a counselor. A total of 165 rehabilitation workers, most of whom are professional social workers, are employed in the Branch Offices.

The Foundation for Rehabilitation Programs

The Foundation was established in 1964 by the Israeli government, and its legal status is that of public non-profit organization. It has since been incorporated. The Foundation began operating in 1965. Today it serves as the *main vehicle of the Rehabilitation Department of the Ministry of Labor and Social Welfare for the operation of vocational rehabilitation and employment services.*

The purposes of the Foundation are (1) to initiate programs for the disabled, and (2) to operate such programs.

Programs must be approved by the Ministry of Labor and Social Welfare before they can be set up. In effect, the Rehabilitation Department of the Ministry is the body that determines the establishment of new frameworks, obtains the budget for them and has the Foundation put them into operation.

The Foundation provides professional and employment services through its field units. These units are of several types:

- Eight Vocational Rehabilitation Centers provide comprehensive rehabilitation services: intake, diagnosis, complementary services, vocational training, placement and follow-up.
- Three Diagnostic and Observation Centers function in a manner similar to that of the Rehabilitation Centers on a smaller scale.
- Four Rehabilitation Programs provide intake services, teach work habits and give placement services.
- Six Programs for Long-term Employment provide sheltered work.
- Two Centers for the Rehabilitation of Young Handicapped Persons take in youth who have dropped out of special education frameworks and prepare them to function in social and employment settings.
- Home Employment Services supply knitwork to handicapped women confined to their homes and provide work for clubs for the blind.
- Rehabilitation Centers for the Brain-Damaged are in the process of being set up.

Rehabilitation Department—Ministry of Labor and Social Welfare

The Rehabilitation Department of the Ministry of Labor and Social Welfare is responsible for providing rehabilitation services to the entire population of disabled residing in the community. The Department is responsible for the operation of Rehabilitation Services throughout the country for all categories of handicapped, ministering to all handicapped persons on an equal basis.

The Social Service Offices in the field provide *on-going rehabilitation for the general population of disabled from age 0 to 65, regardless of social or economic situation.* The field services include medical and functional evaluation and diagnosis, vocational-employment diagnosis and evaluation, vocational counseling, psychological therapy and social or medical care, and follow-up during the period of training, studies or placement, accompanied by supportive care.

The purposes of the Department are: (1) to deploy services throughout the country in order to provide maximum accessibility for the handicapped; (2) to concentrate services in a general rehabilitation framework, coordinating and integrating medical, rehabilitation, employment, family, social and community care; (3) to develop an awareness of the subject of rehabilitation in the community through social, medical, public and volunteer services; (4) to develop both intra-departmental and inter-departmental cooperation with governmental agencies, as well as with professional organizations at home and abroad; (5) to develop rehabilitation frameworks, tools and institutions that will cater to a variety of rehabilitation needs; (6) to promote innovative activities, methods and models to suit the needs that arise; and (7) to develop personnel and professional knowledge in order to improve the level of services.

"Ha 'Meshakem" Company, Ltd.

In 1956, tens of thousands of disabled (veteran residents and new immigrants) were without suitable employment. The free market turned down every appeal to employ these workers. This situation induced Golda Meir, then Minister of Labor, to charge a Parliamentary Committee with the responsibility for finding an urgent and acceptable solution to the problem of the country's aged and disabled. The Committee came to the conclusion that a special institution should be created in which such individuals would be able to find suitable employment that would provide them with a respectable living for themselves and their families.

In accordance with the recommendation of the above Committee, "Ha 'Meshakem" Company was established in 1958 as a voluntary organization; in 1962 it became a limited liability company operating in the framework of the Ministry of Labor and Social Welfare (Shoshani, 1982).

Up until 1979, the Company was financed by the Jewish Agency; since

then, it has been financed jointly by the Ministry of Labor and the Jewish Agency (each taking on 50%). The administration of the Company is independent of both the Jewish Agency and the government.

According to Shoshani (1982), the *purpose of the company* is to rehabilitate aged and disabled persons, to provide them with employment, to ensure them minimum income and to restore their self-respect.

This is to be done by establishing programs and services to employ the disabled, by assisting enterprises that do employ them, by marketing products produced by the disabled, and by obtaining donations, allowances and grants from the government, the local authorities, the World Zionist Federation, and other agencies, institutions, bodies, or individuals.

The staff of "Ha 'Meshakem" Company includes 206 employees who work at Company headquarters and in field units scattered throughout the country.

The target population. There are 4 main agencies which refer disabled persons to "Ha 'Meshakem" Company:

(1) The Employment Service. In the past, the Service was the only referring agency. In 1983, it accounted for about 65% of new referrals.
(2) The Rehabilitation Department of the National Insurance Institute.
(3) Rehabilitation Centers and Social Service Offices.
(4) The Ministry of Defense—Rehabilitation Department.

In addition to the above agencies, the Company has non-contractual relations with additional bodies (mental hospitals, sheltered workplaces, social clubs, etc.) These relations are a result of the financial or medical needs of the handicapped persons.

About 6,000 individuals (75% men and 25% women) are employed by "Ha 'Meshakem" Company every year.

In spite of the fact that one of the original aims of the Company was to provide a source of income and employment for aged persons unable to find work on the free market, today the Company finds itself dealing with a growing number of disabled young people—persons 30 years old or less.

***The Major Achievements of the Company* (from Shoshani, 1982)**

From the start, "Ha 'Meshakem" fixed the working day at 5 hours instead of the customary 8—and this because of the special circumstances of the population it served and because of the economic conditions prevailing in the country at the time. This was in accordance with the assumption that an aged or disabled person should not be required to work an 8-hour day. This arrangement also made it possible to provide work for a larger number of individuals in need of a way to make a living.

The salary paid by "Ha 'Meshakem"—which today is based on the minimum wage in Israel—supplemented by a government maintenance allowance—ensures basic sustenance. In addition, employees receive travel allowances and other fringe benefits, including pensions, the amount of

which depend on years of employment. These benefits add another 50% to employees' wages.

Every employee is entitled to the usual working conditions: sick leave, annual paid vacation, clothing allowance and vacation allowance—which increase with years of employment.

The Company has become a national project, and a highly resourceful one.

"Ha 'Meshakem" Industries

At present, "Ha 'Meshakem" employees are concentrated primarily in a few service industries, like gardening and tree nurseries. However, most of the thought, energy and resources of the Company are being invested in the development of new industries which will constitute the future mainstay of "Ha 'Meshakem". Today the Company is already operating modern industrial plants across the country, among them factories which manufacture plastic products, toys, paper and cardboard products, and disposable tissues and diapers. It also takes special orders for product assembly and operates modern sewing workshops in which employees produce various items of clothing for the Ministry of Defence.

In summary, "Ha 'Meshakem" Company has become a large enterprise which provides work and a living wage for 6,000 persons yearly. In the wake of the change in target population (a sharp rise in disabled young people), the institution must revamp its program so that it can absorb the increasing population of young people; it must prepare the necessary means for their rehabilitation—including the provision of machines, buildings, counselors, and, above all, work which is suitable to this population—and a stable market for the products of their labor.

Finally, Wizer states (1981), the rehabilitation activities of the institution are of utmost importance, for *"Ha 'Meshakem" is not the last stop; it often serves as a transition, an opportunity for training and a period in which the client acquires confidence and work habits.* Thus, "Ha 'Meshakem" can be seen as a temporary framework operating in times of crisis with the purpose of returning the person to normal functioning within a short period of time. It can also constitute a training ground which prepares individuals for the job market, turning dependent persons into independent and productive ones.

Strategies for Finding Employment

The Employment Service was created in order to provide employment for both the general population and handicapped persons. This agency, which originated as a political body identified with political parties, is now a state institution.

The Employment Service Law adopted in 1959 states, among other things, that employers may not hire persons unless the latter are referred to them by the Employment Service, which fact is to be stated in writing by the

Service. This was to prevent employers from giving preference to individuals with connections, and to stress the social justice of giving employment to the first comer.

The Employment Service has a special department for selective placement, whose task is to find suitable employment for handicapped persons.

Despite the fact that it is required by law, employers do not always work through the Employment Service, and at higher levels the Service is all but ignored. *The law requires every person to use the Employment Service;* all persons under the care of the formal social services are referred to the Employment Service in the final stage of the rehabilitation process.

In a study carried out in the framework of the Center for the Study of Rehabilitation and Development (Taler, 1984), it was found that two thirds of the handicapped persons who found employment did so on their own, without the help of the Employment Service or any other part of the formal system.

Sheppard and Belitsky (1966), for example, show that there is a *significant disparity between the strategy which is actually the most efficient for finding jobs and that which is supposed to be the best.* For instance, while Company Gate and Employment Services were both seen as the best ways of finding jobs by 29% of the respondents, and 16% ranked friends and relatives as the best method, in fact, friends and relatives were the best and most efficient way of finding work, while the other methods were less efficient in the same measure.

Moreover, it appears that rehabilitation clients will derive more benefit from a program that prepares them to look for work on their own than from one that trains them in general or specific work skills. For this reason, a number of rehabilitation programs are being developed whose purpose is to improve the skills needed to succeed in job interviews, as well as other skills which help the person to obtain employment. These programs include Job Clubs, ESPA—a series of units for instructing rehabilitation clients in effective job hunting, and ISS—a training program created by the Department of Education of Sangor called the Program for the Development of Job Survival Skills.

It is our belief that the traditional methods inadvertently encourage the development of passivity and dependency. The client learns to expect the rehabilitation worker or the employment counselor to evaluate his abilities, perhaps refer him to training, and afterwards find suitable employment for him. He himself tends to simply wait for help to arrive. In contrast, the innovative methods which train the client to develop job seeking skills emphasize the need for independence and teach the person to develop and actively employ his abilities.

Social Attitudes Toward Handicaps and the Employment of Handicapped Persons

The literature contains many examples of groups of workers discriminated against because of strong social stigma.

The Attitude of Employers

Ravi (1983) states that it has always been the public and non-profit sectors that have taken the initiative in hiring the handicapped—that is, government offices and organizations, educational institutions and social welfare agencies. At the same time, we know that small private companies are more likely to employ this population than large or public companies.

Florian (1981) examined employers' attitudes toward hiring disabled persons in both the public and private sectors of the Israeli economy. He found that employers' reluctance to hire disabled employees was often explained by existence of technical obstacles. However, when the possibility of financial aid for eliminating these obstacles was proposed, the employers still expressed reservations.

In another article (1978), Florian states that because of the special political and security situation, was veterans suffering from disabilities are viewed by society as a separate and preferred group. Not only are they accepted by society in general, but as we saw before, they also receive special rehabilitation services. Although Israel has mandated legislation requiring the employment of disabled war veterans (Florian, 1981), Florian found that not all employers were aware of this, and almost half of those who were did not employ disabled persons.

Florian (1978) found that employers had different attitudes towards other categories of handicapped persons: The most frequently expressed first preference (95%) was for hiring the war injured; the next preference was for employing those whose disability was the result of a work accident. Disabilities caused by other circumstances had lower preference, perhaps because the employers did not have enough information about the limitations caused by these kinds of disabilities. Although the results indicate that employers clearly discriminated among different kinds of injury, in general 3 principal groups were evident: the group that was most readily employable in positions requiring responsibility included those who had amputations and facial disfigurement. In contrast, the group that employers were least likely to employ include epileptics, the mentally ill, and the blind. The group that elicited moderate opinions as to employability included permanent users of crutches, persons with heart disease, persons dependent on the wheelchair, and the deaf. Employers tended to be ambivalent toward this group and did not want to express commitments with regard to their employment practices with the group.

Discussion

The professional literature usually emphasizes the effect of the negative attitudes of the general population on the population of handicapped persons and on their absorption and integration into society and suitable employment. There is no doubt that such an effect exists in Israel as well, but there are other factors which act as negative incentives.

One of them is the fact that the minimum wage in Israel is identical to the maintenance allowance received by handicapped persons. This situation fails to provide the individual with the incentive to work, and work, as we have seen, is basic to a person's integration into society—and basic to his mental health.

The motivation and willingness to go out and work are necessary if a person is to find and maintain employment. In Israel, rehabilitation programs are not focussed enough and do not do enough to prepare the individual for the world of work.

Selective placement is no longer considered an effective method. For this reason, the Center for the Study of Rehabilitation and Development saw fit to innovate new job seeking methods in Israel. We have adopted the idea of "Job Clubs" in various areas. As a result, the National Insurance Institute, the Rehabilitation Centers, and other organizations have begun to employ new job seeking strategies, strategies which develop new skills for job hunting and whose effect is to increase the independence of the disabled person—from the very beginning of the process of job seeking.

We have described in some detail the "Ha 'Meshakem" Company, an Israeli institution which provides employment for disabled persons who are unable to find work on the free market. We have seen how that institution broadened the scope of its activities to include the entire country, until at present it provides work for 6,000 persons a year, making it possible for them to earn a normal wage, with all the attendant benefits.

This institution constitutes a unique framework and model which integrates employment under sheltered conditions with creative work that demands productivity and enables the person to work in an industrial atmosphere and to receive all the normal benefits.

Although the purpose of the institution is not to serve as a "last stop" for the handicapped person, but rather as a temporary framework whose intent is to return him to normal functioning and enable him to find work on the free market, it is not always successful. Most of the employees of "Ha 'Meshakem" also receive a supplementary allowance and therefore have no incentive to go out into the free market. They tend to remain in the sheltered framework of the institution—and with the label and self-perception of "handicapped". This retards the process of rehabilitation in its broad sense, for most of the employees at "Ha 'Meshakem" are young people of 30 years of age or less.

Finally, looking toward the future, we can state that most of the persons undergoing rehabilitation are now entering low-level industrial jobs. These jobs are marked for extinction, and it is imperative that we prepare handicapped persons for employment in the new technological age of the 21st century, an age of computers, high-level service work, and sophisticated equipment.

It is vital that we make this effort, for today the available industrial employment is uninteresting, routine and often just plain boring.

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EMPLOYMENT FOR THE HANDICAPPED IN THE NETHERLANDS

John Franquinet, Jelle Jan Klinkert, Ph.D., Jan Vlaanderen

Introduction

The present article describes how the Dutch government promotes employment for people with disabilities. A brief description is given of the major characteristics of the socio-economic system in the Netherlands, followed by a description of some institutions which work in the field of rehabilitation.

Special attention is paid to the Gemeenschappelijk Medische Dienst /GMD (Joint Medical Service) and its activities.

The structure of the socio-economic-political system in the Netherlands

The socio-economic-political system in the Netherlands is structured in a way which can neither be characterized as a free-market economy nor as a planned economy. It is pluralistic which is the result of recent sociopolitical history.

Into the fifties Dutch society was characterized by the fact that it was divided into segments each of which had its own ideology. Most important were: the socio-democratic segment, the Protestant and Roman-Catholic segments, which often formed an alliance, and the liberal segment. At bottom level there was little communication among these groups but at government level cooperation was constructive.

The various segments held the following views as to how the country should be structured socially and economically:

- the social-democrats were in favour of government control and interference in order to equally distribute wealth;
- the liberals wanted to minimize state interference and to let the people take responsibility for themselves;
- the denominational groups (the Protestants and Roman-Catholics) held a different view: they maintained that the government should not interfere in the specific spheres of religion, education and industry. The people involved in these institutions should be responsible for solving problems in a harmonious fashion.

As a result of the central position of the denominational groups in Dutch politics the latter view to a large extent has shaped the socio-economic institutions in the Netherlands. In the present social security system, as well as in health care and labour relations, the same characteristics always occur: the parties concerned (employers and employees for example) take care of a

particular matter themselves, while the government only regulates through legislation and supervision.

For example, the freedom of concluding contracts between employers and employees is restricted by:

- legislation relating to (collective) labour agreements;
- legislation relating to protection in case of dismissal;
- legislation relating to occupational safety and labour conditions;
- social security legislation.

It should be noted that the ensuing laws are not made until after the social groups concerned have been consulted.

As a result, it appeared that well into the 1960's the government made a great many laws by way of ratification of the agreements made among the social parties. Moreover, these parties are largely represented in the controlling bodies created by the government.

It would appear that the relationships among the various social groups are quite harmonious. This was certainly true in the period after the Second World War but since the early 1970's these relationships have become less harmonious: relations between employers and trade unions have hardened, economic growth has decreased, prospects for the future have become bleak, and everywhere people are talking about going back to a more sober socio-economic system. Also, the various sections of society, which have existed since the end of the last century, have begun to crumble.

The Joint Medical Service Center (GMD)

In the Netherlands under the Employment Exchange Act the government has the monopoly of the *exchange of employment.* For this purpose the government has set up Gewestelijke Arbeidsbureaus (Local Employment Offices), where on a voluntary basis employers can report jobs for which persons seeking work can apply if they are registered.

However, in comparison with the number of unemployed persons, the number of jobs available is so small that only very few succeed in finding work.

Disabled people clearly stand little chance of finding work. Moreover, the Local Employment Offices have given priority to fighting youth unemployment. Consequently, the elderly handicapped are often at a disadvantage. For this reason handicapped persons who are seeking work are often referred to the Gemeenschappelijke Medische Dienst/GMD (Joint Medical Service). The Service operates especially for the handicapped.

Health care and rehabilitation

Especially at the rehabilitation centres disabled people are prepared for the labour market. These centres are incorporated in the health care system and are financed by the health care funds, viz. the sickness benefit insurance funds (for people who are in a low income bracket), private medical insur-

ance companies and the central government (which finances high medical risks, e.g. when a patient is hospitalized for over a year).

Socio-medical care within the framework of social security and employment exchange does not come under the health care system. The rehabilitation centres work closely together with GMD. It is considered important that when a person becomes handicapped or when he is receiving therapy or is being rehabilitated the issue of going back to work is taken into account at the earliest possible stage.

Social Security

Two important social security acts are the Algemene Arbeidsongeschiktheidswet/AAW (General Disablement Benefits Act) and the Arbeidsongeschiktheidsverzekering/WAO (Disability Insurance Act). Under these Acts benefits and provisions in kind are awarded. The Acts are implemented by the "bedrijfsverenigingen" (Occupational and Industrial Associations). These are quasi-governmental organizations in which both employers and workers are represented.

The GMD gives medical advice required to assess the level of benefit and to determine what kind of aid must be awarded. The GMD also guides the long-term handicapped.

The GMD is an organization with a highly qualified staff of about 1,200. The GMD operates in the field of employment for the handicapped. The Service was founded in 1967 to develop specific expertise in the field of long-term incapacity for work. This was required due to the fact that the new invalidity legislation—the Disability Insurance Act (WAO) applicable to all wage-earning people—became operational. The WAO was followed by the General Disablement Benefits Act (AAW) applicable to all residents regardless of whether they are wage-earners. The AAW therefore also applies to the self-employed and young people who are handicapped. Under these Acts people who as a result of sickness or disability are unable to work are entitled to benefits (guidance and training, for instance) and provisions in kind (adjustments to the home, wheelchairs, etc.)

The GMD employs medical insurance officers and labor experts. The first group determines the restrictions resulting from a given disease or impairment. On the one hand the patient's consulting physician or specialist diagnoses and prescribes the therapy, on the other hand the medical insurance officer consults with them and then examines in what way the patient's functional capacities are influenced by his physical condition.

The labor expert uses functional capacities to explore the client's potential for performing wage-earning employment. The labor expert then considers existing jobs in the labor market; the status of the jobs should be similar to the job(s) the client used to have. Together with a legal assessor the labor expert and the medical insurance officer form a team. This team

attempts to reduce the adverse effects of the patient's handicap at home or at work. First vocational training is attempted. then the handicapped person is helped to obtain wage-earning employment.

Methods of assessment

Exactly when is a person considered handicapped in the Netherlands? In order to answer this question we must describe how the degree of incapacity for work is assessed. At first it must be investigated in what measure the handicapped person is capable of performing wage-earning work despite his particular impairment. It is then established how much this person can earn. The job should be attuned to his experience and educational level and should be available in the area. The amount of income is then compared with the wages the person earned before he became handicapped. If he has never worked the legal minimum wage is taken as a basis. The comparison thus produces the degree of handicap and incapacity for work. In this method of disability assessment factors relating to the labour market play a role as well, as the medical aspects.

However, the government is presently contemplating a law review aimed at minimizing the influence of the labour market on the degree of incapacity for work.

Provision of employment

Under the Wet Sociale Werkvoorziening/WSW (Act on the Provision of Work) a number of sheltered workshops operate in the Netherlands. This form of employment has been created for people aged 18-64 who for medical or socio-psychological reasons are unable to find a job. The wages are paid from general funds. These are regular wages; the handicapped sometimes receive supplementary invalidity (WAO) benefit. Initially the workshops were intended to create temporary employment for people who in the end would get an ordinary job. As a result of the economic recession this has not materialized. Most people working under the WSW stay in their jobs in sheltered workshops.

At present a bill is being drafted aimed at improving the position of the handicapped in the labour market. In effect, on the one hand under this law employed persons who become handicapped may keep their job, on the other hand employers may hire handicapped persons. The aim is for employers and trade unions in the branches of industry to make agreements about the percentage of handicapped persons to be employed by each company.

In order to keep a handicapped person in a job under certain conditions employers can be compelled to make certain adjustments. They can be asked to make a contribution towards the costs involved in adjusting the labour conditions to the handicapped. Employers can also be liable to redress if they do not give a handicapped person who is unable to perform his job the

oppoprtunity to carry out suitable work which is performed elsewhere in the company. The GMD will play an important role here.

Conclusion

The following tables will give some information regarding the number of handicapped people in the Netherlands. It might be useful to point out, as we have done before, that the definition of "handicapped" in this context has been derived from the social secuity legislation, i.e. the General Disablement Benefits Act and the Disability Insurance Act. Instead of using the term handicapped we will therefore use "beneficiaries".

TABLE 1
Number of Beneficiaries/Age 1983

Age Group	Privately Employed %	Self Employed %	Early Handicapped %	Others %	Total %
15-24	2	—	27	4	4
25-34	9	2	35	14	11
35-44	17	10	18	17	17
45-54	27	26	12	24	26
55-64	44	60	9	41	42
	100	100	100	100	100
n	560.588	37.797	56.661	18.274	673.320

TABLE 2
Number of Beneficiaries/Diagnosis Per December 31 During Four Years

Diagnosis	1980	1981	1982	1983
	%	%	%	%
Mental Disorders	17	18	19	19
Cardiovascular	11	11	11	11
Musculoskeletal	20	22	22	23
Accidents	4	4	4	4
Others	48	45	44	43
	100	100	100	100
Total n	628.413	648.405	665.505	673.320

TABLE 3
Number of Beneficiaries/by Sex 1983

Men	492.772	73%
Women	180.548	27%
Total	673.320	100%

THE SHAW TRUST'S EXPERIENCE WITH SUPPORTED EMPLOYMENT
by Ron Whitehouse, General Manager, The Shaw Trust

To be disabled is to be presented with problems, and nowhere is this more apparent than in the employment field. Indeed, in a "hostile" climate of high unemployment, a depressed economy and constant changes in industrial activity, many disabled people experience great difficulty in securing employment of any kind. At present there are 76,000 unemployed disabled people registered with Disablement Resettlement Officers at Job Centres throughout England, with a further 7,000 registered who, being severely disabled, face the greatest problems in terms of job prospects.

Out of this concern was born *Shaw Trust*, an independent voluntary organization which actively seeks out permanent employment opportunities for severely disabled people and, by so doing, endeavours to promote the social and economic integration of disabled people into society, believing that the work ethic is a necessary stimulus in progressive human development and the dignity of earning one's living can be the springboard for an independent and self-reliant lifestyle.

The Trust is unique in that its concern with the employability of disabled people is not restricted in terms of any particular area of handicap or age group, but encompasses all handicaps and disabilities both physical and mental, spanning the whole of an individual's working life—from 16 to 65.

Since its inception in 1982 the prime activity of the Trust has been in the area of Sheltered Employment provision and has now reached the position of acknowledged leadership in the field in the U.K. Sheltered Employment is by no means a new concept, since 1944 legislation and a variety of Government initiatives, including Sheltered Employment provision, have been targeted towards helping unemployed disabled people train for and secure employment. Despite a record of "positive input" by Central Government administered by the Manpower Services Commission, many of the provisions often remain more appropriate to the needs of the less severely handicapped/disabled person of whom it can be said need a "helping hand" to enable them to secure and maintain gainful employment on the open job market. For the more severely disabled person, however, the "handicap" imposed by their disability is often so severe that it would be unlikely that the individual would be able to retain work under normal conditions. For such people, provision is made available within The Disabled Persons (Employment) Act of 1944 and 1958 for "Sheltered Employment"—The basic rationale of Sheltered Employment recognises that, by reason of the nature, severity and duration of a disability, an individual would be unable to compete for or maintain a job without some measure of protection from the stresses and problems that

working life can bring while, at the same time, recognising that severely disabled people can make a major contribution to their own support through work and also derive benefits which flow from participation in the working life of the community.

Over the years Sheltered Employment has in the main been made available in the form of purposely established workshops and factories run either by Local Authorities, voluntary bodies or Central Government and provide a working environment where severely disabled people, unable to cope with the demands imposed in an "open" employment situation, can work within their capabilities. By 1981 13,000 severely disabled people were working in 216 Sheltered Workshops and factories throughout the country, earning a standard weekly wage and performing, in the main, routine, unskilled or semi-skilled tasks.

With a growing concern that, while workshops were providing work for severely disabled people in our society, the segregation and "labelling" process remained unchanged, an alternative form of Sheltered Employment emerged in the form of the "Sheltered Placement."

In essence this, now commonplace, alternative provision places the severely disabled person in an open employment setting, working alongside able-bodied colleagues and offers the sheltered employee a package which includes total integration within the work situation. The disabled person receives the same rate of pay as an able-bodied person carrying out the same job; there exists a greater scope for the disabled person to extend the range of jobs within industry, commerce or the business field. In brief, this type of Sheltered Employment provision goes a long way to overcome the rigid dichotomy of sheltered and open employment and gives the severely disabled person a real chance to break away from the "labelling as disabled" process while still affording a measure of protection from the usual stresses and expectations associated with open employment.

From the outset The Shaw Trust recognised the untapped potential that clearly exists for employment possibilities within the framework of Sheltered Employment provision and has succeeded in exploiting this potential to the full, often breaking into areas of employment hitherto considered inaccessible for severely handicapped people. The Trust employs regional Development Officers, all of whom have considerable industrial and/or commercial experience, whose major task is to seek out suitable employment opportunities for severely disabled people in the local community of whom the Trust has been made aware; unemployed severely handicapped candidates are referred to the Trust by Disablement Resettlement Officers, Careers and Social Services Departments and hospital authorities. By skillful interviewing the Development Officer identifies an individual's employment needs and potential with reference to his/her past experience, mobility and skills he/she can offer a prospective employer. The Development Officer, having

an overall picture of the candidate and the type of job he/she is looking for, seeks out job opportunities within both the private and public sector in the individual's local community. The success of the Trust to date, in terms of placing severely disabled people in sheltered full-time employment, can be attributed in part to the basic convictions held by the organization: in realising the employment potential of a severely disabled person, the emphasis is always placed on an individual's *ability*, not disability. Similarly, in approaches to prospective employers, the officers of the Trust recognise the financial constraints on companies and always negotiate a Sheltered Placement in a business-like manner, with never the suggestion that to offer a job opportunity to a severely disabled person is a "hand-out"—but rather that it is a chance to contribute to the working life of a community.

When a suitable job opportunity has been identified, a three-way agreement is entered into involving the Shaw Trust, the organisation where the sheltered employee will work (the host) and Manpower Services Commission. The disabled person is taken on to the payroll of the Trust, who takes on board all the administrative and contractual obligation of an employer. The host employer, providing the working environment and the work to be done, agrees to pay only for the level of productivity/work capacity of the sheltered employee. The Trust "tops up" and pays the wage/salary to the sheltered employee equivalent to that which would be enjoyed by an able-bodied employee carrying out the same task. The Trust then recoups most of its costs within certain limits retrospectively from the Manpower Services Commission.

Each placement is negotiated by the Development Officer with particular reference to the specific job to be done and the capabilities of the disabled candidate. There is no "blue print" for establishing sheltered placements. Great attention is paid to each individual work situation and sheltered employee to make sure the integration into the work place is as smooth as possible for both host and employee. It is often necessary, for example, to provide special aids and/or adaptation to make access to the "job" easier. Every effort is made to comply with conditions of service in operation at the host company—the manner in which wage/salary is paid, holiday entitlement, hours of work, etc. are all complied with so that on a day to day basis the disabled employee is treated the same as his/her able-bodied colleagues. Indeed, dealing with such a wide range of disabilities as the Trust does, a flexible and imaginative approach is essential to enable integration into the work place for the severely disabled worker.

At present the Trust has 205 severely disabled on its payroll which represents a success rate of 24% in terms of the total number of people referred to the Trust. Each one of these 205 placements is, however, a success story in itself—a severely disabled person working in a totally integrated work situation. It is likely that the Trust will place an additional

200 employees during 1985 throughout England and Wales.

The span of jobs being undertaken is impressive and exemplifies the unlimited possibilities that exist for sheltered employment provision. The following examples demonstrate the type of employment being undertaken.

Nature of handicap	Type of Employment	Employee's ability
Hemiplegia/speech impairment	Physiotherapist Assistant	65%
Registered Blind	Technical Clerk	35%
Multiple Sclerosis/ Epilepsy	Printer	60%
Hypochondroplagia	Chambermaid	60%
Mentally handicapped	Market Garden Assistant	35%
Mentally handicapped	Bandsaw Assistant	40%
Cystic fibrosis	Accounts Clerk	40%
Epilepsy (grand mal)	Houseparent Assistant	33 1/3%
Mentally handicapped	Photographic Assistant	65%
Cerebral palsy	Computer VDU Operator	40%

The sheltered employee usually settles into the new job and routine of work very quickly, having had potential problems ironed out by the Development Officer and host company well in advance.

Once a sheltered placement is established the Development Officer makes periodic, though discreet, visits to the host company. Although informal, it is during these visits that the Development Officer will check the progress and performance level of the sheltered employee and discuss issues such as pay raises and holiday arrangements. The employee also has the opportunity to iron out any problems and discuss his/her own progress and aspirations. Of course, should there be a problem in the work situation between visits, the Trust prides itself that the Development Officer will respond to the situation within 24 hours—at no time is either the employee or host left to feel "isolated."

Sensitive to the needs of our employees on the Trust's payroll, a number of support officers with considerable experience in the field of severe handicap are employed from whom employees and candidates awaiting possible placements can seek advice and assistance.

The support officers have a wide range of responsibility to provide the link between the development side and the caring face of the statutory authorities. Where problems occur, not specifically of an employment nature, the support officers are called in either by the placement, host company or Development Officer. They provide advice and assistance on such matters as State Benefits, taxation, as well as emotional and family problems that arise.

Earlier mention was made of the Trust's concern to promote the integration of disabled people into society. So often the experience of earning a living becomes the platform for the disabled person to participate in areas of everyday life previously denied. The "luxury" of a disposable income in itself opens up a sense of possibilities. One such area—a "way of life" in Britain, is the annual summer holiday. In 1984 the Trust organised a holiday for our employees in Jersey and this proved so successful that a further four holiday packages are planned for 1985. With the long term welfare of our sheltered employees in mind the Trust can now offer the option of personal pension schemes to everyone in Sheltered Employment. In consultation with specialists in the field of insurance and retirement provision, disabled people sponsored in employment by the Trust have the opportunity to plan ahead for retirement age by participating in the superannuation scheme especially created to meet the long term needs of our employees.

Although the major emphasis and success of the Trust over the past three years has been the development of a Sheltered Employment programme, it is recognised that a variety of initiatives in the employment field are called for if we are to achieve our primary objective—"to provide permanent employment for the severely disabled." One such initiative is the development of a 2½-acre site in Trowbridge, Wiltshire, where, in conjunction with the local authority, the Trust is developing a Garden Centre and horticultural facility along commercial lines, employing a predominantly handicapped workforce. The Centre will also provide training and educational facilities in the horticultural field for both severely handicapped and able-bodied people from within the local community.

Conscious of the fact that, while achieving considerable success in the field of sheltered employment, there was a lack of provision available for the many unemployed handicapped people whose disabilities did not qualify them for sheltered employment, the Trust entered the field of short term employment initiatives by becoming actively engaged in the Manpower Services Commission's Community Programme. The Programme provides an opportunity for individuals to be employed for up to 52 weeks in a non-commmercial environment, but one which none the less brings with it a need to conform to the requirements of a working life, to which it is hoped they will progress.

The Sheltered Employment programme remains the main thrust of the Trust's work, providing a secure base form which new and perhaps untried initiatives can be launched. It is anticipated that many aspects of the Trust's activities will be of an innovative nature, since it is accepted that many of the current concepts and provisions available came about in the 1940s and 1950s and are no longer valid in the rapidly changing world of the 1980s.

Whatever new initiatives are developed, the Trust holds the view that severely disabled people have the same rights of access as the able-bodied to

SECTION FOUR
TWO NATIONAL OVERVIEWS OF POLICIES AND PROGRAMS

UTILIZING THE LABOR POTENTIAL OF DISABLED PERSONS: DISABILITY POLICIES IN THE SOVIET SYSTEM

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Introduction

One risks oversimplification assuming to interpret a country's social system of care from a foreigner's perspective. One tends to notice more what is different and rushes into zealous comparisons with one's familiar settings. Whether positive or negative such value judgments, more often than not, rest on externalities and perceived realities not necessarily understood in their cultural context. The latter is a most difficult task.

The challenge is onerous when one tries to establish a meaningful and fair composite of social phenomena in the Soviet Union; a society which consists of a multitude of cultures, a society of the most complex ethnic, linguistic, and rural diversity. We are actually talking about a country of 270 million people spread across eleven time zones. There are more than one hundred officially recognized nationalities in the Soviet Union. An even larger number of languages are spoken within the country's borders. As Murray Feshbach, the "Dean of Facts" on the Soviet Union, is quoted: "(T)here is no average Soviet. There isn't even an average Russian. From a statistical viewpoint I consider it as fifteen different countries" (Gelb, 1984, p. 76).

The following discussion, therefore, is a hesitant analysis of Soviet social policies regarding disability and some tentative conclusions about the state of disabled persons in the Soviet Union.

The purpose of this paper is to explore social factors influencing the integration of the disabled in the mainstream of Soviet society. Such integration, according to the International Labor Organization, is best achieved through enabling a disabled person to secure, retain and advance in suitable employment. Based on this perspective, this discussion addresses primarily opportunities allowed Soviet disabled individuals to fulfill that most important role: job holder. Overall, however, social mainstreaming is operation-

alized as the individual's ability for social participation and economic self-sufficiency. Therefore attention is given to the mix of Soviet social provisions which individually and synergistically support the disabled peoples' entry into society's mainstream, and sustain their partaking in the functioning of social institutions.

Institutional Structure

One may say that Soviet social policies for disabled persons began from the onset of the October Revolution, since the ideals of freedom from exploitation and of the right to citizenship were proclaimed at that time. Comprehensive social security, in its conceptual terms as well as its programmatic expressions, is seen as an integral part of socialist society and a manifestation of its inner harmony (Rimlinger, 1971). In this context, a guarantee from want is a gift from the state and a fundamental right of the citizen irrespectively of any personal qualifications. The following areas of social security are of particular importance for disabled persons.

Income Maintenance

An attempt towards some form of income maintenance was already on the books for those individuals who became disabled because of work related injuries. The Industrial Accident Act of 1903, and the Health and Accidents Act of 1912 provided cash benefits financed by employers. However, coverage was extremely inadequate, limited to a small part of the labor force. Needless to say, prevailing political conditions were not conducive to social care.

The cause of disabled persons was also espoused by Lenin who, in 1921 in the Prague Conference, set the principles for a socialist social security system. Among other things, such a system should provide assistance in all cases of incapacity, including physical disability.

Early Soviet legislation (October 1918) on social insurance programs covered all population groups and risks. Stalin's economic plans restricted the nature of the provisions and coverage, confining benefits to wage-earners. Even then, eligibility requirements were narrow. The emphasis in social planning was on industrial growth and therefore distribution of resources and conditions for benefits favored work. This shift did not affect disabled war veterans and victims of industrial accidents as they were presumably covered by their respective pensions and, after all, had been "workers."

The emphasis on work has not been eliminated even after Stalin, but gradually universality of protection recovered, with significant steps taken in 1956 and again in 1964. Finally in 1977, the Fourth Constitution explicitly established the right to income maintenance as a part of provisions addressing the quality of life. Since then, income maintenance policies remain the same with significant increases in the amount of grants to improve living standards for people with disabilities.

Payment of benefits depends on several factors, all aiming not only to

help disabled people maintain their purchasing capacity but also to safeguard the needs of labor (George & Manning, 1980). These factors include the individual's previous earnings from employment, the length of his work history, the type of employemnt he was involved in prior to disability, whether his disability was work related and the severity of disability. The latter divides the disabled into three categories. Class A identifies those who are the most severely disabled and require the most care. Class B includes the remaining severely disabled persons, while Class C refers to partial disability.

In all instances, the pension formula is weighted in favor of those with the worst predicaments: that is, low earnings, limited work experience, dangerous line of work, highest degree of disability. Those who need continuous care are provided with an additional 15% of their pension while all those with total disability receive supplements for their dependents as well.

Health Care

Health care policies have had a similar history. While the concept of universal and comprehensive health care was declared in the early statements of Soviet planning, the present health care system has had a slow development. Early priorities have been: public health, industry-related health care, and maternal and child health services.

There were realistic reasons for this early emphasis on prevention. Prerevolutionary Russia suffered high mortality, as she did during the period of War Communism. Acute epidemics of typhus, small pox, typhoid and relapsing fever caused more than ten million deaths between 1916 and 1924. Wars devastated the population and destroyed the western part of the country all the way to Caucassus and Central Asia. The desperate need for fast industrial development led to crude and unsafe working conditions, adding to the number of maimed and sick. The lack of male labor power precipitated women's entry into the labor force, thus necessitating provisions for the health needs of mothers and children.

As stated earlier, political constraints such as investment priority in industrial and economic developments further delayed ful-scale implementation of universal health care policies. However, these emphases on prevention and industry-related health care hold great significance for disabled persons, since most of present day disabilities in the country's population are due to war injury, industrial accidents and culture-related life patterns, such as diet, alcohol consumption and smoking. The latter have only recently been recognized as health hazards. Another recent hazard that USSR shares with the rest of the world is the result of affluence in the form of car and motorcycle accidents. Slow technological developments in specific areas, such as neonatal care and pharmaceutical chemistry, have so far spared the country of some of the misfortunes of progress. For instance USSR has not suffered the devastation of thalidomide children because the drug had not reached the general public. Infant mortality has also delayed Soviet society's

exposure to the dilemmas of some of the most serious disabilities associated with premature births. In any case, present health policies provide comprehensive health care free at the time of consumption or need. Thus, whatever the health problem, care is available: a reassuring condition to people whose disability may necessitate ongoing medical intervention.

A central feature of the Soviet health care delivery system is accessibility. It is insured through locating hospitals, clinics or health stations near the work place, schools and neighborhoods. The Soviet Union boasts a present capacity of 3.2 million hospital beds; one third of all the world's doctors, (in addition to more than 3 million other medical personnel such as nurses and *feldshers,* a health professional unique in Soviet medical tradition performing a variety of medical tasks); the world's largest hospital equipped with high-pressure chambers for surgical operations; and more than 60,000 medical and disease prevention establishments (Soviet Economy Today, 1981). Administrative districts also have their own sanitary-epidemiological stations for environmental control. Schools, nurseries and day care centers are equipped with their own physicians and nurses, and doctors are expected to make regular home visits to insure maintenance of treatment and healthy environmental conditions. Widespread screening of those at medical risk aims at early intervention and has resulted in a recent provision for mandatory annual health examinations.

Rehabilitation

The above arrangements are particularly important to rehabilitation efforts on behalf of the disabled persons. The presence of "preventoriums" on factory grounds or near by, theoretically at least allows for convenient treatment needed regularly, thus facilitating one's maintaining a job and providing significant reassurance to those interested in employment but concerned about risks to their physical condition.

On a more administrative perspective these industrial clinics are in congruence with the goals of social policy, as the entire network of Soviet social policy is dominated by the needs of the labor market. Not only are disability benefits affected by the person's place in the labor force, but vigorous provisions are in operation to restore the individual's employability. Such provisions include physical rehabilitation, prosthetics and other technical support systems, provision of special means of support, access to vocational training, job-placement services and, of course, all those health related facilities such as spas and sanatoria for short and long term use. As with other health care any of these services are free of charge.

One cannot talk as if such rehabilitation services are at a uniformly high technological level. For instance, at an industrial hospital in Erevan, associated with the local synthetic rubber factory, the physical therapy department was rather primitive. The explanation given was that this was a small general hospital and patients with specialized needs were referred to more appropriate facilities. However, the situation at the hospital attached to the

Moskovitz care factory in Moscow which specialized in industrial injuries was not much more advanced. Far worse is the state of rural areas where facilities are fewer and specialists rare.

Nonetheless, what appears constant in the Soviet system is the comprehensive apparatus set to promote the entry into the world of work and the vocational readjustment of any disabled person who wishes to work. Having adopted a policy of "the right to work,"—with antithetical implications to our own laws of the same name—Soviet society promises a job to everyone and has instituted an array of provisions to carry out this promise. Such provisions include: work at regular employment places where, depending on one's disability, one may have shorter work hours, smaller work quotas and longer leaves; provision of a secretary paid for by the state for blind workers who are engaged in "intellectual work" (such as teachers, lawyers, scientists); an interpreter for the deaf, when more than twenty people with hearing disabilities work in the same business enterprise; additional scholarships to disabled students who pursue higher education. Severely disabled persons may work in sheltered workshops or at home. Managers of industrial enterprises are expected to continue employing workers even after the latter become disabled. Should a job in the original workplace be unavailable, the manager secures placement in another enterprise. If wages in the new position are smaller than those in the former job, the manager subsidizes them in order to assist the individual to maintain his standard of living.

Disabled war veterans receive even more special attention. They have free transportation on city transit, generous discounts on rent and public services, free medicine; they do not have to wait in lines when boarding a plane or train; they receive free tickets for cultural events and other such privileges.

As a result of these efforts, over 40% of the disabled in all classes (77.7% of the C category) are employed in the Soviet economy (Gitlis, 1984). Facilitating this outcome, no doubt, is the fact that the USSR still suffers severe labor shortages and, due to the type of economy, she still relies on cheap unskilled labor. Nevertheless, disabled individuals have made undisputed inroads in the professions, administrative and managerial fields. A recent issue of *Soviet Life* gives several anecdotal references of individuals who transcended their physical handicaps and reached their vocational dreams. The president of the health professionals union, a physician, talked passionately about his overcoming the paralysis he suffered because of a stroke and (through continuous health supports) his re-entering gradually the labor market. His story demonstrates the available measures that can be mobilized to maintain one's employability.

Social/Personal Services

Social services or rehabilitation counseling, as we know them in the United States, do not exist in the Soviet Union. That is, there is no identified profession of social workers or counselors assigned the tasks of personal and

advocacy services. However, all the functions of social work are carried out by other professionals, individuals or institutions in a multitude of contextual structures. For instance personal counseling is often provided by the visiting physician or nurse at home or workplace. Interventional efforts on behalf of workers could be by union representatives, teachers, or specially assigned officials of the cooperatives. This section, therefore, is rather broadly interpreted as social/personal services identifying those *interventional structures* that contribute to the management of affairs important to the lives of disabled people.

One such structure is found in the system of voluntary associations, or societies, of disabled persons. Particularly influential have been the Societies for the Blind (VOS) and the Deaf (VOG). Established much before social insurance legislation was activated, these associations have been functioning on a national network and have been excepted from conforming to the regional administrative jurisdictions that have been the pattern of all other organization, a pattern that preserves the sovereignty of the Republics and the autonomy of localities.

These societies have advocated for their respective memberships and have been instrumental in establishing training and business enterprises, promoting the cooperative movement for the disabled long before the State paid any attention to the needs of people with lifelong physical handicaps. At present, the USSR Society for the Blind unites 178,000 members, runs 178 factories which employ about 100,000 people. According to some estimates (Gitlis, 1984) VOS factories (specializing mostly in electronics), make an annual profit of 80 million rubles which is spent on building appropriate housing for people who are blind, expanding production, developing recreational facilities and other similar investments.

Deaf persons seem to work mostly in public industry and farms. Their lives too are enriched through the efforts of their society. It is reported (Gitlis) that in the Republic of Russia alone there are over 500 clubs and cultural centers for the deaf.

One important institutional change was the transferring, early in the 1930's, of the administration of social insurance from governmental departments to trade unions (George & Manning). Whatever this change meant politically, for disabled workers it provided an advocate nearby, at the workplace, where personal exchanges allow for better understanding of the particular needs an individual has. Through this arrangement, work placement and all labor related planning became locally controlled. Quotas of disabled workers, a national mandate, could be more closely observed. According to employment regulations, there is a tri-party arrangement making certain that disabled workers are indeed given jobs and these jobs are appropriate to the capabilities of the individual under consideration: the disabled person's physician, a trade union committee member, and representatives of VTEK, the Medical-Labor Expert Commission. Such arrange-

ments are favorable to an individual seeking appropriate work placement, since more person-to-person contacts are affordable, preferences are more easily articulated, and assessment of situations could be more realistic, and most important: the worker could give more authoritative input since her/himself is a member of that union.

The role of the cooperatives in the vocational adjustment of disabled persons cannot be overestimated. A cooperative is a setting based on membership, functioning on the strength of collectivity of which the disabled worker is part. Opportunity for participation in the decision-making and for direct communication of one's needs and interests is closer at hand and gives assurance that one's particular abilities and requirements will be given the attention they merit. Such arrangements encourage, on the part of the disabled worker, investment in the objectives of the cooperative enterprise—itself a very important rehabilitative force

Delivery Structure

Distribution of social provisions is determined by need in accordance with central planning. While ultimate authority rests with national administrative units, there are intermediary arrangements that suggest the possibility of some kind of "back-and-forthness" in social planning. For instance the Medical Workers Union, the largest of all trade unions consisting of all health professionals, is the main agent through which the definition of health care need is negotiated. This central control is balanced by detailed administration at the regional level, even at the locality of the industrial enterprise or farm collective. The latter "modernized" an old institution, *Zemvsto*—the local government responsible for public relief in Tsarist Russia—combining an ethnic tradition with a contemporary concept of participation.

The projected picture of Soviet social planning is one of central direction with set, universal goals, but with local implementation and with a margin for diversification within the parameters of national guidelines. Theoretically at least, this allows for better monitoring of social policies, prevents duplication in social provisions and safeguards congruence in social investments. This would seem to be a planner's dream especially since the areas of social policies discussed above are functioning within a comprehensive network of social provisions that includes education, subsidized recreation and cultural opportunities, an aggressive program of housing, public transportation and so on.

Ideological Antecedents

In its essence, the Soviet system of social care drew from three cultural traditions: from Germany's social philosophy came its worker-class character; from England's political economy came its prophylactic measures; and from France's socialism the idea of free and accessible services. What we can identify as the particularly Russian addition is the moral and spiritual character that is imbued in the expressed reciprocity between the State's provision

and the individual's response. The latter is not expected to be one of gratitude alone, but of responsibility as well, a duty to contribute to the welfare to the other members of society.

This emphasis upon the collectivity, so alien to us in the United States, has deep roots in the Slavic culture and the traditions of the majority of Soviet republics. No visitor to the Soviet Union can remain unaffected by the conveyed sense of community, the passionate expressions of patriotism and the declared pride over the sacrifice and resulting triumph of the Patriotic Wars, particularly World War II, known as the Great Patriotic War and seen as a time of social cohesion and national unity. "Without question" wrote Smith some time ago, "a deep and tenacious love of country is the most powerful unifying force in the Soviet Union, the most vital element in the amalgam of loyalties that cement Soviet society" (Smith, 1976, p. 303).

It is this patriotism that makes the combined use of material and moral stimuli effective (Osborn, 1971). Slogans like "Ready for Labor and Defense" or "Your Body belongs to the State" appeal to the citizen's sense of social obligation to maintain good health habits and promote her/his physical well-being. In turn, comprehensive social provisions aim to influence the citizen's standard of living directly and indirectly. Through cash and service benefits the effort is to maintain the individual's income and to uplift the material and cultural level of the population. It is expected that thus improved living conditions will enhance the individual's capacity and zeal for work and, in turn, enable her/him to become a productive participant in society's functioning and contribute to the general welfare.

Such ideological commitments are supported by interventional structures that contribute to the management of affairs important to the lives of disabled people. Structures of the VOS and VOG discussed earlier provide opportunities for disabled persons to become advocates of their own concerns along with enjoying the support of social reformers. Their membership in trade unions, and the latter's role in decision making further expands the horizons for the disabled's social participation. Collectives do much more than uniting a brigade of workers on the job; they provide a variety of services, such as housing, educational and leisure activities, which involve disabled persons in the social arena and sustain their investment in the group.

Within this ideological framework, Soviet social policies have the potential to lead to the social mainstreaming of disabled persons as they support—at least aim to support—what Field calls "shaping of capacity." That refers to an individual's ability to interact with other members of the society and to perform in the variety of social roles ascribed to her/him in the course of life (Field, 1976, p. 235). Soviet social policies lead to mainstreaming through provisions that are considered entitlements. Such entitlements validate disabled person's identity as a citizen. As a result neither do they see themselves as social outcasts, nor does the public consider them peripheral

to society's functioning and, therefore, treat them as a social burden.

It is interesting to note that nowhere through this writer's visits in the Soviet Union did the matter of cost for services come up. Whether the encounters were with professionals or laymen, discussions centered around the needs and rights of citizens. There was no value conflict in this acceptance of free services. Such social comfort is particularly important in the social rehabilitation of disabled persons. Universal policies, studies have shown, are highly successful in promoting social integration. In addition, such policies have minimal controlling impact upon recipients while they carry low administrative costs. On the other hand, means-tested programs, by their very need to scrutinize eligibility potential, are costly both in administrative expenditures and individual freedoms. This is particularly disruptive when it comes to the care of the disabled, because in addition to costs, means-tested programs separate recipients from the rest of society and further project the differences and dependencies of people with impairments (See Coudroglou & Poole, 1984).

Situational Realities

The above discussion does not intend to convey that disabled people have found heaven in the Soviet Union. The real needs of disabled persons rarely receive priority consideration in any society. The USSR is no exception.

There are serious questions whether disability pensions are adequate in meeting financial needs of the disabled. Pensions have not kept up with rising earnings and prices. In Bernice Madison's words: "The longer a disabled person remains alive, the less able his unchanging pension becomes to provide a level of living commensurate with the general living standard of the country" (Madison, 1985, p. 42).

In addition to economic and social contingencies, the country's long-term planned inattention to the Consumption Fund (Social Welfare), has caused severe delays in the development of rehabilitative treatment mechanisms. A recent survey undertaken by the Dunns reveals that the total capacity of rehabilitative programs is small relative to the need.

Mechanical equipment is sorely lacking. Only recently the Soviet Union has made trade arrangement with East Germany for the construction of wheelchairs. Another recent effort is to intensify the technology of public transportation so that physically handicapped people do not depend on the "special arrangements" now in use. And of course, the total field of environmental accommodation is still unchartered in the Soviet Union, a reality that prompted a medical official to admit that USSR "has a lot to learn" from the USA in this area.

While rehabilitation technology has been delayed, education has always been vigorously supported in the USSR. The educational level of the work force has increased faster than the industrial conditions that were to utilize

it. Overqualified workers are assigned to tasks that do not allow them to make use of their skills. Both morale and productivity are affected. A recent study conducted at the University of Illinois has indicated that the Soviet economy has been steadily slowing down from about 4% annual growth in the 1970's to 2-3% in this decade (Gelb, 1984). Modern Soviet youth are literate and well-educated in terms of degrees. They find it undesirable to work in manual jobs. Yet the available job market is in the blue collar sector. There is, as a result, unrest among the new working class, job turnover, and shifting from the rural areas to large urban centers. These conditions affect disabled persons in the labor force as well since disabled individuals have been provided with excellent educational opportunities, and therefore are not prepared for the kinds of jobs which are available.

With no employment statistics (such indices stopped five years before the constitution was adopted) there is no accurate way of estimating labor conditions. It is sensible to assume that there is significant underemployment. One may further assume that the state of employment of disabled people has not escaped such market dynamics. Furthermore, while a variety of laws forbids discrimination in hiring, no law compels any enterprise to *create* jobs for employment seekers.

These conditions strongly affect a full employment policy. While the implementation of such a policy is always dependent on economic factors, the discrepency between labor preparation and equality of jobs threatens the integrity of labor. There is a characteristic Russian old saying that, perhaps, is applicable here. It translates: "We pretend we are working and they pretend they are paying us."

Conclusion

Evaluating a system of social care from the perspective of a non-participant observer is, of course, inadequate especially since one depends on official translators, controlled visiting sites and formalized answers. Nevertheless one can form an opinion if one is able to separate social provisions from the political state and one's prejudices against it.

The official Soviet stand places heavy emphasis on the ability of disabled people to work. This stand is supported by the belief that human dignity is preserved and maintained by one's ability to be useful. The purpose of rehabilitation then is the attainment of the highest possible level of social, labor, and household activity of disabled persons.

Despite severe existing current realities limiting the effectiveness of Soviet disability policies, there exists a set of preconditions that, given the resources, both technological and material, disabled people could find an easier entry into society's mainstream. Most important among these conditions is the policy of full employment. I share the conviction that the best rehabilitator is a full employment economy.

A full employment propels employers to use people's capabilities to the

maximum. Real job opportunities provide incentives to impaired individuals to redevelop their capacities. And a goal of full employment gives training facilities more realistic targets for which to offer training. But a full employment economy secures more than income. Beveridge, the social architect of Britain's policy system, identifies two distinct social ills: want and idleness. In his second report to the British parliament he appeals for "freedom from idleness." He says that "idleness is not the same as want, but a separate evil, which men do not escape by having an income. They also must have the chance of rendering a useful service" (Beveridge, 1944, p. 20). Full employment, Beveridge states further, "Must be the centerpiece of social citizenship" (Ibid, p. 19). There is a very important messsage in a policy of full employment, one that links the success of disability-related policy directly to our ideology about people with disabilities and disability itself: A policy's success depends on how much emphasis it places on the abilities of the people. The policies in the Soviet Union suggest such an emphasis.

I have stated elsewhere (Coudroglou, 1984) that an ideology of success, as that of "abilitation," implies confidence in the future and supports the kind of enthusiasm for planning that gives rise to creativity and innovation in social design. Is this capacity present in the Soviet Union?

I find myself in agreement with the widespread opinion (George & Manning; Lewitt & Field in Panhurst, 1980; and others) that the Soviet system in its mono-organizational, party-controlled character may damage its capacity for flexibility in policy choices and creativity in social intervention. Also, there may be a serious dilemma in the Soviet social direction at this point in time. To quote Field, "...(T)he party now may contrive to retard and constrict the society it inhabits and helped to develop, since further differentiality (and) decentralization could be secured only at the cost of ideological erosion and power concessions, a price it is extremely reluctant to pay" (In Panhurst, p. 179). Nevertheless, even within such situational conflicts, Soviet social policies safeguard against the disabled's social exclusion, at least not as an identifiable separate group.

Whether a "Cult of Party" (Field, *Ibid*) could be averted—and there are indications that this may be possible as there seems to be growing unrest by Republics with large ethnic minorities, the number of non-party members of the legislature is increasing and individuals talk publicly of the temporary life of the one-party system—Soviet society through its universalist policies has established a concept of a "social minimum" as an equalizer among its members. Such a concept, incorporated by the individual disabled person, creates a sense of social membership—another force that interweaves him in the social fabric. Through universal policies, an individual's level of living will be defined not only in terms of fulfillment of needs but also in terms of control over resources in areas as basic to human functioning in today's society as education, employment, health, economic and political resources, family relations, security to life and property and even leisure and recrea-

tion. These elements have come to be too essential to be given up. One does not withdraw from such social aspirations. And the Soviet citizen, disabled or not, has come to rely on his right to them.

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RETENTION OF WORKERS: A CHALLENGE FOR AMERICAN BUSINESS AND INDUSTRY

by Jay F. Rochlin

The U.S. Perspective

The retention of qualified workers is becoming of paramount importance to American business and industry. Several issues have generated this concern, the most significant being cost, experience and labor market availability.

Employee medical and benefit costs are escalating at an alarming rate. The largest subcontactor of one of the nation's leading auto makers is its health care provider. Business is seeking new and innovative ways to reduce these costs while at the same time protecting employee benefits. A number of employees are giving their workers a series of options from which to create their own benefit program within a fixed dollar amount.

Employers are also recognizing the high cost of other expenses associated with workers who become disabled. For example, the United States Chamber of Commerce reports that the annual payout in workers compensation amounts to 22 billion dollars.

Business is learning that human resources are one of their most valuable assets. Knowledge and experience is recognized as an important resource that is expensive to develop. Thus the motivation to retain experienced employees who become disabled.

Changes in the labor force are beginning to create other problems for employers. The overall workforce is aging. The youngest of the baby boom'' of the '50's is now 21 years of age. Children of the ''baby bust'' generation of the '60's are coming of age and beginning to seek employment. The number of teenagers living in the United States will decline by 6 million between 1980 and 1990. Already, pockets of full employment are appearing in parts of the nation.

These concerns have made business realize that employees can no longer be viewed as a disposable resource. Numbers of employers have come to recognize people with disabilities as one of the most underutilized groups of qualified or potentially qualified workers in the labor market today. Several major business firms have established training programs specifically aimed at tapping the talent of this population.

Three programs are proving of value to employers in reducing disability costs and retaining experienced workers. These are:

- **Employee Assistance Programs (EAP)**
- **Return to Work Programs (RTW)**
- **Homebased Employment**

Employee Assistance Programs

The first of these, Employee Assistance Programs, have existed in many corporations for a period of time long enough to prove their worth. Most were originally established to assist employees with alcohol related problems. However, these programs have generally been expanded to address problems resulting from other substance abuse, stress and emotional pressures.

The most successful EAP's have maintained a high level of confidentiality. Employees are able to seek the assistance of counselors without fear that supervisors, peers or other persons are aware of their situation. In fact, employees are encouraged to use this resource with this assurance.

Employees may also be referred to EAP counselors by medical or management personnel when health or performance circumstances justify such action. In some extreme situations an employee with problems that are affecting job performance who has not sought assistance on their own may be given the option of entering the EAP or being terminated.

Initially EAP's were administered by persons who were recovered alcoholics. However, in recent years the trend has been to employ trained counselors. Many major corporations employ EAP counselors generally assigning them to the medical organization. Other firms contract for EAP services from private health care providers. In either case, EAP's have proven an effective tool to retain experienced workers.

Return To Work Programs

Return To Work Programs are relatively new to the corporate world. Those in use have demonstrated the value of early intervention after an employee has become disabled by either accident or illness. Often, this involves the RTW counselor visiting the employee in the hospital. Initially, the counselor provides reassurance of the company's commitment to assist the employee return to work. Subsequently, the counselor coordinates the rehabilitation process and, if necessary, retraining program.

RTW programs are based on the importance of work to an individual's well being. Yet experience has shown that employees who remain out of work longer than a year after incurring a disability generally will never return to work. Such an absence causes a loss of self-confidence and self-worth.

The primary objective of a RTW program is to return the employee to his/her former position, if possible; if not, then to retrain the individual for another position of comparable worth, if possible. One program even trains individuals for employment in other businesses, if they cannot return to any job with the present employer.

RTW programs should be presented to employees as a benefit much like insurance, something the employee hopes never to receive, but is reassured to know exists.

Certified Rehabilitation Counselors generally administer RTW programs. Like EAP's the counselors are sometimes employed directly by a corporation. More often, RTW services are contracted from health care providers.

A major drawback to RTW programs results from how corporations allocate benefit costs. Often the salaries of employees absent on disability are charged to a corporate benefit account. Thus, a line manager has no financial incentive to encourage a disabled employee to return to work. In fact, managers sometimes refuse to accept an employee back to work in other than full time employment. Success of RTW programs may necessitate a change to allocate benefit expense to operational accounts.

When properly administered, RTW programs can assist employers retain the services of valuable employees and reduce benefit expenses. Workers benefit by retaining the dignity, self-worth and sense of purpose that comes from gainful, productive employment.

Homebased Employment

A more recent development is the advent of home**based** employment which sometimes is referred to as homebound employment. In the interest of preventing another negative stereotype of people with disabilities I prefer the former term. The term home**based** has wider application, too, since in the future non-disabled people may also have the opportunity to work at home.

For many people with severe disabilities home**based** employment may provide the only opportunity for gainful productive employment. However, home**based** employment should be offered as an option to persons with disabilities. For most people the opportunity for socialization at the workplace is very important, often, to the extent that some people with severe disabilities may prefer to accept the rigors of commuting in order to be with their peers. Others may welcome the opportunity to remain at home. Each individual should have a voice in the decision as to their work location.

Employers must recognize the need for options. One danger of home**based** employment is that some employers may perceive it as the opportunity to fulfill their obligation to employ persons with disabilities. They may consider it easier to have such persons work at home than accommodate them at the workplace, thus contributing to a modern day stereotype of the kind of work persons with disabilities should have.

Organized labor, having fought the battle of cottage industries, is concerned about any attempt to return employees to the home. Labor must recognize that for some persons with disabilities home**based** employment may be the only choice.

Home**based** employment has the potential of providing job opportunities to many persons who otherwise would never be able to work. As a result,

even individuals with severe disabilities can become self-sufficient and no longer dependent on government support.

One example involes a young man who lives in Northern Virginia. A gunshot accident left him a C-1 quadriplegic. He is completely paralyzed from the neck down, able to move only his eyes and mouth; even turning his head to face someone speaking to him is impossible.

Yet he is employed as a computer programmer. He lives and works at home. Each morning his mother switches on the power to his computer system, connects the telephone to the modem, turns him on his side to face his terminal and puts on his headset microphone. He brings the computer on line with the command, "attention", and he begins programming by talking to the computer which recognizes only his voice. Should he wish to stop work he gives the command "rest" and the computer stops listening to his voice until he again gives the command attention.

As an employee he receives pay and benefits and in turn contributes to his employer as a productive worker and to the government as a taxpaying citizen.

Upward Mobility

No discussion of employment opportunities for persons with disabilities would be complete without mentioning upward mobility. I view this as the next frontier in the history of employment of persons with disabilities. Entry level employment should no longer be viewed as the end result. Persons with disabilities entering the workplace today have the same desires, ambitions and expectations as their non-disabled peers. Employers must recognize this need and be prepared to offer opportunities for career mobility to all employees. However, given this responsibility, it must be realized that employers are not rehabilitation experts and may need technical assistance from rehabilitation professsionals in order to provide the accommodations necessary to advance employees with disabilities.

In conclusion, employers now have the tools available to retain qualified workers who become disabled and to aid in the control of medical and benefit expense. Used effectively, these tools can serve the mutual interests of business and persons with disabilities.

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