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84th Congress
2d Session } HOUSE COMMITTEE PRINT NO. 281

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COMPENSATION FOR SERVICE-CONNECTED DISABILITIES

A GENERAL ANALYSIS OF VETERANS' AND MILITARY DISABILITY BENEFITS, MORTALITY RATES, DISABILITY STANDARDS IN FEDERAL PROGRAMS, WORKMEN'S COMPENSATION, AND REHABILITATION

A REPORT

ON

VETERANS' BENEFITS IN THE UNITED STATES

BY

THE PRESIDENT'S COMMISSION ON VETERANS' PENSIONS

STAFF REPORT NUMBER VIII, PART A

AUGUST 3, 1956

Printed for the use of the Committee on Veterans' Affairs

UNITED STATES
GOVERNMENT PRINTING OFFICE
78811 WASHINGTON : 1956

AUTHENTICATED U.S. GOVERNMENT INFORMATION GPO

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PREFACE

This is the first of three sections of the Commission's staff report on programs concerned with service-connected disability. Part B of this series deals with (1) the historical development of the Veterans' Administration Schedule for Rating Disabilities, and (2) an appraisal of this schedule by a selected group of eminent medical specialists. Then, part C describes and sets forth major findings of the Commission's statistical study of veterans receiving disability compensation. Information is presented on some of the important characteristics of these veterans including income, age, occupation, education, and effects of the disabilities.

In this volume, part A, information on service-connected disability benefits for veterans and ex-servicemen is given from a number of different standpoints. The laws and benefits described in this volume are those in effect as of June 30, 1956. The first chapter presents the framework of the laws and regulations carried out by the Veterans' Administration with respect to all individuals who were disabled in the Armed Forces.

Closely related is a comparative analysis (ch. II) of the military disability retirement program which is concerned primarily with the regular career services. Chapter III sets forth data from a statistical study of servicemen who were retired or separated from the Armed Forces because of physical disability. This study covered the disability ratings of a sample group of military retirees, who applied for benefits under the Veterans' Administration after they received disability ratings from their respective armed services department.

The Commission believed that mortality rates may have a bearing upon the effectiveness of the present system of compensation; the actuarial study which was thereby undertaken is described in chapter IV. A summarization of certain Federal programs concerned in some measure with disability (social security, railroad retirement, and Federal employees compensation) and ways in which their standards compare with the Veterans' Administration are discussed in chapter V. In the next two chapters, relevant experience from the field of State workmen's compensation is analyzed and contrasted with the administration of veterans' disability compensation.

The final chapter is devoted to a review of the problem of rehabilitating disabled veterans and the relationship between the Armed Forces, the Veterans' Administration, and the State-Federal programs of vocational rehabilitation. Here, the concept of compensation is explored from the standpoint of adequate medical care, counseling services, and vocational rehabilitation for developing the disabled individual to the fullest extent of his capabilities. It is well-recognized that in the steps through which the disabled person moves toward social and economic readjustment, all phases must be closely integrated in the continuous process that makes for his return to useful life in the community. Rehabilitation thus becomes an important objective of the compensation process.

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COMPENSATION FOR SERVICE-CONNECTED DISABILITIES

CHAPTER I

VETERANS' SERVICE-CONNECTED DISABILITY BENEFITS

The American system of disability compensation for war veterans has gone through developments which are closely allied to the evolution of warfare and the Nation itself. Our early patterns for care of individuals injured in defense of the colonies followed the British heritage, the same as with our civil development. Engagements with hostile Indians, as well as the French and Spanish enemies of the British, were met with forthrightness. Each colony, guided by experience from the mother country, developed methods for seeing that those injured or maimed were taken care of in ways adequate for the times. The depth of this background is worthy of emphasis: When we look back over the three centuries of our history the colonial era equals in time the period from the founding of the United States under the Constitution, up to the present date.

Under the new Republic, the first laws relating to payment for service-connected disability were of an enabling nature with administration of the system placed directly under the President. He in turn assigned the carrying out of the responsibilities to the Secretary of War, while Congress retained control of the actual allowance of claims. Within 3 years (i. e., by 1792), Congress enacted a requirement that United States circuit courts would adjudicate the veterans' claims. Quickly, however, the courts held that these were administrative functions which Congress had no power to impose upon the judiciary. As a compromise, the act of 1793 provided that judges of the United States district courts would receive the evidence in such claims and submit them to the Secretary of War, who in turn placed the claims before Congress for final adjudication. In 1803, however, Congress transferred this adjudicating power to the Secretary of War. The actual payment of the awards was carried out through bonded "pension agents" from 1790 until 1912. A system of semiannual and then quarterly payments was used; it was not until 1917 that payment of awards on a monthly basis went into effect.

In 1833 Congress provided for the appointment of a Commissioner of Pensions whose duty was to administer Navy as well as Army "pensions" under the Secretary of War and Navy. Thus, the handling of all Federal pensions, civil as well as military, was placed under a single national agency. The Bureau of Pensions became a part of the Department of Interior when that office was established in 1849 and remained there until its transfer to the Veterans' Administration through the Consolidation Act of 1930. The monetary benefits pay-

able for service-connected disabilities have since the First World War been looked upon as "compensation" rather than "pension."

The bewildering complex of laws and regulations relating to service-connected disability compensation which are before us today are the complicated, intricate product of an evolution that has been meandering and devious. The present legal basis for the compensation program affecting most veterans and their dependents stems from Public Law No. 2, 73d Congress, act of March 30, 1933 (48 Stat. 8, codified in vol. 38, U. S. Code, sec. 701 and the following). Special benefits accorded to World War II veterans were extended to the veterans of the Korean conflict by joint resolution of May 11, 1951 (38 U. S. C. 745).

FOUNDATIONS FOR MEASUREMENT OF DISABILITY

Under the American system, from the earliest days up to the present, recompense for injuries incurred by virtue of service in the Armed Forces has been based upon the principle that everything possible would be done to help the disabled veteran readjust in the community. During colonial times a disabled soldier was assured that he would be "maintained competently * * * during his life." There was no rating standard; each individual case was considered on its own merits. This continued throughout the Revolutionary War period despite the rapid increase in number of disabled servicemen. It was not until 1792 that a unified system came into being. Under this first congressional enactment (1 Statutes at Large 243), the degree of disability was to be ascertained and the proportion of monthly award that the claimant would receive. This concept has continued up to the present day. The aim has always been that the disabled veteran should receive an amount which would assure maintenance of a reasonably adequate living standard as a civilian.

With the advent of the Civil War a kind of codification of the various earlier statutes took place through the passage of a "general pension law." The rates for total disability were $8 per month for a private, ranging to $30 a month for lieutenant colonel and above. Due to inequities in the rates under the general law, the Congress in 1873 enacted an auxiliary rate of $18 for total disability with smaller awards based on proportions of this amount to be provided for certain less disabling conditions. This general law system continued to apply at these levels even up to World War I and beyond; it is still effective for certain individuals. Prior to the First World War, payments for disability were called "pensions," while the awards for non-service-connected disabilities were classified as "service pensions."

With the idea of introducing some of the forward-looking philosophy that was growing out of the newly emerging State workmen's compensation programs, efforts succeeded in the World War I legislation to designate the payments for war-incurred injuries as "compensation," thus removing any possible stigma attached to the term "pensions." Furthermore, there was to be a more accurate and logical method of determining the amount of the compensation award. Thereafter disability ratings were to be based upon the latest actuarial and insurance knowledge that was available. The rating process was to be based upon the "average impairment of earning capacity resulting from such injuries in civil occupations and not upon the impairment

of earning capacity in each indivdual case." This method of rating has continued in effect to the present day although it has gone through a number of revisions since 1917. (For the historical development, see pt. B of this report.) The same evaluation schedule (Veterans' Administration Schedule for Rating Disabilities) began to be used by the Armed Forces with the enactment of the Career Compensation Act in 1949.

Most veterans today receive their monthly awards under this essentially proportionate system; the compensation ranging from $17 to $181, depending upon the degree of disability with graduations in 10 intervals from 10 to 100 percent (total disability). Under a second method the individual receives a specified amount according to statute—the amount being based upon a specific injury or condition. These payments are called "statutory awards" and will be discussed in detail later.

The third method is the awarding of a claim to an individual by special act of Congress. This is similar to the type of action which may be taken by anyone seeking recompense for damages not covered by existing legislation. Since the numbers of these cases are rather small in comparison with the methods mentioned above, and, since it is difficult to distinguish between service connection and nonservice connection, they are omitted from discussion here. It is of interest to note, however, that the period from the 59th Congress (1905 to 1907) through the 64th Congress (1915 to 1917) the numbers of awards granted by special acts showed a considerable upturn; they ranged from 5,000 to over 9,000 each session.[1] During the last decade the number on the rolls has dropped steadily from about 3,000 to 943 at the end of the latest fiscal year (1955).[2] During these years practically all of the cases involving wartime service were for service prior to World War I. Thus, only two cases involved World War I veterans, while none was represented from World War II or the Korean conflict.

Distinction Between Wartime and Peacetime Veterans

At this point, the distinction between "wartime" and "peacetime" service should be brought out. Although the advent of Public Law 2 of 1933 was the first time that peacetime veterans as such were specifically provided for in legislation, for all practical purposes the differentiation took place in 1917 through the passage of amendments to the War Risk Insurance Act. With the first great world conflict upon us, these amendments made specific reference to their applicability to wartime veterans. By this move any peacetime veterans were forced to look to the "general law" system for disability compensation benefits. Since Public Law 2 repealed all laws dealing with persons in the military service after 1898, any individual with peacetime service before that time would have to look for coverage under the "general law." In other words, section 17 of Public Law 2 was a repealer of the "general law" for all persons except those who served before the

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[1] Gustavus A. Weber, the Bureau of Pensions (Baltimore: Johns Hopkins Press, 1923).
[2] Veterans' Administration annual report, p. 96.

Spanish-American War. With the passage of Public Law 269, 74th Congress (1935), however, provisions in earlier laws relating to the Spanish-American War group were reenacted, thus permitting coverage, even to the present date, of these individuals under the "general law."

Compensation can be awarded to any veteran, determined to have a service-incurred disability, by virtue of duty with the Armed Forces of the United States, either in peacetime or in wartime. Inasmuch as periods of war are defined by statute it becomes easy to identify peacetime. Wartime periods may be summarized as follows:

Spanish-American War: Active service between April 21, 1898, and August 12, 1898; or enlistment on or after April 21, 1898, and before August 13, 1898, where the injury or disease was incurred on or aggravated by service prior to July 5, 1902.

Philippine Insurrection: Actual participation in the Philippine Insurrection between August 13, 1898, and July 4, 1902 (or before July 15, 1903, in Moro Province).

Boxer Rebellion: Actual participation in the Boxer Rebellion between June 20, 1900, and May 12, 1901.

World War I: There are two overlapping periods which use Armistice Day as a benchmark:

1. Enlistment on or after April 6, 1917, and before November 12, 1918 (or before April 2, 1920, if in Russia); and reenlistment on or after November 12, 1918, and before July 2, 1921 (where there was prior service between April 6, 1917, and November 11, 1918).

2. Except as to blind cases on the rolls March 19, 1933, entry into active service on or before November 11, 1918, with incidence or aggravation of the disease or injury before July 2, 1921 (except that service in Russia extends to April 1, 1920); and reenlistment on or after November 12, 1918, and before July 2, 1921 (where there was prior service between April 6, 1917, and November 11, 1918).

World War II: Service between December 7, 1941, and December 31, 1946, and through July 25, 1947, if service continuous from before January 1, 1947.

Korean conflict: Service between June 27, 1950, and January 31, 1955.

BASIC OR PERCENTAGE AWARDS

Under the system of percentage awards, peacetime veterans receive an amount which is approximately 80 percent of the wartime rates, as can be seen in the 10-degree steps listed below:

Percentage of disability [1]	Wartime	Peacetime	Percentage of peacetime to wartime	Percentage of disability [1]	Wartime	Peacetime	Percentage of peacetime to wartime
10	$17	$14	82	60	$109	$87	79
20	33	26	78	70	127	102	80
30	50	40	80	80	145	116	80
40	66	53	80	90	163	130	79
50	91	73	80	100	181	145	80

[1] Percentages of disability from 10 to 90 percent are considered "partial"; those at 100 percent, "total."

Veterans of peacetime service may receive the higher amounts (so-called wartime rates) for disabilities resulting while the veteran was: (1) Engaged in armed conflict or extrahazardous duty, including service under conditions simulating war; or (2) serving when the United States was engaged in war. Thus, individuals who performed peacetime service but were engaged in dangerous activity under simulated wartime conditions or incurred a disability during that part of service which took place when the United States was actually at war, would receive the wartime rate.

The general procedure for rating any disabled veteran is the same for peacetime as for wartime service. The percentage awards are based on the 10 graduations of disability, ranging from 10 percent to total or 100 percent. These degrees of disability are determined on the basis of the Veterans' Administration Schedule for Rating Disabilities. The schedule is a compilation of percentage evaluations of disabilities due to disease or injury resulting from military service, with correlated medical criteria indicative of the stated percentages of disability. Most veterans currently receiving disability compensation have been rated according to the 1945 edition of the Veterans' Administration Schedule for Rating Disabilities.

The 1925 schedule rather than the 1945 schedule, however, is used for a certain number of veterans of World War I (now numbering over 120,000). Their disabilities are evaluated from the standpoint of average impairments of earning capacity resulting from such injuries in civilian occupations similar to the occupation of the veteran at the time of his enlistment. In these cases, impairment in ability to secure specific employment is considered in the rating process. (The 1925 schedule still applies to these veterans, who are in a kind of "protected" category, but to no one else.)

Numbers on the Rolls

It is important to keep in mind the current overall size of the disability compensation rolls. The average number of veterans during the fiscal year ending June 30, 1955, was 2,076,026. The total payments made during this period amounted to $1,429,771,000. (See Table 1).

TABLE 1.—*Veterans receiving service-connected disability compensation from Veterans' Administration as of June 30, 1955* [1]

[Number of cases and annual cost classified by degree of disability and type of award]

Combined degree of impairment	Total		Award			
			Statutory [2] [3]		Basic percentage [3]	
	Number	Annual value (thousands)	Number	Annual value (thousands)	Number	Annual value (thousands)
Grand total	2,076,026	$1,429,771	121,892	$231,039	1,954,134	$1,198,732
No percent [4]	3,044	1,914	3,044	1,914		
10 percent	838,325	173,656	2,173	1,736	836,152	171,920
20 percent	345,860	150,151	28,014	22,780	317,846	127,371
30 percent	318,615	196,922	19,958	19,298	298,657	177,624
40 percent	164,899	135,717	10,710	15,102	154,189	120,615
50 percent	116,225	149,080	5,759	11,047	110,466	138,033
60 percent	88,813	140,045	10,836	23,623	77,977	116,422
70 percent	42,726	79,441	8,131	19,774	34,595	59,667
80 percent	26,458	57,815	7,990	21,492	18,468	36,323
90 percent	7,544	19,680	4,277	12,676	3,267	7,004
100 percent	123,517	325,350	21,000	81,597	102,517	243,753

[1] Figures cover veterans of all wars, Korean conflict, and peacetime service, and include direct and presumptively service-connected disabilities. Veterans with 50 percent disability or more are entitled to additional allowances for dependents. These are included in the annual value of awards.

[2] Statutory awards are in addition to, or in lieu of, basic percentage awards. They are tabulated according to percentage of rated impairment.

[3] Approximately 65,000 cases receiving statutory awards also receive basic percentage awards, but are not included in number of cases shown as receiving the basic percentage awards.

[4] The zero percent group represent statutory awards for certain conditions, e. g., loss or loss of use of creative organ and arrested tuberculosis.

Source: Veterans' Administration.

The vast bulk of veterans receiving disability compensation is concentrated in the lower percentage categories. Of the more than 2,076,000 individuals, over 841,000, or about two-fifths, were in the 10 percent and zero categories. An additional 664,000 were disabled 20 to 30 percent. Thus, over 1,500,000 veterans, or nearly three-fourths, were disabled 30 percent or less. At the upper extreme, 124,000 were rated as 100 percent disabled, only 6 percent of the total. About one-fiifth of the veterans were in ranges from 40 to 90 percent.

Additional Amounts for Dependents

Additional compensation for dependents is awarded to any veteran disabled 50 percent or more. However, the additional amounts for dependents are not payable during any period in which the veteran is in receipt of an increase of compensation or of subsistence allowance on account of dependents under any other law administered by the Veterans' Administration—although in this situation he may elect to receive the greater amount. The amount of compensation for dependents of peacetime veterans is 80 percent of the wartime rate, as can be seen in the following:

Dependent	Wartime	Peacetime	Dependent	Wartime	Peacetime
Wife, no child	$21.00	$16.80	No wife, 2 children	$24.50	$19.60
Wife, 1 child	35.00	28.00	No wife, 3 or more children	35.00	28.00
Wife, 2 children	45.50	36.40	Dependent parent	17.50	14.00
Wife, 3 or more children	56.00	44.80	Dependent parents	35.00	28.00
No wife, 1 child	14.00	11.20			

The rates listed above are for 100 percent disability. If and while rated partially disabled, but not less than 50 percent, additional compensation is authorized a veteran in an amount having the same ratio as the degree of disability bears to the total disability. For example, with a wartime disability of 50 percent, the compensation rate is $91 per month. If the veteran has a wife, his compensation is increased as follows: $91 plus 50 percent of $21 (or the rate for "wife, no child") or, in other words, $91 plus $10.50 or $101.50.

As of June 30, 1955, there were 303,668 veterans of 50 percent or higher disability who were receiving additional compensation for dependents. On that date, total current monthly payments were running at an annual rate of $598 million to this group, including extra dependents' benefits of $93 million. Of that number, less than 5 percent were peacetime veterans.

Special Considerations Relating to Total Disability

1. A rating of total disability is made when there is any disability of mind or body of a nature which makes it impossible for the average person to follow a substantially gainful occupation.

2. A total disability rating continuously in force for at least 20 years may not thereafter be reduced except for fraud.

3. Permanence of total disability may be acknowledged if reasonably certain that the condition will remain unimproved throughout life, and when the probability of permanent improvement under treatment is slight.

4. A rating of total disability for insurance purposes has no effect on ratings for compensation purposes.

5. Age may be a factor in determining permanence; however, permanent total disability ratings would not be granted as a result of any incapacity resulting from acute infection, disease, or injury unless there is present one of the recognized conditions of permanent disability, or the person is permanently helpless or bedridden, or when it is reasonably certain that a subsidence of the acute or temporary symptoms will be followed by total disability.

Other Factors

1. Combinations of ratings and payment of compensation at wartime rates is accorded to veterans who had both wartime and peacetime service with disability occurring during each period of service.

2. If a veteran has two or more separate permanent disabilities, which interfere with his normal employability even though none of the disabilities is of a compensable degree under the schedule, a 10-percent rating will be applied, but not combined with any other rating.

3. In cases where an impairment incurred in peacetime service is aggravated during wartime, or conversely, where a war-incurred injury is aggravated during peacetime, the entire disability resulting therefrom is considered as war-incurred.

Major Diagnostic Categories

A presentation of the diagnostic classifications of veterans receiving disability compensation is shown in table 2. The general medical and surgical conditions comprise upward of three-fourths of the total while over a fifth of the veterans were afflicted with psychiatric and neurological diseases.

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TABLE 2.—*Veterans receiving service-connected disability compensation from Veterans' Administration as of June 30, 1955* [1]

[Number of cases, classified by preponderant compensable disabilities according to Veterans' Administration major disability classification]

Major disability classification	Total	Percent of grand total
Grand total	2,076,026	100.0
Total tuberculosis of the lungs and pleura	92,129	4.4
Total psychiatric and neurological diseases	450,944	21.7
Psychoses	92,914	4.5
Psychoneuroses	245,854	11.8
Organic diseases of the central nervous system	99,868	4.8
The epilepsies	12,308	.6
Total general medical and surgical conditions	1,532,953	73.9
Bones and joints, acute, subacute, or chronic, diseases of	189,052	9.1
Amputations of upper and lower extremities including fingers and toes	47,564	2.3
Other impairments of upper and lower extremities including fingers, toes, spine, skull, and ribs	342,363	16.5
Muscle injuries	239,786	11.5
Eye, diseases of, and impairment of visual acuity	44,395	2.1
Ear and other sense organs, diseases of, and impairment of auditory acuity	81,693	3.9
Systemic conditions	6,632	.3
Respiratory system, diseases of:		
Nose and throat	19,907	1.0
Trachea and bronchi	71,845	3.5
Lungs and pleura—nontuberculous	26,148	1.3
Cardiovascular system, diseases of:		
Heart	56,623	2.7
Arteries and veins	85,637	4.1
Digestive system, diseases of	136,439	6.6
Genitourinary system, diseases of	30,363	1.5
Gynecological conditions	1,631	.1
Hemic and lymphatic systems, diseases of	4,139	.2
Skin conditions	132,808	6.4
Endocrine system, diseases of	14,004	.7
Dental and oral conditions	1,924	.1

[1] Figures cover veterans of all wars, Korean conflict, and peacetime service and include direct and presumptively service-connected disabilities for which statutory or basic percentage awards are being paid.

Source: Veterans' Administration.

SPECIFIC INJURY OR STATUTORY AWARDS

These awards represent a kind of dichotomy in our attempt to recompense individuals disabled by virtue of their service in the Armed Forces. Inherent in our central purposes has been the idea of developing a monetary payment sufficient to enable the veteran to readjust financially in his home community. If too high, the payment might encourage malingering; if too low, it would simply be a relief grant. Ideally, the compensation would approximate as closely as possible the amount necessary to maintain a decent standard of living. This problem has vexed our legislators and public administrators from earliest times. It is extremely difficult regardless of whether the veteran is totally and permanently disabled, or partially disabled.

Evolvement of the Flat-Rate Payment

From the beginning we have tried to equate compensation with the proportion of a person's disability and its presumed effect upon his earnings. Thus, we developed methods for calculating the degree of disability and making a monetary payment in accordance therewith. What seemed to be a logical and liberal plan based on this concept was put into effect when the Civil War began. But when

many of the early casualties returned home with shocking injuries like the loss of both hands or legs, or the sight of both eyes, great sympathy was aroused and it was thought that the rate for total disability, $8 per month, was simply inadequate.[3] Congress moved quickly in making an exception in these extreme cases; flat rates were established so that the rate for loss of both hands or loss of sight of both eyes would be more than three times the maximum $8 rate (i. e., $25) while loss of both feet would be $20. By 1866, 15 additional specific injuries were added to the above. The number has increased through the years and at the same time the awards have risen with the increased costs of living.

At the time of World War I, arguments in Congress questioning the soundness of flat-amount statutory awards were met with this kind of a barrage:

> "We do not want to leave the rate * * * for these well-determined injuries to the uncertain calculations of some bureau official or clerk"; no Congressman needs "the chattering of some compensation expert to enable him to come to the conclusion as to the amount * * * he should vote for a blind man or an armless or legless man injured while fighting his country's battles." [4]

Following World War I, Congress began the practice of authorizing certain awards additional to either the statutory amount or the amount based on the percentage rating scale.

Amounts and Characteristics of the Awards

Under our system today, as in prior years, statutory awards are primarily associated with anatomical losses, the loss of use of limbs or eyes, blindness, deafness, and tuberculosis. As of June 30, 1955, a total of 121,892 veterans received this type of compensation; the total expenditures, $231,039,000. (See table 1.) Regardless of whether an individual qualifies for a statutory award, he is given an examination and a proportionate rating, the same as anyone else. Thus, the totals just given would be a part of the overall total of individuals receiving disability compensation.

As can be seen from the middle column of table 1, over 3,000 of these cases were rated at zero (in terms of the basic percentage-award criterion). About 64,000, over half of the total, were rated from 20- to 50-percent disabled. At the other extreme, nearly one-sixth were rated as 100-percent disabled.

The two kinds of awards.—These awards at present are of two kinds (here, also, the peacetime rates are 80 percent of the wartime rates shown below): First, permanent monthly rates of $47 are payable in addition to the basic percentage awards for loss, or loss of use, of a foot, hand, creative organ, or blindness in one eye. As of January 1956, there were about 65,000 individuals receiving awards of this type.

The much larger remaining group are encompassed within a complex variety of awards which are paid in lieu of the basic percentage rates. As can be seen below, these usually exceed the percentage amounts:

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[3] William H. Glasson, Federal Military Pensions in the United States, p. 129.
[4] Cited by Edward T. Devine, Disabled Soldiers and Sailors (New York: Oxford Union Press, 1919), pp. 330–331.

1. (*a*) Loss or loss of use of both hands, both feet, 1 hand and 1 foot; (*b*) blind in both eyes; (*c*) permanently bedridden, or (*d*) helpless and in need of aid, $279.

2. Loss or loss of use of two extremities at a level, or with complications preventing natural elbow or knee action with prosthesis in place; or blind in both eyes and requiring aid and attendance, $329.

3. Loss of two extremities so near shoulder or hip as to prevent use of prosthetic appliance; or anatomical loss of both eyes, $371.

4. A group of World War I veterans are "protected" by law for disabling conditions similar to the above, $231–$300.

5. When disability exceeds requirements for any of the above rates, the Administrator of Veterans' Affairs may allow next higher rate or intermediate rate, not to exceed, $420.

6. If a veteran has two or more losses listed in item 1, above, or has total deafness in combination with total blindness, $420.

7. Tuberculosis, all forms, completely arrested, is compensated for at a minimum monthly rate of $67 for life. The law also provides graduated reduced percentage ratings over an 11-year period of 100 percent for the first 2 years; 50 percent for the next 4 years; 30 percent for the next 5 years; then a 30-percent permanent rating for arrested far-advanced lesions; a 20-percent permanent rating for arrested, moderately advanced lesions; and a zero percent for all other forms. However, the monetary payment does not go below the minimum of $67.

(*a*) A group of World War I veterans are "protected" by law and receive a 100-percent rating for 6 months after discharge from hospitalization and then a minimum of $67 monthly for life. This group is awarded a minimum permanent 25 percent rating for arrested or apparently cured tuberculosis with no observation or reexamination required. Reactivation of the condition, however, would bring the case within the purview of the preceding paragraph.

(*b*) The permanent $67 rate for completely arrested tuberculosis is not payable in combination with the $47 additional award for single losses mentioned above, except for World War I veterans receiving statutory awards under section 202 (3), World War Veterans Act of 1924, as amended.

Number of cases classified by payment rate and type of loss.—Table 3 shows the distribution of the statutory award cases on June 30, 1955, by the kinds of disabilities. Over one-third were receiving the award for arrested tuberculosis. Another 67,000, or 55 percent, were receiving the $47 award for the single loss of hand, eye, foot, or creative organ. Of the seriously disabled (roughly 10 percent), nearly 10,000 had multiple losses such as both eyes, both hands, both feet, or one hand and one foot. These veterans were receiving statutory awards of $279 to $371 a month or their 80-percent peacetime equivalents.

Of the 67,000 veterans drawing the $47 rate, or its peacetime equivalent, an estimated 65,000 were also receiving additional payments under the basic percentage category—largely in the 30- to 50-percent bracket. This meant that the typical veteran who had sustained the loss of a hand, an eye, or a foot was receiving an award in excess of $100 monthly under both sets of these benefits.

TABLE 3.—*Veterans receiving specific statutory compensation awards from Veterans' Administration as of June 30, 1955* [1]

[Number of cases and rates paid classified by type of loss]

Specific statutory disability	Number paid single or combined awards	Monthly wartime rate [2]
Grand total	121,892	
1. Arrested tuberculosis	41,818	$67
2. Arrested tuberculosis and creative organ	82	114
3. Loss or loss of use of [3]	66,912	47
Creative organ	6,986	
1 hand	12,810	
1 eye	21,984	
1 foot	25,132	
4. Multiple loss or loss of use of	9,791	279/371
Both eyes	2,085	
Both hands	321	
Both feet	5,927	
Hand and foot	1,458	
5. Multiple loss of other combinations of eyes, feet, and hands	1,427	156/420
6. Other	1,422	279/326
Aid and attendance	1,412	
Aid and attendance and creative organ	10	
7. Combinations of 3, 4, 5, or 6	440	[4] 97/420

[1] Figures cover veterans of all wars, Korean conflict, and peacetime service, and include direct and presumptively service-connected disabilities.

[2] Peacetime rates are 80 percent of wartime rates. Veterans with not less than 50 percent disability are entitled to additional allowances up to $91 for dependents.

[3] Basic percentage compensation awards are payable in addition to the specific statutory awards to veterans in this category if they can qualify, and such awards generally ranging from $50 to $181 monthly were being paid to an estimated 65,000 veterans as of June 30, 1955.

[4] These rates are applicable to the bulk of cases in this category.

Source: Veterans' Administration.

PRESUMPTION OF SERVICE-CONNECTED DISABILITY

Although the impairment must be due to a condition resulting from service or aggravated by service, there are a number of special provisions in the various laws and regulations which help a claimant establish service connection for his disability. This is accomplished by so-called presumptions which under certain conditions remove the necessity for proof. When an individual is accepted for duty he is considered to be in sufficiently good health to participate in whatever activities are required. Under the customs and rules of the service he has little possibility of avoiding the orders issued to him and the risks consequent to them. Medical examinations often have to be hurried in a national emergency situation. Accordingly, various legal prescriptions have been enacted which provide that an impairment occurring while in service or for a certain period thereafter will be considered service connected.

Statistics are not available as to the extent to which disabilities established as service connected on the basis of presumptions were neither incurred in nor aggravated by service, but it is evident that some of the presumptions are quite broad in application. Available information indicates that about 2.5 percent of all veterans receiving

compensation established claims solely on the basis of the presumption of the service connection through a disease which became manifest after discharge. This is only one of the types of presumption provided; several of the others such as that of sound condition and of aggravation are probably of even greater importance. Additionally, the law provides that where evidence may not clearly demonstrate service connection of a disease, all reasonable doubt is to be resolved in favor of the veteran.

Soundness of Condition Upon Entry Into Service

In evaluating service-connected disability the Veterans' Administration presumes that the veteran was in sound physical and mental condition at the time of his enlistment or induction into the armed services except for defects, infirmities, or disorders noted at the time of his examination. The same presumption prevails for peacetime service except that the individual must have been in active service for 6 months or more. In the case of either wartime or peacetime service this presumption of soundness is rebuttable on the basis of clear and unmistakable evidence.

Many individuals have entered military service with known physical defects noted at the time of the entrance examination. If accepted, such individuals are usually required to execute a statement which has been designated as a waiver. Such a statement does not waive any rights which the individual may accrue but simply acknowledges the existence of certain physical defects. Thus, the individual would be precluded from claiming benefits on the basis of the fact that the defects existed prior to military service, not because a waiver had been executed. Actually, any requirement of the veteran's signature on a statement with respect to any impairment, against his interest, is invalidated by law. The term "waiver" is rather unfortunate since it is not applied in the strict legal sense. The thought behind this designation apparently was that the armed services department waives the specified defects and accepts the individual for service regardless of their existence.

The Concept of Line of Duty [5]

The right to disability compensation rests primarily upon the circumstances upon which the incident takes place. Since the term "line of duty" was first placed in statutes (act of March 2, 1799; 1 Stat. 719), the meaning has changed and expanded through the years. In general, there has been a gradual liberalization through congressional enactment, administrative determination, and judicial interpretation. At times there has been considerable uncertainty since various agencies of the Government have interpreted the statutes in different ways. The legal departments of the Armed Forces (judge advocates general), the Attorney General, the Comptroller General, the Administrator of Veterans' Affairs, and the Federal courts have not always been in complete agreement.

Although any definition of the term "line of duty" is at best an approximation, it is generally conceded that diseases or injuries

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[5] Much of this section was adapted from Leo E. Fitzgibbons, Disability Benefits for Discharged Soldiers—Law, Regulation, and Procedure, Iowa Law Review, vol. 31, November 1945, pp. 1–6.

arising coincident with an individual's performance of active military service are considered to have been incurred in line of duty unless the impairment: (1) Was caused by the individual's own misconduct or willful neglect; (2) was incurred while absent without permission; or (3) had existed prior to service and was not aggravated by such service.

During the Revolutionary War the term had a very restricted application in that a disability to be service connected must have been the direct result of the performance of a duty which was distinctly and definitely military in character. (*Rhodes* v. *United States*, 70 Fed. 740.) At present, however, an injury or disease is considered to have arisen in line of duty unless one of the disqualifying factors mentioned above is involved.

For certain peacetime and Spanish War veterans whose eligibility for disability compensation comes under the general law, compensation is payable only for injury or disease actually incurred or contracted in—as distinguished from "aggravated by"—active military or naval service in the line of duty. For peacetime veterans who served prior to April 21, 1898, there are no specific provisions requiring either an honorable discharge or barring compensation on account of misconduct. But for certain Spanish War veterans a discharge under honorable conditions is requisite. It should be noted, however, that the requirement in the general law that the disability must have been incurred in line of duty is tantamount to a requirement that the disability must not be due to misconduct. For all veterans of World War I willful misconduct bars the right to compensation except for those eligible under the World War Veterans' Act of 1924 who are suffering with paralysis, paresis, or blindness, or who are helpless or bedridden as a result of any disability.

For almost all veterans, except the few mentioned above, injuries or diseases resulting from a serviceman's own misconduct or willful neglect may not be considered as having occurred in line of duty. Misconduct or willful neglect would include, for example, acts resulting from gross negligence, gross carelessness, or deliberate self-inflicted injuries. Simple negligence, however, might not be within the purview of gross negligence or willful neglect.

If an injury resulted from intemperate use of liquor, it could be classified as misconduct. On the other hand, the contraction of venereal disease is not misconduct unless the person does not report and receive treatment in accordance with military regulations. An injury or disease occurring while the serviceman was absent from duty without permission would be regarded as not in line of duty. Thus, any disability benefits would be forfeited regardless of the cause or circumstances which might militate in favor of the individual.

The Veterans' Administration may have more latitude in considering mitigating facts and circumstances by virtue of the act of September 27, 1944 (Public Law 439, 78th Cong.), which states that:

> The requirement for line of duty will not be met if it appears that, at the time the injury was suffered or disease contracted, the person on whose account benefits are claimed (1) was avoiding duty by deserting the service, or (2) by absenting himself without leave materially interfering with the performance of military duties * * *."

Thus, it is possible in a given case for the Veterans' Administration to conclude that official duties were not materially interfered with, and disability benefits could be obtained.

Although the armed services may have records or make a determination with respect to an individual's line-of-duty status, this is not binding on the Veterans' Administration which has the authority to make an independent determination. Thus, a military determination is only advisory in character but even so it would probably be carried out by VA. The practical effect of this second determination amounts to a kind of VA review of the military determination.

Those persons who were provisionally accepted for service in World War II or later but suffered an injury or disease in line of duty prior to final acceptance are regarded as having been on active service for compensation purposes.

Aggravation of Injury or Disease

A preexisting disease or injury will be considered to have been aggravated by active military service where there is an increase in disability during active service unless it is found that the increase is a result of natural progress of the disease. If a disease or injury existed prior to service, then the circumstances giving rise to its disabling character must be determined by medical authorities. But. when there is clear and unmistakable evidence that the natural progress of the impairment resulted in the existing disability, then it would not be considered as service connected. If there is no such medical evidence, however, the conclusion would likely be that the disease or injury was aggravated during service and therefore in line of duty. Aggravation need not be caused by the service; it is sufficient that it occurs during the service. In other words, for aggravation in service, the line-of-duty status would be resolved in favor of the individual unless there was a disqualifying factor.

Presumption for Diseases Appearing After Discharge

Approximately 40 types of chronic diseases and 17 tropical diseases are presumed by statute to be incurred in service when shown to exist within 1 year after separation, except that: (1) For tropical diseases this time interval is variable to when accepted treatises indicate that the incubation period commenced during active service; (2) for active tuberculosis, all forms, the time interval is 3 years, but by administrative ruling active pulmonary tuberculosis diagnosed within the fourth year is held to have preexisted the diagnosis for 6 months in minimal cases, 9 months in moderately advanced cases, and 12 months in far advanced cases; (3) for multiple sclerosis the time interval is 2 years; and (4) for World War II and Korean veterans developing an active psychosis the time interval is 2 years but only for purposes of hospitalization and out-patient treatment.

Only the tropical disease presumption is available to peacetime veterans providing they served at least 6 months.

Total Disability

Although not a "presumption" in the strict sense of the term, total disability is said to exist when there is present any impairment of mind or body which is sufficient to render it impossible for the average person to follow a substantially gainful occupation. Permanent total disability would exist when the impairment is reasonably certain to continue throughout the life of the disabled person.

In the Veterans' Administration programs the following are considered to be permanent total disabilities: The permanent loss of the use of both hands, or of both feet, or of one hand and one foot, or of the sight of both eyes, or becoming permanently helpless, or bedridden.

PROCESSING OF CLAIMS

Application

In each of about 66 regional offices and many other suboffices, there are contact officers whose task is to explain the services available to veterans and assist them in making formal application for benefits. Space is also provided in VA buildings for the service officers of accredited veterans' organizations. These officers represent veterans in processing their claims. Applications are filed in the regional offices, each with its own rating boards which establish the degree of disability if the claim is allowed. Decisions are by a majority vote of the three-member boards.

Physical Examinations and Reexaminations

An examination may not be authorized unless there is enough evidence of record to show the reasonable probability of a valid claim. Where the application is made within 6 months from date of separation for disability, the initial rating may be based on the service records; otherwise, an examination would be in order. The individual applicant for compensation is obliged to avail himself of such examinations as are reasonably required by the Veterans' Administration, including observation time in a hospital if necessary. Reexaminations will be required where the evidence indicates that the disability will decrease or improve materially in the future. Where a claim is made for increased compensation, reexamination is authorized only when there is competent evidence indicating that there is reasonable probability of increased disability.

From the examination or reexamination it follows that changes in ratings will likely result, it being understood, of course, that the decision is not based solely on the physical test. Chart I shows the trend over the past two decades in the number of increased and decreased ratings of disability compensation and pension cases.[6] By the close of World War II the decreased ratings began to exceed the increases, reaching a peak in 1947–48. Since 1949 this trend has reversed, with the amount of difference remaining fairly constant.

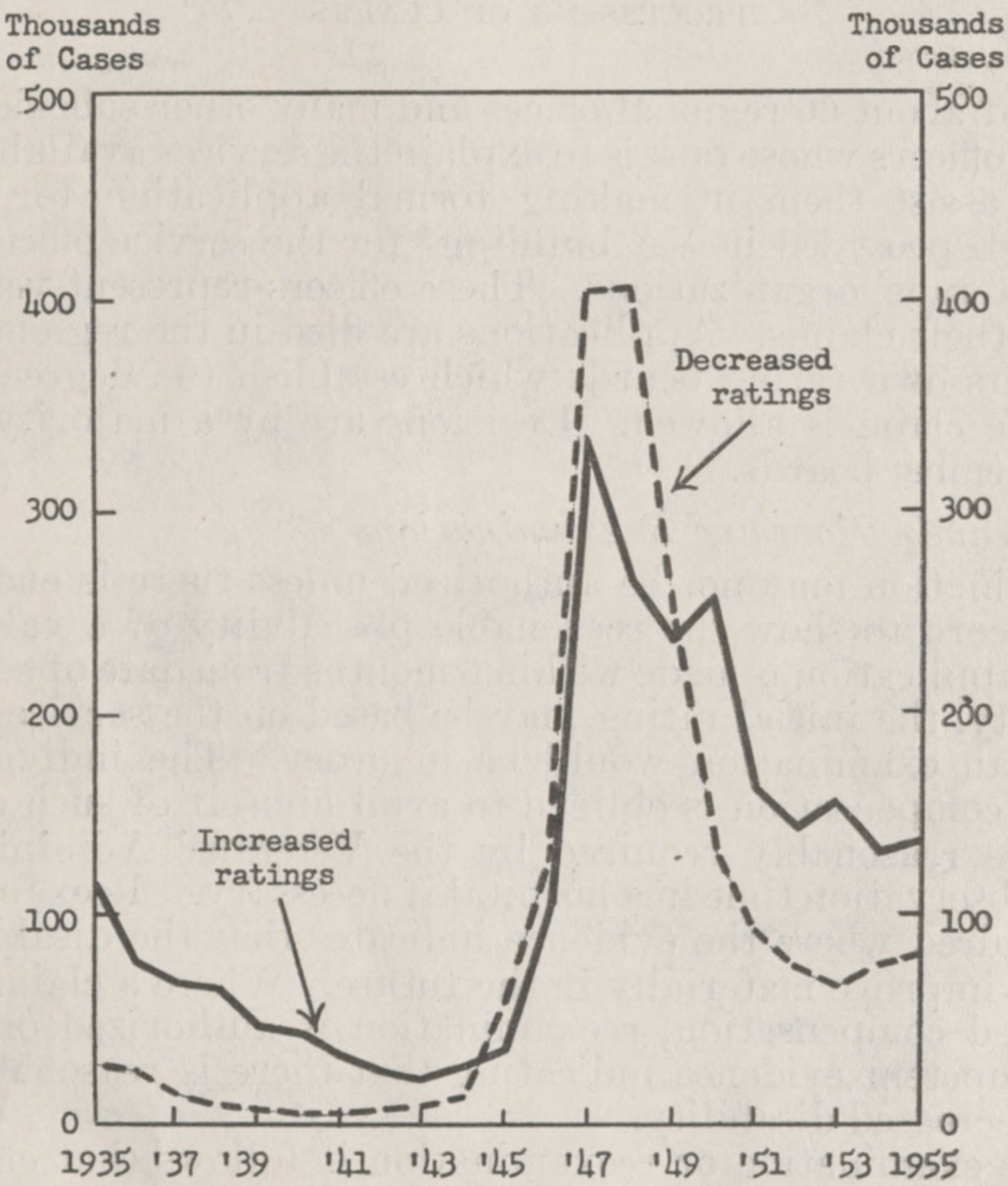
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[6] VA does not separate these statistics as between compensation and pension.

CHART I

DISABILITY COMPENSATION AND PENSION CASES BEFORE THE RATING BOARDS: A COMPARISON OF THE NUMBER OF DECREASED RATINGS AND THE NUMBER OF INCREASED RATINGS

By Fiscal Years, 1935-1955



Source: Veterans Administration

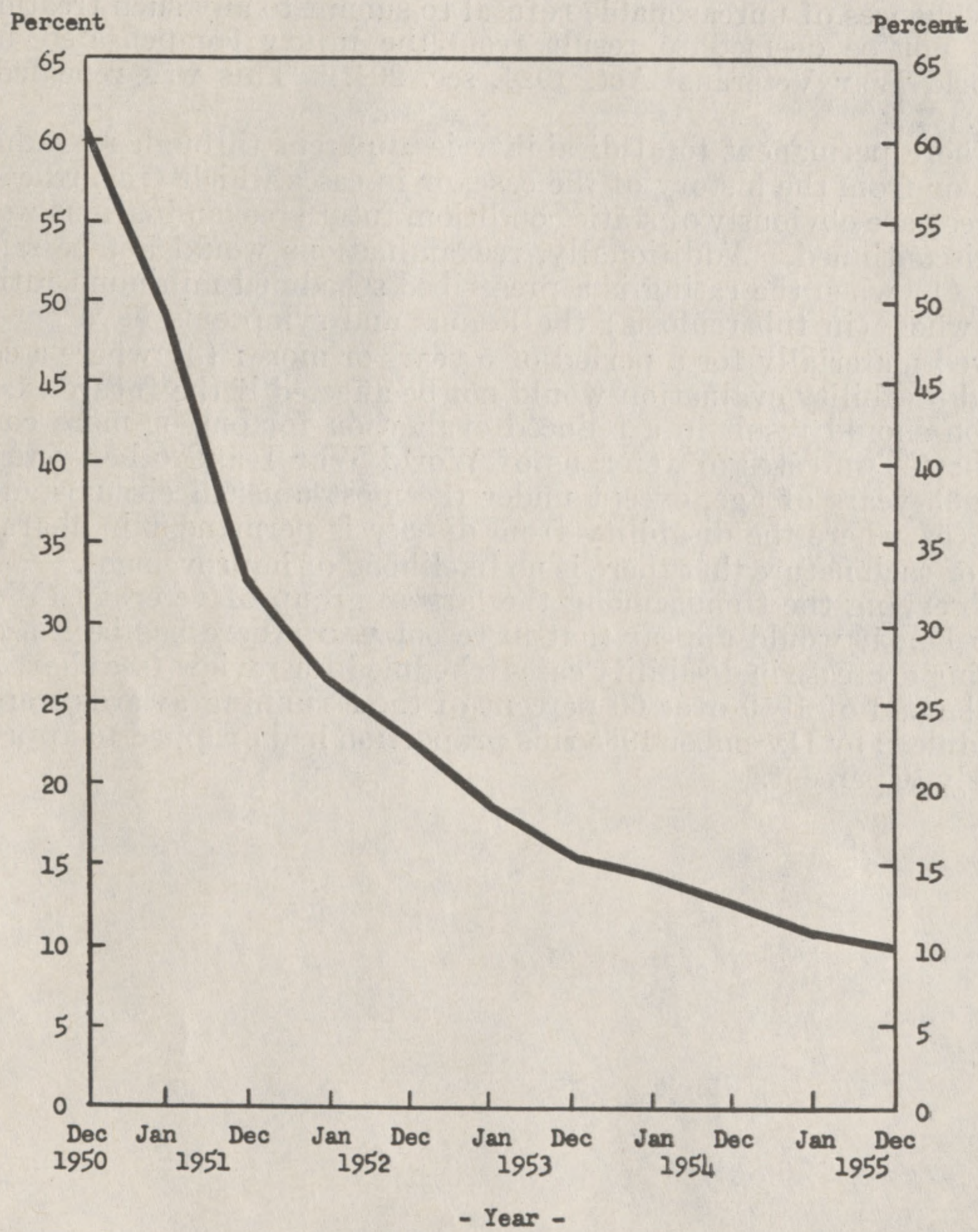
An example of a reduction in rating for refusal to undergo medical treatment or examination is with regard to arrested tuberculosis. A veteran who refuses to undergo treatment or examination during the first 2 years after arrest may have his disability rating reduced from 100 to 50 percent (Veterans Regulation 3 (a), par. II). There was a period following World War I when veterans receiving disability compensation could be compelled to submit to "any reasonable medical or surgical treatment furnished by the [Veterans'] Bureau, and the consequences of unreasonable refusal to submit to any such treatment shall not be deemed to result from the injury compensated for." (World War Veterans' Act, 1924, sec. 204.) This was repealed in 1933.

Where permanent total disability is apparent through reexamination, or from the history of the case, or in cases which (regardless of degree) are obviously of static condition, future reexaminations would be discontinued. Additionally, reexaminations would not be scheduled (1) when the rating is a prescribed scheduled minimum rating; (2) when (in tuberculosis) the lesions and symptoms have not improved materially for a period of 5 years or more; (3) where a combined disability evaluation would not be affected if the future examination should result in a reduced evaluation for one or more conditions; (4) in cases of veterans of World War I and other veterans over 55 years of age, except under the most unusual circumstances; and (5) where the disability from disease is permanent in character and of such nature that there is no likelihood of improvement.

Observing the trend among the largest group of veterans (World War II), it would appear that in recent years there has been a continuing decrease in disability cases scheduled for review (see chart II). At the end of 1950 over 60 percent of these running awards were so scheduled; by December 1955 this proportion had dropped to approximately 10 percent.

CHART II

PERCENT OF WORLD WAR II RUNNING AWARDS (DISABILITY) SCHEDULED FOR REVIEW



Source: Veterans Administration

Where the veteran fails to appear for reexamination without adequate reason, the compensation may be suspended. If a veteran has both static and nonstatic conditions, his award may continue for the degree of disability resulting from the static condition. If failure to report is in connection with an application for increased compensation, the claim will be considered as given up until a new application takes place.

Disallowances

Obviously there may be a great many factors involved in the decision of a rating board to refuse the claim requested by the veteran. Disallowed claims may be reconsidered by the local rating board with recourse to the Board of Veterans' Appeals at the central office in Washington. There is no further appeal to the courts.

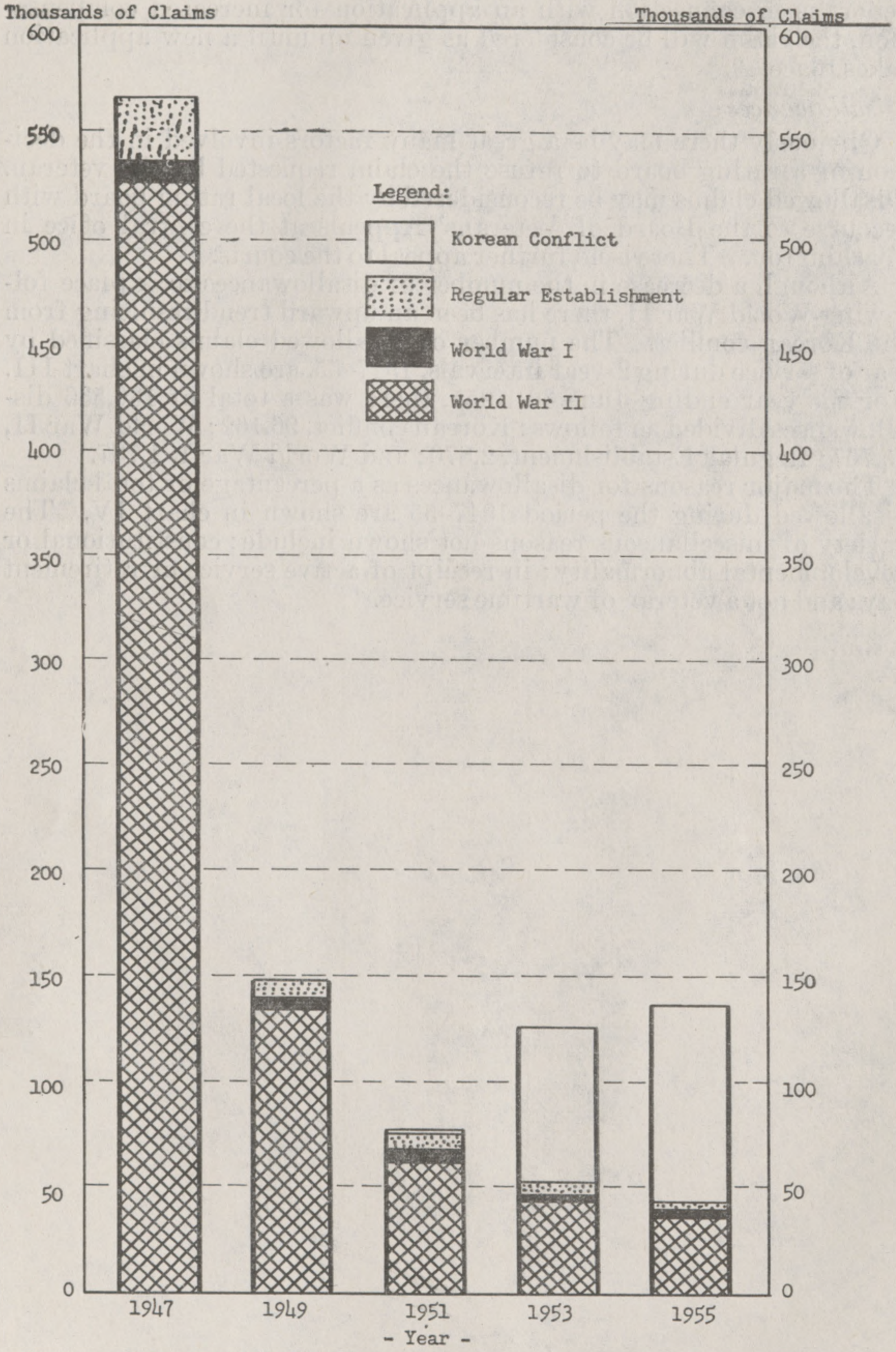
Although a decrease in the number of disallowances took place following World War II, there has been an upward trend resulting from the Korean conflict. The number of disallowed claims classified by war of service during 2-year intervals, 1947–55, are shown in chart III. For the year ending June 30, 1955, there was a total of 136,536 disallowances divided as follows: Korean conflict, 96,162; World War II, 35,767; Regular Establishment, 2,870; and World War I, 1,737.

The major reasons for disallowances as a percentage of total claims disallowed during the period 1947–55 are shown in chart IV. The variety of miscellaneous reasons not shown include: constitutional or developmental abnormality; in receipt of active service or retirement pay; and not a veteran of wartime service.

Chart III

NUMBER OF DISABILITY COMPENSATION CLAIMS DISALLOWED

By War of Service - Selected Years, 1947-1955

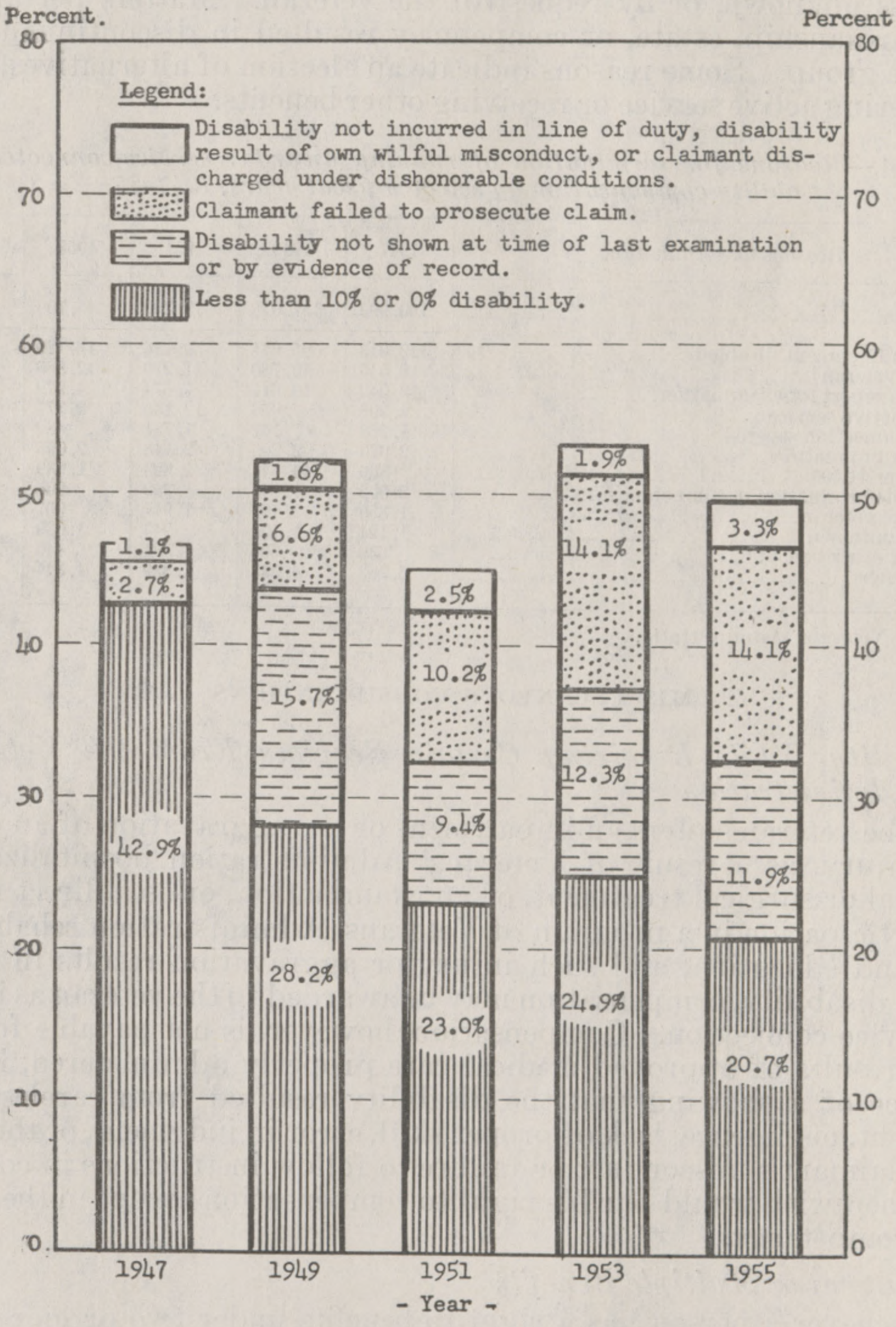


Source: Veterans Administration

CHART IV

REASONS FOR DISALLOWANCE OF DISABILITY COMPENSATION CLAIMS: A COMPARISON OF CERTAIN REASONS – SHOWN AS PERCENTAGE OF TOTAL CLAIMS DISALLOWED

Selected Years, 1947-1955



Source: Veterans Administration

Terminations

Awards may be ended for many reasons; the principal ones are shown in table 4 for single fiscal years (at 2-year intervals) during the period 1947–55. The greatest number of terminations resulted directly from the veteran's disability status, such as a finding of less than 10 percent disabled, or severing service connection. The steady rise in the number of deaths will, of course, be expected to continue. A considerable number drop out for reasons probably known to the individual alone, such as failure to report for physical examination, address unknown, or by request of the veteran. Matters pertaining to guardianship, estate, or competency resulted in discontinuance of a large group. Some reasons indicate an election of alternatives, such as entering active service or receiving other benefits.

TABLE 4.—*Reasons for termination of running awards; service-connected disability compensation by selected fiscal years, 1947–55*

Reasons for termination	1947	1949	1951	1953	1955
Total	160,993	157,078	73,389	45,706	51,986
Less than 10-percent disabled	113,013	95,641	30,126	16,129	20,006
Death of veteran	9,545	10,780	11,219	12,885	13,081
Failure to report for examination	13,042	19,617	7,574	4,972	5,235
Entered active service	9,208	7,056	12,136	2,377	2,361
Service connection severed	1,268	7,152	1,781	682	1,817
Guardianship matters	2,020	2,205	2,148	2,095	2,337
Estate over $1,500	899	4,544	1,823	1,939	2,405
Pending determination of competency	2,002	1,848	1,282	906	773
Request of veteran	1,850	2,497	1,947	907	841
Address unknown	1,124	1,104	943	1,030	821
Receiving other benefits	639	606	581	440	713
Other reasons	6,383	4,028	1,829	1,344	1,596

Source: Veterans' Administration.

MISCELLANEOUS CONSIDERATIONS

Disability While Receiving Certain Services From the Veterans' Administration

If the veteran suffers an impairment or the aggravation of an existing injury, as a result of Veterans' Administration hospitalization, medical or surgical treatment, or an examination, or as a direct result of participation in a program of Veterans' Administration rehabilitation and education, and such injury or aggravation results in additional disability, compensation may be awarded to the veteran as if due to service connection. Compensation, however, is not payable for the after-results of approved medical care properly administered, in the absence of a showing that the disability resulted from carelessness, accident, negligence, lack of proper skill, error in judgment, or the like. The claimant's misconduct or failure to follow instructions in connection therewith would bar his right to compensation except in the cases of incompetency.

Concurrent or Multiple Benefits

Whenever a person has a right to benefits under two or more laws he may elect to take the benefit of his choice, regardless of whether it is the greater or lesser benefit and even though his election results in reducing the benefits of his dependents. Furthermore, any veteran who elects to receive monetary benefits under any law places his right under another law in suspense. He may, however, at any time, cause

the suspension to be lifted by again electing monetary benefits under the other law. Thus, a veteran who elected to receive retirement or retired pay is not precluded from exercising his right of election between compensation or pension and retirement or retired pay. A veteran receiving retired pay pursuant to any law relating to retirement of persons in the regular military or naval service and who would be eligible to receive a Veterans' Administration pension or disability compensation if he were not receiving such retired pay is entitled to receive the Veterans' Administration pension or disability compensation upon waiving so much of his retired pay as would equal the amount of the Veterans' Administration pension or disability compensation.

With certain exceptions, the compensation of single veterans (without dependents) receiving Veterans' Administration hospital treatment, institutional, or domiciliary care continues without reduction until the first day of the seventh month. If the treatment extends beyond that period, the compensation, if it is less than $30 per month, continues without reduction. But, if it is greater than $30 per month, it is reduced to 50 percent of the amount payable, or to $30 per month, whichever is greater. All amounts withheld are payable upon termination of the treatment, subject to certain conditions.

Punishment for Wrongful Acts

With respect to delinquency on the part of a serviceman, Veterans' Administration regulations (No. 10, par. VIII) specify that, even though the disability takes place while he is confined under sentence of court-martial or civil court, this will not prevent the payment of compensation, providing that the sentence of the court-martial did not involve an unremitted dishonorable discharge or if the offense for which he was convicted by the civil court did not involve a felony as defined by the court where he was convicted.

The Federal laws make provision for punishment of such acts as forgeries, false claims, wrong impersonations, and wrongful acceptance of benefits. With certain exceptions, a veteran would be precluded from receiving compensation if discharged from the armed services by sentence of a general court-martial, or discharge on the grounds that he was a conscientious objector who refused to perform military duty or refused to wear the uniform or otherwise comply with lawful orders of competent military authority, or was a deserter, or if an officer, resigned for the good of the service. Also the individual would forfeit any rights he may otherwise have to compensation if guilty of such wrongful acts as making false claim, mutiny, sabotage, or aiding the enemy. As mentioned earlier, compensation payments may be suspended as to non-static disabilities, if the veteran does not report for a required medical examination. Furthermore, compensation would not be paid if the disability resulted from the individual's own misconduct.

ADDITIONAL BENEFITS AVAILABLE TO VETERANS RECEIVING SERVICE-CONNECTED DISABILITY COMPENSATION

Veterans with service-connected disabilities who receive monthly compensation payments may, under certain conditions, be eligible also for additional benefits administered through the Veterans' Adminis-

tration. These include medical services and hospitalization, prosthetic appliances, as much as $1,600 toward the purchase price of an automobile, service-disabled veterans' insurance, seeing-eye dogs, mechanical electronic equipment, and special housing grants.

The program of vocational rehabilitation and education is of special significance to disabled veterans and is discussed separately in chapter VIII.

Medical Benefits.

Veterans with service-connected disabilities (the individual is not necessarily required to be in receipt of disability compensation) have a priority over non-service-connected disabled veterans in entitlement to medical benefits. Hospitalization is granted to them in this order:

1. Those needing such care due to injuries or diseases incurred or aggravated in line of duty in wartime service including military disability retirees (under certain conditions Veterans' Administration beneficiaries and Army retirees may enter Army hospitals).

2. The same, except that active service need not be in wartime. Also included in this group are:

(*a*) Military disability retirees who agree to pay the subsistence rate.

(*b*) Those who elected to receive Veterans' Administration disability compensation in lieu of disability retirement pay.

(*c*) Certain pre-Pearl Harbor servicemen.

(*d*) Certain cadets and midshipmen discharged from the Army, Navy, and Coast Guard Academies.

3. Those discharged for disability incurred in line of duty or those having compensable service-connected disabilities who are found to need hospitalization for non-service-connected disabilities, providing beds are available.

Eligibility for outpatient medical treatment is determined in accordance with the above principles, for service-connected disabilities. (Under Public Law 314, 78th Cong., a military retiree who waives part of his pay and receives Veterans' Administration disability compensation to that extent, thereby qualifies for outpatient treatment for service-connected disabilities.) Hospitalization or outpatient treatment upon Veterans' Administration authorization may be given by a hospital or physician at the place where the veteran resides.

The extent of medical services is so broad that no attempt is made here to present even a brief statistical picture.

Prosthetic Appliances

Veterans with service-connected disabilities which require the use of wheelchairs, artificial limbs, trusses, orthopedic footwear, hearing aids, and other appliances may be furnished them through Veterans' Administration facilities. Assistance and training in the use of such devices, as well as their repair or replacement, may be made by the Veterans' Administration.

These appliances include (1) those purchased or repaired through commercial sources, as well as (2) those fabricated or repaired in Veterans' Administration shops or clinics.

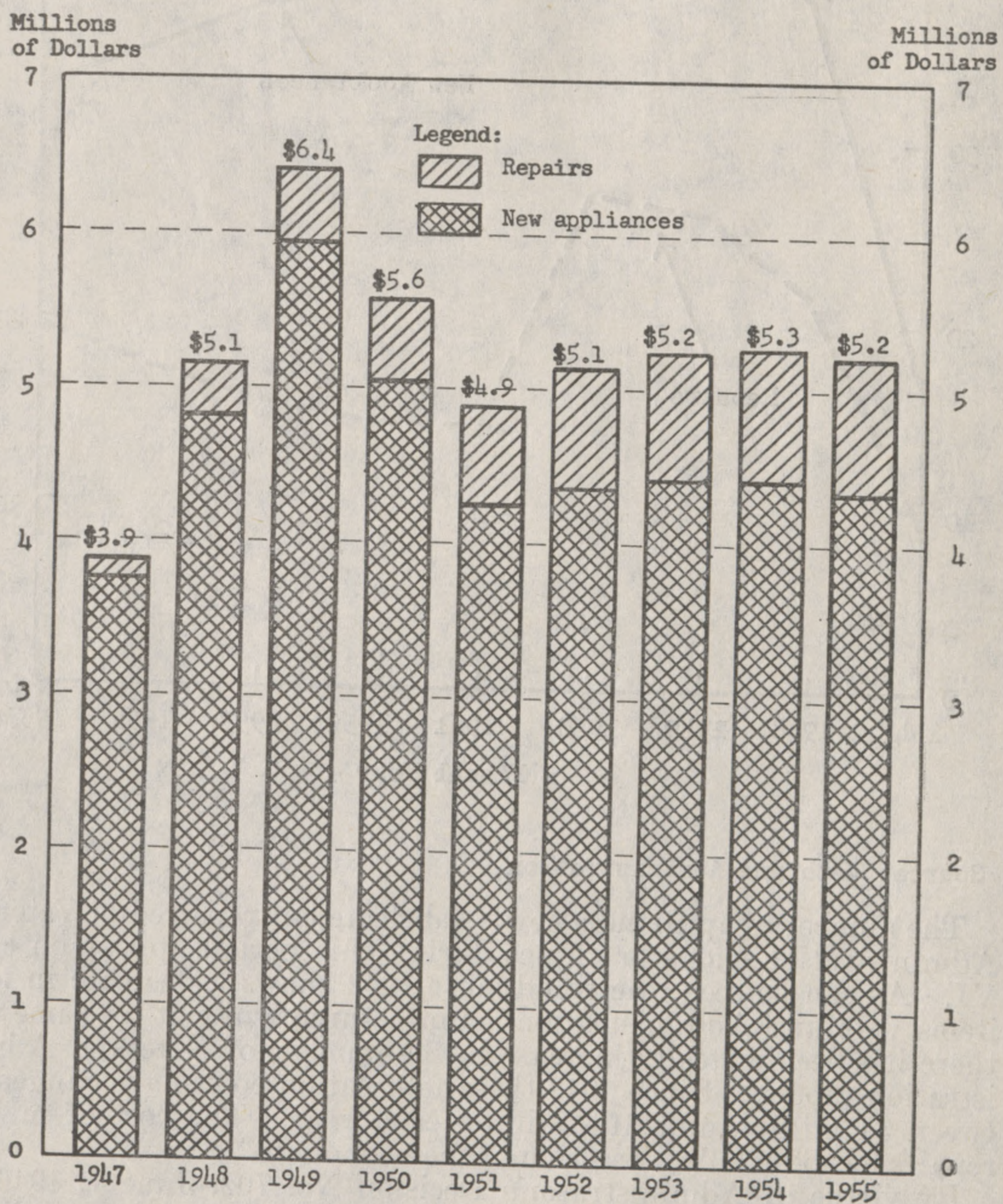
As to the former, during the 9 fiscal years 1947 through 1955, over 19 million new appliances were supplied through commercial sources to disabled veterans at a total cost of almost $41,500,000. Since 1949,

the annual number of new items has been between 2.25 and 2.75 million.. Repairs purchased from commercial firms during this 9-year period reached a total of nearly 475,000 and a cost of over $5.3 million. The annual number of repairs has shown a continuous rise from 13.5 thousand in 1947 to nearly 75,000 in 1955. The yearly costs of prosthetic appliances and repairs procured from commercial sources during the 1947–55 period may be seen on chart V.

CHART V

COST OF PROSTHETIC APPLIANCES AND REPAIRS*

Fiscal Years 1947-1955



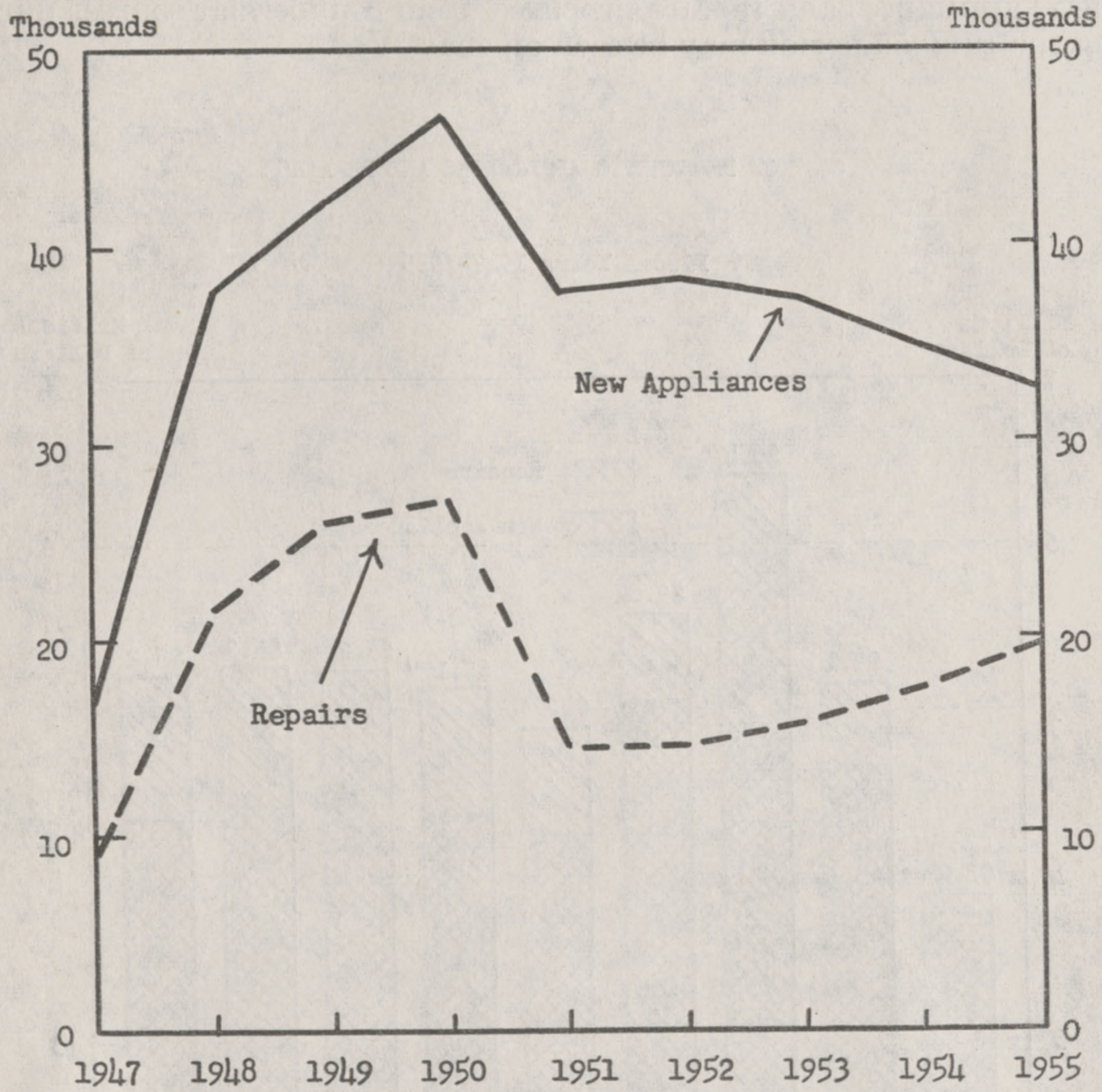
* Procured from commercial sources only. Does not include appliances fabricated or repaired in VA shops or clinics.

Source: Veterans Administration

CHART VI

NUMBER OF APPLIANCES FABRICATED OR REPAIRED IN VA SHOPS AND CLINICS

Fiscal Years 1947-1955



Source: Veterans Administration

The number of appliances newly fabricated or repaired in Veterans' Administration shops or clinics during this period appear on chart VI. As can be seen, the trend since 1952 shows a decrease in these items Veterans' Administration-manufactured while at the same time there has been a steady increase in the number of Veterans' Administration repairs. Since 1948 these fabrication costs have ranged between $1 million and $1.3 million each year. The cost of making repairs has been only a fraction of these amounts.

By virtue of Administrator's Decision No. 702, June 7, 1946, an automobile was classified as not being a prosthetic or other appliance that may be furnished under these provisions. As can be seen from the following, Congress was quick to respond to this ruling.

Automobiles or Other Conveyances

Separate provision for an automobile or other conveyance for a disabled veteran was initially made in the First Supplemental Appro-

priation Act, fiscal year 1947.[7] This act appropriated $30 million to enable the Administrator of Veterans' Affairs to provide an automobile or other conveyance at a cost per vehicle or conveyance of not to exceed $1,600, including equipment with such special attachments and devices as the Administrator might deem necessary, for each veteran of World War II entitled to compensation for the loss, or loss of use, of one or both legs at or above the ankle. This first law, as others since, specified that payment be made to the seller from whom the veteran was purchasing the car.

Other appropriation acts continued to make automobiles available to disabled veterans until a basic law [8] was enacted September 21, 1950. This law was essentially the same as the earlier one with respect to benefits and eligibility requirements. However, it permitted the payment of $1,600 toward the purchase price of an automobile if the one desired by the buyer was priced in excess of that amount. And it specified that no veteran would be entitled to receive more than one automobile or other conveyance.

Thirteen months later, October 20, 1951, Public Law 187, considerably extending eligibility, was passed by the 82d Congress over the President's veto. The President, previously, in October 1949, had withheld approval of S. 2115, 81st Congress, which similarly would have extended coverage.

Public Law 187 effected important changes. Persons with specified service-connected disabilities who served on or after June 27, 1950, and before a date later set as February 1, 1955 were brought under it. The disability requirement of the earlier laws, "loss or loss of use of both legs at or above the ankle," was replaced by "(*a*) loss or permanent loss of use of one or both feet; (*b*) loss or permanent loss of use of one or both hands; and (*c*) permanent impairment of vision of both eyes" to a prescribed degree constituting virtual blindness. The payment toward purchase was permitted, in the case of a veteran otherwise qualified who could not drive, on an automobile to be driven for him by another person.

Application for benefits under Public Law 187, 82d Congress, was required to be made within 3 years after the effective date of enactment or within 3 years after the date of separation from active service, whichever came later. These time limits were extended by Public Law 92, 84th Congress, enacted June 21, 1955. Under the law as it now stands, application for payment on the purchase of an automobile or other conveyance must be made by October 20, 1956, or within 5 years after the date of the veteran's discharge or release from active service if that discharge or release was not until on or after October 20, 1951. An exception is that if the entitling disability shall have occurred subsequent to the veteran's discharge or release from active service, the application may be made within 3 years after the occurrence of the disability. Also, no otherwise eligible veteran shall be denied the benefits who makes application within 1 year from the date on which his entitlement to compensation for one of the specified entitling disablements shall have been determined.

During the life of this program, up to the end of December 1955, over 43,500 vehicles had been certified and delivered (see chart VII).

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[7] Public Law 663, 79th Cong., approved August 8, 1946.
[8] Public Law, 798, 81st Cong.

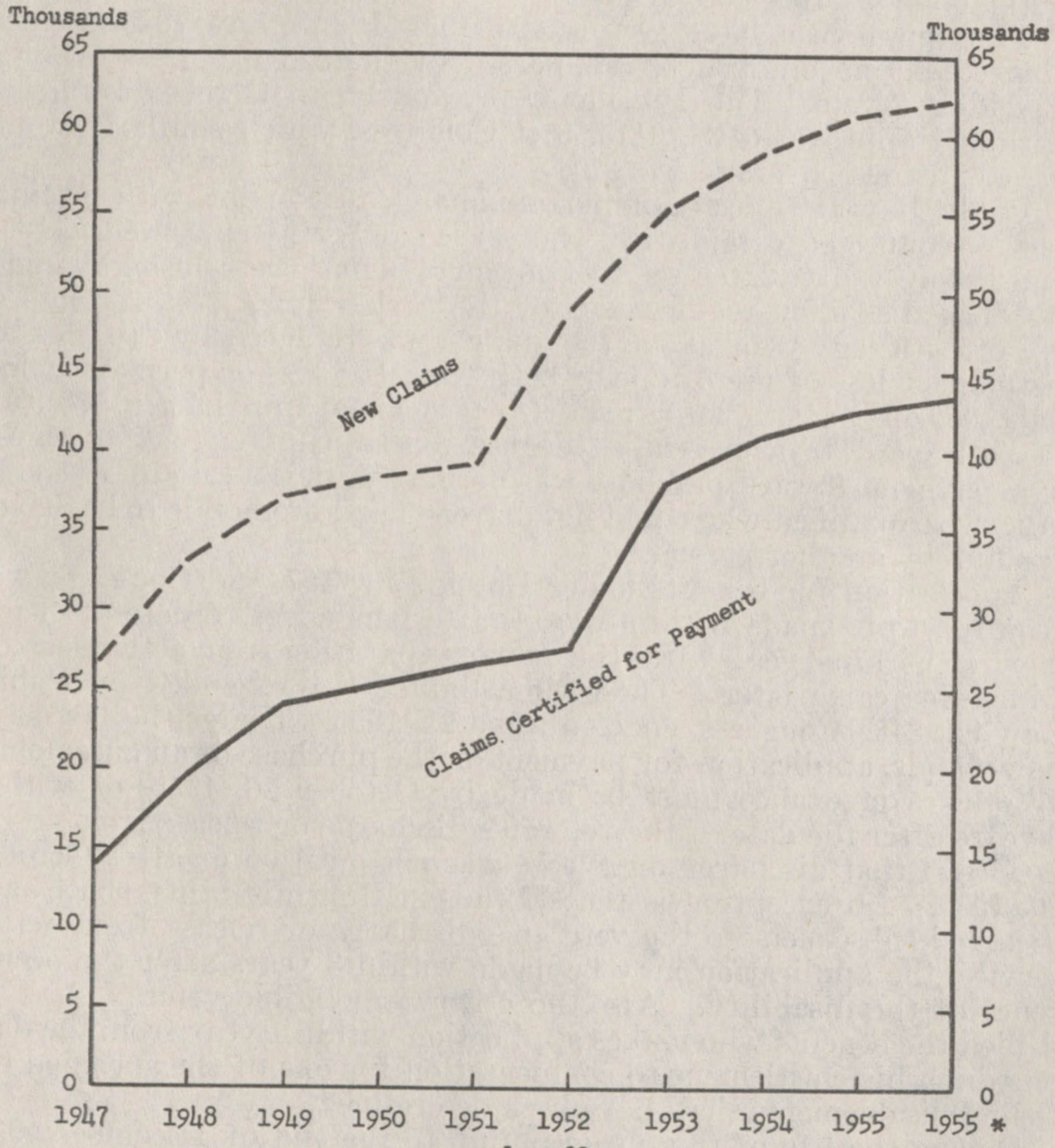
As can be seen, however, there were always goodly numbers of applicants whose claims were not approved; by the end of 1955 this number had reached a cumulative total of nearly 19,000. Although this program dispensed automobiles for the most part, the following other types of vehicles were certified during this period of over 8 years: Trucks, 630; station wagons, 254; tractors, 231; and jeeps, 50.

The total cost of vehicles during this time reached nearly $70 million by December 31, 1955; amounts by fiscal years are shown on chart VIII. The effect of the liberalized legislation became fully apparent in the 1953 fiscal year, with a sharp drop afterward.

CHART VII

TOTAL NUMBER OF APPLICATIONS RECEIVED AND CERTIFIED FOR PAYMENT FOR AUTOMOBILES AND OTHER CONVEYANCES

Cumulative Totals for Fiscal Year 1947 through December 31, 1955



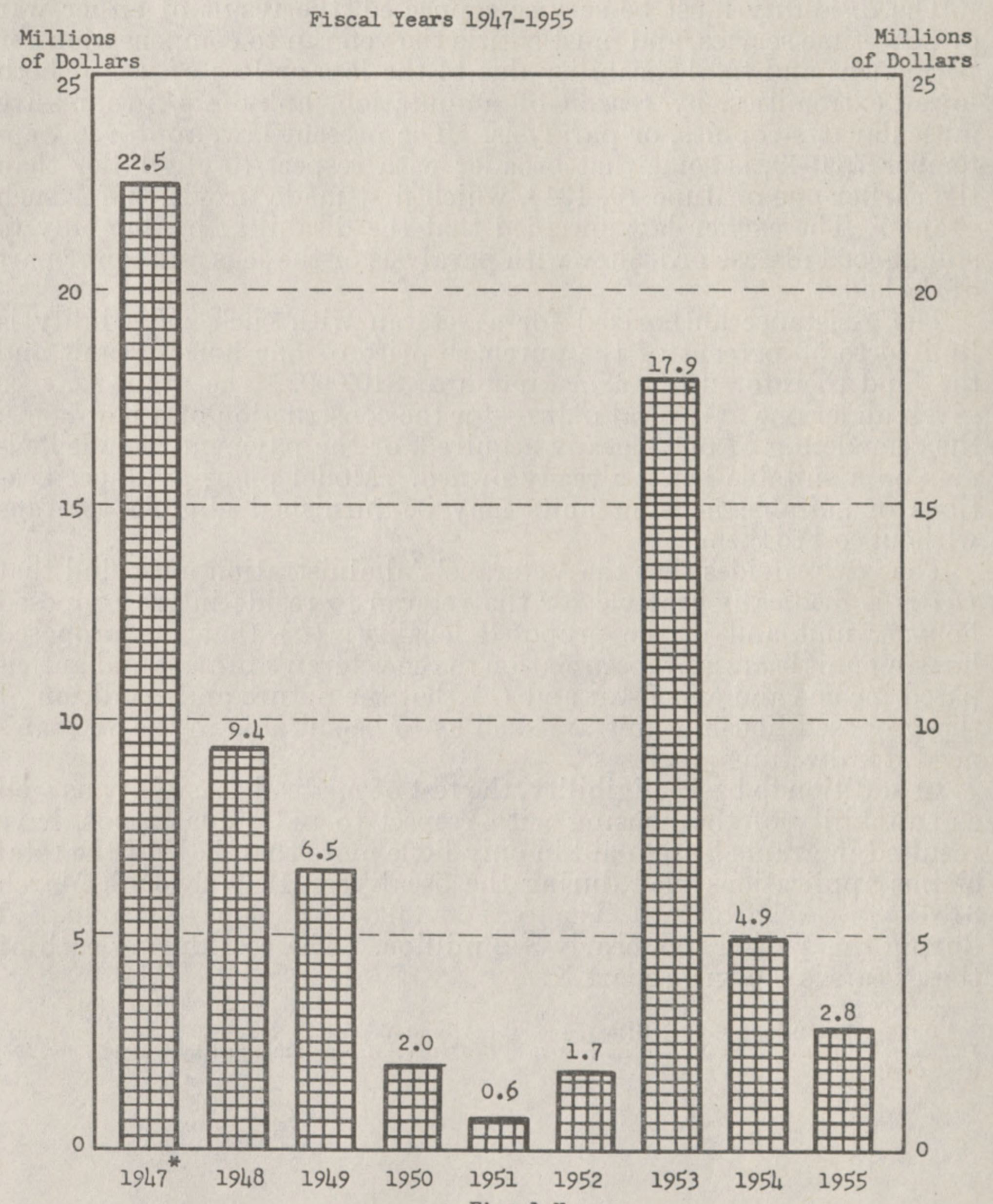
* December 31, 1955

Source: Veterans Administration

Chart VIII

COST OF GRANTS FOR AUTOMOBILES AND OTHER CONVEYANCES FOR DISABLED VETERANS

Fiscal Years 1947-1955



* First report October 1946.

Source: Veterans Administration

Special Housing Grants

Certain seriously disabled veterans who are unable to move about without the aid of braces, crutches, canes, or a wheelchair are entitled to special assistance in acquiring a suitable housing unit with special fixtures or movable facilities made necessary by the nature of their disability.

The disability must be service connected, the result of either war or peacetime service, and must entitle the veteran to compensation for permanent and total disability due to the loss or loss of use of both lower extremities, by reason of amputation, ankylosis, progressive muscular dystrophies, or paralysis. The present law, approved September 7, 1949, is somewhat broader with respect to eligibility than the earlier one of June 19, 1948, which first made provision for such grants. The earlier law specified that the disability be due only to spinal-cord disease or injury with paralysis of the legs and lower part of the body.

The assistance authorized for a veteran with such a disability is limited to 50 percent of the purchase price of one housing unit and the land therefor up to a maximum of $10,000. The grant may be given under one of several plans—for the construction of a new home, the remodeling of one already acquired, or the payment of indebtedness on a suitable home already owned. Model plans and specifications of suitable housing units may be furnished eligible veterans without cost to them.

The law provides that the Veterans' Administration must find that (*a*) it is medically feasible for the veteran to reside in the proposed housing unit and in the proposed locality; (*b*) that the proposed housing unit bears a proper relation to the veteran's present and anticipated income and expenses; and (*c*) that the nature and condition of the proposed housing unit are such as to be suitable to the veteran's needs for dwelling purposes.[9]

In addition to basic eligibility, the test of medical feasibility as well as suitability of the housing with respect to individual needs, have resulted in grants being paid in only little more than half of the total claims applications filed during the fiscal year 1949 through March 31, 1956 (see chart IX). The total cumulative amount of grants paid during this period was nearly $42 million. The cost during each of these years is shown on chart X.

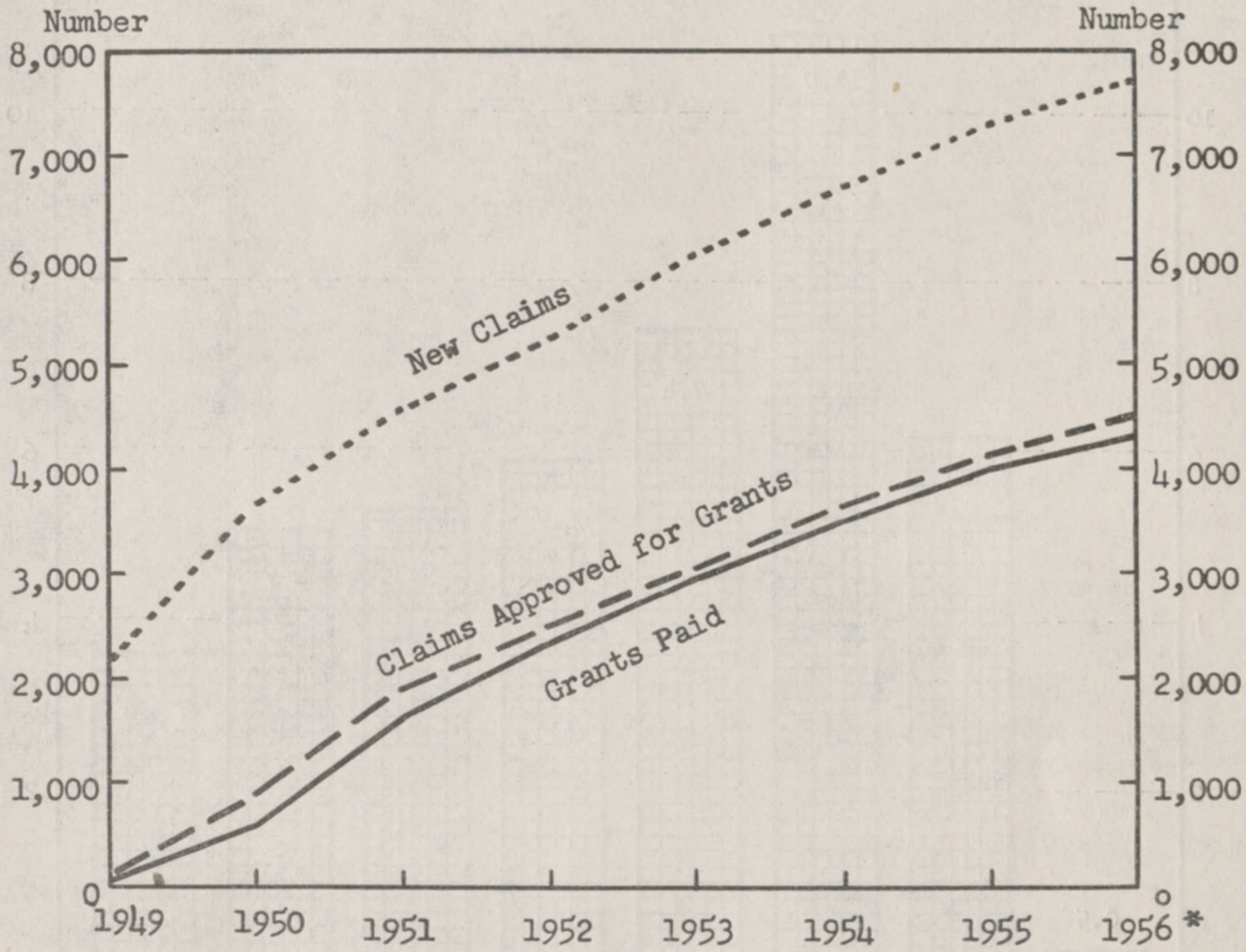
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[9] Public Law 2, 83d Cong., title I, sec. 1 (g), and Veterans' Regulation No. 1 (a), part IX, both as added to by Public Law 702, 80th Cong.; also as amended by Public Law 286, 81st Cong.

CHART IX

TOTAL NUMBER OF SPECIAL HOUSING GRANTS TO VETERANS
WITH CERTAIN AMBULATORY DISABILITIES

Cumulative Totals for Fiscal Year 1949 through March 31, 1956



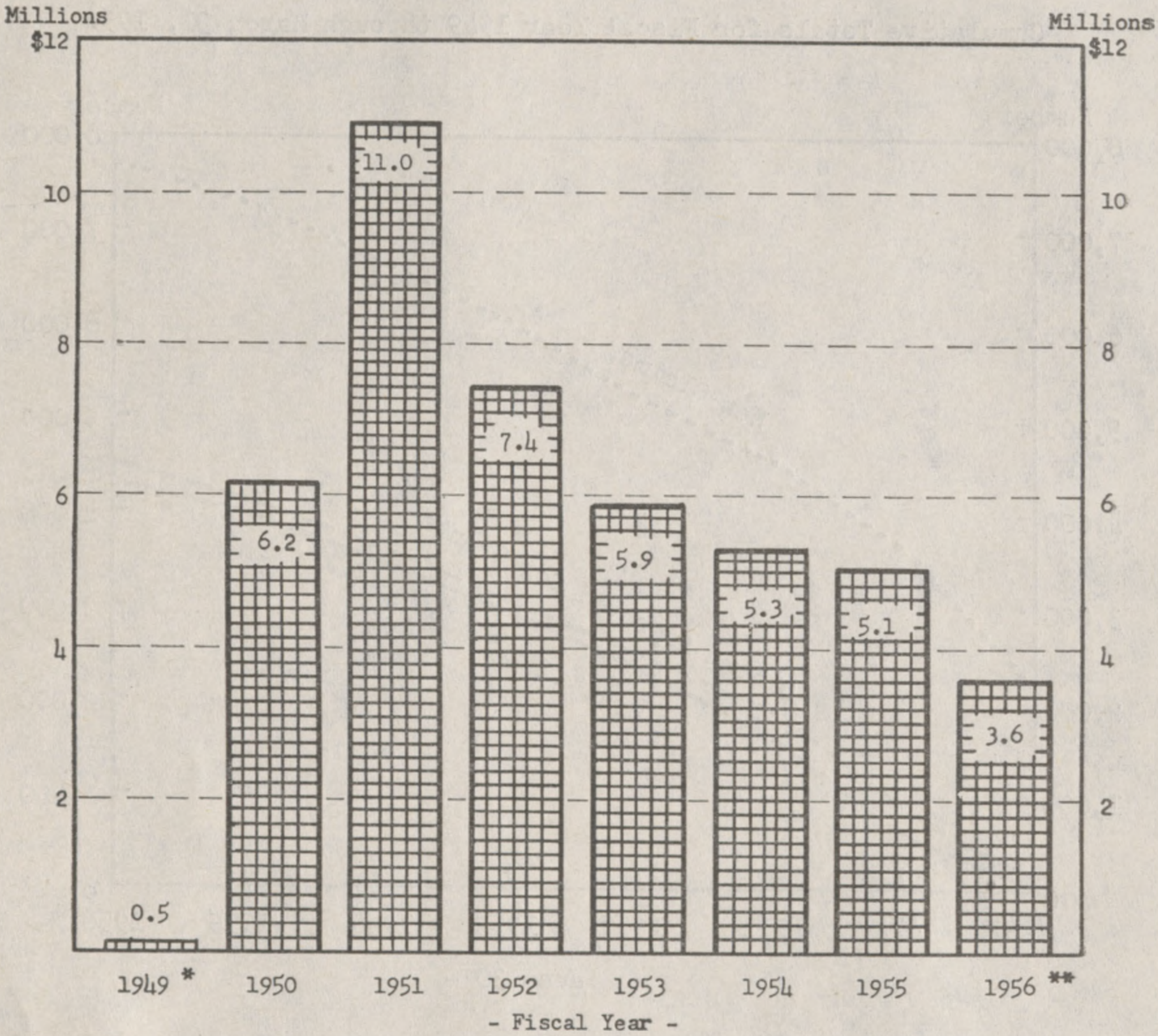
* March 31, 1956

Source: Veterans Administration

CHART X

COST OF SPECIAL HOUSING GRANTS TO VETERANS WITH CERTAIN AMBULATORY DISABILITIES

Fiscal Year 1949 through March 31, 1956



* First Report October 31, 1948.
**Through March 31, 1956.

Source: Veterans Administration

Seeing-Eye Dogs and Mechanical Electronic Equipment

The Veterans' Administration has been authorized since May 1944 to provide special aid to veterans who are blind and who are entitled to compensation for service-connected disabilities. The blindness itself need not be service connected.

The benefits specified in the law are a seeing-eye or guide dog, all necessary travel expenses to and from the veteran's home and other expenses incurred in his becoming adjusted to the dog; also approved mechanical electronic equipment.[10] The Veterans' Administration interprets "mechanical electronic" equipment as "mechanical and/or electronic." Medical care and treatment for the dog with meals and

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[10] Public Law 309, 78th Cong.

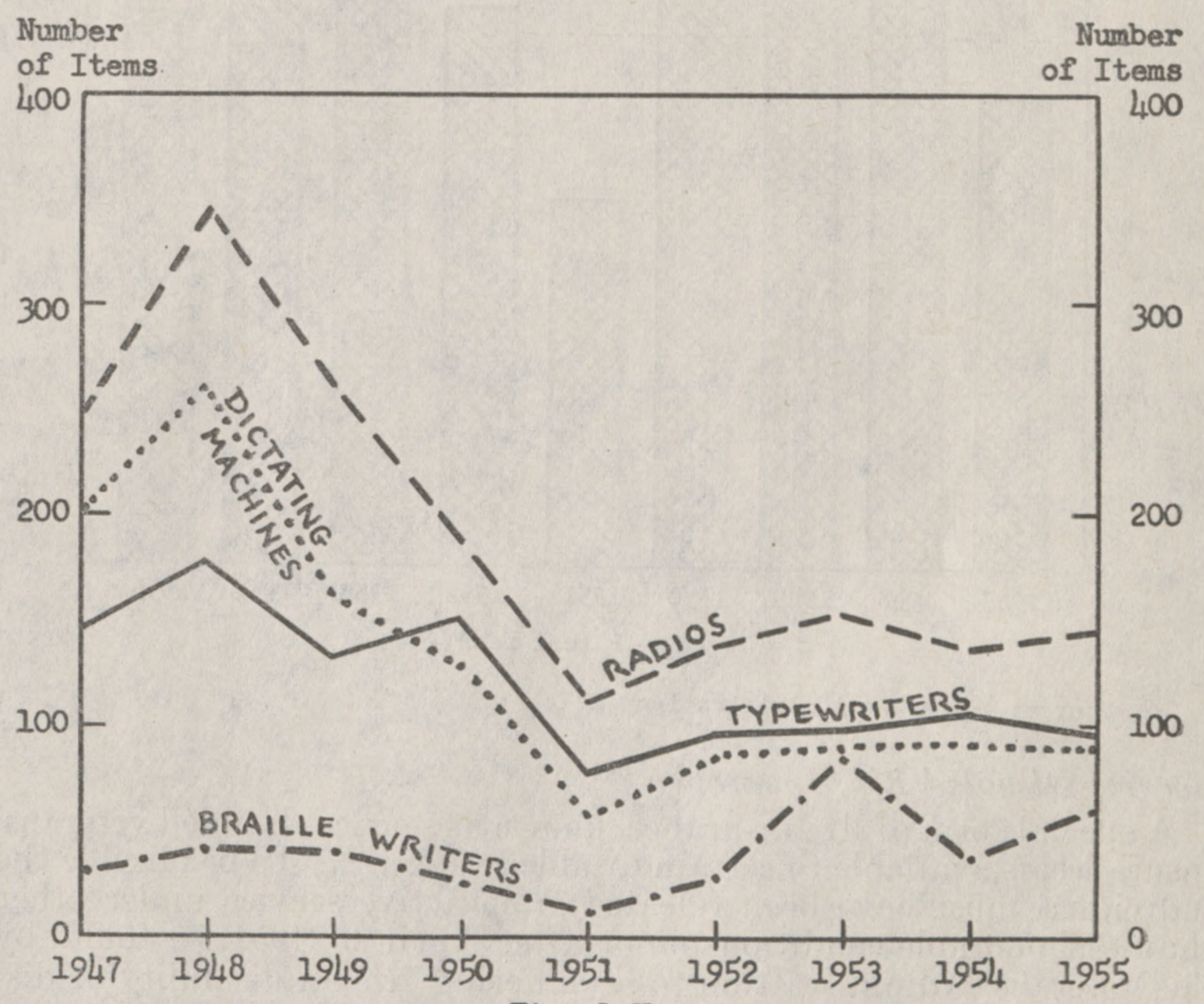
lodging for the veteran during the period of adjustment, provided the veteran is required to be away from his usual place of residence, may be received. Equipment supplied as aiding in overcoming the handicap of blindness includes braille writers, radios, dictating machines, typewriters, and braille watches. Repair and replacement of such items are authorized under special conditions.

The seeing-eye, or guide dogs for the blind, have apparently not been very popular as evidenced by the fact that during the 11-year period, 1944 through 1955, only 110 blinded veterans have been furnished with them. As to certain selected items—radios, typewriters, dictating machines, and braille writers—an estimate of the number supplied on an annual basis during fiscal years 1947–55 can be seen on chart XI. The overall total of new appliances for the blind during this period exceeded 30,000 items, at a cost of over $600,000. A certain amount of repair work took place, the total number of repairs being over 5,000 with the cost approaching $50,000. The costs for each of the fiscal years, 1947 through 1955, are shown on chart XII.

CHART XI

SELECTED ITEMS OF SPECIAL EQUIPMENT FOR BLINDED VETERANS

Total Number Furnished During Fiscal Years 1947-1955

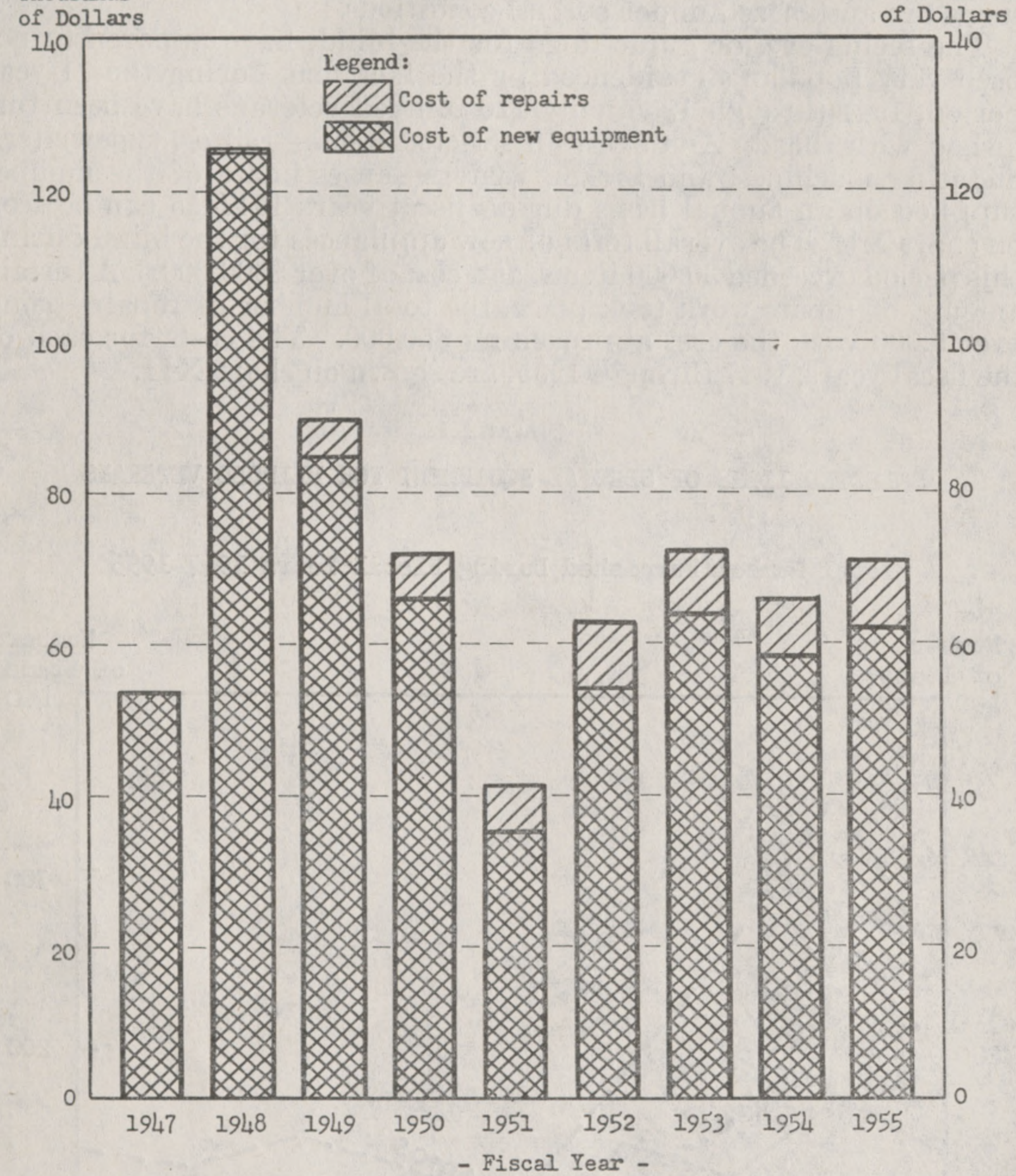


Source: Veterans Administration

CHART XII

TOTAL COST OF SPECIAL EQUIPMENT FOR BLINDED VETERANS

Fiscal Years 1947-1955



Source: Veterans Administration

Service-Disabled Life Insurance

A special form of life insurance, known as service-disabled veterans' insurance, is available to certain disabled veterans. To be eligible the individual must have been released from active service under other than dishonorable conditions on or after April 25, 1951, be found by the Veterans' Administration to be suffering from a disability or disabilities for which compensation would be payable if 10 percent or more in degree, and except for the disability be insurable as in good health. The insurance must be applied for within 1 year after service

connection of the disability is established. Each application must be accompanied by the necessary premium.[11]

This special insurance is issued in the same plans as is regular national service life insurance—5-year renewable term policy, ordinary life, 20- and 30-payment life, and three endowment-type policies. Term insurance can be converted into any of the other types. The premium rates, however, are on a different basis. The insurance is nonparticipating, i. e., pays no dividends, and the benefits upon maturity differ from those under regular national service life insurance because they are based on different actuarial tables. The premium rates are in consequence considerably lower.

The permanent plans have reserve value with the right of loan, cash surrender, extended insurance, and paid-up insurances. The benefits are payable in the event of death or upon maturity of an endowment-type policy. Provision is made for waiver of premiums in the event of total disability of 6 or more months' duration. The waiver of premiums for total disability may be granted even though the total disability may have existed at the time the man made application for the insurance. The maximum amount of all Government insurance on any one life is $10,000. As of June 30, 1955, a total of 12,529 policies under this form of insurance were in force in the amount of $106,822,173.[12]

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[11] Public Law 80, 76th Cong., October 8, 1940, as amended by Public Law 23, 83d Cong., which added sec. 620.

[12] Veterans' Administration Statistical Summary, Monthly Report, July 1955.

CHAPTER II

AN ANALYSIS OF THE MILITARY DISABILITY SEPARATION AND RETIREMENT SYSTEM

EARLY HISTORY AND GENESIS [1]

The United States has provided various forms of compensation for veterans of its wars since the colonial period. Disability payments were provided throughout the 19th century for veterans who became disabled as a result of military service. Invalid pension provisions for the Regular Army were contained in the act of April 30, 1790, which governed the peacetime Army and delegated partial disability determination to the President of the United States. Under this legislation, which extended from 1790 to 1861, an invalid pension was paid to any commissioned officer, noncommissioned officer, or musician of the Regular Army who was wounded in the service. Enlisted men received $5 per month and officers received half pay.

Later laws fixing the Regular Establishment, or raising volunteers or militia for various purposes, commonly included a section dealing with the matter of pensions, although such provisions were, in the aggregate, of pecuniary importance. Although apparently of small financial importance in the larger sense, their value to the disabled enlisted soldier or sailor of the Regular Establishment was inestimable; they kept him from becoming a public charge and nurtured him through the several decades before retirement provisions came into being. The legislative history of the period clearly underscores, first, the piecemeal development of a retirement system for officers (in which disability was associated with senility), and, secondly, the almost surreptitious coverage for the neglected Regular enlisted man.

The basic provisions which applied to invalid pensions for members of the Regular Army before the Civil War are found in the act of March 16, 1802, section 4 of the act of April 25, 1808, and the act of April 24, 1816. The developments concerning rates and benefits for survivors under these statutes have been summarized as follows:

> * * * Until 1816, the invalid-pension rate for total disability of officers was not to exceed one-half of the monthly pay, and for noncommissioned officers and privates not to exceed $5 per month. The act of April 24, 1816, however, increased the allowance for noncommissioned officers and privates to $8 per month, and also increased the rate for the lower grades of commissioned officers. In cases of partial disability, a proportionate allowance was made. For many years, the only provision for widows and orphans was a grant of half pay for 5 years to the widows, or children under 16 years of age, of commissioned officers in the troops of the United States, dying in the service in consequence of wounds received.
>
> * * * * * * *
>
> * * * Prior to the Civil War, the provisions of the act of March 16, 1802, were frequently extended to [volunteer, militia, and other] emergency forces.

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[1] This discussion is adapted mainly from William H. Glasson, Federal Military Pensions in the United States, New York, Oxford University Press, 1918, pp. 98–104.

In time of war the widows and orphans of private soldiers of both the Regular Army and the militia were usually allowed half pay for 5 years in the same manner as the widows and orphans of commissioned officers. Upon its expiration, this half pay was often continued from time to time. Eventually, the act of June 3, 1858, granted to all those surviving widows and minor children, who had been allowed 5 years' half pay under the provisions of any previous general law, a continuance of such half pay to commence from the date of the last payment. This pension was to be paid to widows during life, and where there was no widow, or in case of her death or remarriage, to the minor children while under the age of 16 years.[2]

Although the general military pensions of the United States have applied to both the Regular Army and the Regular Navy, there developed in our history a special plan for the payment of Navy disability pensions out of funds derived from the sale of prizes taken at sea. Under the Continental Congress provisions were made for the payment of part of the proceeds of prizes taken by the Navy to disabled officers and sailors and to the widows and children of the slain. From the establishment of a naval armament in 1791 up to about 1800, disability pensions were provided for officers, seamen, and marines in the same manner and at the same rate as for the Regular Army. Under the laws of 1799 and 1800, a Navy pension fund, which was to be made up of the Government's share of money accruing from the sale of naval prizes was established. It was intended that the fund should provide half-pay pensions for life, or during disability, to all disabled officers and men of the Navy; however, if the fund should not prove sufficient for the purpose, the public faith was pledged to make up the deficiency.

The naval activities of the War of 1812 were such as to bring about a rapid growth of the fund, and the income from investments was considerably in excess of the outlay for pensions. Alternating periods of liberalization and retrenchment were typical of the naval pension fund so that in 1842 it was finally exhausted and the pensions were paid by annual appropriations made by Congress. But with the opening of the Civil War, large sums of money again began to come to the Government from the sale of prizes taken at sea, and Congress by the act of July 17, 1862, expressly sanctioned the reestablishment of the Navy pension fund for invalid pensions only. Liberalization of eligibility followed in the ensuing decades so that by 1918 the income of the fund available for the payment of pensions was only a small part of what was required for that purpose. The retirement of personnel of the Regular Navy has been placed on a different basis since 1918, although it should be emphasized that the number of persons serving in the Navy prior to World War II was never very large.

DEVELOPMENTS DURING THE CIVIL WAR [3]

In the Regular Army prior to the Civil War an officer once appointed remained on the rolls until death even though he became disabled or was incompetent. No means existed for the involuntary removal of officers from the active list, except by dismissal. Incapacitated officers were usually left behind to perform light duties or enjoy

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[2] Ibid., pp. 98–99.

[3] Much of this section and the one following have been taken from the unpublished Report of the Committee To Study Retirement Legislation and Policies Submitted to the Assistant Chief of Staff, G1, War Department (December 1944), pt. I, pp. 1–12. Additional background summary data may be found in Compendium Review of Legislation and Policies Governing Retirements, Survivor Benefits, and Severance Pay for the Uniformed Services (mimeographed) compiled by Subcommittee, Personnel Policy Board, Office of the Secretary of Defense (1950), pt. IV.

leaves of absence while junior officers frequently exercised high command in the field. It can thus clearly be understood why, in 1861, many field officers of the Army might be unfit (because of physical incapacity due to advanced age, disease, wounds, injuries, or other infirmities) to exercise command in the field.

In all of the debates in Congress concerning enactment of the first retirement law in 1861, no mention was made of officers disabled or expected to be disabled in the war then in progress. There was no retirement list in existence for officers of the Regular Army. Although laws for the raising of volunteers were being considered and enacted at the same time (in 1861), it was never suggested that retirement be made available to temporary personnel. The act of July 14, 1862, the so-called general law, made elaborate provisions for pensions, according to rank, for all individuals disabled in the service.

In summary, at the beginning of the Civil War it became evident that the absence of a statutory age limit for retirement of military personnel was seriously handicapping the effectiveness of both the Army and Navy.[4] At that time there were large numbers of elderly senior officers on active duty. In 1861 Congress approved "an act for the better administration of the Military Establishment," which (1) provided for the retirement of officers (only) of the Regular Army, Regular Navy, and Regular Marine Corps; (2) established retiring boards; (3) authorized retirement because of incapacity for active service; and (4) permitted any officer who had 40 years of service to retire upon his own application. The new idea of retirement pay for officers, the recognition of the need for it, was substituted for the colonial and European concepts of pensions. This change was adopted to enhance the efficiency of our traditionally small Regular Establishment. An examination of the succeeding legislation on military retirement suggests that this concept is predominant in our present military retirement system.

One of the provisions of the law of 1861, which became an impediment to achieving the goal that retirement was designed to attain, was the stipulation that the number of officers on the retired list could not exceed 7 percent of the whole number of officers authorized for the Army. On July 15, 1870, this percentage limitation was dropped and a fixed number, not to exceed 300, was substituted. On June 18, 1878, the number was raised to 400; and on February 16, 1891, it was established at 350, the number which remained the authorized strength of the so-called limited retirement list during World War II. The obvious and immediate effect of the limitation upon the number of officers who might be placed upon the retired list was to require other officers, no matter how seriously incapacitated, to remain upon the active list until the death of a retired officer left a vacancy on the retired list. The limitation thus defeated the very purpose behind the law of 1861. Under this system there were a few older officers, incompetent to command in the field, whom the retiring boards did not find incapacitated and who would not avail themselves of the opportunity for voluntary retirement. The next step in retirement legislation was designed to retire forcibly those older officers who were considered unsuitable for retention and who did not elect to retire.

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[4] U. S. Senate, Document No. 89, Retirement Policy for Federal Personnel (Kaplan committee report), 83d Cong., 2d sess. (1954), pt. II, p. 11.

Involuntary nondisability retirement of Army officers was provided in the act of July 17, 1862, which stipulated that when an officer was over 62 years of age, or had served over 45 years, he might be retired at the discretion of the President of the United States. This provision afforded a means for the honorable retirement of older officers and the advancement of younger officers better fitted for duty in the field. The law was interpreted with respect to its effect upon each individual rather than the improvement of the service as a whole. For this reason it was used much less frequently than could have been the case, primarily because of an assumption that some stigma is attached to a retirement of this nature. Moreover, during some portions of its existence it was virtually inoperative because of the limitation upon the number of retired officers. The discretionary power vested in the President was at times troublesome; personal and political considerations not always being avoidable.

An act approved December 21, 1861, made retirement for officers of the Regular Navy compulsory upon reaching the age of 62 or upon the completion of 45 years' service. An attempt at that time to make such conditions for retirement applicable to the Army was defeated, and similar proposals during the next 20 years also failed. However, in the act of June 30, 1882, it was provided that every officer of the Regular Army be retired upon reaching the age of 64 years. One effect of the provision for compulsory retirement at 64 years of age was to render virtually inoperative the provision of the act of July 17, 1862, that the President might, at his discretion, retire officers over 62. It soon became the practice to permit elderly officers to remain in active service until they reached the age of 64. This practice strengthened the belief that enforced retirement was evidence of inefficiency.

FROM 1870 TO WORLD WAR II AND BEYOND

Post-Civil War legislation, 1870–1900.—Economy rather than desire to promote efficiency is reflected in the legislation enacted in 1870. The strength of the Regular Army was fixed at 30,000 enlisted men and approximately 2,200 officers with reduction in size to be accomplished by discharge, muster-out, and retirement. These changes and modifications in the retirement system were incorporated in the appropriation act of July 15, 1870. Retirement at the discretion of the President was authorized for officers upon their application after 30 years' service and the number on the retired list was left up to the President but could not exceed 300. The action taken concerning the Army appears to have been designed solely to meet an existing situation, one problem of which was the disposition of nearly 500 surplus officers. The general principle of retirement, its merit and fundamental aim, received little attention. The interests of the general public seemed to be subordinated to the desires of individuals with a special interest in this legislation.

The legislation enacted in 1870 continued the principle of limiting the number of retirements on account of incapacity for active service. In January 1872, the retired list had reached its authorized maximum and it again became necessary to retain on active duty officers who were disabled or should for other reasons have been retired.

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The act of March 3, 1883, marked the inception of the so-called unlimited retired list upon which were placed officers retired at the age of 64 or after 40 years of service. The conditions of a limitation upon the retirement of physically incapacitated officers and those over 62, whom the President believed should be retired, was retained and it remained impossible to retire all incapacitated officers from service. In the act of February 16, 1891, legal recognition was given the limited and unlimited retired lists by providing that all officers upon the limited list be transferred to the unlimited list upon attaining the age of 64. The unlimited retired list was further enlarged by a provision in the act of September 17, 1919, that officers retired for physical disability be placed on the unlimited retired list.

The necessity for eliminating from the service officers who became physically unfit received further recognition in the act of October 1, 1890. Provision was made that if an officer, examined for promotion, were found incapacitated for service by reason of physical disability contracted in line of duty, he should be retired with the rank to which his seniority entitled him to be promoted.

In 1898, then, the three existing laws with respect to retirement of officers of the Regular Army provided for a limited retired list of 350 including those officers over 62 years of age or with over 45 years' service who were retired by the President, officers of over 30 years' service whose applications for retirement were approved by the President, and officers found by retiring boards to be incapacitated. There was also an unlimited list comprising officers of over 40 years' service who applied for retirement, officers transferred from the limited list or retired upon reaching the age of 64, and officers found physically disqualified for promotion. Under these retirement laws the United States entered the Spanish-American War with a Regular Army in which old, incompetent and, in some cases, incapacitated officers remained and in which promotion of the competent had been blocked. Interest in the retirement of enlisted men was apparently either nonexistent or suppressed. These volunteers were left to fend for themselves, which meant that they might qualify for benefits under the various pension laws designed to benefit veterans of the citizen army serving in times of special emergency. The disabled enlisted Regular could qualify if he happened to serve at a time which coincided with a period that Congress had considered deserving of recognition.

Male commissioned officer retirement legislation 1900–49.—After the turn of the century there was a growing tendency in the Military Establishment to reward long service by advancing officers to the grade of brigadier general before their retirement. From 1901 to 1905, 149 general officers were retired, some of whom served only 1 day in grade as a general officer. As a result of this practice Congress in 1906 inserted in an appropriation bill a clause providing that no officer holding a rank above that of colonel might be retired except for disability or on account of having reached the age of 64 unless he had served at least 1 year in such rank. In effect, this law proved a limitation with respect to other statutes providing for the retirement of officers of the Regular Army for length of service.

The period of 20 years following the Spanish-American War produced virtually no change in the system of retirement for officers of the Regular Army. There continued to be some accumulation of

officers on the active list whose retention prevented the promotion of younger officers with greater physical vigor and stamina.

Immediately after World War I the question arose as to why disabled emergency officers should not receive benefits comparable to those of Regular Army officers who had suffered disabilities under the same conditions. The former were entitled to benefits under the War Risk Insurance Act, whereas the latter received three-fourths of the Regular pay and allowances upon retirement. These emergency Army officers were the only ones who had not been retired for disability, all Navy and Marine Corps officers—Regular, emergency, and provisional—having been thus retired. The emergency Army officers alone (of the nine classes of officers who served) had been left to draw less liberal benefits under the War Risk Insurance Act, and in this sense it might be said that there was discrimination against them. Attempts were made to influence legislation for disability retirement pay for emergency officers on the grounds that they had performed the same function as Regular Army officers and should, therefore, be similarly retired after the war at three-fourths of their regular pay and allowances.

Opponents of this position pointed out that retirement for an officer of the Regular Army was part of his contract and functioned to overcome disadvantages which might be connected with the life of a professional soldier. The emergency officer had not chosen to be a professional; there was no contract, either expressed or implied, that he would receive retirement pay. It seemed more sensible to group the emergency officers and the emergency soldiers together rather than to consider the Regular officers and emergency officers in the same category.[5] The American Legion took the stand that all disabled officers should be treated alike because the average age of disabled officers was much greater than that of enlisted men and the officers had carried greater responsibility during the war.

In the wake of the controversy, a bill covering emergency officers 30 percent or more disabled and providing retirement at 75 percent of pay and allowances at time of separation was passed by Congress in 1928. However, it was vetoed by President Coolidge on the following grounds: (1) The distinction between officers and men was invidious and contrary to established principles for World War I veterans; (2) the bill discriminated against officers who suffered disabilities of less than 30 percent; and (3) the program would be too expensive. The President's veto was overridden.[6]

It was anticipated that about 3,000 badly wounded officers, for the most part young lieutenants who led platoons through fierce machine-gun fire in the Argonne Battle, would benefit from the legislation. But the language of the act was too general and, as a result, former officers with disabilities of presumptive or statutory origin found their way to the retirement list. In 1929 there were 4,243 emergency officers receiving retirement pay; in 1932, the number reached a peak of 6,415. Benefits were curtailed greatly by the Economy Act of 1933; by 1940 the number on the roll had decreased to 1,784.[7] With the inclusion of provisional, probationary, and temporary officers of

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[5] See below, p. 65.

[6] Dillingham, William P., Federal Aid to Veterans, 1917–1941, Gainesville, University of Florida Press, 1952, pp. 174–177.

[7] Ibid., p. 180, Citing Administrator of Veterans' Affairs, Annual Report, 1941, pp. 53, 56.

World War I,[8] there was an increase in the number receiving this type of retirement pay. As of June 30, 1955, there were 1,789 emergency, provisional, probationary, or temporary officers of World War I receiving retirement pay.[9] Evidence of the cleavage in administration as between civilian and military is the fact that the amounts of pay are determined on a service basis, while the payments are made by the Veterans' Administration.

Following World War I, attention was refocused upon retirement problems of the Regular Establishment. In section 24 of the act of June 4, 1920, provision was made for the classification of all officers of the Regular Army into either class A or class B. Officers finally placed in class B were to be separated from the service in the following manner: (1) By retirement if having over 10 years' service; (2) by honorable discharge, with 1 year's pay if having less than 10 years' service; or (3) by discharge, if such classification was found to be due to neglect, misconduct, or vicious habits. Because this law directed attention to the debilitating aspects of age, it stands out as different from a series of legislative enactments which assumed that an officer had permanent tenure in office during good behavior until 64 years of age.

Under the act of July 31, 1935 (as amended by the act of June 13, 1940), provision was made for officers with 15 years' service to be retired at the discretion of the Secretary of War upon their own application. Movement toward a system of involuntary retirement was taken by the act of June 13, 1940, which provided for the retirement, commencing June 30, 1942, of all brigadier generals of the line at 62 and of all promotion-list officers (other than general officers) at 60, except for a small percentage of colonels specifically authorized to be exempted by the Secretary of War. Furthermore, the act of July 29, 1941 (a temporary law in effect during World War II), provided for removal from the active list by the Secretary of War of any officer whose performance of duty or general efficiency compared unfavorably with other officers of the same grade and length of service, or whose retention on the active list was not justified for good and sufficient reasons. Officers who had less than 7 years' service and were removed under this authority were discharged, and those having 7 or more years of service as an officer were retired.

Retirement for enlisted men and warrant officers, 1900–49.—Although motivated in part by the same considerations as are applicable to officers of the Regular Army, less legislation has been directed to the retirement of enlisted Regulars. Mention has been made of some of the legislation relating to the retirement of enlisted men up to 1861. The act of February 14, 1885, provided for retirement after 30 years' active duty. This concept was carried on in the act of March 2, 1907, which provided for the retirement of any enlisted man who served 30 years in the Army, Navy, Marine Corps, or in all, upon his application to the President.

Retirement of Army enlisted men on account of physical disability was authorized by the act of June 30, 1941. Thus enlisted men of long service who suffered physical disability in line of duty would be entitled to retirement benefits similar to those which for many years

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[8] Public Law 746, 76th Cong., approved July 18, 1940.
[9] Administrator of Veterans' Affairs, Annual Report, 1955, p. 240.

had been granted to officers. But an enlisted Regular of less than 20 years' service who became permanently incapacitated was discharged without retirement pay. He was then free to apply for disability benefits under laws administered by the Veterans' Administration. Navy and Marine Corps enlisted Regulars, on the other hand, were not given the same right, but continued to be eligible only for veterans' benefits.

The peculiar position of warrant officers (that is, whether they should be treated for retirement purposes as enlisted men or commissioned officers) was partly resolved by the act of July 9, 1918, under which warrant officers of the Army Mine Planter Service were retired as provided by law for officers of the Regular Army. Later legislation provided that all other warrant officers would be entitled to retirement under the same conditions as commissioned officers.

Retirement for regular nurses, 1890–1949.—The act of August 5, 1892, granted service pensions to Army nurses of the Civil War who had served 6 months and had been honorably relieved from the service provided they were unable to support themselves. Members of the Army Nurse Corps and the Navy Nurse Corps were eligible for disability compensation under the War Risk Insurance Act Amendments of 1917. These benefits were provided out of the legislation applicable to all bona fide veterans and were separate from those provided in the established career service.

The Army Nurse Corps became a permanent part of the Regular Establishment on February 2, 1901, but the first legislation providing retirement benefits based on age and length of service was the act of May 13, 1926. This law permitted the retirement of nurses, at the discretion of the Secretary of War, after 30 years' service or upon attaining 50 years of age with 20 years' service. Subsequently retirement for physical or mental incapacity, upon a finding by a board of medical officers that the nurse had become disabled in line of duty, and approval by the Secretary of War of such a finding, was for the first time extended to nurses by the acts of June 30, 1930, and October 17, 1940.

The situation prior to the enactment of the Career Compensation Act of 1949.—The principal legislative developments of the 19th and early decades of the 20th century having been outlined, it would be well to summarize the features of the system relating to disability retirement that existed through the close of World War II.[10]

Disability benefits were available to all officers and to enlisted men having 20 years or more service, upon permanent incapacity for military service in line of duty. No means existed for relating the amount of retired or retirement pay paid to the actual degree of disability for civilian pursuits. No provision was made for periodic checks on those in receipt of disability benefits to determine whether changes had taken place in their condition. There was a wide disparity between the treatment of: (1) Officers; (2) enlisted men with 20 or more years' service; and (3) enlisted personnel with less than 20 years' service. Upon separation for disability, the latter group could go to the Veterans' Administration and receive compensation proportionate

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[10] For details of the existing military retirement system see Brannon, Thurza J., Outline of Federal Retirement Systems (U. S. Social Security Administration, Bureau of Research and Statistics, Bureau Report No. 15, 1948), pp. 77–109.

to their disability only so long as they remained disabled. The seriousness of the problem resulted from the fact that the number of officers of civilian components being separated for disability was rapidly increasing. Thus, immense payments were scheduled to be made in future years to persons whose ability to earn a livelihood might have been little impaired.

Changes in the laws were needed to correct certain obvious defects. Should pay or benefits for disability be on an all or none basis? Or should they be based upon the amount of impairment that would prevent the career person from sustaining himself in civil life? What should be the considerations with respect to rank and length of service? Questions of this nature were in the vanguard of the action which culminated in broadened legislation for the career person in uniform.

THE CAREER COMPENSATION ACT OF 1949

The Career Compensation Act[11] encompasses the subjects of pay, allowances, and retirement for members of the "uniformed services," namely, the Army, Navy, Air Force, Marine Corps, Coast Guard, Coast and Geodetic Survey, Public Health Service, National Guard, Air National Guard, and the Reserve components. Title IV of this legislation, toward which this analysis is directed, includes separation, disability retirement, calculation of retirement pay, and severance pay for disability.

Any member of the uniformed services found to be unfit to perform the duties of his office, rank, grade, or rating by reason of disability and found qualified may be retired on the temporary disability retired list (TDRL), or the permanent disability retired list (PDRL), or be separated from the service with severance pay.

The following conditions must be met before the Secretary of the appropriate department may place a person's name on a disability retirement list: (1) The individual must be a member of the Regular services, or a member of a Reserve component who has been ordered to extended active duty for over 30 days, and be unfit to perform the duties of his office, rank, grade, or rating by reason of disability; (2) the impairment must not be due to intentional misconduct or willful neglect or incurred during unauthorized absence; (3) it must be at least 30 percent as measured by the Schedule for Rating Disabilities of the Veterans' Administration; (4) the disability must be the proximate result of the performance of active duty; and (5) (*a*) if the disability is shown to be of a "may be permanent" nature according to accepted medical principles, the member's name is placed on the TRDL; (*b*) if it is of a "permanent" nature his name is placed on the permanent list. If the person's disability is rated at less than 30 percent, he is not eligible for disability retirement but instead is given severance pay.

Any disability shown to have been incurred during a period of active duty in time of war or national emergency is considered to be the proximate result of the performance of active duty. When there is no war or national emergency this provision concerns those with less than 8 years of service. If the disability is in line of duty but not the proximate result of the performance of active duty, the member with less

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[11] The discussion which follows is based directly on this act, Public Law 351, 81st Cong. (37 U. S. C. 271 et seq.).

than 8 years' service is entitled only to severance pay, even though his disability is 30 percent or more. Thus, for members qualifying for retirement pay or severance pay as a result of having served on active duty for 8 years, or longer, there is no requirement that the disability be the proximate result of active duty.

Persons who have served less than 30 days, and meet the requirements (2), (3), and (5) enumerated above, and who also incur an injury as the proximate result of the performance of active duty, full-time training duty, other full-time duty, or inactive duty training are entitled to disability retirement pay, if the impairment is found to be 30 percent or more. If the disability is determined to be less than 30 percent the member is entitled to severance pay.

A person on either the temporary or permanent disability retired list is entitled to receive disability retirement pay calculated by multiplying his monthly basic pay by (1) the number of years of active service (not to exceed 30) multiplied by 2½ percent, or (2) the percentage of his disability as of the time his name was placed on the temporary disability retired list or at the time of retirement, whichever is greater.[12]

Some of the basic thinking in deriving the first formula has been stated as follows:

> * * * For a great many years it has been the practice to retire an officer who is found physically incapable of active military service, and pay him a compensation equal to 75 percent of his base and longevity pay. No differentiation was made as to the actual degree of the disability, so long as it was sufficient to constitute an incapacity for active service. Nor did retirement practices extend to the enlisted grades, as a whole. The proposed legislaton would relate the amount of compensation to the degree of disability, and would establish an incapacity of 30 percent as the minimum which would qualify the individual for retirement. A lesser degree of incapacity is compensated by the granting of lump-sum "serverance" pay instead of long-term retirement pay. Further, the principle of retirement for physical disability is extended to the enlisted grades on the same relative basis as is applied to the commissioned grades.[13]

The effect of having two formulas can be illustrated by considering the active duty pay and longevity pay of a colonel with over 26 years' service, $780 per month. Assume he is 50-percent disabled. He may collect either 26 times 2½ percent of $780 or 50 percent of $780. It can be seen that in this case he would obtain more under the first method of computation (65 versus 50 percent). If he were 90-percent disabled, it would be to his advantage to use the second formula (65 versus 75 percent maximum). These formulas were intended to establish an equitable retirement system which would avoid abuses such as the kind which permitted retirement at 75 percent of pay by officers with minor disabilities. They differ from the formula for computing the amount of disability compensation under the Veterans' Administration which (1) offers no election, and (2) provides for payments according to a flat schedule based on degree of disability rather than according to rank. A colonel with 26 years' service or a private with 26 months' service would receive the same amount ($91 per month) for a 50-percent disability. Moreover, the Veterans' Administration does not maintain a temporary disability list, although

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[12] Public Law 351, title IV, sec. 402. However, persons on the TDRL are accorded a minimum of 50 percent of base pay.

[13] U. S. Congress. Senate. Career Compensation Act of 1949, Hearings Before the Committee on Armed Services on H. R. 5007, 81st Cong., 1st sess. (1949), p. 353.

the concept of rating subject to reexamination and, consequently, increasing or decreasing the award would seem to bear a resemblance to the military system.

When a person's name is placed on the temporary disability retired list, several other considerations should be recognized. In computing length of service, the fractional part of a year which is 6 months or more is counted as a whole year. The temporary disability retired pay cannot exceed 75 percent of the basic pay upon which the computation is based. On the other hand, it cannot be less than 50 percent of the basic pay as long as the member's name is carried on the temporary list. The disability retirement pay of any member who held a temporary rank, grade, or rating higher than that held at the time of the placement of his name upon the temporary disability retired list or at the time of his retirement and who served satisfactorily in the temporary position is computed on the basis of the monthly basic pay of the higher position. If the disability is found to exist as a result of a medical examination given in connection with a promotion, the disability retirement pay is based upon the basic pay of the higher position to which the person would have been promoted.

Furthermore, if while in retired status a member were called to active duty and incurred a disability of 30 percent or more, he would be entitled, on his return to the retired list, to receive either (1) disability retirement pay, using as multipliers the highest percentages of basic pay which he attained while serving on active duty, or (2) retirement on the basis of any law in effect at the time. If a person is promoted, and has served satisfactorily during a period of active duty, to a rank, grade, or rating higher than that on which his disability retirement pay was based, he is entitled, on resuming his prior status to disability retirement pay computed on the basis of the higher position. This is a principle which also applies to nondisabled retirees who may be called for periods of active duty.

Persons whose names are placed upon the temporary disability retired list are given periodic physical examinations at least every 18 months, to determine whether there is any change in their condition. If, as a result of any of these examinations, or upon termination of the 5-year period, it is determined that the physical disability is of a permanent character and is found to be 30 percent or more, the person's name is transferred to the permanent disability retired list. Thus, he would receive disability retirement pay as computed by the formulas mentioned above, with the percentage of his disability determined as of the time of his permanent retirement and not when examined earlier.

On the other hand, if, as a result of any of the examinations during or upon termination of the 5-year period, the disability is rated less than 30 percent, the individual's name is removed from the temporary disability retired list and he may be separated from the service, at which time he is entitled to receive severance pay. Severance pay is an amount equal to 2 months of basic pay, multiplied by the number of years of active service, but not to exceed a total of 2 years of basic pay.

In computing length of service, the fractional part of a year, which is 6 months or more, is counted as a whole year. Also as in disability retirement pay, the severance pay of a person who served temporarily in a rank higher than the one held at separation is computed on the basis of the monthly basic pay of the higher position. Likewise, if

impairment is found to exist as a result of a physical examination given in connection with a promotion, the disability severance pay would normally be based upon the higher position to which the person would have been promoted except for the disability.

In cases where the separated serviceman or his dependents may be eligible for compensation from the Veterans' Administration, the amount of severance pay would be deducted from any compensation for the same disability, but no deductions would be made from any death compensation to which his dependents may become entitled subsequent to his death.

Any member of the uniformed services whose name is placed upon the temporary disability retired list may be required to submit to periodical physical examinations during the period in which his name is carried on the list. Failure of any member to report for a periodic physical examination would be sufficient reason for terminating his disability retirement pay, except that payments would be reinstated if just cause existed for the failure to report. A travel and transportation allowance (based upon the position while on active duty) is authorized for persons reporting for physical examinations.

If, as a result of a periodic physical examination, a Regular who has been on the temporary disability retired list is found to be physically fit to perform appropriate duties, he is (subject to his consent): (*a*) If an officer, called to active duty and reappointed to the active list of his Regular component; or (*b*) if an enlisted man, is reenlisted in his Regular component. Similarly, a member of a Reserve component who is found physically fit would, subject to his consent, rejoin his Reserve component. In the case of Regular commissioned officers, a special condition prevails. The President, by and with the advice and consent of the Senate, authorizes reappointment. With reference to Regular warrant officers, however, the President or Secretary concerned would authorize reappointment, senatorial advice and consent not being required.

Irrespective of vacancies in any grade, the authorized number of officers for a grade may be temporarily increased to absorb changes arising from the removal of names from the temporary disability retired list. A person who recovers from his disability may be returned to a position not lower, and may be placed immediately above the rank, grade, or rating which he permanently held at the time of the placement of his name on the termporary disability retired list. Likewise, if seniority is a factor in qualifying a recovered member for future promotion, he may be given seniority in rank or credited with years of service insofar as the Secretary is authorized to give. Action in these regards is to be taken on a fair and equitable basis, and attention is given to the probable opportunities for advancement to which a member might reasonably have become entitled except for the placement of his name upon the temporary disability retired list.

If a person recovers from his disability and is found physically fit to perform the duties of his position, his name is removed from the temporary disability retired list. If the person is an officer of a Regular component, his name is removed from the temporary disability retired list and his disability retirement pay is terminated on the date of his reappointment to the active list. If he is an enlisted person of a Regular component, both his status on the disability retirement list

and his disability retirement pay terminate on the date of his reenlistment in the Regular component from which he was placed on the temporary disability retired list. If the individual was a member (officer or enlisted) of a Reserve component, his status and his disability retirement pay are terminated on the date of his reappointment or reenlistment in a Reserve component, as the case may be. If a member does not consent to an appointment, reappointment, enlistment, or reenlistment, if found by a physical examination to have recovered from his disability, his status on the temporary disability retired list and his disability retirement pay is terminated as soon thereafter as practicable.

Any former member who has been separated for physical disability from any of the uniformed services and paid disability severance pay, unless he again becomes a member of the uniformed services, is not entitled to receive payment for any monetary obligation provided under any provision of law administered by any uniformed service or for such uniformed service by any other uniformed service on account of or arising out of the member's service on or prior to his separation. The separation does not operate to bar the former member from receiving, or the service from paying, money due on the date of separation or money that becomes due as a result of a valid claim processed against the Government pursuant to any provision of law.

There are several other areas in the Career Compensation Act which are in contrast with earlier legislation and which are important principles in the military disability retirement system as it now operates.

(1) Any member of the Regular or Reserve components of the Armed Forces who has completed at least 20 years of satisfactory Federal service and who is otherwise qualified to be retired for physical disability except that his disability is less than 30 percent may, in lieu of being separated under title IV of the Career Compensation Act, be transferred to the inactive status list of the service concerned and granted retired pay upon attaining the age of 60, if he is eligible in all other respects to be granted retired pay. That part of the disability retirement pay computed on the basis of percentage of disability is tax-free, while any additional retirement pay on the basis of years of active service is taxable income for income-tax purposes. All members of the Reserve components who are retired or granted retirement pay because of physical disability are entitled to the same pay, rights, benefits, and privileges provided by law or regulation for retired members of the Regular services.

(2) Similar to the Veterans' Administration rating system, which includes disqualification for disability compensation on account of misconduct, when a member of the uniformed services incurs a physical disability which is determined to render him unfit to perform the duties of his office, rank, grade, or rating and which is determined to have resulted from his intentional misconduct or willful neglect, or was incurred during a period of unauthorized absence, such a member is separated from his service without entitlement to severance pay, disability retired pay, or any of the benefits of title IV of the Career Compensation Act.

(3) Any member or former member of the uniformed services, including Army and Navy nurses, who was retired or was en-

titled to receive retired or retirement pay for disability prior to the passage of the Career Compensation Act and who applied within 5 years after the passage of the act could have received disability retirement pay or disability severance pay under the provisions of the act, using the Veterans' Administration Schedule for Rating Disabilities.

PROCESSING OF PHYSICAL DISABILITY SEPARATIONS [14]

The purpose of this section is to study the present system of separations as it is being executed by the various military services in order to learn how the Career Compensation Act of 1949 has operated for its first 6 years; to point out how differences in basic concepts, opinions, interpretations, definitions, and experience lead to various methods of practice with resulting complaints, dissatisfaction, and inequities; and to show the interrelationship of the Career Compensation Act with the practices and entitlements involving the Veterans' Administration.

Before October 1949, an officer, or an enlisted man with 20 years of service, when found permanently incapacitated for service because of a disability, could be retired at 75 percent of his basic pay. The severity and the nature of the disability could vary considerably. Retirement was a permanent action, and once retired, the recipient was entitled to his pay for life. At the close of World War II, using the basic finding of "incapacitated for military service," many officers, mostly Reserve, were being retired and it was apparent that a large percentage of those retired had diseases, defects, or disabilities which were not severe or which might considerably improve or recover completely. In these cases the loss of ability to earn a livelihood in civil life would not appear to be, and was not, commensurate with the monetary benefits derived from the retired pay.

Since so many officers were involved, this method of retirement was indeed expensive and obviously unfair. The Career Compensation Act was designed to improve the retirement procedure so that it would apply to all military personnel alike, and would be based upon the principle that lesser pay would be given for lesser disabilities. The primary requirement of the law is that the member "is unfit to perform the duty of his office, rank, grade, or rating by reason of physical disability." No further definition is given of the term "unfit," the amplification of this term being left to the various departments. This is a most important point and it will be discussed later. The law provides other requirements and outlines the methods or formulas for computing the various retirement pay or benefits.

Implementation by the Services

The details of carrying out the provisions of the Career Compensation Act were left to the Secretaries of the Armed Forces. The procedures are set forth in regulations and other directives as noted above. There are only a few minor variations. When a member develops a

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[14] This discussion based upon the following: Med. Serv., Standards of Fitness and Unfitness for Retention on Active Duty (Army Regs. 40–504), pp. 4–5. Manual for Courts-Martial, U. S. Naval Supp., Disposition of Cases of Physical Disability (ch. IX, effective from December 1, 1955), pp. 137–138. Physical Evaluation for Retention, Retirement, and Separation of Military Personnel (Air Force Manual 35–4), p. 2.

disability and separation from the service is considered certain, or probable, the following boards take action:

1. *Medical board.*—These boards operate at the hospital level; each board consists of three medical officers. It may send the member back to duty, or recommend his appearance before a physical evaluation board.

2. *Physical evaluation board.*—This board operates at selected hospitals: (Army, 13; Navy, 11; Air Force, 5). It consists of 3 members (1 medical) and makes recommendations relative to (*a*) fitness or unfitness, (*b*) eligibility for compensation, (*c*) percentage rating of disability, and (*d*) type of disposition. These recommended findings are forwarded to the physical review council.

3. *Physical review council.*—Operates at Headquarters level in Washington. All physical evaluation board proceedings are reviewed at this level. The council therefore is very important for its stabilizing effect on all cases being processed. Roughly, 90 percent of the physical evaluation board findings are concurred in and the cases disposed of as recommended. In those cases in which the physical review council makes revised recommended findings, less favorable to the individual, he is so notified. If he does not concur with the recommended change, his case then goes to the appeal board.

4. *Physical disability appeal board.*—This board also operates in Washington and usually consists of 5 members (2 medical). Its findings and recommendations are final when approved by the Secretary of the appropriate Department.

The above steps complete the processing that may take place prior to separation from the service for reasons of disability. Beyond these steps, however, there is additional recourse to the Board of Correction of Military Records. This board, though not designed primarily to handle disability cases, is now hearing an increasing number of them. It likewise operates in Washington and consists of five civilian members. (See charts I and II.)

CHART I

Flow chart of patient

Hospital →	1. Well or cured. Return to duty. 2. Develops a disability or defect which disqualifies for general service. 3. Died.	→	1. Ward officer considers member still effectively retainable, to duty with or without waiver.* 2. To Medical Board. 3. Separate under EPTS procedures, not aggravated.	→	1. Effectively retainable, to duty with or without waiver.* 2. Forward to physical evaluation board.	→	1. Effectively retainable, to duty with or without waiver.* 2. Rating less than 30 percent. Separate with severance pay. 3. Rating 30 to 100 percent disability, "may be permanent", put on temporary list. 4. Rating 30 to 100 percent disability is "permanent", put on permanent list. 5. Disability is EPTS not aggravated. Separate without severance pay.	Reexamine in 18 months or less. →	1. Fit. Remove from temporary list, with privilege of returning to duty. No more pay. 2. Rating less than 30 percent. Separate with severance pay. 3. Return to the temporary list. 4. Rating 30 to 100 percent and disability now considered permanent in nature. Place on permanent list.	→ Reexamine in 18 months and dispose of as before. →	Before end of 5 years on the temporary disabled retired list, must dispose of as: →	1. Fit as before. 2. Severance pay. 3. Permanent list.

*Upon termination of service, these cases will be carefully reexamined and if not qualified for general service, will be considered by the physical evaluation board before separation.

Source: U. S. Department of Defense.

CHART II

Flow chart of medical records

Medical board report → Physical evaluation board →

1. Informal board. Considers record makes findings, which are given to member for concurrence. If member does not concur requests a formal board.
2. Formal board. Same but member or counsel or both are present.

→ If member does not concur with physical evaluation board finding, he or counsel may submit a rebuttal which is sent on with the record for consideration by the physical review council. → Physical review council action →

1. Concur with physical evaluation board or make minor change and separate.
2. Concur with physical evaluation board regardless of rebuttal.
3. Does not concur with physical evaluation board, makes revised recommended findings, which are to the disadvantage of member.
   1. Member concurs. Separate.
   2. Member submits rebuttal, case is reconsidered by physical review council and →
      1. Concur with member. Separate.
      2. Send to physical disability appeal board for final action and disposition.
4. Does not concur with physical evaluation board, makes changes in favor of member. Separate.

After separation appropriate cases can be heard by the board for correction of military records or by the Air Force disability review board.

Veterans' Administration may process case.

Source: U. S. Department of Defense.

The physical review council, the physical disability appeal board and the board of correction of military records each have the authority to act upon any one of the various findings recommended by the physical evaluation board.

DISPOSITION POLICIES FOR MEMBERS WITH DISABILITIES

Clearly defined physical standards are established for acceptance of the individual into the service. If he does not qualify, he is not accepted. Once in the service a member may develop many conditions which would have been disqualifying at the time of original acceptance. After an impairment has taken place his condition is evaluated and a decision must eventually be made as to whether he is retained or separated for disability. The policy of the three services is generally the same—efficient utilization of the individual. Those cases in which retention is not deemed advisable are classified as "unfit" and are separated. A comparison of the definitions or descriptions of "fitness" and "unfitness" in the three services shows that they are not the same. In application, therefore, wide variations in separation actions may be the expected result.

Regulations of the Army provide that:

> * * * Each member's case will be considered on its individual merits, the object being to aid in the determination of whether or not an individual is physically or mentally qualified for further military service.
> * * * Most members possess some physical imperfections which are recorded in the Veterans' Administration schedule for rating disabilities, but [the Career Compensation Act] does not provide rights or benefits for physical disability to members who are not determined to be unfit, regardless of the percentage of disability under that schedule from a single disability or accumulation of disabilities. The fact that a member has physical disability which is ratable in accordance with the Veterans' Administration schedule for rating disabilities must not be considered a guide in judging fitness or capacity to perform active duty, but this determination is based wholly on the individual's physical and mental capacity to serve in the military service. The presence of ratable disabilities, though not causing unfitness [under the Career Compensation Act], may provide rights and benefits under laws administered by the Veterans' Administration and should be made a matter of record whenever discovered.* * *[15]

The Navy Department in its provision for disposition of cases involving physical disability states that:

> In the absence of convincing evidence to the contrary, a party before a physical evaluation board is presumed fit and physically qualified to perform the duties of his rank, grade or rating. The presence of physical disability or the fact that the party concerned is currently on the sick list or hospitalized does not necessarily require a finding of unfitness for duty. If the board is of the opinion that the party concerned will be fit for duty after a reasonable period of time, such party should be considered as fit for duty. On the other hand, a finding of unfitness for duty is to be made when the evidence discloses that the member is not physically capable of performing all the duties of his rank, grade or rating to a degree that would reasonably fulfill the purposes of his employment.[16]

The Air Force defines unfitness as:

> Physical inability to perform the duties of the office, rank, or grade held, which are required during the performance of full military duty, field as well as garrison, in both peace and war.[17]

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[15] Army Regulations 40–504, section 1.
[16] Navy Supplement to the Manual for Courts-Martial (1955) chapter IX, section 0913d (1).
[17] Air Force Manual 35–4, chapter 1, paragraph 1, n.

The policies of the three services as recently expressed concerning the retention and utilization of members with defects, disabilities or handicaps, are presumed carried out by the application of fitness criteria which include the following:

1. *Army.*—In evaluating physical disabilities * * * the standards prescribed * * * will be liberally interpreted * * * thus members may be found qualified for retention on active duty even though they have diseases, injuries, or infirmities which would disqualify them for original appointment or enlistment, provided that such diseases, injuries, or infirmities are—

(1) Of such nature and degree as not to affect adversely the performance of continued duty on any assignment commensurate with the individual's grade or rating including assignments to positions which may be held by an individual regardless of his basic branch.

(2) Not subject to complications or serious aggravation by reason of continued active duty.[18]

In cases where the person's condition is such that his fitness for full duty cannot be evaluated without some convalescence the individual would be retained on a trial duty basis for a limited period of time in order that an appropriate evaluation of the impairment be made.[19]

2. *Navy (extract of policy supplied by Department).*—As a general rule the Navy does not consider it practicable or efficient to retain large numbers of personnel in service who are not fully qualified to perform their duties both ashore and afloat. Therefore, disabled Navy members usually are separated from service under the authority of and with benefits provided by title IV of the Career Compensation Act of 1949. However, in those cases wherein the individual is not fully qualified to perform all his duties ashore and afloat it is the policy of the Navy to retain such individual in a limited-duty status under certain conditions, as follows: (1) If the services of the individual can be effectively utilized; and (2) the individual desires to remain in the service; and (3) retention on duty will not aggravate the disability or jeopardize the health or safety of his service associates and provided the disability is a result of combat injury or the result of prisoner-of-war status, or occurs after completion of 18 years of service and is ratable at less than 30 percent.

In addition, certain individuals are retained to perform specific jobs because they possess unique skills even though the person concerned is not fully qualified to perform unrestricted duty. In cases wherein the individual's condition is such that his fitness for full duty cannot be evaluated accurately without a reasonable period of convalescence, it is the policy of the Navy to retain such members in a limited duty status for periods of 3 to 12 months in order to more accurately evaluate residual functional impairment. The policy and practices of the Navy have not changed significantly in the last 5 or 10 years. * * * at the present time the Navy does not have a broad retraining program designed to utilize partially unfit personnel. In this regard, it has been the view of the Navy for many years that it is not feasible to undertake such a program, primarily because of the limited number of shore duty billets available under the best of circumstances, and considering that if these few billets were occupied by persons who by virtue of physical infirmities were unable to perform sea duty, the inevitable result would be that the physically fit would always be afloat with little hope of being periodically rotated to shore duty. It is apparent that if shore billets were filled with limited duty personnel it would create a serious, if not disastrous, effect on the recruiting and reenlistment program.

3. *Air Force (extract).*—The policy pertaining to retention on active duty consists basically of gainful economic utilization of the individual with his disability. If he can be utilized without becoming a problem in treatment or assignment he may be retained—retraining will depend upon many factors such as experience, length of service, and motivation. The procedural requirement follows:

> For Continued Performance of Duty * * * appropriate consideration will be given to a person's records of performance of duty, age, grade, and

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[18] Army Regulations 40–504, section 1, paragraph 2, b. See also AR 616–41.
[19] Army Regulations 40–680.

> military specialty. Trained and experienced personnel will not be summarily disqualified. Their value to the service and future capabalities must be carefully considered. However, a person will not be found fit for the performance of duty unless he is physically capable of performing duties commensurate with his grade, experience, and training, at stations throughout the world. For air crew members the physical standards will be interpreted so as not to compromise flying safety, the efficient performance of flying duty, or the member's well-being.[20]

All agree that if manpower can be effectively used the individual may be kept in the service.

As a measure of what happens in actual practice, physical disability separation statistics are interesting to compare. They are the direct result of separation actions taken presumably in accordance with existing directives of the three services.

Charts III and IV show the separations in the armed services for each of the 5 years, 1950–54. The upper line shows the total, with the lower line showing those processed through the retirement system. The differences represent those separated under abbreviated methods for disabilities which existed prior to enlistment. The Army had by far the largest number and the Air Force the least.

Since the number of personnel in each of the services is not the same, other comparisons must be made. In chart V the total disability separations per 1,000 of personnel are show for this same period. Here again, there are some marked differences. Several obvious yet important factors that may result in an increase or decrease in the number separated are listed below:

1. *Selection or qualification standards.*—The higher the acceptance standards the fewer will disabilities of the existed-prior-to-service (EPTS) variety be found. In the Air Force, for example, it can be shown that those disabilities which result in separation occur much less frequently for officers, who must meet higher acceptance standards.

2. *Length of service of each member.*—Short enlistment periods and low rates of reenlistment necessitate processing larger numbers of recruits. It is in this population that the greatest loss occurs due to disabilities existing prior to service (EPTS). (See chart VI.)

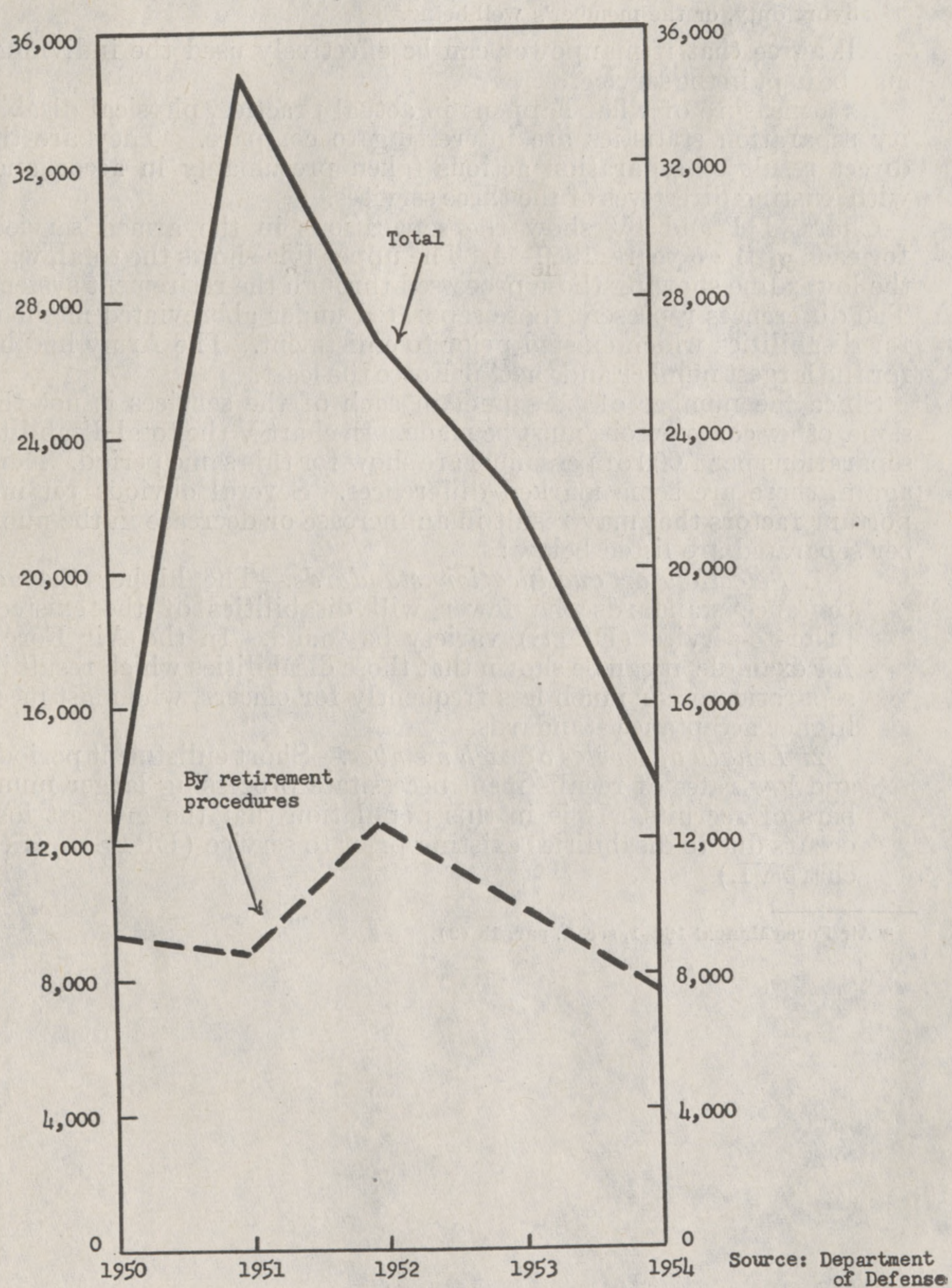
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[20] Air Force Manual 160–1, sec. 1, par. 1b (2).

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CHART III

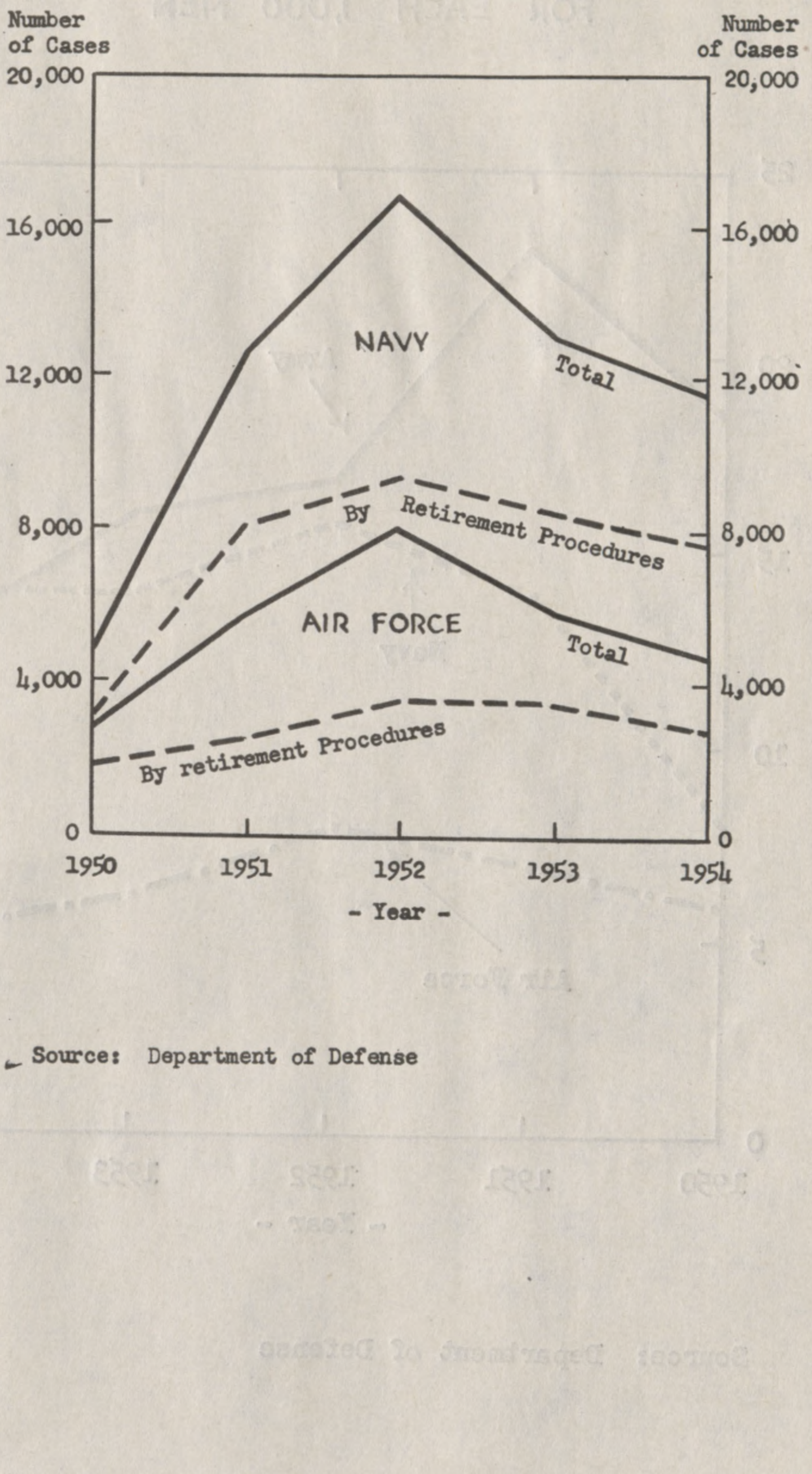
ARMY PHYSICAL DISABILITY SEPARATIONS



Source: Department of Defense

CHART IV

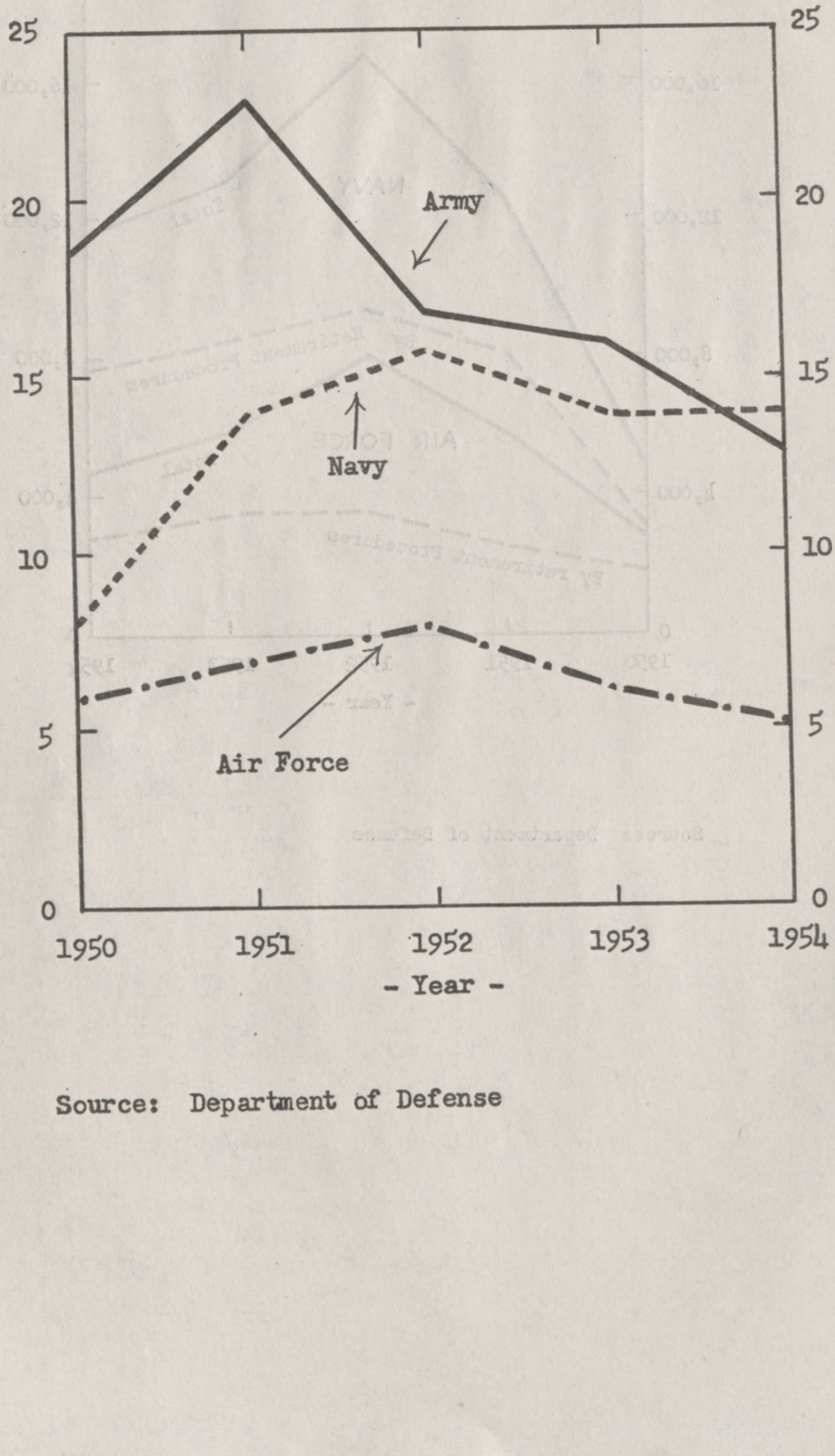
PHYSICAL DISABILITY SEPARATIONS - NAVY AND AIR FORCE



Source: Department of Defense

CHART V

TOTAL DISABILITY SEPARATIONS IN EACH SERVICE FOR EACH 1,000 MEN



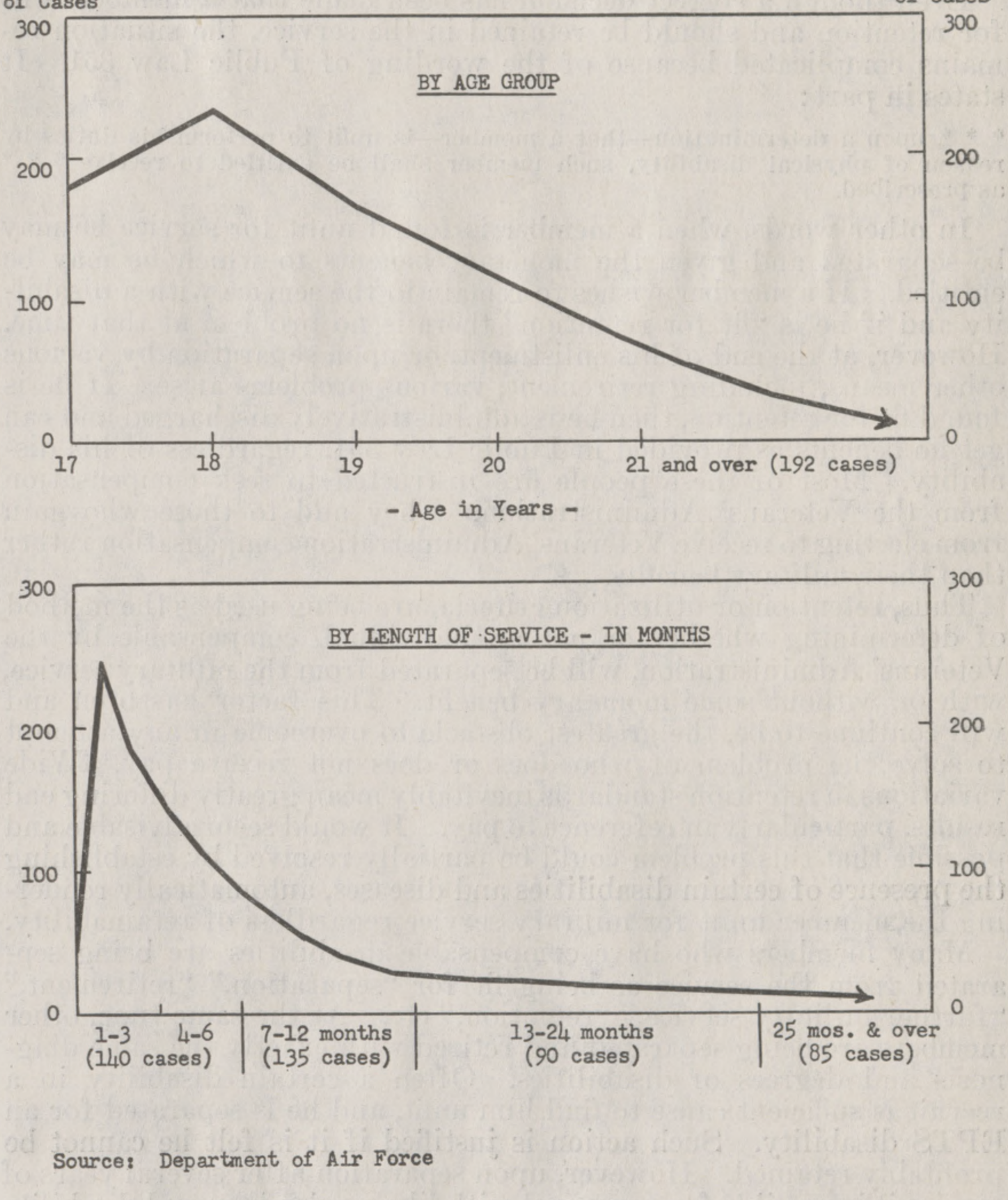
Source: Department of Defense

CHART VI

900 AIR FORCE PHYSICAL DISABILITY SEPARATIONS

AFM 35-4, CHAPTER 9

1955 (Five Months)



Source: Department of Air Force

This may account for the high rate of separations in the Army and partly for the lower rates in the Air Force. If periods of enlistment, and reenlistment rates, were comparable in the Navy and the Air Force, then how is the high Navy rate to be explained?

3. *Fit and unfit.*—Criteria for fitness is a most important factor and varies considerably. The Navy and Air Force definitions indicate that a member must be able to do his job anywhere at any time. If he cannot, he should be found unfit for service. The Army has set up criteria for retention and those considered qualified for retention are found fit.

Profiling is a numerical designation, from 1 to 4 (the first quartile representing best physical condition), designed to answer the problem of the assignment of disabled members to duties which they can perform. Definite information concerning its successful utilization is not available.

Even though a correct decision has been made that a member is fit for retention and should be retained in the service, the situation remains complicated because of the wording of Public Law 351. It states in part:

> * * * upon a determination—that a member—is unfit to perform his duties by reason of physical disability, such member shall be entitled to receive * * * as prescribed.

In other words, when a member is found unfit for service he may be separated and given the monetary benefits to which he may be entitled. If a member wishes to remain in the service with a disability and if he is "fit for retention" there is no problem at that time. However, at the end of his enlistment, or upon separation by various other means, including retirement, various problems arise. If he is found fit for retention, then he is administratively discharged and can get no benefits as provided in Public Law 351, regardless of his disability. Most of these people are instructed to seek compensation from the Veterans' Administration. They add to those who gain from electing to receive Veterans' Administration compensation rather than their military benefits.

Thus, retention or utilization criteria, are being used as the method of determining whether or not an individual, compensable by the Veterans' Administration, will be separated from the military service, with or without some monetary benefit. This factor has been and will continue to be, the greatest obstacle to overcome in any attempt to solve the problem of who does or does not receive pay. Wide variations in retention standards inevitably mean greatly differing end results, particularly in reference to pay. It would seem advisable and possible that this problem could be partially resolved by establishing the presence of certain disabilities and diseases, automatically rendering the member unfit for military service regardless of retainability.

Many members who have compensable disabilities are being separated from the service as being fit for "separation," "retirement," "further military service," "retention," etc. At the same time, other members are being separated and retired with exactly the same diagnosis and degrees of disabilities. Often a certain disability in a recruit is sufficient cause to find him unfit, and he is separated for an EPTS disability. Such action is justified if it is felt he cannot be profitably retained. However, upon separation after several years of service it is possible for personnel with like service-incurred disability to be adjudged as "fit for retention" and have to seek disability benefits from the Veterans' Administration. Public Law 351 in no way prevents the services from separating and awarding monetary benefits to all their unfit personnel. The application of the criterion of retainability need not jeopardize eligibility for severance or retired pay.

Of those found fit, on the basis of present criteria, many who could be retired for reasons of disability after years of service, fail to understand why others were physically retired and they were not. Furthermore, many personnel fail to see why a member can be retained in service and then found "unfit" upon retirement. Allowance can be made in older members for some degree of arteriosclerosis, hypertension, vision or hearing loss, and other conditions attributed to age. On the other hand, it cannot be said that diabetes, multiple sclerosis, carcinoma, Hodgkins disease, ankylosed joints, coronary disease, tuberculosis, and many other diseases are not the result of active pathology and do not ordinarily render an individual unfit for military service regardless of his age or length of service. Why should a man with a hearing aid be any less unfit than one with a prosthesis for walking or with an artificial eye?

USE OF THE TEMPORARY DISABILITY RETIRED LIST (TDRL)

When a member has been found unfit with a rating of 30 percent or more, a determination must be made as to whether his name will be placed on the temporary or permanent disability retired list.

The approximate numbers of individuals on the temporary disability retired lists in the three services at the end of 1955 were as follows:

Army	5,400
Navy	9,300
Air Force	3,000

A study of the directives of the three services indicates that the purpose and use of the temporary list are not clear. It seems that an original idea existed to the effect that many members found unfit for service would eventually become well or well enough to return to service. This was probably a carryover from the old law. It might also be conjectured that the purpose of the temporary list is to give the member an additional 5 years to accrue disability percentage.

Most illnesses or injuries are of a temporary nature and after treatment, usually do not result in permanent changes sufficient to render the individual unfit to perform duty in the Armed Forces. On the other hand, many diseases and injuries after a reasonable period of treatment, do render an individual unfit to perform military service. In many cases particularly amputations, the impairment can be readily and acurately described and evaluated. Furthermore, this type of disability will not likely change in the future. In diseases such as ulcer, diabetes, coronary disease, arteriosclerosis, and arthritis, an accurate evaluation can also be made at the time of separation from the service but these diseases may be expected to become gradually worse as time goes on, thus gradually increasing the degree of disability. In diseases such as tuberculosis, the psychoses, and traumatic encephalopathies, it is obvious that an extremely long period of treatment and/or observation will be required to make an equitable final evaluation. In diseases such as Hodgkin's and multiple sclerosis, the degree of disability may be comparatively low upon separation. However, such cases usually have a certain and fatal termination in a comparatively short time.

Present procedure requires all disabilities to be divided into two classes: (1) Permanent; (2) may be permanent.

The original intent of the law in setting up a "permanent" and "temporary" list should be carefully considered. It is obvious that the original intent was to separate unfit personnel, but for compensation or pay purposes an accurate evaluation of the disability has to be made. Usually that evaluation is made when maximum hospital benefits have been attained. It is apparent that in some cases it might not be possible to make a fair medical evaluation of the disability after a period of reasonable hospitalization. Too, in obscure cases in which the diagnosis is questionable or in such cases where a carcinoma has been removed, additional time will be needed for that determination. In tuberculosis and in the psychoses, long periods of treatment are needed for the disability to stabilize. The law provides a maximum period of 5 years in which to make a final evaluation.

Some few cases can be expected to improve and return to duty but most of them will reach a stationary stage or become progressively worse. In those cases which are put on the temporary list and improve, thus either returning to duty or stabilizing at a lower percentage rating, payments will decrease. But for those cases which become worse, payments would increase. For example, in the case of traumatic encephalopathies, symptoms may disappear in 18 months and the individual will no longer be compensated. If he had been permanently retired he would have been paid the rest of his life. In cases such as arthritis, arteriosclerosis, hypertension, diabetes, and many others, all of which certainly may reasonably be expected to change by simple progression, these cases when placed on the temporary list, cannot ever be expected to return to duty but must be expected to become worse. These cases, if kept on the temporary list for 5 years, can be expected to be given a higher disability rating when eventually separated, thus incurring more liability to the Government. It cannot be possible that the original intent of the law was to establish the temporary list to retain an unfit member for a period of 5 years if his disability could be properly evaluated at the time of retirement.

An analysis of the use of the temporary list reveals many inconsistencies of action, particularly when the nature or characteristics of the various disabilities are considered. It would appear that the basic intent for the use of the temporary list would be to give responsible personnel a period of up to 5 years in which to determine at what percentage level the disability will become stabilized or, in other words, what percentage rating will be an equitable or an average lifetime rating for that particular case.

Beginning in 1952 and 1953 there was a change resulting in the more extensive use of the temporary list by the Department of Defense. Since most of the tubercular patients and about 35 percent of all schizophrenics are placed on the TDRL, this list has grown to extensive proportions. Unless criteria for its use change, it should level off in 1957 or 1958.

There is considerable lack of knowledge and understanding about the TDRL. Many patients believe that they will be returned to duty. Experience shows that in the Air Force, for example, 4 to 5 percent of those cases placed on the TDRL are later found fit. Most of these have had tuberculosis. A negligible number ever elect to return to

the service and some have recurrences of the disease for which they were placed on the TDRL.

The terms "temporary" and "may be permanent" are somewhat misleading. With rare exception it can be said all disabilities are permanent in which retirement is indicated. Usually it is only the percentage that may change and 5 years are allowed for stabilization. Many examples could be cited to show that to obtain more uniformity in actions there must be a better understanding of the purpose and the mechanics of the TDRL.

PROXIMATE RESULT OF THE PERFORMANCE OF ACTIVE DUTY

This term is often not well understood. Perhaps it is because of others that have been in use for a long time, such as line of duty, service-connected, incurred while in service, incurred while entitled to receive basic pay, etc. No definition of the term seems to be foolproof; and it may be expected that when a state of emergency no longer exists, the various judge advocates general will begin to publish their opinions.

The mechanics of its operation can be simply stated; an individual, with less than 8 years of service, in time of peace (but not war or national emergency) who incurs a disability in line of duty, but not as the "proximate result of the performance of active duty," upon separation will be paid only severance pay regardless of the percentage rating of his disability. (In time of war or national emergency all disabilities incurred in line of duty would be considered as proximate result.) Since so many more individuals serve in the Armed Forces in time of war or emergency, and since interpretation of proximate result was not intended to be too rigid or harsh, it would appear that the provision of "not the proximate result of performance of active duty" will never be applicable to more than a comparatively few individuals. The following diagram may add some clarification:

Peacetime

UNDER 8 YEARS' SERVICE		OVER 8 YEARS' SERVICE	
Proximate result	*Not proximate result*	*Proximate result*	*Not proximate result*
Serverance pay or retirement as indicated by disability percentage rating.	Severance pay only.	All considered proximate result. Severance pay or retirement as indicated by disability percentage rating.	

War or national emergency

In those disability cases with less than 8 years of service, there is no division and all are considered as proximate result.

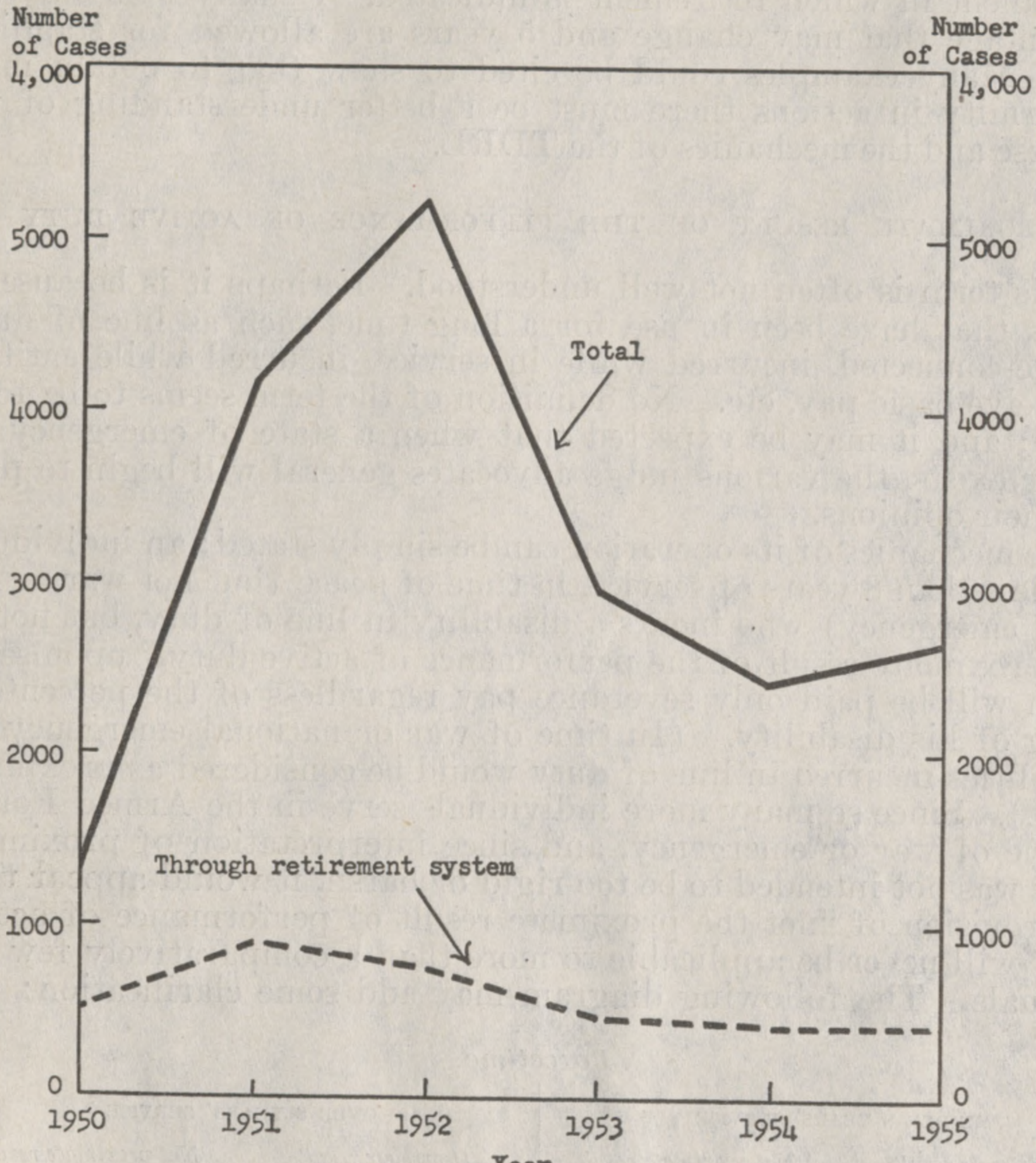
EXISTING PRIOR TO SERVICE (EPTS) DISABILITIES

A survey of Air Force physical-disability separations for the first 5 years under the Career Compensation Act, 1950 to 1954 inclusive, shows that almost 60 percent were for EPTS disabilities (chart VII). All may apply to the Veterans' Administration and certainly many claims are approved.

Chart VII

AIR FORCE PHYSICAL DISABILITY SEPARATIONS FOR EPTS DISABILITIES

Total Equals 58% of All Disability Separations



Source: Department of Air Force

Charts III and IV indicate that the Army and Navy rates are also high. Nervous and mental diseases constitute the greatest single cause. When considering the cost of transportation, loss of training given, unproductiveness, cost of medical treatment and hospitalization, disposition, etc., it is obvious that the resulting economic loss is not small. Certainly it would be impractical to hope that they could all be prevented from entering the service but it would seem that something could and must be done to reduce this loss. Factors for consideration:

1. Higher standards for induction.
2. Eliminate quota requirements for recruiters.
3. Enlistment examinations must be improved and be given by qualified personnel, preferably military.
4. Raise the age limit to 20 or 21 years of age so that enlistees have gained more maturity, education, responsibility, etc.

5. Maintain the incentives for military service high enough to insure a high reenlistment rate—more selectivity would be possible.

COMPARISON OF THE VETERANS' ADMINISTRATION AND ARMED FORCES SYSTEMS OF PAYMENT FOR SERVICE-CONNECTED DISABILITY

This section will attempt to contrast in summary fashion the outstanding features of the two systems.

Both the Veterans' Administration and the military disability retirement system are similar to those parts of workmen's compensation theory and practice which consider: (1) That the injury or loss should be measured by the severity of the loss; and (2) that the amount of compensation should be scaled according to the severity of the loss. Generally speaking, under both workmen's compensation and the Veterans' Administration-military systems the attempt is made to compensate the disabled person for a presumed wage-earning loss (i. e., loss of earning capacity) due to an accident, injury, disease or other debilitating factor. The concept in the Veterans' Administration-military system is average impairment of earning capacity, whereas in workmen's compensation the concern is with the individual worker and his specific job.

Rank is not used by the Veterans' Administration in awarding disability compensation. This may be a reflection of the belief held by some persons that the disabling condition per se is the significant desideratum in attempting to compensate former members of a citizens' Army and Navy. This belief is related to the concept that the rank of the citizen while he serves a period of duty in the military or naval service in time of war or emergency bears no necessary relation to what his social and economic status is or will in the future be in civilian life. On these grounds, the career concept is absent, and equalization of benefits, regardless of rank or length of service, is considered appropriate.[21]

A distinction deserving of special attention can be made between the Veterans' Administration program and the military disability retirement system on the basis that the latter is aimed at maintaining officers and men who are fit to perform the duties of their rank, grade, or rating. As was demonstrated in the historical sketch set forth earlier, the military retirement system has always been aimed at weeding out, to use a 19th century adjective, decrepit personnel, officers in particular. Avowedly, the same purpose is implicit in title IV of the Career Compensation Act.

The basic problem of defining criteria of fitness and unfitness which can be interpreted uniformly and applied equitably and consistently for every branch of the service has been discussed. Under the military disability separations and retirement system the rating schedule of the Veterans' Administration is used (after personnel have been determined to be unfit) for the purpose of measuring disabilities in computing benefits. In the Veterans' Administration, eligibility for benefits is not determined by military unfitness, but by the presence of a compensable service-connected disability.

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[21] De Champ, Cyrille, The Compensation of War Victims Geneva, International Labour Organization (1940), pp. 7–8. Also see above, p. 41.

The Veterans' Administration rating boards, located in each region, consist of an occupational specialist, a legal specialist, and a physician. In the armed services, comparable bodies known as physical evaluation boards consist of three commissioned officers, one being a physician. The physical review council, a higher tribunal, which reviews all cases considered by the various physical evaluation boards, consists of a medical, a legal and a personnel member. Under Veterans' Administration procedure, an aggrieved veteran may appeal to the central veterans' appeal board in Washington. The comparable tribunal in the military system is called physical disability appeal board; for those separated under this system there is additional recourse to the board of correction of military records.

Moving from the basic considerations of underlying purposes and standards, it is appropriate to consider next the differences and similarities in the formulas in the two systems. In attempting to give an empirical content by which career military service might be defined, it was suggested that a person begins at the end of his second enlistment, or the beginning of his third, to accept the military as his career.[22] It was further suggested that at the end of the first 6 years the person presumably made up his mind concerning a professional military career. The matter was discussed later, and consideration was given to the eligibility of civil service employees with 5 years of service to disability retirement pay as compared with the proposal of the Hook committee [23] of 15 years of service, and to similar practices in private industry. Without the advancement of any cogent arguments, either for or against the adoption of 8 years as the criterion, this benchmark was placed in the legislation. The number does bear a natural relationship to a military career in the sense that the typical hitch of peacetime service has been 4 years. Applying the reasoning of the earlier argument that a career begins at the end of the second enlistment or the beginning of the third, 8 years as the criterion seems logical, for this would correspond to two 4-year hitches. As mentioned above, the Veterans' Administration rating procedure is not concerned with the necessity of finding a satisfactory career formula.

In considering the practicability of setting up 30 percent as an element in the retirement formula attention was directed to the great number of Reserve officers who were retired during World War II who had disabilities of less than 30 percent and were able to actively engage in civilian business.[24] It was suggested that 30 percent is a reasonable disability in the sense that a man with a disability of this extent would have to slow down. He would be handicapped but not totally unable to work, although he might have to leave his customary type of employment. This would imply that such a man was only 70 percent efficient. Presumably this is not a passing grade. On the other hand, those rated less than 30 percent disabled would not be so materially handicapped for normal civilian pursuits as to require more than a temporary payment to tide them over their period of adjustment.

It was recognized that the Veterans' Administration rating schedule was intended to be based on average impairments of earning capacity

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[22] U. S. Congress. Senate, op cit. Hearings on H. R. 5007, pp. 294–305.
[23] U. S. Department of Defense, Advisory Commission on Service Pay (1948).
[24] Career Compensation for the Uniformed Forces, hearings before subcommittee No. 2 of the Committee on Armed Services, on H. R. 2553, 81st Cong., 1st sess., 1949, p. 1922.

in civilian occupations, and it was anticipated that the actual percentage might not have the same meaning as representative of a significantly disabling condition for a career military person. It was also recognized that there would be a temptation to boost a person's rating to 30 percent, irrespective of his true disability, so that he could receive disability retirement pay. However, it was hoped that, while the person who was less than 30 percent disabled could receive disability severance pay, that the services would try to retain him and place him. The fundamental design was that disability retirement would rid the service of genuinely unfit personnel. The use of the Veterans' Administration rating schedule was not to usurp the authority of the services to determine whether or not a man was fit to perform his duties, but to provide a device for measuring the extent of the disability so that comparably equitable payments could be made. Needless to say, the people who constructed the Veterans' Administration rating schedule were not required to wrestle with this problem of agreeing upon fitness or unfitness for a military career and proceeding to rate a man thereafter.

The concept of severance pay was thought to be an entirely new departure in military retirement although limited use was made of it as far back as 1861. The basic idea was reportedly adapted from the practice in "reputable industries" of providing an employee with money to tide him over after being released because of a reduction in force. It was believed common in industry to base severance pay on length of service rather than upon position in the organizational structure. The theory was that the older the employee and the longer he had been in the service of an employer, the less was the likelihood of his success in some other endeavor, therefore, the greater his entitlement and need for severance pay. There was considerable discussion as to the scope of severance pay—should it be based upon 5 years, 10 years, or 20 years of service and what percentage formula should be used? The practices of industrial firms were examined and 15 years was agreed upon as the eligibility cutoff figure which best represented industrial experience. Ultimately, the formula decided upon provided for 2 months' pay for every year of service, with a maximum of 2 years' pay.[25] The idea of less than 8 years' service or less than 30-percent disability appears to have been placed in the law so that all the criteria in the law would be similar and the application of the law would not be "too harsh" but rather, "humane" and "businesslike."

The idea of attaching severance pay to a disability system seems unique although perhaps not unwarranted. Insofar as there is no concept of limited duty in the Armed Forces a device is necessary to keep physical standards uniform throughout the services, with some leeway for "fair wear and tear." This idea has been expressed very clearly.

> [Speaking of the Armed Forces] * * * we are faced with this difference as we see it vis-a-vis industry: If we * * * retain people on the active list with disabilities which limit their usefulness, then we are also faced with the possibility of that expanding to the point where we come up for mobilization, and where we have to look into the physical condition of each individual to determine whether or not we can use him in a particular spot.[26]

Thus, severance pay, as conceived by the Armed Forces, was proposed as a device for disability separation for personnel with shorter lengths

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[25] U. S. Congress. Senate op cit., hearings on H. R. 5007, pp. 313, 298.
[26] Ibid., p. 295.

of service or lower percentages of disability. It was also to fulfill a second function.

> [Severance pay] * * * was designed with the thought that some of the people who were thrown out through forced attrition would want an immediate cash benefit with which they could retrain themselves for an occupation.[27]

Under the Veterans' Administration system, disabilities of less than 30 percent—in fact, some at 0 percent—are not considered settled or fully compensated by the Defense Department lump-sum payment. Veterans' Administration compensation is continued indefinitely, subject to reexamination. It is well known that an overwhelming number of veterans are receiving disability compensation for disabilities ranging from 10 percent to 30 percent. Moreover, it is possible, as mentioned, for ex-servicemen to have received severance pay from one of the branches of the Armed Forces and then to apply to the Veterans' Administration for disability compensation, obtain a rating, and be given an award, after recoupment of the severance pay. Overlap between the two systems has arisen since the passage of title IV of the Career Compensation Act; seemingly this was unanticipated when hearings were held. As a result, the two different systems encompass many of the same group of potential beneficiaries. (See tables 1 and 2.)

TABLE 1.—*A comparison of overlapping benefits by degree of disability—Veterans' Administration and armed services, January 1956*

Nature of disability	Service benefits (Defense Department)	Veterans' Administration benefits
Disability rating	Service determines unfitness	Veterans' Administration determines entitlement to compensation.
EPTS	No pay	May be paid upon Veterans' Administration determination or aggravation of service-connection.
0	Severance pay	After recoupment of severance pay, may be entitled to monthly payments from Veterans' Administration. Percentage is subject to change higher or lower on reexamination.
10	Severance pay	After recoupment of severance pay, may be entitled to monthly payments from Veterans' Administration. Percentage is subject to change higher or lower on reexamination.
20	Severance pay	After recoupment of severance pay, may be entitled to monthly payments from Veterans' Administration. Percentage is subject to change higher or lower on reexamination.
30	Retirement on the temporary or permanent list.	Disability may be rated by the Veterans' Administration, and if higher than that of services may elect the Veterans' Administration; usually true in the lower grades. In higher grades and extensive service, retired pay is usually higher than Veterans' Administration compensation.
40	Retirement on the temporary or permanent list.	Disability may be rated by the Veterans' Administration, and if higher than that of services may elect the Veterans' Administration; usually true in the lower grades. In higher grades and extensive service, retired pay is usually higher than Veterans' Administration compensation.
50	Retirement on the temporary or permanent list.	Disability may be rated by the Veterans' Administration, and if higher than that of services may elect the Veterans' Administration; usually true in the lower grades. In higher grades and extensive service, retired pay is usually higher than Veterans' Administration compensation.
60	Retirement on the temporary or permanent list.	Disability may be rated by the Veterans' Administration, and if higher than that of services may elect the Veterans' Administration; usually true in the lower grades. In higher grades and extensive service, retired pay is usually higher than Veterans' Administration compensation.
60	Retirement on the temporary or permanent list.	Disability may be rated by the Veterans' Administration, and if higher than that of services may elect the Veterans' Administration; usually true in the lower grades. In higher grades and extensive service, retired pay is usually higher than Veterans' Administration compensation.
70	Retirement on the temporary or permanent list.	Disability may be rated by the Veterans' Administration, and if higher than that of services may elect the Veterans' Administration; usually true in the lower grades. In higher grades and extensive service, retired pay is usually higher than Veterans' Administration compensation.
75	Retirement on the temporary or permanent list.	Disability may be rated by the Veterans' Administration, and if higher than that of services may elect the Veterans' Administration; usually true in the lower grades. In higher grades and extensive service, retired pay is usually higher than Veterans' Administration compensation.
80	Retirement on the temporary or permanent list.	Disability may be rated by the Veterans' Administration, and if higher than that of services may elect the Veterans' Administration; usually true in the lower grades. In higher grades and extensive service, retired pay is usually higher than Veterans' Administration compensation.
90	Retirement on the temporary or permanent list.	Disability may be rated by the Veterans' Administration, and if higher than that of services may elect the Veterans' Administration; usually true in the lower grades. In higher grades and extensive service, retired pay is usually higher than Veterans' Administration compensation.
100	Retirement on the temporary or permanent list.	Disability may be rated by the Veterans' Administration, and if higher than that of services may elect the Veterans' Administration; usually true in the lower grades. In higher grades and extensive service, retired pay is usually higher than Veterans' Administration compensation.
Found fit (by service)	No pay	Veterans' Administration will rate and pay monthly for partial disabilities amounts ranging to $181 for total (wartime rate) disability. Higher rates up to $420 are payable for certain serious disabilities.

Source: Veterans' Administration and Department of Defense.

[27] Ibid., p. 131.

TABLE 2.—*Examples of variations in monetary disability benefits of Veterans' Administration and armed services, January 1956*

[Amounts of pay are rough estimates only, to show relative values which may be received]

Diagnoses	Rating (percent)	Fit or unfit	Rank	Years of service	Severance pay	Retirement pay [1]	Veterans' Administration compensation per month (wartime cases)
Diabetes	20	Fit	E–1	2	No	No	$33.
Do	20	Unfit	E–1	2	$320	No	$33 after recoupment of severance pay.
Do	20	Fit	O–3	2	No	No	$33.
Do	20	Unfit	O–3	2	$700	No	$33 after recoupment of severance pay.
Blind eye	30	Fit	O–6	10	No	No	$50 and $47.[1]
Do	30	Unfit	O–6	10	No	$210	$50 and $47.[1]
Coronary disease	60	Fit	E–3	8	No	No	$109.[2]
Do	60	Unfit	E–3	8	No	$70	$109.[2]
Do	60	Fit	O–6	21	No	$350	$109.[2]
Do	60	Unfit	O–6	21	No	Disability $420	$109.[2]
Do	60	...do	O–6	30	No	Service $600, disability $420.	$109.[2]

[1] Statutory award.
[2] Basic rate; additional compensation payable for dependents when rated 50 percent or more.

Source: Veterans' Administration and Department of Defense.

One of the striking differences between the Veterans' Administration and military disability retirement formulas is the provision of extra compensation for wives and dependents of veterans whose disability rating is 50 percent or more and the extension of the disability compensation system into a death compensation system under certain circumstances. Under the military disability retirement system there is no extra compensation provided for the wives and dependents of ex-servicemen (regardless of the extent of their disability) and there is no direct link between the disability provisions and survivors' benefits. Despite the apparent inequity in providing extra disability compensation for the veteran and none for the ex-serviceman, it should be recalled that the latter very often collects a larger average benefit for the same percentage of disability as that of a veteran because of the formulas relating the military base pay to either percentage of disability or years of service. For those veterans who receive a statutory award plus a percentage award it is possible that they would fare better than the disabled ex-serviceman, especially one with a lower rank and shorter length of service.

Another element in the formula of the Veterans' Administration which affects the amount of disability (and death) compensation which a beneficiary receives is the time during which the veteran served; peacetime or wartime, peacetime rates being approximately 80 percent of those of wartime. Under the military disability retirement system there is a distinction in the provisions of the law referring to Regular and Reserve personnel (both of whom could have service either in war or peace) and to service in times of war and national emergency, but the distinctions which are made along these lines are not designed to reduce the benefits of personnel who served in time of peace to 80 percent of those who served in time of war.

Another way the Veterans' Administration and military disability retirement systems may be compared and contrasted is the utilization

by the armed services of the temporary disability retired list. It seems that the purposes of this list were to insure that the disabled individual receive a proper and equitable final medical rating and that the Federal Government be protected from the economic dangers of ratings which knowingly become less. Personnel whose names were placed upon the temporary disability retired list were to be examined at least once every 18 months and were to have their names removed no later than 5 years after their names were placed on the list. Under the disability compensation system of the Veterans' Administration all cases may be considered subject to reexamination at the discretion of the Veterans' Administration and ratings and compensation changed accordingly. In filing a claim for disability, evidence of record, either from the armed services or in the form of certified statements, indicating the reasonable probability of a valid claim, must be filed. If the evidence indicates the probability of a valid claim exists, an examination may be requested. Where the claimant appears in person and a preliminary inquiry establishes the reasonable probability of a valid claim, an immediate physical examination may be requested by the Veterans' Administration. If a claim is filed within 6 months from the veteran's date of separation, his disability may be initially rated on the records of the armed services.[28]

Following the initial Veterans' Administration examination (or an examination in lieu of a Veterans' Administration examination) and initial rating, reexaminations are scheduled based upon the combined nonstatic disabilities as follows:

	Years
Ratings between 80 and 100 percent	2
Ratings between 40 and 70 percent	3
Ratings between 10 and 30 percent	5

After the first reexamination, the Veterans' Administration usually schedules other future examinations. If the disability rating is increased 10 percent or more, future reexaminations are scheduled in accordance with the table above. If the disability is decreased 10 percent or more, reexaminations are held in 2 years regardless of the rating. If the disability rating is unchanged, the veteran is not reexamined for 5 years, except for running awards for tuberculosis. Scheduled future reexaminations may be ordered at earlier dates than those mentioned above when there is evidence pertinent to the individual case that the disability is likely to improve materially in a shorter period.[29] No reexaminations are scheduled: (1) When the disability is established as static; (2) when (in tuberculosis) the lesions and symptoms have not improved materially for a period of 5 years or more; (3) where the disability from disease is permanent in character and of such nature that there is no likelihood of improvement; (4) in cases of veterans of World War I and other veterans over 55 years of age, except under the most unusual circumstances; (5) when the rating is a prescribed scheduled minimum rating; and (6) where a combined disability evaluation would not be affected if the future examination should result in a reduced evaluation for one or more conditions.[30] If a veteran fails without adequate reason to report

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[28] Veterans Administration Regulation 1076.
[29] Ibid., 1185 (B) (1).
[30] Ibid., 1185 (B) (2).

for a physical reexamination, the award is suspended as of his last payment.[31] However, if a veteran has one or more compensable static disabilities and one or more nonstatic disabilities, the award is continued in an amount commensurate with the degree of disability resulting from the static disabilities and suspended only as to the nonstatic disabilities for which the physical examination was primarily requested. Both the Veterans' Administration system and the military disability retirement system share the idea of reexamination, but their practices differ as to how often, with the Armed Forces being enabled to cease all reexaminations after 5 years.

A final point of contrast between the two systems is the requirement under the Career Compensation Act that servicemen who in time of no emergency have served less than 8 years (but over 30 days) must have incurred in their disability of 30 percent or more as the proximate result of the performance of active duty in order to be eligible for disability retirement pay but that personnel who have served 8 years or longer are eligible for these benefits without reference to the proximate result of the performance of active duty. If the disability was due to intentional misconduct or willful neglect or was incurred during a period of unauthorized absence, the serviceman is disqualified from receiving disability retirement pay or severance pay. The Veterans' Administration also disqualifies veterans from receiving disability compensation under the same conditions of misconduct, neglect, or unauthorized absence, although it is difficult to ascertain to what extent the definitions of the conditions as used in the two systems are similar or dissimilar.[32] The Veterans' Administration, however, has no provision akin to the demarcation line of 8 years as a desideratum for eligibility, although, as indicated above, peacetime and wartime rate differentials are used.

The similarities and divergencies in the systems may be the consequences of using the same rating instrument for two different purposes. Chart VIII is a diagrammatic sketch showing some of the related factors of the two systems. Changes required to harmonize the unintended consequences arising from having two different governmental agencies administer closely related and overlapping programs can probably best be brought about by discussion along the lines of comparison, contrast, and basic philosophy. (1) The Career Compensation Act emerged in response to the challenge of: (a) Keeping a fit Military Establishment; (b) a remedy for the overpayment which took place by retirement for minor disabilities; (c) more comparable disposition of officers and enlisted men; and (d) putting reservists on a par with Regulars. (2) The present Veterans' Administration system of disability compensation evolved in response to the challenge of making appropriate recompense to citizen-soldiers whose disabilities were incurred during shorter periods of service, principally in time of war.

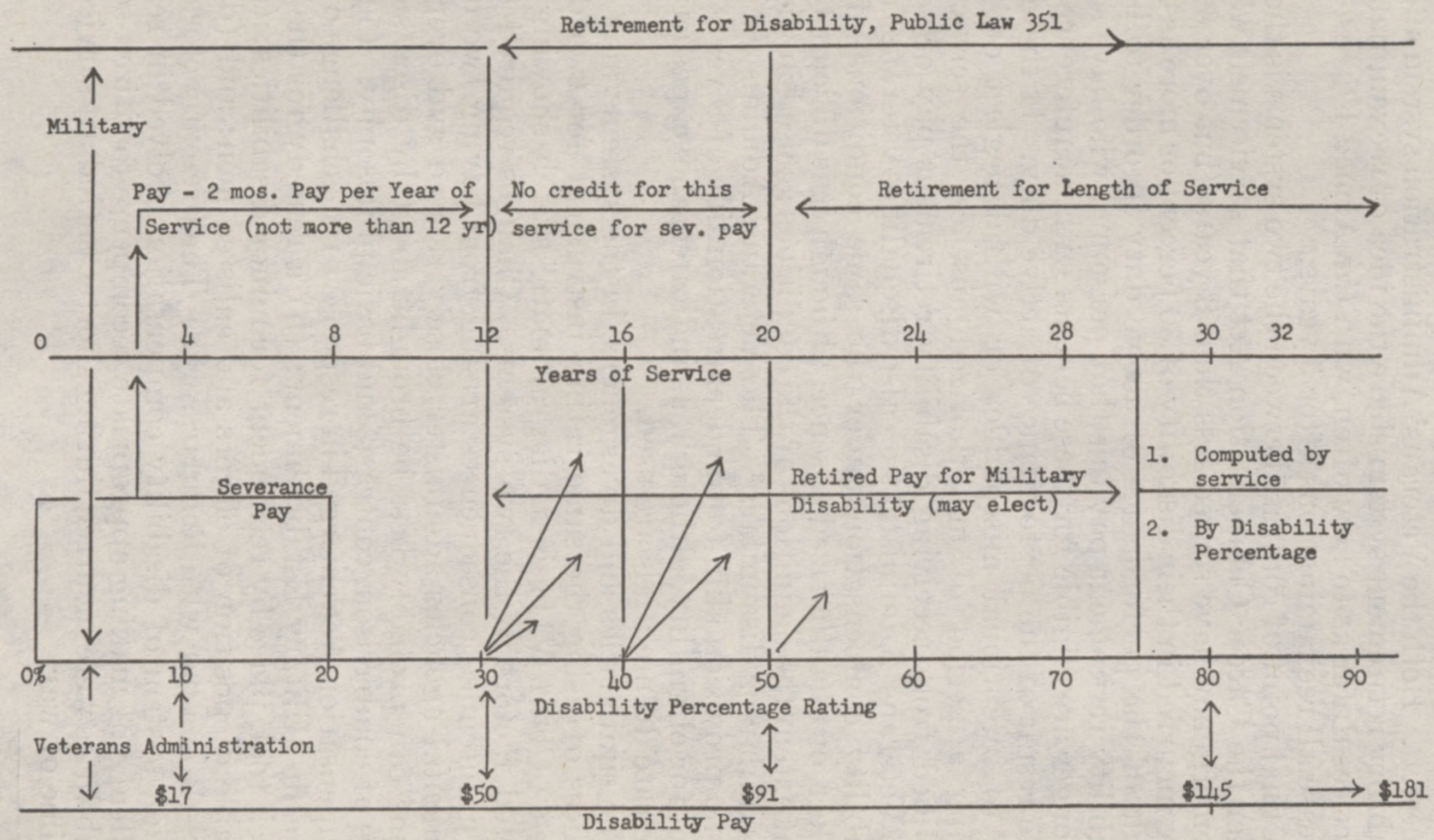
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[31] Ibid., 1251 (A).
[32] See ibid., 1065, 1067, for a view of the breadth of the definitions currently in use.

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CHART VIII DIAGRAMATIC SKETCH

DISABILITY PERCENTAGE RATINGS COMPARING VETERANS ADMINISTRATION AND MILITARY PROCESSES AND PAY



This applies in time of war or emergency. At other times a disability incurred during first eight years of service, considered not the proximate result of performance of active duty, rated over 30% is entitled only to severance pay.

Although enlisted personnel, prior to 1949, were not eligible for military disability retirement benefits until they had served 20 years, most of these individuals could apply for service-connected disability benefits under laws and regulations of the Veterans' Administration. They were not rated for disability benefits by the military departments, consequently there was no overlapping of disability-evaluation procedures. Officers, on the other hand, were free to apply for both military disability retirement and Veterans' Administration benefits, and could choose to receive whichever set of benefits was more advantageous in their individual instance. However, since officers constitu e such a small fraction of all armed services personnel, and since military disability retirement benefits were geared to 75 percent of their base pay, it was advantageous for them to take benefits under the military retirement system, with recourse to the Veterans' Administration benefits only in cases of more severe disabilities or for special reasons.

Since the enactment of the Career Compensation Act in 1949, enlisted men, as well as officers, are eligible for disability retirement benefits and Veterans' Administration benefits, with the choice of the most beneficial course of action. Thus, the two systems overlap in their coverage since almost every disabled service person has to consider which program is more favorable in his particular situation. As a consequence, persons with disabilities arising from service with the Armed Forces are rated by the appropriate Department and by the Veterans' Administration as well. This results in the programs being open to a considerable amount of "shopping" as between one agency and another by the individual before he determines which course to follow.

A small sample study by the Commission of about 1,500 cases from the disability retirement and separation files of the various departments of the armed services indicated that approximately 970 of them had also been rated by the Veterans' Administration. It was found that with respect to the same individuals, there were large variations in the ratings by the two agencies. Although the armed services use the same rating instrument (the Veterans' Administration Schedule for Rating Disabilities), less than one-fourth of the cases were assigned the same rating. (See chapter III.)

Apart from the factor of sound administration there are other considerations which indicate that attention should be given to the problem of disability coverage for former members of the armed services. An example of this is the question of utilization of Veterans' Administration disability benefits by military personnel retired on a length-of-service basis, in order to obtain an advantage with respect to income tax. Since Veterans' Administration disability benefits are tax exempt, many persons who have retired either on the basis of age or service and receive a service-retirement benefit from the Department of Defense, also obtain from the Veterans' Administration a disability rating and correspondingly small monthly disability compensation payment (which is deducted from their military retired pay) on which they may receive a tax exemption. There is still another reason for recourse to the Veterans' Administration by personnel receiving length-of-service retirement pay from their branch of service, namely, the factor of eligibility for medical care from the Veterans' Administration. A disability rating is required from that agency in

order to obtain outpatient care in its facilities for service-connected disabilities.

An approach toward a solution of the problem of overlap between the military retirement system and the Veterans' Administration disability compensation system requires a clarification of the basic role of the two systems. Seemingly, the proper role of a military retirement system is to serve as the staff retirement plan for "career" personnel. On the other hand, the basic function of the Veterans' Administration disability compensation system has been to provide protection for the large groups of citizen-soldiers called for temporary military duty during the intermittent conflicts in which the Nation has engaged. One possible solution is to clarify the function of the two systems by means of a clear-cut though somewhat necessarily arbitrary definition of when personnel attain "career" status. This might be along the lines of the 8-year interval incorporated in the Career Compensation Act of 1949 with respect to severance pay.

Other solutions are also undoubtedly possible. Accordingly, intensive work needs to be done, not only on this aspect, but also with respect to the whole question of the relationship between fitness standards and standards for disability compensation in order that personnel in the armed services be treated equitably and the public interest protected.

RECAPITULATION

Similar Aspects of Service and Veterans' Administration Benefits

1. Laws provide for benefits for disabled persons.
2. Both use the Veterans' Administration Schedule for Rating Disabilities.
3. Eligibility for benefits may be denied in cases involving misconduct, neglect, etc.
4. Some chronic diseases are sent to the Veterans' Administration from service hospital to continue treatment.

Some Basic Differences

1. *Eligibility to receive benefits.*—

Service: Member must be found physically unfit by reason of disability incurred while entitled to receive basic pay.

Veterans' Administration: Disability must be service-connected, and rating may be more (or less) than that given by the service.

2. *Rate of pay* (monthly benefits).—

Service: Monthly benefits change with the monthly pay which is different for various ranks and length of service. If pay is less than $181 per month, those in lower grades get more by applying at the Veterans' Administration.

Veterans' Administration: All eligible personnel receive benefits based on the amount of $181 per month for total disability, with specific rates for specified disabilities up to $420 per month, plus additional amounts for dependents if 50 percent or more disabled.

3. *Income tax problem.*—

Service: Pay based on disability is income tax exempt. Retired pay (no disability) is not exempt. If separated as fit, may apply to the Veterans' Administration for a disability rating. If granted may receive part of pay from Veterans' Administration which is tax exempt.

Veterans' Administration: All disability compensation is income tax exempt.

4. Degree of disability—

Service: Uses Veterans' Administration schedule, percentage ranges from 0 to 100, only applicable to 75 percent of basic pay. Unfitness not definitely established by any certain percentage rating.

Veterans' Administration: Uses Veterans' Administration schedule, ranges from 0 to 100 percent. May not agree with service rating.

5. Length of service—

Service: Determines pay benefit in part. 10 to 20 percent rating—2 months' pay for each year of service; 30 to 100 percent rating—30 to 75 percent of basic pay, or may elect pay computed on basis of length of service, if more.

Veterans' Administration: Length of service not material.

6. Retirement—

Service: Disability over 30 percent may be retired. Service retirement after 20 years. (Military retirees are subject to military law.)

Veterans' Administration: No retirement provisions.

7. Reexaminations—

Service: If member is on permanent list or receives severance pay—none. If placed on TDRL, reexamine at least every 18 months until disposed of (not longer than 5 years).

Veterans' Administration: Subject to Veterans' Administration policy as indicated in each case. There is no time limit set by law.

8. Presumptions—

Service: None.

Veterans' Administration: Various presumptions are made which may entitle veteran to benefits, depending on time periods and the nature of the impairment.

9. Statutory awards (for disability)—

Service: None.

Veterans' Administration: Various, depending on disability.

10. Family benefits—

Service: None.

Veterans' Administration: Allowed when qualify by Veterans' Administration criteria.

All military personnel after leaving the service are entitled to submit claims to the Veterans' Administration and if approved may elect to receive Veterans' Administration benefits if they are more advantageous. Due to various differences (1 and 2 above) many in the higher ranks, found fit by the services and later given disability ratings by the Veterans' Administration, are paid less for their rating. Most of those whose military salary is less than $181 per month gain by electing Veterans' Administration benefits. Under the present system, those given severance pay also gain in the long run by being eligible for Veterans' Administration compensation after recoupment of the severance pay by the Government.

SUMMARY

There has developed through the years a system of financial assistance to those who incur disabilities in the military service. The benefits have varied and changed with time, necessity, and circumstances.

A system of retirement of officers had been operating before World War I; as a result of that conflict, and problems developing therefrom, the Veterans' Administration was established.

Until 1949, retirement was available to officers for length of service and for disability. For enlisted men, service retirement was possible after 20 years but those disabled were required to seek aid from the Veterans' Administration.

As a result of World War II, due to the large number of disabilities involved, certain inequities and abuses in the system were brought into clearer focus. Officers with minor disabilities, for example, were being retired at 75 percent of base pay, but enlisted men were not so covered.

The Career Compensation Act of 1949 provided more comparable disposition of officers and enlisted personnel for disability retirement. The amount of benefits would be determined by the degree of impairment using the Veterans' Administration Schedule for Rating Disabilities. Retirement for length of service and for disability were integrated to some extent. Disability separations were to be determined by a finding of unfitness based on criteria set forth by each branch of service.

At the same time the Veterans' Administration has operated a system of compensation based on degree of disability at a uniform scale and related to the average impairment of earning capacity. A considerable overlapping of eligibility from the armed services to the Veterans' Administration has resulted in a double method of rating in most disability cases. With the large numbers of personnel who are now veterans, this double system has developed a tremendous duplicate load for the armed services departments and the Veterans' Administration. Since military and Veterans' Administration criteria differ in respect to monetary benefits, many injustices result. Directly affected are the cases of high percentage disability rating determined "fit" by the services. There is also duplication of much effort. Military personnel are, or can be, evaluated at the termination of service. Regardless, however, disability evaluation is repeated when Veterans' Administration claims are submitted.

Differences in procedure result in duplication of effort, a great deal of which could be prevented. In the military, retirement ends a case, except for those placed on the temporary list and terminated within 5 years. Those not retired are given severance pay and the case is closed. In the Veterans' Administration, disability compensation may continue for many years requiring reevaluation, changes in payment, and so forth.

As the problems of disability separation and compensation increase, with the continuing rise in the number of eligible veterans, it seems apparent that constant monitoring of many factors will be required. Policies and practices should change to fit the times, with the objective being an equitable disability separations and benefits program that can be carried out with effectiveness and efficiency.

CHAPTER III

STATISTICAL COMPARISON OF DISABILITY RATINGS BY THE ARMED SERVICES AND BY THE VETERANS' ADMINISTRATION

DEVELOPMENT OF THE SURVEY

One of the basic factfinding surveys conducted by the Commission dealt with disability retirement from the Armed Forces and its relationship to the Veterans' Administration.[1] Several considerations led the Commission to undertake this survey. One of these was the overlapping of jurisdiction between the Veterans' Administration and the armed services with respect to persons who retire or are separated by reason of disability. Practically all of such servicemen so released from the Armed Forces since 1949 may receive retirement or severance pay under the Career Compensation Act. These individuals have the option of seeking compensation payments under the Veterans' Administration but would not be inclined to do so unless the amounts turned out to be more favorable than the payments they would receive from the Armed Forces. Certain additional benefits are available to both veterans and military retirees, such as vocational rehabilitation, civil-service preference, dental and medical services from Veterans' Administration facilities. The Commission was, therefore, interested in knowing the extent and nature of overlapping and duplication between the Veterans' Administration and the several branches of the armed services.

Since the adoption of the Career Compensation Act of 1949, the Armed Forces are required to use the disability rating schedule of the Veterans' Administration in rating personnel deemed unfit for service because of disability. The actual amount of retirement pay takes into consideration length of service and previous salary levels, elements which are not considered under the veterans' compensation program. The assessment of percentage of disability in these programs, however, is made on the basis of the same rating schedule. Thus, a study of a sample of service personnel retired or separated on account of disability would provide additional basic information to the Commission in its study of disability rating and loss of earning capacity. The carrying out of this statistical survey was accomplished with the cooperation of the Office of the Secretary of Defense and each department of the armed services.

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[1] Two other statistical studies based on questionnaires which went direct to individual veterans are discussed in part C of this report and in staff report No. IX, pt. A, "Readjustment Benefits : General Survey and Appraisal."

Perhaps the most important phase of the study of military disability retirement lies in the fact that it provides an excellent opportunity to test the operation of the disability rating schedule. The Commission was aware of variations in evaluations by different raters as well as various disability rating teams. The fact that many service personnel had ratings both from a department of the Armed Forces and the Veterans' Administration provided the Commission with a unique opportunity to check on the consistency of the ratings accorded to the same individual by two independent agencies.

Selection of the sample

The group selected for this survey consisted of a simple random sample of 1 percent of the disability retirement cases on the military rolls as of September 1955, plus a limited number (about 50 each from the 4 service branches) of those with severance pay. Sampling was carried out through a set procedure, selections being made from the rolls of each of the services—Army, Navy, Air Force, and the Marines. It was done systematically, selecting certain combinations of the digits in the service serial number. The sample yielded 1,508 cases—776 from the Army, 352 from the Navy, 277 from the Air Force, and 103 from the Marines. These included 1,305 retirement cases and 203 severance cases.

The questionnaire

The questionnaire sent to these ex-servicemen was essentially the same as the one used in surveying veterans receiving compensation for service-connected disabilities.[2] Certain adjustments were made, however, to reflect differences in training, hospitalization, medical services, or cash benefits received from the Armed Forces, as distinct from parallel services or payments from the Veterans' Administration. A letter dated December 9, 1955 (Exhibit A) transmitted the "Questionnaire to Persons Who Have Been Retired or Separated from the Armed Forces Because of Physical Disability" (Exhibit B). A followup letter, dated December 27, 1955, was sent to those who had not responded by that date (see Exhibit C). Finally, for those individuals who were not heard from by January 11, 1956, a second followup letter (Exhibit D) was sent, by registered mail. By the time of the cutoff date a short time later, completed usable questionnaires had been received from 1,259 of these individuals, representing 83 percent of the total.

EXHIBIT A

PRESIDENT'S COMMISSION ON VETERANS' PENSIONS,
Washington, D. C., December 9, 1955.

DEAR SIR: This Commission has been asked by the President to study existing programs for veterans and ex-servicemen, and to give him a report on how these programs meet their needs.

The Commission is especially interested in individuals who have been retired or separated from the Armed Forces because of physical disability. Informa-

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[2] The basic questionnaire had earlier been pretested both by the Census Bureau in its surveys and by the Commission in the study of over 13,000 veterans receiving disability compensation through the Veterans' Administration (see footnoe 1, p. 77).

tion the Commission requires can come only from the disabled persons themselves. Accordingly, we are conducting a special survey of those who were disabled in the Armed Forces of the United States.

The purpose of the survey is to obtain information on the past experience and present employment of the Nation's ex-servicemen who are receiving disability benefits, the problems they have had to meet in civilian life, and how well the various programs designed to assist them have met their needs. The facts provided by you and other disabled ex-servicemen will be of great assistance in planning future programs to serve the needs of disabled veterans and the Nation.

You and a few other disabled ex-servicemen in your area have been selected to help us by providing this information. It will take only a few minutes of your time to answer the questionnaire. It is important to have replies from every disabled individual selected in this nationwide sample, so that results will be properly representative.

The information you give will be accorded confidential treatment, and will be used only in preparing statistical summaries in which no individual person is identified. No information about you as an individual will be made a part of the records of the Veterans' Administration or any branch of the Armed Forces.

Please answer the questions as accurately as possible, and return the form to this Commission within 5 days in the enclosed envelope, which requires no postage.

Your help in returning the form promptly will contribute to the success of the survey.

Sincerely,

OMAR N. BRADLEY,
General of the Army, Chairman.

EXHIBIT B

Budget Bureau No. 111-5503; Approval Expires March 31, 1956

President's Commission on Veterans' Pensions

QUESTIONNAIRE TO PERSONS WHO HAVE BEEN RETIRED OR SEPARATED FROM THE ARMED FORCES BECAUSE OF PHYSICAL DISABILITY

SECTION I - TO BE FILLED BY ALL INDIVIDUALS

1. Please check the highest grade of school that you completed BEFORE ENTERING the Armed Forces:

	1	2	3	4	5	6	7	8
Elementary or Grade School..	☐	☐	☐	☐	☐	☐	☐	☐
High School...	☐	☐	☐	☐				
College.....	☐	☐	☐	☐	☐ (5 or more)			

2. Did you attend any other kind of school (vocational, trade, business, etc.) BEFORE ENTERING the Armed Forces?

☐ No

☐ Yes _____ (Number of years)

3. While on active duty with the Armed Forces did you receive any full-time training in general or special schools or in civilian institutions (for example; gunnery, radio, officer training, supply, command and general staff, engineering, accounting, etc.)?

☐ No

☐ Yes: **a. How many months of full-time training?**..... _____ (Number of months)

b. Give the main fields in which you took training in such schools (for example; communications, civil affairs, medicine, business administration, etc.)

_____

_____

_____

_____

4. Have you completed one or more full years of school or college SINCE YOU LEFT the Armed Forces?

☐ No

☐ Yes: **How many full years did you complete?**

a. Regular school or college _____ (Number of years)

b. Vocational, trade or business school..... _____ (Number of years)

5. Have you been in any other organized training program or programs such as on-job, apprentice, or on-farm training SINCE YOU LEFT the Armed Forces?

☐ No

☐ Yes: **How many months did you train?**

a. Under VA..... _____ (Number of months)

b. Under other programs..... _____ (Number of months)

6. Please describe the job at which you worked the longest during the YEAR BEFORE you entered the Armed Forces. If you had more than one period of service in the Armed Forces, describe the job you held before the period of service in which you received your service-connected disability.

☐ Check here if you had no job during that year.

a. What kind of work did you do?
Please give an exact answer, for example; truck driver, locomotive fireman, able seaman, mechanical engineer, etc.

_____

_____

_____

b. In what kind of business or industry did you do this work?
Please give an exact answer; for example; radio factory, wholesale radio company, retail radio store, radio repair shop, lawyer's office, etc. DO NOT GIVE name of company.

_____

_____

_____

7. What was your MAIN job or occupational specialty in the Armed Forces, that is, your most important single specialty? (For example; deck officer, platoon leader, dentist, rifleman, yeoman, bombardier, tank commander, etc.)

_____

_____

_____

8. After leaving the Armed Forces, when did you get your first job that lasted 6 months or more?... _____ (Month and year)

If you had more than one period of service in the Armed Forces, this refers to the period during which you received your service-connected disability.

☐ Check here if you have had no such job since leaving the Armed Forces.

a. What kind of work did you do?
Please give an exact answer as in Question 6a.

_____

_____

_____

b. In what kind of business or industry did you do this work? Please give an exact answer as in Question 6b.

_____

_____

_____

9. When did you start working regularly in your present trade or occupation (whether before or after service)?..... _____ (Month and year)

☐ Check here if you have not had a regular job since leaving the service.

10. Employment during the 12 months from October 1954 through September 1955:

a. In how many weeks during these 12 months did you do some work for pay or profit? (Include paid vacations and paid sick leave.)..... _____ (Enter number or "0")

b. In how many of the weeks in which you did not work were you looking for work?..... _____ (Enter number or "0")

c. When you worked, did you usually work full-time or part-time?

☐ Full-time ☐ Part-time

11. Please describe the job at which you worked longest during the 12 months from October 1954 through September 1955:

☐ Check here if you did no work for pay or profit during these 12 months.

a, What kind of work did you do?
Please give an exact answer as in Question 6a.

_____

_____

_____

_____

b. In what kind of business or industry did you do this work?
Please give an exact answer as in Question 6b.

_____

_____

_____

_____

_____

12. **During the 12 months from October 1954 through September 1955, how much income did you receive from each of the following sources?**

	Enter total amount for 12 months or "0"
a. Wages or salary (before deductions for taxes, social security, bonds, etc).....	$
b. Net income from own business, farm or professional practice	$
c. Armed Forces disability retirement or severance pay.....	$
d. VA payments--compensation, pension or other allowances...	$
e. Income from all other sources including dividends, interest, rents, social security, or any other source	$

13. Please indicate on the lines below, the number of relatives LIVING WITH YOU and their incomes during the period October 1954 through September 1955:

☐ Check here if married and living with wife. Please enter wife's total income received from all sources during these 12 months... $_____

☐ Check here if not married or not living with wife.

Give the following information for children and other relatives living with you:

	Enter number of relatives or "0", on each line	Enter total income for 12 months or "0", for relatives on each line
Sons and daughters under age 18.....		$
Sons and daughters age 18 or over.....		$
Parent or parents.....		$
Others under age 18.....		$
Others age 18 or over.....		$

14. During the 12 months from October 1954 through September 1955, how many days were you unable to work because of any illness or disability?..... _____ (Enter number of work days or "0")

15. Have you been hospitalized (had to stay overnight in a hospital) at any time during the 12 months October 1954 through September 1955?

☐ No

☐ Yes: **How many days during these 12 months did you spend in military, naval, Veterans Administration, or other hospitals?**

	Number of days
a. In a military or naval hospital (or as a military or naval patient in other hospitals).....	
b. In VA hospitals (or as a VA patient in other hospitals).....	
c. In any other hospital (not as a VA, military or naval patient)...	

16. Please give in the boxes below the number of times DURING THE 12 MONTHS October 1954 through September 1955 that you have seen a doctor or doctors for the treatment of ANY illness, injury or other medical condition. (**DO NOT** include physical examinations or other times when you were not sick or injured. **DO NOT** include times you saw a doctor when you were in a hospital overnight or longer.)

	Enter number or "0"
a. How many times did you receive out-patient medical treatment for your service-connected disability at a military or naval hospital, clinic, dispensary, etc.? (Out-patient treatment is treatment that did not involve staying overnight in a hospital.).....	
b. How many times did you receive out-patient treatment for your service-connected disability at VA clinic or hospital?.....	
c. How many times did you receive treatment for your service-connected disability from a "hometown" doctor that was paid for by the VA or the Armed Forces?.....	
d. How many times did you see a doctor ON YOUR OWN (that is, not paid for by VA or Armed Forces) **for treatment:**	
(1) For an illness, injury, or condition specifically determined by VA or the Armed Forces to be service-connected?....	
(2) For any other illnesses, injuries, or medical conditions?.....	

17. Looking back, how did your SERVICE-CONNECTED DISABILITY affect you in the kind of civilian work you were able to do or were trained to do BEFORE the disability occurred?

☐ Check here if you had no specific civilian line of work or training before becoming disabled, then skip to Question 18.

a. ☐ Little or no effect.

b. ☐ Was able to stay in my old line of work but unable to do as much as before.

c. ☐ Was able to stay in my old line of work but could work only part-time.

d. ☐ Had to change kind of work because of my disability.

e. ☐ Have been unable to do any kind of work because of my disability.

18. How does your SERVICE-CONNECTED DISABILITY affect your ability to do your PRESENT line of work?

a. ☐ Has little or no effect.

b. ☐ Bothers me, but I don't let it keep me from working. *(If you answer here, please check one or more of the following five boxes.)*

(1) ☐ It is a nuisance but I can do my work all right.

(2) ☐ Have to take time off once in a while.

(3) ☐ I can't turn out quite as much work or do my work as well.

(4) ☐ Prevents me from doing some of the things usually required in my work.

(5) ☐ Other *(Explain)*

_____

_____

_____

c. ☐ Makes me take time off quite often.

d. ☐ Permits me to work only part-time or off and on.

e. ☐ Prevents me from working at all.

19. Have you had to look for work in the past 5 years?

☐ No

☐ Yes: **How has your SERVICE-CONNECTED DISABILITY affected your success in GETTING JOBS?** *(Check one)*

a. ☐ Makes it impossible to get jobs.

b. ☐ Has made it much harder to get jobs.

c. ☐ Makes it a little harder, but I manage all right.

d. ☐ Has not had much effect.

e. ☐ Has made it easier to get jobs.

20. Please read the following statements and check the one which best describes how your SERVICE-CONNECTED DISABILITY affects your non-job activities. *(Check one)*

a. ☐ Confined indoors all or nearly all of the time.

b. ☐ Can go outside but need the help of another person in getting around.

c. ☐ Can go outside alone but have trouble in getting around freely such as crossing streets, getting on and off buses, street cars, etc.

d. ☐ Can get around without any help but have had to cut down on some activities, (for example: hobbies, sports, chores, visiting, churches, clubs, etc.)

e. ☐ Bothers some but I don't let it affect my activities.

f. ☐ Doesn't limit my activities in any way.

21. Do you now have any injury, chronic illness or medical condition that you got either in civilian life or in the Armed Forces which affects YOUR ABILITY TO WORK, TO GET JOBS, OR YOUR OTHER ACTIVITIES, but which has NOT been determined by the VA or the Armed Forces to be service-connected?

☐ No

☐ Yes: **What is the nature of this condition?**

_____

_____

22. Since your disability occurred have you ever received any "vocational rehabilitation" training?

☐ No

☐ Yes: **From whom did you receive this service?** *(Check one or more)*

a. ☐ Armed Forces

b. ☐ Veterans Administration

c. ☐ State Vocational Rehabilitation Agency

d. ☐ Non-Governmental Organization

Enter the TOTAL number of months you received such "vocational rehabilitation" training..... _____ (Number of months)

23. Please explain and give examples of how your service-connected disability has affected your employment, social activities, family life, etc.:

_____

_____

_____

_____

_____

24. Do you have any comments on the benefits and services (such as hospitalization and medical care, disability processing, disability rating, retirement pay, severance pay, etc.) for disabled servicemen which will assist in making improvements? *(Please explain, using examples of how the programs administered by the Armed Forces or the Veterans Administration have affected you.)*

_____

_____

SECTION II - TO BE FILLED ONLY BY INDIVIDUALS WHO SERVED IN ARMED FORCES AFTER SEPTEMBER 16, 1940

1. **If you have NOT received any schooling or training under a VA "vocational rehabilitation" training program (P.L. 16 for World War II veterans or P.L. 894 for Korean veterans), what were your main reasons?** *(Check one or more)*

a. ☐ I was able to return to my usual line of work without special training.

b. ☐ I was able to go into another line of work without special training.

c. ☐ I believed my disability did not require any special "vocational rehabilitation" training.

d. ☐ I was too ill or disabled to take such training.

e. ☐ I applied, but the VA ruled I did not need "vocational rehabilitation" training.

f. ☐ I did not know about VA "vocational rehabilitation" training.

g. ☐ I had to go to work to support my dependents because the VA allowances were not enough to get by on

h. ☐ I took education or training under the "GI Bill" instead of under VA "vocational rehabilitation."

2. **If you went to school or took training under only the "GI Bill" programs (P.L. 346 or P.L. 550) instead of under VA "vocational rehabilitation" training programs, OR if you changed from VA "vocational rehabilitation" to "GI Bill" training, what were your main reasons?** *(Check one or more)*

a. ☐ I believed my disability did not require special "vocational rehabilitation" training.

b. ☐ I applied for "vocational rehabilitation" training but was turned down by the VA.

c. ☐ I did not know "vocational rehabilitation" training was given by the VA.

d. ☐ I was interested only in part-time schooling or training.

e. ☐ I was interested in full-time training but I wanted to work at the same time.

f. ☐ I chose the "GI Bill" instead of "vocational rehabilitation" training because I would have more freedom to take what I wanted.

g. ☐ I could begin schooling or training sooner under the "GI Bill" than I could under "vocational rehabilitation."

3. **If you received VA educational or training benefits under ANY of the veterans' "GI Bill" or "vocational rehabilitation" training laws (P.L. 346, P.L. 16, P.L. 550 or P.L. 894) how much do you use such skills, education, or training in your present job or business?** *(Check one)*

a. ☐ Very much — without VA training, I would not have been able to get present job.

b. ☐ Skill or training is used a great deal.

c. ☐ Skill or training is fairly useful.

d. ☐ Skill or training is used only a little.

e. ☐ Skill or training is not used at all.

4. Vocational Counseling and Employment Counseling. Please answer each part of question.

a. **Since leaving the Armed Forces have you received EMPLOYMENT counseling through the United States Employment Service or State Employment Service?**

☐ No ☐ Yes: **If yes, what years?**_____

b. **Since leaving the Armed Forces, have you received VOCATIONAL counseling or guidance from a VA counselor (or a private counselor paid by VA) to help you in deciding what kind of training to take or what kind of work to do?**

☐ No ☐ Yes: **If yes, what years?** _____

c. **If you received counseling or vocational guidance was it useful to you in either of the following ways?** Please answer both (1) and (2).

(Check in the appropriate column)

	Very Useful	Of some value	Not useful
(1) In giving you a better understanding of yourself and what you could do.....			
(2) In helping you to decide what kind of work to do, or what kind of training to take.....			

5. **Since leaving the Armed Forces have you sought assistance in getting a job through the U.S. Employment Service or State Employment Service?**

☐ No ☐ Yes: If yes, please answer a, b and c.

a. **Did you obtain a job through the assistance of the Employment Service at any time since leaving the Armed Forces?**

☐ No ☐ Yes: Date you last obtained a job through the assistance of the Employment Service?..._____
(Month and year)

b. **Did the Employment Service assist you in obtaining a job during the first year after leaving the Armed Forces?**

☐ No ☐ Yes

c. **Did the Employment Service assist you in obtaining your present job, or a job with your present employer?**

☐ No ☐ Yes

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EXHIBIT C

PRESIDENT'S COMMISSION ON VETERANS' PENSIONS,
Washington, D. C., December 27, 1955.

DEAR SIR: About 2 weeks ago we sent you a letter and a questionnaire as part of a survey of disabled exservicemen which is being conducted by this Commission. The information is needed for a report to the President on how the needs of veterans have been met, also how the programs might be improved.

We are particularly interested in disabled persons, their past experience and present employment, the problems they have had to meet in civilian life, and how well the various programs designed to assist disabled ex-servicemen have actually met their needs. We believe that the facts provided by you and other veterans will help greatly in planning future programs which will serve the needs of disabled ex-servicemen and the Nation.

Your help is needed to complete this survey. Please fill out the questionnaire and return it within the next 5 days in the enclosed envelope, which requires no postage.

The information you give will be accorded confidential treatment and will be used only in preparing statistical summaries in which no individual person is identified. No information about you as an individual will be made available to the Veterans' Administration or any branch of the Armed Forces.

Your help in returning the form promptly will contribute to the success of the survey and will assure us of obtaining a response from a cross section of all disabled ex-servicemen.

Sincerely,

OMAR N. BRADLEY,
General of the Army, Chairman.

EXHIBIT D

PRESIDENT'S COMMISSION ON VETERANS' PENSIONS,
Washington, D. C., January 11, 1956.

DEAR SIR: Recently we sent a letter to you and to a number of other disabled officers and enlisted personnel, in which we asked for help in a special survey that will assist us in making a report to the President. We enclosed a questionnaire which would give us information that can come only from disabled persons like yourself.

We have not yet received the completed questionnaire from you. Perhaps you did not receive the questionnaire, or you may think your answers would not matter one way or the other.

It is extremely important that you answer this questionnaire. It has been sent to only a small number of service-disabled persons, most of whom have replied. In order to get the highest degree of accuracy and completeness possible, it is essential that returns from all individuals be secured.

Accordingly, we sincerely hope that you will fill out the enclosed questionnaire, as soon as possible, and return it in the enclosed envelope which requires no postage.

The information you give will be kept strictly confidential, and will be used only in preparing statistical summaries in which no individual person is indentified. No information about you as an individual will be made a part of the records of the Veterans' Administration or any branch of the Armed Forces.

If you have already mailed back the questionnaire to us you need do nothing more.

Your help in this important matter is appreciated.

Sincerely,

OMAR N. BRADLEY,
General of the Army, Chairman.

To encourage frank responses the questionnaire did not bear the name of the individual. Identification was made by a numerical code.

Additional Information

For each individual included in the sample, other needed information was obtained from statistical cards already on file in the armed services. These included, besides the name, address, and the service serial number:

1. Year of birth
2. Sex
3. Branch of service
4. Status—regular or other
5. Total length of active service
6. Type of disability retirement; i. e., permanent, temporary, or severance pay
7. Percentage of disability rating
8. Diagnosis of major disability, according to the Veterans' Administration disability rating schedule code

9. Diagnosis of secondary disability according to the Veterans' Administration disability rating schedule code
10. Monthly rate of retirement pay separately for disability, and service retirement—the latter for those with more than 8 years' service
11. Date of separation from the armed services
12. Grade or rank on retirement roll
13. Law under which retired

Processing the Data

With coordination by the Office of the Secretary of Defense, questionnaires received and identified were relayed to the Personnel Statistics Division, Department of the Air Force which did the coding and a number of tabulations, with the advice and guidance of the Commission staff. The codes were identical with those used in the survey of veterans receiving disability compensation from the Veterans' Administration. Where necessary, of course, the code was modified to accommodate additional or different information.

There was little time to edit the returns and no questionnaires were returned for correction, clarification, or addition of missing information. The coded information from the questionnaire was punched on two IBM cards. For the tabulations which are presented in this report the information was derived from a single IBM card which, in addition to the service serial number, and information derived from the statistical cards already on file, included the following items of information:

1. Age as of January 1, 1956
2. Disability rating agency
3. Total years of regular schooling
4. Years of schooling before entering the Armed Forces
5. Weeks of full-time or part-time work in the last 12 months (last 12 months refers to the period prior to October 1955)
6. Longest occupation in the last 12 months
7. Total income in the last 12 months
8. Effect of wartime service on preservice occupation or skills
9. Size of family and marital status
10. Total income of the family in the last 12 months
11. Work days lost because of disability in the last 12 months
12. Receipt of vocational rehabilitation training or services
13. Use of training received through Veterans' Administration in current job

Question of Comparability

In planning its surveys the Commission had in mind comparability of the end results. The questionnaires used and the coding devised were such as to carry out this objective. However, limitations of time prevented any empirical tests of the extent that this objective was attained.

The surveys of military retirement cases and veterans receiving Veterans' Administration compensation for service-connected disabilities covered all persons in the sample residing in the continental United States including those in institutions. This difference in coverage would affect to some extent the comparability of the returns from these two surveys and the survey undertaken by the Bureau of the

Census for the Commission since the latter excludes and the other two include an unknown proportion of institutional cases. Theoretically at least, the results of the Veterans' Administration and military surveys should be comparable. However, the major threat to lack of comparability among all three surveys is not the inclusion or exclusion of institutional cases, but the selective factors which operated in determining the respondents in each survey and possible differences that may have been introduced by the coding, since entirely separate groups of coders and supervisors were used in coding the returns of each survey.

BASIC CHARACTERISTICS

Only a minimum number of tabulations were run on the disability retirement cases of the Armed Forces. These are being presented here with the thought that they will prove useful for those who are interested. Shortage of time made it impossible for the Commission staff to do much analysis of these tabulations.

Tables 1, 2, and 3 indicate the population sampled in terms of percentage of disability rating according to branch of service, types of disability retirement, and grade or rank of the retired persons.

Tables 4 and 5 show the distribution by degree of disability rating by age and earned annual income reported for the 12-month period ending September 30, 1955.

Tables 6, 7, and 8 relate earned income to age, type of retirement, and the grade and rank of the retired persons.

Table 9 shows the cross-classification of reported Government payment for the 12-month period ending September 30, 1955, with earned income for the same period. The distribution of frequencies indicates little relationship between the two. Of course, Government payment is not only a function of disability rating but also total years of military service and salary level as determined by grade and rank prior to retirement.

Table 10 relates the responses as to the effect of wartime service on civilian job which the individual was doing, or skills which he had, and earnings in the 12-month period ending September 30, 1955.

Table 11 shows the relationship between total years of schooling and earnings in the 12 months ending September 30, 1955.

Table 12 shows the relationship between the occupation pursued longest in the 12-month period ending September 30, 1955, and earned income, and table 13, the relationship between full-time or part-time work and weeks worked and earned income for the identical 12-month period.

Table 14 relates duration of vocational services received to earned income. It is apparent that most persons who returned a completed questionnaire did not respond to this question, in all probability because most of them had not had any rehabilitation services or post-service training.

Table 15 also deals with vocational rehabilitation training, relating the extent of use of such training to earnings. The question of use of training was to be limited to retired persons who entered the armed services after September 16, 1940, and who received training through the Veterans' Administration.

Table 16 gives the cross classification between the monthly retirement pay from the official records of the Armed Forces with the total

income reported by these retired individuals. It is obvious there are inconsistent returns since there are a number of persons who reported no income who have a monthly retirement payment, and there are instances in which the monthly retirement payments multiplied by 12 will exceed the total income reported.

Tables 17 and 18 deal with total family incomes of these individuals for the 12-month period ending September 30, 1955. Table 17 shows the relationship of marital status and family size of the retired individual to the total family income reported, and table 18, the age of the retired person to the total family income.

Table 19 shows the relationship between disability rating and the years of active military service.

Table 20 gives the distribution by years of military service by the branch of service from which the individual retired.

Tables 21 through 25 deal with rehabilitation training and the extent to which the skills acquired from it are being used. Table 21 shows the relationship between disability rating and receipt of rehabilitation training either from the Armed Forces or from the Veterans' Administration.

Table 22 shows the length of vocational rehabilitation training related to the present age of the retired serviceman. Table 23 indicates the response as to the extent to which training received from Veterans' Administration was being used in current job, crossed by percentage of disability rating. Responses with respect to use of training were to be restricted to those who joined the Armed Forces after September 16, 1940. Table 24 gives the age of the retired person crossed with the extent to which any vocational training obtained through the Veterans' Administration was being used in the current job. Table 25 gives the relationship between the longest occupation in the last 12-month period prior to October 1955 to the extent to which rehabilitation skills acquired through vocational training from the Veterans' Administration were being used in the present job.

Tables 26 to 30 show the interrelationship of governmental payment either for retirement alone or for disability. Table 26 relates percentage of disability rating to the amount paid to the individual from the Armed Forces and/or the Veterans' Administration. The amount shown is what the individual reported.

Table 27 shows the interrelationship of the grade or rank of the retired person to the governmental payment reported by him either from the Armed Forces or the Veterans' Administration, or both.

Table 28 shows a cross tabulation of the retirement payments as such reported by the respondent against the veteran's payments also reported by him. It will be seen that a significant proportion of the respondents received benefits from both. Payments are, of course, for the 12-month period ending September 30, 1955.

Tables 29 and 30 show the relationship between age and retirement payments and age and veteran's payments, respectively.

Table 31 shows the interrelationship between the weeks worked in the 12-month period ending September 30, 1955, part-time or full-time and degree of disability rating.

Table 32 shows the relationship between the longest occupation in the 12-month period ending September 30, 1955, and age.

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Table 33 shows the response as to the effect of wartime service on ability to pursue occupation engaged in or trained for prior to entering the service, and age.

Tables 34 and 35 indicate work days lost in the 12-month period ending September 30, 1955. Table 34 relates percentage of disability rating to work days lost, and table 35 relates age to the work days lost on account of sickness or disability.

Finally, table 36 shows the interrelationship between total years of schooling completed and years of schooling before entry in the Armed Forces.

OPERATION OF THE DISABILITY RATING SCHEDULE

Not all disability programs use a rating schedule. For instance, the Federal Bureau of Employees' Compensation administers a disability program for Federal employees injured in the course of their work without the use of a comprehensive percentage rating schedule. Similarly, the Civil Service Commission administers the disability retirement program without such a schedule. Many other disability programs are administered without this kind of measuring device.

Those who favor a schedule, such as the Veterans' Administration has developed, claim that it facilitates administration and helps achieve objectivity and consistency in the rating process.

Unquestionably one of the most important attributes of a rating schedule should be the consistency with which different raters can arrive at the same rating. To shed some light on this, the Commission requested the Veterans' Administration to check against its records the sample consisting of 1,508 individuals retired or separated for disability by the Armed Forces. There is some question as to how exhaustive this phase of the work was, largely because of shortage of time. The matching had to be done in the Veterans' Administration Regional Offices, the choice of these being made on the basis of the stated address of the serviceman. It is known that at least one regional office failed to return the cases sent to it. It is possible also that in some instances the files might have been in transit between regional offices. The results, nevertheless, showed that in all there were 971 separated or retired military personnel identified who were also rated by the Veterans' Administration—always subsequent in time, of course, to the rating by the armed services.

The identified individuals who had a Veterans' Administration rating were heavily concentrated in the younger ages as may be seen below.

Number and proportion of former servicemen in the sample who were found to have disability rating from the Veterans' Administration, by age as of January 1, 1956

Age	Total in sample	Number with VA rating	Percent of total with VA rating
All ages	1,508	971	64.4
Under 25	144	124	86.1
25–34	593	484	81.6
35–44	363	215	59.2
45–54	207	93	44.9
55–64	148	43	29.1
65 and over	37	4	10.8
Unknown	16	8	50.0

An analysis of tables 37 to 44 reveals a wide disparity in the ratings given by the Armed Forces and the Veterans' Administration, even though both use the same rating schedule. Table 37 compares the disability ratings of the 971 cases by the Veterans' Administration and by the Armed Forces. The distributions indicate a less generous rating by the Veterans' Administration in comparison with the ratings of the Armed Forces. Thus, nearly 36 percent of all of these cases rated by the Veterans' Administration were rated zero percent, while the Armed Forces rated less than 6 percent as zero percent. These variations are apparent in all other ratings. Of the total cases, the Veterans' Administration rated less than 18 percent as 100 percent disabled. On the other hand, the Armed Forces gave this rating to 25 percent of the cases. The mean rating of the Veterans' Administration is 37 percent disabled, while that of the Armed Forces is 53 percent. To some extent this may reflect later ratings by the VA, but it also suggests that the use of the veterans' disability rating schedule does not eliminate personal judgment and different raters can arrive at different percentage rating with the same subject.

Table 38 shows comparative ratings of the two agencies according to current age of the retired individuals. It is obvious that the disparity of the two agencies becomes greater with the age of the individual involved. In other words, the Armed Forces tend to be progressively more generous in their rating, the older the individual being rated. This relationship is clearly reflected in the mean percentage rating for the different age groups. For those under 25 years of age the mean rating given by Veterans' Administration is 46 percent while that by the Armed Forces is 50 percent; the difference is comparatively small, but this gap widens progressively in subsequent ages.

This growing gap between the ratings of the two agencies, in part, might be due to selective factors. Those separated from the Armed Forces in older ages are often career personnel; they can seldom expect to improve their compensation by going to the Veterans' Administration, so they seek disability determination from the Veterans' Administration only if they are seeking admission to a Veterans' Administration hospital, rehabilitation services, civil-service preference, or the like. Some may also come who, for one reason or another, feel their rating was not proper. How much selective factors such as these account for the differences cannot be said without more intensive analysis, but since a large proportion of the cases included in the sample have ratings from both agencies, and since the number with a Veterans' Administration rating would have been even greater had the search to identify these cases been more intensive, selective factors could hardly account for all of this sharp and growing disparity in the ratings with advancing age.

Table 39 compares the respective ratings for officers and enlisted men separately, by the two agencies. The mean rating of the officers by the Armed Forces is 48 percent. The mean rating by the Veterans' Administration of these same officers is only 15 percent. This disparity in the rating of the two agencies is much greater than the disparity in their rating of enlisted men. The mean rating of the enlisted men by the Armed Forces is 54 percent; the parallel mean rating of these same men by the Veterans' Administration is 43 percent. The Commission, because of shortage of time, was unable to examine elements responsible for this much wider difference in Vet-

erans' Administration rating of officers from the ratings by the Armed Forces in comparison to the respective ratings by the two agencies of Regular enlisted men.

Table 40 shows the joint distribution of these servicemen according to the rating that they had from the Veterans' Administration and the Armed Forces, respectively. Line 1, column 2, for instance, indicates that of the total group rated, 347 were rated zero percent disabled by the Veterans' Administration. Only 7 of these were servicemen whom the Armed Forces had also rated zero percent; 40 were cases which the Armed Forces had rated 10 percent, and so on; and 72 were cases which the Armed Forces had rated 100 percent disabled. The mean rating of these 347 cases by the Armed Forces was 49, as against the zero rating by the Veterans' Administration. At the other extreme, line 12, indicates that there were 170 cases which received a rating of 100 percent from the Veterans' Administration. From the Armed Forces 95 of these had a 100 percent disability rating and 3 had a rating of zero percent, with intermediate ratings in larger numbers. This table indicates wide variation in the rating of identical servicemen by the Armed Forces and the Veterans' Administration, even though both agencies used the same rating schedule.

Column 15 shows the mean disability rating by the Armed Forces of servicemen with specified ratings from the Veterans' Administration as shown in columns 1 and 2. Line 13 shows the parallel mean ratings by the Veterans' Administration of servicemen with specified ratings from the Armed Forces. Thus, for the 55 servicemen who received a rating of zero from the Armed Forces their mean rating from the Veterans' Administration was 22 percent.

A relationship, such as that shown in table 40 may be measured in terms of coefficient of correlation. Had the agreement in the ratings been perfect, the coefficient would have been 1; had there been no association at all, the coefficient would have been zero. The coefficient of correlation for table 40 is .38. As a rule, correlation is considered of little significance if it is less than .60. In educational and psychological testing where the reliability of the test is measured by correlation of split halves or between equivalent forms of the same test, the test would be considered unsatisfactory if the resulting coefficient is below .90. By this criterion the agreement in rating by the two agencies falls far below commonly accepted standards of consistency of rating scales.

To help the reader to see the significance of this relationship, one may regard a serviceman who appears before a Veterans' Administration rating board without a prior rating as faced with 100 percent uncertainty as to the rating which he might receive. On the average, taking into consideration a rating from the Armed Forces based on the results of this survey, this uncertainty would be reduced only by 14 percent.[3] In other words, the extent of his uncertainty is reduced on the average to 86 percent of what it would have been in the absence of this additional item of information. There is little consistency in the present disability ratings.

Table 41 shows the distribution of cases by age, comparing the rating by the Veterans' Administration and the Armed Forces for

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[3] This is the coefficient of determination d, which equals r^2 and indicates the percentage of variability in the "dependent" variable that may be accounted for by the "independent" variable.

the same serviceman. Column 3 shows the number of servicemen that had identical disability ratings from the Armed Forces and the Veterans' Administration. Column 4 indicates that these constitute 23 percent of all the cases. Considering by age, it is to be noted that the percentage with identical rating is highest for servicemen under age 25. For this age group 34 percent of the servicemen had identical ratings. The percentages with identical rating from the two agencies decline with age to 9 percent for servicemen in ages 55–64.

Column 5 shows the number of cases in which the disability rating by the Armed Forces exceeded the corresponding rating by the Veterans' Administration. Column 6 shows the percentage of servicemen in which this was the case. For the total group 50 percent of the servicemen had ratings from the Armed Forces that were higher than their rating from the Veterans' Administration. The corresponding percentage for servicemen under age 25 was 36, and the percentage increases progressively with age—being 84 percent for servicemen at ages 55 to 64. Columns 11 to 20 show the frequency distribution of cases in column 5 by the percentage by which the ratings of the Armed Forces exceeded the corresponding rating of the Veterans' Administration. Thus, in 72 cases this difference was 100 percent, i. e., servicemen rated 100 percent disabled by the Armed Forces were rated zero percent disabled by the Veterans' Administration. Eight cases were rated 90 percent higher than the corresponding rating by the Veterans' Administration. These could have been servicemen rated 100 percent by the Armed Forces or 90 percent who got ratings of 10 or zero percent, respectively, from the Veterans' Administration, etc.

Column 7 shows the number of servicemen whose disability rating from the Armed Forces was lower than the rating which they received from the Veterans' Administration. Column 8 shows the percentage of such servicemen. Of the total number, 26 percent had a higher disability rating from the Veterans' Administration in comparison to their rating from the Armed Forces. This percentage was 29 for servicemen under 25 years of age and 32 percent for those in ages 35 to 44; 19 percent for those aged 35 to 44; 20 percent for those aged 45 to 54; and only 7 percent of those aged 55 to 64. The extent of excess in Veterans' Administration ratings over the corresponding rating by the Armed Forces is shown in columns 21 to 30. Thus, for all cases, irrespective of age, in 78 cases the rating by the Veterans' Administration exceeded the corresponding rating of the Armed Forces by 10 percent.

Finally, columns 9 and 10 show the mean rating of these cases by the Veterans' Administration and by the Armed Forces, respectively. As it has been shown earlier, the rating by the Armed Forces is on the average higher, and this disparity is particularly marked in the older ages.

Table 42 parallels table 41; it is, however, limited to enlisted men only. Of this group, in 26 percent of the cases there was agreement in the ratings of the two agencies. Again, agreement is highest for servicemen under 25 years of age. This percentage is 33 for those under age 25 and it declines progressively with age up to ages 45 to 54. Of this age group only 9 percent had identical rating; in the age group 55 to 64, 12 percent of the servicemen had identical ratings.

The percentage of enlisted men who had a higher disability rating from the Armed Forces is 43. This percentage is only 37 for men under 25 years of age and increases to a maximum of 85 for those in ages 55 to 64.

In 30 percent of all the cases the disability rating from the Veterans' Administration was higher. This percentage is highest—34 percent—for enlisted servicemen in ages 25 to 34 and tends to decline with age.

The mean ratings given by the Armed Forces are consistently higher for each age than those of Veterans' Administration and the disparity becomes greater with age. Columns 11 to 20 give the frequency with which the ratings by the Armed Forces exceeded the corresponding rating by the Veterans' Administration and the percentage of the excess. Thus, out of a total of 328 cases in which the Armed Forces rating was higher, 72 were servicemen rated 100 percent disabled by the armed services and at zero percent disabled by the Veterans' Administration. Of these, 52 were servicemen aged 25 to 34. Columns 21 to 30 give the distribution of cases by the extent to which the rating given by the Veterans' Administration exceeded the corresponding ratings by the Armed Forces.

Table 43 parallels tables 41 and 42, but it is restricted to officers who had disability ratings from the Veterans' Administration. Of these only 12 percent had comparable ratings from both agencies. This percentage decreases with age, at least through ages 45 to 54. In 74 percent of the cases the rating by the Armed Forces was higher. This percentage tends to rise with age. The extent of this excess is shown in columns 11 to 20.

In 12 percent of all these cases the rating by the Veterans' Administration was higher in comparison to the corresponding rating by the Armed Forces and the extent of the excess is shown in columns 21 to 30.

Tables 44 to 46 indicate that the disparities in ratings by the Armed Forces and the Veterans' Administration are not explained by the fact that the armed services maintain a temporary disability retired list.

Summary

This analysis has indicated very low correlation between ratings by the Armed Forces and the Veterans' Administration for the same serviceman and using the same disability rating schedule. As a rule, the ratings of the Armed Forces are higher; this is particularly true for servicemen in more advanced ages and is much more true for officers than for enlisted men. Undoubtedly, some of these differences may result from the selectivity of the servicemen who seek ratings from the Veterans' Administration. This, however, does not at all invalidate the basic conclusion that much needs to be done to secure greater objectivity and consistency in disability ratings by the Armed Forces and by the Veterans' Administration.

TABULAR DATA

The following pages present the results of the study in tabular form.

TABLE 1.—*Number of disability retirement and severance cases in October 1955 sample of persons on military disability roll*

[Classified by branch of service and disability percentage rating]

Degree of disability rating	Branch of service				
	Total	Army	Air Force	Navy	Marines
All	1,508	776	277	352	103
0	69	12	7	50	----
10	127	47	63	11	6
20	114	49	48	11	6
30	241	93	58	73	17
40	168	86	24	45	13
50	90	44	12	19	15
60	132	68	24	29	11
70	63	43	3	11	6
80	57	29	14	12	2
90	10	6	----	2	2
100	432	294	24	89	25
Unknown	5	5	----	----	----

TABLE 2.—*Number of disability retirement and severance cases in Armed Forces sample*

[Classified by type of separation and disability percentage rating]

Degree of disability rating	Type of disability			
	All types	Permanent	Temporary	Severance pay
All	1,508	1,023	285	200
0	69	9	----	60
10	127	43	3	81
20	114	60	3	51
30	241	174	65	2
40	168	132	36	----
50	90	68	21	1
60	132	103	29	----
70	63	53	10	----
80	57	52	5	----
90	10	9	1	----
100	432	319	112	1
Unknown	5	1	----	4

TABLE 3.—*Number of disability retirement and severance cases in Armed Forces sample*

[Classified by type of personnel and disability rating]

Degree of disability rating	Type of personnel				
	Total	Enlisted men	Officers	Warrant officers	Unknown
All cases	1,508	1,004	475	24	5
0	69	50	18	1	----
10	127	76	48	3	----
20	114	49	62	1	2
30	241	165	71	3	2
40	168	129	37	2	----
50	90	66	22	2	----
60	132	96	35	1	----
70	63	44	19	----	----
80	57	37	19	1	----
90	10	10	----	----	----
100	432	281	141	10	----
Unknown	5	1	3	----	1

TABLE 4.—*Number of disability retirement and severance cases in Armed Forces sample*

[Classified by age and disability percentage rating]

Degree of disability rating	Age[1]							
	All ages	Under 25	25–34	35–44	45–54	55–64	65 and over	Unknown
All cases	1,508	144	593	363	207	148	37	16
0	69	9	38	14	6	1	----	1
10	127	23	47	32	13	10	1	1
20	114	9	25	39	22	14	2	3
30	241	24	102	57	35	16	3	4
40	168	16	92	30	15	10	2	3
50	90	8	44	26	4	7	----	1
60	132	11	51	26	24	12	7	1
70	63	3	30	16	8	4	2	----
80	57	2	22	16	11	4	2	----
90	10	3	4	2	1	----	----	----
100	432	35	136	104	68	70	18	1
Unknown	5	1	2	1	----	----	----	1

[1] In this and subsequent tables where age of serviceman is shown it is as of January 1, 1956.

TABLE 5.—*Earned income of Armed Forces disability retirement and severance cases*

[Classified by degree of disability]

Degree of disability rating	Earned income[1]												
	Total	None	$100 to $499	$500 to $999	$1,000 to $1,499	$1,500 to $1,999	$2,000 to $2,999	$3,000 to $3,999	$4,000 to $4,999	$5,000 to $5,999	$6,000 to $7,999	$8,000 and over	Unknown or other
All	1,508	344	74	67	56	57	146	163	90	57	55	50	349
0	69	8	1	4	2	4	7	5	7	3	2	----	26
10	127	14	2	4	6	5	12	19	11	4	4	4	42
20	114	19	2	3	3	3	9	15	8	10	9	8	25
30	241	44	14	11	10	8	31	31	18	12	12	7	43
40	168	29	12	12	5	8	23	21	10	5	2	2	39
50	90	25	5	8	3	3	11	8	6	4	5	3	9
60	132	35	7	7	5	4	14	17	6	2	2	4	29
70	63	19	5	1	2	1	2	7	5	1	3	2	15
80	57	22	2	2	2	1	2	4	4	1	----	3	14
90	10	5	----	1	----	----	3	1	----	----	----	----	----
100	432	124	24	13	18	20	32	35	15	15	16	17	103
Unknown or other	5	----	----	1	----	----	----	----	----	----	----	----	4

[1] Earned income is for the 12 months ending Sept. 30, 1955.

TABLE 6.—*Earned income of Armed Forces disability retirement and severance cases*

[Classified by age]

Age	Earned income[1]												
	Total	None	$100 to $499	$500 to $999	$1,000 to $1,499	$1,500 to $1,999	$2.000 to $2,999	$3,000 to $3,999	$4,000 to $4,999	$5,000 to $5,999	$6.000 to $7,999	$8,000 and over	Unknown or other
All	1,508	344	74	67	56	57	146	163	90	57	55	50	349
Under 25	144	37	9	7	10	7	16	7	5	----	1	----	45
25 to 34	593	127	36	31	18	21	69	73	31	19	7	6	155
35 to 44	363	54	11	16	16	14	31	48	36	25	28	20	64
45 to 54	207	52	8	7	7	10	19	20	11	6	10	17	40
55 to 64	148	55	8	5	5	4	7	12	2	4	6	5	35
65 and over	37	19	2	----	----	1	1	----	1	----	2	2	9
Unknown	16	----	----	1	----	----	3	3	4	3	1	----	1

[1] Earned income is for the 12 months ending Sept. 30, 1955.

TABLE 7.—*Earned income of Armed Forces disability retirement and severance cases*

[Classified by type of separation]

Type of separation	Earned income [1]												
	Total	None	$100 to $499	$500 to $999	$1,000 to $1,499	$1,500 to $1,999	$2,000 to $2,999	$3,000 to $3,999	$4,000 to $4,999	$5,000 to $5,999	$6,000 to $7,999	$8,000 and over	Unknown or other
All	1,508	344	74	67	56	57	146	163	90	57	55	50	349
Permanent	1,020	244	47	41	34	32	86	111	63	45	48	46	223
Temporary	285	76	23	19	14	16	38	27	10	5	4	2	51
Severance pay or unknown	203	24	4	7	8	9	22	25	17	7	3	2	75

[1] Earned income is for the 12 months ending Sept. 30, 1955.

TABLE 8.—*Earned income of Armed Forces disability retirement and severance cases*

[Classified by type of personnel]

Type of personnel	Earned income [1]												
	All income	None	$100 to $499	$500 to $999	$1,000 to $1,499	$1,500 to $1,999	$2,000 to $2,999	$3,000 to $3,999	$4,000 to $4,999	$5,000 to $5,999	$6,000 to $7,999	$8,000 and over	Unknown or other
All	1,508	344	74	67	56	57	146	163	90	57	55	50	349
Enlisted men	1,004	257	58	51	41	41	112	111	40	14	6	3	270
Officers	475	82	15	16	14	15	29	47	46	42	48	46	75
Warrant officers	23	4	1		1	1	3	5	3	1	1	1	2
Unknown or other	6	1					2		1				2

[1] Earned income is for the 12 months ending Sept. 30, 1955.

TABLE 9.—*Earned income of Armed Forces disability retirement and severance cases*

[Classified by amount of Government payment]

Government payment [2]	Earned income [1]												
	All incomes	None	$100 to $499	$500 to $999	$1,000 to $1,499	$1,500 to $1,999	$2,000 to $2,999	$3,000 to $3,999	$4,000 to $4,999	$5,000 to $5,999	$6,000 to $7,999	$8,000 and over	Unknown or other
All	1,508	344	74	67	56	57	146	163	90	57	55	50	349
None	91	29	4	4	4	6	15	9	8	3	4	5	
$100 to $499	65	11	5	2	5	3	12	16	3	2	4	1	1
$500 to $999	139	26	14	9	11	8	31	27	9	1	2		1
$1,000 to $1,499	130	27	13	14	8	8	24	21	9	3	1	1	1
$1,500 to $1,999	202	53	12	16	4	11	26	30	22	14	7	6	1
$2,000 to $2,999	354	120	15	16	17	15	24	50	25	23	29	20	
$3,000 to $3,999	94	35	7	3	4	3	8	8	7	5	3	11	
$4,000 to $4,999	33	17	1	1	2	1	1	1	2	1	2	4	
$5,000 to $5,999	21	11	1	1		1			2	2	3		
$6,000 to $7,999	17	9	1		1	1	3			1		1	
$8,000 and over	6	4					1		1				
Unknown or other	356	2	1	1			1	1	2	2		1	345

[1] Earned income is for the 12 months preceding Sept. 30, 1955.
[2] Includes Veterans' Administration and military payments.

TABLE 10.—*Earned income of Armed Forces disability retirement and severance cases*

[Classified by effect of disability on ability to do prior civilian work]

Effect of disability	Earned income [1]												
	Total	None	$100 to $499	$500 to $999	$1,000 to $1,499	$1,500 to $1,999	$2,000 to $2,999	$3,000 to $3,999	$4,000 to $4,999	$5,000 to $5,999	$6,000 to $7,999	$8,000 and over	Unknown or other
All	1,508	344	74	67	56	57	146	163	90	57	55	50	349
No civilian work	417	122	29	22	16	19	53	53	35	12	12	10	34
Little or no effect	70	6	4	7	2	7	9	11	3	7	5	8	1
Able to stay in old line of work	168	15	4	2	9	9	20	28	17	14	21	16	13
Able to stay in old line part time	51	13	3	11	2	2	7	0	0	3	2	4	4
Change job because of disability	339	60	29	19	22	16	46	57	34	19	11	9	17
Unable to work	124	95	3	3	2	0	0	3	0	1	3	0	14
Unknown or other	339	33	2	3	3	4	11	11	1	1	1	3	266

[1] Earned income is for the 12 months preceding Sept. 30, 1955.

TABLE 11.—*Earned income of Armed Forces disability retirement and severance cases*

[Classified by total years of regular schooling]

Total regular schooling (years)	Earned income [1]												
	Total	None	$100 to $499	$500 to $999	$1,000 to $1,499	$1,500 to $1,999	$2,000 to $2,999	$2,000 to $3,999	$4,000 to $4,999	$5,000 to $5,999	$6,000 to $7,999	$8,000 and over	Unknown or other
All	1,508	344	74	67	56	57	146	163	90	57	55	50	349
0–7	95	32	4	3	6	5	16	11	1	1	----	----	16
8	186	73	14	8	8	8	25	20	9	----	4	1	16
9–11	307	93	23	16	18	17	43	33	20	4	4	1	35
12	267	59	18	20	10	11	33	46	22	10	8	7	23
13–15	193	54	7	10	6	8	14	27	16	20	9	12	10
16 or more	217	33	8	9	8	8	15	25	22	22	30	29	8
Unknown or other	243	0	0	1	0	0	0	1	0	0	0	0	241

[1] Earned income is for the 12 months preceding Sept. 30, 1955.

TABLE 12.—*Earned income of Armed Forces disability retirement and severance cases*

[Classified by present occupation [1]]

Occupation [1]	Earned income [2]												
	Total	None	$100 to $499	$500 to $999	$1,000 to $1,499	$1,500 to $1,999	$2,000 to $2,999	$3,000 to $3,999	$4,000 to $4,999	$5,000 to $5,999	$6,000 to $7,999	$8,000 and over	Unknown or other
All	1,508	344	74	67	56	57	146	163	90	57	55	50	349
Professional	171	10	5	4	4	4	14	26	21	22	28	30	3
Farmers	13	3				1	4		1	3			1
Managers	71	3	2	4	4	3	6	13	7	8	7	10	4
Clerical	95	5	5	9	6	6	14	24	16	4	3	1	2
Sales	79	2	11	6	4	3	10	16	8	9	5	2	3
Craftsmen	134	6	11	7	9	9	28	29	18	5	3	1	8
Operative	103	6	9	10	4	8	26	20	11	2	3	1	3
Service	99	12	14	8	11	7	19	17	2				9
Farm laborers	18	6	1	2	1	2	2	1	1				2
Laborers or never worked	61	9	7	6	7	5	14	8	2	1			2
Unknown or other	664	282	9	11	6	9	9	9	3	3	6	5	312

[1] Longest occupation in the 12 months ending Sept. 30, 1955.
[2] Earned income is for the 12 months ending Sept. 30, 1955.

TABLE 13.—*Earned income of Armed Forces retirement and separation cases*

[Classified by number of weeks worked]

Number of weeks worked [1]	Earned income [2]												
	Total	None	$100 to $499	$500 to $999	$1,000 to $1,499	$1,500 to $1,999	$2,000 to $2,999	$3,000 to $3,999	$4,000 to $4,999	$5,000 to $5,999	$6,000 to $7,999	$8,000 and over	Unknown or other
All	1,508	344	74	67	56	57	146	163	90	57	55	50	349
None	296	210	6	5	6	5	10	6	3	1	3	3	38
1–26 full time	141	12	31	19	12	11	15	16	6	8	3	4	4
27–47 full time	114	8	2	2	11	17	33	14	10	3	6	3	5
48–52 full time	394	13	4	4	9	9	62	110	65	37	35	30	16
1–26 part time	84	9	23	23	4	3	8	2	0	2	2	1	7
27–52 part time	81	1	4	7	10	10	14	12	5	3	5	6	4
Unknown	398	91	4	7	4	2	4	3	1	3	1	3	275

[1] Weeks of full-time or part-time work in the 12 months preceding Sept. 30, 1955.
[2] Earned income is for the 12 months preceding Sept. 30, 1955.

TABLE 14.—*Earned income of Armed Forces retirement and severance cases*

[Classified by months of vocational rehabilitation received]

Vocational rehabilitation received (months)	Earned income [1]												
	Total	None	$100 to $499	$500 to $999	$1,000 to $1,499	$1,500 to $1,999	$2,000 to $2,999	$3,000 to $3,999	$4,000 to $4,999	$5,000 to $5,999	$6,000 to $7,999	$8,000 and over	Unknown or other
All	1,508	344	74	67	56	57	146	163	90	57	55	50	349
None	16	2	2	1	2	2	3	2	1	0	0	0	1
Less than 3	16	3	0	2	0	2	2	4	0	0	0	0	3
3–5	38	8	3	3	1	1	8	5	1	2	2	1	3
6–8	35	14	2	1	3	2	4	2	3	1	0	1	2
9–11	22	8	3	2	0	0	4	1	1	0	1	1	1
12–17	27	15	2	1	1	0	2	3	2	1	0	0	0
18–23	21	8	1	4	1	3	2	1	0	1	0	0	0
24–29	30	10	2	1	2	1	3	3	1	4	2	0	1
30–35	6	4	0	0	1	0	0	0	1	0	0	0	0
36–41	19	7	0	2	0	3	1	2	2	1	1	0	0
42 or more	13	2	2	0	0	1	2	3	1	2	0	0	0
Unknown [2]	1,265	263	57	50	45	42	115	137	77	45	49	47	338

[1] During 12 months ending Sept. 30, 1955.
[2] Probably none in most instances.

TABLE 15.—*Earned income of Armed Forces disability retirement and severance cases*

[Classified by extent to which Veterans' Administration training was reported as useful in present job]

Use of VA training	Earned income [1]												
	Total	None	$100 to $499	$500 to $999	$1,000 to $1,499	$1,500 to $1,999	$2,000 to $2,999	$3,000 to $3,999	$4,000 to $4,999	$5,000 to $5,999	$6,000 to $7,999	$8,000 and over	Unknown or other
All	1,508	344	74	67	56	57	146	163	90	57	55	50	349
Basis of present job	115	18	7	7	5	6	10	19	16	10	9	5	3
Used great deal	80	20	4	5	4	3	8	11	3	4	3	7	8
Fairly useful	61	8	3	3	4	4	10	9	4	7	4	3	2
Used little	38	9	5	3	3	4	2	5	5	0	0	0	2
Not used	96	21	7	10	2	6	13	14	4	6	2	2	9
Unknown or other [2]	1,118	268	48	39	38	34	103	105	58	30	37	33	325

[1] During 12 months ending Sept. 30, 1955.
[2] Most of these cases probably had no VA training.

TABLE 16.—*Total income of Armed Forces disability retirement and separation cases*

[Classified by monthly rate of retirement payment]

Monthly rate of retired payment	Total income [1]												
	Total	None	$100 to $499	$500 to $999	$1,000 to $1,499	$1,500 to $1,999	$2,000 to $2,999	$3,000 to $3,999	$4,000 to $4,999	$5,000 to $5,999	$6,000 to $7,999	$8,000 and over	Unknown or other
All	1,508	286	95	87	64	59	152	164	90	53	73	36	349
None	592	127	29	36	23	18	62	56	26	11	5	5	194
$1 to $19	12	4	0	0	0	2	0	0	1	0	0	0	5
$20 to $39	34	2	1	1	2	3	7	3	2	2	1	0	10
$40 to $59	67	15	2	5	3	3	10	10	1	1	2	1	14
$60 to $99	114	19	10	11	9	8	18	15	3	1	0	0	20
$100 to $199	366	62	30	13	14	12	36	48	34	21	21	16	59
$200 to $299	208	34	13	11	8	8	12	25	19	12	27	12	27
$300 to $399	67	14	6	5	1	3	4	6	3	3	6	5	11
$400 to $499	22	5	3	2	2	0	1	1	1	1	3	1	2
$500 to $599	13	2	1	0	1	2	1	0	0	1	2	0	3
$600 and over	13	2	0	3	1	0	1	0	0	0	1	1	4

[1] For the 12-month period preceding Sept. 30, 1955. Includes military retirement or other Government payments.

TABLE 17.—*Total family income of Armed Forces disability retirement and severance cases*

[Classified by size of family and marital status]

Size of family and marital status	Family income [1]												
	Total	None	$100 to $499	$500 to $999	$1,000 to $1,499	$1,500 to $1,999	$2,000 to $2,999	$3,000 to $3,999	$4,000 to $4,999	$5,000 to $5,999	$6,000 to $7,999	$8,000 and over	Unknown or others
All	1,508	14	10	30	33	65	189	171	138	129	168	172	389
1 person	204	2	1	15	16	23	54	24	15	10	5	7	32
2 persons, unmarried	42			2	2	4	12	9	4	4	2	0	3
3 persons, unmarried	43		1			1	11	6	4	3	7	6	4
4 or more, unmarried	42	2		1	2	4	2	5	6	4	4	9	3
2 persons, married	248	3	4	7	6	11	37	40	33	28	42	29	8
3 persons, married	175	1	0	2	3	8	24	32	24	19	33	17	12
4 persons, married	220	2	0	3	3	5	23	27	29	34	33	49	12
5 persons, married	126	1	2		1		14	18	10	15	26	33	6
6 Persons, married	79	2				5	7	6	9	11	15	19	5
Unknown or other	329	1	2			4	5	4	4	1	1	3	304

[1] Family income is the income of all the members for the 12 months preceding Sept. 30, 1955, and includes Government payments.

TABLE 18.—*Total family income of Armed Forces disability retirement and severance cases*

[Classified by age of ex-serviceman]

Age [1]	Family income [2]												
	Total	None	$100 to $499	$500 to $999	$1,000 to $1,499	$1,500 to $1,999	$2,000 to $2,999	$3,000 to $3,999	$4,000 to $4,999	$5,000 to $5,999	$6,000 to $7,999	$8,000 and more	Unknown or other
All	1,508	14	10	30	33	65	189	171	138	129	168	172	389
Under 25 years	144	1	3	7	4	10	23	18	8	9	9	2	50
25–34	593	4	2	13	21	31	88	83	64	44	47	31	165
35–44	363	3	----	1	1	8	38	35	34	38	60	71	74
45–54	207	3	1	1	3	5	22	18	20	21	26	40	47
55–64	148	3	2	6	3	8	16	14	10	11	17	17	41
65 and over	37	0	2	2	1	3	----	2	1	1	6	8	11
Unknown	16	0	0	0	0	0	2	1	1	5	3	3	1

[1] Age as of Jan. 1, 1956.
[2] Family income is the income of all the members for the 12 months preceding Sept. 30, 1955.

TABLE 19.—*Years of active service in Armed Forces disability retirement and severance cases*

[Classified by degree of disability]

Degree of disability rating	Years of active service							
	Total	Under 2	2–3.9	4–5.9	6–9.9	10–19.9	20 or more	Unknown or other
All	1,508	116	369	234	205	208	265	111
0	69	12	15	20	14	6	2	0
10	127	20	36	13	17	12	14	15
20	114	6	24	15	10	12	28	19
30	241	28	67	32	28	37	35	14
40	168	14	54	28	21	22	20	9
50	90	7	24	17	15	8	11	8
60	132	4	30	16	27	23	24	8
70	63	1	16	14	7	11	7	7
80	57	2	15	6	6	16	10	2
90	10	3	3	0	0	2	1	1
100	432	18	85	73	60	59	113	24
Unknown [1]	5	1	0	0	0	0	0	4

[1] The number of unknown cases in some later tabulations is shown at 4 due to mechanical differences in basic tabulations.

TABLE 20.—*Years of active service in Armed Forces disability retirement and severance cases*

[Classified by branch of service]

Branch of service	Years of active service							
	Total	Under 2	2 to 3.9	4 to 5.9	6 to 9.9	10 to 19.9	20 or more	Unknown or other
All	1,508	116	369	234	205	208	265	111
Army	776	57	202	130	111	90	152	34
Air Force	277	32	88	40	39	41	33	4
Navy	352	27	79	64	55	65	62	----
Marines	103	----	----	----	----	12	18	73

TABLE 21.—*Vocational rehabilitation training received by Armed Forces disability retirement and severance cases*

[Classified by degree of disability]

Degree of disability rating	Training received				
	Total	None or unknown	Armed Forces	Veterans' Administration	All other
All	1,508	1,244	20	232	12
0	69	61	1	7	----
10	127	111	2	13	1
20	114	98	1	14	1
30	241	191	5	44	1
40	168	138	3	24	3
50	90	73	1	16	----
60	132	110	----	21	1
70	63	52	1	10	----
80	57	49	----	7	1
90	10	7	----	3	----
100	432	349	6	73	4
Unknown	5	5	----	----	----

TABLE 22.—*Extent of vocational rehabilitation training received by Armed Forces disability retirement and severance cases*

[Classified by age]

Vocational rehabilitation received (months)	Age [1]							
	Total	Under 25 years	25 to 34	35 to 44	45 to 54	55 to 64	65 and over	Unknown or other
All	1,508	144	593	363	207	148	37	16
None	16	1	7	4	1	3		
Less than 3	16	4	7	3	1	1		
3 to 5	38	4	16	13	2	2	1	
6 to 8	35	2	18	8	1	2	3	1
9 to 11	22	2	12	6	1	1		
12 to 17	27	2	11	6	1	3	1	3
18 to 23	21	1	10	4	5	1		
24 to 29	30		14	11	2	2	1	
30 to 35	6	2		2	2			
36 to 41	19		10	9				
42 or more	13		3	6	3			1
Unknown	1,265	126	485	291	188	133	31	11

[1] As of Jan. 1, 1956.

TABLE 23.—*Use of Veterans' Administration training by Armed Forces disability retirement and severance cases*

[Classified by degree of disability]

Use of Veterans' Administration training in present job [1]	Degree of disability rating												
	Total	0	10	20	30	40	50	60	70	80	90	100	Unknown
Total	1,508	69	127	114	241	168	90	132	65	56	9	432	5
Basis of present job	115	3	13	7	27	14	7	9	9	2	2	22	
Used great deal	80	2	5	7	18	11	3	5	6	4	1	18	
Fairly useful	61	4	2	7	12	2	8	4	1	5		16	
Used little	38	1	1	5	11	2	3	3	2	1		9	
Not used	96	6	10	4	14	11	8	9	2	3		29	
No Veterans' Administration training or unknown	1,118	53	96	84	159	128	61	102	45	41	6	338	5

[1] Includes both vocational rehabilitation and "GI Bill" training and education.

TABLE 24.—*Use of Veterans' Administration training by Armed Forces disability retirement and severance cases*

[Classified by age]

Age [1]	Total	Use made of Veterans' Administration training					
		Basis of present job	Used great deal	Fairly useful	Used little	Not used	No Veterans' Administration training and unknown
All	1,508	115	80	61	38	96	1,118
Under 25 years	144	1	6	4	5	7	121
25–34	593	48	38	25	12	40	430
35–44	363	43	22	18	11	22	247
45–54	207	18	6	7	6	11	159
55–64	148	1	4	6	3	16	118
65 and over	37		2	1			34
Unknown or other	16	4	2		1		9

[1] As of Jan. 1, 1956.

TABLE 25.—*Use of Veterans' Administration training by Armed Forces disability retirement and severance cases*

[Classified by occupation]

Occupation [1]	Use made of Veterans' Administration training						No Veterans' Administration training or unknown
	Total	Basis of present job	Used great deal	Fairly useful	Used little	Not used	
All	1,508	115	80	61	38	96	1,118
Professional	171	49	16	17	4	6	79
Farmers	13	1	2	2	1	----	7
Managers	71	6	8	4	3	5	45
Clerical	95	6	6	6	5	12	60
Sales	79	3	4	4	2	7	59
Craftsmen	134	13	10	5	6	7	93
Operative	103	7	1	4	2	6	83
Service	99	9	7	5	4	14	60
Farm laborers	18	2	1	1	----	2	12
Laborers, never worked	61	3	3	3	3	7	42
Unknown or other	664	16	22	10	8	30	578

[1] Longest occupation in last 12 months ending Sept. 30, 1955.

TABLE 26.—*Government payments to Armed Forces disability retirement and severance cases*

[Classified by degree of disability]

Degree of disability rating	Government payment (Armed Forces+Veterans' Administration) [1]												
	Total	None	$100 to $499	$500 to $999	$1,000 to $1,499	$1,500 to $1,999	$2,000 to $2,999	$3,000 to $3,999	$4,000 to $4,999	$5,000 to $5,999	$6,000 to $7,999	$8,000 and over	Unknown or other
All	1,508	91	65	139	130	202	354	94	33	21	17	6	356
0	69	22	5	3		4	6	1	1		1		26
10	127	17	10	12	5	15	16	3	1	1	1	2	44
20	114	12	11	6	6	11	26	6	4		3	2	27
30	241	10	18	40	23	43	51	7	5		1		43
40	168	9	2	27	31	20	28	5	2	2	1		41
50	90		2	18	14	13	23	8	1		1		10
60	132	2	4	9	13	26	29	14	1	2	3		29
70	63	1	2	3	4	10	17	6		1	3	1	15
80	57	4	1	1	2	4	15	8	6	1	1		14
90	10	2				2	4	2					
100	432	12	10	20	31	54	139	34	12	14	2	1	103
Unknown	5				1								4

[1] For year ending Sept. 30, 1955.

TABLE 27.—*Government payments to Armed Forces disability retirement and severance cases*

[Type of personnel]

Type of personnel	Government payment (Armed Forces and Veterans' Administration) [1]												
	Total	None	$100 to $499	$500 to $999	$1,000 to $1,499	$1,500 to $1,999	$2,000 to $2,999	$3,000 to $3,999	$4,000 to $4,999	$5,000 to $5,999	$6,000 to $7,999	$8,000 and over	Unknown or other
All	1,508	91	65	139	130	202	354	94	33	21	17	6	356
Enlisted men	1,004	67	47	132	118	135	192	28	6	6		1	272
Officers	475	24	17	5	11	60	151	65	27	14	16	5	80
Warrant officers	24		1		1	7	10			1	1		3
Unknown	5			2			1	1					1

[1] For year ending Sept. 30, 1955.

TABLE 28.—*Comparison of military retirement and Veterans' Administration payments to Armed Forces disability retirement and severance cases* [1]

Retirement payments	Veterans' payments												
	Total	None	Under $300	$300 to $899	$900 to $1,499	$1,500 to $2,099	$2,100 to $2,699	$2,700 to $3,299	$3,300 to $3,899	$3,900 to $4,499	$4,500 to $5,099	$5,100 or more	Unknown or other
All	1,508	762	25	90	96	76	61	22	10	6	1	7	352
None	359	91	6	45	52	67	54	22	10	5	1	5	1
Less than $600	85	52	6	11	10	3	3						
$600 to $999	116	82	4	10	14	4	1						1
$1,000 to $1,999	220	186	3	15	13		2			1			
$2,000 to $2,999	242	229	4	3	5		1						
$3,000 to $3,999	71	62	1	3	2	1						2	
$4,000 to $4,999	27	26		1									
$5,000 to $5,999	14	12		1		1							
$6,000 to $6,999	7	6	1										
$7,000 and over	12	11		1									
Unknown or other	355	5											350

[1] During year ending Sept. 30, 1955.

TABLE 29.—*Military disability retirement payments to Armed Forces disability retirement and severance cases*

Age	Retirement payments [1]											
	Total	None	Less than $600	$600 to $999	$1,000 to $1,999	$2,000 to $2,999	$3,000 to $3,999	$4,000 to $4,999	$5,000 to $5,999	$6,000 to $6,999	$7,000 and over	Unknown or other
All	1,508	359	85	116	220	242	71	27	14	7	12	355
Under 25	144	58	18	11	5	8			1			43
25–34	593	201	42	78	67	35	10	1			1	158
35–44	363	51	11	13	72	115	26	1	2	1	4	67
45–54	207	23	6	8	41	45	22	13	7			42
55–64	148	17	7	5	26	29	11	9	2	4	4	34
65 and over	37	5	1		5	4	2	3	2	2	3	10
Unknown or other	16	4		1	4	6						1

[1] During year ending Sept. 30, 1955.

TABLE 30.—*Veterans' Administration payments to Armed Forces disability retirement and severance cases*

[Classified by age]

Age	Veterans' payments [1]												
	Total	None	Under $300	$300 to $899	$900 to $1,499	$1,500 to $2,099	$2,100 to $2,699	$2,700 to $3,299	$3,300 to $3,899	$3,900 to $4,499	$4,500 to $5,099	$5,100 or more	Unknown or other
All	1,508	762	25	90	96	76	61	22	10	6	1	7	352
Under 25	144	45	4	10	8	18	8	3	2	----	1	1	44
25 to 34	593	211	9	47	61	38	40	17	6	4	----	4	156
35 to 44	363	231	9	15	17	10	9	2	1	1	----	1	67
45 to 54	207	134	3	11	7	7	2	----	----	1	----	1	41
55 to 64	148	102	----	5	2	2	2	----	1	----	----	----	34
65 and over	37	26	----	1	----	1	----	----	----	----	----	----	9
Unknown or other	16	13	----	1	1	----	----	----	----	----	----	----	1

[1] During year ending Sept. 30, 1955.

TABLE 31.—*Weeks worked by Armed Forces disability retirement and severance cases*

[Classified by degree of disability]

Number weeks worked [1]	Percentage disability rating												
	Total	0	10	20	30	40	50	60	70	80	90	100	Unknown or other
All	1,508	69	127	114	241	168	90	132	63	57	10	432	5
None	296	4	18	18	32	30	19	31	16	16	4	108	----
1 to 26 full time	141	8	12	10	24	23	10	18	4	2	----	29	1
27 to 47 full time	114	7	8	11	24	17	12	7	2	3	----	23	----
48 to 52 full time	394	18	40	41	79	42	24	30	18	12	4	86	----
1 to 26 part time	84	2	5	2	17	8	8	7	6	2	----	26	1
27 to 52 part time	81	4	2	5	15	9	3	5	2	2	1	33	----
Unknown or other	398	26	42	27	50	39	14	34	15	20	1	127	3

[1] During year ended Sept. 30, 1955.

TABLE 32.—*Occupations of Armed Forces disability retirement and severance cases*

[Classified by age]

Occupation	Age							
	Total	Under 25 years	25 to 34	35 to 44	45 to 54	55 to 64	65 and over	Unknown or other
All	1,508	144	593	363	207	148	37	16
Professional	171	----	41	74	34	15	2	5
Farmers	13	----	3	2	4	3	1	----
Managers	71	1	15	31	18	5	----	1
Clerical	95	5	40	31	10	6	1	2
Sales	79	6	28	30	8	3	1	3
Craftsmen	134	15	64	28	17	7	----	3
Operative	103	16	57	12	10	7	----	1
Service	99	9	44	25	16	4	1	----
Farm laborers	18	1	8	5	3	1	----	----
Laborers, never worked	61	8	36	4	5	8	----	----
Unknown or other	664	83	257	121	82	89	31	1

TABLE 33.—*Effect of disability on ability to do prior civilian work by Armed Forces disability retirement and severance cases*

[Classified by age]

Effect of wartime service	Age							
	Total	Under 25 years	25 to 34	35 to 44	45 to 54	55 to 64	65 and over	Unknown or other
All	1,508	144	593	363	207	148	37	16
No civilian work	417	59	155	92	48	52	7	4
Little or no effect	70	6	24	23	8	7	----	2
Able to stay in old line of work	168	12	54	52	29	14	3	4
Able to stay in old line work, part time	51	1	20	13	9	6	2	----
Change jobs because of disability	339	23	140	96	52	20	4	4
Unable to work	124	11	49	24	14	13	12	1
Unknown or other	339	32	151	63	47	36	9	1

TABLE 34.—*Work days lost because of disability by Armed Forces disability retirement and severance cases*

[Classified by degree of disability]

Degree of disability rating	Work days lost because of disability [1]											
	Total	None	Less than 10	10 to 19	20 to 29	30 to 49	50 to 74	75 to 124	125 to 174	175 to 224	225 or more	Unknown or other
All	1,508	346	152	150	81	98	41	57	25	25	112	421
0	69	9	8	3	6	7	2	1	3	0	3	27
10	127	20	15	15	8	5	2	3	3	5	6	45
20	114	26	12	16	5	10	6	5	4	0	6	24
30	241	36	31	35	12	25	10	16	3	5	13	55
40	168	39	19	13	13	11	1	7	2	1	10	52
50	90	28	10	15	5	3	2	5	1	2	8	11
60	132	40	9	12	8	12	4	5	2	2	6	32
70	63	17	3	10	2	5	0	2	2	0	5	17
80	57	18	4	2	0	1	0	3	0	0	8	21
90	10	6	1	1	1	0	0	0	0	0	1	0
100	432	107	40	28	21	18	14	10	5	10	45	134
Unknown or other	5	0	0	0	0	1	0	0	0	0	1	3

[1] During year ending Sept. 30, 1955.

TABLE 35.—*Work days lost because of disability by Armed Forces disability retirement and severance cases*

[Classified by age]

Age	Work days lost because of disability											
	Total	None	Less than 10	10 to 19	20 to 29	30 to 49	50 to 74	75 to 124	125 to 174	175 to 224	225 or more	Unknown or other
All	1,508	346	152	150	81	98	41	57	25	25	112	421
Under 25	144	30	13	10	4	5	2	7	2	3	17	51
25 to 34	593	134	53	54	35	46	15	17	11	6	43	179
35 to 44	363	77	56	50	20	24	11	18	6	8	17	76
45 to 54	207	50	17	22	11	18	7	9	4	5	9	55
55 to 64	148	40	7	12	7	3	5	6	1	3	19	45
65 and over	37	10	1	0	3	1	1	0	1	0	7	13
Unknown or other	16	5	5	2	1	1	0	0	0	0	0	2

TABLE 36.—*Comparison of years of schooling by Armed Forces disability retirement and severance cases before service and at present*

Total present regular schooling (years)	Years of schooling before entering Armed Forces							
	Total	0 to 7	8	9 to 11	12	13 to 15	16 or more	Unknown or other
Total	1,508	96	192	321	318	168	170	243
0 to 7	95	95						
8	186		186					
9 to 11	307	1	5	301				
12	267			13	254			
13 to 15	193		1	7	49	136		
16 or more	217				15	32	170	
Unknown or other	243							243

TABLE 37.—*Comparison of disability ratings by Veterans' Administration and Armed Forces in military disability retirement and severance cases*

[Distribution of ratings and computed averages][1]

Degree of disability rating	Veterans' Administration ratings		Armed Forces ratings	
	Number	Percent	Number	Percent
All	971	100.0	971	100.0
Percent:				
0	347	35.7	55	5.7
10	69	7.1	85	8.7
20	42	4.3	68	7.0
30	72	7.4	158	16.3
40	73	7.5	120	12.4
50	57	5.9	60	6.2
60	68	7.0	91	9.4
70	38	3.9	40	4.1
80	24	2.5	39	4.0
90	11	1.1	9	.9
100	170	17.6	242	24.9
Unknown [2]	----------	----------	4	.4
Mean rating	----------	37.2	----------	52.9

[1] Means are computed assuming each rating as shown and not by use of the midpoint.
[2] Due to mechanical differences in basic tabulations the number of unknown cases in some other tables is shown as 5.

TABLE 38.—*Comparison of disability ratings by Veterans' Administration and Armed Forces in military disability retirement and severance cases, distributed by age categories*

[Percentage distribution of ratings, and computed averages]

Degree of Disability Rating	Under 25		25 to 34		35 to 44		45 to 54		55 to 64		65 and over		Unknown	
	VA ratings	Armed Forces ratings	VA ratings	Armed Forces ratings	VA ratings	Armed Forces ratings	VA ratings	Armed Forces ratings	VA ratings	Armed Forces ratings	VA ratings	Armed Forces ratings	VA ratings	Armed Forces ratings
All—Number	124	124	484	484	215	215	93	93	43	43	4	4	8	8
Percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Percent:														
0	25.8	6.5	23.4	6.8	51.1	4.2	62.4	4.3	62.8	2.3	75.0		50.0	
10	7.3	16.1	9.5	7.0	4.2	9.8	3.2	7.6	2.3	4.7			12.5	12.5
20	5.6	4.9	3.7	4.6	4.7	11.2	1.1	10.7	9.3	7.0		25.0	25.0	25.0
30	8.9	16.1	8.1	15.9	5.1	16.7	6.4	18.3	11.7	18.2				12.5
40	8.1	9.7	9.3	15.9	6.5	8.8	3.2	10.7	2.3					25.0
50	6.5	5.6	7.6	6.8	4.7	6.9	2.2	2.2		7.0				
60	.8	8.1	10.1	8.9	5.6	7.4	5.4	14.0	2.3	16.6				12.5
70	5.6	2.4	4.8	4.8	1.9	4.2	3.2	3.2	2.3	4.7				
80	3.2	1.6	3.5	4.3	.9	4.7	1.1	6.4						
90	2.4	1.6	1.2	.8	.5	.9	1.1	1.1						
100	25.8	26.6	18.8	24.0	14.8	24.7	10.7	21.5	7.0	39.5	25.0	75.0	12.5	
Unknown		.8		.2		.5								12.5
Mean percentage rating	46.0	50.4	43.8	53.1	28.5	52.1	22.9	52.0	16.5	68.4	25.0	80.0		

TABLE 39.—*Comparison of disability ratings by Veterans' Administration and Armed Forces in military disability retirement and severance cases for officers and for enlisted men*

[Distribution of ratings, and computed averages]

Degree of disability rating	Officers				Enlisted men			
	VA ratings		Armed Forces ratings		VA ratings		Armed Forces ratings	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All	213	100.0	213	100.0	758	100.0	758	100.0
Percent:								
0	143	67.1	12	5.6	205	27.0	43	5.7
10	11	5.2	27	12.7	58	7.6	58	7.6
20	12	5.6	34	16.0	30	4.0	34	4.5
30	10	4.7	36	16.9	62	8.2	122	16.1
40	7	3.3	13	6.1	66	8.7	107	14.1
50	7	3.3	10	4.7	50	6.6	50	6.6
60	7	3.3	13	6.1	61	8.0	78	10.3
70	4	1.9	6	2.8	34	4.5	34	4.5
80			8	3.8	24	3.2	31	4.1
90					11	1.5	9	1.2
100	12	5.6	51	23.9	157	20.7	191	25.2
Unknown			3	1.4			1	.1
Mean percentage rating [1]		14.9		47.6		43.3		54.4

[1] Means are computed assuming each rating as shown and not by use of the midpoint.

TABLE 40.—*Joint distribution of disability ratings by Veterans, Administration and Armed Forces in disability retirement and severance cases*

[Distribution of ratings by degree of disability, and computed averages]

Disability ratings by Veterans' Administration		Disability ratings by Armed Forces (percent)												Mean rating by Armed Forces [1]
Rating	Number	0	10	20	30	40	50	60	70	80	90	100	Unknown	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
All	971	55	85	68	158	120	60	91	40	39	9	241	5	----------
Percent:														
0	347	7	40	32	78	38	21	33	12	11	2	72	1	49.2
10	69	24	11	8	11	2	2	2	2	1	--------	5	1	22.8
20	42	10	6	14	1	4	--------	2	1	--------	--------	3	1	27.1
30	72	5	14	3	23	5	1	2	3	1	--------	15	----------	42.4
40	73	2	1	6	11	35	6	1	2	2	--------	6	1	43.3
50	57	2	4	--------	9	11	8	5	--------	1	--------	17	----------	56.7
60	68	1	5	3	5	11	7	22	--------	4	--------	10	----------	54.3
70	38	1	1	--------	6	5	1	6	6	--------	1	11	----------	63.4
80	24	--------	--------	--------	1	1	3	3	5	4	1	6	----------	73.3
90	11	--------	--------	--------	1	1	--------	1	4	2	1	1	----------	69.1
100	170	3	3	2	12	7	11	14	5	13	4	95	1	78.4
Mean Rating by Veterans' Administration [2]	----------	21.8	18.3	15.7	24.1	34.0	42.0	42.6	47.3	56.7	71.1	54.4	----------	----------

[1] For cases rated by Veterans' Administration at rates shown in column 1 and frequencies in column 2.
[2] For cases rated by Armed Forces at rates shown at top of corresponding column.

TABLE 41.—*Comparison of disability ratings by Veterans Administration and Armed Forces in military disability retirement and severance cases (all personnel)*

[Distribution of cases according to differences in ratings, classified by age]

Age	Number of cases [1]	Both ratings agree		Military rating, higher		Military rating, lower		Mean percentage ratings		Number of cases in which the rating by the military exceeds (in percentage) the rating of the Veterans' Administration										Number of cases in which the rating by the military was lower (in percentage) than the rating of the Veterans' Administration										Rating unknown
		No.	Percent	No.	Percent	No.	Percent	VA	Mil.	10	20	30	40	50	60	70	80	90	100	10	20	30	40	50	60	70	80	90	100	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)
All ages	971	226	23	486	50	255	26	37	53	67	60	96	57	42	41	28	15	8	72	78	70	26	29	21	10	13	2	3	3	4
Under 25	124	42	34	45	36	36	29	46	50	14	3	14	4	2	1	2	1	1	3	13	7	2	7	2	2	3	----	----	----	1
25 to 34	484	134	28	192	40	157	32	44	53	24	22	36	29	21	17	14	5	4	20	56	44	14	13	11	7	8	1	2	1	1
35 to 44	215	35	16	138	64	41	19	28	52	21	21	26	13	13	8	4	4	1	27	6	15	5	4	5	1	----	----	----	----	1
45 to 54	92	7	8	67	73	18	20	23	52	6	9	15	7	3	7	3	4	2	11	3	4	4	5	1	----	----	----	----	1	1
55 to 64	44	4	9	37	84	3	7	16	68	2	4	4	2	3	7	5	1	----	9	----	----	1	----	2	----	----	----	----	----	----
65 and over	4	1	25	3	75	------	------	25	80	----	1	----	----	----	----	----	----	----	2	----	----	----	----	----	----	----	----	----	----	----
Age unknown	8	3	38	4	50	------	------	------	------	----	----	1	2	----	1	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

[1] Includes unknown.

TABLE 42.—*Comparison of disability ratings by Veterans' Administration and Armed Forces in military disability retirement and severance cases (enlisted men)*

[Distribution of cases according to differences in ratings, classified by age]

Age	Number of cases[1]	Both ratings agree		Military rating, higher		Military rating, lower		Mean percentage ratings		Number of cases in which the rating by the military exceeds (in percentage) the rating of the Veterans' Administration										Number of cases in which the rating by the military was lower (in percentage) than the rating of the Veterans' Administration										Unknown
		No.	Percent	No.	Percent	No.	Percent	VA	Mil.	10	20	30	40	50	60	70	80	90	100	10	20	30	40	50	60	70	80	90	100	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)
All ages	758	200	26	328	43	229	30	47	54	45	38	63	46	33	29	22	9	8	35	72	65	23	25	16	10	13	1	2	2	1
Under 25	123	41	33	45	37	36	29	46	50	14	3	14	4	2	1	2	1	1	3	13	7	2	7	2	2	3	----	----	----	1
25 to 34	443	123	28	171	39	149	34	46	54	19	19	33	27	20	15	13	4	4	17	52	43	14	12	9	7	8	1	2	1	-------
35 to 44	107	26	24	52	49	29	27	44	56	9	7	9	7	7	4	2	1	1	5	5	11	4	2	3	1	2	----	----	1	-------
45 to 54	55	5	9	36	65	14	25	27	51	3	6	5	7	2	5	1	2	2	3	2	4	3	4	1	----	----	----	----	----	-------
55 to 64	26	3	12	22	85	1	4	22	72	----	3	2	1	2	4	4	1	----	5	----	----	----	----	1	----	----	----	----	----	-------
65 and over	3	1	33	2	66	------	------	33	100	----	----	----	----	----	----	----	----	----	2	----	----	----	----	----	----	----	----	----	----	-------
Age unknown	1	1	100	------	------	------	------	10	10	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	-------

[1] Includes unknown.

TABLE 43.—*Comparison of disability ratings by Veterans' Administration and Armed Forces in military disability retirement and severance cases (officers)*

[Distribution of cases according to differences in ratings, classified by age]

Age	Number of cases [1]	Both ratings agree		Military rating, higher		Military rating, lower		Mean percentage ratings		Number of cases in which the rating by the military exceeds (in percentage) the rating of the Veterans' Administration										Number of cases in which the rating by the military was lower (in percentage) than the rating of the Veterans' Administration										Unknown
		No.	Percent	No.	Percent	No.	Percent	VA	Mil	10	20	30	40	50	60	70	80	90	100	10	20	30	40	50	60	70	80	90	100	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)
All ages	213	26	12	158	74	26	12	15	47	22	22	33	11	9	12	6	6	----	37	6	5	3	4	5	----	----	1	1	1	3
Under 25	1	1	100	------	------	------	------	10	10	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----
25 to 34	41	11	27	21	51	8	20	23	40	5	3	3	2	1	2	1	1	----	3	4	1	----	1	2	----	----	----	----	----	1
35 to 44	108	9	8	86	80	12	11	13	48	12	14	17	6	6	4	2	3	----	22	1	4	1	2	2	----	----	1	1	----	1
45 to 54	37	2	5	31	84	4	11	15	55	3	3	10	----	1	2	2	2	----	8	1	----	1	1	----	----	----	----	----	1	----
55 to 64	18	1	6	15	83	2	11	8	52	2	1	2	1	1	3	1	----	----	4	----	----	1	----	1	----	----	----	----	----	----
65 and over	1	------	------	1	100	------	------	------	20	----	1	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----
Age unknown	7	2	29	4	57	------	------	20	30	----	----	1	2	----	1	----	----	----	----	----	----	----	----	----	----	----	----	----	----	1

[1] Includes unknown.

TABLE 44.—*Comparative disability rating by Veterans' Administration and the Armed Forces of servicemen retired for disability under the Career Compensation Act of 1949—Permanent disability retirements*

Age	Number of cases	Both ratings agree		Military rating higher		Military rating lower		Mean percentage ratings		Number of cases in which the rating by the military exceeds (in percentage) the rating of the Veterans' Administration										Number of cases in which the rating by the military was lower (in percentage) than the rating of the Veterans' Administration										Unknown
		Number	Percent	Number	Percent	Number	Percent	VA	Military	10	20	30	40	50	60	70	80	90	100	10	20	30	40	50	60	70	80	90	100	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)
All ages	600	132	22.0	334	55.7	134	22.3	38	59	31	46	70	40	31	29	17	12	5	53	42	33	16	16	10	7	9	0	0	0	
Under 25	54	21	38.9	18	33.3	15	27.8	59	63	1	2	9	3	0	0	1	1	0	1	5	2	2	2	0	2	2	0	0	0	
25 to 34	273	78	28.6	113	41.4	82	30.0	48	59	10	15	23	18	16	12	5	3	2	9	32	20	9	7	5	4	5	0	0	0	
35 to 44	150	22	14.7	104	69.3	24	16.0	28	56	15	15	21	11	9	4	3	3	1	22	4	8	3	2	4	1	2	0	0	0	
45 to 54	74	6	8.1	56	75.7	12	16.2	20	55	3	9	12	5	3	5	3	4	2	10	1	3	3	4	1	0	0	0	0	0	
55 to 64	41	4	9.8	36	87.8	1	2.4	14	66	2	4	4	1	3	7	5	1	0	9	0	0	0	1	0	0	0	0	0	0	
65 and over	4	1	25.0	3	75.0	0	0	25	80	0	1	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	
Unknown	4	0	0	4	100.0	0	0	0	43	0	0	1	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

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TABLE 45.—*Comparative disability rating by Veterans' Administration and the Armed Forces of servicemen retired for disability under the Career Compensation Act of 1949—temporary disability retirements*

Age	Number of cases	Both ratings agree		Military rating higher		Military rating lower		Mean percentage ratings		Number of cases in which the rating by the military exceeds (in percentage) the rating of the Veterans' Administration										Number of cases in which the rating by the military was lower (in percentage) than the rating of the Veterans' Administration										Unknown
		Number	Percent	Number	Percent	Number	Percent	VA	Military	10	20	30	40	50	60	70	80	90	100	10	20	30	40	50	60	70	80	90	100	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)
All ages	206	62	30.1	113	54.9	31	15.0	46	70	7	6	26	16	11	12	11	3	2	19	4	9	4	6	3	2	3	0	0	0	
Under 25	35	14	40.0	14	40.0	7	20.0	57	71	1	0	5	1	2	1	1	0	1	12	1	2	0	3	1	0	0	0	0	0	
25 to 34	125	40	32.0	65	52.0	20	16.0	48	70	3	5	13	11	5	5	9	2	1	11	2	6	4	2	2	1	3	0	0	0	
35 to 44	33	8	24.2	25	75.8	0	0.0	33	74	2	1	5	2	4	4	1	1	0	5	0	0	0	0	0	0	0	0	0	0	
45 to 54	13	0	0.0	9	69.2	4	30.8	36	57	1	0	3	2	0	2	0	0	0	1	1	1	0	1	0	1	0	0	0	0	
55 to 64																														
65 and over																														
Unknown																														

TABLE 46.—*Comparative disability rating by Veterans' Administration and the Armed Forces of servicemen retired for disability under the Career Compensation Act of 1949—severance pay only*

Age	Number of cases	Both ratings agree		Military rating higher		Military rating lower		Mean percentage ratings		Number of cases in which the rating by the military exceeds (in percentage) the rating of the Veterans' Administration										Number of cases in which the rating by the military was lower (in percentage) than the rating of the Veterans' Administration										Unknown
		Number	Percent	Number	Percent	Number	Percent	VA	Military	10	20	30	40	50	60	70	80	90	100	10	20	30	40	50	60	70	80	90	100	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)
All ages	[1] 160	31	19.4	38	23.7	91	56.9	[2] 23	[1] 10	30	8	----	----	----	----	----	----	----	----	32	29	4	8	7	2	1	2	3	3	5
Under 25	34	6	17.6	14	41.2	14	41.2	15.	9	13	1	----	----	----	----	----	----	----	----	7	3	0	2	1	0	1	0	0	0	1
25 to 34	84	16	19.0	13	15.5	55	65.5	24	9	11	2	----	----	----	----	----	----	----	----	22	18	1	4	4	2	0	1	2	1	2
35 to 44	31	5	16.1	9	29.0	17	54.9	27	11	4	5	----	----	----	----	----	----	----	----	2	7	2	2	1	0	0	1	1	1	1
45 to 54	6	1	16.7	2	33.3	3	50.0	27	7	2	0	----	----	----	----	----	----	----	----	1	0	1	0	0	0	0	0	1	1	0
55 to 64	2	0	0.0	0	0.0	2	100.0	60	25	----	----	----	----	----	----	----	----	----	----	0	1	0	0	1	0	0	0	0	0	0
65 and over	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----
Unknown	3	3	100.0	0	0.0	0	0.0	38	17	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	1

[1] Excludes 5 unknown with respect to military rating.

[2] Includes 5 unknown with respect to military rating.

CHAPTER IV

ACTUARIAL STUDY OF MORTALITY RATES AMONG VETERANS RECEIVING DISABILITY COMPENSATION THROUGH THE VETERANS' ADMINISTRATION

The mortality rate in any group of persons furnishes a measure of the physical vitality [1] of the group. Loss of physical vitality from injuries or disease arising out of military service or civilian employment is a justification for the payment of compensation, though not the sole justification. Certain types of injuries that result in amputations have relatively little effect on physical vitality, though they represent a loss of physical integrity and may cause a loss in earning power. This study is therefore concerned with only one facet of the matter of disability compensation. The public commonly assumes that a person receiving disability compensation has suffered an impairment of health.

The mortality rates among veterans receiving disability compensation from the Veterans' Administration on account of military service in World War I or World War II have now been calculated for the first time. Rates have been obtained for the calendar years 1950 through 1954 for disabilities resulting from service in World War I, and for the years 1946 through 1954 for service in World War II. In some of these years the rates have been obtained by the percentage of disability, ranging from 10 percent to 100 percent, and also by medical diagnosis. Limitation of time and funds has restricted the scope of the inquiry very substantially; there is a great deal more that could and should be done in this area.

The results of this inquiry appear to warrant the following conclusions for the average veteran, though not necessarily for particular individual veterans:

1. Veterans still receiving disability compensation on account of service in World War I are on the average better off from the standpoint of physical vitality than men of the same age in the general population. They probably are as well off from this standpoint as World War I veterans generally, including those not receiving disability compensation, though this point has not been established conclusively.

2. Veterans receiving disability compensation on account of service in World War II were slightly better off from the standpoint of physical vitality in 1954 than men of the same age in the general population. In 1953 and in earlier years they were somewhat worse off. Currently, they are worse off than World War II veterans generally, including those not receiving disability compensation.

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[1] Vitality, as used here, means the power of continuance. The common usage to indicate animation, vigor, or liveliness is not intended.

3. The disabilities that result in ratings of 10 percent or 20 percent by the Veterans' Administration do not represent any impairment of physical vitality on the average. Persons having these ratings appear to be as well off as veterans generally, and much better off than men of the same age in the general population.

4. In general, a higher disability percentage rating in the Veterans' Administration's rating schedule means a greater loss in physical vitality, though not consistently so, and not proportionally so. Thus, a 50-percent rating does not mean half as much of a loss in vitality as a 100-percent rating.

5. The standards for a 100-percent disability rating by the Veterans' Administration represent less in the way of a loss of physical vitality, on the average, than the standards used by commercial life insurance companies in determining the existence of total disability. In this sense, therefore, a 100-percent rating is not synonymous with total disability. When coupled with an income test, however, it can be synonymous, as indicated by the mortality rates among World War II disability pensioners, which is discussed elsewhere.

6. The present compensation of $181 per month for 100 percent disability can almost be justified on the basis of loss of physical vitality alone, without recourse to other bases such as loss of earning capacity, loss of physical integrity, etc. The present compensation for ratings of 30 percent to 90 percent can be partly justified on the basis of loss of physical vitality. No part of the present compensation for ratings of 10 percent or 20 percent can be justified on loss of physical vitality.

OVERALL MORTALITY RATES

This section is a discussion of mortality rates on an overall basis without regard to percentage rating or to diagnosis. The following sections deal with the percentage rating and diagnosis, while the final section presents a technical statement of the procedure followed in obtaining the various rates.

Mortality rates can be stated in either of two ways. One way is to state them in absolute terms, such as the rate per 1,000 persons per year, obtained by dividing the number of deaths occurring during a year by the average number of persons in the group during the year. The other way is to state them relatively, as a percentage of the rates at the same ages in some other group. Both methods will be used here.

Table 1 and chart I show the mortality rates for each of the calendar years covered in this study. The average number receiving compensation represents the average number of veterans on the disability compensation rolls throughout the year. This average has been calculated from the reported number on the rolls at the end of each month in the year. The actual deaths represent the number receiving compensation who died at some time during the year. The numbers under the heading United States males, 1949–51, represents the number of deaths there would have been in the group if the mortality rates on an age by age basis had been the same as those of the United States males mortality table, 1949–51. This table was compiled and published by the National Office of Vital Statistics of the Public Health Service,

Department of Health, Education, and Welfare. The last column in table 1 shows the percentage that the actual deaths are of the number based on the United States males table. Where this percentage is less than 100, the death rates are lower than for men of the same age genrally; where they are more than 100, the mortality rates are higher than for men of the same age generally.

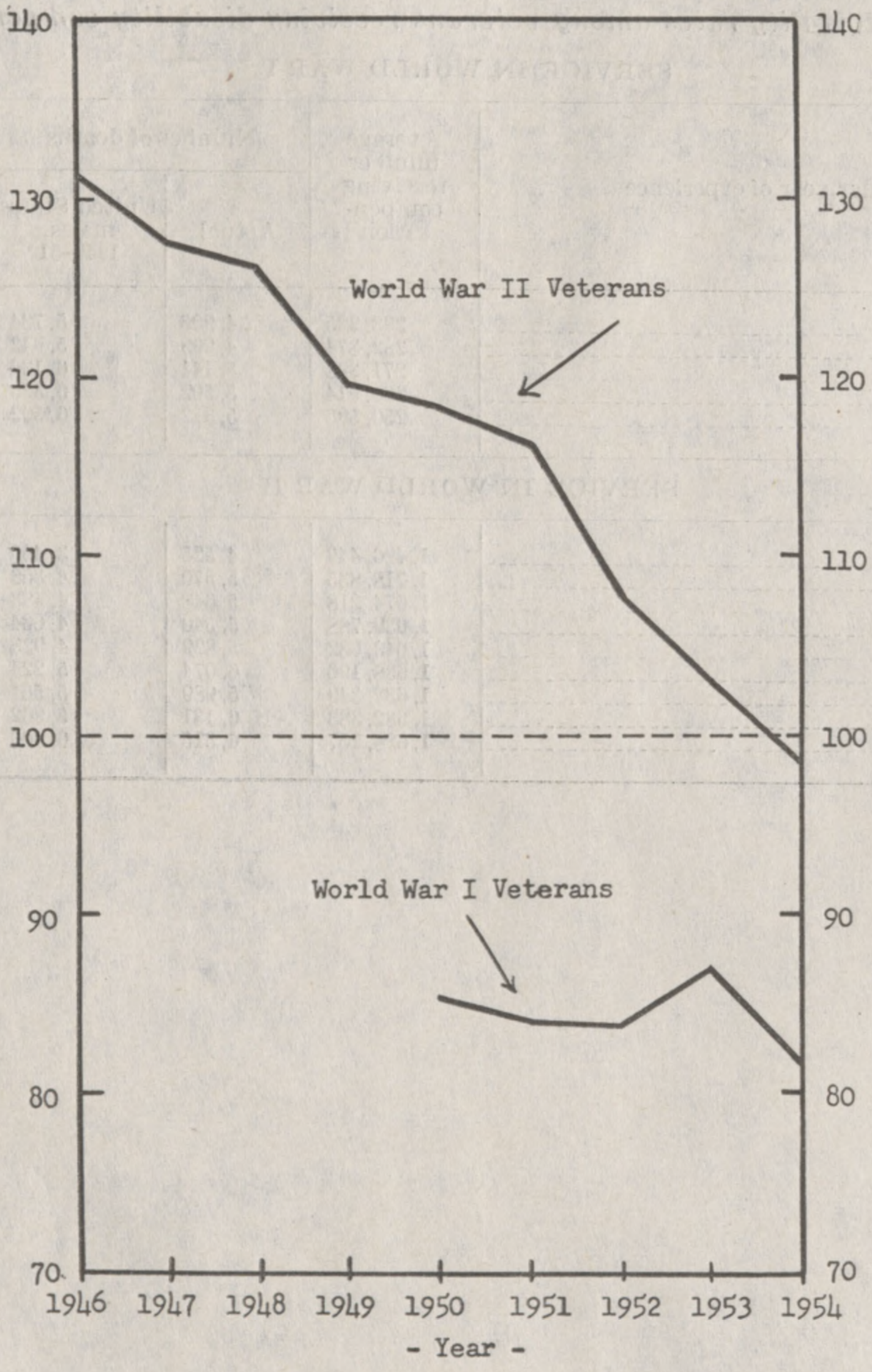
TABLE 1.—*Mortality rates among veterans receiving disability compensation.*

Calendar year of experience	Average number receiving compensation	Number of deaths		Percent ratio
		Actual	United States males, 1949–51	
SERVICE IN WORLD WAR I				
1950	293,225	4,900	5,734	85.4
1951	282,374	4,999	5,942	84.1
1952	271,388	5,141	6,136	83.8
1953	260,914	5,502	6,325	87.0
1954	250,595	5,312	6,502	81.7
SERVICE IN WORLD WAR II				
1946	1,426,449	4,525	3,450	131.2
1947	1,718,835	5,570	4,358	127.8
1948	1,674,218	5,648	4,483	126.0
1949	1,639,788	5,540	4,634	119.6
1950	1,643,732	5,829	4,929	118.3
1951	1,638,196	6,074	5,224	116.3
1952	1,632,349	5,989	5,561	107.7
1953	1,632,383	6,131	5,962	102.8
1954	1,628,257	6,315	6,400	98.7

CHART I

MORTALITY RATES AMONG VETERANS RECEIVING VA DISABILITY COMPENSATION

As Percentage of Rates at Same Ages in U.S. Male Population, All Ages Combined



It would be desirable to have as a basis for comparison a table representing the mortality rates by age among veterans generally, both those receiving disability compensation and those not receiving it. Theoretically, there are two ways in which such rates could be obtained, but actually they cannot now be obtained in either way, due to an incomplete reporting of deaths. The forms for reporting deaths, in all of the States but one, have a space for indicating whether the deceased was a veteran; however, this space is not filled out in many cases, due either to lack of knowledge or due to inattention. A very large proportion of deaths among veterans either occur in Veterans' Administration hos-

pitals or are reported to the Veterans' Administration for the purpose of claiming the veterans' burial allowance; however, it is thought by Veterans' Administration personnel that some of the deaths do not come to their attention. For the present therefore it is possible only to estimate the death rates among veterans generally. On the basis of the number of deaths known to the Veterans' Administration and with a 2 percent allowance for unreported deaths, the mortality rates of veterans generally would be about 75 percent of the United States males table. With a somewhat larger allowance for unreported deaths, the rate might be about 80 percent.

Veterans were able to pass the medical examination at the time of entering military service and, even though they subsequently acquire impairments either during or after military service, it appears that their mortality rates remain below those of the general population for a considerable period of time. However, this point has been established only to the extent indicated above.

As shown in table I, the mortality rates among veterans still receiving compensation for service-connected disabilities from World War I are below that of the general male population. In the years prior to 1954 the mortality rates for World War II service were above those of the general male population, but in 1954 were definitely below. It was not practicable in this study to obtain the World War II rates for 1944 and 1945, the years in which at least 75 percent of the disabilities originated, but the information that is available indicates that the rates were substantially higher than in 1946. The higher rates in 1944 and 1945 were partly the result of the fact that persons with lesser disabilities were retained in the military service.

The mortality rates for living veterans with disabilities originating in World War I service appear to be very nearly equal to the mortality rates for all World War I veterans. In cases where the service resulted in a very serious impairment of physical vitality, the individual had long since died, leaving only those who were less seriously impaired and those who have recovered substantially from the impairment.

Living World War I veterans are now approaching what was a normal life expectancy for men of the corresponding ages in 1918. This is true both for those receiving disability compensation and those not receiving it. As might be expected from this fact, there is little difference in the mortality rates in the two groups.

The mortality rates among World War II veterans receiving disability compensation declined from 131.2 percent of the United States males table in 1946 to 98.7 percent in 1954 (table I). This declining rate is characteristic of any closed group containing a substantial proportion of severely impaired individuals. A closed group is one in which, after some point in time, no new members are added. The group under discussion is a closed group since the disability had to be the result of service in World War II. World War II disability pensioners would not be a closed group, as new members are and will continue to be added, owing to the fact that service-connection is not required for a pension.

The largest decline in mortality rates in a closed, disabled group occurs in the early years of the disability. The more seriously impaired ones die early, leaving the less seriously impaired. Presumably

the rates in the World War II disabled group will eventually decline to about the level of the present rates for World War I disabled veterans.

MORTALITY RATES BY PERCENTAGE RATING

Mortality rates by the percentage disability rating are shown in table 2 and chart II for the years for which data could be obtained.[2] The years are 1950 and 1954 for World War I service, and 1946, 1950, and 1954 for World War II. The percentage rating is the combined degree of impairment when an individual has more than one disability that is service-connected.

Table 2 and chart II show that a higher percentage rating is accomplished by higher mortality rates, but that the rates do not progress consistently from the lower to the higher rates, nor is the progress in proportion to the rating. Thus, a 100 percent rating is accompanied by considerably more than twice as much extra mortality as a 50 percent rating. While it does not necessarily follow that the extra mortality should increase in direct proportion to the percentage rating, it would seem that the relationship should be closer than it is. However, as stated previously, impairment of health is only one facet of disability compensation.

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[2] The term "exposure" that appears in tables 2 and 3 represents the average number receiving disability compensation during the year.

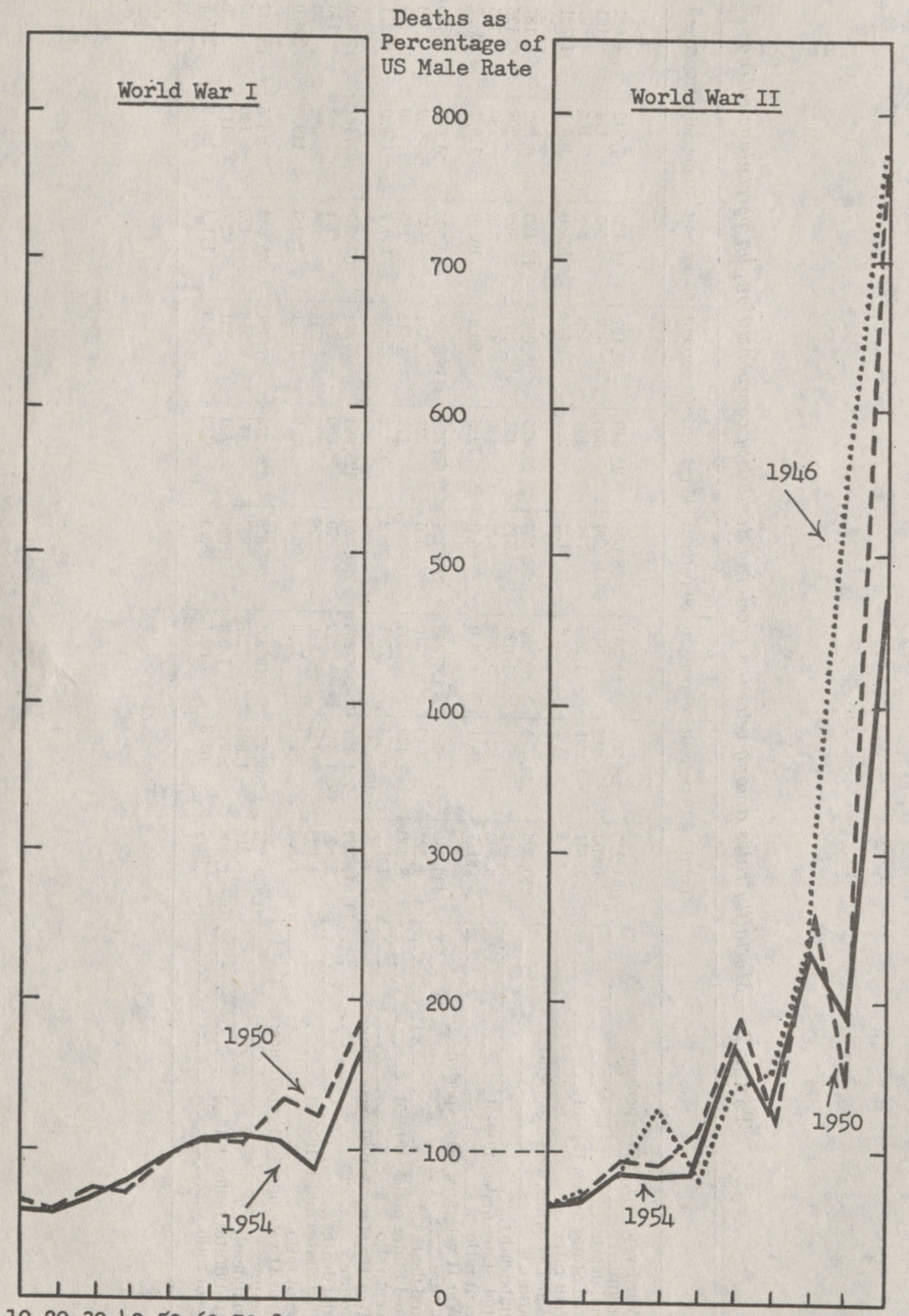
TABLE 2.—*Mortality rates among veterans receiving disability compensation, by percentage rating*

	Total	10 percent	20 percent	30 percent	40 percent	50 percent	60 percent	70 percent	80 percent	90 percent	100 percent
World War I veterans, 1950 experience:											
Exposure	293,225	68,804	83,563	38,634	23,649	19,137	14,490	7,942	4,681	960	31,365
Actual deaths	4,900	848	947	530	336	369	307	174	131	26	1,232
United States males, 1949–51	5,734	1,291	1,590	744	464	389	298	164	97	21	676
Percent ratio	85.4	65.7	59.6	71.2	72.4	94.9	103.0	106.1	135.1	123.8	182.2
World War I veterans, 1954 experience:											
Exposure	250,595	54,770	69,885	32,553	20,975	18,006	13,483	6,892	4,187	861	28,983
Actual deaths	5,312	787	1,020	548	434	469	399	208	125	22	1,300
United States males, 1949–51	6,502	1,354	1,758	826	546	488	373	189	115	25	828
Percent ratio	81.7	58.1	58.0	66.3	79.5	96.1	107.0	110.1	108.7	88.0	157.0
World War II veterans, 1946 experience:											
Exposure	1,426,449	591,665	157,458	246,124	67,755	189,188	45,563	16,969	7,740	899	103,088
Actual deaths	4,525	949	310	526	221	352	159	62	46	11	1,889
United States males, 1949–51	3,450	1,429	402	598	171	432	113	40	19	2	244
Percent ratio	131.2	66.4	77.1	88.0	129.2	81.5	140.7	155.0	242.1	550.0	774.2
World War II veterans, 1950 experience:											
Exposure	1,643,732	721,173	248,263	270,329	128,691	86,224	62,067	29,181	17,320	5,028	75,456
Actual deaths	5,829	1,368	572	770	360	289	371	98	133	19	1,849
United States males, 1949–51	4,929	2,125	780	799	396	251	195	82	50	13	238
Percent ratio	118.3	64.4	73.3	96.4	90.9	115.1	190.3	119.5	266.0	146.2	776.9
World War II veterans, 1954 experience:											
Exposure	1,628,257	709,256	249,851	259,578	128,273	87,381	65,633	30,655	19,247	5,698	72,685
Actual deaths	6,315	1,691	718	897	444	288	473	140	165	36	1,463
United States males, 1949–51	6,400	2,715	1,031	1,007	521	331	276	113	70	19	317
Percent ratio	98.7	62.3	69.6	89.1	85.2	87.0	171.4	123.9	235.7	189.5	461.5

CHART II

MORTALITY RATES AMONG VETERANS RECEIVING VA DISABILITY COMPENSATION

By Disability Percentage Rating



There is one problem in investigating mortality rates by percentage rating or by diagnosis that does not exist in investigating the overall rates. There is a tendency for the rating to be increased or the diagnosis changed as death approaches. This has the effect that an individual may live in one rating or diagnosis and die in another one. An effort was made to limit this effect by using the rating or diagnosis that the diseased had at the beginning of the calendar quarter in which the death occurred. However, this did not eliminate the effect entirely, and consequently the mortality in the lower ratings is somewhat understated and in the higher ratings is somewhat overstated, particularly in the 100 percent rating. If time and facilities had permitted, it would have been desirable to determine the death rates separately for those who had held a particular rating or diagnosis for more than 1 year, or even longer, and those who had held it for a shorter time.

Even with the possible understatement of mortality in the lower ratings, it appears that World War I disabled veterans with ratings of 10 percent to 40 percent inclusive, and World War II veterans with ratings of 10 percent or 20 percent, were physically as healthy as veterans generally, and healthier than men of the same age in the general population.

It is said that the relatively large number of World War II veterans having a 50 percent rating in 1946 and the relatively low mortality rate in this group was the result of 2 factors: (1) The change in the rating schedule that became effective during the year, and (2) the large number of applications received during the rapid demobilization. The new rating schedule was much more complex than the old, and required time for the adjudication personnel to master. Instructions were issued therefore to assign a tentative rating when an appropriate rating was not immediately apparent, and to review the rating after the initial rush was over. It would appear from the low mortality rate that a rather large proportion of those assigned a 50-percent rating really belong in the lower ratings, though this does not follow conclusively.

MORTALITY RATES BY DIAGNOSIS

It has not been possible in this study to investigate the mortality rates by diagnosis as thoroughly as by percentage rating. It has been possible to obtain the rate per 1,000 persons per year, but where 2 rates differ it is not possible to say, except for 3 large groups, how much of the difference is due solely to the severity of the disability and how much is due merely to a difference in the age composition of the group. Also, a change in the rating schedule that became effective in 1946 made it necessary to convert the old diagnostic codes into the new ones. This could not be done in some of the cases, thereby requiring the use of a miscellaneous category. The results also show some evidence of the changing of diagnosis as death approaches.

The information that has been obtained on mortality rates by diagnosis is shown in table 3. Chart III displays a summary in the three diagnostic groups. Where the veteran had more than one disability, the diagnosis of the major disability is the one that has been

used in this table. The higher rates per 1,000 for World War I veterans are, of course, the result of their higher average age. A comparison with the rates for the general male population is shown in all of the instances where it could be obtained, as the percentage ratio to the United States males 1949–51 table. This comparison could be obtained for the 3 groups; tuberculosis, psychiatric and neurological, and general medical and surgical.

TABLE 3.—*Mortality rates among veterans receiving disability compensation*

[Rates per 1,000 persons per year]

SERVICE IN WORLD WAR I

VA code		1950			1954		
		Exposure	Deaths	Rate per 1,000	Exposure	Deaths	Rate per 1,000
100	Total, tuberculosis of lungs and pleura	43,248	711	16.44	38,842	717	18.46
	Percent ratio to United States males, 1949–51			85.7			72.2
210	Psychoses	10,988	187	17.02	10,000	300	30.00
220	Psychoneuroses	28,777	437	15.19	29,940	471	15.73
230	Organic diseases of central nervous system	9,874	222	22.48	8,969	226	25.20
240	The epilepsies	2,149	37	17.22	1,896	61	32.17
	Total, psychiatric and neurological	51,788	883	17.05	45,805	1,058	23.10
	Percent ratio to United States males, 1949–51			86.3			87.7
301	Bones and joints, acute, subacute or chronic, diseases of	51,802	772	14.90	21,702	507	23.36
302	Amputations of upper or lower extremities, including fingers and toes	6,166	126	20.43	5,690	142	24.96
303	Other impairments of upper and lower extremities				22,313	335	15.01
310	Muscle injuries	30,269	358	11.83	25,545	477	18.67
320	Eye, diseases of and impairments of visual acuity	7,002	109	15.57	6,386	125	19.57
330	Ear and other sense organs, diseases of and impairment of auditory acuity	18,312	253	13.82	14,077	234	16.62
340	Systemic conditions	508	9	(1)	132	15	113.64
	Respiratory system, diseases of—						
351	Nose and throat				2,147	35	16.30
352	Trachea and bronchi	27,136	501	18.46	18,857	465	24.66
353	Lungs and pleura, nontuberculosis				3,636	85	23.38
	Cardiovascular system, diseases of—						
361	Heart	18,924	591	31.23	11,396	451	39.58
362	Arteries and veins				4,946	92	18.60
370	Digestive system, diseases of	15,076	233	15.46	12,749	228	17.88
380	Genitourinary system, diseases of	4,987	87	17.45	4,646	101	21.74
394	Gynecological conditions	56			48		
395	Hemic and lymphatic systems, diseases of	82	4	(1)	232	9	38.79
396	Skin conditions	11,248	144	12.80	9,294	145	15.60
397	Endocrine system, diseases of	2,359	57	24.16	1,943	39	20.07
398	Dental and oral conditions	22	7	(1)	209	4	(1)
399	Miscellaneous	4,240	55	12.97		48	
	Total, general medical and surgical	198,189	3,306	16.68	165,948	3,537	21.31
	Percent ratio to United States males 1949–51			85.1			84.2
	Grand total	293,224	4,900	16.71	250,595	5,312	21.20
	Percent ratio to United States males 1949–51			85.4			81.7

[1] Data too scanty for reliable results.

TABLE 3.—*Mortality rates among veterans receiving disability compensation*—Continued

SERVICE IN WORLD WAR II

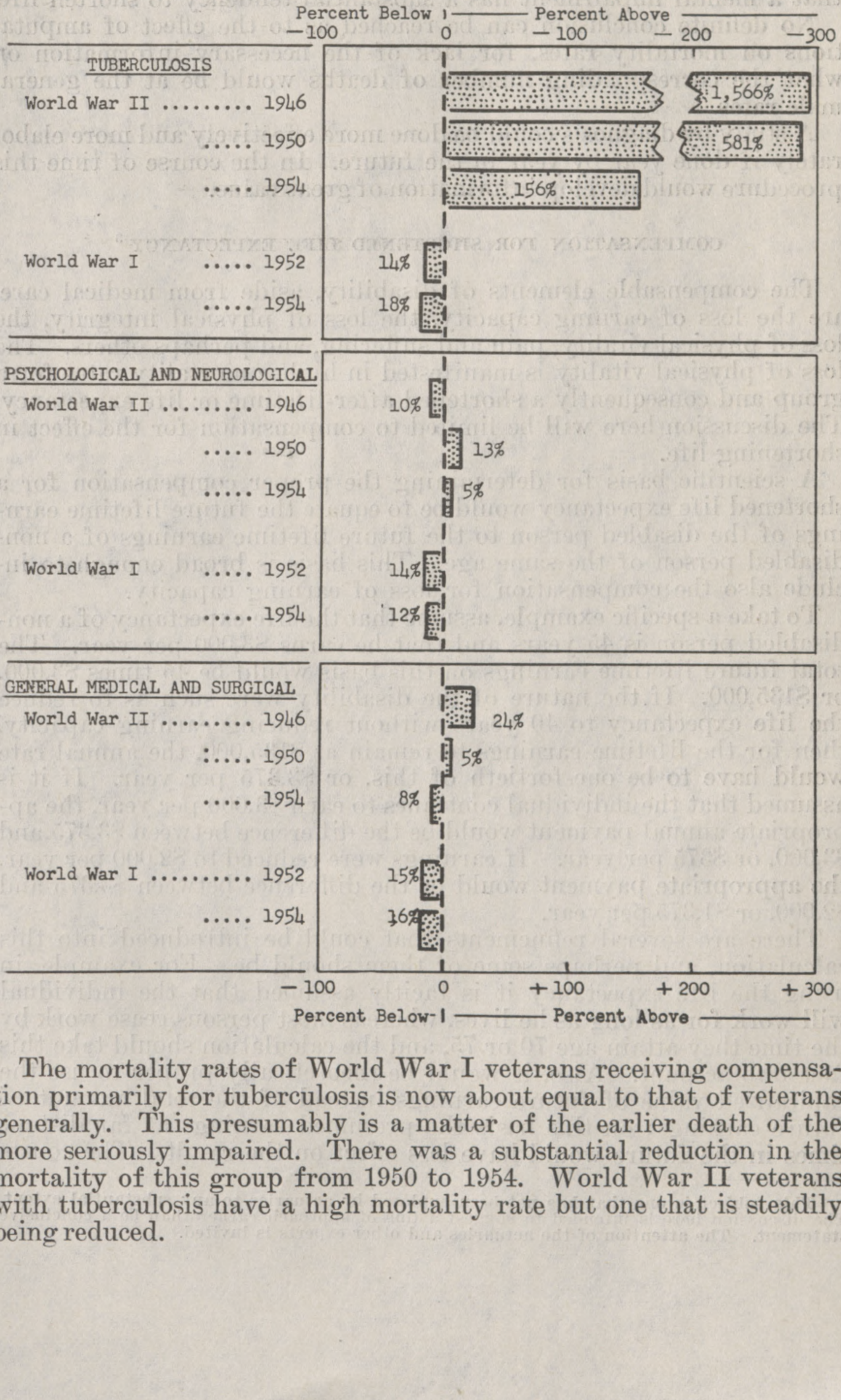
VA code		1946			1950			1954		
		Exposure	Deaths	Rate per 1,000	Exposure	Deaths	Rate per 1,000	Exposure	Deaths	Rate per 1,000
100	Total: Tuberculosis of lungs and pleura	15,538	633	40.74	32,685	633	19.37	43,162	399	9.24
	Percent ratio to U. S. males 1949–51			1,665.8			680.6			255.8
210	Psychoses	63,901	234	3.66	65,072	260	4.00	66,918	279	4.17
220	Psychoneuroses	287,188	445	1.55	241,413	643	2.66	215,772	699	3.24
230	Organic diseases of central nervous system	63,758	181	2.84	78,764	297	3.77	78,991	374	4.73
240	The epilepsies	10,945	38	3.47	9,360	69	7.37	8,454	82	9.70
	Total: Psychiatric and neurological	425,792	898	2.10	394,609	1,269	3.22	370,135	1,434	3.87
	Percent ratio to U. S. males 1949–51			89.6			113.2			104.9
301	Bones and joints, acute, subacute or chronic, diseases of	303,615	517	1.70	418,539	951	2.27	155,099	525	3.38
302	Amputations of upper or lower extremities, including fingers and toes	18,280	44	2.41	31,374	100	3.19	35,049	84	2.40
303	Other impairmants of upper and lower extremities							285,439	734	2.57
310	Muscle injuries	104,106	135	1.30	201,252	272	1.35	192,606	319	1.66
320	Eye, diseases of and impairment of visual acuity	19,828	38	1.92	30,213	64	2.12	31,093	79	2.54
330	Ear and other sense organs, diseases of and impairment of auditory acuity	47,843	97	2.03	71,633	121	1.69	58,070	145	2.50
340	Systemic conditions	150,437	201	1.34	8,216	73	8.89	5,516	77	13.96
	Respiratory system, diseases of—									
351	Nose and throat							16,397	43	2.62
352	Trachea and bronchi	67,035	192	2.86	69,805	310	4.44	49,435	294	5.95
353	Lungs and pleura, nontuberculosis							19,912	52	2.61
	Cardiovascular system, diseases of—									
361	Heart	62,676	438	6.99	85,149	934	10.97	39,672	664	16.74
362	Arteries and veins							74,550	326	4.37
370	Digestive system, diseases of	81,254	304	3.74	99,746	368	3.69	105,774	453	4.28
380	Genitourinary system, diseases of	14,461	188	13.00	20,199	248	12.28	21,248	240	11.30
394	Gynecological conditions	503	2	(1)	1,293	4	(1)	1,463	5	3.42
395	Hemic and lymphatic systems, diseases of	1,703	181	106.28	1,288	156	121.12	2,878	68	23.63
396	Skin conditions	76,879	166	2.16	89,228	193	2.16	110,136	245	2.22
397	Endocrine system, diseases of	7,106	71	9.99	9,068	85	9.37	9,164	95	10.37
398	Dental and oral conditions				60	4	(1)	1,459	2	(1)
399	Miscellaneous	29,393	420	14.29	79,375	44	.55		32	(1)
	Total General medical and surgical	985,119	2,994	3.04	1,216,438	3,927	3.23	1,214,960	4,482	3.69
	Percent ratio to United States males 1949–51			124.2			105.7			91.9
	Grand total	1,426,449	4,525	3.17	1,643,732	5,829	3.55	1,628,257	6,315	3.88
	Percent ratio to United States males 1949–51			131.2			118.3			98.7

[1] Data too scanty for reliable results.

CHART III

MORTALITY RATES BY DIAGNOSIS AMONG VETERANS RECEIVING VA DISABILITY COMPENSATION

As Percentage of Rates at Same Ages in U. S. Male Population



The mortality rates of World War I veterans receiving compensation primarily for tuberculosis is now about equal to that of veterans generally. This presumably is a matter of the earlier death of the more seriously impaired. There was a substantial reduction in the mortality of this group from 1950 to 1954. World War II veterans with tuberculosis have a high mortality rate but one that is steadily being reduced.

World War II veterans with psychiatric or neurological impairments had a higher mortality rate than the general male population in 1950 and 1954, but not in 1946. It is understood that this is a result of some changes in the rating schedule. World War I veterans have a rate that is below the population generally, but above the rate for veterans generally. It is apparent in the World War II group that a mental impairment has a substantial tendency to shorten life.

No definite conclusion can be reached as to the effect of amputations on mortality rates, for lack of the necessary information on what the corresponding number of deaths would be at the general male rates.

A study by diagnosis could be done more effectively and more elaborately if done year by year in the future. In the course of time this procedure would develop information of great value.

COMPENSATION FOR SHORTENED LIFE EXPECTANCY [3]

The compensable elements of disability, aside from medical care, are the loss of earning capacity, the loss of physical integrity, the loss of physical vitality, pain and suffering, and perhaps others. The loss of physical vitality is manifested in higher mortality rates for a group and consequently a shortened after-lifetime or life expectancy. The discussion here will be limited to compensation for the effect in shortening life.

A scientific basis for determining the proper compensation for a shortened life expectancy would be to equate the future lifetime earnings of the disabled person to the future lifetime earnings of a nondisabled person of the same age. This basis is broad enough to include also the compensation for loss of earning capacity.

To take a specific example, assume that the life expectancy of a nondisabled person is 45 years and that he earns $3,000 per year. The total future lifetime earnings on this basis would be 45 times $3,000, or $135,000. If the nature of the disability were such as to reduce the life expectancy to 40 years without reducing earning capacity, then for the lifetime earnings to remain at $135,000, the annual rate would have to be one-fortieth of this, or $3,375 per year. If it is assumed that the individual continues to earn $3,000 per year, the appropriate annual payment would be the difference between $3,375 and $3,000, or $375 per year. If earnings were reduced to $2,000 per year, the appropriate payment would be the difference between $3,375 and $2,000, or $1,375 per year.

There are several refinements that could be introduced into this calculation, and perhaps some of them should be. For example, in using the life expectancy it is tacitly assumed that the individual will work for as long as he lives, whereas most persons cease work by the time they attain age 70 or 75, and the calculation should take this fact into account. Also, it would be theoretically proper to use the capitalized value of future earnings instead of the total amount of future earnings; on this basis the presumed earnings at far distant times in the future would have less effect on the result. The courts

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[3] This subject is one that has not been explored by actuaries to any substantial extent. The discussion here is intended to suggest a line of approach rather than be a conclusive statement. The attention of the actuaries and other experts is invited.

sometimes use calculations of this kind in determining the amount of damages for personal injuries, though in such cases the amount is usually awarded in a lump sum.

This basis for determining the amount of compensation will run counter to popular notions, though, when the disability is such as to prevent the individual from earning anything at all. The common notion in such cases is that the amount of compensation should be less than the full time earnings of a nondisabled individual, to prevent malingering and to discourage rash actions that might lead to total disability. These are practical problems that cannot be introduced into any theoretical calculation. Therefore, it would appear that some practical compromise might be necessary. Similar problems do not arise when the compensation is paid in a lump sum.

An approximate calculation shows that the following monthly payments can be justified on the basis of impairment in longevity by service in World War II for those veterans who have been awarded disability compensation:[1]

Disability rating:	*Monthly amount*	Disability rating—Continued	*Monthly Amount*
10 percent	0	60 percent	$27
20 percent	0	70 percent	13
30 percent	$4	80 percent	45
40 percent	5	90 percent	29
50 percent	6	100 percent	153

A similar table would be very difficult or impossible to prepare for service in World War I on the basis of existing information. The World War I veteran whose health was very seriously impaired have long since died, and the remainder show only a small amount of health impairment on the average.

As stated previously, any compensation payment that cannot be justified by loss of physical vitality would need to be justified on some other basis.

SOURCE OF DATA AND METHODS OF PROCEDURE

This section is intended primarily for experts in the matter of obtaining and interpreting mortality rates, and for anyone who may have occasion to repeat or extend this study.

The basic data were furnished by the Veterans' Administration. The data consisted of the number of running awards of disability compensations at the end of each month in the years under study, for service in World War I or II; the number of running awards on June 30 of each year classified by attained age, or in certain of the years, by attained age, percentage rating, or medical diagnosis (in three groups); and the corresponding number of deaths and other terminations. The running award cards maintained by the Veterans' Administration do not show the date of disability and consequently an investigation by duration and attained age could not be made. However, as the study was confined to disabilities arising from service in a war period, the spread of durations is necessarily limited, particularly as a large proportion of the disabilities occur toward the end of the war period. Disabilities resulting from World War I are of course in the ultimate period, and duration would have no significance anyway.

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[1] These calculations do not take into account the substantial death compensation benefits which are payable in service-connected death cases, which would, of course, reduce these disability payments.

At the death of a serviceman or a veteran from a service-connected cause, the survivors are eligible for substantial benefits. Veterans with severe service-connected disabilities are more likely to die from service-connected causes, particularly when the disabilities are of a kind that tend to shorten life. It would seem reasonable to take the greater actuarial value of the survivors benefits into account in determining the compensation. However, a shortened life expectancy is a personal loss to the individual as well as a loss to the survivors, so that the greater value of the survivor benefits should not be considered as being a complete offset.

For analysis of mortality on the basis of age all deaths among persons receiving Veterans' Administration disability compensation were used. Both deaths and exposures on the basis of 100 percent reporting were taken from Veterans' Administration records. For World War I veterans the study covered the calendar years 1950–54, inclusive, making a total of 25,854 deaths; for World War II veterans, the period 1946–54, inclusive, and covered 51,621 deaths. (See table 1.)

To obtain data for analyzing mortality experience by percentage of disability or by diagnosis, it was necessary to use a sampling approach because the death cards maintained by the Veterans' Administration do not show the percentage rating nor the diagnosis. It was necessary to obtain this information from the case folders. This was done on a sample basis in such a way that one-half of the case folders would be examined. This sample was restricted for reasons of economy and time to 4,671 World War I deaths during calendar years 1950 and 1954, and 7,634 World War II deaths during the calender years 1946, 1950, and 1954.

The cards from the sample were tabulated on the assumption that exactly one-half had been sampled, but it was then discovered that actually only about 45 percent had been examined. The remaining 5 percent had evidently been omitted for the reason that the case folder was not immediately available. The tabulated deaths by rating or diagnosis were adjusted proportionately to the tabulated totals without regard to rating or diagnosis, which were used as a control. This adjustment was made within each 5-year attained age group, and as a check, also on the totals without regard to age. This classified procedure will explain why an unduly large proportion of the deaths by rating or diagnosis end in even digits.

The total exposure for any year was determined from the number of running awards at the end of each month, using the trapezoidal rule. The total exposures by rating or diagnosis were determined in the same way, but using a quarterly instead of a monthly basis. When the exposures in the subgroups failed to add to the previously determined total exposure derived from the monthly figures, the subgroups were adjusted proportionally. These adjustments were quite small. The exposures were then distributed by attained age on the basis of a census on June 30 of each year, except that for 1946 a census on June 30, 1947 had to be used, set back 1 year in attained age. The exposures were determined and used throughout without adding back the one-half year on the deaths; consequently, m_x was used to determine the tabular deaths in place of o_x. Tabular deaths were calculated age by age using IBM equipment.

There was no discoverable bias in the figures, except that there appeared to have been a number of misstatements of age among per-

sons who really were too young to enter the military service. The running award cards carried the date of birth claimed by the individual, but upon death the true age (or at least, a different one) was obtained from the death certificate or from other sources and recorded on the death card. This resulted in some rather high death rates at the extreme low ages. While some mispunching of ages was evident, the numbers were too small to vitiate the results.

The death rates by rating or diagnosis appear to be reflecting the effect of migration to some extent. An effort was made to limit the effect of migration by using the rating or diagnosis at the beginning of the calendar quarter in which the death occurred, since exposures were developed from quarterly data. A further limitation would be desirable, perhaps as much as 1 year, but this would require a corresponding adjustment of the exposures. The results by rating or diagnosis should be interpreted with this factor in mind.

The Veterans' Administration was unable to furnish an age census by individual diagnoses for any time in the past. The card records are not maintained in a way to permit the reconstruction of a past census, but one could be obtained on a current basis.

The terminations other than by death have been tabulated but time has not permitted any analysis.

The Veterans' Administration was unable to state the racial composition due to incomplete recording on the punch cards, and hence the racial composition could not be checked against that of the United States males mortality table. Also, the fact that a very small proportion of the veterans receiving disability compensation were females has not been taken into account.

The conclusion that a 100 percent rating on the Veterans' Administration rating schedule represents a lower standard than that employed by the commercial life insurance companies in determining the existence of total disability was based on a comparison of the crude death rates with those shown in the 1952 Reports of Mortality and Morbidily Experience, Transactions of the Society of Actuaries, for benefits 2 and 3 combined. The form of the data did not permit any precise comparison but the crude rates were definitely lower for World War II veterans and slightly lower for World War I veterans.

CHAPTER V

A COMPARISON OF STANDARDS IN THE DISABILITY PROGRAMS OF THE VETERANS' ADMINISTRATION AND CERTAIN OTHER FEDERAL AGENCIES

In addition to the Veterans' Administration and the armed services, there are a number of other Federal Government agencies concerned with methods of compensating disabled individuals. Elements of common concern include the kinds of benefits and the standards for their administration. In order to ascertain the relationships among these programs and to derive the benefit of their experience, a comparative study was made of relevant parts of programs administered by; (1) the Bureau of Employees' Compensation of the Department of Labor, (2) the Railroad Retirement Board, and the Bureaus of (3) Old-Age and Survivors Insurance and (4) Public Assistance of the Social Security Administration, Department of Health, Education, and Welfare.

The Bureau of Employees' Compensation administers the Federal Employees' Compensation Act which is a workmen's compensation law for Federal civilian employees, including, with certain exceptions, peacetime reservists of the Armed Forces. The program under the Railroad Retirement Act is somewhat similar to old-age and survivors insurance, but for years has included permanent disability as a cause for retirement.

The so-called disability freeze provision under the old-age and survivors insurance system was enacted in 1954 (Public Law 761, 83d Cong.). This does not provide retirement payments but is rather a means for holding in abeyance, or "freezing," the wage credits of disabled workers so that their social security benefits (payable at age 65) will not be lost. Currently, the 84th Congress is considering legislation to provide for the payment of monthly benefits after age 50 to covered workers who are totally disabled from impairments which are likely to continue for an indefinite period. [Editorial note: H. R. 7225 providing disability benefits at age 50 was enacted in July 1956.] These aspects involve amendments to the basic legislation for OASI.[1] The grants-in-aid to the States designed to care for special groups of the needy, including aid to the blind[2] and aid to the permanently and totally disabled,[3] are administered through the Bureau of Public Assistance.

In the analysis which follows, pertinent parts of the above programs are contrasted with the administration of veterans' disability benefits. At the beginning there is a summation of disability standards and inter-agency relationships. This is followed by a more detailed analysis of the 4 programs, with emphasis on standards for disability

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[1] Social Security Act, title II.
[2] Ibid., title X.
[3] Ibid., title XIV.

evaluation, eligibility requirements, benefits, follow-up including rehabilitation, number of beneficiaries and costs.

DISABILITY STANDARDS AND ADMINISTRATION

The disability freeze and H. R. 7225, Railroad Retirement in one area (as noted later), and public assistance (for the two groups discussed), are concerned only with the totally and permanently disabled. The program under the Federal Employees' Compensation Act is similar to that of the Veterans' Administration in the sense that what is in the nature of workmen's compensation is given not only for total disability but also for impairments of widely varying lesser degree. The Railroad Retirement Board in deciding that an individual is too disabled to work in his regular occupation may be considering a degree of disability which would be less than total for another occupation but which, because of the nature of the program, does not call for a rating to scale.

Definition of Total Disability, and of Permanent

The basic definitions of total disability under the various programs do not vary greatly. The real differences lie in the interpretations given the words.

The Veterans' Administration states:

> Total disability will be considered to exist when there is present any impairment of mind or body which is sufficient to render it impossible for the average person to follow a substantially gainful occupation.

And adds that—

> permanent total disability shall be taken to exist when the impairment is reasonably certain to continue throughout life.[4]

The Old-Age and Survivors Insurance freeze provision defines (permanent total) disability as—

> (A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued or indefinite duration, or (B) blindness,

with the definition of blindness corresponding to the Veterans' Administration's highest rating for this disability. The definition of disability for insurance benefits under H. R. 7225 is the same as under (A) alone of the freeze law. The railroad retirement law specifies that the individual's permanent physical or mental condition must be (*a*) such as to be disabling for work in his regular occupation or (*b*) such as to make him unable to engage in any regular employment. The board extends the latter to mean—

> unable to perform regularly * * * in the usual and customary manner, the * * * duties of any regular and gainful employment which is substantial.

The Bureau of Public Assistance has defined "permanently and totally disabled" as having some permanent physical or mental impairment, disease, or loss that substantially precludes him from engaging in useful occupations within his competence, including homemaking. That is, under this program alone is prevention from other than gainful employment given consideration.

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[4] Schedule for Rating Disabilities (1945), p. 5, par. 15.

Implementation of Definition

To implement the definition of disability—both total and other—the Veterans' Administration, under Veterans Regulation No. 3 (a) has drawn up a schedule for rating specific disabilities or combinations of disabilities. The ratings are based primarily upon the theoretical average impairment in earning capacity resulting from the same types of injuries in civil occupations. This schedule provides 10 grades of disability with "total" given as 100 percent. However, a rating of 100 percent is not always required in order for the individual to be classed as totally disabled.

When the disabled person is, in the judgment of the Veterans' Administration, unable to secure or follow a substantially gainful occupation as a result of his disabilities, total disability ratings may be assigned without regard to the specific provisions of the rating schedule in service-connected cases, and when the requirements of permanence are met, in non-service-connected; "provided that, if there is only one disability, this disability shall be ratable at 60 percent or more, and that, if there are two or more disabilities, there shall be at least one disability ratable at 40 percent or more, and sufficient additional disability to bring the combined rating to 70 percent or more." [5]

In non-service-connected cases, that is, those in which a pension rather than compensation is given, the percentage requirements are reduced on the attainment of age 55 to a 60 percent rating for one or more disabilities, with no percentage requirement for any one disability; and the requirement at age 60 is a 50 percent rating for one or more disabilities. At age 65 there is no percentage requirement for a total disability rating other than one disability ratable at 10 percent or more.[6]

The Bureau of Old-Age and Survivors Insurance has set up Disability Evaluation Standards—a list of impairments with a degree of severity such that usually the condition is incompatible with "substantial gainful activity." The Railroad Retirement Board has established standards which permanently disqualify individuals for work in specific occupations in the railroad industry. With the exception of certain schedule losses the Bureau of Employees' Compensation does not rate physical impairment as such. What it determines is the specific individual's loss in wage-earning capacity as measured by the difference between his wage before and his wage after injury. Neither does the Bureau of Public Assistance have a rating schedule. Its determination of total disability is reached by considering the facts as to the ability of the person concerned to perform activities necessary to the carrying out of specific responsibilities. The philosophy of all the agencies other than the Veterans' Administration is to determine the degree of disability in the light of the individual's own occupational situation.

Interpretation of Definitions

When it comes to interpretation of the definitions of total disability there is wide variation. Two examples are given here.

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[5] *Ibid.*, p. 5, par. 16.

[6] Extension 5, 1945 Schedule, Permanent and Total Disability Ratings, Veterans Regulation 1 (a), pt. III.

Minimal tuberculosis.—The Veterans' Administration schedule (1945) originally rated minimal tuberculosis with moderate, slight, or no symptoms as 70-percent disabling for compensation purposes.[7] Under extension 6 of the schedule, dated November 8, 1949, this was increased to 100 percent, as required by Public Law 339, 81st Congress. The same extension provides, pursuant to such law, that the 100-percent rating is to continue for 2 years after the date of arrest, or inactivity, following clinically identified tuberculosis; that for the next 4 years it shall be 50 percent; and for the next 5, 30 percent. That is, once minimal tuberculosis is diagnosed as such, a rating of 0 disability is not reached before 11 years. Whatever the rating, however, arrested tuberculosis has been designated by Congress as a disability for which no less than a specific statutory amount will be paid as long as the veteran lives. (This amount is $67 in wartime cases, $53.60 in peacetime.) In contrast, the Bureau of Old-Age and Survivors' Insurance (BOASI), administering the disability freeze program, has recently announced the conclusion that minimal active tuberculosis does not fit into the group of impairments which might be considered presumptively disabling in the absence of employment; that the recovery potential for this illness is not consistent with the concept of long-continued and indefinite duration; and that in consequence these cases will be considered on an individual basis, on all the facts. In cases involving other degrees of tuberculosis, disability is considered as continuing for 1 year after reaching the arrested stage unless the individual, before the year is up, with medical advice, engages in substantial employment. The Railroad Retirement Board's position does not differ from that of the Bureau of Old-Age and Survivors' Insurance in this regard.

Blindness.—The OASI disability freeze law defines "central visual acuity of 5/200 or less in the better eye with the use of a corrective lens" as blindness which is to be classed as totally disabling. In the functioning of the freeze program, persons having a central visual acuity of no better than 20/200 in the better eye after correction may be found "under a disability" if unable to engage in substantial gainful activity. At the same time, it is recognized that under certain circumstances a blind individual may suffer moderate or no loss. Blindness to the extent of 5/200 is rated by the Veterans' Administration as "totally disabling" and the veteran is awarded special monthly compensation at statutory rate. And blindness of less than 20/200 might be compensated as total disability under the definition given earlier. The Bureau of Employees' Compensation and the Bureau of Public Assistance use a definition of economic blindness arrived at by the American Medical Association. The Railroad Retirement Board, under the occupational disability provisions of the Railroad Retirement Act (but not under the provisions with respect to disability for any regular employment), considers not only industrial blindness but impairments disabling for a railroad industry occupation, which the Veterans' Administration would rate as much less than totally disabling. In the proposed bill H. R. 7225, the United States House of Representatives has expressed the belief that blindness does not constitute presumed disability; that for purposes of disability

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[7] Rating schedule, 6704 (j).

benefits, individuals with visual impairments must be disabled to the same extent as those with other physical impairments.

Statutory Rates

Both for veterans and for employees coming under the Federal Employees' Compensation Act (FECA), Congress has singled out certain disablements for special consideration.

Under FECA the loss, or loss of use, of both hands, or both arms, or both feet, or both legs, or both eyes or the sight thereof constitutes permanent total disability. The disabled person receives as basic compensation two-thirds of the wage he received at the time of the injury within the minimum and maximum limits of $112.50 and $525, respectively. With dependents his compensation would be increased, but not beyond the maximum stated.

The Veterans' Administration by law or regulation gives an amount set by statute for each of these combined impairments which are rated as totally disabling. In the event an individual is so injured that he loses both hands and both feet, or both feet and both eyes, or the like, he is given compensation for "double total and permanent disability" or what corresponds to that. Nothing similar is found in FECA. Obviously, in such awards more than the loss of earning capacity, the stated base for the ratings, is involved.

Under both the veterans laws and the Federal Employees' Compensation Act, statutory awards are given for less than total disability. FECA specifies a definite period of payment at the full rate for total disability for a given number of weeks for injuries involving members or functions of the body, or involving disfigurement. The amount paid—again no set sum, but basically two-thirds the wage at the time of injury—is continued only for the time set, no longer. It is not altered whether the injured individual returns to work before the scheduled time is up or not. Obviously, the scheduled payment contains an element of indemnity for more than wage loss. It is thought that in the case of all minor anatomical losses and some of the major, no actual loss in wage-earning capacity occurs after the period of recovery from the temporary illness involved. It is recognized, however, that with a major injury the loss may extend beyond the period scheduled. In such event compensation is continued for the wage loss as long as the loss itself continues.

The Veterans' Administration pays compensation at rates fixed by law for many of the same injuries specified in the Federal Employees' Compensation Act. The Veterans' Administration, however, pays throughout the life of the individual for anatomical losses. For complete loss of hearing of both ears FECA provides 200 weeks compensation at two-thirds of the wage when the injury occurred. The Veterans' Administration pays for life the standard amount for total disability, which currently is $181 monthly in wartime cases. Under FECA the loss of a hand calls for 244 weeks compensation, the loss of a foot, 205 weeks, while a fourth finger lost is compensated for 15 weeks only. The injured veteran who receives a statutory award for an anatomical loss or loss of use may earn as much as he is able throughout his lifetime without a reduction in benefits.

Rehabilitation

Injured persons coming under the Federal Employees' Compensation Act are comparable with veterans with service-connected disabil-

ities under the Veterans' Administration in the sense that they are entitled to all in the way of rehabilitation—physical or vocational—they will take. Under the Veterans' Administration the disabled may refuse to take any. Under FECA, however, the Bureau of Employees' Compensation may direct any permanently disabled individual whose disability is compensable to undergo vocational rehabilitation and if the employee, without good cause, fails to do so the Bureau may reduce his compensation and base the reduction upon a loss of the earning capacity he would have attained had he undergone training.

The programs in effect or in prospect under the Department of Health, Education, and Welfare emphasize vocational rehabilitation with the aim that every individual for whom it is feasible will have an opportunity to be rehabilitated. The individual has the power of refusal under both public assistance and the disability freeze. Under the proposed legislation, H. R. 7225, however, benefits would be suspended in the case of the refusal without good cause to accept available vocational services.

With a view to giving economic encouragement, the individual who is performing services in the course of vocational rehabilitation under H. R. 7225 could be compensated as disabled for up to 1 year after he first rendered such services. Under the disability freeze the "period of disability" usually will not be terminated until the individual has successfully engaged in work in the competitive labor market over a reasonable period of time.

The Railroad Retirement Board does not engage in rehabilitation activities.

Followup

The Veterans' Administration has continuing jurisdiction over a compensation case as long as the individual lives. Followup is close while he remains under medical care. Reexaminations are required where the evidence indicates that the disability will decrease materially. After a 5-year period without change the Veterans' Administration would not initiate a reexamination. In static cases such as loss of a foot, there is held to be no need for a reexamination unless aggravation develops which causes the veteran to ask for greater compensation. This, because of the requirement that no veteran with a service-connected disability shall be penalized for overcoming his handicap. In the cases of pensions for non-service-connected disability, the Veterans' Administration follows up once each year by means of a questionnaire as to income.

All of the other Federal disability programs now in effect do more or less in the way of following up the disabled who receive some form of benefit. Under the Federal Bureau of Employees' Compensation, supervision is continued to such degree as seems desirable over all injured employees as long as any disability exists which affects the employee's earning power. Disability freeze procedure requires the State agency which gives the patient the physical examination to advise the BOASI as to whether the medical impairment is such as to warrant re-examination at some later date because of improvement in the applicant's condition or as the result of physical restoration. The BOASI itself through its wage-reporting system is in a position to learn of any return of the disabled individual to substantial work.

Should H. R. 7225 become law, the procedure would probably be similar to that established under the disability freeze. The Railroad Retirement Board makes inquiry once a year as to the retired disabled individual's disability, his state of health and his earnings. The Bureau of Public Assistance requests that the local office review and redetermine eligibility within a 12-month period. This requirement, however, presumably is related more to need than to disability.

RELATIONSHIP OF THESE OTHER FEDERAL DISABILITY PROGRAMS TO VETERANS' COMPENSATION

Whenever a person is entitled to benefits under the Federal Employees' Compensation Act and because of the same injury is also entitled to receive benefits under another act of Congress he must elect which to receive. Reserve personnel on active or training duty in peacetime who are disabled as a result of duty may elect benefits under this act in lieu of Veterans' Administration compensation. Benefits have been paid under it for injuries throughout the Korean conflict as this was technically not a state of war.

Provided they meet the standard eligibility requirements as others do, ex-servicemen receiving Veterans' Administration compensation may obtain full benefits under the disability freeze provision of old-age and survivors' insurance inasmuch as duality of benefits at age 65 is not forbidden by law. It has been stated that a large proportion of those receiving Veterans' Administration compensation benefits are able to work and to obtain OASI-insured status. Also, as the Social Security Act now stands, they are able to count all military service between September 16, 1940, and July 1955 toward OASI benefits and receive veterans' compensation benefits as well.

The situation is different with respect to the disability-insurance benefits proposed in H. R. 7225. This prospective law contains an offset provision which insures that if a disability benefit is payable for the same period and the same impairment, under the system established by the Veterans' Administration, the Department of the Army, the Bureau of Employees' Compensation, or any other agency of the United States or under a State workmen's compensation law, the disability-insurance benefit would be suspended if smaller than the benefit under the other system, or, if larger, reduced by the amount of the other benefit.

Any person awarded an annuity or pension under the Railroad Retirement Act may decline to accept all or any part of it by a waiver filed with the Board. This waiver may be revoked in writing at any time. It is possible for a disabled individual to receive compensation both from the Veterans' Administration and from the Railroad Retirement Board, but the instances of dual payment would probably be few. If an employee has less than 10 years of service when he retires, he is not entitled to benefits under the Railroad Retirement Act, but his credits will be transferred to old-age and survivors' insurance. His period of railroad service will have been lengthened, however, by the fact that the Federal Government paid the whole payroll tax on creditable military-service earnings which were assumed to be $160 a month.

The Bureau of Public Assistance supplements Veterans' Administration compensation when need is shown. At the time of a study

made in mid-1951, somewhat over 1.3 percent of those receiving assistance under the program of aid to the permanently and totally disabled were also receiving benefits in the form of either compensation or pension from the Veterans' Administration.

A more detailed presentation of the several disability programs follows in order that there may be a fuller understanding of their activities and relationships.

FEDERAL EMPLOYEES' COMPENSATION ACT

General purpose

The Federal Employees' Compensation Act is a workmen's compensation law for Federal employees. The act applies to all civilian personnel in the service of the United States.[8] It has been extended to include certain other personnel, sometimes with limitation as to coverage and the benefits that may be extended. In time of peace, Reserve members of the Army, Air Force, Navy, Marine Corps, and Coast Guard (exclusive of Army and Air Force Reserve officers on extended active duty who are entitled to benefits under the Career Compensation Act, Public Law 108, 81st Cong.) are among those covered. Their number is not available. Exclusive of the reservists, employees covered averaged 2,393,000 in the fiscal year 1955.[9]

The objectives of the law are: First, to provide adequate medical care for the individual who suffers an injury while in the performance of his duties; second, to compensate him for loss in wages during the period of his temporary incapacity; and third, to provide him with compensation for the effect of his injury—theoretically or actually—on his earning power. In addition, to enable the employee so far as possible to overcome the economic effects of his injury, the law helps provide rehabilitation service.

Administration and financing

The program established by the Federal Employees' Compensation Act is administered by the Bureau of Employees' Compensation of the United States Department of Labor.

To finance the program, Congress established in the Treasury a separate fund, known as the employees' compensation fund, to which it adds from time to time (in practice annually) by appropriation such sums as may be necessary to maintain it.[10]

Eligibility requirements

Under the Federal Employees' Compensation Act any personal injury sustained by an employee while in the performance of his duty makes him eligible not only for compensation in the event of disability or death (sec. 1) but also for medical care whether or not disability has arisen (sec. 9 (a)). The latter provision has a major effect upon the operating procedures of the program.

Under the law the term "injury" includes, in addition to injury by accident, any disease proximately caused by the employment (sec. 40 (g)). However, with respect to Naval, Marine Corps, and Coast Guard reservists, Public Law 732, 75th Congress (act of June 25,

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[8] Public Law 267, 64th Cong., as amended, sec. 40.
[9] Figures supplied by the Bureau of Employees' Compensation.
[10] Federal Employees' Compensation Act, sec. 35.

1938), specifically provides that in no case shall sickness or disease be regarded as an injury. "Any disease proximately caused by the employment" is interpreted to include aggravation or acceleration of the progress of an already existent disease.

The term "performance of duty" has been construed to mean "arising out of and in the course of employment," the latter expression being the one customarily used in State workmen's compensation legislation.

Army and Air Force reservists to be eligible must have been "injured in line of duty (1) while on active duty, or (2) when engaged in authorized travel to and from such duty, or (3) when engaged in authorized training without pay." [11] Naval, Marine Corps, and Coast Guard reservists must have been "injured in the line of duty while on active duty with or without pay, training duty with or without pay, drills, equivalent instruction or duty, appropriate duty, or other prescribed duty, or while performing authorized travel to or from such duties." [12] It is conceivable that Army and Air Force members may likewise be covered while performing travel to or from inactive-duty training, depending upon the wording used in the official orders. The policy of the Bureau of Employees' Compensation in interpreting the phrase "in line of duty" is "to follow the principles and interpretations in respect thereto as may be applied by the particular service in which the disabled or deceased individual served." [13]

Eligibility under the Federal Employees' Compensation Act is similar to eligibility of the Armed Forces under veterans' compensation legislation in that a showing of causal relationship of the disability in the employment is required.

An employee is not entitled to compensation other than medical services for the first 3 days of temporary disability unless the disability exceeds 21 days in duration or is followed by permanent disability (sec. 2). If at the time the disability begins the employee has annual or sick leave to his credit, he may use sick leave until it is exhausted (sec. 8).

Disability evaluation

In establishing disability the Bureau of Employees' Compensation does not use a percentage rating schedule. Its procedure, basically, is not to establish a percentage of physical disability but rather the loss of earning capacity by reason of disability. (In certain cases of permanent disability for which scheduled benefits are provided by statute it does determine the proportionate anatomical loss or disfigurement.)

For any injury, whether or not disability has arisen, the law requires that the employee be furnished all the medical care—services, appliances, and supplies—which

> are likely to cure or to give relief or to reduce the degree or the period of disability or to aid in lessening the amount of the monthly compensation (sec. 9 (a)).

This means that medical care is provided without limit as to time or cost. The only statutory limitation with respect to medical care is that it be furnished by or upon the order of Federal medical officers and hospitals, or if this is not practicable upon the order of private

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[11] Act of July 15, 1939, as amended by act of August 7, 1946.
[12] Act of June 25, 1938, as amended by act of August 7, 1946.
[13] Bureau of Employees' Compensation, Procedures Manual for Claims Branch, Statement Relative to Substantive Rules (c).

physicians and hospitals approved by the Secretary of Labor. The Bureau has designated approximately 4,000 physicians throughout the United States to serve. In the designation of physicians, the Bureau is concerned only with their professional ability to provide the medical service. When neither Government nor private designated facilities are available, provision is made for the use of any licensed physician practicing within the State. The term "physician" includes surgeons and osteopathic practitioners within the scope of their practice as defined by State law (sec. 40 (d)).

The medical care of the employee is slated to begin as promptly as possible after the injury. The law requires the employee, or some one on his behalf, to give written notice of the injury within 48 hours to the employee's immediate supervisor (sec. 15). Unless written notice is given within 48 hours or unless the immediate superior has actual knowledge of the injury, compensation may be refused. The employee's official superior records the cause, nature, and extent of the injury, secures the signed statements of witnesses,[14] and sends the employee to a hospital or physician with a request for treatment. This is done both when it is certain the employee was injured in the performance of duty and when the connection is somewhat doubtful.[15] In the latter instance the treatment authorized is of an emergency nature until the situation is clarified; the physician is asked to advise the Bureau whether in his opinion the disability is due to the alleged injury.

Bureau regulations require that—

> Medical officers, designated physicians, other physicians and hospitals shall keep adequate records of all injury cases treated by them sufficient to supply the Bureau with a history of the employee's accident, the exact description, nature, location, and extent of injury, the degree of disability arising therefrom, the X-ray findings if X-ray examination has been made, the nature of treatment rendered, and the degree of disability arising from the injury.

For any injury calling for more than what amounts to first-aid treatment, a report must be submitted to the Bureau by the physician.[16] A detailed supplementary report in the form of a letter is filed in all cases of serious injury, including cases requiring hospital treatment or cases in which it is anticipated that disability for work will exist 1 month or more.[17] The letter is requested to include the degree of disability for the individual's usual or other employment as a result of the injury. This approach is in contrast to that under the veterans' law, which bases the rating upon the theoretical average impairment of earning capacity resulting from such an injury. The Bureau asks that in evaluation of disability the nature and extent of impairment from the condition due to the injury be expressed in terms of percent, and that when the injury involves a member, the percentage of loss of use of that member should be specified. The Bureau requires this information for determination of schedule awards.

In the initial stages of a case, the Bureau of Employees' Compensation follows the medical care closely. Later on it is left to the discretion of the medical adviser and the claim examiners as to how frequently an examination may be required. That depends entirely

[14] Regulations 1, 2 (a) and (b).
[15] Forms CA 16 and CA 17.
[16] Regulation 2.10.
[17] Regulation 2.10; and Division of Hospitals Circular Memorandum No. 51–149, Attachment No. 1, Preparation of the Narrative Summary.

on the case itself. For example, a patient not hospitalized, receiving physiotherapy for a back injury, would be followed up more frequently than one remaining in a tuberculosis sanatorium.

The disability for which compensation is paid need not be permanent. If there is some permanent impairment, compensation may be paid under 1 of 2 different methods; either as an indemnity for the effects of the injury, theoretically based on loss of wage-earning capacity, or, if not covered by the specific indemnity provision, by the effect of the injury on earning power.

Under section 3 (b) of the act, "loss, or loss of use, of both hands, or both arms, or both feet, or both legs, or both eyes or the sight thereof, shall, prima facie, constitute permanent total disability."

Section 5 (a) sets forth a schedule which specifies a definite period of payment at the full rate for total disability for a given number of weeks for different types of injuries involving the physical members or functions of the body, or involving disfigurement. The schedule is broken down into 2 parts, 1 dealing with major members, which include the arm, leg, hand, foot, eye, and total deafness in both ears. In such cases where the disability involves a 100-percent loss or loss of use of a major member, in addition to the scheduled period of payment, if the employee as a result of his injury also has a loss in wage-earning capacity which continues beyond that scheduled period, compensation is paid on loss of wage-earning capacity during the continuance of that loss. Losses involving the fingers and other minor members and losses involving major members to less than 100 percent are paid for the scheduled period of weeks only. No additional benefit is extended in these cases except medical care if needed, or, in the case of recurrence of disability, additional compensation for the period of the recurrence.

Except for the schedule losses noted, the Bureau is not concerned with the rating of physical impairment as such. With respect to other types of permanent disabilities, the rating is solely as to the loss in wage-earning capacity. The fact that an employee may actually have a substantial physical disability which does not impair his earning capacity does not entitle him to compensation after the temporary disability ends.

The schedule established in section 5 was added to the law October 14, 1949, for reasons not fully clear. Obviously, the schedule has resulted in the payment of compensation for permanent disability in every case involving one of the physical members covered by it. Prior to passage of the amendment, certain of the schedule losses, the most typical one being the loss of an eye, very often did not result in any compensation, except for temporary total disability, to the injured person, because, notwithstanding the physical impairment, he was able to return to his employment and so suffered no loss in earning capacity.

In determining the degree of loss of hearing for a schedule award, the medical officers of the Bureau utilize the formula established by the American Medical Association as recommended by the Council on Physical Therapy and the section on Laryngology, Otology, and Rhinology. As the formulas are revised periodically by the American Medical Association, the instructions to the medical officers of the Bureau are revised accordingly. The evaluation of hearing loss for schedule-award purposes is made without regard to correction through hearing aids.

In evaluating loss of vision for schedule-award purposes the medical officers are instructed to follow the formula established by the American Medical Association, utilizing the most recent revision. This is after maximum healing has been attained. The determination for schedule award is made without regard to correction by glasses.

Determination of loss of earning capacity in all cases not covered by the schedule is strictly on an individual basis. The Bureau obtains from the examining physician a detailed medical report showing all the findings required to evaluate the extent of the disability. The case is reviewed by the Bureau's medical staff which is comprised of physicians detailed from the Public Health Service. This medical staff estimates the degree of physical impairment resulting from the injury. In doing so they use as guides: McBride's work on the evaluation of disability resulting from injury,[18] Kessler's work,[19] and others. The doctors establish that there is a disability, and what kind it is, and furnish advisory opinions as to how it may affect the man's future employability.

In establishing for compensation purposes the effects of an injury on an individual's wage-earning capacity, not only the permanent disability but the individual's age, education, training, previous work experience, previous disabling conditions and general physical condition are taken into consideration.[20] It is decided that in his disabled condition he can probably do a certain kind of job and he will be charged with an earning capacity for that employment. The difference between his earning capacity in that employment and the wage received at the time of the injury will be the loss in earning capacity on which the compensation will be based. If he sustains no loss in earning capacity, he will receive no compensation. Only if he is unable to earn anything will he be considered totally disabled. The degree of partial loss of earning capacity is given as a percentage.

In letters notifying claimants or other interested parties of awards for partial-disability compensation, and when explaining such awards to them, the awards are expressed in percentages of disability and not in terms of dollars representing loss of earning capacity. However, "the wage loss due to the injury in dollars must appear in the case record in appropriate notation." [21]

Followup

The Bureau of Employees' Compensation continues supervision to a greater or lesser degree over all injured employees as long as any disability exists which affects the employee's earning power. And whether a disability is classed as temporary or permanent, total or partial, does not greatly affect the operation of the program. As long as the employee is classed as temporarily disabled, each claim for compensation must be accompanied by a physician's statement; a physician's certificate is not required in cases of permanent disability where the medical evidence of record indicates the disability is static. A case may be carried as a temporary disability for several years or classed as a permanent one relatively soon. A disability is considered total or partial until such time as it ceases, or becomes presumably

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[18] Earl D. McBride, Disability Evaluation, 5th edition, 1953, J. B. Lippincott.
[19] Henry H. Kessler, Accidental Injuries, 1941, Lea & Febiger.
[20] Procedures Manual, II, 50.
[21] Ibid.

static. When a temporarily totally disabled person becomes partially disabled, there will be a readjustment of the compensation based upon the circumstances in the individual case. Most of the ratings are on a tentative basis to start with and are reviewed from time to time to see if there is any change in conditions which would indicate that a different earning capacity should be established.

Schedule awards.—Individuals with disabilities scheduled under section 5 (a) and (b) of the Employees' Compensation Act are given the necessary medical care on a temporary basis of total disability until such time as maximum healing has been attained and disability is no longer total. The award is then made for the exact number of weeks the schedule provides. (For example, 312 weeks compensation for an arm lost, 200 weeks for complete loss of hearing of both ears.) A schedule award is not followed up until just before its expiration. At this time it is reviewed and there is a reexamination to determine whether or not the original estimate was correct. If the reexamination shows the disability to be greater than estimated, a revision is made in the award. If during the subsequent period the man is required to undergo further medical treatment, the award is suspended and the man given temporary total disability compensation until his condition is thought to be static again. Under veterans' law, scheduled awards once made for anatomical losses continue for life.

Nonschedule awards.—When a determination based on loss of earning capacity is made after maximum improvement has been attained and the claimant is clearly shown to have a permanent disability, the finding is subject to review in from 3 to 12 months, depending on the individual situation.[22] A callup is made for an "affidavit of earnings" at 6 months later if the disability is partial, 1 year if it is total and likely to be permanent.[23]

Instructions call for the injured employee to be requested to register at least once each month with the nearest local office of the State Employment Service.[24] On review, a detailed report is asked of the State employment office with respect to the earning capacity of the claimant, kinds of work for which he is suited, salary for such employment, and availability of such work locally, together with information as to whether the client cooperated.[25]

Section 4 (b) of the Federal Employees' Compensation Act provides:

> If a partially disabled employee refuses to seek suitable work or refuses or neglects to work after suitable work is offered to, procured by, or secured for him, he shall not be entitled to any compensation.

As a general rule, if a case has gone more than 5 years without a change in extent of loss in wage-earning capacity, it is not considered necessary to review the earning capacity oftener than once in 2 years. At the end of 10 years without change, the case might be called up for review in 5 years. Emphasis is placed on having the examiner each time the case is reviewed be sure that all available information is on file as to the claimant's loss in earning capacity.

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[22] Ibid.
[23] Procedures Manual, II, 25.1.
[24] Procedures Manual, II, 15.
[25] Procedures Manual, II, 50.

Vocational rehabilitation

Under section 9 (b) of the Federal Employees' Compensation Act, the Bureau may direct any permanently disabled individual whose disability is compensable to undergo vocational rehabilitation. In these cases the Bureau would make provision for furnishing vocational rehabilitation services. In providing for such services the Bureau is directed to utilize so far as practicable the services or facilities of State agencies cooperating with it in carrying out the purposes of the Vocational Rehabilitation Act, except to the extent that medical and related services are provided for under section 9 (a). Also, the Bureau may pay to any disabled individual who is undergoing vocational rehabilitation pursuant to the Bureau's direction, additional compensation necessary for his maintenance, but not to exceed $50 per month (sec. 6 (b) (2)). This is not an automatic allowance. It is made to cover the costs of carfare, lunches, and other items which are an added expense to the employee in training.

Instructions to medical personnel contain the following directive:

> Since the objective of treatment is to achieve maximum recovery and return to employment as rapidly as possible, recommendations should include any non-medical rehabilitation services indicated to enable the patient to return to his previous employment or fit him for other employment better suited to his physical capacities.

The Bureau of Employees' Compensation makes the decision as to whether the case shall be referred to the vocational rehabilitation facilities. All cases in which there is a serious injury and the employee is unable to return to employment are automatically referred.

If the employee, without good cause, fails to apply for and undergo vocational rehabilitation when directed, the Bureau may reduce his compensation and base the reduction upon a loss of the earning capacity determined that he would have had if he had undergone training.[26]

The Bureau of Employees' Compensation requires the State authorities to submit a specific plan for the rehabilitation of an individual. If that appears feasible to the Bureau's rehabilitation adviser, he authorizes the State to carry out the program. No limitation is placed on the Bureau as to what may be given the injured employee in the way of training.

At present the Bureau of Employees' Compensation has no funds for personnel and expenses of promoting rehabilitation programs among the beneficiaries other than those appropriated directly to the Bureau for its general administrative use.

The efforts of the Bureau have been concentrated more on placement than on retraining or educational development because of the belief that the operations of the Government are sufficiently large and diversified to enable most agencies to reemploy their permanently disabled employees. The policy is influenced in part by the lack of operating funds to carry on other types of rehabilitation service.

Benefits

The basic compensation paid a totally disabled employee is 66⅔ percent of his monthly pay (sec. 3) up to $525 per month but not less than $112.50 per month unless his monthly pay is less, in which case

[26] FECA Sec. 37; Procedures Manual, II, 80.

his monthly rate of compensation is equal to his full monthly pay (6 (c)). The basic compensation of a partially disabled employee is 66⅔ percent of his loss in earning capacity (sec. 4 (a)). During such time as the disabled employee has one or more dependents, his basic compensation is augmented at the rate of 8⅓ percent of his monthly pay up to $420 a month in the case of the totally disabled, 8⅓ percent of the loss in earning capacity for the partially disabled (sec. 6 (a)).

In addition to the monthly compensation otherwise specified, the Bureau may pay an injured employee, who has been awarded compensation, an additional sum of not more than $75 a month when the Bureau finds that the service of an attendant is necessary constantly by reason of the employee's being totally blind, or having lost both hands or both feet or the use thereof, or being paralyzed or unable to walk, or by reason of other disability resulting from the injury actually rendering him so helpless as to require constant attendance (sec. 6 (b) (1)).[27]

Lump-sum settlements.—The Federal Employees' Compensation Act provides that in cases of permanent total or permanent partial disability if the Secretary of Labor "determines that it is for the best interests of the beneficiary the liability of the United States for compensation to such beneficiary may be discharged by the payment of a lump sum equal to the present value of all future payments of compensation computed at 4 percent true discount compounded annually." (Sec. 14) Before the Secretary makes such a determination it is the practice of the Bureau to require the claimant to submit a definite project showing that a "lump-sum settlement would give greater financial benefit as well as greater financial security than the periodic payments of compensation." [28]

Election of benefits.—Whenever a person is entitled to benefits under the Federal Employees' Compensation Act and by reason of the same injury is also entitled to receive under another act of Congress because of service by him, he must elect which to receive. Such election must be made within 1 year after the injury, or such further time as the Secretary of Labor may for good cause allow, and when made shall be irrevocable unless otherwise provided by law.[29] Section 6 of the Civil Service Retirement Act, however, by providing that the right of any claimant to the greater benefit conferred by that act or by the Federal Employees' Compensation Act for any part of the same period of time shall not be barred, permits transfer between retirement and compensation from time to time at the option of the beneficiary.

Beneficiaries

Detailed data as to cases compensated under the Federal Employees' Compensation Act are not available. However, it is reported that of approximately 90,000 injury cases approved for care in the fiscal year 1955, about 12,000 were compensated, nonfatal.[30] The number of permanent disabilities of all degrees was less than a thousand a year, with the number of permanent total disabilities exceedingly small.

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[27] Procedures Manual, II, 70.
[28] Ibid., II, 60.
[29] FECA, sec. 7 (a).
[30] Bureau of Employees' Compensation, table I–E—Operations Under the Federal Employees' Compensation Act, July 1, 1950, to June 30, 1955.

Military reservists with nonfatal injuries who come under the act are few in number. The story for the last three fiscal years is as follows:[31]

Year	Nonfatal reservist cases		Amount disbursed during year
	Received during year	On payroll at end of year	
1953	192	5	$73,098
1954	433	5	153,212
1955	193	4	75,169

THE "DISABILITY FREEZE" (OLD-AGE AND SURVIVORS' INSURANCE)

General Purpose

A new program of importance to disabled persons—called the disability freeze program—was instituted by Congress in the Social Security Amendments of 1954.[32] This does not provide money payments to disabled workers, but is designed to protect their insured status and average monthly wage under old-age and survivors insurance. Thus, they would not lose prospective retirement or survivor insurance benefits as a consequence of disability.

Under the law as it stood previous to the passage of the 1954 amendments, an individual's right to old-age and survivors insurance benefits might be reduced or lost entirely because of an extended period of total disability before retirement age or death earlier. Unless the worker was already permanently insured when he became disabled, the entire period of his disability was included in the elapsed time that was the basis for determining his insured status. And, inasmuch as benefit amounts were based on the worker's average monthly earnings from a specified starting date, an extended period of disability reduced the figure for earnings and so the benefit based upon them. The 1954 amendments provide for the preservation of benefit rights of totally disabled individuals by eliminating periods of disability from the computations of insured status and average monthly earnings. The freeze provision corresponds in a sense to the "waiver of premium" used in commercial insurance policies.

Administration

The disability freeze program is administered by the Bureau of Old-Age and Survivors Insurance.

The Secretary of Health, Education, and Welfare is required to enter into an agreement with each State willing to make one, under which the State agency or agencies administering the State plan approved under the Vocational Rehabilitation Act, or any other appropriate State agency or agencies (or both types) will determine whether or not an individual is under a disability, the day such disability began, and the day on which it ceases. The plan may cover all individuals in the State who come under the freeze or be limited to such

[31] Bureau of Employees' Compensation, special data sent the President's Commission on Veterans' Pensions.

[32] Public Law 761, 83d Cong., signed September 1, 1954.

class or classes of individuals as may be designated in the agreement at the State's request.[33]

As of January 27, 1956, agreements were signed with one or more agencies in every State. However, in only 17 States do these agreements cover all classes of those disabled under the law. More than half the States have not undertaken to make disability determinations in cases where the onset of the disability was more than 2 years before filing of the application.

Determinations in the cases of individuals in a State which has no agreement, those outside the United States, and those of any class or classes of individuals not included under a State agreement are made by the Secretary under regulations prescribed by him.[34]

Eligibility Requirements in Addition to Disability

To qualify for the disability freeze a disabled individual must first meet certain conditions with respect to his insured status. He must have not less than 6 quarters of coverage during the 13-quarter period ending with the quarter in which the period of disability begins. He must also have 20 quarters of coverage during the 40-quarter period that ends with such quarter. "These requirements are intended to limit the application of the provisions to individuals who have had a reasonably long, as well as recent, record of earnings in covered work. They operate to screen out those individuals who had voluntarily retired from gainful activity and had not been compelled to leave the labor force because of their disability." [35]

The time required with respect to recent coverage for disability is the same as for a "currently insured individual" under old-age and survivors insurance.[36]

Disability Determination

As defined in the social security law, section 216 (i) (1),

> The term "disability" means (A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration, or (B) blindness; and the term "blindness" means central visual acuity of 5/200 or less in the better eye with the use of a correcting lens. An eye in which the visual field is reduced to 5 degrees or less concentric contraction shall be considered for the purposes of this paragraph as having a central visual acuity of 5/200 or less.

The BOASI in its disability freeze State manual implements the law by a number of definitions. These may be paraphrased as follows:

> An applicant is unable to engage in any "substantial gainful activity" if he cannot substantially perform regular competitive employment or self-employment.
>
> "Medically determinable impairment" means that the condition should be one that can be determined on the basis of medical facts, particularly those aspects that relate to the severity and curability of the impairment and its effect on the ability to perform physical and mental functions.

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[33] Social Security Act, sec. 221.
[34] Ibid., sec. 221g.
[35] Social Security Bulletin, September 1954, p. 11, Social Security Amendments of 1954; A Summary and Legislative History by Wilbur Cohen, Robert M. Ball, and Robert J. Myers.
[36] Social Security Act, 214b.

"Long-continued and indefinite" applies to an impairment existing at least 6 months and for which, at the date of filing application, no date of improvement or recovery in the future can be reasonably determined.

The applicant's condition need not be hopeless. It is always possible that by extraordinary effort or through new developments in medical science or rehabilitation techniques the applicant may become able to do gainful work. This would not ordinarily invalidate a decision that the impairment was expected to be of indefinite duration. The requirement applies to the impairment and not to employability. Hopefully, rehabilitation will restore a significant number of these persons to gainful employment.

An individual is held not to meet the definition of "disability" if he can, by reasonable effort and with safety to himself, achieve recovery or substantial reduction of the symptoms of his condition.[37] However, should his condition deteriorate to a point at which there is no longer a probability that it can be improved, he may be found to be under a disability, even though his own neglect produced the deterioration.

"Period of disability" is a legal concept which provides the basis for freezing the individual's OASI record. The law states that it "means a continuous period of not less than 6 full calendar months * * * during which an individual was under a disability" and adds a number of qualifying provisions.[38]

Evidence of disability.—The responsibility for submitting sufficient evidence that a freeze determination may reasonably be made in his case is that of the applicant. It is expected that in most instances the applicant will want his current attending physician to supply a medical report on his condition. Physicians are asked to make the report complete enough to enable a reviewing physician to determine the nature and severity of the impairment.

In some cases the applicant for a disability freeze determination will have previously undergone a medical examination in connection with another program administered by the agency making the disability determination, (such as vocational rehabilitation, Aid to the Blind, APTD, or general assistance). In the event that such an examination is recent, the agency will use its existing records to determine whether the applicant is under a disability and he need not submit a medical report from any other source unless he wishes to supplement the evidence in possession of the State agency.

Disability evaluation standards.—To insure that determinations of disability have a sound medical basis, that applicants receive equal treatment, irrespective of where the determinations are made and that in the evaluation great emphasis be placed on the nature and severity of the medical impairment, the BOASI has set up disability evaluation standards. Listings of impairments by body systems are given outlining a degree of severity that, in most individuals, prevents them from engaging in any substantial gainful activity. An applicant

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[37] The Senate Finance Committee Report on the Social Security Amendments of 1954, p. 21.

[38] Social Security Act, 216 (i) (2).

who is under an impairment meeting the listed severity and who is not working will be determined to be under a disability in the absence of any contrary information. A combination of serious impairments may also prevent an applicant from engaging in substantial gainful activity though none of them alone would meet the listed severity. Minor impairments will not ordinarily be combined. It is expected that sound professional judgment will be exercised in determining whether a combination of impairments constitutes a disability. The guides or listings of impairments are based on experience in administering Federal and State disability programs and on the most recent medical and vocational knowledge. They have been carefully considered and revised after discussion with specialists in many fields of medicine.

Standards call for determinations of disability to be made by teams in the State agency consisting of a physician, who is particularly responsible for the medical aspects, and a trained nonmedical member who considers the work history, education, capacities and other facts to reach a finding of inability to engage in substantial gainful activity. In addition to the medical report and work record, some cases will require evaluation of age, education, training, experience and other individual factors.

One of the listings of impairments, for example, is for special sense organs. Under this are discussed: (a) visual acuity, (b) blindness, (c) combinations of visual impairment, (d) degrees of impairment, (e) general conditions of relation of blindness to substantial gainful activity, (f) determination of auditory acuity, and (g) breakdown of impairments, special sense organs. For example, the material under (e) above, discusses the fact that a gradually developing loss of visual acuity while a person is engaging in work for which he is well-trained and experienced may cause only a moderate loss, if any, in remaining capacity even though reaching a degree of impairment equalling that set forth in the listings. A sudden loss of vision to the same degree may cause inability to pursue any occupation and, therefore, constitute a much greater disability. The nature of the physical requirements, particularly the visual requirements, of a person's regular job or any occupation for which he has the necessary skills will have a bearing on his ability to engage in substantial gainful activity.

As mentioned earlier, the State agency is responsible not only for determining whether or not an individual is under a disability and the day it began, but also the day on which it ceases. In many instances recovery from the disability is not anticipated. Where it is, a control is provided for calling up the case for reexamination and the preparation of a new determination as to whether or not the disability has ceased. The reexamination will permit an evaluation of his condition from that point on.

The disability freeze program has been in operation only a short period. In its development, disability evaluation policy, presumptions and guide lines, particularly in the area of substantial gainful activity, are being given continuing appraisal.

One BOASI decision, recently announced, is of special interest in light of the Veterans' Administration policy with respect to the same ailment. Minimal active pulmonary tuberculosis has been removed from the listing of serious conditions with the advice and consent of

the Medical Advisory Committee. This, because under modern methods of treatment it is not generally considered to be of long-continued and indefinite duration. Special considerations in individual cases, however, may be held sufficient to establish the existence of a disability.

Followup

The State agency is required to advise the BOASI whether the medical impairment is such as to warrant reexamination at some later date by reason of probable improvement in the applicant's medical condition or as the result of contemplated physical restoration. For impairments which may be expected to improve or be arrested at some point in the future may require medical review to determine continuing eligibility. If a review at a later date is deemed necessary, the State agency will indicate the approximate date for such reexamination and the BOASI will be responsible for noting the date and taking the appropriate steps for followup. The BOASI through its wage-reporting system is in a position to learn of the disabled individual's return to work or of his death or removal to another State before the scheduled reexamination date.

Benefits

Federal Old-Age and Survivors Insurance is designed to provide, for insured individuals and their families, partial replacement of earnings lost through retirement or death of the worker. Entitlement to benefits does not depend on a determination of financial need, but upon insured status. Under the disability freeze, as under the OASI parent program, no benefits are paid prior to age 65 or death. But in consequence of the disability freeze provisions more individuals will be entitled to benefits and in many instances the benefits will be larger.

January 1955 was the first month in which an application for a disability freeze could be filed, July 1955 the first for which an OASI benefit payment could be made which was computed or recomputed with the exclusion of a period of disability. In processing cases priority has been given to those in which an applicant has already been receiving old-age insurance benefits and seeks a recomputation based on his establishment of a period of disability. Also included in the "priority" group are other applicants already 65 years of age, or who will attain age 65 within 6 months of filing the freeze application. In priority cases, it is desirable that the disability determination be made as promptly as possible, since the applicant stands to gain an increase in his benefit amount immediately or within a short time.

Vocational Rehabilitation

To the other Social Security Act amendments in 1954 the following section dealing with referral for rehabilitation services was added:

SEC. 222. It is hereby declared to be the policy of the Congress in enacting the preceding section that disabled individuals applying for a determination of disability shall be promptly referred to the State agency or agencies administering or supervising the administration of the State plan approved under the Vocational Rehabilitation Act for necessary vocational rehabilitation services, to the end that the maximum number of disabled individuals may be restored to productive activity.

The appropriate representatives of the Department of Health, Education, and Welfare and each State vocational rehabilitation agency have been authorized to make arrangements for referrals to voca-

tional rehabilitation agencies of persons inquiring at BOASI district offices about the freeze and giving their written consent. In accord with these arrangements the district office refers persons for rehabilitation services. Where the individual has not filed an application for a disability freeze determination and has indicated that he wishes to be referred a simple referral form is used. Where the applicant has applied for a disability freeze the referral is more elaborate. The State vocational rehabilitation agencies have agreed to advise the BOASI of the acceptance or nonacceptance of individuals for rehabilitation services and of the completion of such services. These advices are to be used to determine whether cases should be developed for possible termination of a period of disability.

In order that rehabilitation efforts made by disabled individuals will not result in disadvantage to them, the BOASI does not terminate a period of disability for a person who undergoes a course of retraining or rehabilitation until the individual has demonstrated ability to engage in substantial gainful activity. Ordinarily, such an ability will be demonstrated by successfully engaging in work in the competitive labor market over a reasonable period of time, such as 6 months.

Number of Beneficiaries and Expenditures

The Social Security Administration has estimated that the cost of the disability freeze benefits—the level premium cost using an intermediate cost estimate—will be 0.07 percent of payroll on an approximately self-supporting basis. Benefit payments as percent of taxable payroll are estimated to range from 0.04 percent in 1960 to 0.09 percent in 2020.[39]

Inasmuch as increased old-age or survivors' benefit payments ascribable to the disability freeze program were first payable in July 1955, and the program is still in process of organization, the number of beneficiaries and the amounts paid them pursuant to the disability freeze are as yet small, and no information has been made available for general use.

PROPOSED DISABILITY BENEFITS UNDER OLD-AGE AND SURVIVORS INSURANCE (H. R. 7225)

A bill amending title II of the Social Security Act to provide, among other items, disability insurance benefits under Old-Age and Survivors Insurance—H. R. 7225, 84th Congress, 1st Session—passed the House of Representatives July 18, 1955, and is now (May 1956) under consideration by the Senate. [Editorial note: H. R. 7225 was enacted by the Congress in July 1956.] Cited as "The Social Security amendments of 1955", the bill as it passed the House provided five main changes:

(1) Monthly benefits for disabled insured individuals who have attained age 50;

(2) A reduction in the benefit eligibility age for women to 62 years;

(3) Continued monthly benefits for disabled children after they attain age 18;

(4) Expanded old-age and survivors insurance coverage; and

(5) An adjustment in the contribution schedule. Correlative amendments are made to the Internal Revenue Code of 1954.

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[39] Social Security Bulletin, October 1954, p. 13, table 5, and p. 14, table 7.

The provision in H. R. 7225 of particular interest in relation to veterans is that for the payment of monthly benefits at or after age 50 to insured workers who are permanently disabled yet are not old enough to be retired for age. The "disability freeze" law does not go beyond preserving the insurance rights of disabled workers and their families to benefits payable at the time the worker attains 65 or dies.

Eligibility Requirements Other Than Disability

To be eligible for benefits under H. R. 7225, a worker must have had not only the 6 quarters of coverage in the 13-quarter period ending with the quarter of his disablement and 20 quarters of coverage in the 40-quarter period ending with the quarter of his disablement required under the disability freeze. He must in addition be "fully insured."

Standards for Disability Evaluation

"Disability" is defined in H. R. 7225 as "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which is expected to be of long-continued and indefinite duration." The definition of "disability" for purposes of disability-insurance benefits is "the same as that provided under the existing disability freeze provision, except that blindness does not constitute presumed disability; for purposes of disability benefits, individuals with visual impairments must be disabled to the same extent as those with other physical impairments." [40] An individual who is able to engage in any substantial gainful activity will not be entitled to disability-insurance benefits even though he is in fact severely disabled. The procedures for determining and defining disability are the same under both the disability-freeze law and the disability-benefits bill. Under the bill the determination of disability will be made by the State agencies which make the determinations under the "freeze" provisions.

Benefits

Under H. R. 7225 benefits would not be payable to the disabled until after a 6-month waiting period. They would not be payable to dependents.

Section 224 of the proposed law contains an offset provision which ensures that if a periodic disability benefit is payable under a system established by any other agency of the United States for the same month, the disability-insurance benefit would be suspended if it is smaller than the disability benefit, or, if larger, it would be reduced by the amount of the other benefit. This means, for example, that there would be no duality of benefits in the case of Veterans' Administration, the Department of the Army, or the Bureau of Employees' Compensation. The same provision is in effect with respect to an individual under a State workmen's compensation law.

Benefits would be suspended in the case of the refusal, without good cause, to accept vocational rehabilitation services available to the individual under a State plan approved under the Vocational Rehabilitation Act. An individual who is performing services in the course of his rehabilitation, under a rehabilitation program being carried out under an approved State plan, would be considered disabled for a year after he first rendered such services.

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[40] House of Representatives, 84th Cong., Rept. No, 1189, p. 28.

Beneficiaries and Expenditures

The Committee on Ways and Means, in its report to accompany the bill, estimated that in the first year of operation disability-insurance benefits would be payable to about 250,000 workers, in 25 years to 1 million workers; that monthly disability benefits would amount to about $200 million the first year, $859 million in 1980, $1,044 million in 2020.[41] Cost estimates given by others range to twice these amounts.[42]

DISABILITY PROGRAMS FOR RAILROAD EMPLOYEES

Two disability programs have been established for workers in the railroad industry—one for the permanently disabled under the Railroad Retirement Act, the other for the temporarily disabled under the Railroad Unemployment Insurance Act. Both programs are administered by the Railroad Retirement Board, the former under the Bureau of Retirement Claims, the latter under the Bureau of Unemployment and Sickness Insurance. (Wage records are maintained by the Bureau of Wage and Service Records.) Both acts cover all employees of any railroad carrier, switching and terminal company, express company, or sleeping car company subject to part I of the Interstate Commerce Act, of certain other railroad-connected organizations, of any railway labor organization national in scope, its subordinate units and affiliates, also employee representatives who received any form of money remuneration. The number of persons who worked in the railroad industry some time or other during the calendar year 1953 is reported as 1,968,000.[43] Other millions have a record of railroad service.[44]

Program under the Railroad Retirement Act

Financing

The funds for all the programs provided under the Railroad Retirement Act—retirements for age and for disability, and survivor benefits—come chiefly from payroll taxes collected in equal shares from employees and employers in the railroad industry. The tax rate for each has been 6¼ percent, beginning with 1952. Since July 1954, taxes have been paid on employee earnings up to $350 a month. Before that, earnings were taxed only up to $300. The Federal Government is required to pay both the employee and employer shares on creditable military service earnings, which are assumed to be $160 a month.[45]

The taxes which finance the programs "are collected by the Internal Revenue Service under the Railroad and Retirement Tax Act (subch. B. of ch. 9 of the Internal Revenue Code) and are deposited in the general fund of the United States Treasury * * * the taxes collected are credited directly to the railroad retirement account." [46]

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[41] Rept. No. 1189, pp. 2 and 22.
[42] Washington Star editorial, July 20, 1955; see Congressional Record, July 21, 1955, p. A5366.
[45] Railroad Retirement Board, 1950 annual report, pp. 8–9; 1951 annual report, p. 6;
[44] The number of persons with a record of railroad employment in the period 1937–50 is stated to be 8,425,000. Railroad Retirement Board, 1952 annual report, p. 109.
[45] Railroad Retirement Board, 1950 annual report, pp. 8–9; 1951 annual report, p. 6; 1952 annual report, p. 6; 1953 annual report, p. 6; 1954 annual report, p. 7.
[46] Railroad Retirement Board, 1954 annual report, p. 5.

Eligibility Requirements Other Than Disability

The Railroad Retirement Act provides two types of employee disability annuities; one is based upon an individual's permanent disability for work in his regular occupation (sec. 2 (a) 4), and the other is based upon permanent disability for any regular employment (sec. 2 (a) 5). To qualify for either of these annuities an individual must have completed at least 10 years of service which is creditable under the Railroad Retirement Act. If an employee has less than 10 years of service when he retires he is not entitled to benefits under the Railroad Retirement Act, but his credits will be transferred to the Social Security Administration. Before a disability annuity begins the individual must have ceased all work for pay. He must also be under 65 years of age.

By 10 years of service is meant 120 months. A month of service is a calendar month in which an employee worked for a railroad for any part of the month, and any 12 such months make up a year of service. Months in which the employee was in creditable military service may be added to his railroad service in calculating the total.[47]

Beyond proving the required extent of disability, no further qualification must be met by the individual unable to engage in any regular employment.

To obtain an annuity for occupational disability, the individual, in addition to proving that he is permanently disabled for work in his regular occupation, must have a current connection with the railroad industry and if under 60 years of age have 20 years of railroad service; no more than 10 years is required of those aged 60 or older. An employee has a current connection if he has worked in the railroad industry at least 12 out of the last 30 months before his annuity begins. Any other 30-month period may be used if the employee had no regular nonrailroad employment subsequently.[48]

Standards for Disability Evaluation

(1) *Occupational disability.*—Section 2 (a) 4 of the Railroad Retirement Act provides: "The Board, with the cooperation of employers and employees, shall secure the establishment of standards determining the physical and mental conditions which permanently disqualify employees for work in the several occupations in the railroad industry, and the Board, employers, and employees shall cooperate in the promotion of the greatest practicable degree of uniformity in the standards applied by the several employers. * * *"

In order to comply with the provisions of this section of the Act, a plan of administrative procedure has been devised which centers about an occupational disability rating schedule. The plan was drafted by the Disability Division of the Bureau of Retirement Claims with the cooperation and assistance of a committee on standards composed of representatives of the employers, employees and the Railroad Retirement Board. The individual members of this committee were medical, legal, occupational or administrative specialists with many years of experience.[49]

To meet the requirement for an annuity that the employee's disability be of a permanent nature, it "must be one which is reasonably ex-

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[47] Leaflet—How To Compute Railroad Retirement Annuities.
[48] Railroad Retirement Act, sec. 1 (o).
[49] U. S. Railroad Retirement Board, Provisional Occupational Disability Rating Schedule.

pected to continue throughout the lifetime of the individual and is not one which is usually subject to medical correction." Whether or not it is disabling for work in a particular employee's regular occupation depends in great measure upon the type of duties to be performed in that occupation. Recognizing that the duties of many occupations are analogous in character insofar as the mental and physical requirements are concerned, the rating schedule places the railroad occupations—listed alphabetically—in eight groups, called "family groups." Medical standards in systemic groups are listed for each "family group." An individual whose occupation is placed in the group having the necessarily highest physical and mental standards because of the hazards involved and because of the high degree of responsibility attached to the work, requires less disability to become eligible for an occupational annuity than does the individual whose occupation appears in any of the other groups where the hazards and responsibilities are not so great. If none of the "family groups" closely represent the individual's duties, the case is considered an exceptional one and is rated independently.

To implement further Section 2 (a) 4 of the Railroad Retirement Act, the Board has adopted the following regulation (20 CFR.):

Section 208.11. *Establishment of permanent disability for work in the applicant's "regular occupation"*: (a) An individual's physical or mental condition shall be deemed to be permanently disabling for work in his "regular occupation", whether or not he has been disqualified for such work by his employer, if, in accordance with the occupational disability standards established by the Board, he is physically or mentally unable to perform the duties of such occupation, and the facts of his physical or mental condition afford a reasonable basis for an inference that such condition is permanent. The cause of the disabling physical or mental condition is immaterial * * * The condition of permanent disability for work in the individual's regular occupation must be established in each particular case in the manner and to the extent prescribed by the Board.

(2) *Permanent Disability for Any Regular Employment.*—Section 2 (a) 5 of the Railroad Retirement Act provides simply for the payment of annuities to "Individuals whose permanent physical or mental condition is such that they are unable to engage in any regular employment." To implement this the Railroad Retirement Board has adopted the following regulation:

Section 208.17 *Establishment of permanent disability for any regular employment.* (a) An individual is permanently disabled from engaging in any regular employment whenever his physical or mental condition is such that he is unable to perform regularly, in the usual and customary manner, the substantial and material duties of any regular and gainful employment which is substantial and not trifling, with any employer, whether or not subject to the Act, and the facts of his physical or mental condition afford a reasonable basis for an inference that such condition is permanent.

(b) The condition of permanent disability for any regular employment must be established in each particular case in the manner and to the extent prescribed by the Board. The following disabilities, while not an exclusive or exhaustive catalogue of conditions under which an individual may be considered permanently disabled from engaging in any regular employment are disabilities from which the Board will presume, in the absence of facts to the contrary, that an individual is so disabled:

(1) Loss of, or permanent loss of use of, both feet.
(2) Loss of, or permanent loss of use of, both hands.
(3) Loss of, or permanent loss of, use of, one hand and one foot.
(4) Permanent industrial blindness (corrected vision of twenty two-hundredths or less in both eyes).

(5) Permanent total loss of hearing in both ears (inability to hear the conversational tone of voice at any distance) unless offset or capable of being offset by some practical device.

(6) Permanently helpless or permanently bedridden.

(7) Aphonia (complete loss of vocalization (phonetic) from organic, i. e. nonfunctional cause).

The Railroad Retirement Board's administrative practice is "to consider a case under the less strict occupational disability standards whenever possible, even though the employee may be totally disabled. This procedure is followed because the amount of the annuity is the same in either case, and an occupational disability is more easily demonstrated. Therefore, many totally disabled employees receive occupational disability annuities." [50]

Of 9,495 individuals awarded disability annuities in the calendar year 1953, more than 81 percent had 20 years or more of service.[51]

During the fiscal year 1953–54 initial determinations were made in 11,170 cases—8,853 for disability in regular occupation, 2,317 for disability for all employment. Of the occupational disability claims, 8,033 or 91 percent were allowed; of the claims for disability for all employment only 1,491, or 64 percent; a total of 9,524, or 85 percent.[52] In addition about half of 1,000 claims which had been disallowed in earlier years were allowed. About 10,000 disability annuities in all were allowed in the fiscal year 1953–54. All data for 1954–55 are not yet available, but the rounded figure for disability annuities granted is 9,400—a reduction by about 600 from the previous year.[53]

Disability annuities accounted for 28 percent of all retirement awards in 1953–54, about the same proportion as in the preceding year.[54]

The disability rating board does not itself examine applicants for disability annuities. Disability determinations are made on the basis of medical evidence received. If the applicant is hospitalized at a Veterans' Administration facility, or confined to a Federal, State, county or municipal hospital or institution, a transcript without cost to the Railroad Retirement Board is requested of his most recent physical examination. If such medical evidence is not obtainable, a report of the applicant's physical condition is requested from his employer. Where the applicant appears in person at the field office and the disability is obvious (for example, amputation of both legs), a brief statement by the Board's field employee describing the disability accurately is sufficient. If evidence cannot be obtained from these sources, a doctor, termed a designated examiner, is selected by the field office to conduct a complete general physical examination, for which the Board pays. A case will not knowingly be rated solely on the basis of medical evidence furnished by the applicant's personal physician. The applicant may, however, at no expense to the Board, furnish medical evidence or lay evidence of any nature or source in connection with a claim and all such evidence will be given proper consideration.[55]

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[50] Railroad Retirement Board, 1954 annual report, p. 25.
[51] Ibid., p. 95, table B–4.
[52] Ibid., p. 116, table B–19.
[53] Ibid, Monthly Review, August 1955, p. 142. A Review of Board Activities in 1954–55.
[54] Ibid., 1954 annual report, p. 18.
[55] Field Operating Manual, Retirement 217.06 and 218.

If the evidence submitted to the rating board in any case is not sufficient for a determination, the Board arranges for a special physical examination.[56]

The chairman of the Railroad Retirement Board stated in a letter dated January 5, 1956 that:

> Over 50 percent of the medical evidence needed by the Board as a basis for its employee disability decisions is furnished by the railroad companies and the employee's hospital association upon a cooperative basis and without cost to the Board.

Benefits

The benefit in the case of retirement for permanent disability is an annuity paid monthly to the retired employee. No payment is made as an allowance to a spouse or any others there might be in the family.

In general terms, the amount of the retirement annuity depends upon the number of years of railroad service the employee has to his credit and the amount of pay received for that service.

Election.—Section 20 of the Railroad Retirement Act provides that:

> Any person awarded an annuity or pension under this act may decline to accept all or any part of such annuity or pension by a waiver signed and filed with the Board. Such waiver may be revoked in writing at any time, but no payment of the annuity or pension waived shall be made covering the period during which such waiver was in effect * * *.

Followup

The Railroad Retirement Act in the last paragraph of section 2 (a) provides that such satisfactory proof shall be made from time to time as prescribed by the Board of the disability and of the continuance of the disability, according to the standards applied in establishing its existence, until the employee attains the age of 65. If the individual fails to comply with the requirements prescribed by the Board as to proof of continuance, his right to a disability annuity shall cease, but without prejudice to his rights to any subsequent annuity to which he may be entitled. If an employee in receipt of a disability annuity is found to be no longer disabled, his annuity shall cease upon the last day of the month in which he ceases to be so disabled.

Section 2 (d) of the Retirement Act provides that no disability annuity shall be paid for any month in which the annuitant under age 65 earns more than $100 either in employment or self-employment. This amount was embodied in Public Law 746 enacted August 31, 1954. Prior to that time, effective January 1, 1947,[57] if a disability annuitant under age 65 earned more than $75 a month in any kind of employment or self-employment for six consecutive months, his annuity was stopped at the end of the sixth month. Also, under the new law a penalty is provided for failure of an employee to report such earnings. To continue to receive the annuity while earning up to $100 the annuitant must remain disabled and the work he does must not be for a railroad or his last nonrailroad employer.

The Board follows up with respect to continuance of an annuitant's eligibility by sending out once each year a somewhat detailed form calling for information as to his disability, state of health, and treatment by a physician, and as to his employment and earnings. Any false statement in answering is punishable by a fine of not more than

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[56] Monthly Review, June 1954, p. 103—Disability Determinations in 1952–53.
[57] Public Law 572, 79th Congress.

$10,000 or imprisonment not exceeding 1 year. The letter accompanying the questionnaire calls attention to the requirements of the law and advises the annuitant that failure to furnish the requested information within 30 days may result in suspension of the annuity. In event the form is not returned within a reasonable period, the nearest field office is notified and it asks the individual to report in person. Regulation 208.29 provides that payment of the disability annuity will cease if the annuitant fails to comply with a notice mailed to him requiring him to furnish additional proof of the continuance of his disability; or if he fails to appear for, or submit to, a required examination; or if he fails to furnish required information relating to employment, earnings and his physical or mental condition.

Recovery from disability of those on the railroad retirement rolls is relatively infrequent. The Board has reported that at the end of June 1954, about 1,000 disability annuities were in suspended status because the annuitants had recovered from disability.[58] The number of disability annuities in current-payment status at that time was reported as 82,161.[59] In about 4 out of 5 of the 1,000 cases the annuitant was considered to have recovered from his disability under the standards set up by the 1946 amendments, that is, before reaching age 65 he earned more than $75 in each of six consecutive months. In the remaining cases, medical examination established that the individual had improved to the point where he was no longer disabled as originally determined.

Rehabilitation

The Railroad Retirement Act makes no mention of the rehabilitation of disabled annuitants; consequently the Board does not consider rehabilitation to be in its province.

Beneficiaries and Expenditures

The total number of employee annuities under the Railroad Retirement Board with monthly benefits in current-payment status in June 1955 was 306,565 of which 84,846, or 27.7 percent, were disability annuities.[60] The corresponding figures for the preceding year were, respectively, 290,085 and 82,161 or 28.3 percent.[61]

The number of disability annuities awarded annually has not varied greatly in recent years. Beginning with 1951–52 the figures for the 4 years ending June 1955 are in sequence 8,870; 9,033; 10,047 and 9,415.[62]

Of the disabled employees receiving annuity awards in the year ending June 1955, 47 percent were 60–64 years of age, 44 percent were 50–59 and 9 percent were under 50. These proportions were much the same as in the year ending June 1954.[63]

The Railroad Retirement Board estimates that $101,700,000 was expended in disability annuities during the fiscal year 1954–55. The total amount for all annuities, i. e., including those for age, during the same period was $372,154,998.[64]

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[58] Railroad Retirement Board, 1954 annual report, pp. 25–26.
[59] Railroad Retirement Board, Monthly Review, August 1954, p. 166.
[60] Monthly Review, August 1955, p. 159, Selected Current Statistics, June 1955.
[61] Monthly Review, August 1954, p. 166.
[62] Ibid., August 1953, p. 158; August 1954, p. 166; and August 1955, p. 159.
[63] Monthly Review, August 1955, p. 143.
[64] Ibid., p. 160.

Program under the Railroad Unemployment Insurance Act

The program for the temporarily disabled administered by the Railroad Retirement Board is simply an extension of the railroad industry's system of unemployment insurance, already in operation, to cover periods of unemployment due to sickness. Its relationship is slight to compensation for long-term disability as administered by the Veterans' Administration.

FEDERAL-STATE PUBLIC ASSISTANCE PROGRAMS

General Purpose

In the same act which established the Old-Age and Survivors Insurance system—the Social Security Act which became law August 14, 1935—the Congress of the United States, as a consequence of the experiences of the depression, set up a program of public assistance for the needy. Basically this is a system of Federal grants to States financed out of general tax funds and is "for the purpose of enabling each State to furnish financial assistance, as far as practicable under the conditions in such State" to the needy in four categories. The aged, dependent children in the home of an adult relative, and the blind were covered in the original law. The permanently and totally disabled were added under amendments enacted in 1950. The category of the aged will not be discussed here because age rather than disability is the basic requirement. Nor will aid to dependent children, for while the physical or mental incapacity of a parent is responsible for between one-fifth and one-fourth of all families who receive aid to dependent children being on the rolls, that incapacity need not be permanent or total and disability evaluation standards are not comparable with those in the other programs.

Administration and Financing

In the operation of the Federal-State public assistance programs the development of statewide plans and the actual dispensing of assistance have been the responsibility of the State and local welfare offices. The Secretary of the United States Department of Health, Education, and Welfare through the Bureau of Public Assistance has been responsible for the development of program policies and standards, for the review and approval of State plans and grants, and for seeing that in the administration of the approved plan by the State there is no failure to comply in substance with the Federal law. The Federal Bureau has also been available for consultation and advice. All States have plans in effect for aid to the blind. As of May 15, 1956 seven do not have such plans for the permanently and totally disabled.

The public assistance grants are entirely different from most grants-in-aid made by the National Government. The amount to be contributed from Federal funds is left open—to be determined by the number of cases in each State to which benefits are granted in accord with the terms of the Social Security Act. Congress has fixed the maximum individual monthly payments subject to Federal participation for assistance to persons in each of the categories and has made provision for sharing administrative costs. It has authorized the appropriation for each fiscal year of sums sufficient to meet State and local payments made in the States under the act.

Federal payments are made from general tax funds. The States' shares are financed in various ways with different proportions coming from State and from local funds.

Eligibility Requirements in Addition to Disability

Need.—Before aid may be given in any category, need must be established. The definition of need is left to each State, subject to the approval of the Federal agency, with the proviso that the State agency shall, in determining need, take into consideration any other income and resources. The customary definition, with slight variations in the wording, is: "Has insufficient income and other resources to provide a reasonable subsistance compatible with decency and health." The definition of what constitutes insufficient income and other resources has a wide spread.

With respect to the blind, an amendment to the Social Security Act, effective October 1, 1950, specifies that in determining need, the first $50 monthly of earned income shall be disregarded. This provision was optional with the State until July 1, 1952, when it became mandatory. The aim of this legislation was that blind workers be given an incentive to "achieve greater use of their capacities and increased satisfaction as productive members of their communities." [65]

Standards for Disability Evaluation

As a result of definitions in the social-security law, the interpretations of the law by the Bureau of Public Assistance and the recommendations of the Bureau to the States, definitions of the blind and of the permanently and totally disabled have come to present a great degree of uniformity in the approved plans of the different States.

The blind.—Title X of the Social Security Act does not define "blindness." "In order to assure a broad and realistic" determination of blindness, the Social Security Board, the original agency charged with administration of the act, "on September 15, 1936, interpreted 'blind individuals' to include persons having insufficient vision to perform tasks for which sight is essential, as well as persons without vision. A definition of 'economic blindness' had been adopted by the section on ophthalmology at the 85th annual session of the American Medical Association, held in Cleveland, in June 1934." Based on this definition, the Social Security Board adopted the following as a recommended definition of blindness:

> In terms of ophthalmic measurement, central visual acuity of 20/200 or less in the better eye with correcting glasses is generally considered as economic blindness. A field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field subtends at an angular distance of no greater than 20 degrees may be considered equally disabling.[66]

Permanently and totally disabled.—The Federal agency in interpreting the law has defined "permanently and totally disabled" in general to mean "that the individual has some permanent physical or mental impairment, disease or loss (or combination of impairments) that substantially precludes him from engaging in useful occupations within his competence, such as holding a job or homemaking." [67]

The Bureau has suggested that—

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[65] Bureau of Public Assistance, Report No. 19, Aid to the Blind Recipients With Earnings in September 1950, foreword.
[66] Handbook of Public Assistance Administration, part IV 3320, October 27, 1954.
[67] Ibid., IV 3820, April 15, 1952; and 3830, August 5, 1953.

any condition which is considered by the medical reviewer as not likely to respond to any known therapeutic procedures shall be deemed to be permanent; furthermore, any condition which is likely to remain static or to become worse unless certain therapeutic measures are carried out shall be deemed to be "permanent" so long as treatment is unavailable, inadvisable, or the individual refuses treatment and his decision is reasonable[68] (e. g., when the treatment may be extremely hazardous).[69]

"Permanent" does not rule out the possibility of vocational rehabilitation or even recovery from the impairment, but is considered a proper classification pending actual physical improvement.[70]

As interpreted, the term "totally," like "permanently," is not used in an absolute sense but must be considered in reference to the ability of the person as revealed by the facts in his case to perform activities necessary to carrying out specific responsibilities. The State's plan is required to provide for obtaining and recording sufficient social data—such as age, education, training, skills, work experience, and the existence in the community of an occupation within his competence—to make it possible to relate the medical findings to the types of activity the individual is competent to perform and thus pertinent for judging whether the individual is "totally" disabled in the light of his ability to carry on in his situation.[71]

The State plan must include a method by which the existence of an impairment and its permanent nature is to be determined. This method must provide for recorded medical information, including a substantiated diagnosis, based either on existing medical evidence or upon a current medical examination. Medical evidence may be available from sources which include the individual's doctor, agency records, clinics, or hospitals. Where medical evidence is not available, the plan must provide for a current examination and a report of the medical findings.[72] If the State's definition of "permanently and totally disabled" is confined to complete helplessness, or provides for such a classification of cases, the plan may provide for establishment of this eligibility factor for these cases on the review of medical findings alone.[73]

Provision must be made for review as to adequacy both of the medical information and the social data by technically competent persons, acting cooperatively on behalf of the State agency, charged with responsibility for making the finding as to the permanent and total disability of the individual for the consideration of the agency official(s) responsible for making the decision as to eligibility for assistance * * *. These shall include, in addition to a physician and a social worker qualified by professional training and pertinent experience, such other persons from technical fields, including rehabilitation, vocational counseling and placement, as the State considers essential in order to assure a valid finding under its definition.[74]

The Bureau of Public Assistance in its Handbook of Public Assistance Administration[75] discusses Criteria for Presumptions as to Disability.

Decisions must be made on the basis of the facts in the individual case, but this requirement does not preclude the use of governing criteria which create strong presumptions and which can be used as the base of the decision unless contrary evidence is actually established in the individual situation. A few "classifications" have been worked out in other disability programs and these should be carefully considered by the assistance agencies in setting up their programs and in developing criteria to guide the team. The following is only

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[68] Ibid., IV 3820.1.
[69] Ibid., IV 3851.
[70] Ibid., IV 3820.1.
[71] Ibid., IV 3820. 2.
[72] Ibid., IV 3830. 2.
[73] Ibid., IV 3830 3.
[74] Ibid., IV 3830. 4.
[75] Ibid., IV 3853, August 5, 1953

one example of the kind of classifications which have been developed as creating "very strong presumptions" in showing that a given Impairment is totally disabling:

Loss of, or loss of the use of, one hand and one foot.
Loss of, or loss of the use of, both hands.
Loss of, or loss of the use of, both feet.

The following is an example of the kind of classification which is usually considered to establish a somewhat weaker presumption, but one to be seriously considered: Organic loss of speech, total and unimprovable loss of hearing, physical loss of one eye and loss of use of one hand or one foot, industrial blindness. The use of all such classifications is limited to creating the "presumption" which must be substantiated by the medical and social data relating to the individual's functioning within the definition established by the State.

With respect to reexaminations, the Bureau advises as follows:

> In accordance with the concept that "permanently and totally disabled" does not preclude improvement or recovery, it will be necessary in many cases to redetermine this factor of eligibility on the basis of examination by a physician. In cases in which changes toward improvement in the physical or mental condition seem possible, periodic medical examinations and review of the new medical information are part of establishing continuing eligibility * * *. Actual decision as to reexamination should rest with the State's reviewing physician at the time the [original] decision is made as to the individual's being permanently and totally disabled.

It is noted further that changes in the individual's social situation may make review of the disability necessary periodically. The Bureau recommends that decisions that permanent and total disability continues or has ceased to exist rest with the review team.[76]

Followup

For Federal financial participation in individual payments to continue to be available to the agency administering the public assistance programs the agency must:

1. Review and redetermine eligibility within a 12-month period;
2. Take prompt action within 30 days to review indications of ineligibility as they occur; and
3. Discontinue or revise the payment within 30 days of the date the agency obtains facts which establish ineligibility or decreased need for assistance.[77]

The above requirements are presumably more related to need than to disability but would include the latter. Reevaluations of disability have been discussed in connection with original determinations of disability.

Benefits

In the original Social Security Act "assistance" was defined as "money payments" to the blind, to the aged, and with respect to a dependent child or children. Amendments to the law in 1950 extended this definition to include payments by the agency directly to physicians, hospitals, clinics, and others supplying needy individuals with medical or any type of remedial care recognized under State law. Before 1950 the State and local agencies often made vendor payments for medical care provided to recipients, particularly when they required expensive hospital or nursing home care, but the Federal Government did not participate in such payments until October 1, 1950. It does so to the extent that such payments when added to any assistance paid

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[76] Ibid., IV 3852.
[77] Ibid., IV 2232, September 3, 1947.

the individual as a money payment do not exceed the monthly maximums in individual payments made to or for those in the specified categories. Assistance to the permanently and totally disabled is handled as it is to other adults.

The maximum monthly payment subject to Federal participation since October 1, 1952, has been $55 for a blind individual and the same for one totally disabled.

Monthly payments in the different States—utilizing Federal, State and local funds—in June 1955 ranged from $32.13 in West Virginia to $128.12 in Minnesota for aid to the blind; from $24.60 in Mississippi to $107.13 in Connecticut for aid to the permanently and totally disabled. The averages for all jurisdictions (including Puerto Rico and the Virgin Islands) were $57.41 for the blind and $54.93 for the disabled. These figures include vendor payments for medical care and cases receiving only such care.[78]

Cash benefits from social insurance and related programs.—According to a study of recipients of aid to the permanently and totally disabled, mid-1951, made by the Bureau of Public Assistance, only 2.7 percent also received cash benefits from such programs as old-age and survivors insurance, workmen's compensation, veterans benefits, and industrial retirement plans. In all, some 2,495 persons of a total 93,359 received such benefits. Of these 49.6 percent received a benefit from the Veterans' Administration, 14.2 percent an old-age and survivors insurance benefit, and 11.1 percent a benefit under an industrial retirement plan. Other figures were 7.6 percent from the Railroad Retirement Board, 7.4 percent from Workmen's Compensation, and 8.9 percent from other public programs. These data are exclusive of the 1.2 percent that received benefits from more than one other source.[79] [80]

Benefits from the Veterans' Administration were substantially larger than benefits of other types; 67.7 percent of these were $50 to $74.99 a month. In contrast, 55.5 percent of the other benefits were less than $35 a month.[81]

Vocational Rehabilitation

The philosophy of the Bureau of Public Assistance is that "The assistance programs should help persons meet their particular exigencies in such a way that they will be able to resume making their own way without aid." [82] In its dealings with the States the Bureau has stressed the value of coordinating the services of the assistance agencies with those of other agencies, and in particular of using the services of other agencies such as those concerned with health, employment and vocational rehabilitation.

The policy of the Bureau has long been that "All disabled applicants and recipients of public assistance should be considered as

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[78] Social Security Bulletin, September 1955, pp. 24 and 26, tables 13 and 16.

[79] U. S. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance, Report No. 22, Characteristics of Recipients of Aid to the Permanently and Totally Disabled, mid-1951, table 16, pp. 34–35.

[80] NOTE.—An unpublished tabulation from a study of old-age assistance—a sample study made in 49 States in a selected month, December 1952 to May 1953—shows that 0.4 percent of recipients of old-age assistance were also getting some type of benefit from the Veterans' Administration. (The study was "Recipients of Old-Age Assistance in Early 1953, Part 1—State Data," Public Assistance Report No. 26, U. S. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance. The unpublished table was sent to the Commission by Jay L. Roney, Director, Bureau of Public Assistance.

[81] Same as footnote No. 79, table 17, pp. 34–35.

[82] Phyllis Hill, "Aid to the Permanently and Totally Disabled," Social Security Bulletin, December 1950, p. 5.

potential clients of the vocational rehabilitation agency."[83] As early as December 15, 1943, a memorandum "was sent by the Office of Vocational Rehabilitation to State Boards of Vocational Education and to State Commissioners and other agencies for the blind which presented principles and policies agreed upon by the Office and the Bureau of Public Assistance to be used as a guide to the State cooperating agencies in the formulation of agreements or cooperative relationships. A similar statement was sent under the same date by the Bureau of Public Assistance to State public assistance agencies.[84] The Senate Report No. 1669 to accompany H. R. 6000 (81st Cong., 2d Sess.), page 3, stated: "* * * The problem is not limited to the feasibility of providing income or pensions merely to maintain disabled workers. At least of equal significance is the need for assuring fullest use of rehabilitation facilities so that disabled persons may be returned to gainful work, whenever this is possible." The Joint Conference Committee Report on the Social Security Act Amendments of 1950, in discussing the addition of title XIV to the Social Security Act noted: "With the authorizations for an assistance program to cover this group it is believed that the State public assistance agencies will work even more closely than before with State rehabilitation agencies in developing policies which will assure that every individual for whom vocational rehabilitation is feasible will have an opportunity to be rehabilitated." The Federal Bureau of Public Assistance requires each State plan for aid to the permanently and totally disabled to include a description of the way that working agreements are to be developed with related programs.

Beneficiaries and expenditures

Recipients of aid to the permanently and totally disabled numbered 236,840 in June 1955, the last month of the fiscal year; and 103,906 persons received aid to the blind. Payments to recipients for June amounted to $13,010,252 and $5,965,151, respectively. (The data for the blind include some recipients of payments made without Federal participation and the payments to them.)[85]

Persons receiving aid to the blind probably represent one-third of the blind population of the Nation.[86] The number of long-term disabled, i. e., those unable to work or to follow other normal activities on a regular basis, in the United States on an average day in 1954 has been estimated at 5,310,000, of whom 250,000 were under 14 years of age, 2,900,000 were 14 to 64 years, and 2,160 were 65 years and over.[87] Those 14 to 64 years are estimated to comprise 2.9 percent of the civilian population of the United States of that age. Recipients of aid to the permanently and totally disabled under the Federal-State program were 3.3 per 1,000 population 18 to 64 on the average for the 43 States having such a program in June 1955.[88]

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[83] Handbook, IV, 9121.
[84] Ibid., 9120.
[85] Social Security Bulletin, September 1955, pp. 24 and 26, tables 13 and 16.
[86] Reprint, Public Assistance, an article that appeared in the 1954 edition of the Social Work Yearbook, by Anne E. Geddes and Charles E. Hawkins.
[87] Estimated Prevalence of Long-Term Disability, 1954, Social Security Bulletin, June 1955, pp. 20–21.
[88] Social Security Bulletin, September 1955, p. 25, table 15.

CHAPTER VI

THE RELEVANCE OF WORKMEN'S COMPENSATION TO THE VETERANS' COMPENSATION PROGRAM

Workmen's compensation and the present veterans' service-connected disability compensation program share similar historical origins. The idea of compensating wounded veterans goes back to colonial times, while statutory monetary awards for specified disabilities date from the Civil War. The present program, which specifically relates the amount of benefits to the degree of impairment of earning capacity, dates only from 1917. It represented part of an effort to get away from the old pension system with its long history of discriminations, fraud and inequities, and to substitute therefor a form of social insurance, in which benefits would be related primarily to presumptive need.[1]

Workmen's compensation also has a long and independent antecedent history in the 19th century common law of negligence or tort liability and the legal system of employers' liability derived therefrom. Under this system, the injured worker's right to obtain indemnity for industrial injury depending upon his bringing the case to court and winning it, a sort of grim sweepstakes in which individuals occasionally recovered damages out of all proportion to their need, but many got nothing or a miserable pittance.

The workmen's compensation movement started in this country during the first decade of the 20th century and came to a climax in 1917, the year the United States Supreme Court established its constitutionality. It sought to replace this costly and socially unsatisfactory situation by a system in which the hazards of occupational injury would be met on a social insurance basis. Costs were to be borne by the employers, and to be regarded as a cost of production, regardless of fault in any particular accident. Recoveries or benefits were to be limited, but certain, and related primarily to previous earnings or loss of earning capacity as a measure of presumptive need.[2]

Thus, both programs emerged as part of the general widespread social insurance movement which developed in this country before and during World War I and which aimed to meet the major hazards of modern life in adequate but economical fashion. In keeping with this aim, both programs defined disability primarily in terms of its economic effects rather than its personal aspects. The disability to be

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[1] William P. Dillingham makes a good deal of this point. He says, "The War Risk Act may be considered as one phase of the movement toward social insurance. The social-insurance idea had been gaining favor in the United States, but it had not been applied to veterans' benefits. Even in the United States, however, where military pensions constituted a patchwork based on the principle of gratuities and political favor rather than on a sense of social justice and mutual obligation, the system was recognized as a failure. This act was an attempt to apply the principles of social insurance to the compensation of war victims." Federal Aid to Veterans, 1917–41, University of Florida Press, 1952, p. 11.

[2] For the background and history of workmen's compensation development in this country, see H. M. and A. R. Somers, Workmen's Compensation: Prevention, Insurance, and Rehabilitation of Occupational Disability, Wiley, 1954, ch. II.

compensated was, in both programs, not the physical injury per se, nor all of its consequences, but the effects of the injury on the injured man's earning capacity and hence his ability to support himself and his dependents.

During the past four decades, both programs have undergone great pressures and have experienced significant changes. This was an inescapable consequence of radical changes in science and technology, economic, political and social institutions during the same period. This chapter attempts to relate these developments to the workmen's compensation and Veterans' Administration compensation programs and to determine where trends in the two programs have been analogous, where divergent.

A brief résumé is given at the outset followed by a comparison of the major provisions of the two programs. The sections which then follow, analyze in summary fashion some of the major developments in three important areas: Eligibility, benefits, and the relation of the disability compensation program to rehabilitation. A fourth problem, disability evaluation, is discussed in detail in chapter VII.

AN ANALYSIS OF BASIC PROVISIONS OF THE TWO PROGRAMS

Unlike the Federal compensation laws for veterans with service-connected injuries which apply uniformly throughout the country, workmen's compensation developed and is administered on a State-by-State basis. Altogether there are now 54 separate United States compensation jurisdictions: The 48 States, 3 Territories, and 3 Federal. The Federal Employee's Compensation Act covers civil employees of the Federal Government, public employees of the District of Columbia, and a number of other categories including the Armed Forces Organized Reserve when on active duty in time of peace. The Longshoremen's and Harbor Workers' Compensation Act, enacted for these groups of workers after they had been barred by the Supreme Court from State coverage, has since been extended to several additional categories, including private employers of the District of Columbia. Although the provisions for longshoremen and District of Columbia private employers are almost identical, they are usually listed as separate jurisdictions.

There are great variations in the provisions of the different workmen's compensation laws. They vary as to coverage, benefits, financing, and administrative arrangements. In view of this diversity it is exceedingly difficult to generalize with accuracy. And yet generalizations must be employed if the program is to be at all comprehensible and if comparisons with the Veterans' Administration compensation program are to be made. The reader should be mindful of this overall caution.

Coverage

No one knows exactly how many workers are presently included under workmen's compensation. Official estimates vary from about two-thirds to four-fifths of United States employees, with the proportion varying widely from State to State. The Social Security Admin-

istration has estimated that in 1954, 38 to 39 million workers were covered.[3]

An injured employee may find himself excluded for a variety of reasons within two principal categories: (1) Because his particular type of employment or employer may not be covered under the law, or (2) because his particular injury may not be covered under the law.

1. *Excluded employments and employers.*—Among the prominent exclusions are the 1,500,000 interstate railway workers and the 132,000 merchant seamen. Originally they objected to exclusion but, unlike other groups, they obtained special Federal employers' liability legislation and now prefer to remain outside the compensation system.

Most of the other exclusions can be traced back to the crucial days when the issue of constitutionality hung in the balance. While that question has long since disappeared, the limitations it engendered have proved immortal. In some States, the laws apply only to a list of so-called hazardous employments. Many States exempt employees having less than a specified number of employees. Farm workers, domestic servants, and casual employments are almost universally excluded. Hired farm workers constitute the largest group deprived of protection.

By contrast, the veterans' disability compensation program covers all disability resulting from disease or injury incurred in or aggravated by active military or naval service of veterans who were discharged under other than dishonorable conditions. There are two categories of benefits: for wartime service and peacetime service, as defined in Veterans Regulation No. 1 (a) and official interpretations. Rates for peacetime service are 80 percent of the wartime rates. Nearly all 22 million living United States veterans were or are covered for disabilities or deaths arising from causes connected with service, whether these conditions were identified in service or afterward.

The population covered by veterans' compensation laws has fluctuated much more than that covered by workmen's compensation. The change in workmen's compensation coverage over the years has been relatively small, as there have been few statutory expansions. The total has naturally increased with the growth of the labor force, and there has been a gradual increase in the proportion covered due to a shift in employment away from farm and domestic employment into the covered industries. But workmen's compensation has not had to cope with any such coverage problems as faced the Veterans' Administration as a result of World War II or the Korean conflict.

2. *Excluded injuries.*—Under workmen's compensation, even if both the employment and the employer of an injured worker are covered by the compensation law, several questions regarding any particular injury remain to be answered affirmatively before the worker's right to compensation can be established: (*a*) Is the disability of sufficient duration not to be disqualified by the statutory waiting period? (*b*) Has the worker made a claim within the time limits specified? (*c*) Is the injury compensable under the law of his jurisdiction? (*d*) Did the injury arise out of and in the course of employment?

(*a*) *The waiting period.*—Numerically, the most important basis for excluding injuries from compensation indemnity benefits has been

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[3] U. S. Department of Health, Education, and Welfare, Social Security Administration, Social Security Bulletin, December 1955, p. 24.

the establishment of a minimum period which the disability must exceed in order to be compensable. The purpose of the waiting period is to exclude minor injuries, prevent malingering, and avoid excessive costs as well as administrative overhead.

The length of the waiting period has been steadily reduced from an original standard of 2 weeks to 1 week in most States. Furthermore, most jurisdictions now permit retroactive payments to the beginning of disability if it extends beyond a given period, such as 3 or 4 weeks. In these jurisdictions, the waiting period affects temporary disability only.

In the veterans' program there is never any waiting period. Benefits are effective from date of separation from service if claim is filed within 1 year from separation; otherwise from date of application.

(*b*) *Time limits.*—All compensation laws have specified limits on the time which may elapse between the date of disability and the date that the claim is filed, and most also have a specific time limit for notifying the employer. However, the latter is considered excusable in most cases and the former is extensible in certain jurisdictions.

The range of limits is great, but the most frequent requirement for notification to the employer is 30 days, and for claim filing from 1 year (for disability) to 2 years (for death).

Rigid limits have often caused personal hardship and legal difficulty, especially in the case of occupational diseases. The problem of determining just when the disease started, for the purpose of applying the statute of limitations, is frequently very difficult. Moreover, some diseases are amazingly slow in manifesting themselves. Pneumonitis following exposure to beryllium, some radiation injuries, and lung cancer from chrome poisoning may not become apparent for 40 years after exposure. The injustice of short-time limitations in such cases is clear, and several States now provide extended time limits for the slow-starting diseases.

On the other hand, generous time limits have been abused by claimants. For example, in States which permit the reopening of old cases, it is frequently alleged that dubious claims are made, especially in times of unemployment.

The veterans' program has no limit on the amount of time which may elapse between separation from service and filing of application for service-connected disability or death compensation. Moreover, the statutory presumptions regarding the service-connected origin of various specified diseases, discussed below, have the effect of greatly extending eligibility for benefits in borderline cases.

Thus, there is recognition in both programs that different time limits may be required for disabilities resulting from disease as opposed to traumatic occurences.

(*c*) *Definition of "compensable injury."*—Exclusions from workmen's compensation benefits under (*c*) and (*d*), above were originally very severe. In recent years, however, there has occurred a significant expansion in the legal definition of a compensable injury and in the interpretation of the phrase "out of and in the course of employment" which tests the causal relationship between the injury and the job.

In the veterans' program the test of compensability for any particular disability lies in the phrase, "resulting from personal injury or disease contracted in line of duty, or for aggravation of a preexisting injury or disease contracted or suffered in line of duty." (Veterans Regulation 1 (a).) Here too, there has been a vast expansion. This significant parallel trend in the two programs is discussed below.

Benefits

There are three categories of compensation benefits—cash, medical, and rehabilitation—designed to indemnify the injured worker or his dependents for the major misfortunes resulting from industrial injury: loss of wages, medical and hospital expenses, and loss of occupational capacity and skills. Originally, benefits were generally limited to cash payments. Today, however, medical benefits represent about one-third of the total. Rehabilitation benefits are still small in amount but potentially a highly significant aspect of the program. For distribution of the workmen's compensation benefit dollar by type of benefit, see chart I. Medical and cash benefits will be discussed separately.

Cash benefits vary in accordance with four major categories of compensable injuries: temporary-total disability, permanent-total disability, permanent-partial disability,[4] and death.

A temporary total disability is one in which the injured employee is unable to perform any work for pay but may be expected to recover fully from the injury. About 95 percent of all injuries now fall in this category, but they represent a much smaller percentage of compensated cases.

A permanent total disability in workmen's compensation results from the loss or the permanent loss of use, of any body part or function which renders the person unable to work at (his, any) occupation for example, blindness in both eyes, amputations, and paraplegia. Fortunately, the annual number of such tragic injuries is small, averaging about 1,600 a year, during 1943–52, less than 0.1 percent of all work accidents, and going down. That ratio of compensated permanent total cases to all cases is higher than the accident ratio, but even in New York, which accounts for about one-fifth of all permanent total cases in the country, they represent only about 0.3 percent of all cases in the State.

A permanent partial disability is one that involves loss of a member of the body—an eye, a foot, or a finger—or the permanent impairment of the use of some part or function of the body in any degree less then permanent total disability. These now average about 89,500 a year, less than 5 percent of all injuries. The ratio of permanent partial cases to all compensated cases varies greatly among the States, ranging from not much higher than the injury ratio to figures such as 40 percent in Illinois and 66 percent in New Jersey.

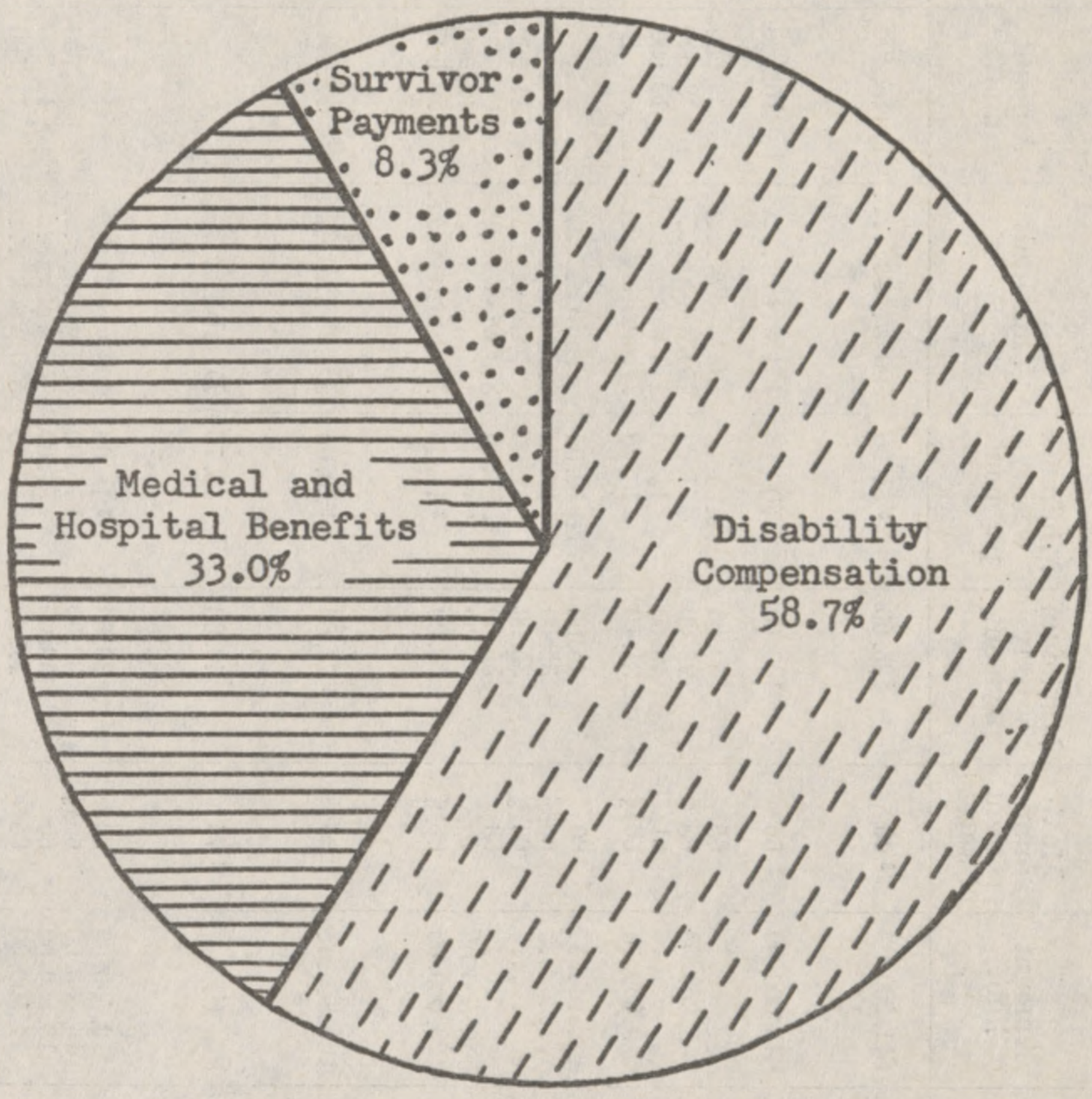
Fatalities now average more than 16,000 a year, or about 1 percent of the total injuries. The compensation ratios in 5 important industrial States range from 0.5 percent in New Jersey to 1.5 percent in Pennsylvania, with its concentration of mines and heavy industry.

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[4] The following are statistical definitions adopted by the International Association of Industrial Accident Boards and Commissions, 1953.

CHART I

DISTRIBUTION OF WORKMEN'S COMPENSATION BENEFITS BY TYPE OF BENEFIT PAYMENT, 1952



Source: Department of Health, Education and Welfare

In this paper, discussion will be largely confined to the two categories relevant to the veterans' disability compensation program—permanent total and permanent partial.

In workmen's compensation, cash benefits are generally paid on a weekly basis. The basic formula in all types of cases is similar but the factors involved are many and complex: (1) A specified maximum percentage of the worker's normal or average wages, (2) a weekly dollar maximum and minimum, (3) a maximum total or aggregate dollar amount, (4) a maxmium duration or amount of time for which beenfits may be paid, (5) variations according to the number of dependents, (6) a waiting period, and (7) a formula by which average wages are computed.

For basic benefit provisions in all jurisdictions see Table 1, Permanent and Temporary Total Disability Benefits (as of January 1956), and table 2, Permanent Partial Disability Benefits (as of January 1956).

TABLE 1.—*Workmen's compensation benefits for permanent and temporary total disabilities, Jan. 1, 1956*

Jurisdiction	Limitations on permanent total					Limitations on temporary total					Notations
	Maximum percent of wages	Maximum weekly payment	Minimum weekly payment	Time limit	Amount limit	Maximum percent of wages [1]	Maximum weekly payment	Minimum weekly payment	Time limit	Amount limit	
Alabama	[2] 65	$28.00	[3] $5.00	550 weeks [4]	$11,200.00	[2] 65	$28.00	[3] $5.00	300 weeks	$8,400	Defined permanent total disability. Disfigurement benefits to 100 weeks.
Alaska	([5])	([5])	([5])	None	[6] 15,000.00	65	100.00	([7])	104 weeks	10,400	Disfigurement limits $4,000.
Arizona	65	[8] 150.00		Life		65	150.00		433 weeks	65,000	
Arkansas	65	25.00	7.00	450 weeks	8,000.00	65	25.00	7.00	450 weeks	8,000	
California	61.75	35.00	15.00	Life [1]		61.75	40.00	15.00	240 weeks	12,800	40 percent after 400 weeks.
Colorado [9]	50	31.50	10.00	Life [1]	9,859.50	66⅔	31.50	10.00	Disability		Lump-sum maximum, $9,859.50.
Connecticut	60	40.00	12.00	Life		60	40.00	12.00	do		
Delaware	66⅔	35.00	[3] 18.00	do		66⅔	35.00	18.00	do		
District of Columbia	66⅔	35.00	12.00	do		66⅔	35.00	12.00	do	11,000	
Florida	60	35.00	[3] 8.00	do		60	35.00	[3] 8.00	350 weeks		
Georgia	60	30.00	[3] 10.00	400 weeks	10,000.00	60	30.00	[3] 10.00	400 weeks	10,000	
Hawaii	66⅔	[1] 50.00	[1] 18.00	Life	[10] 20,000.00	66⅔	50.00	[3] 18.00	Disability	20,000	Director may order payment of $150 per month for attendant, to be paid from special fund.
Idaho	60	[1] 23.00	[1] 10,00	Life [11]		60	[1] 23.00	[1] 10.00	Disability [11]		Maximum $28 with dependent spouse. Add $3 each child, maximum, $40.
Illinois	75	40.00	16.75	Life	([1])	[1] 75	40.00	16.75	Disability	([1])	Limited to amount would receive if accident had resulted in death. Life pension thereafter.
Indiana	60	33.00	[3] 18.00	500 weeks	12,500.00	60	33.00	[3] 18.00	500 weeks	12,500	
Iowa	66⅔	32.00	[3] 15.00	500 weeks	16,000.00	66⅔	32.00	[3] 15.00	300 weeks	9,600	
Kansas	60	32.00	7.00	416 weeks	13,280.00	60	32.00	7.00	416 weeks	13,280	
Kentucky	65	27.00	7.00	520 weeks	11,500.00	65	27.00	7.00	520 weeks	11,500	Disfigurement benefits allowed.
Louisiana	65	30.00	[3] 3.00	400 weeks	12,000.00	65	30.00	[3] 3.00	300 weeks	9,000	
Maine	66⅔	30.00	15.00	500 weeks	12,000.00	66⅔	30.00	15.00	500 weeks	12,000	
Maryland	66⅔	35.00	[3] 15.00	Life	15,000.00	66⅔	35.00	[3] 15.00	312 weeks	5,000	Disfigurement benefits allowed.
Massachusetts	66⅔	35.00	[8] 20.00	do		66⅔	35.00	20.00	Disability	10,000	$2.50 additional each dependent.

Michigan	66⅔	[1] 42.00	18.00	800 weeks [12]	33,600.00	66⅔	[1] 42.00	18.00	500 weeks	21,000	Reducing schedule if less than 5 dependents.
Minnesota [13]	66⅔	40.00	17.50	Life	(14)	66⅔	40.00	17.50	310 weeks	12,400	Additional $5,000 allowable in certain cases. Disfigurement benefits.
Mississippi	66⅔	25.00	[1] 10.00	450 weeks [15]	[15] 8,600.00	66⅔	25.00	[1] 10.00	450 weeks [15]	[15] 8,600	$7 in partially dependent cases. Maximum $2,000 disfigurement benefit.
Missouri [16]	[1] 66⅔	35.00	16.00	300 weeks [17]		66⅔	35.00	[3] 16.00	400 weeks	14,000	25 percent after 300 weeks
Montana	66⅔	[1] 32.50	19.50	500 weeks	16,250	66⅔	[1] 32.50	19.50	300 weeks	9,750	Reducing schedule if less than 5 children.
Nebraska	[1] 66⅔	[1] 30.00	[3] 20.00	Life [18]		[1] 66⅔	[1] 30.00	[3] 20.00	300 weeks [18]		45 percent after 300 weeks, maximum $25, minimum $17 (or actual wage if less).
Nevada	90	[19] 47.70	34.50	do		90	[19] 41.53	[19] 41.53	433⅓ weeks	18,000	Additional allowance for constant attendant if necessary, $50 a month.
New Hampshire	66⅔	33.00	20.00	341 weeks	11,250	66⅔	33.00	12.00	341 weeks	11,250	$15 for each schedule injury to 2d injury fund.
New Jersey	66⅔	[1] 30.00	10.00	450 weeks [1]		66⅔	30.00	10.00	300 weeks	9,000	After 450 weeks of reduced rate for employees undergoing vocational rehabilitation.
New Mexico	60	30.00	[3] 17.00	550 weeks	16,500	60	30.00	[3] 17.00	550 weeks	16,500	50 percent additional compensation payable by employer for failure to provide safety devices.
New York	66⅔	36.00	[3] 15.00	Life		66⅔	36.00	[3] 12.00	Disab lity	6,500	Additional compensation for vocational rehabilitation.
North Carolina	60	32.50	10.00	400 weeks [1]	[1] 10,000	60	32.50	10.00	400 weeks	10,000	Life in some cases without limit.
North Dakota	80	45.50	[3] 15.00	Life		80	[1] 45.50	[3] 15.00	Disability		$31.50 plus $2.80 for each child under 18. Maximum $45.50 per week.[20]
Ohio	66⅔	40.25	[3] 25.00	do		66⅔	40.25	14.00	312 weeks	8,000	
Oklahoma	66⅔	28.00	[3] 15.00	500 weeks	14,000	66⅔	28.00	[3] 15.00	300 weeks	8,400	
Oregon		[1] 61.15	[5] 23.08	Life		66⅔	[1] 61.15	25.38	Disability		Reducing schedule if less than 6 children.
Pennsylvania	66⅔	32.50	[21] 22.50	700 weeks	20,000	66⅔	32.50	[21] 22.50	700 weeks	20,000	
Rhode Island [22]	60	32.00	[21] 17.00	1,000 weeks	16,000	60	32.00	17.00	1,000 weeks	16,000	
South Carolina	60	35.00	5.00	500 weeks	8,000	60	35.00	5.00	500 weeks	8,000	
South Dakota	55	28.00	[3] 12.00	Life [1]	9,000	55	28.00	[3] 12.00	312 weeks	8,736	After 300 weeks, maximum $12 per week. Minimum $10.
Tennessee	65	30.00	[23] 15.00	550 weeks [1 24]	10,000	65	30.00	[23] 15.00	400 weeks	10,000	After 400 weeks $15 per week (or actual wage if less, but not less than $12).

See footnotes at end of table.

TABLE 1.—*Workmen's compensation benefits for permanent and temporary total disability, Jan. 1, 1956*—Continued

Jurisdiction	Limitations on permanent total					Limitations on temporary total					Notations
	Maximum percent of wages	Maximum weekly payment	Minimum weekly payment	Time limit	Amount limit	Maximum percent of wages	Maximum weekly payment	Minimum weekly payment	Time limit	Amount limit	
Texas	60	$25.00	$9.00	401 weeks	$10,025	60	$25.00	$9.00	401 weeks	$10,025	Special provisions for occupational disease.
Utah	[1] 60	[25] 30.00	[3] 19.50	Life [1] [26]	[17] 12,100	60	[25] 30.00	[3] 19.50	312 weeks	10,725	After 260 weeks—45 percent plus 7 percent for each child (not to exceed 35 percent).
Vermont	66⅔	[28] 28.00	[3] 16.00	330 weeks	9,240	66⅔	[27] 28.00	[3] 16.00	330 weeks	9,240	
Virginia	60	27.00	6.00	500 weeks	10,800	60	27.00	6.00	500 weeks	10,800	
Washington		[1] 46.15	23.07	Life			[1] 42.69	23.07	Disability		Additional allowance for constant attendant, if necessary, $50 per month. Reducing schedule if less than 5 children.
West Virginia	66⅔	30.00	18.00	do		66⅔	30.00	18.00	208 weeks	6,240	
Wisconsin	70	45.50	14.00	do		70	45.50	8.75	Disability		Additional compensation for vocational rehabilitation.
Wyoming		(1)	21.23	do	13.850		[29] 46.16	25.38	do		Permanent—$27.69 plus $4.85 for each child (no limit).[30]
Federal Employees' Compensation Act.	75	[1] 121.00	[3] 26.00	do		75	[1] 121.00	[3] 26.00	do		Additional allowance of $75 per month for constant attendant if necessary.
Longshoremen and Harbor Workers' Act.	66⅔	35.00	[3] 12.00	do		66⅔	35.00	[3] 12.00	do	11,000	
Alberta	75	43.26	[3] 25.00	do		75	43.26	[3] 25.00	do		
British Columbia	75	57.69	[3] 25.00	do		75	57.69	[3] 25.50	do		
Manitoba	70	40.38	[3] 15.00	do		70	40.38	[3] 15.00	do		
New Brunswick	70	38.46		do		70	38.46	[3] 15.00	do		
Newfoundland	66⅔	38.46	[3] 15.00	do		66⅔	38.46	[3] 15.00	do		
Nova Scotia	66⅔	38.46	19.62	do		66⅔	38.46	[3] 15.00	do		
Ontario	75	57.69	[3] 23.10	do		75	57.69	[3] 15.00	do		
Prince Edward Island	75	37.00	[3] 15.00	do		75	37.00	[3] 15.00	do		
Quebec	75	57.69	[3] 15.00	do		75	57.69	[3] 15.00	do		
Saskatchewan	75	57.69	[3] 25.00	do		75	57.69	[3] 25.00	do		
Canadian Merchant Seamen Compensation Act.	66⅔	32.00	12.50	do		66⅔	32.00	12.50	do		

[1] See notations column.
[2] Percentage increased 5 percent each, for dependent wife and children. Maximum 65 percent, wife and children.
[3] Actual wage if less.
[4] For specified injuries—others limited to 400 weeks.
[5] As Industrial Board may provide.
[6] Actual wage if less, but not under $10 for workweek of 15 hours or over.
[7] Not specified.
[8] No actual limit in computing average monthly wage. All wages in excess of $1,000 per month excluded.
[9] Disfigurement maximum $1,000.
[10] Single $12,000, married $14,400, $1,800 for each child under 18.
[11] Only 400 weeks at maximum disability, reduced thereafter.
[12] Further payments from 2d injury fund.
[13] Additional compensation (not to exceed $2,500) for successive injuries.
[14] Old-age and survivors' insurance benefits credited on compensation after $18,000 has been paid.
[15] Whichever is less.
[16] Not to exceed $1,000 additional for disfigurement.
[17] 25 percent thereafter but not less than $16 or more than $18.
[18] Reduced amounts after 300 weeks.
[19] Or percentage of wage, whichever is less.
[20] Actual wage if less, but in no case less than $12.50.
[21] May exceed actual wage if minimum wage applied.
[22] Disability extending beyond maximum period compensated. Employers and insurers reimbursed from 2d injury fund.
[23] Actual wage if less but in no case less than $12.
[24] Only 400 weeks at maximum disability; reduced thereafter.
[25] 7 percent additional for each dependent child under 18 years, not to exceed 5.
[26] 260 weeks; thereafter reduced.
[27] Payments from rehabilitation fund provided employee has cooperated and has exhausted benefit limits. These payments continue for the life of the employee if rehabilitation not successful.
[28] Additional amount of $2 per week for each dependent child under 21.
[29] Schedule of benefits by number of dependents.
[30] Court will supervise disbursement of fund for children.

Source: U. S. Chamber of Commerce.

TABLE 2.—*Maximum benefits for permanent partial disability as of January 1956*

State	Maximum percentage of wages or wage loss [1]	Maximum period		Maximum payments per week	Total maximum stated in law
		Schedule injuries	Nonschedule injuries		
Alabama	[2] 55–65	400 weeks	300 weeks	$28.00	$11,200
Alaska					[3] 14,400
Arizona	55	260 weeks [4]	During disability [4]	$126.92	
Arkansas	65	200 weeks [4]	450 weeks [4]	$25.00	8,000
California	61¾	399 weeks [5]	399 weeks [4 5]	$35.00	
Colorado	66⅔	208 weeks [4]	During disability [4]	$31.50	[15] 8.190
Connecticut	60	275 weeks [4]	780 weeks [4]	$40.00	
Delaware	66⅔	250 weeks [4]	300 weeks [4]	$35.00	
District of Columbia	66⅔	288 weeks [4]	During disability [4]	$35.00 [6]	[7] 11,000
Florida	60	200 weeks [4]	350 weeks [4]	$35.00	
Georgia	60	225 weeks [4]	350 weeks	$20.00 $30.00 [8]	[9] 6,000
Hawaii	66⅔	280 weeks [4]	During disability [4]	$50.00 [6]	20,000
Idaho	60	240 weeks [4]	([4 10])	$25.00	
Illinois	[2] 75–97½	235 weeks [4]	417 weeks [4]	$34.00–$40.00	9,250–12,000
Indiana	60	250 weeks [4]	500 weeks [4]	$33.00	12,500
Iowa	66⅔	230 weeks	([10])	$32.00	
Kansas	60	210 weeks [4]	415 weeks [4]	$32.00	
Kentucky	65	200 weeks [4]	450 weeks [4]	$24.00	9,500
Louisiana	65	400 weeks	300 weeks	$30,00	
Maine	66⅔	150 weeks [4]	300 weeks	$30,00	
Maryland	66⅔	252 weeks [4]	During disability [4]	$25.00	[7] 12,500
Massachusetts	66⅔	500 weeks [4]	During disability	$30.00 plus $2.50 for each dependent.[10]	[11] 10,000
Michigan	66⅔	269 weeks	500 weeks	$32.00–42.00	
Minnesota	66⅔	[12]460 weeks [4 6]	310 weeks [4 6]	$40.00	
Mississippi	66⅔	200 weeks [4]	450 weeks [4]	$25.00	8,600
Missouri	66⅔	232 weeks	400 weeks	$35.00	
Montana	66⅔	250 weeks	500 weeks	26.50–32.50 [2]	
Nebraska	66⅔	225 weeks [4]	300 weeks	$30.00	
Nevada	50	260 weeks [4]	429 weeks [4]	$20.77	
New Hampshire	66⅔	214 weeks [4]	341 weeks	$33.00	
New Jersey	66⅔	300 weeks [4]	550 weeks [4]	$30.00	
New Mexico	60	180 weeks [4]	([4]) ([10])	$30.00	
New York	66⅔	312 weeks [4]	During disability [4]	$36.00 [6]	
North Carolina	60	220 weeks [4]	300 weeks	$32.50	10,000
North Dakota	66⅔	250 weeks	450 weeks	$31.50	
Ohio	66⅔	225 weeks [4 6]	250 weeks [4 6]	$40.25	10,000
Oklahoma	66⅔	250 weeks	500 weeks	$28.00	
Oregon		([12])	([12])	$25.38–45.00 [2]	
Pennsylvania	66⅔	215 weeks	350 weeks	$23.00–32.50 [8]	
Puerto Rico	50	300 weeks [4]	([4]) ([10])	$20.00	3,000
Rhode Island	[8] 50–60	300 weeks [4]	800 weeks [4]	$22.00–24.00 [8]	
South Carolina	60	200 weeks	300 weeks	$35.00	8,000
South Dakota	[8] 50–55	200 weeks [4]	312 weeks [4]	$28.00	
Tennessee	65	400 weeks [4]	400 weeks [4]	$30.00	10,000
Texas	60	200 weeks	300 weeks	$25.00	
Utah	60	[12]00 weeks [4]	312 weeks	$30.00–40.50 [2]	6,875
Vermont	50–66⅔	330 weeks [4]	330 weeks [6]	$16.00–28.00 [8]	
Virginia	60	200 weeks	300 weeks	$27.00	10,800
Washington		([4]) ([13])	([4]) ([9])		[13 4] 6,000
West Virginia	66⅔	240 weeks	340 weeks	$30.00	
Wisconsin	70	500 weeks [4]	1,000 weeks [4]	$37.00 [6]	
Wyoming		([14]) ([4])	([14]) ([4])	$17.77–22.85 [2]	
United States					
Federal employees	[2] 66⅔–75	312 weeks [4 15]	During disability [4]	$121.15 [6]	
Longshoremen	66⅔	288 weeks [4]	----do.[4]	$35.00 [6]	[7] 11,000

[1] Generally for schedule injuries percentage is figured on average weekly wages, and for nonschedule injuries on the basis of difference between wages before injury and wages after injury.

[2] According to number of dependents; Oregon according to marital status and number of dependents, in Wyoming according to marital status.

[3] Benefits for schedule injuries are fixed sums ranging from $300 to $7,200 and varying according to marital status and number of dependents: for nonschedule injuries benefits are in proportion to permanent total injuries, but may not exceed a total of $14,400.

[4] In addition to compensation for temporary total disability which is limited in some States to a specified number of weeks. In Indiana, in case of "loss of use" of certain members, payments under the schedule are in lieu of all other compensation. In Wisconsin, the 500 weeks for schedule injuries increased in case of a combination of injuries.

[5] Four weeks of compensation for each 1 percent of permanent disability, and thereafter if disability is 70 percent or more, life pension of 1 percent of average weekly earnings for each 1 percent of disability in excess of 60 percent.

[6] Additional benefits in specific cases, such as vocational rehabilitation, constant attendant, etc.

[7] For schedule injuries; in Alabama, $8,400 for nonschedule injuries; in the District of Columbia and for longshoremen, $10,000 for nonschedule injuries; in Maryland, $7,500 for nonschedule injuries.

[8] According to type of injury; in Georgia $20 for nonschedule, $30 for schedule; in Pennsylvania $23 for nonschedule, $32.50 for schedule; in Rhode Island 50 percent and $22 for schedule injuries, and 60 percent and $24 for nonschedule injuries; in South Dakota 50 percent for nonschedule injuries and 55 percent for schedule injuries; in Vermont 50 percent and $16 for nonschedule, 66⅔ percent and $28 for schedule.

[9] For nonschedule injuries.

[10] In proportion to schedule injuries.

[11] Maximum limited to weekly wage. In case of loss of members, hearing, eyes, or bodily disfigurement, payments in addition to all other compensation are authorized of $20 weekly for specified periods ranging from 100 to 500 weeks.

[12] No maximum period specified. Law provides for payment of $45 for each degree of disability, which ranges for schedule injuries from 2 to 192 degrees, and for nonschedule injuries from 2 to 132 degrees, with special provision for loss of vision. Payable monthly. Minimum monthly payment $100. Payments are in addition to compensation for temporary total disability.

[13] Benefits are fixed sums ranging from $60 to $6,000.

[14] Benefits for schedule injuries are fixed sums ranging from $200 to $4,000; for nonschedule injuries an amount proportional to the extent of disability, based as nearly as possible on schedule injuries, up to a maximum of $7,425.

[15] Thereafter in cases involving loss or loss of use of an arm, hand, leg, foot, or eye or loss of hearing in both ears, 66⅔ percent or 75 percent (if 1 or more dependents) of difference between monthly pay and monthly wage-earning capacity.

Source: U. S. Department of Labor, Bureau of Labor Standards, Washington, D. C.

1. *Permanent-total benefits — workmen's compensation.* — The amount of weekly benefit payments in all but four jurisdictions—Alaska, Oregon, Washington, and Wyoming—is based in theory on a percentage of the worker's preinjury wages, most frequently two-thirds, but varying from a high of 97½ in Illinois (when 4 or more dependent children are involved) to a low of one-half in Georgia, Vermont, and Puerto Rico. As of 1955, maximum weekly limits of $30 or more, if dependent allowances are included, are provided in 45 jurisdictions. Arizona had the highest limit, $150; Arkansas, Mississippi, and Texas the lowest—$25.

Only 29 jurisdictions pay benefits for life or the period of disability. Six of these 29 jurisdictions reduce benefits after a specified number of weeks, usually 300–400. All others set time or total amount limits. The variation is great, ranging in time from 300 to 700 weeks, and in money from $3,500 in Puerto Rico and $8,000 in Arkansas and South Carolina to $20,000 in Hawaii.

Thirteen jurisdictions vary the amount of benefit according to number of dependents, and five also take into account the marital status of the beneficiary. The Federal Employees' Compensation Act (FECA) and the laws of Arizona, Hawaii, Nevada, and Washington provide additional payments for an attendant if required.

2. *Permanent-partial benefits—workmen's compensation.*—The benefit formula for permanent-partial cases is basically similar to that for total disability, except that duration and aggregate amount limits are usually stricter and, in a few States (as can be seen in table 2), the weekly maximum is also lower. In all jurisdictions but California there is a further classification of permanent partials into "schedule" and "nonschedule" disabilities. The California law calls for a single comprehensive schedule of ratings and benefits for all permanent disabilities. In the other States, separate schedules have been set up for a limited number of specified permanent-partial injuries, typically involving the loss, or loss of use of, a limb or member of the body. Benefits for the schedule injuries are set forth in the statute, usually in terms of the number of weeks for which benefits are payable. The total amount payable to an injured worker is calculated by multiplying

the maximum number of weeks allowed for his type of injury by the maximum weekly benefit amount indicated in table 2.

The other, nonscheduled, permanent-partial cases, those of a more general nature such as back and head injuries, are usually compensated on the basis of the difference in earning capacity before and after injury. The conflicting philosophies between the two approaches to permanent-partial disability compensation, some of the practical problems involved, and recent developments are discussed in chapter VII.

In all but nine States as of January 1, 1956, compensation for permanent-partial disability in scheduled cases is in addition to all or part of the period of temporary-total disability, the "healing period." In these, the amount of the temporary-total benefit payment is subtracted from the amount due for scheduled injury. (See table 3.)

In 31 laws, specified amounts are also allowed for disfigurement. In some jurisdictions these are in addition to schedule benefits.

TABLE 3.—*Workmen's compensation—Maximum amounts which could be paid in dollars for scheduled injuries, Jan. 1, 1956*

IN THIS GROUP OF STATES COMPENSATION FOR TEMPORARY DISABILITY IS ALLOWED IN ADDITION TO ALLOWANCE FOR PERMANENT PARTIAL DISABILITY

Jurisdiction	Arm at shoulder	Hand	Thumb	First finger	Second finger	Third finger	Fourth finger	Leg at hip	Foot	Great toe	Other toes	1 eye	Hearing, 1 ear	Hearing, both ears
Alaska	$7,200	$5,800	$1,800	$1,200	$500	$500	$500	$7,200	$5,400	$900	$300	$5,600	$1,500	----
Arizona [1] [2]	3,300	3,750	825	495	385	275	220	2,750	2,200	385	138	1,650	1,100	$3,300
Arkansas [3]	5,000	3,750	1,500	875	750	500	375	4,375	3,125	750	250	2,500	1,000	3,750
Colorado	6,352	3,276	1,575	819	567	346	409	6,552	3,276	819	346	4,378	1,102	4,378
Connecticut	11,000	8,320	3,000	1,920	1,520	1,000	800	8,320	6,240	1,520	520	8,320	2,080	6,240
Delaware	7,700	7,000	2,100	1,225	1,050	700	525	7,700	5,250	1,050	350	4,375	1,820	3,640
District of Columbia	9,800	7,420	1,785	980	610	515	245	8,680	6,055	910	280	4,900	1,820	7,000
Federal Employees' Compensation Act	37,850	29,500	9,080	5,580	3,630	3,030	1,815	34,800	24,800	4,600	1,935	19,350	6,300	24,200
Hawaii	14,000	10,600	2,550	1,400	900	850	350	12,400	8,650	1,300	400	8,000	2,600	10,000
Idaho	6,000	5,000	1,750	1,000	1,000	750	500	4,500	3,125	750	300	3,500	875	3,750
Indiana [4]	8,250	6,600	1,980	1,320	1,155	990	660	6,600	4,950	1,980	[5]	4,950	2,475	6,600
Longshoremen and Harbor Workers Act	9,800	7,420	1,785	970	630	595	245	8,680	6,055	910	280	4,900	1,820	7,000
Maine	4,500	3,750	1,500	900	750	540	450	4,500	3,750	750	300	3,000	1,500	3,000
Maryland	6,300	4,900	1,250	750	625	500	375	6,300	4,375	625	250	5,000	1,875	4,375
Massachusetts [6]	----	----	----	----	----	----	----	----	----	----	----	----	----	----
Michigan	11,298	9,030	2,730	1,596	1,386	924	672	9,030	6,804	1,386	462	6,804	----	----
Mississippi	5,000	3,750	1,500	875	750	500	375	4,325	3,125	750	250	2,500	1,000	3,750
Missouri [1]	8,120	6,125	2,100	1,575	1,225	1,225	770	7,235	5,250	1,400	490	4,130	1,540	5,880
Nevada [1]	5,400	4,500	1,350	810	630	450	360	4,500	3,600	630	225	2,700	1,800	5,400
New Jersey	9,000	6,900	2,250	1,500	1,200	900	600	8,250	6,000	1,200	450	4,500	1,800	6,000
New Mexico [1] [3]	5,400	3,300	1,500	750	600	450	360	5,400	3,000	900	360	3,750	1,050	4,050
North Carolina [7]	7,150	5,525	2,112	1,300	1,137	715	520	6,500	4,600	1,137	325	3,900	2,275	4,875
North Dakota [8]	7,875	6,300	2,047	1,260	945	630	504	7,471	4,725	945	378	4,725	1,575	6,300
Ohio	9,056	7,044	2,415	1,409	1,207	805	604	8,050	6,037	1,207	402	5,031	1,006	5,031
Oregon [5]	8,640	6,750	1,620	1,080	720	450	270	6,750	4,680	810	180	4,500	2,700	8,640
Rhode Island	7,200	4,776	1,440	864	624	480	432	7,200	3,600	720	240	2,880	1,440	3,600
South Dakota	5,600	4,200	1,400	980	840	560	420	4,480	3,500	840	280	4,200	----	----
Tennessee	6,000	4,500	1,800	1,050	900	600	450	5,250	3,750	900	300	3,000	----	4,500
Utah [10]	8,100	6,075	2,430	1,215	1,215	810	486	7,290	5,062	1,215	486	4,860	[9]	[9]
Washington [1]	5,400	3,480	1,320	710	540	490	190	6,000	3,250	870	300	2,590	1,140	4,100
Wisconsin [11] [3]	18,500	14,800	4,625	2,220	1,665	962	1,036	18,500	9,250	3,083	Scheduled	10,175	1,850	[12] 12,333
Wyoming	4,000	2,750	550	400	300	300	300	4,000	2,400	500	200	3,400	----	----

See footnotes at end of table.

TABLE 3.—*Workmen's compensation—Maximum amounts which could be paid in dollars for scheduled injuries, Jan. 1, 1956*—Continued

IN THIS GROUP OF STATES COMPENSATION FOR TEMPORARY DISABILITY IS ALLOWED IN ADDITION TO PERMANENT PARTIAL DISABILITY WITH CERTAIN LIMITATIONS AS TO PERIOD [13]

Jurisdiction	Arm at shoulder	Hand	Thumb	First finger	Second finger	Third finger	Fourth finger	Leg at hip	Foot	Great toe	Other toes	1 eye	Hearing, 1 ear	Hearing, both ears
California [14]														
Florida	$7,000	$6,125	$2,100	$1,225	$700	$700	$525	$7,000	$6,125	$1,050	$350	$6,125	$1,400	$5,250
Georgia [15]	6,000	4,500	1,800	1,200	1,050	900	750	6,750	3,750	900	600	3,750		4,500
Illinois [10]	12,000	7,600	2,800	1,600	1,400	1,000	800	11,000	6,200	1,400	480	6,000	2,000	5,000
Kansas [16]	6,720	4,800	1,920	1,184	960	640	480	6,400	4,000	960	320	3,520	790	3,200
Kentucky	4,800	3,600	1,440	1,080	720	480	360	4,800	3,000	720	240	2,880	1,800	
Minnesota [17]	9,200	8,800	2,600	1,600	1,400	1,000	800	8,800	6,600	1,400	400	4,400	2,200	6,800
Montana [10]	8,125	6,078	2,438	1,203	1,203	813	488	8,125	5,070	1,203	488	4,940	813	4,875
Nebraska	6,750	5,250	1,800	1,050	900	600	450	6,450	4,500	900	300	3,750	1,500	3,000
New Hampshire [3]	5,100	4,200	1,200	750	600	450	300	5,100	3,600	600	240	3,000	1,260	5,100
New York	11,232	8,784	2,700	1,656	1,080	900	540	10,368	7,380	1,368	576	5,760	2,160	5,400
Vermont [3]	4,760	3,920	1,120	700	560	420	280	4,760	3,360	560	224	2,800	1,190	4,760

IN THIS GROUP OF STATES COMPENSATION FOR TEMPORARY DISABILITY IS DEDUCTED FROM THE ALLOWANCE FOR PERMANENT PARTIAL DISABILITY

Alabama	5,600	4,200	1,680	1,260	840	560	420	4,900	3,500	840	280	2,800	1,400	4,200
Iowa [3]	7,360	5,600	1,920	1,120	960	800	640	6,400	4,800	1,280	480	4,000	1,600	5,600
Louisiana	6,000	4,500	1,500	900	600	600	600	5,250	3,750	600	300	3,000	[18]	[18]
Oklahoma	7,000	5,600	1,680	980	840	560	420	4,900	4,200	840	280	2,800	[19]	[19]
Pennsylvania	6,988	5,688	1,950	1,148	975	650	488	6,988	4,875	1,300	520	4,063		4,875
South Carolina	7,000	5,250	2,100	1,225	1,050	700	525	6,125	4,375	1,050	350	3,500	2,450	5,250
Texas	5,000	3,750	1,500	1,125	750	525	375	5,000	3,125	750	300	2,500		3,000
Virginia	5,400	4,050	1,620	945	810	540	405	4,725	3,375	810	270	2,700	1,350	
West Virginia	7,200	6,000	2,400	1,200	840	600	600	7,200	4,200	1,200	480	3,960		

NOTE.—The Canadian laws contain no provisions for scheduled injuries and the board decides each case on its merits.

[1] Computations for major members and in Washington 25 percent less for disability not involving amputations.
[2] Calculated as $100 a month basis.
[3] Additional weeks for healing periods.
[4] 26 weeks total disability without deduction.
[5] Scheduled by degrees.
[6] Specified schedule in addition to all other compensations. Proportional benefits for functional loss of use of leg, foot, arm, or hand.
[7] Total loss of use of back, $9,750.
[8] 25 percent additional for loss of master hand or member thereof.
[9] Commission may provide benefits up to maximum of $6,875 for loss of bodily function not otherwise specified.
[10] Figures are maximum with children, or dependents.
[11] Computations based on employees 50 years of age or less.
[12] Special provision for occupational deafness.
[13] Hawaii limits aggregate amount.
[14] Aggregate amounts for schedule not determined.
[15] Not to exceed 10 weeks total disability may be paid in addition.
[16] Additional healing period up to 15 weeks may be allowed.
[17] 301 weeks for back injury.
[18] Commission may provide benefits up to maximum of 100 weeks ($3,000).
[19] To be fixed by commission but not to exceed $3,000.

Source: United States Chamber of Commerce.

3. *The Veterans' Administration benefit structure.*—The veterans' program provides two types of cash benefits. The first and most generally used are the percentage awards, provided in 10 rates based on the rated degree of disability, ranging from 10 percent to total or 100 percent.

The monthly benefit rates paid for the various degrees of partial disability for wartime service-connected disabilities are as follows:

10 percent disability	$17	60 percent disability	$109
20 percent disability	33	70 percent disability	127
30 percent disability	50	80 percent disability	145
40 percent disability	66	90 percent disability	163
50 percent disability	91	100 percent disability	181

These awards are payable for as long as the specified degree of disability exists. In practice, a large proportion are for life. The monetary rates for peacetime service-connected disabilities are 80 percent of wartime rates.

The second type of cash compensation benefit is the "statutory award." These special payments are provided by legislation for specific disabilities. Here also, peacetime rates are 80 percent of the wartime rates. These statutory awards are of two kinds: first, permanent rates of $47 per month which are payable *in addition to* the percentage awards for loss, or loss of use, of a foot, hand creative organ or blindness in one eye. The second group of statutory awards, listed below, includes permanent monthly rates paid for specified disabilities *in lieu of* the percentage awards. As can be seen, these usually exceed the percentage rates:

1. (*a*) Loss or loss of use of both hands, both feet, 1 hand and 1 foot; (*b*) blind in both eyes; (*c*) permanently bedridden; or (*d*) helpless and in need of aid, $279.

2. Loss or loss of use of two extremities at a level, or with complications preventing natural elbow or knee action with prosthesis in place; or blind in both eyes and requiring aid and attendance, $329.

3. Loss of two extremities so near shoulder or hip as to prevent use of prosthetic appliance; or anatomical loss of both eyes, $371.

4. A group of World War I veterans are "protected" by law for disabling conditions similar to the above, $231–$300.

5. When disability exceeds requirements for any of the above rates, the Administrator of Veterans' Affairs may allow next higher rate or intermediate rate, not to exceed $420.

6. If a veteran has two or more losses listed in item 1, above, or has total deafness in combination with total blindness, $420.

7. Tuberculosis, all forms, completely arrested is compensated for at a minimum monthly rate for life, of $67. The law also provides graduated, reduced percentage ratings over an 11-year period of 100 percent for the first 2 years; 50 percent for the next 4 years; 30 percent for the next 5 years; then a 30 percent permanent rating for arrested far advanced lesions; a 20 percent permanent rating for arrested, moderately advanced lesions; and a zero percent for all other forms. However, the monetary payment does not go below the minimum of $67.

(*a*) A group of World War I veterans are "protected" by law and receive a 100 percent rating for 6 months after discharge from hos-

pitalization and then a minimum of $67 monthly for life. This group is awarded a minimum permanent 25 percent rating for arrested or apparently cured tuberculosis with no observation or reexamination required.

(*b*) The permanent $67 rate for completely arrested tuberculosis is not payable in combination with the $47 additional award for single losses mentioned above, except for World War I veterans receiving statutory awards under section 202 (3), World War Veterans Act of 1924, as amended.

Veterans who are in receipt of compensation for disabilities of 50 percent or more are entitled to extra amounts for their wives, minor children, and dependent parents. This additional compensation for totally disabled (100 percent) veterans varies from $21 (peacetime—$16.80) for a wife but no child, to $56 (peacetime—$44.80) for wife and 3 children or more. If the veteran is partially disabled, but not less than 50 percent, the additional compensation for dependents is a corresponding proportion of the above rates.

4. *Number and classification of beneficiaries.*—The total number of beneficiaries under the Veterans' Administration service-connected disability program as of June 30, 1955, was 2,076,000. Of these, approximately 94 percent were receiving percentage (loss of earning capacity) benefits and only 6 percent statutory awards. Table 1 in chapter I indicates the relative number of cases and cost of both types of benefits, by degree of disability.

No one knows how many workmen's compensation beneficiaries there are. The most authoritative estimates, by the Department of Health, Education, and Welfare, placed the number of injured workers and survivor families receiving benefits in an average week in 1952 within the range of 340,000 to 470,000, probably slightly under 400,000. Since the majority of these are only temporarily disabled, the number of different recipients during the course of a year is very much greater.

Table 4 indicates the number of beneficiaries receiving various types of cash benefits as indicated by cases closed in 1951 in five important industrial States, as well as the average payment per case and the percentage of total benefit payments going to the different types of cases.

Table 5 shows the amounts that could be paid by the Veterans' Administration for various types of injuries, as of January 1956. In comparing tables 3 and 5 it should be borne in mind that ordinarily payments by the Veterans' Administration do not start until after the disability has been determined as residual in nature.

TABLE 4.—*Compensated cases closed [1] 1951—Cash benefits and beneficiaries by categories in five States*

State	Number of cases					Cash indemnity payments					Average payment per case				
	Total	Percent				Total (in thousands)	Percent				All cases	Death	Permanent-total	Permanent-partial	Temporary
		Death	Permanent-total	Permanent-partial	Temporary		Death	Permanent-total	Permanent-partial	Temporary					
Illinois [2]	46,250	0.8	0.1	[2] 40	52	$18,042	7	1	[2] 78	11	$390	$4,208	$7,426	$756	$85
New Jersey	47,145	.5	.1	66	33	23,138	7	2	85	6	490	8,335	8,491	630	87
New York	117,147	.7	.3	37	62	84,064	12	8	57	24	718	13,302	19,735	1,089	274
Pennsylvania	56,486	1.5	.3	8	[3] 91	18,945	23	7	19	[3] 52	335	5,135	7,392	844	[3] 191
Wisconsin	26,538	.6	.3	10	89	7,676	15	2	56	27	289	7,772	15,936	1,589	89

[1] Exclusive of reopened cases.

[2] Illinois lists "disfigurement" cases in a separate category, while most States include them with permanent-partials. Here they are included in all the total columns but omitted from the breakdowns which therefore do not add up to the totals. They accounted for almost 7 percent of the cases closed in Illinois in 1951.

[3] Includes special category of temporary partial as well as usual temporary total.

NOTE.—These data are presented as indicators of indemnity levels in a few of the more important States which maintain better than average records. The 5 States include approximately 35 percent of covered workers in the United States. The data are not designed for comparative purposes. Lack of uniform statistical definitions and procedures not only preclude accurate comparisons among States but even make it difficult to interpret precisely the relationship if injury classes within States. For example, "cases closed" in some States means that full payment has already been made. Thus some of the payments shown in 1951 may go back a considerable period of time and represent indemnity paid under benefit provisions existing at the time of the injury, but now obsolete. In other States, cases are closed at the date of approval of agreement or award. Thus the indemnity shown is an amount computed for future benefits to be paid over a period of time. These are, of course, only actuarial estimates. Some States, like Pennsylvania, use both methods simultaneously: Fatal and permanent disability cases are computed as of the date of approval of award, while temporary disability cases are considered closed only after compensation payments have been made in full.

Source: H. M. Somers and A. R. Somers, Workmen's Compensation: Prevention, Insurance and Rehabilitation of Occupational Disability, Wiley, 1954, p. 79.

TABLE 5.—*Monthly rates paid by Veterans' Administration for specified disabilities, with estimated total lifetime and equivalent lump-sum [1] payments for veterans without dependents; wartime rates; as of January 1956*

Type of loss	Monthly rate	Total lifetime payments	Equivalent lump-sum value [1]
Arm at shoulder	$210	$114,106	$60,480
Hand	174	94,545	50,112
Thumb	66	35,862	19,008
First finger	50	27,168	14,400
Second finger	33	17,931	9,504
Third finger	33	17,931	9,504
Fourth finger	33	17,931	9,504
Leg and hip	210	114,106	60,480
Foot	113	61,400	32,544
Great toe	50	27,168	14,400
Other toes	33	17,931	9,504
One eye	113	61,400	32,544
Hearing, one ear	17	9,237	4,896
Hearing, both ears	181	98,348	52,128

[1] That is, commuted, discounted, or present value.

NOTE.—The total lifetime and equivalent lump-sum payments are calculated on the assumption that the veteran is 24 at the time when payments begin. If the veteran were age 40 the lifetime payments would be reduced by about one-third and the equivalent lump sum by about one-fourth. Commuted or discounted values are at 3 percent interest.

Source: President's Commission on Veterans' Pensions.

Major developments with respect to benefit structures and payments in both programs are discussed below.

Financing

This is the area where there is the least comparability between the two programs. The veterans' system is financed entirely by appropriations from general revenues and there is no effort to maintain actuarial relationships between benefits and costs.

Total expenditures for service-connected disability awards have increased from approximately $175,000 in 1918 [5] to $160 million in 1930 and $1,427 million in 1955. Compensation paid to survivors of veterans deceased from service-connected causes accounted for an additional $34 million in 1930 and $401 million in 1955.

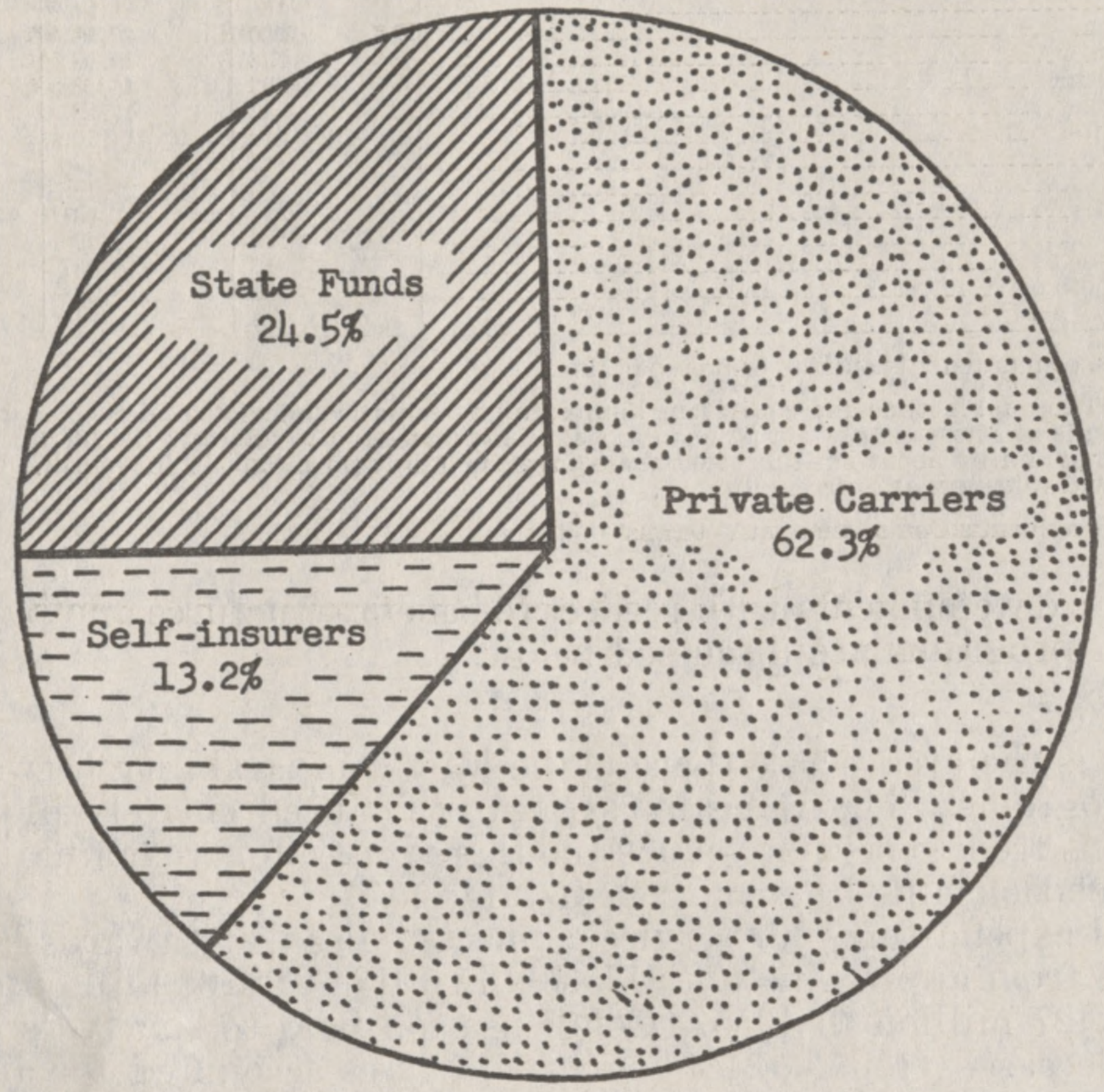
By contrast, workmen's compensation benefits are generally financed on an insurance basis and are paid for by the covered employers who may insure with a private carrier, the most common method, or with a State fund in the 19 jurisdictions which provide such a system, or, if they can meet certain financial qualifications, may carry their own risk, i. e. "self-insurance." For distribution of workmen's compensation benefit payments by type of carrier, see chart II.

The cost of compensation insurance has also increased greatly since 1910 when the first policy was written. In 1923 total premiums were probably about $120 million. By 1953, it is estimated that the total compensation insurance costs for the country, including the cost of self-insurers and Congressional appropriations for the Federal program amounted to about $1.5 billion. However, the figure more comparable to the Veterans' Administration figures above would be the amount actually expended for benefits. In 1953 this was approximately $846 million.

[5] Dillingham, *op. cit.*, p. 101.

CHART II

DISTRIBUTION OF WORKMEN'S COMPENSATION BENEFIT PAYMENTS BY TYPE OF INSURER, 1952



Source: Department of Health, Education and Welfare

It should be noted, of course, that in contrast to the veterans' program, workmen's compensation benefits cover disability, survivors', medical and some rehabilitation benefits all in the same program. Roughly one-third of the payments are in the form of medical care provision. The Veterans' Administration provides hospital, prosthetic and out-patient care through a medical department separate from the compensation program. Vocational rehabilitation for wartime veterans is provided through still another program.

Compensation insurance premiums are based on covered payroll. The national average net cost of compensation insurance to employers, 1 percent of payroll, means 1.5 cents per hour for every employee earning $1.50 an hour. This may rise to 50 cents an hour or above in extra-hazardous industries. Whether costs are "high" or "low" is relative to the advantages derived from their expenditure. It is impossible to obtain precise figures on the ratio of benefits paid out to insurance costs. A careful study of insurance statistics, however, indicates that since the later 1930's benefits have averaged only about 55 percent of the

amount which employers pay in premiums. By contrast, the ratio of total compensation benefits to total expenditures including administration under the veterans' system is around 98 or 99 percent.

Administration

There are many peculiarities of workmen's compensation administration which distinguish it from other social insurance programs. Partly, these are due to the predominant role of private insurance, partly to the persistent remnants of old common law and employer's liability concepts and practices under which all cases were settled through law suits. These facts have produced two unique administrative situations: (1) the large degree of actual administrative responsibility which has been delegated, or simply left by default, to the private carriers or self-insured employers; and (2) the persistent and increasing role of adversary proceedings as a method of settling disputed cases, including even the determination of technical questions such as individual disability ratings.

It is both impossible and unnecessary for the main purposes of this report to summarize fully the administrative procedures of the 54 jurisdictions. In general, the statutes are, at least nominally, administered by special agencies set up for this purpose,[6] typically a 3- to 5-man commission or board. Theoretically the commission is responsible for supervising all claims, but in practice it rarely intervenes except when cases are contested. In a handful of States, including New York, Wisconsin, and Michigan, and in the Federal Employees' Compensation Act, and where it operates an exclusive State fund as in Oregon, the commission has much greater authority to act on its own motion.

All commissions have authority to hear and settle contested cases. As a rule, two or more levels of review are provided within the commission itself. All laws also permit court review of commission decisions. In the majority of States, courts may review only questions of law; the facts as found by the administrative authorities are considered binding. In 22 jurisdictions, however, the courts also pass on questions of fact. There are all degrees of fact review among this group. In most, the review is on the record made by the Commission, but a few permit reopening the entire case from scratch. Trial by jury is now permitted in 6 States.

The proportion of cases appealed to courts appears to be on the increase. Some States are notoriously remiss in the extent to which cases are permitted to reach the courts. This results in long and harmful delays in payment and has proved a stimulant to "sharp" practices.

The administration of the veterans' program is, in general, simpler than that of workmen's compensation. One responsible agency, the Veterans' Administration, handles the program for the entire country. In each of about 66 regional offices and many other suboffices there are "Contact Officers" whose task is to explain the services available to veterans and assist them in making formal application for benefits. Space is also provided in VA buildings for the service officers of ac-

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[6] In 5 States no administrative agency was ever created. Responsibility for enforcing the law was left to the courts. In these jurisdictions, there is no supervision of claims settlements. The injured worker and his employer, or the latter's carrier, are expected to agree on the applicable benefits. In the event of controversy, the dissatisfied party may sue.

credited veterans' organizations. These officers represent veterans in processing their claims. Applications are filed in the regional offices, each with its own rating boards which establish the degree of disability if the claim is allowed. Decisions are by a majority vote of the 3-member boards.

Disallowed claims may be reconsidered by the local rating board with recourse to the Board of Veterans' Appeals at the central office in Washington. There is no further appeal to the courts.

Aside from the differences already pointed out, the overriding distinguishing characteristic of the veterans' program is its consistent liberality toward claimants arising out of the repeated statutory injunction that the law is to be applied by the resolution of all reasonable doubt in favor of the veteran. In certain cases the burden of proof is on the Government in disallowing a claim rather than on the veteran in establishing it. For example:

> A pre-existing injury or disease will be considered to have been aggravated by active military service * * * where there is an increase in disability during active service unless there is a specific finding that the increase in disability is due to the natural progress of the disease (Veterans' Regulation No. 16 pt. I, I (d)).

With regard to the presumption of tuberculosis or multiple sclerosis, service connection shall hold "in the absence of affirmative evidence to the contrary." (Veterans' Regulation No 1 (a), part I, I (c)).

In connection with the procedure for review of presumptive claims for World War I veterans (Veterans' Regulation No. 2 (a), part III), the following instructions to the review boards were written into the law:

> * * * determine on all available evidence the question of whether service connection shall be granted * * * (notwithstanding the evidence may not clearly demonstrate the existence of the disease or any specific clinical findings within the terms of or period prescribed by Veterans' Regulation No. 1 (a), part I, par. I (c), issued under Public, No. 2, 73d Cong.), and shall in their decisions resolve all reasonable doubts in favor of the veteran, the burden of proof in such cases being on the Government * * * in any case, where in the view of the peculiar circumstances and in the exercise of sound judgment it is determined that the veteran is entitled to service connection an affirmative determination may be made even though literal adherence to such principles (Vet. Reg. 1 (a), pt. I) would prevent the granting of service connection.

In this type of legal and political climate where the claimant is presumed to be right and the burden of denying a claim is entirely on the administering agency, one can hardly cast blame upon the Veterans' Administration for alleged overliberalization. Special administrative problems in connection with the maintenance and application of the rating schedule are discussed in chapter VII.

1. *The issue of commutation.*—Compensation benefits were designed to be paid in regular weekly or biweekly installments as a substitute for wage income. Most States, however, permit workers under certain circumstances to accept a single lump-sum payment or commutation, in lieu of periodic payments.

The major traditional argument advanced for commutation relates to the vocational rehabilitation of the injured. In certain cases of permanent disability, for example, a man who has been blinded or has lost a leg, wise investment of his total potential benefits may permit him to establish a small business and perhaps become self-supporting.

The logic of the argument is attractive, but the facts run counter to it. The vast majority of disabled persons cannot or do not employ their money in this way. Most injured workers are not prepared to undertake management of a capital investment, upon which the entire future security of their families depend. Furthermore, the evidence is overwhelming that the whole process of lump-sum settlements actually interferes with physical and vocational rehabilitation.

A lump-sum settlement, in the large majority of the States, means a final closing of the case, a release from further liability, contrary to the concept of "continuing jurisdiction" discussed later. The compensation agency consequently loses all control of a case, both in terms of correcting injustices to either party due to errors in the appraisal of the disability and in terms of supervising appropriate medical care arrangements and encouraging rehabilitation.

Lump-sum payments are also associated with the worst abuses found in workmen's compensation. As presently practiced, commutation usually involves a "compromise settlement," i. e., settlement for less than the total a claimant would receive through periodic payments if his claims were validated, and thus opens up a profitable avenue of "claims paring" by carriers and employers. "Ambulance chasing" by lawyers, malpractices, and malingering by workers are induced by the attraction of a single large sum of money. This is particularly true in the case of nonschedule permanent partial injuries, such as back and head injuries and neuroses, where a definitive diagnosis is extremely difficult, the stakes are relatively high, and the premium on high-priced legal and medical chicanery is great.

Recognition of such dangers led most States to reject lump-sum settlements in principle and to impose special restraints upon their use, usually requiring commission approval. Yet great and increasing pressure from all sides—carriers, claimants, lawyers, labor leaders—combined with slack administration in many States, has resulted in the relaxation of effective restraints and a marked increase in the volume of lump-sum payments.

In Illinois, for example, it is estimated that 80–85 percent of all cash benefits are so paid. In Rhode Island, it is reported that during the 8-month period June 1, 1952, to February 1, 1953, $750,000 was approved in lump-sum settlements, nearly one-third of the total amount of benefits paid during the year. Over $200,000 of this sum went to lawyers. In this State the law requiring that such settlements have the advance approval of the administrative agency or court has proved to be "pretty much of a farce," according to testimony of lawyers handling cases for both sides.

Many factors are responsible for such conditions. A major element is the fact that weekly benefits are too low for maintenance of the worker in most jurisdictions. Settlements for a lump sum often seem to the worker to be the only way out. Further, he sometimes feels that a lump sum offers the only possibility of obtaining a good lawyer and having his interests protected at all. Many lawyers see in lump payments the only possibility of obtaining a respectable fee, promptly paid. To the carrier and employer, commutation is almost always a financial gain. Aside from the frequent possibility of "claims paring," the overhead economy of closing a case promptly is obvious. Under the circumstances, the lump-sum practice is extraordinarily difficult to keep within bounds.

The carriers, once the major proponents of lump-sum settlements, are apparently awakening to the dangers inherent in the situation. Referring to the Rhode Island developments, the president of Liberty Mutual Insurance Co. said in 1953,

> What this represents is nothing less than the erosion of the compensation system. If we imagine that it can continue indefinitely, we deceive ourselves.[7]

Mr. Black knows whereof he speaks. In England, widespread abuse of the commutation privilege was one of the major factors leading to a complete overhauling of the workmen's compensation system, including the abolition of private insurance.

Commutation is not used under our present veterans' laws.[8] Considering the problems which the practice has raised in workmen's compensation, this may be sound. On the other hand, it should be kept in mind that the worst abuses of the practice in workmen's compensation are associated with two features of compensation administration which are totally absent from the veterans' program: (1) private financing, especially merit rating with its inducement to fight claims, and (2) the prevalence of litigation with fee-basis lawyers.

Arrangements under the Veterans' Administration laws differ materially from those under the military disability retirement law administered by each department of the armed services, under which personnel who are discharged with disabilities may be compensated. The military system provides for lump-sum severance benefits for disabilities under 30 percent.

In the Federal Employees' Compensation Act, where the first of these features has hitherto been absent and where litigation has been kept to a minimum, the law provides for commutation of small awards—$5 or less per month—at present value of future payments less 4 percent. Given this monetary limit, the practice under the FECA is negligible except for foreign beneficiaries. But it does suggest that the administrative convenience resulting from the commutation of small awards may be achieved without necessarily producing the negative results associated with workmen's compensation in too many States. This issue is discussed below in relation to Veterans' Administration problems.

2. "*Continuing jurisdiction.*"—This is an issue of mounting controversy in workmen's compensation. A few States have authorized their commissions to maintain jurisdiction over a claim after a case has been settled. An original award is not necessarily final, since the case may be reopened and the amount of the award increased or decreased if new evidence appears to justify such action. This might be true, for example, in the event that an apparent temporary injury later turned out to be permanent, or if an assumed 75 percent permanent disability was later found to be only 50 percent, or if some other error of fact had been made.

The New York law (sec. 123) provides:

> The power and jurisdiction of the board over each case shall be continuing and it may, from time to time, make such modification or change with respect to former findings, awards, decisions or orders relating thereto, as in its opinion may be just * * *

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[7] S. Bruce Black, The Anomalies of Workmen's Compensation, Industrial and Labor Relations Review, October 1953, p. 45.

[8] In some other countries, notably Canada and Great Britain, strict limits have been set on the duration of benefits for all disabilities rated less than 20 percent.

Under FECA, the Bureau of Employees' Compensation appears to have unlimited continuous jurisdiction, including authority to require new physical examinations (sec. 21) and to review, modify and rescind awards (sec. 37). California has jurisdiction for 5 years; Wisconsin for up to 6 years, with more latitude permitted for occupational disease cases than for those resulting from accidents (102.18 (5) and (6)). The majority of States, however, do not permit the reopening of closed cases.

It is easy to understand why, in general, employers and carriers have opposed such power. They say that it encourages unjustified claims, disguised retroactive benefit increases, and creates extraordinarily difficult problems in estimating reserves. New York has attempted to meet this objection through a special fund for reopened cases, maintained by assessments on all carriers. Labor and most compensation administrators defend the need for such power by pointing to the high incidence of recurring disability after cases are closed and to the frequently inadequate basis for final judgment at the time of the original settlement. Claims on the New York fund increased to the point that it had to establish time limits: 18 years from the date of disability and 8 years from the date of last compensation payment.

The question, like so many others, is on its surface procedural but at its base reflects profound disagreement on the fundamentals of workmen's compensation. If workmen's compensation is simply an extension of tort liability with some revisions in the legal ground rules, with each party expected to look after its own rights and the commission acting largely in a judicial capacity, then continuing jurisdiction is difficult to justify. If, on the other hand, the arguments for workmen's compensation by its original proponents are still valid, that it is a form of necessary protective labor legislation, and that "the primary objective of administration is to make sure that the law is observed, and that an injured worker gets everything to which the law entitles him," then continuing jurisdiction appears justifiable.

The Veterans' Administration has clear "continuing jurisdiction" over its beneficiaries for life, and each beneficiary generally may consider his case continually "open" for reconsideration in the event of new developments.

THE PROBLEM OF ELIGIBILITY

Under workmen's compensation, as under the veterans' program, entitlement to benefits depends upon establishment of connection between the disability and some prior experience; in the case of workmen's compensation, the claimant's previous occupation; in the veterans' program, the service-connection of the claimant's disability. The test common to workmen's compensation law, that the disability must be due to "personal injury" or "occupational disease" arising "out of and in the course of employment" is analogous to but more restrictive than the requirement that the veteran's disability must result from "personal injury or disease contracted in line of duty or for aggravation of a pre-existing injury or disease contracted or suffered in line of duty."

In workmen's compensation, the establishment of causal relation between the injury and the job has historically been more difficult than in

the veterans' program, for several reasons. First, the workmen's compensation requirement is a dual one: The injury or disease must not only have occurred during, that is, "in the course of," the employment but must have been demonstrably related to that employment. Thus, traditionally, the fact that a worker died from a heart attack while he was at work would not be adequate proof of work connection. Some special and unusual exertion, beyond the routine requirements of the job, had to be shown to establish proof.

Second, while the veterans' law specifically covers "aggravation" cases, the opposite was true of workmen's compensation. If an employer could demonstrate, for example, that an employee, who had developed a case of mercury poisoning on the job, was allergic to mercury, he could escape liability.

Third, although workmen's compensation laws were considered protective labor legislation and many statutes specified that they were to be "liberally" interpreted, the fact that a private party, the employer, pays for the cost (usually of insurance coverage), and the further fact that, under prevalent experience-rating procedures, an employer's cost varies directly in proportion to the amount of benefits which his own employees collect, have provided powerful deterrents to liberal interpretations of eligibility requirements. This was further reinforced by the close historical connection between workmen's compensation and tort liability law under which the burden of proof was clearly on the claimant.

All this is, of course, diametrically opposed to procedure under the veterans' program, where the burden of proof is clearly laid on the Government as defendant. See the ruling regarding proof of "aggravation" cited on page 194.

In spite of these significant historical differences with regard to establishing eligibility or entitlement to benefits, a number of interesting parallels have developed in practice. Workmen's compensation law has been greatly liberalized in this respect, especially during the past two decades, as a result of both judicial and legislative action. The chief contribution of the legislatures has been the general inclusion of occupational diseases under workmen's compensation coverage. By January 1956, all but 2 States covered some occupational diseases, although only 26 included the list of diseases commonly accepted as occupational in origin.

In many jurisdictions the courts have gone much farther and as a result the definition of "personal injury" is increasingly taken to include the incidence of disease or other nontraumatic occurrence. Furthermore, the occurrence of an injury "in the course of employment" is more and more frequently taken to presume that it arose "out of the employment." Aggravation of pre-existing conditions such as tuberculosis and diabetes is more and more frequently considered compensable.

The following excerpts from a March 1955 decision of the Illinois Supreme Court, upholding the agency's decision to compensate a worker who collapsed from a coronary occlusion while performing his regular work, suggest more the atmosphere of the veterans' program than of traditional workmen's compensation law:

> The Workmen's Compensation Act is not limited in its application to healthy employees, and where an employee in the performance of his duties, and as a

result thereof is suddenly disabled, an accidental injury is sustained even though the result would not have been obtained had the employee been in normal health.

There need be no external violence to the body to constitute an accidental injury, and compensation may be allowed where a workmen's existing physical structure, whatever it may be, gives way under the stress of his usual labor. Contrary to the defendant's contention, there need be no showing of unusual strain or activity beyond the habitual job requirements in such cases in order to establish an accidental injury.[9]

This is a development the propriety of which is continually challenged by employers, insurance carriers and defendants' attorneys, but thus far it has proved irresistible.

In the Veterans' Administration program, the major liberalization has taken place through statutory additions as to the physical condition of the veteran at the time of entrance into service, and a long list of "presumptions of service incurrence" of specified disabilities. The first of these—a 2-year presumption for active pulmonary tuberculosis and neuropsychiatric disease producing at least 10 percent disability—dates back to 1921. The height of liberality was reached in the 1924 law which extended the presumption for these two diseases and a number of new ones to January 1, 1925.

During the "economy period" of the 1930's, some of the presumptions were repealed or modified but the liberal trend was soon resumed. Today the list of service-incurrence presumptions includes:

(*a*) A 1-year presumption for about 40 types of "chronic diseases," manifest to a degree of at least 10 percent. This list may be extended by the Veterans' Administration. This presumption applies only to wartime veterans with 90 days of service.

(*b*) A 1-year presumption for about 17 tropical diseases. It applies to all veterans, including those serving in peacetime if they have a 6-month period of service.

(*c*) A 3-year presumption for all types of tuberculosis resulting in 10 percent disability for wartime veterans only. A fourth year was added by administrative ruling for wartime far-advanced pulmonary tuberculosis.

(*d*) A 2-year presumption for multiple sclerosis resulting in 10 percent disability, wartime only.

Another early liberalization resulted from reinterpretation of the statutory bar to compensating a disability resulting from the veterans' own misconduct. Originally, this was taken to exclude disability resulting from venereal disease.

It seems clear that both programs are confronted with the inescapable truth that in many disabilities it is difficult, legally or medically, to separate compensable from noncompensable origins. The attempt to compartmentalize and isolate the specific causes of diseases and even of some injuries runs contrary to modern medical science which increasingly stresses the complex etiology of disease and the impossibility of isolating or even ranking in importance the various causes. Thus, a coronary thrombosis occurring while a miner is at work may be due in more or less equal parts to heredity, a generally harsh living environment, personal dietary habits, and to unusual exertion on the job the day or the week that the fatal attack occurred. The decision of a liberal court to permit compensation for such a case

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[9] *Laclede Steel Co.* v. *Industrial Commission et al.*, Illinois Supreme Doc. No. 33404, March 1955.

may not constitute precise accuracy, but neither would the decision of a more conservative court to disallow it. Similarly, the veteran's claim that a neurosis, hypertension or cancer which occurs a number of years after discharge has its roots in his military experience may, in some cases, be just as accurate as the contrary contention.

What this seems to imply is that, in the present medical and political climate, any disability program which attempts to provide adequate benefits to a restricted group of eligibles on the basis of causation is going to have trouble. It is, almost inevitably, going to be under pressure to bear the burden of many disabilities which are of dubious service—or work connection. This, in part, reflects the absence in our society of any general program of disability insurance. Where this need has been met, for example, through sick leave or collectively bargained disability insurance, the pressure on workmen's compensation has decreased significantly.

SOME ISSUES RELATING TO BENEFITS

The most striking historical developments with regard to workmen's compensation benefits have been (1) the movement away from the original design of relating compensation to wage loss or loss of earning capacity by a statutory percentage, (2) the movement toward a flat rate of weekly benefit payments as determined by the statutory weekly minimum, (3) spread of dependents' allowances—a device related to need rather than previous earnings, (4) the skewing of the benefit formula in favor of the less seriously injured, (5) the trend, in permanent disabilities, toward compensating physical impairment, per se, rather than loss of earning capacity, and (6) the widespread current use of commutation of benefits in permanent cases.

The first two of these developments have resulted primarily from the subordination of the percentage factor in the benefit formula to the statutory weekly minimum. This, of course, is contrary to the original philosophy of workmen's compensation. The relation of benefits to wage loss was a theoretical foundation stone of workmen's compensation in the United States. Today, however, the specified percentage has been virtually submerged by more restrictive qualifications, particularly the maximum dollar amounts.

As already noted, the most common benefit-wage-loss ratio given in the laws is two-thirds, but recent studies indicate that, in fact, workmen's compensation is indemnifying on the average for only one-third or less of actual wage loss. In practice, there has been a virtual transformation of the formulas into flat-rate schedules. And the flatter the schedules become the lower the average rate of compensation. This was an almost inevitable consequence of the anomaly of rigid dollar maximums in a dynamic economy of rising prices and wage levels. It would have required frequent and anticipatory legislative action to do no more than keep up with even the original low standards, an impractical expectation of any legislative body.

In such a situation, the addition of the dependent's allowances was logical. They provided a device for raising benefits in cases of most obvious need without reversing the trend toward flat rates.

The relative disadvantage in the benefit position of the serious disability cases is indicated by recent studies of relative wage-loss recov-

eries in Minnesota and Illinois. Both studies indicate a consistently inverse relationship between severity of injury and amount of benefit per day: [10]

	Minnesota	Illinois
Fatal	$0.76	$0.76
Permanent total	1.62	1.91
Permanent partial	1.68	1.80
Temporary	3.15	3.25

This skewing of the benefit formulas in favor of the less seriously injured appears to be well-nigh universal and difficult to resist. Insofar as it can influence the allocation of the benefit dollar, organized labor—presumably speaking for the beneficiaries of the program—consistently favors using more of it for the less severe cases, probably because more individuals are affected. Insurance carriers concur, for other reasons; presumably economy and avoidance of the actuarial problem involved in setting up reserves, especially for cases without fixed limits.

A divergence in theory has developed among the experts on the question of whether this emphasis is desirable. Reasoning perhaps from analogy to unemployment insurance, some social insurance authorities now agree with labor that when there is insufficient money to compensate adequately all the injured, priority should be given to the less severe cases which can be compensated fairly for relatively small amounts. The severely injured must look to other forms of social insurance better designed for the purpose, or to extensive rehabilitation, or make a basic readjustment in standard of living. Aside from the questions of equity which this position raises, it suggests the base inability of the workmen's compensation program to meet the problem of occupational disability unless dovetailed with other social insurance programs.

There appears to be a hen-and-egg relationship between this trend, the increasing emphasis on physical impairment per se, and the increase in lump-summing. The very low benefits typical in many States in serious permanent cases have been a major cause for the resort to litigation, the growing emphasis on visible physical impairment and encouragement of the practice of commutation. At the same time, these latter trends, while they have helped many desperate individuals in emergencies, have also served to divert attention from the basic problem of maintaining an overall equitable relationship between permanent and temporary cases, severe and less severe disabilities—a relationship which could best be served by concentrating on objective rating procedures and schedules of relative values combined with adequate weekly benefits for the duration of the disability.

In the Veterans' Administration program, 3 of the 6 benefit trends listed for workmen's compensation appear also to be present. There has been an analogous movement away from compensating for the loss of earning capacity toward greater emphasis on physical impairment

[10] Report of the Interim Commission on Workmen's Compensation to Minnesota Legislature, 1953, p. 48; Illinois Department of Labor, division of statistics and research, Annual Report on Industrial Accidents, 1953, pt. II, p. A–13, table 9. In both studies, American Standards Association time charges were used in calculating average benefits for permanent injuries.

per se (see ch. VII) and an even more complete use of dependents' allowances.

The movement toward a flat weekly rate in workmen's compensation brings it closer to what the Veterans' Administration has been doing all along. Since the veterans' benefits are related to average impairments in earning capacity rather than individual wage loss, the benefit rates for each of the 10 designated degrees of disability (10 to 100 percent) were always flat. The brief (1925–33) effort to vary these rates through an occupational disability rating was discarded as unsatisfactory. Since there is no regular occupation or stable wage-earning experience in the preinduction history of most veterans, some such arbitrary flat rate appears inevitable in their case, whatever the pros and cons as applied to injured workers.

On point (4) above, the Veterans' Administration has a far better record than workmen's compensation. The trend toward slighting the seriously injured in favor of the less seriously disabled, so prominent in workmen's compensation, is relatively absent in the veterans' program, largely due to the statutory benefits for various categories of permanent total disability. There is some question, indeed, whether in the 10 and 20 percent ratings by VA there is actually a corresponding impairment of earning or physical capacity. The range of monthly rates is now $17 to $420. This can, however, be misleading since the vast majority of cases are nonstatutory and there the ceiling is $181. In June 1955, only about 17 percent of the totally disabled were eligible for more than $181 per month. The differentials are also tempered by the fact that all ratings—10 percent no less than 100 percent—carry lifetime benefits for permanent disabilities.

In this connection, another basic question has been raised in relation to Veterans' Administration benefits: Are the lowest ratings, 10 and 20 percent, for example, really disabling enough to justify lifetime benefits? If not, what device could be found for compensating them for some lesser and perhaps more justifiable period? In any event, would commutation be desirable in such cases?

In considering such questions, workmen's compensation experience may offer some guidance. It will be recalled that the variation in benefits for different degrees of injury is achieved not by varying the weekly benefit but by varying the duration of benefits. In Wisconsin, for example, the loss of an arm at shoulder pays 500 weeks; the loss of a hand 400 weeks; the loss of a thumb at proximal joint 100 weeks; the loss of an index finger, including the metacarpal bone 60 weeks; the loss of a middle finger at second joint 20 weeks; the loss of a little finger at distal joint 6 weeks. In California every disability pays 4 weeks for each degree of injury.

Thus, every worker who sustains a permanent disability, no matter how slight, is compensated to some extent, but only for a period of time which is presumed to be commensurate with the extent of the disability or, more realistically, the character of the physical impairment. In workmen's compensation the awards tend to be extremely parsimonious by veterans' standards. Even a relatively liberal State like California gives only 40 weeks' benefits for a permanent 10 percent disability. The veterans' program could offer 1 year, or 2, or even 3, whatever standard Congress saw fit. The proper level of standards is not being considered in this paper. The purpose is only to call attention to the

availability of an administrative device which has proved practicable in workmen's compensation.

However, it needs to be pointed out that there are other basic differences in workmen's compensation theory which give larger justification to time limits than in the veterans' program which is administered by a Federal Government agency. The employer's liability is definitely limited. This is historically based upon a legal compromise in which the employer accepted liability without fault in exchange for the worker's acceptance of limits on such liability. There is no parallel situation in the veterans' program.

Moreover, the present articulated theory of veterans' compensation, that it is paid for loss of earning capacity, does not lend itself as readily to benefits limited in time as would a recognition that compensation is in fact being paid for physical impairment as such. A franker approach to what is being done might be required. (See ch. VII.)

Nonetheless, the problem of minor injuries is serious and administratively costly and is worthy of close thought. About 57 percent of all veterans' cases drawing compensation benefits have only 10 and 20 percent disabilities. This has also led to the question of whether benefits for such cases might be lump summed. The merits of this question are tied in with the previous issue. If payments are designed for lifetime duration, lump sums might be large, both from the point of view of the beneficiary and the Government. Young veterans with only 10 or 20 percent disability have a long life expectancy. Under present standards they might be entitled to large gross sums which both their youth and the experience of workmen's compensation indicate would be squandered in a majority of cases.

The basis for possible commutation under veterans' programs would have to be carefully determined and the philosophy clarified. Research might show that minor disabilities of the type rated at 10 percent are not an economic handicap and may not constitute a significant physical handicap. If true, this in itself would be an important factor for commutation on a reasonable basis.

Furthermore, lump summing in relation to liability reasonably limited in time presents a different picture. The amounts would be manageable. It has been noted that in workmen's compensation commutation has been associated with many abuses. But the major problems associated with commutation under workmen's compensation would not be present in the Veterans' Administration program. Without private financing, the incentive to use it for claims paring or to compromise contested cases would be absent. Moreover, FECA experience indicates that provision against claims paring can be written into the law. Similarly, without paid claimants' attorneys, there would be no possibility that one-third or one-half of the award would go to the lawyer.[11] Furthermore, the Veterans' Administration environment makes it possible to combine commutation and continuing jurisdiction, whereas in most workmen's-compensation jurisdictions such a combination is virtually impossible.

A serious question raised by present Veterans' Administration practice is the possible adverse effect on the recipient, especially those

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[11] No amount of legal protection can prevent a claimant from making some unofficial deal with a lawyer. If, as we understand, most legal services are now provided free to veterans by their organizations, this should not be too much of a problem.

suffering from relatively mild neuropsychiatric disorders. Monthly payments are made while the disability continues; when the patient recovers the payments stop. There is, accordingly, a strong motivation working against recovery. In fact, it appears that some veterans develop a fear of getting well and thus losing their compensation.

Many social-insurance experts rightly regard commutation as a veritable "Pandora's box" of evils, and the workmen's compensation experience supports this attitude. It must, therefore, be approached with caution. But it does not necessarily follow that it could not serve a useful purpose for special situations in the veterans' program.

MEDICAL BENEFITS AND REHABILITATION

Unlike the veterans' program, workmen's compensation combines medical and, to a lesser extent, rehabilitation benefits in the same program and under the same overall administration with cash disability benefits.

This was not always true. In the early American experience, the importance of medical and surgical treatment was not yet understood and, with what proved to be highly expensive "economy," it was not looked upon favorably by many legislatures. It was entirely possible for an injured worker to use all or more than his compensation benefits for medical expenses and have none for the wage loss for which it was intended.

A major trend toward meeting the deficiency started during World War I, and has continued. In 1955 unlimited medical care was available in 37 jurisdictions either through statutory or administrative authority, although several of these have special limits on medical aid for certain occupational diseases. Seventeen States still impose arbitrary limits on the amount or duration of medical care for which the employer is liable.

All but five States now require provision of artificial appliances when necessary, although several limit this by providing that the cost shall be included in the total amount allowed for medical care.

The development of medical aid from its original small part in workmen's compensation to its present position of accounting for approximately one-third of total benefits, and costing nearly $300 million a year, has been spurred, in part, by concrete experience demonstrating that provision of medical aid is practical economy. Enlightened employers and insurance carriers have increasingly recognized that good medical care generally reduces the period for which indemnity payments need be paid, and very often lessens the overall cost of an injury. Indeed, for such practical reasons as well as for good public and industrial relations, certain employers and carriers exceed the legal maximum allowances in the restricted jurisdictions. Some employers did this by providing complete medical care even including the worker's family.

For the short-term injured in particular, the availability of medical care is now the greatest boon of the compensation program. In practice, however, the achievements in this area have been something less than is suggested by the great improvement in legislation and the large increase in amounts expended for medical benefits. A good part of the increase represents only the rise in medical costs, a source of

concern to the insurance carriers and employers without being of any direct benefit to the injured worker. Another situation subtracting from the net benefit to workers, although less prevalent than some of the publicity would indicate, is the existence in some states of medical malpractice in the compensation field. More basic is the general problem created by the usual lack of adequate supervision of medical care and the failure to orient it toward rehabilitation.

No aspect of workmen's compensation has aroused as much interest in the past few years as rehabilitation, the modern "miracle" which has demonstrated that the legless man can walk again, the armless can work with remarkable dexterity, the paralyzed can leave their beds and support themselves, and that victims of many other disabilities, once considered permanently and totally disabling, can be restored to take their places in productive employment and in self-esteem.

The subcommittee on Industrial Relations of the American College of Surgeons adopted five principles, which were approved by the Board of Regents of the College, on the role of the medical profession in the restoration of an injured worker to gainful employment as follows:

1. Rehabilitation of the injured worker and his return to gainful employment should be the basic concept of an improved workmen's compensation system. We recognize that the disabled worker wants to be rehabilitated, and restored to gainful employment. Settlement of cases on a basis of cash awards alone does not meet the continuing needs of the injured worker and his family.

2. The need of higher standards and broadened benefits in workmen's compensation is recognized. Such standards and benefits should be developed against the background of presently known advances in physical restoration and vocational rehabilitation and adequate standards of individual and family needs.

3. Full utilization of all our potential manpower is essential to the welfare and strength of the country at all times. The discarding of disabled workers is an economic extravagance detrimental to the welfare of our country, wholly aside from the personal effect on the worker and his family. Solution of the problem of training requires cooperation, and not competition, between all interested groups and agencies. We must, therefore, improve and expand all activities, public and private, that aid in rehabilitation of the disabled worker.

4. The medical profession should adopt the concept that the responsibilities of the treating physician extend over the entire period of disability to the end that the patient is restored to gainful employment at his highest attainable skill.

5. Rehabilitation and restoration to gainful employment of the injured worker must begin with first aid and continue through the period of disability. In order for a physician to carry out this responsibility, it is essential for him to recognize the total medical problem of the patient in addition to his injury, as well as his personal problems. The physician must bring to bear on these problems all the skills and disciplines that science and society can offer, and utilize all community resources which can assist him in the accomplishment of these objectives.[12]

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[12] IAIABC Proceedings, 1954, U. S. Bureau of Labor Standards, Bulletin 180, p. 32.

In 1952 the International Association of Industrial and Accidental Boards and Commissions, professional association of the compensation administrators, endorsed the following proposition:

> Rehabilitation is the end result of the compensation process. If we, as compensation administrators, fail to realize this important fundamental, and we are satisfied merely to sit back and dole out to the injured workman a certain percentage of his wage, according to our various laws, then the entire compensation process becomes archaic and outmoded.[13]

The same economic logic which dictated increasing resort to medical treatment in order to hold down the costs of cash indemnity is now demanding widespread utilization of rehabilitation which has so clearly demonstrated its ability to reduce costs, especially in the more serious, i. e., expensive cases. While rehabilitation involves a complex of medical, paramedical psychosocial, counseling and vocational training skills, the medical aspects remain central. Indeed, medical treatment and rehabilitation are, or should be, inseparable and continuous elements of the same process. Just as rehabilitation is properly the final phase of medical care, the primary purpose of medical care from the very beginning of treatment or first aid is, or should be, the maximum physical restoration of the injured worker. Medical care thus directed is itself an essential stage of rehabilitation.

While the logic of the above may appear simple and incontrovertible, the implications of this new concept of "total" medical care are wide-ranging and more revolutionary than is immediately apparent. It requires as great a readjustment in social institutions and programs dealing with the disabled as it does in medical thinking and practice.

The extent to which such a readjustment is needed in workmen's compensation is indicated by the judgment of one of the country's leading authorities on both rehabilitation and workmen's compensation. According to Dr. A. P. Aitken, medical director of the Liberty Mutual Rehabilitation Center in Boston and chairman, subcommittee on industrial relations, American College of Surgeons:

> One of the most formidable roadblocks to restoration of the injured worker lies in the workmen's compensation system itself.[14]

In short, words and practice are widely at variance. Even in States which make some provision for rehabilitation, it is, at best, something entirely apart from the normal claims administration rather than an integral function of the program. At worst, claims procedures involve built-in conflicts between indemnity rights and rehabilitation possibilities.

The conflicts lie deeply embedded in the historical development and present organization of the compensation system.[15] As already noted, its legal and administrative structure was designed before the modern concept of rehabilitation was known, even before ordinary medical care benefits were a generally accepted part of the programs. It is, therefore, not surprising that the structure is generally attuned to a program whose major concern is assuring the payment of cash benefits. But it seems unlikely that such a situation can be indefinitely tolerated. Workmen's compensation costs more than it needs to and

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[13] IAIABC Proceedings, 1952, U. S. Bureau of Labor Standards, Bulletin 167, p. 83.
[14] IAIABC Proceedings, 1954, U. S. Bureau of Labor Standards, Bulletin 180, p. 32.
[15] H. M. and A. R. Somers, op. cit., pp. 254–263.

there is a much higher proportion of residual disability than can be justified in the present state of medical knowledge.[16] The result is not only tragic from the point of view of the disabled individuals but is a serious waste of our most valuable possession—manpower.

In chapter VII there is a discussion of one of the major problems in the rehabilitation-workmen's compensation conflict—the impact of rehabilitation on the "earning capacity" test for disability rating purposes, and vice versa. Other problems in the integration of the two programs involve the supervision of all medical benefits, the early evaluation of cases to determine appropriateness of medical care and need for rehabilitation, adequate funds for provision of necessary rehabilitation facilities, administrative authority to require rehabilitation where indicated, and withholding permanent disability rating and award until maximum rehabilitation effort has been made.

There was a period following World War I when veterans disability compensation recipients could be compelled to submit to "any reasonable medical or surgical treatment furnished by the Bureau; and the consequences of unreasonable refusal to submit to any such treatment shall not be deemed to result from the injury compensated for."[17] This was repealed in 1933. The only instance in which there is now any relationship between disability benefits and medical treatment or examination is with regard to arrested tuberculosis. A veteran, who refuses to undergo treatment or examination during the first 2 years after the arrest, may have his disability rating reduced from 100 percent to 50 percent (Vet. Reg. 3 (a) par. II).

The disability compensation program and the rehabilitation program are both deficient to the extent that they maintain isolation. When the importance of coordination is pointed out, the reply is often made that it is a principle of the veterans' program not to penalize successful rehabilitation, or enterprise, by any curtailment in compensation. The principle is an excellent one. In fact, once this principle is clearly established and accepted, there is all the more reason for integration of compensation and rehabilitation services, for then the basis for suspicion and psychological barriers to rehabilitation is removed and a job can be done. Certainly such a slogan ought not be used as a rationalization for behaving as if rehabilitation was of no consequence to the compensation system or its beneficiaries. We should not go to the other extreme of rewarding neglect of rehabilitation because it results in increased disability.

Coordination offers many possible lines of action. Minimally, it could be required that physicians from the Department of Medicine

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[16] In an effort to compare the number of permanent disability cases under workmen's compensation in the United States and in the Canadian Provinces, where medical care is supervised and oriented to rehabilitation, the IAIABC's Medical Committee surveyed the experience of 37 United States and 3 Canadian medical jurisdictions during 1949–51. It found that the ratio of permanent cases to all compensation cases in the United States varied from a low of 7.7 in Florida to a high of 30.6 in Illinois. In Canada, Ontario had the lowest ratio, 3.8, and British Columbia the highest, 5.1. (U. S. Bureau of Labor Standards, Bulletin 172, pp. 58–59.) Even more startling figures come from official records for cases closed in 1951 in two United States jurisdictions not listed in the IAIABC survey. In New York the ratio was over 37 percent; in New Jersey, over 66. The cost to employers of such a large number of permanent disabilities, as measured by cash indemnity payments alone (not counting medical costs) amounted to the following percentage of all cash payments: Illinois, 79 percent; New Jersey, 87 percent; New York, 65 percent; Wisconsin, 58 percent. (Official commission reports, summarized in Somers and Somers, op. cit., p. 79.) Variation in statutory definition of various types of disability and in administrative and judicial interpretation of these definitions should, of course, be taken into account, but the striking contrast with Canada remains.

[17] Sec. 204, World War Veterans' Act, 1924.

examine each applicant for compensation. The physicians should indicate the character of medical attention best suited for rehabilitation objectives and draw up a tentative program of rehabilitation. This should be fully explained to the applicant; its advantages made clear. He can be absolutely reassured that successful rehabilitation will not jeopardize his compensation payments in any way even though it is likely to augment his earnings considerably.

Even if rehabilitation were entirely optional with the compensation claimant, great advantages would accrue. Many more disabled veterans would undoubtedly accept rehabilitation. Ignorance and fear would cease to be barriers. In addition, as the study of disability rating in the following chapter indicates, the quality of rating procedures would be greatly improved if they were consistently adjusted in accordance with the influence of rapid technological changes in medical care.

It might not be either practicable or desirable for the Government to require that a disabled veteran accept medical treatment or rehabilitation as a prerequisite to compensation. But, the compensation system should not be such as to constitute a fence between the veteran and sound medicine. Certainly there will be difficult problems of policy and administration to work out in practice. But even the limited experience available under workmen's compensation in the United States, and especially the dramatic results obtained in Ontario where medical care, rehabilitation and disability benefits have been fully integrated in the workmen's compensation program, indicate that it is not impossible. The potential rewards, to veterans and the Nation, are at least commensurate with the difficulties.

Americans need hardly be reminded that our high standards of individual freedom as well as standards of living rest on a base of productive energy. The need is great that we deal with disabled veterans as potential producers as well as consumers. Manpower resources cannot be squandered without peril to all the veterans' programs and many other valued institutions, as well as to the character of those we want to help. The Veterans' Administration and the Congress have clearly recognized this in other phases of their work, such as the VA medical program. However, in this age no disability compensation program, however excellent its other features, can be considered as performing its whole task if it does not actively aid rehabilitation. To the extent that a disability program fails to take advantage of the social, economic and human conservation implicit in the rehabilitation potential, it limits its own capacity for adequately compensating those who most need its help while increasing the burdens upon society.

CHAPTER VII

DISABILITY RATING: VETERANS' ADMINISTRATION CONTRASTED WITH WORKMEN'S COMPENSATION EXPERIENCE

Disability rating is a subject as important as it is complex. In this country particularly, where general public disability insurance has been much slower in developing than in Europe, the concepts and techniques of disability evaluation are largely shrouded in obscurity.

Crude forms of disability evaluation have long been practiced. When the Federal Congress of 1776 promised pensions of one-half pay to wounded veterans of the Revolutionary War (a promise it was unable to keep for many years) it was setting a value on the injuries of the veteran continentals. Similarly, when 19th century judges and juries established the value of damages for personal injuries to employees, or third parties, they too engaged in a rough sort of evaluation of the injured person's disability as well as the degree of the tortfeasor's negligence.

The development of more elaborate compensation and pension programs for disabled veterans down to the War Risk Insurance Act of 1917, and the institution of workmen's compensation statutes substituting fixed and limited benefits for common law damages, represented a transition to a social insurance approach in meeting the problem of disability for these special groups—veterans and workers injured on the job.

At that point a more objective method of identifying and measuring disability had to be developed. Starting in the second decade of this century, efforts to produce a scientific formula and objective rating schedules were undertaken. For the past four decades legislatures and administrators of these programs have wrestled with the problem. Few outside of these official circles have given close attention to their efforts. Even the beneficiaries and their spokesmen have been far more concerned with benefit provisions than with basic rating procedures upon which every disability benefit must ultimately rest.

However, as the problem was increasing in volume—money and beneficiaries—and technical complexity, all sorts of pressures were brought to bear on original schedules and procedures. The years have therefore seen a series of changes and counterchanges, not only in specific rating techniques and values but in the very meaning of disability and the philosophy underlying its compensability.

Today, the problem is of great urgency, not only because of its obvious effects upon the millions of actual and potential beneficiaries, and the very substantial cost to employers and the general public, but also because much of the efficacy of programs for more general disability insurance now taking shape in Congress and in State legisla-

tures depends upon the ability to devise and administer equitable and acceptable methods of disability evaluation.

The purpose of this chapter is to review the experience in one sector, workmen's compensation, with specific reference to the relevance of that experience to the veterans' program. While the overall design and philosophy of the two programs differ in many important respects the problem of rating disability presents some interesting similarities. The experience in either program should be of value to the other. The developments in both programs, especially where similar trends are unmistakable, may contain important lessons for disability rating.

THE NATURE OF THE PROBLEM

What is "Disability"?

Although the terms, "injury" and "disability" are sometimes used interchangeably, they are not synonymous even in everyday parlance. According to Webster, injury is "damage or hurt done, or suffered" as well as "The act that injures," and, with special reference to the common law, "an actionable wrong." Disability, on the other hand is "the state of being disabled," "absence of competent physical, intellectual or moral power," also "legal incapacity or incompetency."

In workmen's compensation and the veterans' disability compensation programs, disability is a consequence of injury. Thus, the Federal Employees Compensation Act (FECA) provides "compensation * * * for disability * * * of an employee resulting from a personal injury." The veterans' program is also intended to compensate for "disability resulting from personal injury." In both cases, and in disability programs generally, the precise meaning of disability is whatever consequence of injury the legislative authority intends to make compensable.

In workmen's compensation, the original view of disability was limited to the economic loss—loss of wages or ability to earn. The historical basis for the limitation was a legal compromise for the purpose of effecting a social objective. The right to recover tort damages is based upon the fault of the negligent party. The right to workmen's compensation is based on a legislatively created liability, irrespective of fault. The extent and character of losses for which compensation may be awarded are far narrower than under common law "damages" which may encompass all the losses flowing from the injury—physical, mental, economic and social. On the other hand, they are broader in the sense that under common law there can be no recovery without fault.

The veterans' compensation program is also a legislatively created liability which the Federal Government has assumed. It too, perhaps influenced by the older workmen's compensation programs, has largely limited its liability—that is, confined the concept of disability—to economic loss, loss of earning capacity. It is clear, however, that in both programs the limitations upon, or the inclusiveness of, the term disability is entirely a matter of legislative determination as interpreted administratively or judicially.

It is not surprising, therefore, that the meaning of disability has varied from time to time, from program to program, and place to place. In a democratic society the effects of program experience,

changing economic conditions, and shifting social attitudes are reflected in changing policies and administrative determinations. While statutory definitions, and justifications, have tended to remain relatively static, there has in fact taken place over the years gradual but clear enlargement and extension of the legal concept of disability. In workmen's compensation this has taken place despite great resistance by the financially liable parties at each stage. In veterans' compensation the development has been less controversial because the program is not characterized by adversary interests and contesting parties as is workmen's compensation.

Forty years of legislative, administrative, and judicial accretions to the idea of compensable disability have made it an enormously complex concept, or perhaps only helped reveal how much more complicated the original idea was than was generally realized.

A mixture of two, not always clearly distinguishable, elements make up the legal concept of compensable disability: (1) Physical or anatomical impairment—this may include psychological or mental harm; (2) loss of working or earning capacity due to such impairment. Since anything from total loss to no loss of earning capacity may flow from a given physical injury, the relative weight given these two factors will have a crucial influence upon disability rating, and is thus basic to the whole program.

Historical and Legal Primacy of the Wage-Loss Theory

The original primary stated purpose of all workmen's compensation laws is to restore a specified proportion of the injured worker's wage loss, usually stated in such terms as "66⅔ percent of average weekly wages," for total disability qualified by various maximum and minimum limits. The veterans' program took the same general approach. The act of 1917, which established the compensation system, required that disability evaluations be based upon "average impairment of earning capacity in civil occupations." This language is repeated in Regulation No. 3 (a) which directs the Veterans' Administration to adopt and apply "a schedule of ratings of reductions in earning capacity from specific injuries or combinations of injuries." So completely was the general theory underlying workmen's compensation and disability insurance grounded on loss of wage-earning capacity that the major international study of disability rating in these fields, as late as 1937, dismissed summarily any conception of disability based primarily on physical incapacity.[1] In the temporary disability aspects of workmen's compensation, the wage-loss test caused no special technical problems. Wages earned before and after the injury can be measured and compared with relative ease, and the period of time involved is usually brief enough so that actual wages provide a reasonably fair basis of comparison of capacity to earn.

From the beginning, however, problems arose with regard to applying the earning-capacity test to permanent disabilities, due pri-

[1] International Labour Office, The Evaluation of Permanent Incapacity for Work in Social Insurance, Social Insurance Studies No. 14, Geneva, 1937, p. 4. The study quotes with approval a French writer who, in discussing the idea that physical invalidity should be adopted as the criterion in assessing war pensions, stated that the notion of "physical invalidity" (invalidity is the nearest European counterpart to our concept of "disability") is "meaningless and can be dismissed as mere 'medical metaphysics.'" The long study is concerned primarily with the relative advantages of the occupational versus the average approach to "loss of wage-earning capacity."

marily to the problem of defining and measuring future loss of earning capacity. A steelworker, earning $2 an hour or $80 a week becomes permanently and totally disabled. On what basis shall his permanent total benefit be calculated? Two-thirds of $80 or $54 for life? Is the $80 a valid gauge of what his future earning capacity would have been? It leaves out of consideration a host of variable factors which would affect the man's earning capacity, such as inflation or deflation, changes in the wage-rate for his job, the possibility of promotion, demotion, or change of jobs, effect of his age, and many similar factors.

The problem of accurately assessing the effect of an injury on wage-earning capacity becomes even more complex in the area of permanent partial disabilities, where the injured worker is able to earn something but generally less than he would have earned if the injury had not occurred. By contrast with permanent total disability, there are, in permanent partial cases, some actual post-injury wages to help in the measurement of loss of earning capacity. But how accurate are they as a measure? Actual earnings may, or may not, be synonymous with "earning capacity" or "ability to earn." Additional variables now enter into the picture: The effect of the particular injury on his ability to engage in his regular occupation, its effect on alternative occupations, the effect of his age, sex, race, mentality, initiative, friends, community responsibility, employer sympathy, and state of the labor market upon his ability to make a satisfactory occupational adjustment to his injury. Even assuming that he has found a job by the time the disability rating is made, what assumptions should be made regarding his ability to hold this job or get another one in the future?

In the veterans' program there was an additional problem. Many veterans had no regular employment before they went into the service. In the case of many who did, it could not be considered a proper indication of eventual employment plans because of their extreme youth.

The obvious and insuperable difficulties of analyzing all of these factors adequately and consistently in every permanent disability case as the basis for an individual disability rating led, almost from the beginning, to the development of permanent disability rating schedules. That is, a definite list or lists of compensation values to be attributed to specified types and degrees of disablement. Schedules, as such, were simply an obvious and logical administrative response to the needs of the situation. But what sort of schedules? What factors should be included?

Emergence of Two Major Approaches to Measuring Loss of Earning Capacity

Very early in the workmen's compensation program, there emerged two distinct theoretical approaches to the problem of measuring loss of earning capacity and two types of schedules based on the opposing theories. One approach attempts to measure it as nearly as possible in individual terms, considering the person's occupation and its physical demands and sometimes other relevant factors such as age. The most important effort to translate this approach into practice is represented by the California schedule which attempts a refined occupational and age analysis. The occupational feature was also in-

corporated in the Veterans' Administration schedule between 1925 and 1933.

The second approach attempts to measure loss of earning capacity in terms of the effect of the impairment upon an average worker or, to use the ILO phrase, a worker in a general labor market, disregarding individual variations in occupation or other personal factors. This approach is represented by the present Veterans' Administration schedule which bases its rating upon average impairments of earning capacity. It is also presumed in the flat-rate schedules for permanent partial disability effective in practically all workmen's compensation jurisdictions except California.

Although the first method is now confined to one State, its historical importance in the development of disability rating techniques is very great and it remains a lively source of controversy. In current discussions of the inadequacies of present disability rating theory and technique, the question of the desirability of returning to a more scientific occupational analysis is almost always raised. The California experience is the most important upon which judgment can be based.

The special character of the California schedule for rating permanent disability cases, first adopted in 1914, derives from the philosophy enunciated in section 4660 of the California Labor Code:

> (a) In determining the percentages of permanent disability, account shall be taken of *the nature of physical injury or disfigurement, the occupation of the injured employee, and his age at the time of such injury, consideration being given to the diminished ability of such injured employee to compete in an open labor market.*
>
> (b) The commission may prepare, adopt, and from time to time amend, a schedule for the determination of the percentage of permanent disabilities in accordance with this section. Such schedule shall be available for public inspection, and without formal introduction in evidence *shall be prima facie evidence of the percentage of permanent disability to be attributed to each injury covered* by the schedule. [Emphasis supplied]

To carry out the intent of the law the California plan provides for rating all permanent disability—from 100 percent down to 1 percent—in accordance with one comprehensive, internally consistent, schedule, which aims to evaluate precise differentials in loss of earning capacity. In measuring the comparative loss, the schedule uses physical impairment as one factor. However, this factor is related to and modified by three additional factors: (1) The worker's occupation, (2) his age, and (3) his ability to compete in an open labor market.

The result is a multiple correlation schedule of great complexity and considerable length—about 75 pages—which strives for individual equity through accurate comparative measurement and for administrative convenience by having all variations of conditions correlated in one comprehensive schedule. So runs the theory.

The present Veterans' Administration Schedule for Rating Disabilities also constitutes a good-sized book, 161 pages in all. Since the schedule is also used for rating nonservice-connected disabilities for pension purposes, it covers practically all the common disabilities of military and civilian life. As in California, ratings vary according to major or minor members, but unlike California, ratings are based on the single factor of average impairments for all occupations.

The flat-rate workmen's compensation schedules in other States differ far more in appearance from the Veterans' Administration

schedule than they do from the California manual. But in respect to the vital distinction between occupational versus average loss of earning capacity, they resemble the Veterans' Administration schedule and differ from California.

As in the Veterans' Administration schedule, the value of any given physical impairment in general workmen's compensation practice applies to all workers who sustain it and is not varied for occupation, age, etc.[2] Unlike the Veterans' Administration schedule, the values are expressed not in percentages but in actual benefits, i. e., a fixed number of weeks for which benefits are payable for each enumerated disability. They also differ from the Veterans' Administration schedule in that they do not attempt to be comprehensive. Only a few specified permanent partial disabilities are listed, although in most States they probably cover the majority of compensable permanent partial injuries. Since these schedules are not comprehensive, no attempt is made to enumerate degree of disability in a continuum ranging from 100 percent, or total, down. Nonscheduled permanent disabilities, in these jurisdictions, are handled differently. They are individually evaluated in terms of wage-loss or loss of earning capacity, sometimes by analogy to the schedule, sometimes in terms of an arbitrary value attached to permanent total disability, sometimes purely by administrative discretion (which, in practice, may mean by litigation) without any yardstick.

The specific advantages and disadvantages of the two approaches will be analyzed later. First we summarize briefly the historical trends in the use of the two types of schedules and raise a number of questions with regard to permanent disability rating, as a basis for the more detailed analysis that follows.

Trend toward flat-rate schedules

In the early days, the weight of expert opinion was clearly on the side of the California type of schedule. Some of the best known experts in the field had participated in drawing up the law on which it was based and the schedule itself.[3] After hotly debating the pros and cons of the California plan for many years, the International Association of Industrial Accident Boards and Commissions (IAIABC), professional organization of the compensation commissioners, assigned in 1921 to its statistical committee the job of formulating a standard disability rating schedule. The groundwork was done by the Bureau of Labor Statistics, whose chief, Ethelbert Stewart, was secretary of the committee. For 2 years the reports of this committee occupied the center of the stage at IAIABC meetings. The five resolutions eventually adopted on the subject embodied most of the California philosophy although skepticism as to use of the occupational factor in the

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[2] Wisconsin alone introduced some variation for workers over 50 years of age.

[3] These included G. F. Michelbacher and William Leslie, actuaries of the California State fund, who eventually became president of the Great American Indemnity Co. and manager of the National Bureau of Casualty Underwriters, respectively; A. W. Whitney, professor of economics, University of California, who became general manager of the National Workmen's Compensation Service Bureau, New York City; A. J. Pillsbury, chairman of the California Industrial Accident Commission; and R. E. Haggard, supervisor of the California Permanent Disability Rating Bureau for nearly 40 years.

rating schedule resulted in a highly qualified endorsement of this point.[4]

However, the IAIABC recommendations were advisory only. Few States copied the California plan and these only temporarily. One of these was Wisconsin. The results were succinctly stated by Prof. Edwin E. Witte, former secretary of the Wisconsin Industrial Commission:

> Mr. Wilcox, long the chairman of the industrial commission * * * believed in a California type of schedule. He got the legislature to adopt such a schedule and for a short period in the twenties * * * we had that sort of schedule. It was objected to by labor and the employers alike on the ground that it was too complex for workers to understand. Wisconsin dropped this type of schedule for this reason. * * * This type of schedule has generally been approved by the experts but has never caught hold because injured workers have not liked it, except perhaps in California.[5]

Wisconsin's decision to adopt the flat-rate schedule was symbolic. Since then no other State has copied California. Although some administrators and experts still give lip service to the California principle, all other United State jurisdictions have adopted some form of the other type of schedule. This was particularly significant with regard to the two Federal laws, the Longshoremen's and Harbor Workers' Act, adopted in 1927, and the Federal Employees' Compensation Act, when amended in 1949. In both cases, nationally recognized experts and theoreticians of workmen's compensation were influential in framing the legislation. Indeed, each of these two statutes was claimed as a model for its day.

In the international field as well, where permanent disability rating has long been a major problem in social insurances, considerable attention was given to the California rating schedule and an extremely sympathetic evaluation of it appears in the International Labor Office's study. Despite the praise of the experts, however, its fate, internationally, was the same as in the United States. Only one country, Brazil, imitated it.

In California also, the schedule has been having rough sledding. Between 1914 and 1950 there was no major change in the schedule or procedures for its utilization. Inevitable obsolescence and mounting criticism from many sides—labor, carriers, employers, attorneys—led to a considerable revision in 1950. The revision, which resulted in liberalizing benefits by an average of 11.6 percent, mollified major sections of labor but intensified the opposition of carrier-employer groups. This opposition has been reflected in the studies and reports of the California Senate Interim Committee on Workmen's Compensation Benefits which has adopted a steadily more hostile attitude toward the California schedule and the rating specialists who administer it.[6]

The same trend is apparent in the development of the veterans' program as indicated by the abandonment, in 1933, of the brief experiment with occupational rating. Starting in 1864, Congress has provided a series of statutory awards alongside the benefits based on loss

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[4] IAIABC Proceedings, 1922 and 1923, U. S. Bureau of Labor Statistics, Bull. 333, pp. 70–148. Bull. 359, pp. 16–49.

[5] In a letter to Prof. Herman M. Somers, Haverford College, April 2, 1953.

[6] Partial Report, 1951; Report, 1953, Sacramento. After the latter report, the California Senate studies of workmen's compensation were transferred to a newly constituted Committee on Labor. In its 1955 report, there is no discussion of disability rating.

of earning capacity. Some of the statutory awards are *in addition to* the basic percentage awards, for example, $47 per month additional for loss, or loss of use of, one foot or one hand, an eye, or creative organ. Others are paid *in lieu of* the basic percentages, but since the statutory awards are significantly larger than the basic percentages, the *in lieu of* includes a substantial "extra" for the physiological loss. For example, the basic schedule awards for total disability, that is 100 percent loss of earning capacity, are $181 monthly. But certain cases of total blindness and deafness, or paraplegia, obtain a "statutory award" of $420 a month.

Increasing emphasis on physical loss in disability rating

Closer examination of the workmen's compensation rating procedures in effect in most of the States discloses that the victory of the flat-rate schedules has been less complete than is generally assumed, and that some of the distinguishing characteristics of the California-type schedule have found their way into the procedures of other jurisdictions The fact remains, however, that almost all United States legislatures have rejected the approach to permanent disability rating which aims at a measurement of the variable loss of wage-earning capacity in relation to occupation or other individual factors.

On the contrary, the victory of the flat-rate schedules, in spite of the exceptions which will be discussed later, represents essentially an acceptance of the idea that losses must be measured in very broad averages rather than refined to take account of differences in individual circumstances. In so doing, despite the fact that the rationalization in most laws remains average loss of earning capacity, legislatures have at least tacitly, and sometimes overtly, accepted the idea that the physical impairment itself is the best measure of disability and relative entitlement to compensation.

The extent of this trend may be judged by several quotations from one of the best-known authorities in the field of compensation law, Arthur Larson. In 1952 he wrote: "It is uniformly held * * * without regard to statutory variations in the phrasing of the test, that a finding of disability may stand even where there is evidence of actual postinjury earnings equalling or exceeding those received before the accident." [7] Also with the regard to scheduled benefits, "evidence that claimant has actually been engaged at greater earnings than before is completely immaterial." [8]

Even the definition of permanent total disability has been modified to the extent that sporadic earnings are no longer counted—

> if the claimant's physical condition is such as to disqualify him for regular employment in the labor market." [9]

This trend towards increasing reliance on physical impairment, per se, as the primary criterion for determining degree of disability and compensation is evident also in the veterans' program. This is manifest not only in the statutory awards, some of which cannot even be said to carry any presumptive relation to loss of earning capacity—e. g., $47 extra for loss of creative organ; $67 for arrested tuberculosis.

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[7] The Law of Workmen's Compensation, Matthew Bender, 1952, vol. II, p. 5.
[8] Ibid., p. 42.
[9] Ibid., pp. 1–2. Of special interest is the "odd-lot doctrine" referring to workers who, while not altogether incapacitated for work, are so handicapped that they will not be regularly employed in any well-known branch of the labor market.

It is also implicit in the decision to abandon efforts to calculate wage-loss by occupations in favor of a return to the original concept of "average impairments in earning capacity."

Inductive attempts to arrive at average impairments in earning capacity have not been made by the Veterans' Administration on a general basis. The staff of the President's Commission on Veterans' Pensions was unable to determine from discussions with Veterans' Administration officials that there was a clear understanding of what average impairment of earning capacity meant in the veterans' disability compensation program. In the absence of any studies by the Veterans' Administration to measure average impairment of earning capacity on the part of disabled veterans in our changing economy, the real rating criterion became degree of physical impairment.

The basic problem: balancing physical and economic factors

Workmen's compensation is a fascinating and unique double-hybrid, in law and in practice. It is a cross between common law and statutory law. At the same time it is a cross between publicly administered social insurance and privately administered casualty insurance. These competing forces place special strains on the program, producing constant conflicts and shifts in theory as well as in techniques. At the same time, the constant interaction and competition between these diverse forces have provided a valuable testing ground for the development of new administrative devices which may combine the best in both approaches, i.e. the maximum degree of individualized justice, as envisioned in the common law, with the maximum degree of broader social justice, which is the aim of social insurance. Stated with particular reference to disability rating—

> the proper balancing of the medical and wage-loss factors is * * * the essence of the disability problem in workmen's compensation.[10]

This is also the essence of the rating problem in the veterans' disability compensation program. In the effort to shed more light on this essential problem, the following aspects of disability rating experience under workmen's compensation will now be examined:

1. *Relative values.*—Is it practical and desirable to construct a rating schedule which will relate all or most permanent partial disabilities to each other and to permanent total? If so, what is the best way to construct such a comprehensive schedule?

2. *Measuring "loss of earning capacity."*—How feasible or desirable are attempts at refined evaluations which take account of varying occupations, age, and similar factors? To what extent is measurement of physical impairment practical? If physical impairment becomes the sole or major criterion, does this raise new technical problems of application?

3. *Disability rating and rehabilitation.*—How can a rating formula and rating procedures encourage, constructively and equitably, the physical and occupational rehabilitation of the disabled?

4. *Administration.*—What type of schedule is most practicable from the viewpoint of efficient administration and most likely to narrow the areas of conflict?

These questions will be dealt with in order in the parts which follow. In attempting to answer these questions more attention will be given

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[10] Ibid., p. 3.

to the California experience than its present solitary application might seem to warrant. However, it provides the most extensive experience in this country with disability rating on an occupational basis and there is no other place where one can now observe the operation of this type of schedule.

RATING SCHEDULES AND THE RELATION OF PERMANENT-PARTIAL TO PERMANENT-TOTAL DISABILITY

In any system where partial disability is compensated, one of the first questions that arises is the desirability and practicability of relating all partial ratings to permanent total and to each other. Such a relationship is generally assumed to be desirable as a means of ensuring consistency and equity. In practice, however, there are formidable difficulties involved. Even in theory there are some considerations which would suggest that a rigid adherence to such a relationship may have some undesirable consequences.

Among the practical problems to be solved are (1) formulation of a workable, as well as equitable, definition of permanent total disability, and (2) formulation of a workable, as well as equitable, method of determining the comparative values of various permanent partial disabilities to each other and to permanent total.

Definition of Total Disability

The definition of total disability has always been elusive. As already suggested, traditionally, in social insurance and workmen's compensation circles, it has referred to total loss of wage-earning capacity. But this merely poses the difficult problem of defining "total loss of wage-earning capacity." Is a miner, with both legs amputated and paraplegic but sufficiently rehabilitated to operate a small but profitable business of his own, permanently and total disabled, or not? While disabled for the occupation he held when injured he has made a successful adjustment. Or, what about a veteran with the same disability and a similar comeback?

By historical standards the answer would obviously be "no," and there are still some who feel that it violates the basic principle of disability insurance, whether workmen's compensation or veterans' benefits, to pay life-time benefits in such cases. But the apparent injustice of penalizing a man who has made such a heroic recovery, the needs of a dynamic economy for the productive power of every citizen, increasing regard for the physical loss itself, as well as administrative convenience, have led to pragmatic revisions of the definition of permanent-total disability, although it is not always acknowledged that the revision represents a change in basic theory.

Today, the majority of compensation laws contain a provision to the effect that certain serious disabilities, usually the loss, or loss of use, of both hands or both arms, or both feet, or both legs, or both eyes or the sight thereof, shall conclusively or prima facie, constitute total disability. California adds to this list: "practically total paralysis" and "incurable imbecility or insanity." In adding such a provision to the Federal Employees' Compensation Act in 1949, the House committee stated,

> This provision would make it unnecessary, ordinarily, to determine loss of wage-earning capacity in that class of cases which is recognized in other workmen's compensation laws as involving presumptive permanent total disability,

and would make it possible to eliminate consideration of meager or inconsequential earnings which do not, in themselves, reflect any substantial earning capacity in the individual.[11]

The report continues, "Only upon substantial rehabilitation of the employee or proof of substantial wage-earning capacity after injury, would a prima facie case of permanent total disability be overcome." It would be interesting to know how often the Employees' Compensation Bureau or appeals board have disallowed a permanent total case on this basis.

As an indication of the increasing standardization in this area the American Standards Association now includes in its definition of permanent total disability any injury—

which results in the loss of or the complete loss of use of any of the following in one accident: (a) both eyes, (b) one eye and one hand, or arm, or leg, or foot, and (c) any two of the following not on the same limb: hand, arm, foot or leg.[12]

Similarly, the veterans' program provides a statutory award of $279 a month, for example, to a man with both legs amputated but able to use prostheses successfully. This amount is $98 per month higher than the amount normally provided for 100-percent disability.

While this development of recognizing the compensability of the injury itself appears eminently just, administratively sensible, and, in law, may still preserve the the theory of presumptive loss of earning capacity, in actual practice it is perceptibly undermining the concept of "total impairment of wage-earning capacity" as an operating basis for defining permanent disability. Over the years, the concept had already run up against formidable practical and legal hurdles, involved in the necessity of defining "wage-earning capacity" with precision in individual cases.

As already indicated, in many jurisdictions, the definition of permanent total disability has been modified to exclude sporadic earnings and irregular employment. The unreliability of actual post-injury earnings as a measure of earning capacity is admitted in compensation law on the basis of a number of variables, including: an increase or decrease in general wage levels since the time of accident, claimant's greater maturity or training, longer hours worked after accident, additional wages based on employer's sympathy, temporary or unpredictable character of post-injury wages.[13]

The FECA took more pains to meet this dilemma than most laws. It states that an injured worker's "wage-earning capacity" shall be—

determined by his actual earnings if such actual earnings fairly and reasonably represent his wage-earning capacity. Provided, however, that if the employee has no actual earnings, or his actual earnings do not fairly and reasonably represent his wage-earning capacity, such wage-earning capacity as shall appear reasonable under the circumstances of the case shall be determined, having due regard to the nature of his injury, the degree of physical impairment, his usual employment, any other factors or circumstances in the case which may affect his capacity to earn wages in his disabled condition (sec. 13 (b)).

In interpreting this section, the Employees' Compensation Appeals Board has said:

The facts upon which loss of wage earning capacity can properly be determined necessarily include facts bearing upon the economic history of the claimant and his economic potential as a wage-earning individual.[14]

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[11] U. S. Congress, House, H. Rept. No. 729, 81st Cong., 1st sess., p. 6.
[12] American Standard Method of Recording and Measuring Work Injury Experience, New York, December 16, 1954, p. 6.
[13] Larson, op. cit., p. 6.
[14] Edstrom, Axel E., 1 ECAB 33, cited in U. S. Department of Labor, Employees' Compensation Appeals Board, Digest of Decisions, 1953, p. 48.

And again,

> Wages or actual earnings after injury should not be confused with wage-earning capacity, and while wages earned may reflect such ability of the individual to earn, they do not always reflect such ability.[15]

While the legal rationale of the statutory presumptions and the liberal trend in administrative and judicial interpretations preserves the concept of loss of wage-earning capacity as the basis of compensability, their real effect is to expand greatly the meaning of compensable total disability so as to include anatomical and other impairment not reflected in economic loss. The question then, inevitably, arises: if a man who is ambulatory and perhaps even employed is to receive the basic permanent-total benefit, irrespective of earnings, does the completely incapacitated, bed-ridden case need some additional compensation?

The veterans' program has clearly decided this question in the affirmative for some cases. There are now several specific situations where awards larger than the $181 per month basic 100 percent disability benefit may be paid, ranging from $279 for loss of both hands or feet to $420 for combined total deafness and blindness and certain other combinations of disabilities.

There is a similar, although less dramatic trend in the more liberal compensation jurisdictions, some of which pay additional benefits to certain permanent total cases where a "constant attendant" is required, or where there is paralysis from spinal injuries, or loss of mental faculties.

Methods of Determining Comparative Disability Values

In workmen's compensation law and usage, the term "schedule" is ambiguous. It has at least three separate meanings:

1. A statutory list of specified permanent-partial disabilities, to each of which is attached a statutory value and specific benefit, usually expressed in terms of number of weeks for which benefit is payable.[16] This is the familiar so-called flat-rate schedule which applies in every jurisdiction except California.

2. A statistical device or listing through which individual injuries are evaluated. The list may be based on a single rating factor, as in the case of the Veterans' Administration Schedule for Rating Disabilities, or it may include a number of variable factors which must be related, such as occupation and age in California.

3. A conceptual framework through which permanent partial disability ratings are related to each other and to permanent total, and through which disability ratings are converted into benefit rates. California provides the only example in workmen's compensation of a complete schedule of this sort although several other jurisdictions approach it in principle.

The veterans' compensation program has a version of each of these types of schedules. There is a list of statutory anatomical awards. The rating schedule is a perfect example of the second type. Third, there is a statutory compensation schedule translating degrees of permanent disability into benefits. For wartime service-connected disabilities this schedule is as follows:

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[15] Tietze, Elden, Doc. No. 90, cited in ibid., p. 49.

[16] Four jurisdictions define benefits in terms of total aggregate amounts: Alaska, Oregon, Washington, and Wyoming.

10 percent disability	$17	60 percent disability	$109
20 percent disability	33	70 percent disability	127
30 percent disability	50	80 percent disability	145
40 percent disability	66	90 percent disability	163
50 percent disability	91	100 percent disability	181

The first type of schedule shortcuts the problems involved in a rating procedure which calls for use of both 2 and 3. By using only one factor to rate individual injuries—usually the physical impairment alone, based on presumptive loss of earning capacity—and by expressing the relative value of each disability in terms of actual benefits instead of percentages of disability, the two steps have been combined. Therefore, analysis of this type of schedule in workmen's compensation must involve both steps: (1) comparison with the California statutory schedule of comparative benefit values, and (2) comparison with the California manual as a method of determining individual disability ratings.

Section 4658 of the California Labor Code reads:

> If the injury causes disability, the percentage of disability to total disability shall be determined and the disability payment computed and allowed according to the following schedule:

Percentage of permanent disability incurred	Number of weeks for which 65 percent of average weekly earnings allowed	Percentage of average weekly earnings allowed for remainder of life after period for which 65 percent of average weekly earnings allowed
1	4	0
10	40	0
20	80	0
30	120	0
40	160	0
50	200	0
60	240	0
70	280	10
80	320	20
90	360	30
100	400	40

Unlike the Veterans' Administration schedule, it does not round off the ratings to the nearest 10 percent but retains the exact percentage and, in the lower degrees, even fractional percentages. For degrees between the 10-point intervals shown in the table above, the law assigns 4 weeks of benefits for each 1 percent, and thus 1 week for each one-fourth of a percent.

The 400 weeks assigned to 100 percent disability is not the full measure of the value of permanent total disability, since, as indicated in the third column, any disability rated 70 percent or higher carries a small lifetime pension: 1 percent of average weekly earnings for each 1 percent of disability over 60 percent (sec. 4569).

Through the use of such a complete theoretical framework and an unbroken continuum of values from permanent-total down to the lowest possible compensable degree, it was believed that every individual disability could be slotted into the overall spectrum of benefit values with equity to each individual. It was also felt that arbitrary results which usually flow from the use of discontinuous ratings could be avoided and that the proper relation between various degrees of disability could be better maintained.

The nearest approach in other jurisdictions to this ambitious scheme is the provision contained in a handful of laws for rating nonscheduled permanent partial cases in terms of values, usually weeks, related to an arbitrarily assigned value for permanent total.[17] Thus, Wisconsin sets up a yardstick of 1,000 weeks (with 2½ percent reduction per year after age 50), Arkansas 450 weeks, Florida 350 weeks. Ohio specifies an aggregate maximum of $8,050 (which, at the present weekly maximum, equals about 250 weeks). The benefit value of any particular nonscheduled permanent-partial disability must bear the same relation to the value of permanent-total disability as the percentage of disability bears to total disability. For example, in Wisconsin a worker under 50 with a permanent-partial back injury (nonscheduled) rated at 50 percent would receive his benefits for 500 weeks. Ohio has been under attack for its results in this area, the so-called "80–B" cases. However, it is difficult to be sure in this case whether the problems have been due to the method of disability evaluation, which has some unique characteristics, or to general administrative inefficiency.[18]

On the other hand, the flat-rate schedules in effect in all jurisdictions except California specify statutory and discontinuous values for the enumerated permanent-partial disabilities, generally including the following: loss of (by amputation or dismemberment), or loss of use of, an arm, hand, thumb, first, second, third, or fourth finger, leg, foot, great toe, other toes, one eye, hearing in one ear, hearing in both ears. When these schedules were originally adopted, there was obviously some effort to assign values to the enumerated disabilities with some relation to each other and to permanent-total disability. The inadequacy of experience, originally limited pretty much to the records of private accident insurance companies, and data upon which values could have been more scientifically based, the passage of time, and most important, the fact that these values have become subject to political bargaining in the legislatures, have all contributed to the arbitrary and inconsistent results. The well-publicized case of a maladjusted claimant with a mangled thumb could lead to legislative revision of the value of this particular disability without consideration of its relation to the value of other scheduled disabilities.

The great uncertainties regarding the values to be placed upon particular disabilities in this type of schedule show up most obviously through interstate comparisons of values attached to the same injury. For example, the maximum period of compensation for loss of a foot ranges from 100 weeks in New Mexico to 250 weeks in Wisconsin. For total loss of hearing it varies from 100 weeks in Maine to over 5 times as long in Oregon. A New Jersey hand is worth more than an entire arm in Alabama and a number of other States. For a comparison of relative values assigned to specific injuries in various States, see table 1.

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[17] This technique may have been influenced by the development, for industrial safety purposes, of standard time charges by the American Standards Association under sponsorship of the National Safety Council and the Association of Casualty and Surety Companies. The ASA has adopted a formula assigning to permanent total disability a charge of 6,000 days, approximately 857 weeks. This, then, becomes the yardstick against which all other permanent disabilities can be given a lesser proportionate weighting. See American Standard Method of Recording and Measuring Work Injury Experiences, p. 7.

[18] See: Ohio Legislative Service Commission, Workmen's Compensation in Ohio, April 1955, pt. II. The Ohio law has been substantially amended since this report.

TABLE 1.—*Computed percentages of disability for specified injuries based on flat-rate schedules of compensation for permanent total disability under the laws of various States, 1941*

State	Loss of—													
	Arm at shoulder	Hand	Thumb	Index finger	Middle finger	Ring finger	Little finger	Leg at hip	Foot	Great toe	Other toes	Sight of 1 eye	Hearing, 1 ear	Hearing, both ears
Alabama	36	27	11	8	5	4	3	32	23	5	3	18	----------	27
Arkansas	44	33	13	8	7	4	3	39	28	7	2	22	9	33
Connecticut	43	34	12	7	6	5	4	40	30	7	2	40	10	30
Delaware	41	33	13	7	6	4	3	41	28	6	2	24	----------	----------
Florida	57	43	17	10	9	8	4	50	36	9	3	29	11	43
Georgia	57	43	17	10	9	8	4	50	36	9	3	29	11	43
Hawaii	100	78	19	15	10	8	5	92	66	12	5	41	19	100
Indiana	50	40	12	8	7	6	4	40	30	12	2–6	30	----------	40
Iowa	56	38	10	8	6	5	4	50	31	6	4	25	13	38
Kansas	50	36	14	9	7	5	4	48	30	7	2	26	6	24
Kentucky	48	36	14	11	7	5	4	48	30	7	2	24	----------	----------
Louisiana	50	38	13	8	5	5	5	44	31	5	3	25	----------	----------
Maine	30	25	10	6	5	4	3	30	25	5	2	20	----------	----------
Michigan	40	30	12	7	6	4	3	35	35	6	2	20	----------	----------
Montana	40	30	12	6	6	4	2.4	40	25	6	2.4	24	4	24
New Hampshire	57	47	13	8	7	5	3	57	40	7	3	33	14	57
New Jersey	58	44	16	10	8	5	4	44	31	8	3	25	10	40
New Mexico	33	20	9	5	4	3	2	33	18	4	2	20	6	25
North Carolina	50	38	15	9	8	5	4	44	31	8	3	25	18	38
Oklahoma	50	40	12	7	6	4	3	35	30	6	2	20	----------	----------
Pennsylvania	43	35	12	7	6	4	3	43	30	----------	----------	25	----------	30
Puerto Rico	88	59	15	10	7	7	4	74	47	7	4	37	7	59
Rhode Island	10	8	5	4	3	2	2	10	8	3	1	8	----------	----------
South Carolina	40	30	12	7	6	4	3	35	25	6	2	20	14	30
Tennessee	36	27	11	6	5	4	3	32	23	5	2	18	----------	27
Texas	50	37	15	11	7	5	4	50	31	7	2	25	----------	37
Vermont	65	54	15	10	8	6	4	65	46	8	3	38	16	65
Virginia	40	30	12	7	6	4	3	35	25	6	2	20	10	----------

Source: Henry H. Kessler, M. D., Ph. D. Accidental Injuries, Lea & Febiger, 2d ed., 1941, p. 48. There have been some changes since this time but it is doubtful if there is now much more consistency.

A second shortcoming is the tendency, already noted, for these schedules to become "skewed" in favor of the less seriously injured. A careful study in Minnesota of 50 representative severe permanent partial and 18 permanent total disability cases indicated an inverse relationship between benefit payments and earning loss. "In other words, persons whose disability resulted in the greatest earnings loss received smaller benefits than those who were not so severely affected by their disability." [19]

Another criticism sometimes expressed, is the incompleteness of this type of schedule. Many permanent-partial cases do not fall into the type of categories established for the flat-rate schedules. These unscheduled cases must still be evaluated individually, first medically and then in relation to individual earning capacity. As already indicated, the methods generally employed call for administrative determinations without the assistance or discipline of a governing manual and the result is generally a matter of adversary proceedings or unsystemized guesswork. The indefiniteness of this area has made it a breeding place for litigation and accompanying medical chicanery. But this is not properly a criticism of the flat-rate schedule, but the opposite. What it means, in effect, is that they should be used more extensively than they are.

Whatever their shortcomings, the flat-rate schedules clearly have the great advantages of relative simplicity, definiteness, intelligibility, and general acceptability by the parties affected. Whatever their weaknesses, not a single State has ever made a general change from this type of schedule to the California type.

At the same time, however, the persistent effort of administrators in the "flat-rate" States to refine and improve their schedules has led to the introduction of characteristics associated with the other type of schedule. When the statutory benefit schedules were first introduced they were generally worded in the simplest fashion. Thus, the loss of a finger paid so many weeks; of an arm, so many weeks, etc. Today however, many of the schedules have grown in complexity and length to the point where the finger is often broken down into four subschedules, depending on which joint provides the boundary of the injury.

Equally important, the schedules now generally indemnify not only for "loss"; i. e., amputation or dismemberment, but for "loss of use of"; i. e., loss of function. The evaluation of loss of function inevitably calls for a yardstick and implies a continuum of disability, as applied to the particular member. To meet this situation, Wisconsin law, for example, now provides that for partial loss or impairment of a member, "compensation shall bear such relation to that named in this schedule as disabilities bear to the disabilities named in this schedule." Thus, for example, since amputation of an arm at shoulder pays 500 weeks, one-half loss of arm function would pay 250 weeks. To facilitate the evaluation of these "relative" injuries, the Wisconsin commission has adopted an additional administrative schedule of

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[19] Cheit, Earl P., The Effects of Selected Minnesota Workmen's Compensation Benefits, made for Minnesota Interim Committee on Workmen's Compensation, 1952, manuscripts on file in Minnesota State Law Library. Maximum weekly aggregate limits and other elements in the benefit formulas probably contribute even more to this distortion. As one result of this study, the Minnesota law was amended to provide life pensions for permanent total cases.

relative values. Of approximately 3,000 permanent disabilities compensated in 1953, over 2,000 were rated by the administrative schedule, over 600 by the statutory schedule, while only about 350 involved nonscheduled injuries to the head, trunk, and body.[20] The significance of the administrative schedule in filling the vacuum of nonscheduled or "judgment" ratings appears to be considerable.

Wisconsin has also tried to counteract the tendency to weight the schedules in favor of the less seriously injured by an interesting device for rating combined or multiple injuries. It provides that the period for which benefits are payable shall be increased anywhere from 20 percent to 200 percent, depending on what combination of injuries is involved (sec. 102.53).

Finally, there is a perceptible trend toward including in the flat-rate schedules more and more of the conventionally nonscheduled types of disability. Illinois now schedules "skull fracture" and "fracture or fractures of the body or bodies of one or more vertebrae except surgical fractures and fractures of coccyx" (1955 amendments). With regard to injuries of the back, Minnesota calls for an evaluation based on the relation of the disability to an arbitrary total of 330 weeks (sec. 176.101, subd. 3 (39)). Dr. Henry H. Kessler, one of the foremost United States authorities on this subject, who has coupled his vigorous criticism of the flat-rate schedules with the conclusion that they are better than the California alternative,[21] has called for continuation of this trend toward scheduling more and more of the formerly nonscheduled type of injuries, including injuries to the back, chest, thoracic organs, abdomen, and abdominal organs. Commissioner Reid of South Carolina, president-elect of IAIABC, recommends that all permanent partial injuries be scheduled.[22]

It is extremely difficult, even in theory, to make a clear and sharp distinction between the aspect of the rating schedule we have been discussing—the establishment of relative values for different permanent disabilities—and the aspect which will be discussed next: the method of rating individual injuries. However, it does appear that in this first respect the significance of the distinction between California and other jurisdictions is declining as the length, degree of refinement, comprehensiveness, and precision in the flat-rate schedules increases.

The veterans' program, by superimposing special anatomical awards upon the basic rating schedule, has avoided the workmen's compensation tendency to slight the seriously injured relative to the payments made to minor cases. However, this has been achieved at what may have been the avoidable price of depreciating the integrity of the basic schedule and threatening its survival as an equitable measuring device. It is worth considering whether the 2 sets of ratings could not be integrated into 1 continuum. To accomplish this, it might be necessary to acknowledge candidly that the Congress considers some disabilities to exceed 100 percent, because it does place a special importance upon the physical loss per se.

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[20] Letter from Harry A. Nelson, Wisconsin, Director of Workmen's Compensation, August 24, 1955.

[21] Accidental Injuries, Lea & Febiger, Philadelphia 1941, pp. 49–51; Partial Report, 1951, p. 94.

[22] Letter from Commissioner Reid, July 1955.

THE USE OF MULTIPLE FACTORS IN PERMANENT DISABILITY RATING

The California rating schedule, as already indicated, is the only official example in the United States today of multiple-factor disability rating.[23] It takes into consideration the degree of physical impairment, the occupation of the injured, his age, and his "ability to compete in an open labor market." The resulting manual [24] consists of: (1) A list of about 300 permanent injuries to which all other injuries may presumably be systematically related; (2) a list of about 1,300 more frequently found occupations; (3) tables which correlate injury with occupation and, by similarities of injuries and differences in occupational skills and physical requirements, establish a number of occupational groups, now 60; (4) a series of rating tables to correlate the relative severity of an injury with the age of the employee at the time of injury. An unskilled workman, or common laborer aged 39, is taken as the basis for a standard worker. A rating is scaled upward for an employee who is over 39, downward if under 39; and (5) rules for use of the manual so as to arrive at a final rating in terms of a percentage of total disability.

It is reported that the approximately 300 injuries listed, together with the 1,300 occupations and the factors given for variation in occupation and age, allow for approximately 12,700,000 separate combinations or ratings. This omits the vast number of disabilities impossible to describe or anticipate in any schedule.

The authors of the California manual were not seeking after complexity. The complexity seemed inevitable if the elusive concept of "loss of wage-earning capacity" was to be dealt with equitably and scientifically. It seemed clear that persons suffering identical injuries did not necessarily suffer the same degree of disability. An injury which may handicap one type of worker for life may prove no vocational handicap whatever to another. The bookkeeper who loses a leg can return to his former work in a short time, while the structural iron worker with a similar injury is forever barred from his former occupation.[25]

The attraction of this approach to disability rating, on grounds of logic and equity, is great. Whether the logic and equity hold up in practice is another question. Dr. Kessler has attacked the California schedule for an incomplete and overly standardized list of physical impairments, among other weaknesses.[26] But most of the criticism has been directed at its handling of the nonmedical factors. Here is an example of how they affect a rating:

A 69-year-old structural iron worker, who loses a major arm at the shoulder would receive a rating of 90 percent disability which

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[23] An elaborate and interesting schedule, which has many of the characteristics of the California plan, has been devised and published by Dr. Earl McBride, of Oklahoma City. See his Disability Evaluation, Lippincott, 5th edition, 1953.

[24] The following description is based primarily on the California Senate Committee's Partial Report, 1951, passim; also Edison Bowers, Is It Safe to Work? Houghton Mifflin, 1930, pp. 51–60.

[25] The 1952 Minnesota study, already cited, presents persuasive evidence of the hardships which frequently result to severe permanent partial cases under current rating and benefit formulas, and lists six variables which clearly affected the earnings recovery of the cases studied: Age, skill, nature of injury, level of employment, hiring practices, and rehabilitation. The report stops short, however, of recommending a specific change in the rating schedule, but urges "further study * * * of all severe permanent partial cases in Minnesota which might include a factorial analysis of the effects of major variables that affect earning capacity and provide empirically determined, rigorous classifications of levels of earning capacity." Cheit, op. cit., p. 2, p. 94.

[26] Accidental Injuries, p. 52.

would entitle him to 360 weeks at his regular benefit rate plus a lifetime pension of 30 percent of his average weekly earnings. The identical injury to a 19-year-old brewer or flour miller would entitle him to a 63 percent evaluation and regular benefits for 252 weeks with no subsequent pension.[27] By contrast, any worker under the Federal Employees' Compensation Act or the New York Law, with this type of injury, is entitled by statute to 312 weeks at regular rates. One worker's gain is another's loss. Which schedule is generally fairer? To help answer this difficult question, let us look more closely at the three nonphysical factors and the rationale, both original and current, for utilizing them.

The factor of occupation

Clearly, occupations vary tremendously in their physical requirements. One job may require a great deal of physical use of a particular part of the body or of some particular function; another may require no physical use of this part of the body of function. There are all grades and degrees of physical requirements depending on the demands which different jobs make on the various parts of the worker's body.

While there is general agreement on this point, there is no agreement on the next step: that occupation should have a significant bearing upon the degree of compensable disability. Can it be measured? Is it worth trying to measure in view of the inevitable complexities?

In addition to the California officials, leading disability experts including Dr. Earl D. McBride, Dr. Roscoe N. Gray, and Prof. Edison L. Bowers,[28] have advocated some form of occupational factor. The disability laws of a number of foreign countries provide that occupation may or must be taken into account in evaluating loss of earning capacity.

In the IAIABC debates over a standard rating scale, the occupation factor was the major bone of contention. It refused to endorse the California use of the factor on the grounds both of over-complexity and frequent inequity. In the end it adopted a compromise, endorsing increases, limited to 25 percent, for occupations when the disability is of a character which peculiarly unfits the employee for the job on which he was injured or any other job in which he has experience. An effort to include a similar reduction up to 25 percent, when the employee was able to return to work at a lesser reduction in earning power than anticipated in the regular schedule, was defeated.

In contrast with the conflict in expert opinion, the "consumer," labor, has been almost solidly and consistently alined in opposition, alleging that for every equity corrected by the use of the occupational factor, two have been created. It is not easy to persuade one human being that his leg or index finger is worth less than some other man's, simply because he is a manual worker and the other man a toolmaker, or for any man in this day and age to believe that his limbs should be considered solely as a tool or an element of production rather than

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[27] Ratings according to 1950 revised schedule, Partial Report, 1951, p. 349.

[28] Is It Safe to Work? pp. 106–110, 174–179. Bowers recommended a very simple application of the occupation factor. Having concluded from a study of Ohio injury cases that the skilled worker, because of his greater powers of adaptability, suffers less loss of earning capacity than does an unskilled worker, he recommended that all jobs be grouped into 3 classes: A—skilled, B—semiskilled, and C—unskilled. Class A workers would receive a lower disability rating for the same injury than Class B, and Class C would receive a higher rating than B.

as part of his individual personality and integrity. Public law and public administration cannot disregard important social attitudes in favor of abstract principle, even if there were some way of objectively determining whether the principle is "right," which there is not.

As has already been pointed out, more and more the laws appear to reflect a general conviction that a man is entitled to compensation for loss of a physical member or other severe injury, entirely aside from the effect on earning powers. The rapid spread of special benefits for disfigurement in workmen's compensation law is another dramatic example of this trend. In 1952 disfigurement benefits were provided in 31 States. Although the relationship of disfigurement to work opportunity has been the common rationalization, it is clear that this is a concept which goes far beyond the original "loss of earning capacity" concept of the founders of workmen's compensation. Indeed in at least one State, South Carolina, where the workmen's compensation law is comparatively recent (1935) the law explicitly states that—

> in cases of bodily disfigurement it shall not be necessary for the employee to prove that disfigurement handicaps him in retaining or procuring employment, or that it interferes with his earning capacty (7035–34).

And, as already indicated, in scheduled awards in all jurisdictions, the benefits run their full course irrespective of earning capacity or actual earnings.[29]

This is part of the general 20th-Century American trend toward greater recognition of individual dignity, to which so many factors have contributed—our religious and common law heritages, the state of the labor market, the organization of labor and its political power, the continued trend toward technological improvement with its emphasis on brainpower rather than brawn, the ideological fight against totalitarianism, and the growing imbalance between the United States population and that of the rest of the world.

More immediately, criticism of the occupation factor has been based on a growing realization of the difficulty of keeping such a list of occupations and the definition of their physical requirements abreast of changing technological conditions. Not only has the number of occupations grown to formidable proportions (The Federal Dictionary of Occupational Titles, 1949 edition, listed 22,028 defined jobs which are known by an additional 17,995 titles, making a total of 40,023 defined titles), but the physical requirements of many of these jobs vary so greatly from company to company that attempts to generalize have been seriously criticized.[30]

When the revision of the California schedule was first undertaken it was contemplated that a complete field study of all jobs and their physical requirements would be made. But the magnitude of the job led to its abandonment. Eventually the occupational analysis

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[29] For an indication of the trend and one of the reasons: Up to 1949, under FECA, a man losing an eye might receive no compensation if it did not result in loss of earnings. Now he's assured at least 160 weeks' full compensation for the loss of the eye, irrespective of whether he returns to full-time work the day after the injury. Without doubt Congress was influenced by the fact that the ordinary sense of social decency is violated by the idea that a man's loss of an eye can be disregarded simply because it had no clear immediate economic effect.

[30] Mr. Bert Hannan, a consultant to the California commission in the field of physical requirements, gave the following example of the difficulty of generalizing in this area: Taking the specific case of an arc welder in a shipyard, he pointed out that in one shop a man could hold this job even though he had only one arm, impaired vision, leg, back and shoulder disabilities, deaf mutism, a nervous condition, a lung history, and heart condition. In another shipyard any of the disabilities, excepting the impaired vision, would disqualify him from the job (report, 1953, p. 18).

which formed the basis of the revised schedule was conducted simply from a study of the Federal Dictionary of Occupational Titles. Whether the results were more or less accurate and equitable than they would have been if based on detailed field study is not known, but certain it is that doubt has been cast on the ability of anyone to measure accurately the effect of occupation on disability.

Finally, the trend against use of occupation as a factor has been reinforced by the development of rehabilitation and better understanding of psychological and financial incentives to rehabilitation.

The Veterans' Administration experience with occupational rating began in 1925. At that time only the State of California had an occupational rating schedule which, it was understood, was based on experience of several hundred cases, prior to 1917, and not subsequently followed up. There was not then any statistical data as to reductions in earning capacity in the different occupations on which to base the type of rating schedule required. Furthermore, many of the younger veterans had gone into service without an occupation. The problems were such that by 1933 this type of schedule was almost completely discarded.

The 1925 schedule rather than the 1945 schedule, however, is still used for a certain number of veterans of World War I (now numbering over 120,000). Their disabilities are evaluated from the standpoint of average impairments of earning capacity resulting from such injuries in civilian occupations similar to the occupation of the veteran at the time of his enlistment. (See VA Instruction 1a, dated Nov. 21, 1946.) In these cases, impairment in ability to secure specific employment is considered in the rating process. (The 1925 schedule still applies to these veterans, who are in a kind of "protected" category, but to no one else.)

Age As a Factor

The assumptions upon which California adjusts disability rating on the basis of age have been summarized as follows:[31]

1. The older worker has on the average less physical adaptability than the younger.
2. The employment opportunities of older workers are usually less than those of younger.
3. Among handicapped workers of the type served by the State Bureau of Vocational Rehabilitation, the average age of the "satisfactory" occupational adjustments is lower than for "unsatisfactory."
4. The percentage of male handicapped workers employed as compared with the percentage of remaining population employed becomes more unfavorable as age increases.

Bowers felt there was an even stronger case for increasing benefits with advancing age than for the occupational variable. So did the IAIABC, which definitely recommended an age differential. McBride has endorsed its use. It is considered in disability rating in several foreign countries, and five compensation jurisdictions in the United States still provide for its discretionary use in nonscheduled cases. But labor has opposed it just as adamantly as the occupational factor, and for the same general reasons.

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[31] R. E. Haggard, in Partial Report, 1951, p. 107.

With the great change in the economic and social environment, even the theory behind the age differential is now generally questioned. The fact that Wisconsin reduces compensation for those over 50 and FECA permits a reduction in benefits after the injured has reached 70 in accordance with his "probable decreased wage-earning capacity" (Sec. 6 (d) (1)), indicates that there are two completely contradictory theories concerning the effect of age: the second predicated on a decrease in number of dependents and financial responsibility as well as the availability of OASI and other financial aids to the aged, and a number of other relevant considerations.[32]

In line with the second approach to the age factor, Commissioner Reid of South Carolina has recommended that a norm for permanent-partial disability payments be set for a person somewhere between 35 and 40 with reductions on a mathematical scale beyond the division and with additions on a geometrical scale before.[33] Of the laws examined, only FECA attempts anything like this, and then without any formula and at the discretion of the administrator.

It would seem unlikely that any new attempt at mathematical variance of the evaluation with age will be attempted. What is more likely is an increasing effort to mesh compensation and OASI or other old age or disability payments after age 65 or perhaps 50 in the case of permanent total disability. Minnesota has already introduced such a provision. But this would be accomplished entirely outside the area of disability evaluation.

"*Ability to compete in an open labor market*"

This final factor specified in the California law to be used in determining percentage of disability is the most subjective and therefore least satisfactory of all. According to the Senate Committee's history of the schedule, it was not added to the legislative language on the rating formula until 1917, 3 years after the original schedule had been devised.[34] The history continues:

> As thus amended, the formula imposed the obligation to make * * * due allowance for such disabling subjective factors as, for example, pain, discomfort, and psychic or mental disturbance, provided, of course, the subjective factor or factors be considered of a permanent nature.

Since it was then determined that the new factors did not lend themselves to objective measurement or scheduling, they were not utilized, and the 1914 schedule was continued in effect, with a few minor amendments, until 1950. However, it appears that these factors were introduced into the 1950 revision of the schedule, to the advantage of the injured and over the strong protest of employers and carriers. Much of the subsequent criticism from these sources cited in the Senate reports is directed to this point.[35]

The introduction of such factors, especially in view of the clear legislative encouragement, is surprising only for its belated occurrence. When Mr. Haggard testified with regard to the new schedule that—

> The evaluation of disability is limited not only to the effects on working capacity, but some consideration must also be given to the personal loss.[36]

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[32] For example, the younger worker will have to bear the burden of his disability for a longer time; older workers may have a better chance with their preaccident jobs and employers, and so forth.

[33] Letter from Commissioner Reid, July 1955.

[34] Partial Report, 1951, p. 58.

[35] For example, William Leslie, Letter, in Partial Report, 1951, pp. 97–98.

[36] In ibid., p. 68.

he was merely saying what virtually every court in the country is now saying or implying with regard to personal injuries of all types, including occupational injuries. The recognition of personal factors in the computation of compensation for job injuries is simply part of the trend already discussed toward greater emphasis on individual personality and personal loss, as opposed to purely vocational loss, and derives from the same forces, especially the influence of tort recoveries and their frequent large allowances for intangibles such as "pain and suffering," "mortification," etc. The great and growing emphasis on "disfigurement" has already been mentioned.

However, a factor such as psychological injury is extremely difficult to subject to objective measurement in individual cases in a mass program and is especially susceptible to abuse.[37] This is not sufficient reason to disregard it completely if otherwise considered equitable and proper. It may be administratively feasible to take into account the average influence of such a factor within the rating schedule for the various categories of disability. An estimate of the average psychic damage and mortification involved in the loss of a leg, to be applied to all cases of loss of a leg, may be arbitrary, but it is probably less arbitrary than disregarding the fact entirely and certainly more administrable and immune to abuse than an attempt to make and support different appraisals for each case.

Very probably some such considerations were involved in Congress' decision to raise the Veterans' Administration statutory awards for serious permanent total cases and selected permanent partial cases far above the percentage rate based solely on loss of earning capacity.

Correlation of Multiple Factors—Theory of the "Standard Man"

Use of multiple and variable factors in a rating schedule necessitates dealing with extremely complex problems of correlation. In California, the first step was postulation of a "standard man," on the basis of which all deviations could be measured.[38] Because the average age of California workers was 39, at the time the schedule was adopted, the standard man was given an age of 39. His occupation was ordinary unskilled labor, in which he was required to use all parts of his body, but the job required no particular training or skill in any one body member or limb.

The next step was to determine the degree of disability affecting this standard man if he sustained a given injury. Because loss of the major arm at the shoulder joint was at the time generally considered to be the most serious scheduled disability in other States, a start was made here. The extent of disability to the hypothetical man resulting from such an injury was set at 60 percent, by the process of striking an

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[37] The case against use of "subjective" factors was strongly put by one of the California referees. "It has been my experience that the subjective complaint ratings are not fair. They are getting to be a racket as certain classes of individuals are tipped off that certain types of injuries rate higher for subjective complaints and even though they may have very few complaints, when they come up for rating, they complain of severe pains, severe headaches, and severe everything in order to get a big rating. On the other hand, the honest individual that comes up for rating and honestly testifies that he has only slight pain gets a very small rating for the same injury" (Roy Weisensel, cited in report, 1953, p. 48). Referee Douglass A. Campbell was even more emphatic, stating that the new weight on "subjective complaints" has "coverted the California program into a modified damage suit litigation. It invites perjury and rewards it. The whiner is glorified." (Letter from Mr. Campbell, September 7, 1955.)

[38] This description is based primarily on Bowers, Is It Safe To Work? p. 53 ff.; Partial Report, 1951, p. 69 ff.; Report, 1953, p. 20.

average among the ratings then in use for this injury in foreign countries, other American jurisdictions, and those derived from the experience of medical experts and insurance companies. Comparative values were then assigned to all other listed injuries.

Next it was necessary to decide what deviations were to be made from the standard man's rating for real men on the basis of their specific age and occupation. With regard to age it was assumed that a boy of 15 would have complete adaptability, a man of 75 none. It was further assumed that a 10 percent disability at age 15 would correspond to a disability of 17.5 percent at 75. By linear interpolation the values for intermediate ages were determined. Thus, a common laborer who lost a major arm at shoulder would receive the following ratings at the designated age:

Age	Percent of total disability	Age	Percent of total disability
19	54.3	49	62.2
25	56.1	59	65.1
29	57.2	69	67.3
39	60.0	79	69.1

The effect of age on disability originally varied according to occupation, with a greater range, both up and down, for the more skilled occupations. A disability of a given magnitude varied by occupation within a range of 22 percent.

An illustration of how the multiple correlation process is applied in a specific case is given by Dr. Earl D. McBride in describing the evaluation of a permanent disability involving partial limitation of motion of the index finger in the case of a construction carpenter, aged 35.

> The standard rating for complete immobility of the index finger on the major hand is 6 percent of the body. Complete immobility of the fingers is defined as failure of the tip of the finger to touch the midpalm on active flexion by 3 inches or more. For the index finger that fails to touch the midpalm by five-eighths to three-fourths inch, the rating would be adjusted as follows:
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> The occupation is first considered. If the occupation is that of a construction carpenter, the standard rating is raised to 9 percent. If the age is 35, the standard rating is lowered to 8.2 percent. Limited flexion of five-eighths to three-fourths inch of midpalm is given a rating of one-third the adjusted standard rating, which would be one-third of 8.2 percent, or 2.7 percent.[39]

Since the benefit schedule specifies 4 weeks of disability for each 1 percent of disability, this man's benefits would run for 10.8 weeks at the prescribed weekly amount.

When the schedule was revised in 1950, several changes were effected in assumptions regarding the standard man and the ranges of variation from standard. Age 39 was retained since statistics showed that this was the average age of permanently disabled workmen. However, it was decided that the common laborer was no longer a "standard man." Since, it was claimed, the laborer's stock in trade is his strength, he should be given a relatively higher rating for back and leg injuries. This left the schedule with a standard only for age. The evaluation of occupation is now done by comparing the physical

[39] Disability Evaluation in partial report, 1951, p. 377.

demands of each of the 60 occupational groups with the average physical demands for each part of the body.

The new schedule simplified somewhat the age variations by determining that the effect of age on degree of disability was the same regardless of occupation. The overall range was also narrowed to 21–64. With regard to occupations, the range of variation was changed from 22 percent for all occupations to a variable range, depending on the degree of disability. Narrower ranges were applied to the very serious and very minor disabilities.

Without attempting to judge the statistical or economic validity of these operations, their cumbrousness and complexity seem all too evident. The irony appears in the fact that the result of all these painstaking refinements, worked out carefully over many years to avoid the apparent arbitrariness of flat-level schedules, is that they have, probably inescapably, ended up being just as arbitrary, although in a different fashion.

Yet, this does not entirely vindicate the present flat schedules. A standard of judgment is required, even if only one factor is used. Commissioner Reid complains that in South Carolina, undoubtedly not much different from most States in this respect, disability rating is a matter of guesswork. Speaking of scheduled benefits, he says, "These payments are not founded upon any premise and are made without rhyme or reason * * *. We need some 'home plate' from which to start." [40]

After abandoning occupational variants, the Veterans' Administration reflected an attempt to develop a "home plate" in accordance with the legal requirement that it measure "average impairment in earning capacity." As already indicated, in regard to earning capacity, its "average man" has proved just as elusive as California's "standard man." Clearly the common laborer is not the prototype of the modern American technologically advanced labor force. But then, who is?

With changing economic conditions, physical or functional impairment has apparently become the primary criterion in Veterans' Administration practice for measuring degree of disability.[41] This does not necessarily mean that this is the best possible measure or that it can be easily applied. In fact, the clear adoption of such a criterion, while it would solve certain problems, would raise many other problems, especially the lack of standardization in medical evaluations.

Commenting on this, Dr. Henry Kessler said:

> In my view, the greatest inequity in workmen's compensation comes from the conflicting medical opinion. There are no standard criteria, rational methods of guides supported by organized medicine or by scientific professional groups, except in rare instances. Greater equity can only come when the area of difference in medical opinion is narrowed and reduced.[42]

Dr. Kessler's own work and writings in this field and that of a number of other distinguished physicians, including Drs. Howard Rusk, McBride, and Wexler, probably provide the most promising leadership toward the formulation of standards in this area. It is

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[40] Letter from Commissioner Reid, July 1955.

[41] This does not mean that compensation must be restricted to one standard of disability. The FECA, for example, includes a combination of scheduled flat-rate benefits based on physical impairment plus additional benefits for loss-of-earning capacity, after the expiration of the scheduled payments.

[42] Letter from Dr. Kessler, September 6, 1955.

significant that the IAIABC, which scheduled a session on permanent disability rating at its 1955 convention for the first time in many years, has turned the discussion over completely to a group of medical doctors who are specialists in various types of disability. How different this is from the discussions in the early days of the association when the emphasis was entirely on ways of measuring loss-of-earning capacity.

The establishment of standardized schedules of disability values by State medical societies would also prove useful. This has already been done in Idaho, with the result, according to Dr. Kessler, "that much litigation has been eliminated and greater consistency and equity has appeared in administrative determinations."

It may, in the long run, turn out that the measurement of physical loss will prove even more elusive than the attempt to measure earning capacity. Thus far, however, the evidence appears to point the other way. Nor is it necessarily true that a physiological basis for rating must necessarily be too restricted. Since it is a determination of capacity for normal living we are seeking, a rating board could define physical loss to include such considerations as the average loss of ability to earn and the average psychic injury which might be expected to flow from a particular type of injury.

DISABILITY RATING AND REHABILITATION

California was one of the first States to give thought to the potentialities and significance of vocational rehabilitation. In fact, it has been claimed that the underlying idea of the California variable factor schedule was "the rehabilitation theory."

While most workmen's compensation laws claimed as their basic purpose the restoration of a stated percentage of the injured worker's wage loss, California philosophy defined the purpose of cash compensation as provision of the amount necessary to enable an injured workman to adjust himself to his new condition.[43] Continuing with this line of thought, it was asserted that if an injured worker could not regain his previous earning capacity, he should be pensioned for life. If he could, he should be given financial assistance during the time required for rehabilitation. The life span for those with 70 percent or more disabilities reflects the assumption that those with disabilities of this degree of severity could not be expected to rehabilitate themselves completely. As to the length of time required for rehabilitation, an assumption was made that the average person would require about 4½ years to rehabilitate himself from a 60-percent disablement. The schedule was designed to provide him with benefits for approximately this length of time. Similarly, duration limits for other disabilities were presumably related to the anticipated time necessary for rehabilitation.

In addition to these assumptions, the California law gave some concrete evidence of recognizing the importance of rehabilitation to a compensation program. Furthermore, medical benefits are unlimited, an essential attribute of a decent system. Furthermore, rights to these benefits have consistently been construed to include physical rehabilitation when required.

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[43] Bowers, Is It Safe To Work? p. 52.

However, the establishment of benefit durations adequate to allow time for rehabilitation, and the willingness to pay all necessary medical bills, do not in themselves assure that rehabilitation will in fact be attained or even undertaken. A recent study [44] made under the auspices of the University of California (Los Angeles) Institute of Industrial Relations indicates that the actual results in rehabilitation of the industrially injured in California have failed to meet the aims of those who advanced "the rehabilitation theory."

Unlike a number of other State compensation commissions, which have set up or sponsored rehabilitation centers of their own, the California commission must rely entirely on the State-Federal vocational rehabilitation program or voluntary agencies for rehabilitation services to injured workers. And yet the State bureau of vocational rehabilitation reports that in 1953, a year in which there occurred 142,715 disabling work injuries, it rehabilitated only 124 industrially injured workers.[45] The number cared for in the State's three general rehabilitation centers and in rehabilitation facilities of general hospitals was negligible. Only 1 or 2 of the largest compensation insurance carriers are equipped to provide, or even evaluate, the need for rehabilitation. In response to inquiries as to their rehabilitation activities, the claims manager of 1 of the 5 largest carriers in California wrote that "The carrier has not considered rehabilitation itself a responsibility." [46] As of December 1955, 23 compensation acts in the United States contained some sort of special provision for rehabilitation benefits, but California was not among them.[47]

With the advantage of hindsight, it now appears possible to identify a number of reasons for California's failure to live up to its promise in rehabilitation. Among these are: (1) Lack of adequate facilities for the physical or medical aspects of rehabilitation; (2) failure to provide the administrative authority to carry out an effective rehabilitation program, including authority to evaluate cases for rehabilitation purposes, authority to direct a worker to undertake rehabilitation, to pay him adequate living and travel expenses during his rehabilitation, and to penalize him if he refuses to attempt rehabilitation; and (3) the operation of the multiple-factor disability rating system.

Virtually all other United States compensation jurisdictions are also deficient in regard to points (1) and (2) above. But California appears to stand alone in the extent of its built-in conflict between the goal of rehabilitation and its technique of setting cash values on disability.[48]

Consider, for example, the case of John Doe, a city fireman, 49 years old, earning $75 a week, who loses his right hand at the wrist. His disability, age, and occupation entitle him to a rating of 72 percent. The benefit this carries is modest but certain: $30 a week for 284 weeks (about 5½ years); thereafter $9 a week for life. But assuming he makes a valiant effort to rehabilitate himself, succeeds in learning to

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[44] Lee Bamberger, Rehabilitation and Workmen's Compensation in California, UCLA, Institute of Industrial Relations, 1955, MSS.

[45] Ibid., p. 7.

[46] Ibid., p. 17.

[47] U. S. Bureau of Labor Standards, Bulletin 161, p. 42. See, also, Chamber of Commerce of United States, Analysis of Workmen's Compensation Laws, January 1956, pp. 45–46.

[48] For a general discussion of the conflicts between workmen's compensation and rehabilitation, see H. M. Somers and A. R. Somers, Workmen's Compensation, John Wiley & Sons, Inc., 1954, pp. 254–263.

handle his old or at least as good a job with a prosthetic hook in place of the lost hand, the law requires that the commission, in evaluating his permanent disability, take into consideration the "ability of such injured employee to compete in the open labor market." With a rating so near the magic dividing line of 70, which spells the difference between a lifetime pension or the lack of one, is he not running the risk, by rehabilitating himself, of losing those 2 precious points, or, if the commission does not so penalize him, is it not disregarding the clear intent of the law?

The writers are not familiar enough with current interpretations of the California law to know which interpretation is likely to take place. But there can be no doubt that the cited phrase, if taken seriously, can exercise a serious hindrance on the incentive to seek rehabilitation. This is the clearest type of case where a benefit technique unintentionally acts as an impediment to rehabilitation, which should be the primary goal of a modern compensation system.

Other types of interference with rehabilitation can be readily envisioned. In the absence of any provision for maintenance and other special costs during rehabilitation, the age variable in California may actually hamper the rehabilitation prospects of those whom it regards as most rehabilitable, the relatively young. For example, Jim is a young truckdriver, age 29, with 4 young children. He handles extra-heavy tonnage at a rate of $3 an hour. Joe, his neighbor, is also a trucker, but being much older, age 59, handles only light trucks at $1.75 an hour. His children are now all grown and no longer dependent.

Both men are involved in similar accidents resulting in the loss of the right hand for both. Because of the operation of the age factor, Jim's disability is rated at 63 percent, but Joe's at 73 percent. This means Jim is entitled to 252 weeks of regular benefits, but Joe 292 weeks of regular benefits and thereafter a life pension. The discrepancy in benefits is magnified by the $30 weekly benefit maximum in California. This for the younger man represents about 25 percent of his former weekly earnings; for the older man it is almost 43 percent.

The first form of discrimination is justified on the theory that Jim is more rehabilitable. He is. But this is only a prospect, not a reality. Nothing is done to convert the prospect into meaningful reality. To be rehabilitated, Jim would have to go away from the small town where he lives to undergo new surgery, because his stump has not healed suitably for use of a hook. If and when the surgery were successful, he could be referred to the State bureau of vocational rehabilitation for the vocational aspects of his rehabilitation. However, there would be nobody, anywhere, to supervise the entire process or take any responsibility for the outcome. The insurance carrier could probably be persuaded, reluctantly, to pay the actual medical costs. But who would pay Jim's maintenance during the rehabilitation period? Certainly $30 could not cover his living expenses away from home and support his family, too.

The project may appear impossible. If possible at all, it would call for immense family sacrifices, borrowing, and other devices. But since the project has an inevitable element of uncertainty, Jim is faced with another fact which makes the gamble less attractive.

When the whole process is over, he faces the probability of a lowering of his disability rating in proportion to his success in improving his ability "to compete in an open labor market." The system appears designed to inspire discouragement. Jim is likely to end up embittered at the sharply discriminatory treatment he has received as compared to neighbor Joe, because of theoretical rehabilitation potentialities which were given no opportunity to materialize. [49]

By contrast, observe the Wisconsin law in an identical situation. Jim would be entitled to regular benefits for 400 weeks, irrespective of age considerations. If he undertook rehabilitation, and had to travel to another town to do it, he would receive from the compensation agency all actual and necessary expenses of travel and costs of maintenance for as long as 40 weeks. In addition, during the rehabilitation period, compensation benefits would be raised to $45.50 a week from the normal maximum which is $37 in Wisconsin. Whatever the outcome, he could be sure that his permanent disability rating would not be lowered as a result since it is based exclusively, by statute, on the physical disability. On the other hand, Joe, the 59 year old, would have his basic benefit of $37 reduced by $8.33 a week (2.5 percent for each year over 50).[50] Certainly Jim in Wisconsin is far more likely to be encouraged to take on rehabilitation than Jim in California. To that degree, one of the primary objectives of workmen's compensation is better served.

As early as 1924, E. H. Downey, one of the earliest compensation authorities, pointed out:

> Very much that passes by the name of malingering is, in reality, a well-founded fear of forfeiting compensation without being able to hold a place in industry. Much of the reluctance manifested by industrial, as by war, cripples to undergo retraining, is due to the maladroit device which rewards the victim's zeal therein by cutting off his indemnity. The way to promote rehabilitation is not to penalize it. [51]

The original authors of the veterans' disability compensation program understood this point and wrote into the legislation the provision that ratings should not be based on individual earning capacity—

> so that there shall be no reduction of the rate of compensation for individual success in overcoming the handicap of a [permanent] injury.

This was a wise decision and it has been adhered to through the years.

However, it does not follow that the rating schedule can appropriately disassociate itself from the phenomenal scientific advances made in medical and vocational rehabilitation. While a schedule should take care not to penalize individual enterprise and success in overcoming disability, it cannot disregard the degree to which it has become commonplace, or average, to overcome certain specific categories of disability. If it does, grave inequities will soon appear. What were once very serious or dangerous ailments may become very easily curable simply by technological advance. It would be nonsense for a

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[49] Additional factors could make the discrimination appear even more extreme. Because of his age and years of service, Joe is likely to be entitled to a company pension, while Jim could not have earned one. Joe is far more likely to have achieved permanently insured status under the old-age and survivors' insurance program. In any event, he will receive the benefits many years earlier than Jim.

[50] As already indicated, Wisconsin is the only State which reduces benefits with advancing age. While the merit of any adjustments for age needs to be carefully examined, it does appear, in an era of increasing public and private provision for the aged, the Wisconsin type of adjustment has more to commend it than the California type.

[51] Workmen's Compensation, Macmillan, 1924, p. 48.

1955 schedule to rate tuberculosis or a veneral disease at the same levels they were properly rated in 1920. Legislation and administration, and rating schedules, cannot be oblivious to the progress of society. That is one of the reasons a good schedule requires continuous reevaluation and revision.[52]

There are other important problems in the relationship of the veterans' compensation program and rehabilitation. Cash benefits and rehabilitation are frequently interdependent. The operation of the two as if they were separate worlds must fail to develop the best potential of each. However, since these other problems are not primarily aspects of the rating schedules, they are discussed elsewhere. (See ch. VI.)

A RATING SCHEDULE AS AN AID TO ADMINISTRATIVE VITALITY

A major test of the value of any rating schedule is its usefulness in effecting the purposes of the law and its effect on the general vitality of administration of the program. Advocates of both the California schedule and the statutory schedules for specific losses have stressed their value as administrative tools.

The task of administering section 4660 of the California Code and of rating each case de novo in the complex manner prescribed by law was clearly impossible without a detailed schedule. It would have required expert knowledge of industries and occupations, of human anatomy, all common injuries and diseases, and the effects of such injuries or diseases on bodily functioning, and required the statistical ability to correlate losses of members or functions, different occupations and different ages. This was an impossible task. Furthermore, the early advocates believed that "the determination of the percentages of disability for the various combination of injuries, ages, and occupations can be made in advance as easily as after an injury has occurred." [53] It was thus held that a permanent disability rating table could be constructed which would enable any interested party as well as the commissioners to determine without difficulty the rating for a case.

In evaluating any aspect of workmen's compensation administration, certain peculiarities of the program must be kept in mind. Most important is the fact that workmen's compensation benefits are not, in practice, usually administered by a government agency, but, by and large, by insurance carriers or self-insured employers who are expected to pay benefits in accordance with the law without constant surveillance. Except in Wisconsin, Michigan, and New York, where the commissions have much greater authority to supervise noncontested cases and in States where the employer is insured by a State fund the commissions generally have only the most routine contact with a case unless it is contested. In California it is estimated that

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[52] A specific illustration may be useful. There was some nodding of heads when a syndicated newspaper story late in August told how Audie Murphy, the movie actor, who currently earns about $2,000 a week, was receiving a 50 percent veterans' disability compensation for a hip injury. The head nodding probably reflected a misunderstanding of the veterans' schedule. If Mr. Murphy's type of hip injury does, on the average, result in 50 percent loss of earning capacity, his receiving that rating is beyond criticism, no matter how much he personally has the enterprise and skill to earn. However, if medical progress has made it likely that with normal treatment the average person with such a disability should no longer be very much handicapped by it in his earnings, then it indicates that the rating is antiquated and should be revised.

[53] Wm. Leslie, in Partial Report, 1951, p. 103.

about 10 percent of all claims are contested. For the Nation as a whole estimates vary from less than 10 percent to 30 percent. Everywhere of course the percentages for permanent cases is much higher.

Whether a determination is originally made by a carrier or by a hearings officer the value of a schedule depends on both the following factors: (1) its practicality as an instrument for informing injured workers employers and carriers of their rights by providing a reasonably precise, intelligible and dependable guide to disability ratings and hence the amount of cash compensation due under the law; and (2) an effective guide to the commissioners and other hearing officers in deciding cases where the extent of disability is at issue.

Evaluation of the California Schedule

California does not appear to have met adequately the test of either of these criteria. Very early it became apparent that it would prove impossible for the parties themselves to arrive at a legal rating from the schedule without recourse to the commission. Bowers reports that,

> difficulties immediately arose. The seriousness of injuries was many times underestimated. Difficulties arose in adjusting claims. Finally, the actual work of administering the disability rating schedule was taken over entirely by the State Industrial Commission.[54]

A special bureau in the commission had to be established to which all permanent cases were referred for rating. Thus, the schedule's negative value as an intelligible guide to the parties has long been apparent.

Its effectiveness as a precise administrative tool for the commission and its hearing officers has also been strongly challenged. First, in spite of its length, but perhaps in part due to its complexity, it is now alleged that "less than 10 percent of all cases rated are pure schedule ratings."[55] This means that in at least 90 percent of the cases the rating requires application of personal judgment beyond the schedule.

Second, it is now claimed that the schedule is so complex that it is not intelligible to most officials or to the parties. To quote the secretary of the Senate committee:

> It has been charged, and the charge was not challenged, that no 10 members of the entire staff of the Industrial Accident Commission can read, interpret, and apply the schedule. Other persons engaged in and specializing in workmen's compensation claims, such as attorneys representing the claimants and insurance carriers, and claims managers for insurance carriers and self-insurers, are constantly finding their evaluations of cases differing from final official ratings by perfectly bewildering margins which they are unable to understand and, of course, unable to explain to the satisfaction of their clients or to their employers.[56]

To test the usefulness of the schedule in securing consistent and objective ratings, the committee asked: (1) two rating specialists to evaluate a set of hypothetical cases: 12 disabilities of varying degrees of severity, each to be rated for 4 different occupations, all at the age of 39; and (2) a number of specialists to rerate 24 actual cases, drawn from commission files, which had been officially rated during the previous year. Each case was submitted for rerating to the same specialist who made the original computation. The committee claims

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[54] Is It Safe To Work? p. 58.
[55] Senate Report, 1953, p. 20.
[56] H. E. McClellan, executive secretary, Senate Interim Committee, letter to William Connolly, January 12, 1950, in Partial Report 1951, p. 114.

the results amply justify its allegation of "incredible inconsistencies" in the computation of the specialists based on the 1950 schedule.

With regard to the 48 hypothetical cases, it reports that in not one case—

> did these specialists arrive at the same rating. In one case, the rating differed by one-fourth of 1 percent—the equivalent of a difference in compensation payments for 1 week. The maximum difference between the ratings in a single case was 37 percent, the equivalent of a difference of 148 weeks in the payment period, and in terms of cash payments, equivalent to a maximum difference of $4,400. For the 48 cases, the average difference between the ratings is 12.05 percent; the average difference in payment periods, 48 percent; and in terms of cash benefits, the average difference per case (at $30 a week) is $1,440.
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> In each of 9 cases one rating was less than 70 percent while the other rating on the same case would provide for a life pension of from 10 percent to 24 percent.

With regard to the second test, the rerating of actual cases within a year by the same rating specialist, the results were: 6 cases with higher percentages than on original rating; 11 with lower percentages; 3 with the same; and 4 inconclusive due to use of ranges. The largest upward revision meant a difference of $810.80; the largest downward—$1,320.[57]

The results of such tests, assuming their reliability, would appear to contradict the claims of the major sources of superiority over rating procedures elsewhere—precision, certainty, and equity. In the absence of similar tests in other jurisdictions firm comparative conclusions cannot be drawn. We don't know, for example, whether tests of nonscheduled cases in a number of other States would give results better or worse than in California. Because of the nature of the statutory flat-rate schedules, it is likely, however, that a greater degree of intrastate uniformity results in such cases, although the enormous interstate differentials for similar injuries suggests considerable lack of correspondence between degrees of physical disability and compensation benefits generally.

But, since it appears clear that precision and exact equity are impossible on a case-by-case basis in either event, and both systems must settle for approximate rough justice, the fixed flat-rate schedule arrangement can show the great administrative advantages of relative simplicity of operation and ready intelligibility to all parties affected.

Administration Versus Litigation: Narrowing the Area of Conflict

It is difficult to disentangle the problem of administering permanent disability rating in workmen's compensation from the underlying conflict between the exponents of workmen's compensation as social insurance legislation and those who see it primarily as a specialized branch of personal injury law. The long-standing contest between these two approaches and the shifting preferences of the major parties for the administrative or judicial processes have been described elsewhere.[58]

The current debate in California revolves as much about the administrative processes by which ratings are finally assigned in industrial cases as about the techniques of establishing the schedule of the ratings themselves. Particular criticism is directed at the fact that rating specialists, or "experts," rate both nonscheduled and scheduled cases alike from reports and records without seeing the injured party. Critics contrast this procedure unfavorably with that of other States where

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[57] Report, 1953, pp. 60–62.
[58] H. M. and A. R. Somers, op. cit., pp. 186–193.

the parties appear before a hearing officer or the commission with their attorneys and physicians and are given every opportunity to develop their cases along judicial lines.

Supporters of the California system can easily point out that contention over ratings of nonscheduled cases in other States has gone to such extremes that litigation and forensic factors have substituted for administrative responsibility. The process has become expensive, conducive to corruption, and lacking in objective basis for fair comparative administrative determination. Furthermore, if the value of the rating process is judged by the number of cases in which the extent of permanent disability is on appeal before the appellate courts of the jurisdiction, California seems to come off better than most.[59] This judgment, however, fails to distinguish between schedule and nonschedule cases so that it is an inadequate test of the two types of schedules.

"Courthouse medicine" is the contemptuous epithet applied by the famed expert on compensation medicine, Dr. Henry H. Kessler, to the "pseudosystem of medical jurisprudence" widely practiced in connection with the determination of extent of disability. One study of the Illinois scene reports a proceeding in which one side produced 12 expert witnesses, and the other side, 11. The parade of witnesses was such a regular phenomenon that the commission was forced to announce a rule that not more than three expert witnesses would be allowed to each side.[60]

The general uselessness of this type of "expert" has been repeatedly attested to. Perhaps the most authoritative indictment of the whole system has come from the medical profession itself in two reports of medical practices under workmen's compensation in Illinois and Oklahoma [61] which describe and condemn the partisanship, incompetence, and occasional downright fraud in the current practice of medical testimony.

This sort of thing is not entirely avoided for scheduled cases either. For example, in Illinois, it is charged, "The much-publicized amputation schedule * * * is only the beginning of the inquiry; whether the workman has lost one of the listed members, or whether he has not, the question arises as to what other injuries he has." [62] This is not surprising: Arms and legs are rarely severed as cleanly as the schedules suggest. Nor is it surprising that a man who has experienced an accident severe enough to result in the loss of a leg should also be left with some unscheduled permanent injury to some part of the head or trunk. The main trouble with the flat-rate schedules is that they are so limited and incomplete. Within these limits, however, it appears that they do reduce the area of conflict and inducement to litigation. Thus, the case for scheduling as many injuries as possible with specific values (and keeping the values current) is strong.

But this does not necessarily imply a California-type multiple-factor schedule. As already indicated, a schedule should combine the

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[59] Letter from Mr. Campbell, September 7, 1955.

[60] A. F. Conard, R. I. Mehr, and Assoc., Cost of Administering Reparation of Work Injuries in Illinois, University of Illinois, College of Law, 1952, p. 51.

[61] Medical Relations Under Workmen's Compensation in Illinois, AMA Council on Industrial Health and Illinois State Medical Society, Chicago, 1954; Medical Relations Under Workmen's Compensation in Oklahoma, AMA Council on Industrial Health and Oklahoma State Medical Society, Oklahoma City, 1955. (The latter is not available to the public.)

[62] Conard and Assoc., op. cit., p. 50.

provision of firm guideposts with the simplicity and intelligibility necessary for general acceptance. A mass socal insurance program cannot undertake delicate refinements within categories of problems or injury. As one authority has pointed out—

> Although the specific needs of an injured individual even for adequate rather than full social rehabilitation might vary greatly in each individual case and could be correctly determined only by a rather refined process, it is obvious and an inexorable fact that the enormous workload of the system and the necessity for speedy action compel a certain amount of typification and informality foreign to the rather sophisticated standards of judicial administration in tort cases. The true crux of the problem in drafting a modern compensation act lies in the proper scope and degree of this standardization of benefits without sacrifice of the ultimate goal of adequate rehabilitation and the proper extent of detechnicalization without violation of the rudiments of fairness to which all parties are rightfully entitled.[63]

Achievements of these goals of "standardization of benefits without sacrifice of adequate rehabilitation" and "detechnicalization without violation of fairness" present the major challenges to the administration of a rating schedule, whatever basis of disability evaluation is chosen. The evidence suggests that more progress can be made toward these goals in all disability programs, including the veterans', if the lessons of the past four decades in workmen's compensation disability rating are carefully studied.

SUMMARY OF FINDINGS

Forty-five years of experience with the problem of rating permanent disability under workmen's compensation and the veterans' compensation program reveal some definite trends, which are presented here in summary fashion.

1. Despite the fact that no two disabilities are likely to be precisely alike, influencing the future of the disabled persons in exactly the same fashion, a mass compensation program cannot be administered by attempting independent judgment in each case on the particular and special facts which may be involved. A social insurance program cannot be turned into a judicial system.

To achieve administrative efficacy, social insurance relies on the "magic of averages" to arrive at overall equity and social justice. This means inescapably that one individual may get somewhat more and another somewhat less than precise individual justice would indicate. If this suggests arbitrariness, one has only to observe the methods used in nonscheduled permanent disability cases, where administrators are given full discretion to determine each case on its merits. The schedule method has resulted in far less litigation. At the same time, "average justice" should not be confused with "injustice" or made an excuse for perpetuating inequitable or obsolete procedures or schedules.

Firm guideposts and generally applied rules are required for effective administration. In disability rating this means schedules: schedules to determine degrees of disability and schedules to determine compensation for different degrees and/or types of disability.

In the controversy over what kind of schedule is best, it should not be forgotten that all types of schedules discussed have proved more suc-

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[63] Stefan A. Riesenfeld, Minnesota Law Review, January 1952, p. 121.

cessful than no schedules. The medical controversies, the costly litigation, the inordinate delays, and the scandals associated with rating of nonscheduled permanent disabilities have made this clear in workmen's compensation. The techniques used generally turn out to be guesswork. And administrative guesswork on a nonuniform basis can be the zenith of arbitrariness.

All parties to the controversy over which schedules are best could probably agree that the use of schedules ought to be maximized. So far as feasible, every possible type of injury ought to be scheduled in relation to the degree of disability it entails. The greater the number of listings, the less necessary it is to resort to "judgment" ratings. Medical authority supports the view that far more injuries can and should be scheduled than have been under workmen's compensation.

In this respect, the Veterans' Administration has done far better than workmen's compensation, although the problems, of course, are different. It has undertaken to have as complete a schedule as possible. This has contributed to reducing its administrative griefs as compared to workmen's compensation.

On the other hand, the Veterans' Administration schedule for statutory awards, some additional to and some in lieu of the percentage awards, seems completely unrelated to the basic schedule. Attention needs to be given to the problem of general equity and consistency as between the statutory awards (set by legislative enactment) and the basic percentage awards (based on a rating process).

2. For reasons similar to those dictating the use of schedules, experience indicates the desirability of keeping them as simple as possible. The admirable urge to build into the schedule a maximum amount of individual equity has at different times caused some States and the veterans' program to adopt multifactor schedules which vary awards for similar injuries in accordance with the disabled person's occupation, age, or other factors.

The trend has been sharply away from schedules of that type. Today only California, among workmen's compensation jurisdictions, maintains such a schedule, and the Veterans' Administration abandoned it some years ago. Yet proposals keep recurring for the reintroduction of occupational variation in disability rating schedules. The logic of the argument for such variations is attractive. The experience—that of California has been described in detail in this paper— does not, however, support the logic.

A persuasive case for occupational or other variations must succeed in explaining away not only the California experience but also the unsuccessful attempt of the Veterans' Administration to adopt the principle.

3. A major issue which has evolved over the years is: What is the correct general criterion for rating disability. Historically, the criterion and definition of disability have been in terms of loss of earning capacity. Even so, there has been basically a heavy reliance on employment of the criterion of physical impairment per se. Some of the reasons for this trend are not difficult to discern:

(*a*) Loss of earning capacity has proved an extremely elusive and difficult criterion to apply. This is more true of the occupational approach than of "average impairments." In the latter, the main problem has been lack of factual research.

(*b*) Because loss of earning capacity proved so difficult to measure, it frequently ended up, in fact, as a measure of physical impairment alone.

(*c*) A criterion of physical impairment, especially where loss of a bodily member is involved, simplifies administration.

(*d*) A sense of injustice has frequently arisen when serious and conspicuous physical impairment was compensated meagerly—or not at all—only because earning capacity was not reduced. Misunderstanding arises, also, in extremes where awards are paid to persons whose ability to earn is unaffected.

In short, a combination of practical and ethical considerations have caused the de facto shift. But while we now have in practice a mixture of both physical impairment and loss of earning capacity criteria, with considerable emphasis on the former, the theoretical rationale, stated in the laws remains almost exclusively in terms of earning capacity. Doctrine generally lags behind fact and action. The failure, however, to make frank acknowledgment of the real criteria for disability has retarded progress toward maximizing the effectiveness of disability compensation.

The complexities surrounding a physical-impairment test are not to be underrated. Since it is properly a test of general functioning or working and living capacity, it involves a wide range of considerations, psychic effects as well as muscle power and range of motion. The controversies among physicians when measuring disability are notorious. It, therefore, is necessary to attempt to achieve the most objective, scientifically acceptable, definition of this criterion and techniques of applying it. There are encouraging signs of progress in this direction, for example, the work and writings of Drs. Kessler, Rusk, Wexler, McBride, and others. Disagreements between them in detail are less important than the fact that all believe that it is possible to establish objective and generally accepted criteria for rating disability—primarily on a basis of loss of physical and/or mental function.

Progress in this direction depends in good part on a clear legislative and administrative acknowledgment of intent, and therefore a reconsideration of the legal definition of disability and precisely what it is that is being compensated. For example, once the appropriateness of compensating physical loss per se (even where no wage loss is involved) were frankly acknowledged, greater weight could be given to this fact in the basic rating of certain anatomical losses such as those to which the $47 statutory award now applies. Thus, the necessity of such an additional award might be obviated and greater consistency and equity achieved as between different types of disability.

4. While the physical impairment and similar factors are being recognized as increasingly important, any system of disability compensation must necessarily focus on its basic purpose: economic maintenance of the disabled and their families. This means that economic impairment (or impairment of earning capacity) has to be the most heavily weighted factor. This, of course, is recognized in the theory of workmen's compensation. In the Veterans' Administration system the rating schedule is based on impairment of earning capacity, and despite many problems, the results of the Commission's research (discussed elsewhere) show that, on an overall average basis, the schedule

has been doing remarkably well in replacing the lost earning capacity of disabled veterans.

5. Modern technological advance proceeds at a pace which demands unprecedented legislative and administrative flexibility. Antibiotics, new surgical techniques, development of atomic radiation, and similar achievements can and do radically alter the significance of injuries in a very short time. What may be a major disaster 1 month may prove a conventionally curable ailment a few months later.

Disability rating schedules, therefore, require continuous revision. Those who are responsible for the content of the schedule have to be in almost continuous session if current ratings are to reflect current realities accurately. It can be said safely that, in the modern era, any rating schedule which is 10 years old is substantially archaic.

6. Under such circumstances, experience indicates that it is no longer feasible for legislatures to spell out the content of rating schedules in basic legislation. Legislation can set limits, standards, criteria, and objectives. However, it has been found that the administrative bodies are better suited to set up, and constantly adjust and revise the details of the schedules. It is, of course, a legislative responsibility to determine periodically whether adjustments are keeping pace with modern science and whether they subscribe to legislative objectives.

7. Workmen's compensation experience indicates a marked skewing of ratings and benefits in favor of the less seriously injured. On the whole, this appears to have been avoided in the Veterans' Administration program, at least where the statutory awards are operable.

Where statutory awards are to be retained, they should bear some demonstrable relation to the basic schedule. For example, this could be done by expressing the additional weight intended to be given to specially designated injuries in percentage terms, or by specifying purposes for which additional awards are made, such as nursing care, special facilities, etc.

8. Modern technology has forced a recognition that rehabilitation is a major objective of a proper compensation system. Cash compensation and rehabilitation are not mutually exclusive, or even competitors, but can underpin and strengthen one another. Disability rating schedules and procedures are crucial factors in determining this relationship.

The crystallization of many workmen's compensation institutions, long before modern rehabilitation techniques were known, has resulted in some built-in conflicts which impede rehabilitation and, to that degree, cause failure in the system. The Veterans' Administration is not faced with any such inherent problem. It could make all the adjustments necessary to maximize the rating procedure's contribution to rehabilitation. The value of the relationship is reciprocal. As things now stand, there is active danger of Veterans' Administration procedures rewarding failure to undertake rehabilitation measures by a veteran. It is also clear that to the extent that disability ratings are not constantly exposed to and adjusted in accordance with the accelerated pace of rehabilitation techniques, they will become obsolescent and inequitable.

CHAPTER VIII

THE REHABILITATION OF DISABLED VETERANS AND THE RELATIONSHIP OF VETERANS' ADMINISTRATION PROGRAMS TO MILITARY AND CIVILIAN PROGRAMS

This chapter describes the rehabilitation programs of the Veterans' Administration and the Armed Forces, as well as the State rehabilitation agencies receiving Federal financial and technical aid through the Office of Vocational Rehabilitation of the Department of Health, Education, and Welfare. An attempt has been made to give a meaningful description of the sequence of operations involved in the physical and vocational rehabilitation of disabled individuals by these agencies of Government. In viewing some of the basic considerations, an endeavor has been made at the outset to define what is meant by effective rehabilitation.

Since the veteran's impairment originates in the service, physical rehabilitation in the Armed Forces is discussed prior to the other programs. Following these descriptions there is a comparative analysis of the Veterans' Administration rehabilitation activities and those of the State-Federal agencies. Direct contrasts are made of the characteristics that are susceptible of comparison.

SOME BASIC CONSIDERATIONS IN REHABILITATION

A definition

Rehabilitation consists of processes particularly designed to assist physically and mentally impaired persons in establishing or reestablishing themselves effectively in the community. These processes are basically the same as the therapeutic, counseling, and educational procedures that are required for the constructive development of all individuals—disabled or nondisabled. They are referred to as "rehabilitation" processes only when the individuals involved are considered to be "handicapped" and in need of special evaluation and special assistance because of their disabilities.

Special evaluation and assistance are needed in a highly complex society in order to accommodate those who deviate greatly from physical and psychological norms. The ways of human nature and our social organization have tended to inhibit the assimilation of crippled individuals into the community. There is considerable persistence of an almost primitive antipathy toward them. Furthermore, our social and economic standards require a certain conformity to which the disabled, unless specially oriented or trained, often have difficulty adjusting. The assistance given the individual in making this adjustment successfully, constitutes the processes and procedures of rehabilitation.

Rehabilitation is concerned with the whole individual. The environment in which he lives is a part of him and profoundly affects his adjustment requirements. Therefore, not only should all the resources of medicine and psychology be brought into play in serving this individual, but the community in which he lives must also be regarded as a potential facilitating or inhibiting factor in his efforts toward rehabilitation. Rehabilitation is achieved when the disabled person is enabled to give to and receive from the community what nondisabled persons normally expect to be able to give and receive. This can come about only when the community accepts the disabled person as it accepts an individual who has no apparent disabilities, that is, on the basis of his abilities and what he can contribute, rather than of his disabilities.

The point at which "adequate" ends and "handicapped" begins is not well defined. The variations in the statistics of the disabled, or the "handicapped," is evidence of this lack of clear definition. It could be said that everyone is handicapped in some measure; yet if good utilization of abilities is practiced, practically nobody is handicapped. Therefore, just how and to whom rehabilitation procedures should be applied becomes an individual question that can be answered only after a full consideration of the characteristics and potentialities of the individual and of the environment in which he will live and work.

The Public's Interest

The maintenance of large numbers of disabled persons in idleness and dependency, or their continued operation at a level of performance below their capabilities, represents a tremendous social and economic loss. When rehabilitation is well done the cost is high, but it is far less than the cost of failure to rehabilitate.

The Congress has been mindful of the excellent results that can be obtained from programs designed to cope with this problem. As to disabled veterans of World War II, generous provision was made for vocational rehabilitation through Public Law 16, 78th Congress (38 U. S. C. 701), and similar benefits were extended to veterans of the Korean conflict by Public Law 894, 81st Congress (38 U. S. C. 701a). The State-Federal cooperative programs dealing with the problem of vocational rehabilitation were given a heartening boost in 1954 through the passage of Public Law 565, 83d Congress, which laid a foundation for progressive improvement and expansion.

The problem of rehabilitating disabled people is of vital concern to the whole community. To a significant degree the attitudes in the community heighten or decrease the handicap felt by the disabled; deficiencies in their effective adjustment will result in liability to the community, while the achievements of their rehabilitation will enrich the community. Through legislation, recognition is given to the fact that it is of importance to everyone that the handicapped, as well as the physically adequate, achieve full social and economic self-realization.

Some Problems and Principles

Good techniques are available to promote the rehabilitation of the disabled. Some of the basic problems most needing solution are: (*a*) Lack of trained professional workers; (*b*) lack of public acceptance of impaired persons as candidates for jobs; and (*c*) lack of coordina-

tion of professional services and facilities. The first two of these are being attacked in an organized, effective way from several directions. However, the problem of coordination of services and facilities demands for its solution, professional and administrative approaches that will require mature and aggressive leadership.

It is fundamental to rehabilitation that there be unified treatment of the whole individual. The disabled person, like one who is not disabled, must utilize many capabilities. His disability, and the problems that it generates, cannot be treated in discrete segments or in isolation from the many factors with which he must deal in his daily living. No one specialist can, with a reasonable preparatory period, become skilled in all of the special services that the impaired person must receive in order to develop himself. His rehabilitation can most effectively be achieved by utilizing a team of specialists. Workers in physical restoration, in mental health, in counseling, in education, in job placement and in social and occupational adjustment should be on the rehabilitation team.

This team should function as a democratic unit in attacking the complex problems presented in the rehabilitation of a disabled person. Each member, in a dynamic, cooperative setting must be given an opportunity to make his special contribution to the solution of those problems. The disabled individual, referred to here as the "client," is the center of the rehabilitation effort. The procedures that are applied should have as their basic purpose, optimum results for the client. Professional or personal biases and prejudices should and can be avoided if this is the emphasis.

The program for rehabilitation of an individual should be dynamic and flexible. The characteristics and needs of individuals vary. The environment in which the disabled person lives and to which he must adjust also changes. Therefore, any program applicable to the disabled should be subject to revision in the light of the changing situation.

One important task frequently facing the disabled person is that of amending attitudes and assumptions about himself and his disability. Positive emphasis must be given to his abilities rather than his disabilities. This generally requires more emphasis and greater effort if the disability is of long standing.

The program for rehabilitating a disabled individual should be inaugurated as soon as possible after the onset of the disability. Unless a purposeful, coordinated plan of action is outlined early in his convalescence, anxiety, discouragement, lack of motivation, and depression may dominate his outlook. Even those individuals with only mild disabilities should be encouraged as soon as possible to outline rehabilitation goals that take full cognizance of their new limitations. Unless these goals are developed with great care and an awareness of many significant factors, pursuing them might result in a living and working pattern that will aggravate rather than alleviate the disabling condition.

Rehabilitation can be said to begin as soon as the disability comes under initial treatment. Physical restoration is the work of the physician, nurse, and allied professions. Until a reasonable degree of capacity is achieved or restored, the patient cannot undertake the

succeeding steps that lead finally to employment as a rehabilitated individual.

There follows below a description in some detail of the programs in two federally supported hospital systems (the Armed Forces and the Veterans' Administration) that offer services of significance to rehabilitation. Hospital medical staffs, in their responsibility for bringing the patient to full recovery, are inextricably involved in the whole rehabilitating process. In addition to medical treatment, the assistance they give or fail to give in orienting and motivating the patient as to his future, will often determine his success or failure in establishing himself in the keen competitive economic environment which he must face as a physically impaired person.

REHABILITATION IN THE ARMED FORCES

Mission of Armed Forces hospitals.—The primary mission of the medical departments of the Armed Forces is to treat the sick and injured military personnel in order to return them to duty status. Patients with physical and mental disabilities of a residual or permanent nature are evaluated for their fitness to perform useful duty in the service. When a patient is declared unfit for duty he is separated from active service.

Medical rehabilitation.—Medical rehabilitation is that part or phase of rehabilitation, generally conducted in the hospital, which utilizes all the types of medical care including physical medicine (physical therapy, occupational therapy and physical restoration), in conjunction with psychosocial adjustment. It may also include vocational counseling, aptitude testing and work-tolerance survey.

In general almost any type of help or care given a patient may be considered as a factor in his rehabilitation. The general medical and nursing care, the work of social-service and other services within the hospital, all are phases of rehabilitation. In this respect rehabilitation has been practiced in military hospitals for many years.

Medical Rehabilitation in Armed Forces Hospitals, World War II

Rehabilitation as a recognized medical specialty became established in the medical departments of the Army and Navy during World War II. In 1944, President Roosevelt directed the military authorities to insure that casualties receive maximum benefit of hospitalization, including physical and psychological rehabilitation, vocational guidance, prevocational training and resocialization.

The military services during World War II followed the principle that no casualty would be discharged until he had received the maximum benefit of hospitalization and convalescent care. Physical, educational, and psychological reconditioning was begun early during hospitalization and continued through convalescence. In addition, medical rehabilitation included orientation, prevocational guidance and self-teaching courses under the United States Armed Forces Institute, occupational therapy (both functional and diversional), and recreation. This program was provided for the mentally ill as well as the physically disabled until such time as in medical judgment the greatest expected improvement had been obtained.

During the period of World War II and continuing through the period of demobilization, comprehensive, dynamic rehabilitation pro-

grams were in operation. They proved beyond doubt that personnel were able to return to duty sooner and with maximum recovery from their disability. Likewise, patients with permanent disabilities could be separated from the Armed Forces with the maximum benefit of hospitalization and returned to civilian life able to function to the fullest extent compatible with their disabilities and their remaining abilities.

Medical rehabilitation programs were established in all the general hospitals, in special convalescent hospitals, and in designated rehabilitation centers. These rehabilitation centers for a particular type of disability were commissioned in some of the large general hospitals as amputee, paraplegic, blind, deaf, and neuropsychiatric centers.[1]

Medical rehabilitation programs were varied to some degree in the specialized rehabilitation centers in accordance with the type of patient receiving treatment. In a paraplegic center, activities of daily living were stressed. Centers for the blind emphasized travel training and the braille system of reading. Neuropsychiatric centers used occupational therapy to a maximum degree. Amputation centers provided prosthetic restoration. All the rehabilitation programs conformed to the basic principles of total rehabilitation, utilizing the team approach with specific prescription of treatment for the individual patient.

During World War II the Army maintained 7, and the Navy 2, amputation rehabilitation centers. Only slight variations existed in the programs in each of the nine centers. A brief description of the program conducted at the United States Naval Hospital, Mare Island, Vallejo, Calif., could serve as an example of each of the nine centers.[2]

Navy amputee rehabilitation center.—The Bureau of Medicine and Surgery of the Navy Department designated the United States Naval Hospital at Mare Island as an Amputee Rehabilitation Center early in 1943. This was the first such center designated in the Armed Forces, and the programs later instituted in other amputation centers were patterned after this institution. Prior to its official initiation, the program had begun to develop with the arrival of amputees in increasing numbers from Pearl Harbor and later from the battle areas in the Pacific. Personnel throughout the Navy, who had any background or experience in rehabilitation were ordered to the Mare Island hospital. To further strengthen the rehabilitation staff, personnel were given intensified training in physiotherapy, occupational therapy, education service, vocational counselling, physical reconditioning and limb fitting.

With the retrenchment following demobilization, there was a cutback in the rehabilitation programs of the Armed Forces. The amputee rehabilitation program at Mare Island, as it now operates, consists of (1) adequate medical and surgical care; (2) physical reconditioning of the body and stump; (3) providing a modern, comfortable prosthesis; (4) training in the use of the prosthesis; (5) prevocational and educational services; (6) psychological aids and helps to the handicapped, and (7) civil readjustment and selective job placement.

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[1] Handbook for the Newly Blind, Manual 972, Bureau of Med. and Surgery, Navy Dept.; TB Med. 162 War Dept. Tech. Bulletin; TB Med. 195 War Dept. Tech. Bulletin; TB MED. 137 War Dept. Tech. Bulletin; TB Med. 103 War Dept. Tech. Bulletin.

[2] Amputee Rehabilitation, Archives of Physical Med., April 1951.

By 1951 over 5,000 major operations on amputees had been performed at Mare Island without a single fatality due to amputation surgery. In contrast to usual experience, no amputee has become psychotic while undergoing treatment at the center. Up to that time, over 3,000 amputees had received care in this center. Follow-up studies reveal that over 94 percent have been successfully rehabilitated and are in all types of occupations and vocations.[3] Approximately 12 percent of the amputee patients discharged from the center have attended long-term educational or vocational training.

Through whole-hearted inter-program cooperation, amputee patients of the United States Army, Navy, Marine Corps, Air Force, Public Health Service and Veterans' Administration have been cared for at Mare Island.

Army convalescent care and rehabilitation of neuropsychiatric patients.[4]—The Army, Navy, and Air Force medical departments conducted extensive rehabilitation programs for neuropsychiatric cases during and immediately after World War II. These programs were generally conducted in neuropsychiatric centers. The convalescent treatment program was largely carried out in convalescent annexes of general hospitals and included all neuropsychiatric patients who did not require closed-ward care or intensive individual therapy and who presented even a remote chance of being rescued for additional military service.

A majority of patients with psychoneuroses were benefited by the prompt institution of a planned program which prevented the development of apathy, resentment, overconcern about functional ailments, and the opportunity for symptoms to become fixed.

Such a program for neuropsychiatric patients was not only helpful from a treatment standpoint, but also provided a means of caring for the increased numbers of patients by the limited trained personnel that was available. The use of personnel other than neuopsychiatrists made it possible to conduct group activities which had been found to have a beneficial psychotherapeutic effect. A convalescent program for neuropsychiatric patients conserved manpower through rehabilitation, while the movement of patients out of hospitals into the program made available more beds for those who required definitive hospital treatment.

Rehabilitation Activities in Military Hospitals After World War II

The rehabilitation programs in the military hospitals during the period 1946–49 gradually reduced in scope and size with the decrease in battle casualties and the demobilization of specially trained rehabilitation personnel; physicians, nurses, occupational therapists, physiotherapists, social workers, teachers, vocational counsellors, prosthetic technicians and civil readjustment officers. A number of general hospitals and rehabilitation centers, and all convalescent hospitals, were decommissioned. This reduced the facilities for rehabilitation in the Armed Forces.

During this same period, rehabilitation programs were developed and expanded in Veterans' Administration hospitals. A large number of qualified rehabilitation personnel, upon release from active military

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[3] Employment of the Amputee Performance, November 1951. Report to President's Committee on Employment of the Physically Handicapped.
[4] Department of the Army, Tech. Bulletin Med. 80.

duty, accepted service in Veterans' Administration organizations, and helped develop outstanding rehabilitation programs.

Disposition of patients with physical and mental disabilities was handled by medical survey. When a patient received the maximum benefit of hospitalization he appeared before a board of medical officers who determined his fitness for duty in accordance with his disabilities. If he was declared fit for full duty, or in some cases limited duty, he was discharged from the sick list and returned to duty status. When the patient was declared unfit for duty he was separated from the military service with a medical discharge. This applied only to enlisted personnel. In the case of an officer found unfit for duty, he was retired for physical disabilities and placed on the retired list. In some cases, when maximum benefit of hospitalization had not been received and where the disabilities were permanent, precluding return to active duty, the patient could be medically discharged (in the case of enlisted personnel) or physically retired (in the case of officers) and transferred on the sick list to Veterans' Administration hospitals or a State mental or tuberculosis hospital.[5]

On October 12, 1949 the Career Compensation Act (37 U. S. Code 271–285) changed the disposition of the patient in the military service. Patients (officers and enlisted personnel) with physical disabilities appear before a medical board as early as practicable after admission to the sick list (usually in 3 to 6 months). The medical board determines the patient's fitness for duty. The patient is returned to duty if the medical board findings are in accordance with the physical standards of retention on active duty. If a patient is found unfit for duty he is ordered before a physical evaluation board which determines the percentage of his disabilities in accordance with the Veterans' Administration Schedule for Rating Disabilities. If the patient has received the maximum benefit of hospitalization, he is retired for physical disability and placed on the retired list. If further hospitalization is required he is transferred to a Veterans' Administration hospital and placed on the retired list. Those patients with less than 30 percent disabilities and with less than 8 years of active duty are separated from the service and receive severance pay.

The Korean conflict and the Rusk report.—With the onset of the Korean conflict (July 1950) and with the ensuing increase of battle casualties, the Army, Navy, and the new Air Force medical departments were augmented by an increase of both facilities and personnel. Several rehabilitation centers were recommissioned. The scope of rehabilitation in the Armed Forces reached a point of approximately 25 percent of the peak during and shortly following World War II.

On June 15, 1950, the President appointed a committee headed by Howard A. Rusk, M. D., to review veterans' hospitalization programs and needs of disabled veterans. [6]

When the flow of severe casualties to the United States started during World War II, it was apparent that the Veterans' Administration was not, at that time, either staffed or equipped to provide in-

[5] AR 635–40 A–B Personnel Separation; Manual of Medical Department, U. S. Navy, ch. 18.

[6] Report to the President from the Committee on Veterans' Medical Services, September 22, 1950.

tensive rehabilitation services for those patients with severe physical disabilities. Even though it was apparent that many of these patients, such as the blind, deaf, some amputees, paraplegics, and others with severe disabilities, could not be rehabilitated to the point of return to active military service, these patients were kept in military hospitals because of the Veterans' Administration's inability to provide an adequate program.

Having served their purpose, the medical rehabilitation programs in the Armed Forces were curtailed at the end of the war, and the patients needing further rehabilitation were transferred to the Veterans' Administration, which, in the meantime, had developed an outstanding program of rehabilitation in their hospitals. Integrated in the Veterans' Administration's medical service are centers for the rehabilitation of the blind, the hard of hearing, paraplegics, amputees, the tuberculosis and other groups, also special centers for plastic surgery, chest surgery, and other types of specialized medical care. These centers have well-trained, experienced Veterans' Administration personnel as well as the services of outstanding civilian consultants.

Because of the shortage of trained personnel in these fields, and the availability of centers within the Veterans' Administration which could be expended, it was the recommendation of the President's Committee that Armed Forces casualties, whose disabilities were such that it was obvious they would be unable to return to active duty, should be transferred to Veterans' Administration facilities to receive their specialized rehabilitation. It should be reiterated that the above recommendation did not apply to those patients whose physical disabilities were such that there was a probability of their return to active military service.

Executive Orders 10122 and 10400.—With the issuance of Executive Order 10122 of April 14, 1950, and amended by Executive Order 10400 of September 27, 1952, total rehabilitation programs in the military hospitals were greatly curtailed and, in many instances, discontinued.

The Executive orders provided that after April 15, 1953, patients who would require: (1) Prolonged hospitalization; (2) specialized hospital care; and (3) treatment of certain chronic disease, would be transferred to Veterans' Administration hospitals. The term "chronic disease" was construed to include chronic arthritis, malignancy, psychiatric or neuropsychiatric disorder, neurological disabilities, poliomyelitis with disability residual, degenerative diseases of the nervous system, severe injury to nervous system including quadraplegia, hemiplegia and paralysis, tuberculosis, blindness and deafness requiring definitive rehabilitation and major amputations. Military personnel with over 20 years' service were exempted from transfer to Veterans' Administration hospitals, except for blindness, psychosis or neuropsychiatric disorders and tuberculosis.

The Executive orders further provided that all members, or former members, of the uniformed services placed on the temporary disability retired list, or permanently retired for physical disability, or receiving disability retirement pay, who require hospitalization for chronic

disease as defined would be admitted to Veterans' Administration hospitals for required treatment.

The effects of the Executive orders reduced the need for rehabilitation in the military hospitals because most of the severely disabled patients, who especially required rehabilitation, were transferred to Veterans' Administration facilities.

Many of the military patients who were forced to transfer to the Veterans' Administration hospitals opposed this transfer. It was particularly opposed by career personnel who had years of service and had great confidence in their military doctors and hospitals. They had understood at the time of joining the military service that medical care and hospitalization would be provided in military hospitals. The change to Veterans' Administration hospitals had a depressing effect on their morale.

Early retirement of military personnel before maximum benefit of hospitalization results in financial hardship, especially on those who have families to support. When placed on the retired list their gross pay is greatly reduced. The patients who are still undergoing treatment and hospitalization are unable to augment their incomes. Their financial worries may therefore tend to slow their recovery, or interfere with their rehabilitation.

Current practices in military hospitals

With the return to peacetime operations, the medical departments of the Armed Forces have been able to further their efforts toward accomplishing their stated mission—that of providing and maintaining a high caliber, effective military force, through the prevention and treatment of the physical and mental illnesses.

At the present time, the medical departments of the Armed Forces utilize the principle of rehabilitation in the treatment of their patients. Treatment is directed to complete recovery and return-to-duty of the maximum number of patients.

The more seriously ill or injured patients are treated in the general hospitals. Some of the large general hospitals have been designated as specialized treatment centers for specific medical conditions. The Army utilizes 9 hospitals, the Navy 7, and the Air Force 14, as designated centers. The type of treatment or care includes amputations, aural rehabilitation, acrylic ocular prostheses, neurology, neuropsychiatry, neurosurgery, ontology, plastic surgery, thoracic and cardiovascular surgery, tropical diseases, tuberculosis, and oral surgery. Due to the shortage of medical officers and the need for specialization of physicians, military medicine can most efficiently provide the best medical care by concentrating their limited number of highly trained and most experienced specialists in special treatment centers. The patient who requires specialized treatment is transferred to an appropriate center.

The resident training program, civilian medical consultant program, and medical research program are also generally conducted in the large general hospitals. This insures a continuance of the highest quality of medical care for the service patient.

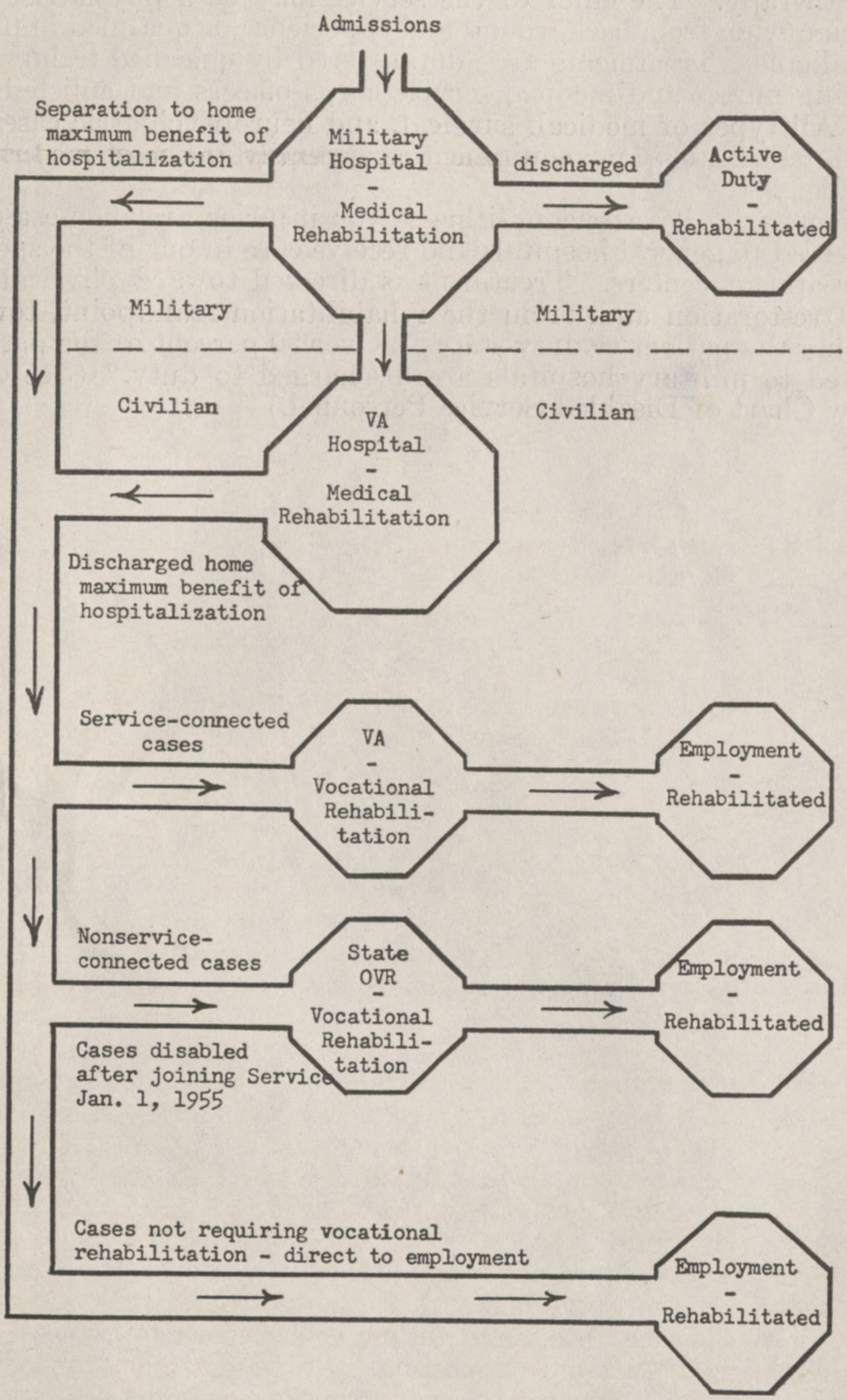
In addition to and in connection with the specialized treatment centers, most of the general hospitals operate an active department or service of physical medicine.

The physical medicine service may include physical therapy, occupational therapy, manual arts therapy, speech therapy, and educational therapy. The chief of the service may be a physiatrist or a physician who, from background and experience, is qualified in physical medicine. Treatments are administered by qualified technicians, including nurses and medical service corps officers and enlisted persons. All types of medical, surgical, and neuropsychiatric cases are treated. Facilities and equipment are generally the most modern available.

Patients who have serious illnesses or injuries are in most cases transferred to general hospitals and receive care in one of the specialized treatment centers. Treatment is directed toward physical and mental restoration and, from the rehabilitation standpoint, toward returning the patient to duty status. Over 90 percent of the patients admitted to military hospitals are discharged to duty. (See chart I, Flow Chart of Disabled Service Personnel.)

CHART I

FLOW CHART OF DISABLED SERVICE PERSONNEL



For the patient returning to duty status the military services not only provide medical rehabilitation but also provide proper job placement and, when necessary, prevocational training for military duty. A disabled patient restored to duty can be considered successfully rehabilitated.

In accordance with the Executive Orders 10122 and 10400, patients with severe disabilities precluding their return to duty and patients with chronic diseases, as defined in the Executive orders, are transferred to a Veterans' Administration hospital as early as practicable after admission. These patients are brought before medical boards or physical evaluation boards, and are temporarily retired as of the date of admission to a Veterans' Administration hospital. Medical rehabilitation is started in the military hospitals for these patients and is continued in a Veterans' Administration hospital upon transfer. The patients transferred to Veterans' Administration hospitals comprise less than 2 percent of the original admissions to military hospitals. However, these patients are the most severely disabled and require prolonged hospitalization. They are also the type of patients requiring the most rehabilitation services.

The remaining 8 percent of patients in military hospitals with residual disabilities who cannot be returned to military duty, are brought before a medical board to determine (1) their fitness for duty, (2) whether their condition existed prior to service or was aggravated by service, (3) whether their condition was a result of their own misconduct or (4) incurred in line of duty. Those cases having received maximum benefit of hospitalization, including medical rehabilitation, are separated from the service and returned to their homes. Their disposition is effected in several ways:

(1) Cases with disability existing prior to service and not aggravated by service, and misconduct cases, are discharged from service without further obligation or eligibility for further rehabilitation in either military medicine or by the Veterans' Administration.

(2) Cases with service-connected disabilities are separated from the service by a medical board (personnel evaluation board) and receive severance pay, in cases of less than 30 percent disability and with less than 8 years' service, under the Career Compensation Act. These individuals are eligible for vocational rehabilitation under the Veterans' Administration if they entered the service prior to February 1, 1955.

(3) The remaining cases with service-connected disabilities are retired from service via the medical board (personnel evaluation board) and placed on the Temporary Disability Retired List in accordance with the Career Compensation Act. Likewise, they are eligible for vocational rehabilitation under the Veterans' Adminis-tion if they entered the service prior to February 1, 1955, and if need for such service is found.

When return to duty is not feasible, use is made of the time the patient spends in a military hospital in laying groundwork for whatever course the patient intends to follow after returning to civil life. Educational and vocational counseling may be given by the educational service, psychologist, social service worker, or by representatives of the Veterans' Administration Vocational Rehabilitation Service assigned full time or part time in a military hospital. Aptitude tests and exploratory tryouts in a variety of work experience may be util-

ized. Patients are encouraged to take appropriate courses of the United States Armed Forces Institute in cultural and technical subjects at both high school and college level. Upon separation from the service, patients are provided with guides for retired personnel which explain their rights and benefits.

Most military hospitals have a full-time or part-time Veterans' Administration representative attached to the staff to advise departing servicemen regarding their benefits under the Veterans' Administration, to help the patient file for his "C" (claim) number, and to direct him to the Veterans' Administration regional office in his home community. In this regard, Military Social Service and the Red Cross also render assistance to departing veterans.

Any individual separated from military service for medical reasons, regardless of status, may receive services under a State vocational rehabilitation program, providing he meets the eligibility requirements.

Job placement and employment is provided disabled veterans under Federal, State, and local employment agencies. Patients leaving the military service are advised to avail themselves of these employment services.

REHABILITATION IN THE VETERANS' ADMINISTRATION

Veterans' Administration Medical Facilities and Resources

The medical services and facilities of the Veterans' Administration may be considered as resources involved in the rehabilitation of disabled veterans and of servicemen transferred to them for treatment. Public Law 293, 79th Congress, defined the functions of the Department of Medicine and Surgery of the Veterans' Administration as follows:

> The functions of the Department of Medicine and Surgery shall be those necessary for a complete medical and hospital service to be prescribed by the Administrator of Veterans' Affairs.

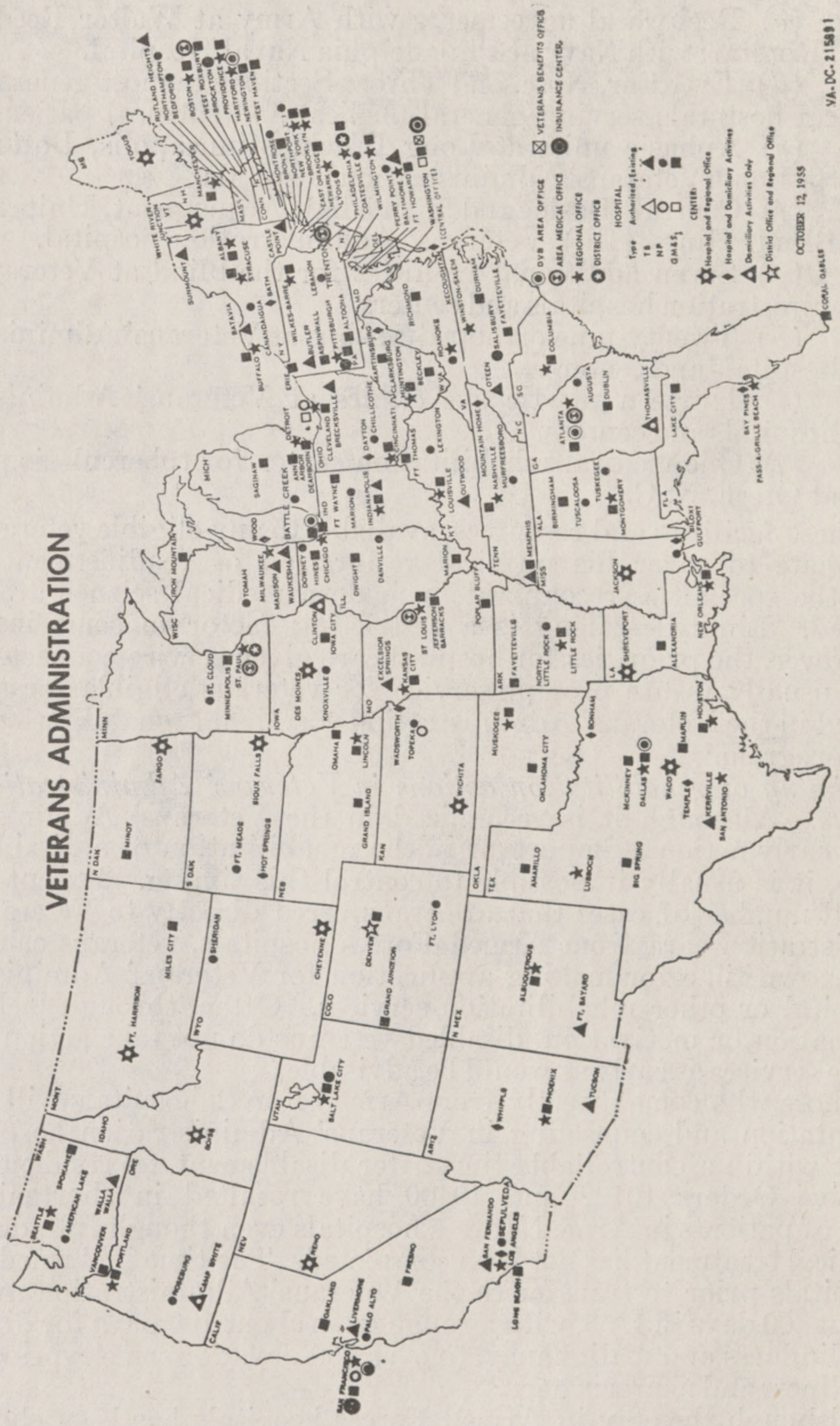
The Veterans' Administration has indicated that its medical services shall include—

> * * * an attempt to provide his total rehabilitation and his total return to the community as a gainfully employed member of the community.

In carrying out its stated medical and rehabilitation missions, the Veterans' Administration employs a large number of facilities that are capable of giving many different medical and related services to veterans. The Veterans' Administration operates 173 hospitals and 17 domiciliary facilities accommodating about 110,000 patients and 17,000 "members," respectively, on an average day. The hospitals are located in each of the 48 States and in the District of Columbia and Puerto Rico. Except in three instances, the domiciliary facilities are located on the same sites as Veterans' Administration hospitals or medical centers. They are distributed over 15 States. (See exhibit A.) The Veterans' Administration utilizes, to a limited extent, private and public hospitals.

There are 69 Veterans' Administration clinics operated in connection with or in proximity to the regional offices. In addition there are 30 subclinics located in large centers of population throughout the country, where outpatient services are given.

EXHIBIT A


VETERANS ADMINISTRATION
VA-DC-21589 1
OCTOBER 12, 1955
DVB AREA OFFICE
AREA MEDICAL OFFICE
REGIONAL OFFICE
DISTRICT OFFICE
VETERANS BENEFITS OFFICE
INSURANCE CENTER
HOSPITAL
Type Authorized Existing
TB
NP
GM&S
CENTER
Hospital and Regional Office
Hospital and Domiciliary Activities
Domiciliary Activities Only
District Office and Regional Office
WHITE RIVER JUNCTION
RUTLAND HEIGHTS
NORTHAMPTON
BEDFORD
BOSTON
WEST ROXBURY
BROCKTON
PROVIDENCE
HARTFORD
NEWINGTON
WEST HAVEN
MANCHESTER
SUMMIT
ALBANY
SYRACUSE
CASTLE POINT
MONTROSE
BRONX
NORTHPORT
NEW YORK
BROOKLYN
EAST ORANGE
NEWARK
LYONS
PHILADELPHIA
COATESVILLE
WILMINGTON
PERRY POINT
BALTIMORE
FT HOWARD
WASHINGTON (CENTRAL OFFICE)
BATAVIA
BUFFALO
CANANDAIGUA
BATH
ERIE
WILKES-BARRE
BUTLER
ASPINWALL
LEBANON
TRENTON
PITTSBURGH
ALTOONA
CLARKSBURG
MARTINSBURG
HUNTINGTON
BECKLEY
RICHMOND
ROANOKE
WINSTON-SALEM
DURHAM
SALISBURY
FAYETTEVILLE
OTEEN
MOUNTAIN HOME
LEXINGTON
LOUISVILLE
OUTWOOD
CINCINNATI
FT THOMAS
DAYTON
CHILLICOTHE
CLEVELAND
BRECKSVILLE
DETROIT
ANN ARBOR
DEARBORN
BATTLE CREEK
SAGINAW
FT WAYNE
MARION
INDIANAPOLIS
DANVILLE
DWIGHT
DOWNEY
HINES
CHICAGO
WAUKEGAN
MILWAUKEE
MADISON
WOOD
IRON MOUNTAIN
TOMAH
ST CLOUD
MINNEAPOLIS
ST PAUL
CLINTON
IOWA CITY
DES MOINES
KNOXVILLE
EXCELSIOR SPRINGS
KANSAS CITY
ST LOUIS
JEFFERSON BARRACKS
MARION
POPLAR BLUFF
MEMPHIS
FAYETTEVILLE
NORTH LITTLE ROCK
LITTLE ROCK
JACKSON
SHREVEPORT
ALEXANDRIA
NEW ORLEANS
BILOXI
GULFPORT
BIRMINGHAM
TUSCALOOSA
TUSKEGEE
MONTGOMERY
ATLANTA
AUGUSTA
DUBLIN
COLUMBIA
THOMASVILLE
LAKE CITY
BAY PINES
PASS-A-GRILLE BEACH
CORAL GABLES
HOUSTON
MARLIN
WACO
TEMPLE
KERRVILLE
SAN ANTONIO
MCKINNEY
DALLAS
BONHAM
HUSKOGEE
OKLAHOMA CITY
WICHITA
WADSWORTH
TOPEKA
GRAND ISLAND
LINCOLN
OMAHA
HOT SPRINGS
FT MEADE
SIOUX FALLS
FARGO
MINOT
FT HARRISON
MILES CITY
SHERIDAN
CHEYENNE
DENVER
GRAND JUNCTION
FT LYON
AMARILLO
LUBBOCK
BIG SPRING
ALBUQUERQUE
FT BAYARD
SALT LAKE CITY
BOISE
WHIPPLE
PHOENIX
TUCSON
SEATTLE
AMERICAN LAKE
SPOKANE
WALLA WALLA
VANCOUVER
PORTLAND
ROSEBURG
CAMP WHITE
RENO
OAKLAND
LIVERMORE
PALO ALTO
FRESNO
SAN FRANCISCO
SAN FERNANDO
SEPULVEDA
LOS ANGELES
LONG BEACH

Other resources include:

(*a*) Nine special centers for audiology and speech correction.

(*b*) Twenty-eight contract (civilian) audiology and speech clinics.

(*c*) Reciprocal agreements with Army at Walter Reed Army Hospital; with Navy at Philadelphia Naval Hospital.

(*d*) Eye, Ear, Nose, and Throat Sections in most general medical hospitals serving general medical and surgical patients.

(*e*) Aphasic units at Long Beach, Minneapolis, Boston, and St. Louis Veterans' Administration hospitals.

(*f*) Central Basic and Remedial Adjustment Unit for the Blind, Hines (Ill.) Veterans' Administration hospital.

(*g*) Seven additional facilities for the blind at Veterans' Administration hospitals and centers.

(*h*) Twenty-nine orthopedic shops at Veterans' Administration hospitals and centers.

(*i*) Thirteen plastic eye clinics at Veterans' Administration hospitals and centers.

(*j*) One medical rehabilitation center for tuberculosis patients at Oteen, N. C.

These facilities and resources, available to any eligible veteran, seem adequate to cover his physical restoration or readjustment needs. All the specialties recognized in modern medical science are represented. Limited staffing is a restricting factor in some instances. However, the priorities for hospital care given service-connected cases will usually insure prompt service for veterans eligible for and engaged in the Veterans' Administration vocational rehabilitation training program.[7]

Timing of rehabilitation actions in Veterans' Administration hospitals.—Although it is recognized in the Veterans' Administration that early action is important in the rehabilitation of a disabled veteran, it is usually impossible to control this timing. Except for the small number of cases that are transferred directly to Veterans' Administration care from Armed Forces hospitals, veterans can choose their own time for making application for Veterans' Administration hospital or other rehabilitation services. Often, through lack of information or motivation, disabled veterans do not take action to seek these services as early as would be advisable.

Those who come directly from Armed Forces hospitals will receive orientation and counseling in Veterans' Administration hospitals at least within a controllable time after disablement. Presidential Executive Orders 10122 and 10400 have resulted in shortening the stay of patients in Armed Forces hospitals even though full, definitive medical treatment has not been completed. The time in Armed Forces hospitals prior to transfer to the Veterans' Administration averaged about 200 days in 1953, with a range from about 100 days for diagnoses of blindness and malignancy, to over 250 days for some types of mental illness and neurosurgery.[8]

Although the stay in Armed Forces hospitals has been shortened, it continues to be longer than is desirable for good rehabilitation prac-

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[7] Only those veterans of World War II and the Korean conflict who have service-connected disabilities and who need training to restore their employability in an appropriate occupation are eligible for rehabilitation training under Public Laws 16 and 894.

[8] These days included time required for travel of patients from military establishments throughout the world to Veterans' Administration hospitals. (This information is from the Department of Defense.)

tice. In general, these hospitals are not adequately oriented or staffed or equipped to contribute significantly to the patient's rehabilitation beyond his physical restoration. Earlier transfer to Veterans' Administration hospitals that are better staffed and equipped would increase the chances for a favorable prognosis for successful rehabilitation.

It should be emphasized, of course, that the number of admissions to Veterans' Administration hospitals from Armed Forces hospitals constitutes only a very small fraction of the total admissions in a year. In 1954, for example, there were about 4,122 such direct transfers. But admissions to Veterans' Administration hospitals from all sources run well over 500,000 a year.

It should also be emphasized that the number of servicemen sent directly to Veterans' Administration hospitals from Armed Forces hospitals represents only a small percentage of the total number separated for physical disability. In 1954, it was 15 percent. Therefore, about 85 percent are separated to civilian status with limited information concerning the resources available to them that might assist in their rehabilitation. In many respects it is unfortunate that the Armed Forces were obliged to eliminate practically all of their programs bearing on occupational rehabilitation, which were established in their hospitals and convalescent centers during World War II. Such programs should be a basic part of all hospital treatment, even though the length of stay in the hospital is to be quite brief. If military hospitals were more completely staffed, good beginnings could be made during those early weeks following the onset of disability when it is most effective and most necessary for good rehabilitation results.

Although all types of medical care and treatment may be said to contribute to the rehabilitation of the patient, the specialty known as "physical medicine and rehabilitation" encompasses those practices and techniques that most directly focus on the return of the patient to normal pursuits. Physical medicine and rehabilitation brings to bear the skills that are offered by physiatrists, physical therapists, occupational therapists, corrective therapists, manual arts therapists, and educational therapists. Supplementing these specialists, and sometimes included in sections on physical medicine and rehabilitation might be audiologists, speech therapists, and therapists for the blind. Vocational counselors and social workers are also available at many Veterans' Administration hospitals.

The various therapies represented in physical medicine and rehabilitation, along with other specialities, are combined in a program to treat the whole person. Specialists in these various therapies, under the direction of the physician in charge of the patient, or the chief of physical medicine and rehabilitation, apply their special techniques according to medical prescription.

Highly specialized procedures are used in the rehabilitation of the blind, deaf, and those requiring speech correction. Special treatment centers have been organized in the various parts of the Department of Medicine and Surgery to provide these specialized services.

Social service.—The Veterans' Administration uses social workers as an integral part of the medical staff that provides total medical care or medical rehabilitation. Certain environmental conditions

should be established before a patient is discharged to his home. Frequently the family needs preparation and orientation so that the patient can be assisted in making the adjustments that are often required by a disability. Social workers can visit the homes and community resources and advise on the conditions that should be established in order to assist in preparing for the physical limitations that often result from injury or disease.

Many patients will find that they cannot return to their old jobs following hospitalization and treatment. Vocational readjustment or rehabilitation is required. Vocational rehabilitation or readjustment is of concern to the professional staff at all phases of medical treatment, but it receives greatest emphasis in physical medicine and rehabilitation. It is considered to be more effective in most cases if the patient is started very early in his convalescence on planning his vocational career and the adjustments that might be required in it because of the disabilities that are left after medical treatment.

Vocational Counseling in Veterans' Administration Hospitals

Vocational counselors (counseling psychologists) are added to the staffs at many Veterans' Administration hospitals to counsel all patients requiring it, prior to their discharge. At the present time (early in 1956), 76 of the 173 Veterans' Administration hospitals have on their staffs, one or more vocational counselors. In looking toward return of the hospitalized veteran to future employment, the counseling psychologist is probably the key specialist. It is in the vocational counseling process that the various aptitudes, special abilities, skills, motivations, and limitations of the individual are measured, evaluated, and balanced against occupational requirements.

These counselors are extensively trained in psychology, a doctor's degree in counseling psychology being the basic educational qualification required for employment. The Veterans' Administration sponsors an extensive training program in cooperation with various universities to assist in increasing the number of qualified counselors available for hospital staffs.

The vocational counselor advises the patient of the results of the measurements of his characteristics in terms of their vocational significance. He also assists him in acquiring information concerning occupational requirements, employment opportunities, small-business outlook, and community services. These counselors are also trained to give personal adjustment counseling when required. The objective in vocational counseling is to help the individual to arrive at an intelligent decision concerning his occupational future and to insure that this decision is based on the best information that it is possible to acquire concerning himself, the resources available to him, and various fields of work.

The counseling psychologist and the veteran in the Veterans Administration hospital call upon other Veterans' Administration programs as well as community resources to assist in rehabilitation. If the veteran is eligible for training under Public Law 346 or 550 or for vocational rehabilitation under Public Laws 16 and 894, he can be referred to the regional office that serves his home address for possible benefits under those laws. If the veteran is not eligible under programs administered by the Veterans' Administration regional offices,

he may be referred to the State-Federal rehabilitation program for a wide range of services offered there. By arrangement with the State employment service he may be entered directly into on-the-job training in an individual program not under Veterans' Administration regional office auspices.

If the veteran needs and is entitled to special housing partly financed by public law the counselor can assist him in making his application for that benefit. He can also assist him in his application for a loan under the Veterans' Administration loan guaranty program, or for any other benefits that might help him to make a good adjustment to civilian living.

Staffing for rehabilitation services.—The extent to which Veterans' Administration hospital staffs can contribute to the rehabilitation of their patients can be measured to some degree by the extent of staffing in certain specialties. The limited or nonexistent staff in some specialties in some hospitals is partly due to unavailability of funds or of qualified professional applicants for jobs with the Veterans' Administration. In some cases the deficiencies are due to the evaluations of the hospital managers as to the need for the services that these specialists can offer. Veterans' Administration hospital managers have considerable authority and prerogative in staffing their institutions. They differ widely in their understanding of and willingness to give support to physical medicine and rehabilitation services. Some will consider that their staff is adequate even if they have no members in certain specialties. Others, with generous staffing in the same specialties will, nevertheless, see the need for more qualified personnel. This emphasizes the need for continued aggressive leadership in orientation and education of hospital administrators and technical staff as to the purposes and objectives of rehabilitation.

The staffing policy of the central office of the Veterans' Administration authorizes a distribution of specialties according to patient needs. This policy permits variations in the staffing pattern of specialties and services when the number of chronic, long-term patients with rehabilitation problems requires emphasis in any of the treatment activities. Special rehabilitation procedures for the blind, in audiology and speech correction, as well as in other areas, can be established where the number of patients requiring such services warrant their use.

Coordination of Services Through the Medical Rehabilitation Board

In describing the processes in Veterans' Administration hospitals that lead toward rehabilitation of the patient, the coordination of services and specialties should be emphasized. This coordination is the special responsibility of the executive assistant to the chief, physical medicine and rehabilitation. The Medical Rehabilitation Board is one of the devices used to achieve this coordination. Such a Board is established in all Veterans' Administration hospitals to insure intensified, coordinated speciality-services for those disabled veterans who present difficult or complicated rehabilitation problems.

On the Medical Rehabilitation Board, the chief of the physical medicine and rehabilitation service acts as chairman. The patient's ward physician and/or the chief of the service will also be on the Board. Usually the ward nurse who has close contact with the patient

will serve on the Board. In addition to these representatives, there will be a representative of social service and a representative of the vocational counseling service, where it has been established. Other individual specialists who have had close contact with or some responsibility for the care and treatment of the patient, and specialists who might later be involved in services to the patient, will also be invited to participate in the Board's proceedings. This might include a representative of the vocational rehabilitation and education division of the nearest Veterans' Administration regional office. Members of community agencies including representatives of the State vocational rehabilitation program and the State employment service will frequently participate in Board meetings.

All patients who are to be considered for domiciliary care, except those who are temporarily in hospital status and are automatically being returned as members of the domiciliary, will be referred to the Medical Rehabilitation Board. No patient is transferred for domiciliary care unless such transfer is recommended by this Board after thorough review of his case and after it has been determined that the greatest possible use has been made of all resources of rehabilitation while the patient was in hospital status.

It should be emphasized that the individuals who are referred for consideration by the Medical Rehabilitation Board may be either veterans with service-connected disabilities or with disabilites that are not considered to be service-connected. This Board and its operations are considered to be a part of the overall medical treatment in the Veterans' Administration hospital. No distinction in treatment is made between those who have service-connected disabilities and those who do not.

The Board studies the problems of the patient from the physical, social, psychological, and vocational aspects. Each member of the Board presents his evaluations and suggested solutions for the overall problems. These presentations are based upon the experience of the specialists with the patient. The patient himself participates in the proceedings if it is considered that his views and reactions will add to the effectiveness of the Board's recommendations or actions.

If it appears that the patient requires additional rehabilitation services not available at the hospital, his eligibility for those services will be investigated and verified. This might include referral to the vocational rehabilitation and education division of the regional office of the Veterans' Administration. It might involve referral of the patient to the State vocational rehabilitation service or it might involve direct referral to the State employment service for employment or for an on-the-job-training opportunity.

A complete plan for the medical rehabilitation of the patient is developed by the Board. A program of treatment is laid out and provision is made for reports of progress, evaluation of results, and further treatment or planning. Those actions that are recommended by the Board that can be taken in the hospital and can be supplied within the programs available there, will be completed before the patient is discharged from the hospital or referred for services to other agencies.

A copy of the record of the actions and evaluations of the Medical Rehabilitation Board is sent not only to the patient's clinical folder but a copy is sent to the vocational counselor if there is such an indi-

vidual on the hospital staff. Should there not be a vocational counselor on the hospital staff, a copy of the record is sent to the vocational rehabilitation and education division of the Veterans' Administration regional office that serves the territory of the veteran's home address, providing, of course, that the veteran appears to be eligible under the appropriate laws and regulations. There is a notation added that the veteran intends to pursue vocational training if he has indicated his interest in such training. In case the veteran does not have eligibility for vocational rehabilitation under Veterans' Administration auspices, a copy of the Board record is sent, with the veteran's consent, to a representative of the State vocational rehabilitation agency.

A copy of the Board report is also sent to the manager of the regional office that serves the area of the Veteran's address (if the patient's disability is service-connected), marked for the attention of the Chief Medical Officer and the Chief of Social Service. This record is sent so as to reach the addressee prior to the time that the patient is likely to report to the regional office for further services. If the patient is to be transferred to a domiciliary, a copy of the Board report is sent to the manager of the place to which he is to be transferred.

Veterans' Administration hospitals have provided for followup of the discharged patient into his home community to assist him in making a successful return to normal living. In many hospitals a "hospital functional committee" has been formed to determine what special assistance is essential to the posthospital plans of the veteran, and to advise on mobilizing local community resources to deliver that assistance.

The chief of professional services is chairman of this committee. The chief of special services at the hospital, along with other specialists, is on the committee. He is also head of a "steering subcommittee" which has the primary function of generating and coordinating community assistance in solving the living-at-home and related problems of the veteran.

Veterans' organizations, church groups, welfare boards, and many other agencies are called upon to contribute their help. This help might range all the way from job finding to modernizing the veteran's home so that it will accommodate his special disabilities. The emphasis is on successful reestablishment of the veteran in the community, rather than therapy or physical rehabilitation.

It should be emphasized that the service and procedures provided in Veterans' Administration hospitals for the rehabilitation of veterans are all considered to be a part of medical treatment. As such, they are applied solely on the basis of the needs of the individual patients. Legal entitlements and "service connection" or "nonservice connection" of the disease or disability are not for consideration. Great latitude is permitted the Administrator of Veterans' Affairs in determining what may be included in "a complete medical and hospital service" such as will permit the hospitalized veteran's "total rehabilitation and his total return to the community as a gainfuly employed member of the community."

Vocational Rehabilitation in Veterans' Administration Regional Offices

Some essential activities are not undertaken or supplied through hospital staff and hospital facilities. These include definitive voca-

tional training or retraining, and job placement. Departments outside the Department of Medicine and Surgery, or agencies outside the Veterans' Administration, are utilized to provide the planning for and supervision of vocational training and employment.

With the enactment of Public Law 16 of the 78th Congress (1943), basic resources (especially vocational training) were made available for rehabilitating veterans disabled in World War II. Similar benefits were extended to veterans of the Korean conflict by Public Law 894 of the 81st Congress. To be eligible under these laws a veteran must have a service-connected disability which would entitle him to compensation, he must have been separated from the armed services under conditions other than dishonorable and must be found in need of vocational rehabilitation services. His disability must have been incurred between the dates of September 16, 1940, to July 25, 1947 (World War II) or June 27, 1950, to February 1, 1955 (Korean emergency period).

Establishment of service connection of a disability.—Veterans who have acquired or believe they have acquired disabilities in the service usually undertake to have those disabilities established as "service connected" under laws administered by the Veterans' Administration. They also apply for adjudication of the degree of disability represented by the impairment.

In order to establish that a disability is service connected as well as to have the degree of impairment authenticated, the individual makes application (VA Form 8–526) to the Veterans' Administration regional office that serves the area in which he lives. (See exhibit B.)

EXHIBIT B

Form approved.
Budget Bureau No. 76-R007.2.

VETERANS ADMINISTRATION

VETERAN'S APPLICATION FOR COMPENSATION OR PENSION

Do Not Write in This Space

NOTE.—Disability compensation is paid for disability resulting from service in the armed forces. Disability pension is paid for disability not resulting from service in the armed forces. Pension is paid only to veterans of wartime service or of service on or after June 27, 1950, and the disability must be permanent and total.

While a claimant may employ an attorney or claim agent recognized by the Veterans Administration to assist him in prosecuting his claim, it is not necessary that he do so. Any attorney or agent so employed may not legally charge any fee other than that allowed and paid by the Veterans Administration, and which is deducted from benefits otherwise payable to the claimant.

Instructions.—Answer all pertinent questions fully. Write plainly, print or typewrite. If you need information about the meaning of any question, write the Veterans Administration Regional Office. If additional space is needed for any item, use "Remarks" section on page 4.

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. ADDRESS (*Number and street, city, zone number and State*)

3. DATE OF BIRTH	4. PLACE OF BIRTH	5. SEX
		☐ MALE ☐ FEMALE

6. NUMBER AND ADDRESS OF SELECTIVE SERVICE BOARD WITH WHICH YOU REGISTERED (*If none, write "None"*)	7. HOME ADDRESS AT TIME OF REGISTRATION

SERVICE INFORMATION

LIST EACH PERIOD OF ACTIVE SERVICE, INCLUDING BEGINNING AND ENDING OF RESERVIST OR NATIONAL GUARD STATUS
(*It is important to show all service numbers, particularly the last number assigned—including Reserve or National Guard*)

8. BRANCH OF SERVICE IN WHICH YOU SERVED (*Check which*)

☐ ARMY ☐ NAVY ☐ AIR FORCE ☐ MARINE CORPS ☐ COAST GUARD ☐ OTHER (*Specify*)

9. ENTERED SERVICE		10. SERVICE NO.	11. SEPARATED FROM SERVICE		12. GRADE AND ORGANIZATION	13. TYPE OF SEPARATION*
DATE	PLACE		DATE	PLACE		

* *Enter "Retired (permanent or temporary)," "Discharged" or "Released from active duty."*

14. IF YOU SERVED UNDER ANOTHER NAME, GIVE NAME AND PERIOD DURING WHICH YOU SERVED

15. IF RESERVIST OR NATIONAL GUARDSMAN, GIVE BRANCH OF SERVICE AND PERIOD OF ACTIVE OR INACTIVE TRAINING DUTY DURING WHICH DISABILITY OCCURRED

16A. HAVE YOU EVER APPLIED FOR ANY BENEFITS OR MEDICAL TREATMENT FROM THE VETERANS ADMINISTRATION?

☐ YES ☐ NO (*If "Yes," complete 16B, 16C, 16D, and 16E*)

16B. VETERANS ADMINISTRATION BENEFITS (*Check those applied for*)

☐ HOSPITALIZATION OR DOMICILIARY CARE
☐ OUT-PATIENT TREATMENT
☐ EDUCATION OR TRAINING UNDER PUBLIC LAW 16
☐ COMPENSATION OR PENSION
☐ EDUCATION OR TRAINING UNDER PUBLIC LAW 346
☐ DISABILITY ALLOWANCE
☐ INSURANCE BENEFITS OR WAIVER OF NATIONAL SERVICE LIFE INSURANCE PREMIUMS

16C. DATE OF APPLICATION	16D. CLAIM NO.	16E. LOCATION OF CLAIMS FOLDER
	C-	

17A. ARE YOU NOW RECEIVING RETIREMENT OR RETAINER PAY?	17B. BRANCH OF SERVICE	17C. MONTHLY AMOUNT
☐ YES ☐ NO (*If "Yes," complete 17B and 17C*)		$

18A. HAVE YOU EVER APPLIED FOR OR RECEIVED DISABILITY SEVERANCE PAY?	18B. AMOUNT
☐ YES ☐ NO (*If "Yes," complete 18B*)	$

19A. HAVE YOU EVER HAD A MEDICAL EXAMINATION FROM ANY U. S. GOVERNMENT CIVILIAN AGENCY?	19B. DATE EXAMINED	19C. NAME AND LOCATION OF AGENCY
☐ YES ☐ NO (*If "Yes," complete 19B and 19C*)		

VA FORM MAY 1953 8-526 Existing stocks of VA Form 8-526, Feb 1952, will be used.

16—66320-2

20. HAVE YOU EVER FILED A CLAIM FOR COMPENSATION FROM THE U. S. BUREAU OF EMPLOYEES COMPENSATION (*Formerly the U. S. Employees' Compensation Commission*)? ☐ YES ☐ NO	21A. ARE YOU NOW HOSPITALIZED OR RECEIVING DOMICILIARY CARE? ☐ YES ☐ NO (*If "Yes," complete 21B*)	21B. NAME AND ADDRESS OF INSTITUTION

22. NATURE OF DISEASES OR INJURIES FOR WHICH CLAIM IS MADE AND DATE EACH BEGAN

Items 23, 24, and 25 should be completed only if disability is claimed to be the result of service in the armed forces. (Veterans of the Indian Wars, Spanish American War, Boxer Rebellion, or Philippine Insurrection need not complete these items.)

23. IF YOU RECEIVED ANY TREATMENT WHILE IN SERVICE, FILL IN THE FOLLOWING INFORMATION

NAME, NUMBER, OR LOCATION OF HOSPITAL, FIRST-AID STATION, DRESSING STATION, OR INFIRMARY	DATES OF TREATMENT	NATURE OF SICKNESS, DISEASE, OR INJURY

24. LIST CIVILIAN PHYSICIANS WHO HAVE TREATED YOU FOR ANY SICKNESS, DISEASE OR INJURY PRIOR TO, DURING, OR SINCE YOUR SERVICE

NAME	PRESENT ADDRESS	DISABILITY	DATE

25. LIST PERSONS OTHER THAN PHYSICIANS WHO KNOW ANY FACTS ABOUT ANY SICKNESS, DISEASE OR INJURY WHICH YOU HAD PRIOR TO, DURING, OR SINCE YOUR SERVICE

NAME	PRESENT ADDRESS	DISABILITY	DATE

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26. MARITAL STATUS (*Check one*) ☐ NEVER MARRIED ☐ MARRIED ☐ WIDOWED ☐ DIVORCED	27. NUMBER OF TIMES YOU HAVE BEEN MARRIED	28. NUMBER OF TIMES YOUR PRESENT SPOUSE HAS BEEN MARRIED

29. FURNISH THE FOLLOWING INFORMATION REGARDING EACH OF YOUR MARRIAGES

DATE AND PLACE OF MARRIAGE	TO WHOM MARRIED	HOW MARRIAGE TERMINATED (*Death, divorce*)	DATE AND PLACE TERMINATED

30. FURNISH THE FOLLOWING INFORMATION REGARDING EACH PREVIOUS MARRIAGE OF YOUR PRESENT SPOUSE

DATE AND PLACE OF MARRIAGE	TO WHOM MARRIED	HOW MARRIAGE TERMINATED (*Death, divorce*)	DATE AND PLACE TERMINATED

31A. DO YOU LIVE TOGETHER? ☐ YES ☐ NO (*If "No," complete 31B and 31C*)	31B. REASON FOR SEPARATION	31C. PRESENT ADDRESS OF SPOUSE

32. LIST EACH LIVING CHILD OF THE VETERAN WHO IS UNDER 18 YEARS OLD AND UNMARRIED, OR OVER 18 AND UNDER 21 AND ATTENDING SCHOOL, OR ANY CHILD OF ANY AGE WHO IS INSANE, IDIOTIC, OR OTHERWISE PERMANENTLY HELPLESS

FULL NAME OF CHILD	DATE OF BIRTH (*Month, day, year*)	PLACE OF BIRTH	NAME AND ADDRESS OF PERSON HAVING CUSTODY OF CHILD

33A. IS YOUR FATHER DEPENDENT UPON YOU FOR SUPPORT? ☐ YES ☐ NO (*If "Yes," complete 33B*)	33B. NAME AND ADDRESS OF DEPENDENT FATHER
34A. IS YOUR MOTHER DEPENDENT UPON YOU FOR SUPPORT? ☐ YES ☐ NO (*If "Yes," complete 34B*)	34B. NAME AND ADDRESS OF DEPENDENT MOTHER

35. NAME AND PRESENT ADDRESS OF NEAREST RELATIVE	36. DO YOU CLAIM TO BE TOTALLY DISABLED? ☐ YES ☐ NO

Items 37 through 45 should be completed only if you claim to be totally disabled. (Veterans of the Indian Wars, Spanish American War, Boxer Rebellion, or Philippine Insurrection need not complete these items.)

37. DATE YOU BECAME TOTALLY DISABLED	38A. ARE YOU NOW EMPLOYED? ☐ YES ☐ NO (*If "No," complete 38B*)	38B. DATE YOU BECAME UNEMPLOYED

39. LIST ALL YOUR EMPLOYMENT, INCLUDING SELF-EMPLOYMENT, FOR 1 YEAR BEFORE YOU BECAME TOTALLY DISABLED

NAME AND ADDRESS OF EMPLOYER	KIND OF WORK	MONTHS WORKED	TIME LOST FROM ILLNESS	TOTAL EARNINGS

40A. WHAT IS THE MOST YOU EVER EARNED IN ANY ONE YEAR $	40B. WHAT YEAR	40C. OCCUPATION IN YEAR YOU EARNED THE MOST

41. LIST ALL YOUR EMPLOYMENT, INCLUDING SELF-EMPLOYMENT, SINCE YOU BECAME TOTALLY DISABLED

NAME AND ADDRESS OF EMPLOYER	KIND OF WORK	MONTHS WORKED	TIME LOST FROM ILLINESS	TOTAL EARNINGS

42. IF YOU WERE SELF-EMPLOYED BEFORE BECOMING DISABLED, JUST WHAT PART OF THE WORK DID YOU DO	43. IF YOU ARE STILL SELF-EMPLOYED, JUST WHAT PART OF THE WORK DO YOU DO NOW
44. EDUCATION (*Circle highest year finished*) 1 2 3 4 5 6 7 8 (GRADE) 1 2 3 4 (HIGH) 1 2 3 4 (COLLEGE)	45. OTHER EDUCATION

Items 46 through 49 should be completed only if you are applying for pension. (Veterans of the Indian Wars, Spanish American War, Boxer Rebellion, or Philippine Insurrection need not complete these items.)

46. WHAT ASSISTANCE DO YOU RECEIVE TOWARD YOUR LIVING OTHER THAN YOUR EARNINGS FROM WORK

47A. IS ANY PART OF YOUR INCOME A PUBLIC ASSISTANCE BENEFIT? ☐ YES ☐ NO (*If "Yes," complete 47B and 47C*)	47B. AMOUNT $	47C. SOURCE

48. WHAT INCOME DO YOU EXPECT TO RECEIVE DURING THIS CALENDAR YEAR $	49. IF YOU BECAME TOTALLY DISABLED DURING THIS CALENDAR YEAR, WHAT INCOME DO YOU EXPECT TO RECEIVE FROM THAT DATE TO THE END OF CALENDAR YEAR $

50. IF CLAIM IS FILED IN BEHALF OF AN INCOMPETENT VETERAN, DOES THE VALUE OF HIS ESTATE EQUAL OR EXCEED $1,500?
☐ YES ☐ NO

51. REMARKS (*Cite item numbers continued in this space*)

CERTIFICATION

I CERTIFY that the foregoing statements are true and complete to the best of my knowledge and belief. I consent that any physician, surgeon, dentist or hospital that has treated me or examined me for any purpose, or that I have consulted professionally, may divulge to the Veterans Administration any information concerning myself and I waive any privilege which renders such information confidential.

52. DATE	53. SIGNATURE OF CLAIMANT

Witnesses to Signature of Claimant If Made by "X" Mark

54A. SIGNATURE OF WITNESS	54B. ADDRESS OF WITNESS
55A. SIGNATURE OF WITNESS	55B. ADDRESS OF WITNESS

PENALTY.—The laws of the United States provide severe penalties involving forfeiture of rights, fines and imprisonment for any false statement or fraud knowingly made or submitted in connection with any claim for, or receipt of, compensation or pension.

16—66320-1

There are 66 of these regional offices, with one or more in each State. Regional offices are also found in the Territories and possessions such as Puerto Rico, Alaska, and Hawaii.

These regional offices are staffed with personnel deemed appropriate to carry out the programs authorized by Congress. Included in these offices is the activity that is concerned with whether a veteran's disability is or is not service connected, the degree or percentage of service-connected disability, and the rate of compensation to be paid. This activity is carried out in the "Adjudication Division."

Veterans' Administration officials do not follow up a veteran's announced intention of filing a claim. They do not undertake to collect the supporting data that he might need to establish his claim beyond advising the claimant of what is required, and securing from the Department of Defense certain basic administrative and medical records. The Veterans' Administration considers that it is not proper to give such a degree of assistance in filing a claim that it can be considered as assisting in soliciting a claim against the Government. However, Veterans' Administration contact officers are located in large centers of population, at all regional offices of the Veterans' Administration and at Veterans' Administration hospitals. For veterans who request them they will supply the necessary forms and instructions for filing a claim.

Many States and localities have designated "veterans' service officers." As State or local officials, they assist veterans in their many problems, including the filing, supporting, and prosecuting of claims that might result in the establishment of service connection of their disabilities.

These service officers are supplemented in many communities by paid or volunteer members of such service organizations as the American Legion, Disabled American Veterans, and the Veterans of Foreign Wars, who also help veterans in filing claims leading toward adjudication of disabilities. They likewise assist veterans in completing the necessary forms, securing the required supporting data, and forwarding these materials to the appropriate Veterans' Administration office.

When the basic papers, including the separation or discharge, have been collected in the regional office, they are included with the veteran's claim forms and routed to the Adjudication Division. There, the veteran's claim with supporting documents are evaluated by an adjudicating or rating board. This board will often find it necessary to supplement the information that the veteran has given. This supplemental data might include the giving of a physical examination in the Veterans' Administration medical outpatient service.

The adjudicating board is composed of a medically trained person, a legally trained person, and an individual who is trained or experienced in employment and occupational matters. These three consider the application and supporting data offered by the veteran and included in the physical examination, and arrive at a decision as to whether the disability which the veteran reports may actually be considered a disability of a compensable degree and whether it may be considered to have resulted from his military service. It is incumbent upon this board to fix the degree (percentage) of disability, according to a rating schedule (the Veterans' Administration Schedule

for Rating Disabilities). Currently, claims are processed from initial filing to final determination in from 60 to 100 days.

Effect of Reexamination on Disability Compensation and Rehabilitation

Once the degree of disability has been fixed by the adjudicating board it is not revised in relation to the veteran's success in readjusting or rehabilitating himself. Reexaminations for disability rating purposes are scheduled by Veterans' Administration regulations as follows: (*a*) Convalescent ratings in 6 months or in 1 year; (*b*) for nonstatic disabilities initially rated 80 to 100 percent, in 2 years; 40 to 70 percent, in 3 years; 10 to 30 percent, in 5 years; (*c*) increase in disability of 10 percent or more according to frequencies in (*b*); (*d*) decrease in disability rating of 10 percent or more in 2 years regardless of the rating; (*e*) unchanged disability rating, 5 years after the date of the last examination.

By regulation, reexaminations are not made in service-connected disabilities when: (*a*) The disability is established as static; (*b*) lesions and symptoms have persisted without material improvement for a period of 5 years or more; (*c*) disability from disease is permanent in character and of such a nature that there is no likelihood of improvement; (*d*) the individual is a veteran of World War I or is over 55 years of age, except under the most unusual circumstances; (*e*) the rating is a prescribed scheduled minimum rating.

In making these reexaminations the Board is concerned only with the disability and not with the adjustment of the veteran to the disability. This is in accordance with the principle which goes back to article III of the War Risk Insurance Act Amendments of 1917, "* * * there shall be no reduction in the rate of compensation for individual success in overcoming the handicap of a permanent injury."

However, if through medical, surgical or psychiatric treatment the disability is reduced or eliminated, there may be a change in the rating and the level of compensation. But the veteran will not be penalized (loss of his compensation award), if he achieves a good vocational adjustment through training or other development.

Veterans with physical or psychological disabilities that might be reduced or eliminated by proper therapy may be referred for treatment in a Veterans' Administration hospital or outpatient clinic. It is not the general practice to refer these veterans to rehabilitation services or resources outside the Veteran Administration.

Application for vocational rehabilitation.—It should be noted here that a large proportion of disabled veterans who file compensation claims are never hospitalized in Veterans' Administration facilities. Therefore, they do not receive the counseling and other facilitating services that might be available at these hospitals.

Usually, following separation from the Armed Forces, the disabled veteran applies for Veterans' Administration compensation, especially if he is not already receiving military disability benefits. This program is administered within the Department of Veterans' Benefits by a claim service that is separate from the vocational rehabilitation and education service. At the claims stage he may be medically examined again by the Department of Medicine and Surgery or he may be rated on the basis of his earlier medical record. However,

there is usually no connection between the claims process and the vocational rehabilitation programs.

At the time that the Veterans' Administration Rating Board sends a notice to the veteran that his claim has been adjudicated (and if his disability has been found to be service-connected) he is supplied with a Veterans' Administration Form 7–1900 with directions for completing the form. (See exhibit C). This is the form on which

EXHIBIT C

Form approved.
Budget Bureau No. 76-R089.4.

VETERANS ADMINISTRATION

DISABLED VETERANS APPLICATION FOR VOCATIONAL REHABILITATION

PUBLIC LAW 16, 78TH CONGRESS, AS AMENDED. PUBLIC LAW 894, 81ST CONGRESS, AS AMENDED

IMPORTANT—Please read instructions on reverse before filling out form. Type or use ink.

1. LAST NAME—FIRST NAME—MIDDLE NAME (*Print or type*)	2. CLAIM NO. C-

3. MAILING ADDRESS (*No., street, city or P. O., zone and State*)	4. TELEPHONE NUMBERS	
	HOME	BUSINESS

5. PERMANENT ADDRESS (*If different than item 3*)	6. NAME AND LOCATION OF HOSPITAL (*If hospitalized*)

7. PLACE OF BIRTH	8. DATE OF BIRTH	9. SEX ☐ MALE ☐ FEMALE

10. FULL NAME USED IN SERVICE (*If different than item 1*)	11. SERVICE NO.

12. BRANCH OF SERVICE (*Check applicable box*) ☐ ARMY ☐ NAVY ☐ AIR FORCE ☐ MARINE CORPS ☐ COAST GUARD ☐ OTHER (*Specify*)	13. IF YOU SERVED IN THE ARMED FORCES OF A GOVERNMENT ALLIED WITH THE UNITED STATES DURING WORLD WAR II, GIVE NAME OF GOVERNMENT

14. DATES ENTERED ACTIVE SERVICE	15. DATES SEPARATED FROM ACTIVE SERVICE	16. WERE YOU SEPARATED BY RETIREMENT BECAUSE OF DISABILITY? ☐ YES ☐ NO

17. EDUCATION (*Give number of years completed in each school attended*)

ELEMENTARY (*Years*)	HIGH SCHOOL (*Years*)	COLLEGE OR UNIVERSITY (*Years*)	OTHER SCHOOL (*Years*)

18A. NAME AND ADDRESS OF HIGH SCHOOL	18B. DATE LEFT HIGH SCHOOL

19A. NAME AND ADDRESS OF COLLEGE, UNIVERSITY OR OTHER SCHOOL	19B. DATE LEFT COLLEGE, UNIVERSITY OR OTHER SCHOOL

20A. HAVE YOU TAKEN (USAFI) GENERAL EDUCATIONAL DEVELOPMENT TESTS? ☐ YES ☐ NO (*If "Yes," fill in item 20B*)	20B. WHEN WERE TESTS TAKEN? ☐ IN SERVICE ☐ SINCE SEPARATION (*Fill in item 20C*)
20C. NAME OF SCHOOL, CITY AND STATE WHERE TAKEN	21A. HAVE YOU TAKEN EMPLOYMENT SERVICE GENERAL APTITUDE TESTS? ☐ YES ☐ NO (*If "Yes," fill in item 21B*)

21B. LOCATION OF EMPLOYMENT SERVICE OFFICE WHERE TAKEN (*City and State*)

22. MARITAL STATUS ☐ MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED	23. DEPENDENTS (*Check applicable boxes. If training is authorized documentary evidence must be submitted before subsistence allowance on behalf of dependents may commence*) ☐ NONE ☐ WIFE ☐ CHILDREN (*Specify No.*) ☐ PARENTS (*Specify No.*)

24. VA BENEFITS PREVIOUSLY APPLIED FOR ☐ HOSPITALIZATION OR MEDICAL CARE ☐ WAIVER OF INSURANCE PREMIUMS ☐ DISABILITY COMPENSATION ☐ EDUCATION OR TRAINING ☐ VOCATIONAL REHABILITATION ☐ DENTAL OR OUTPATIENT TREATMENT	25. EDUCATION OR TRAINING PREVIOUSLY REGEIVED FROM THE VETERANS ADMINISTRATION ☐ P. L. 16 ☐ P. L. 894 ☐ P. L. 346 ☐ P. L. 550

26. IF YOU HAVE APPLIED FOR DISABILITY COMPENSATION, TO WHICH VA OFFICE DID YOU SEND YOUR APPLICATION (*VA Form 8–526*)?	27. ADDRESS OF VA OFFICE WHERE YOUR RECORDS ARE LOCATED (*If any*)

28. REPORTING FOR VOCATIONAL COUNSELING (*Read instruction 4 on the reverse before completing this item*)

☐ I DESIRE TO PAY MY OWN EXPENSES WHEN TRAVELING TO THE PLACE OF COUNSELING AND TO APPLY FOR REIMBURSEMENT ON A MILEAGE OR ACTUAL EXPENSE BASIS

☐ I DESIRE TO BE FURNISHED GOVERNMENT TRANSPORTATION, MEAL AND LODGING REQUESTS FOR THE PURPOSE OF TRAVELING TO THE PLACE OF COUNSELING

29. DATE	30. SIGNATURE OF APPLICANT (*Do not print*) SIGN HERE IN INK

VA FORM NOV 1955 **VB 7-1900** EXISTING STOCKS OF VA FORM 7-1900, APR 1953, WILL BE USED.

the veteran must make application if he wishes to enter the Veterans' Administration program of vocational rehabilitation. In this instance, again, the Veterans' Administration takes the position that any further action beyond giving information and directions to the veteran concerning the application form would be inappropriate since it might constitute what is legally considered to be soliciting a claim against the Government. With this form the veteran is informed as follows:

IMPORTANT INFORMATION FOR VETERANS HAVING DISABILITIES RESULTING FROM SERVICE IN THE ARMED FORCES

1. *Who May Apply for Vocational Rehibilitation*

You have the right to apply for vocational rehabilitation whenever you can meet the requirements stated under (*a*) or (*b*) below:

(*a*) *World War II veterans.*—If you have served on active duty in the Armed Forces of the United States on or after September 16, 1940, and prior to July 26, 1947; or if you served during such period in the active military or naval forces of a government allied with the United States in World War II, provided (1) you were a citizen of the United States at the time of entrance into such service, (2) you are a resident of the United States at the time of making application, and (3) you have not received a similar benefit from the government which you served.

If you have been discharged or released from such service under conditions not dishonorable; or if pending final discharge, you are hospitalized and meet all other requirements for this benefit except actual discharge.

If, as a result of your service you are found to have a disability for which compensation is payable under laws administered by the Veterans' Administration after your discharge or release from service or would be unless at such time you received retirement pay.

(*b*) *Veterans of the Korean conflict.*—If you have served on active duty in the Armed Forces of the United States on or after June 27, 1950, and prior to February 1, 1955.

If you have been discharged or released from such service under conditions not dishonorable; or if pending final discharge, you are hospitalized and meet all other requirements for this benefit except actual discharge.

If as a result of your service you are found to have a disability for which compensation is payable by the Veterans' Administration under the provisions of part I, Veterans' Regulation No. 1 (*a*), as amended, or would be but for the receipt of retirement pay.

2. *Who May Be Provided Vocational Rehabilitation*

The Veterans' Administration provides vocational rehabilitation for a veteran who meets the above requirements if upon consideration of his application it is found by the Veterans' Administration that he is in need of vocational training to restore employability lost as a result of the disability.

3. *How to Apply for Vocational Rehabilitation*

You should fill out the application on the other side of this sheet and mail it according to the instructions given below:

(*a*) If you have applied for, or are receiving disability compensation, retirement pay, retainer pay, or other benefits, mail the application to the Veterans' Administration Regional Office now having the records in your case.

(*b*) If you have not applied for disability compensation or other benefits, mail the application, with a photostat or certified true copy of all Reports of Separation from the Armed Forces, to the Veterans' Administration Regional Office having jurisdiction over the area in which you reside or expect to reside.

(*c*) If you are hospitalized pending final discharge, mail the application to the Veterans' Administration Regional Office having jurisdiction over the area in which you are now located.

4. *Vocational Counseling*

When your application for vocational rehabilitation is received by the Veterans' Administration, you will be notified where and when to report for counseling regarding your occupational plans. If you are found to be in need of vocational rehabilitation you will be assisted in selecting a suitable occupation and the

proper training to prepare for employment in it. When asked to report for counseling to any place outside the community or city in which you live, the Veterans' Administration will pay your transportation. You may pay your own expenses and later claim reimbursement either on a mileage basis at the rate of 5 cents a mile for the total mileage involved, or for your actual and necessary expenses. If you desire, the Veterans' Administration will provide the necessary transportation, meal, and lodging requests for your travel. Come prepared to stay overnight in case it is necessary. Do not report for counseling until you are informed by the Veterans' Administration when and where you are to meet with a counselor.

5. *Vocational training*

After a suitable occupation is selected, the kind of training necessary to prepare for it will be provided in an appropriate educational institution or training establishment as near your home as possible. Tuition and necessary supplies incident to training will be at Government expense. The length of your course of vocational training ordinarily will be that amount of time generally recognized as necessary to qualify for employment at the entry level for a trained worker in the occupation for which you are being trained. However, no course of vocational training can exceed four years in length except by special approval of the Administrator of Veterans Affairs. Training for World War II veterans cannot be afforded beyond July 25, 1956, except in those cases meeting the specific conditions of Public Law 610, 83d Congress.

6. *Subsistence allowance*

While taking training for vocational rehabilitation you may receive subsistence allowance payments each month in addition to compensation or other benefits to which you are entitled. The amount of the subsistence allowance payments will be determined by the type of training, the extent of disability, and the number of dependents.

It is unfortunate that in the Veterans' Administration—particularly in the claims program—it is not felt that more positive action can be taken to induce the veteran to undertake vocational rehabilitation. Many veterans do not consider carefully the advantages of such a program. The mere supplying of a form with instructions concerning its use is not adequate orientation with respect to those advantages. Lack of understanding of the purposes, procedures and outcomes of vocational rehabilitation, results in many disabled veterans not taking prompt, positive action to achieve a satisfactory vocational adjustment. This is borne out by the Commission's study of veterans receiving disability compensation which revealed that an estimated 32,000 eligible veterans did not know about Veterans' Administration vocational rehabilitation training; hence, they did not avail themselves of the advantages of Public Laws 16 or 894.

Those veterans who come in contact with vocational counselors in Veterans' Administration hospitals or those who belong to a veterans' organization that is aggressive in promoting participation of its members in Veterans' Administration programs, will be more apt to have brought to their attention the features of the vocational rehabilitation program and the advantages that might accrue from it.

If the veteran decides to make application for vocational rehabilitation, the Veterans' Administration Form 7–1900 is completed and forwarded to the regional office that serves the territory in which he lives. Certain administrative actions are taken to collect the necessary basic files on the applicant, a Vocational Rehabilitation and Education file is made up, and the application is then forwarded to the Vocational Rehabilitation and Education Division at the regional office for further action.

Vocational Rehabilitation and Education Division.—The Vocational Rehabilitation and Education Division of a Veterans' Administration regional office is made up of three sections—the Educational Benefits Section, the Counseling Section, and the Education and Training Section. The Educational Benefits Section initially receives all applications for rehabilitation or education and training that are forwarded to the Division. A representative in that section studies the documents included in the veteran's file and, if possible, makes a determination as to the eligibility for vocational rehabilitation based on those documents. If additional information is needed to establish this eligibility, the Educational Benefits Representative secures that information.

When the determination has been made that the veteran is legally entitled to or eligible for vocational rehabilitation, the file is forwarded to the Counseling Section. Upon receipt there, administrative action is taken to arrange a counseling interview with the veteran. If he lives some distance from the place where counseling may be supplied, the costs of his transportation to the counseling center may be paid by the Government. If he must remain overnight, the costs of meals and lodging can be paid.

If it is determined through counseling that the veteran should be placed in training for purposes of his rehabilitation, he will be inducted into training and his progress will be followed by a training officer.

Counseling in Veterans' Administration Regional Offices

There is a counseling center maintained at each Veterans' Administration regional office. Additional centers, operating under a standard contract with the Veterans' Administration, may be set up in various parts of the territory served by the regional office as the need dictates. These contract centers are usually operated by universities, colleges, or local boards of education. At the peak of the World War II program (May 1947) there were 382 such contract centers. There are now 65 (May 1956). The Veterans' Administration supplies the standards and detailed procedures and the necessary forms for these centers. At each contract center there is a counselor-administrator, who carries responsibility for taking certain administrative actions as required by the Veterans' Administration. He is a qualified counselor and in most cases will find it feasible to carry a certain amount of the counseling load. The other counselors at these contract centers and the supporting clerical personnel are hired and paid by the contracting agency. The agency is reimbursed by the Veterans' Administration on a cost-per-case basis. A prescribed formula is followed in arriving at the contract rate based upon the admissible costs.

The counseling centers at the regional offices are manned by Veterans' Administration employees. It is at these centers that the most severely disabled veterans are counseled. Other, less seriously disabled veterans, are also served there if schedules permit. On the staff at each regional office counseling center there is usually a chief of the section, a number of counseling psychologists (one or more of whom is qualified to offer personal counseling) and a supporting clerical staff.

Medical consultants, usually including a psychiatrist, and social workers, are also available at the regional office. The services of these specialists are often required before the counselor and the veteran can arrive at a valid selection of a rehabilitation goal.

The basic purpose of counseling is to establish what the veteran needs, including the possible training, and to arrive at a decision as to how those needs should be met. If there is need for training, the veteran is assisted in deciding on a vocational objective. Should there be no need for training, the veteran will be counseled with respect to direct employment, physical restoration services, personal adjustment, etc. Under existing law, the veteran will usually be referred to the State Employment Service for job placement if such assistance is needed.

Under Public Laws 16 and 894, if any one of four conditions is found by the counselor, need for vocational rehabilitation will not have been established. These conditions are as follows:

(*a*) The veteran is already employed in a suitable occupation.

(*b*) The veteran is employable in a suitable occupation.

(*c*) The disability for which the veteran received his service-connected rating does not limit the types of employment which he might secure and hold—even though failure to attain employability is due to lack of training for or lack of experience in a suitable occupation.

(*d*) Loss of employability in a suitable occupation, initially engaged in after separation from the armed service, is due to causes other than the service-connected disability.

The counseling process involves extensive personal interviews with the veteran by the counselor; collection of educational, occupational,[9] medical,[10] family and social data; determination of what tests and measures (if any) should be administered,[11] determination of physical conditions; a summarization and evaluation of all of the data found from the interview or interviews with the veteran. Consultations with the veteran are held during which he is assisted in arriving at an occupational goal and course of action that gives the best promise of effecting his rehabilitation.

Although the counseling center is supplied with whatever medical history is in the file on the veteran, it is sometimes necessary that this be supplemented with a physical examination, a psychiatric evaluation, or a report on the home conditions under which the veteran lives. Without this information to supplement what the counselor can learn from his interviews with the client, and from the tests and measurements which have been taken on him, it is often not possible to arrive at (1) a dependable conclusion as to the feasibility of training, or (2) a reliable choice of vocational goal.

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[9] See exhibit D.
[10] See exhibit E.
[11] See exhibit F.

EXHIBIT D

VETERANS ADMINISTRATION

COUNSELING RECORD SUMMARY

1. REGIONAL OFFICE	2. CLAIM NO. C-
3. NAME OF COUNSELOR	

4. LAST NAME - FIRST NAME - MIDDLE INITIAL OF VETERAN			5. TYPE OF CASE	PL 16 (✓)	PL 894 (✓)
6. ADDRESS OF VETERAN		7. TELEPHONE NO.	NEW		
			REACTIVATED		
8. DATE OF BIRTH	9. MARITAL STATUS ☐ MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED		RECONSIDERATION		
			REVALUATION		
10. SEX	11. HEIGHT	12. WEIGHT - 13. NO. OF DEPENDENTS	OTHER *(Specify)*		

14. EDUCATION *(Check, if graduated, or enter highest year completed)*

SCHOOL LEVEL	GRAD. (✓)	HIGHEST YEAR COMPLETED
ELEMENTARY AND HIGH SCHOOL		
TRADE OR TECHNICAL SCHOOL		
BUSINESS SCHOOL		
COLLEGE		
UNIVERSITY *(Graduate school)*		

15. DEGREES RECEIVED IN COLLEGE OR UNIVERSITY

16. MAJOR OR FAVORITE SUBJECTS OR COURSES

17. PRINCIPAL CIVILIAN EMPLOYMENT

JOB TITLE OR TYPE OF WORK	EMPLOYER OR INDUSTRY	DATES OF EMPLOYMENT FROM	DATES OF EMPLOYMENT TO	WEEKLY PAY

18. PRINCIPAL MILITARY JOB ASSIGNMENTS

ASSIGNMENTS, DUTY, OR FUNCTION	BRANCH OF SERVICE	NUMBER OF MONTHS	RANK OR RATING
	CHECK ☐ ARMY ☐ NAVY ☐ AIR FORCE ☐ MARINE CORPS ☐ COAST GUARD ☐ U. S. PUBLIC HEALTH		

19. SIGNIFICANT INTERESTS, APTITUDES, ABILITIES, AND ACHIEVEMENTS

20. PRINCIPAL FIELDS OF WORK INDICATED BY FINDINGS OF COUNSELING

PART IV CODE	FIELD TITLE	PART IV CODE	FIELD TITLE
X		X	
X		X	

V A FORM JAN 1955 **VB 7-1902h** EXISTING STOCKS OF VA FORM 7-1902h-1, OCT 1952, WILL BE USED.

SPECIAL FACTORS WHICH AFFECT THE CHOICE OF EMPLOYMENT OBJECTIVE

21. DISABILITIES *(Designation and nature of each service-connected or other disability)*

22. LIMITATIONS IN PHYSICAL AND/OR RELATED CAPACITIES
(Principal factors as recorded on VA Form 7-1902i, Part II, Sec. A. CODE: X-limited; 0-no capacity)

FACTOR	CODE	FACTOR	CODE

23. EXPLANATION OF ENTRIES IN ITEM 22, IF NECESSARY

24. ADJUSTMENTS WHICH VETERAN MAY NEED TO MAKE TO CONDITIONS OR ACTIVITIES ESSENTIAL TO TRAINING OR EMPLOYMENT

25. WORK CAPACITY OR TOLERANCE *(From VA Form 7-1902i, Part II, Sec. B)*

☐ FULL-TIME ☐ REDUCED

26. SPECIAL LIMITATIONS

27. OTHER FACTORS AFFECTING CHOICE OF OBJECTIVE *(E.g., dependents, finances, educational deficiencies, special knowledge, job opportunities, etc.)*

28. EMPLOYMENT OBJECTIVE(S) SELECTED *(In order of preference, Cert. B, VA Form 7-1902a)*

PART II CODE	OCCUPATIONAL TITLE	PART II CODE	OCCUPATIONAL TITLE
1.		3.	
2.		4.	

29. INFORMATION FOR TRAINING OFFICER *(E.g., directions to home, possible training facilities, industires containing occupation, etc. In Special Rehabilitation cases, factors to consider, such as type, place, conditions or period of training; special restorative training needs, etc.)*

30. IS RELEASE OF PERTINENT INFORMATION AUTHORIZED BY VETERAN?

☐ YES ☐ NO

31. SIGNATURE OF VA COUNSELOR

32. DATE

78811—56——19

EXHIBIT E

COUNSELING RECORD

MEDICAL INFORMATION—RELATED FINDINGS

REGIONAL OFFICE

LAST NAME—FIRST NAME—MIDDLE INITIAL OF VETERAN	CLAIM NO. C-	TYPE OF CASE	PL 16	PL 894
		NEW		
		REACTIVATION		
NAME AND ADDRESS OF PERSON HAVING POWER-OF-ATTORNEY		RECONSIDERATION		
		REVALUATION		
		OTHER (*Specify*)		

PART I

A. MEDICAL AND RELATED DATA OF RECORD, PRIOR TO COUNSELING

1. IS A COPY OF THE RATING SHEET ATTACHED?

☐ YES ☐ NO *NOTE: A copy should be attached in all Part VII cases.*

2. DATE OF NEXT MEDICAL EXAMINATION, IF SCHEDULED

3. SUMMARY OF MEDICAL DATA, SOCIAL HISTORY, AND OTHER PERTINENT INFORMATION (*Use additional sheet if necessary*)

B. MEDICAL CONSULTANT'S OPINION AND RECOMMENDATIONS (*Based on medical records summarized above*)

4. IS IT PROBABLE THAT VOCATIONAL REHABILITATION IS MEDICALLY FEASIBLE?

☐ YES ☐ NO *(If your answer is "Yes," and you believe (a) that the medical information of record is adequate, (b) that little or no change in the veteran's capacities may be expected, and that, therefore, no medical examination is needed, make appropriate entries in the first column in the chart on page 2 hereof, to indicate those capacities which may be lost or limited by the disability, and which should be analyzed with particular care at time of counseling. Record any comments or recommendations at left of chart.)*

COMPLETE EITHER ITEM 5A OR ITEM 5B

5A. DO YOU BELIEVE THAT MEDICAL EXAMINATION AT TIME OF COUNSELING IS NECESSARY?

☐ YES ☐ NO

5B. DO YOU BELIEVE THAT MEDICAL EXAMINATION IS DESIRABLE?

☐ YES ☐ NO

6. PURPOSE OF THE EXAMINATION, AND ANY COMMENTS

7A. DATE	7B. SIGNATURE OF MEDICAL CONSULTANT	8A. DATE	8B. SIGNATURE OF VA COUNSELOR

VA FORM JUL 1954 **VB 7-1902i** SUPERSEDES VA FORM 7-1902i, OCT 1952, WHICH WILL NOT BE USED. 16—70685-1

PART II

A. ANALYSIS OF MEDICAL AND RELATED DATA OBTAINED AT TIME OF COUNSELING

INSTRUCTIONS. Indicate in chart at right, the extent of veteran's capacity or tolerance for each job factor. Enter "O" if capacity is negligible or entirely lacking; "X" if partial or limited. A space left blank in the completed chart will indicate that the factor has been considered and that the veteran's capacity for that factor is unimpaired.

9. Explain or qualify, as necessary, any entries in the chart, and record any medical or related information obtained during counseling which supplements or differs from that recorded in Part I of this form.

APPRAISAL OF PHYSICAL AND RELATED CAPACITIES				APPRAISAL OF JOB DEMANDS				
	BY MED. CONSULT.	BY COUNSELOR	JOB FACTOR	PROPOSED OBJECTIVES (From VA Form VB7-1902b) 1	2	3	PRESENT OR PREVIOUS JOBS (From VB7-1902a)	
ACTIVITIES			LIFTING					
			CARRYING					
			PUSHING					
			PULLING					
			CLIMBING					
			BALANCING					
			STOOPING					
			KNEELING					
			CROUCHING					
			CRAWLING					
			REACHING					
			HANDLING					
			FINGERING					
			FEELING					
			STANDING					
			WALKING					
			TREADING					
			SITTING					
			TURNING					
			TALKING					
			HEARING					
			SMELLING					
			NEAR VISION					
			FAR VISION					
			DEPTH PERCEPTION					
			COLOR VISION					
CONDITIONS			INSIDE					
			OUTSIDE					
			EXTREME COLD					
			EXTREME HEAT					
			SUDDEN TEMPERATURE CHANGE					
			HUMID					
			WET					
			DRY					
			NOISE					
			VIBRATION					
			CLUTTERED FLOORS					
			SLIPPERY FLOORS					
			HIGH PLACES					
			MOVING OBJECTS					
			HAZARDOUS MACHINERY					
			DANGER OF BURNS					
			ELECTRICAL HAZARDS					
			EXPLOSIVES					
			FUMES					
			ODORS					
			TOXIC CONDITIONS					
			DUST					
			POOR VENTILATION					
			POOR LIGHTING					
SITUATIONS			VARIETY OF DUTIES					
			REPETITIVE WORK					
			FAST PACE OF WORK					
			FOLLOWING SPECIFIC INSTRS.					
			EXACTING PERFORMANCE					
			MEETING EMERGENCIES					
			COMPETITIVE WORK					
			WORKING ALONE					
			WORKING AROUND OTHERS					
			WORKING WITH OTHERS					

16—70685-1

PART II (*Continued*)

B. CONCLUSIONS AS TO MEDICAL FEASIBILITY OF VOCATIONAL REHABILITATION; MEDICAL RECOMMENDATIONS
(To be completed, as appropriate, by counselor or physician)

10. CONSIDERING ALL INFORMATION AVAILABLE AT TIME OF COUNSELING, INCLUDING THAT RECORDED IN PART II, A, IS A PROGRAM OF VOCATIONAL REHABILITATION MEDICALLY FEASIBLE AT THIS TIME? *(Check one)*

☐ YES ☐ NO ☐ DOUBTFUL

(If answer is "Yes," but veteran's work tolerence is limited, or if medical measures of any type are required before or during training, the medical specialist or other physician acting as medical consultant should complete applicable items under "Medical Recommendations," items 11 through 17, below. Insofar as possible, recommendations thus recorded should be made with reference to a specific type of employment objective and mode of training.

If answer is "No" or "Doubtful," counselor will complete Section C, with assistance, as appropriate, of medical consultant.)

MEDICAL RECOMMENDATIONS

DISTRIBUTION OF TIME ▶

11. MAXIMUM NUMBER OF DAYS PER WEEK *(Including necessary travel, instruction, preparation, and week-end assignments)*	MAXIMUM HOURS PER DAY *(Sum of items 12A, 12B, and 12C should equal 24 hours)*			13. AMOUNT OF LATITUDE PERMISSIBLE FOR OCCASIONAL OVERTIME, NIGHT WORK, ETC.
	12A. FOR TRAINING	12B. FOR REST	12C. FOR RECREATION AND OTHER PURPOSES	
DAYS	HRS.	HRS.	HRS.	HRS.

14. EXPECTED DURATION OF LIMITED WORK TOLERANCE	ULTIMATE WORK CAPACITY EXPECTED		16. TIME WITHIN WHICH ULTIMATE CAPACITY IS PROBABLY ATTAINABLE
	15A. PER DAY	15B. PER WEEK	
☐ PERMANENT ☐ TEMPORARY	HRS.	DAYS	☐ 6 MONTHS ☐ 6 TO 12 MONTHS ☐ 12 TO 18 MONTHS ☐ 18 TO 24 MONTHS ☐ OTHER *(Specify)*
(If "Temporary," complete items 15A, 15B, and 16)			

17. *Explain or qualify any of the above entries; identify type of objective and mode of training upon which any recommended work limitations are based; and indicate any examinations, treatments, prostheses, or other medical measures which should be taken before or during training.*

18. SIGNATURE OF PHYSICIAN

C. COUNSELOR'S REQUEST FOR CONSIDERATION OF CASE BY VOCATIONAL REHABILITATION BOARD

19. PURPOSE OF REQUEST FOR CONSIDERATION OF CASE BY THE BOARD *(Check either or both boxes, as appropriate)*

☐ DETERMINATION AS TO GENERAL MEDICAL FEASIBILITY FOR VOCATIONAL REHABILITATION

☐ ADVICE OR ASSISTANCE BY BOARD IN DEVELOPING A PROGRAM OF VOCATIONAL REHABILITATION

20. REASONS FOR QUESTIONING FEASIBILITY; NATURE OF ADVICE OR ASSISTANCE DESIRED; INFORMATION OR SUGGESTIONS WHICH MAY ASSIST THE BOARD IN CONSIDERING THE CASE *(Use additional sheet if necessary)*

21. PLACE OF COUNSELING	22. DATE	23. SIGNATURE OF VA COUNSELOR

18—70685-1

D. DETERMINATION BY VOCATIONAL REHABILITATION BOARD AND RECOMMENDATIONS TO COUNSELING SECTION

24. IS IT THE DETERMINATION OF THE VOCATIONAL REHABILITATION BOARD THAT A PROGRAM OF VOCATIONAL REHABILITATION IS CURRENTLY MEDICALLY FEASIBLE?

☐ YES ☐ NO *(If "No," complete item 25)*

25. INFEASIBILITY OF VOCATIONAL REHABILITATION WILL PROBABLY BE

☐ TEMPORARY *(Less than 12 months' duration)* ☐ INDEFINITE ☐ PERMANENT

26. *STATE, IN DETAIL, THE REASONS FOR THE BOARD'S DETERMINATION. RECORD THE BOARD'S RECOMMENDATIONS RELATIVE TO FOLLOWUP, MEDICAL REHABILITATION MEASURES, FACTORS TO BE CONSIDERED IN COUNSELING AND/OR TRAINING, AND THE NATURE OF ANY ASSISTANCE WHICH MAY BE AVAILABLE THROUGH APPROPRIATE ORGANIZATIONAL UNITS OF THE VA*

27. DATE	28. SIGNATURE OF CHAIRMAN

U. S. GOVERNMENT PRINTING OFFICE 36—70685-1

EXHIBIT F

COUNSELING RECORD—TEST RESULTS

REGIONAL OFFICE OR CENTER

LAST NAME—FIRST NAME—MIDDLE NAME OF VETERAN

CLAIM NO.
C-

TEST SERIAL NO.	NAME AND FORM OF TEST OR SUBJECT	NORM GROUP	RAW SCORE	T- OR STANDARD SCORE	PERCENTILE RANK	EXAMINER'S NAME / DATE OF TESTING

VA FORM 7-1902c EXISTING STOCKS OF VA FORM 7-1902C,

16-70856-1

EXAMINER'S OBSERVATIONS AND COMMENTS

INSTRUCTIONS: Record below any information which may have significance for counseling, including:

(1) factors in the test-taking situation which may have affected performance, such as noise, inadequate lighting, interruptions;

(2) conditions such as fatigue, illness, sensory or motor impediments, etc., which should be considered in interpreting test results;

(3) behavior during testing, such as unusual carefulness, persistence, indecision, impatience, or apathy;

(4) elements in test results which are particularly interesting or significant, such as use of special norm groups, inconsistencies among test scores, significant responses to particular test items.

NOTE.—When referring to a given test, identify by serial number and name.

DATE	SIGNATURE OF EXAMINER

16-70856-1 U. S. GOVERNMENT PRINTING OFFICE

Frequently vocational-rehabilitation training is found to be "non-feasible." This is generally based upon conditions evaluated by a Vocational Rehabilitation Board. On this Board will be the counselor, a training officer, usually a social worker from the local Veterans' Administration outpatient clinic, the physician who is the regular consultant to the counseling section, and a psychiatrist, if needed. The board considers all aspects of the veteran's problems and makes recommendations concerning actions that should be taken in his case. (See Exhibit E.)

Should the veteran be found not in need of vocational rehabilitation training, such a program of course will not be prescribed. However, in a great many cases, veterans who are eligible for education and training under Public Law 346 or Public Law 550, and for whom vocational rehabilitation training will not be prescribed by the Veterans' Administration, will undertake the former (Public Law 346 or Public Law 550) training without concurrence of the person or persons who counseled them.

There are a number of conditions which confront the disabled veteran who is looking into the vocational rehabilitation resources of the Veterans' Administration. If he is found, during the process of counseling, to be in need of vocational rehabilitation training because of his service-connected disability; if training is found medically feasible; if he will accept a goal that is within his capabilities; if he can undertake full-time training or training on a program compatible with his physical condition—a goal will be set up and the broad outline of the program of training will be agreed upon. The veteran selects his own goal. The function of the counselor is to acquaint him with his own abilities (as indicated by test results and other observed factors), the requirements for reaching his objective and such occupational information as the limited time will permit.

After the veteran has selected a rehabilitation goal, a special certificate is executed (see Exhibit G). This certificate indicates that a need for training has been found. It is indorsed by the veteran, the counselor, the training officer and the medical consultant to show that there has been coordination and agreement on the goal and general program established.

EXHIBIT G

Form approved.
Budget Bureau No. 76-R199.3.

VETERANS ADMINISTRATION

COUNSELING RECORD

DETERMINATION AND CERTIFICATION AS TO NEED FOR VOCATIONAL REHABILITATION

1. LAST NAME—FIRST NAME—MIDDLE INITIAL OF VETERAN	2. CLAIM NO.
3. REGIONAL OFFICE OR CENTER	C-
4. NATURE OF DISABILITY	5. RATING
	6. DATE OF RATING

CERTIFICATE A. NEED FOR VOCATIONAL REHABILITATION NOT ESTABLISHED

This certifies that it has been determined that need for vocational rehabilitation of the above-named veteran is not established under Part VII, Veterans Regulation No. 1 (a), as amended, and VA Regulations issued pursuant thereto.

7. SIGNATURE OF MEDICAL CONSULTANT	8. DATE CERTIFICATE EXECUTED
9. SIGNATURE OF VA COUNSELOR	10. FL 7-148 ☐ GIVEN TO VETERAN ☐ MAILED TO VETERAN

CERTIFICATE B. NEED FOR VOCATIONAL REHABILITATION ESTABLISHED— ELECTION OF EMPLOYMENT OBJECTIVE

This certifies that the above-named veteran, having applied for vocational rehabilitation to restore employability lost by reason of service-connected disability, is found to be in need of vocational rehabilitation, and for this purpose the occupation(s) designated below (has) (have) been chosen by agreement of the undersigned parties as the employment objective(s) for which training may be prescribed and provided under Part VII, Veterans Regulation 1 (a), as amended.

It has been explained to the veteran that each training estimate entered below is tentative, and that final determination as to type and duration of training will be made by the Education and Training Section, subject, if applicable, to VA regulations prohibiting the pyramiding of benefits under two or more laws.

(Use the first line below for the employment objective selected. If alternate objectives have been chosen, list in order of preference. If selection is deferred during restorative training, indicate the DOT Part IV field of work from which the objective probably will be chosen. If selection is deferred during period of exploratory professional training, name the professional field (no code required), list occupations from which the employment objective will be selected, and indicate the stage of training at which the selection is to be made.)

11. TITLE OF OCCUPATION (DOT) OR FIELD OF WORK	12. CODE	13. TRAINING ESTIMATES	
		DURATION (*No. of mos.*)	TYPE (*On-job, institutional, etc.*)
(1)			
(2)			
(3)			
(4)			
(5)			

14. SIGNATURE OF VETERAN
15. SIGNATURE OF VA COUNSELOR
16. SIGNATURE OF MEDICAL CONSULTANT

17. SIGNATURE OF TRAINING OFFICER	18. DATE CERTIFICATE EXECUTED

VA FORM JUN 1955 VB 7-1902a EXISTING STOCKS OF VA FORM VB7-1902A, AUG 1954, WILL BE USED.

16—70842-2

A. CHECK OF SUITABILITY OF TYPES OF WORK IN WHICH VETERAN HAS HAD EMPLOYMENT OR TRAINING

1. OCCUPATIONAL TITLE	2. PERIOD OF EMPLOYMENT OR TRAINING		3. If suitable, check "Yes"; if unsuitable, check "No" and indicate reason(s) by checking appropriate code letter(s).						
	DATE FROM	DATE TO	YES	NO	CODE A	B	C	D	E
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									

CODES:

A. The occupation is not regularly pursued in the locality where veteran lives, and to change residence in order to gain employment would be inimical to the veteran's welfare.

B. Employment in the occupation is temporary, transitory, seasonal or otherwise unstable.

C. The occupation is a laborer or simple process job which normally requires only vestibule training.

D. The veteran is not adequately trained for the occupation; OR the occupation has changed so that his previous training for it is obsolete or inadequate.

E. The veteran's residual capacities do not meet the requirements of the occupation, OR he cannot meet those requirements without aggravating his service-connected disability.

NOTE: Enter the line-number of the occupation as shown above, in the heading of one of the right-hand columns of the Capacities Appraisal Chart in VA Form 7-1902i; then enter an "X" in that column beside each job factor for which the veteran's capacity is lacking or limited, if the factor is a substantial demand of the job.

4. EXPLAIN ANY OF THE ABOVE ENTRIES, AS NECESSARY

VETERAN'S AFFIDAVIT: I hereby affirm that the information supplied by me concerning my employment experience is true to the best of my knowledge and belief. If I am found to be in need of vocational rehabilitation, I hereby authorize the Veterans Administration to release this information, and any other information regarding me, including that relating to my disability, to any person, institution, or establishment, when Veterans Administration officials consider the information to be needed to develop or carry out my training or employment. (*NOTE: If veteran does not desire to authorize release of information for this purpose, second sentence above should be lined out.*)

5. VETERAN'S SIGNATURE		6. DATE

B. CONDITIONS TO BE CONSIDERED IN DETERMINING NEED	CONCLUSIONS
1A. IS THE VETERAN EMPLOYED? ☐ YES ☐ NO *(If "yes," complete item 1B.)*	1C. ☐ IF ANSWERS TO BOTH ITEMS 1A AND 1B ARE "YES," THE VETERAN IS SUITABLY EMPLOYED. *(Check.)*
1B. DOES THE EMPLOYMENT CONSTITUTE A SUITABLE OCCUPATION FOR HIM? ☐ YES ☐ NO	
2A. IF UNEMPLOYED OR NOT SUITABLY EMPLOYED, IS HE TRAINED FOR OR EXPERIENCED IN ANY SUITABLE OCCUPATION? ☐ YES ☐ NO *(If "yes," complete item 2B.)*	2C. ☐ IF ANSWERS TO BOTH ITEMS 2A AND 2B ARE "YES," THE VETERAN IS EMPLOYABLE IN A SUITABLE OCCUPATION. *(Check.)*
2B. CAN HE COMPETE SUCCESSFULLY WITH TRAINED WORKERS WITHOUT ADDITIONAL TRAINING OR A REFRESHER COURSE? ☐ YES ☐ NO	
3A. IF HE IS NOT EMPLOYED OR EMPLOYABLE IN ANY SUITABLE OCCUPATION, IS THIS DUE PRIMARILY TO LACK OF TRAINING OR EXPERIENCE OR TO OTHER FACTORS WHICH ARE NOT RELATED TO HIS SERVICE-CONNECTED DISABILITY? ☐ YES ☐ NO *(If "yes," complete item 3B.)*	3C. ☐ IF ANSWERS TO BOTH ITEMS 3A AND 3B ARE "YES," THE VETERAN'S SERVICE-CONNECTED DISABILITY CAUSES NO SIGNIFICANT LIMITATIONS. *(Check.)*
3B. IS THERE CONVINCING EVIDENCE THAT THE VETERAN'S SERVICE-CONNECTED DISABILITY DOES NOT LIMIT THE TYPES OF EMPLOYMENT WHICH HE MAY SECURE AND HOLD AND WILL NOT DO SO IN THE FORESEEABLE FUTURE? ☐ YES ☐ NO	
4A. IF HE HAS NOW LOST EMPLOYABILITY IN AN OCCUPATION IN WHICH HE HAS HAD EMPLOYMENT AFTER SEPARATION FROM SERVICE, WAS THE OCCUPATION SUITABLE FOR HIM WHILE HE WAS SO EMPLOYED? ☐ YES ☐ NO *(If "yes," complete item 4B.)*	4C. ☐ IF ANSWERS TO BOTH ITEMS 4A AND 4B ARE "YES," THE VETERAN'S LOSS OF EMPLOYABILITY IS NOT CAUSED BY HIS SERVICE-CONNECTED DISABILITY. *(Check.)*
4B. IS HIS LOSS OF EMPLOYABILITY DUE TO FACTORS WHICH ARE NOT RELATED TO HIS SERVICE-CONNECTED DISABILITY? ☐ YES ☐ NO	

C. DETERMINATION AS TO NEED FOR VOCATIONAL REHABILITATION

1. If, on the basis of a thorough consideration of all pertinent factors, any one of the four conclusions stated above is reached, it will be determined that need for vocational rehabilitation does NOT exist, and Certificate A will be executed.

2. If none of the four conclusions applies, it will be determined that the veteran is in need of vocational rehabilitation, and the selection of a suitable employment objective and execution of Certificate B are in order. *(If veteran elects training under PL 550, Certificate B will not be executed.)*

3. IS THE VETERAN IN NEED OF VOCATIONAL REHABILITATION? ☐ YES ☐ NO

4. REASONS FOR THE DETERMINATION *(Record in specific terms any statements not previously recorded concerning those conditions in the case which are relevant to the question of need, and which are required to establish or clarify the grounds for the determination. Continue on next page.)*

U. S. GOVERNMENT PRINTING OFFICE 16—70842-1

Induction into and supervision of training.—It is at this point that the representatives of the training section of the Vocational Rehabilitation and Education Division commence their relationship with the veteran. The training officer to whom the veteran is assigned is responsible for finding a suitable place of training. This place of training must not only be one that can adequately train the veteran so as to reach the goal to which he is committed, but it will generally have been approved by a State government agency as being an appropriate place in which to train veterans. It is not a statutory requirement that the Veterans' Administration accept only those places of training for vocational rehabilitation that have been approved by the State agency. (But under Public Laws 346 and 550 it is generally required that the Veterans' Administration may not enroll a veteran in a place of training unless it has been approved by an agency of the State in which he is to train.) However, it is a matter of general practice that any training establishment that has been disapproved by the State approving agency will not be utilized by the Veterans' Administration in the training of disabled veterans under Public Laws 16 and 894.

After the place of training has been selected and the veteran has been accepted, an agreement is made with the training institution or establishment covering such factors as tuition, fees, books, and supplies that will be required, and details of the program of instruction. In the case of on-the-job training, the agreement also indicates the wages that will be paid by the employer-trainer while the veteran is in training and the wages that will be paid to him when he has completed his training. Usually there is a definite understanding that the employer-trainer will accept this veteran as a full-time employee after he has completed his training program.

The length of the training program is directly dependent upon the time needed to acquire the skills inherent in it. Only in exceptional cases will this be longer than 48 months. (In the case of Public Law 16, no training program may now continue beyond July 25, 1956, except in a few rare instances where the veteran's disability has kept him physically unable to undertake training since separation from the service or there has been a delayed amendment of his discharge). The training program must be such as will meet all the requirements for full qualification of the veteran in the occupation for which he is to train. If the goal cannot be reached within the time limits prescribed by the law, the program cannot be undertaken.

After induction into training, the training officer calls on the veteran regularly to make sure that his progress is satisfactory and that the various features of the course are being followed by the training institution or establishment. These supervisory visits are made at intervals of 30 to 90 days. Some training situations are so stable and the responsibility and standards of the trainer are so well established that frequent supervision by a Veterans' Administration training officer is not indicated. On the other hand, some trainers have had limited experience in training individuals to reach occupational goals and, therefore, the training officer can in such situations perform a valuable service through consultations with the veteran and his trainer.

Change of objective—revaluation.—It occasionally develops that the veteran who has been inducted into a training program will fail to

make satisfactory progress. This might be due to some change in his health or disability or it might be related to an incompatibility with the training objective which was agreed upon with him. In the event that there is a lack of good progress and if the training officer is unable to adjust the conditions so as to insure improvement, it might become advisable to refer the veteran for revaluation.

This referral is made by the training officer to the counseling section. The counselor who receives the case will again review the various aspects of the veteran's files. The veteran will be asked to appear at the counseling center where his problems will be discussed in detail. If it appears advisable to change the employment objective and the training program, a new certificate [12] is executed, collaboration of the training officer is again obtained and the veteran is started on a new course of training.

In these revaluation cases, it is essential that the training officer and the counselor make all possible effort to utilize or continue the training that the veteran has already had. Unless there are compelling reasons, the veteran in his new objective will be limited to the number of months that remained in his initial program.

Declaration of "rehabilitated."—If the training program designed for and with the veteran is appropriate he should reach the objective that was agreed upon. When this objective has been reached, the veteran may be declared "rehabilitated." At this time the veteran is, pursuant to law, advanced 2 months of training allowance. This award is made on the assumption that there will be a period of time before he is able to adjust himself fully in his new job. The allowance has significance and can probably be justified for those veterans who have taken their training in schools. However, those that have trained on the job should normally continue with the firm and in the position for which they were trained. They should be on an adequate level of income immediately upon completion of training. Those that had been trained in an institutional on-farm program can normally be expected to continue operating the farms on which they were trained. It is difficult to justify the 2 months' gratuity in these cases.

Under the law the Veterans' Administration is required to refer a rehabilitated veteran to the State Employment Service for job placement. However, it frequently occurs that training officers, in making their many community contacts, are very well informed concerning employment opportunities. In the case of a severely disabled veteran the Veterans' Administration takes positive action, in cooperation with the employment service, to place such individuals in jobs.

If a veteran has once been rehabilitated, it is normally expected that he will not return for further training under Veterans' Administration auspices. However, he is legally entitled to reconsideration if it develops that the objective for which he was initially trained is incompatible with his present medical condition.

Frequently, during a period of rehabilitation training, a veteran will develop illnesses that might prevent the continuation of his program. Under the laws administered by the Veterans' Administration, it is provided that persons who are in rehabilitation training may receive a full range of medical treatment and care in order to restore training feasibility and to continue them in their programs. Fur-

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[12] See exhibit G.

thermore, a disability that is incurred by a veteran in connection with his rehabilitation may be considered as "service-connected" in the adjudication of an adjustment to his rate of disability compensation.

Special rehabilitation procedures.—Veterans who are considered to be severely disabled (30 percent or more, by definition) are placed in a program that is labeled "Special Rehabilitation Procedures." Such veterans will normally have been considered by the Vocational Rehabilitation Board which will have outlined the special considerations that must be observed in the training and rehabilitation of such veterans.

Individuals with high degrees of impairment present special problems with respect to adjustment, training, and employment. Their progress towards rehabilitation is more easily jeopardized by casual problems than might be expected of less severely impaired individuals. More frequent and more thorough supervision is indicated for such veterans when they are in training. This extra attention is given by the Special Rehabilitation Procedures Unit, which is composed of training officers who are specially trained and directed in supervising the rehabilitation programs of severely disabled veterans. Although most of the placement responsibility is delegated to the employment service of the State in which the veteran lives, the Veterans' Administration takes positive cooperative action in finding employment for these severely disabled veterans.

Timing of rehabilitation actions in the Vocational Rehabilitation and Education program.—Some limited data are available concerning the promptness with which a disabled veteran gets started on a program of rehabilitation training. These data show that an average period of 9 months elapses between date of separation from the service and date of application for training. There has been an average period of 5 months between date of application and date of actual entrance into training.

The 9 months between discharge and application in many cases is spent in other phases of rehabilitation; e. g., at hospitals undergoing physical or mental restoration. Furthermore, many veterans have a desire to be at home or in a civilian job for sometime after military service before undertaking any other readjustment actions. It is difficult to arrive at a firm conclusion as to whether that 9-month period is too long. Generally, it is agreed that promptness in getting started on a program of rehabilitation is desirable, especially in the case of a severely disabled veteran. However, some period of readjustment without the pressures of a rigid, short-term goal can often be defended.

The 5 months between application for rehabilitation training and actual entrance upon a program of training appears to be long. However, it should be emphasized that this period is largely made up of waiting for a school or course to open that the veteran is to attend. Over one-half of the veterans who take vocational rehabilitation training enter some type of institutional training course.

A part of the 5 months, of course, can be charged against Veterans' Administration procedures. It will usually require about 30 days after application to get a veteran to his initial counseling appointment. If the evaluation required for counseling becomes an involved problem, that process could consume another 2 or 3 weeks.

A recent Veterans' Administration study shows that for disabled veterans who have completed training programs, the average required

time in training has been 28 months. Those who had to leave their training for medical or other reasons pursued training an average of 11 months. In general, those placed in rehabilitation training have been quite stable and consistent in following toward a single objective. A representative sample of these individuals revealed that 82.1 percent continued in the initially selected objective; 15.4 percent required 1 change; and 2.5 percent changed objectives or goals 2 or more times.

Numbers of Participants and Costs

As of November 30, 1954, about 950,000 disabled veterans of World War II had taken training under Public Law 346, while nearly 610,000 trained under the vocational rehabilitation program, Public Law 16. About 280,000 had trained under both Public Laws 16 and 346. About 57 percent who might have been eligible for Veterans' Administration training did take advantage of such training under Public Laws 16 and/or 346 (see table 1). The more severely disabled veterans (40 percent or higher rating) tended to elect rehabilitation training under Public Law 16. Those veterans with disability ratings who elected training under Public Law 346 were more usually those with the lower ratings.

TABLE 1.—*Disabled World War II veterans trained under programs administered by the Veterans' Administration, by degree of disability, as of Nov. 30, 1954*

Programs	Number	Percent				
		Total	Degree of disablement			
			10 percent	20–30 percent	40–90 percent	100 percent
Total	1,280,000	57	57	58	59	47
Servicemen's readjustment program, Public Law 346	950,000	30	35	28	21	18
Vocational rehabilitation program, Public Law 16	610,000	14	10	16	23	20
Trained under both of the above programs	280,000	13	12	14	15	9

Source: Veterans' Administration.

As of December 31, 1955, 1,234,000 veterans of World War II had applied for rehabilitation training under Public Law 16; of these, 610,500 had entered training; 373,000 had been rehabilitated; 7,000 were still in training. As of the same date 79,000 veterans of the Korean conflict had applied for rehabilitation training under Public Law 894; 36,000 had entered training; 6,000 had been rehabilitated; 18,000 were still in training. About 2,500,000 World War II and Korean veterans had been given vocational counseling by the Veterans' Administration or by institutions under contract with the Veterans' Administration.

Types of objectives selected.—The most common objective category under Public Laws 16 and 894 has been trade and industrial. Others, in order of frequency, are: Professional, agricultural, and semiprofessional. The least-often selected category is that of the service occupations.

Under Public Law 16 over 27,000 selected teaching; 21,000 entered engineering; 23,000 became accountants or auditors; 8,700 studied

law; 2,700 selected medicine; 2,700, social welfare; 2,700 selected the ministry. Over 43,000 selected managerial or "official" occupations; 36,000 clerical; 31,000 sales; and 227,000 trained for trade and industrial jobs.

Perseverance in training.—A study of those discontinuing training revealed that individuals in the lower education levels tended to have a higher rate of noncompletion than those with more education. Veterans studying in below-college-level schools, for short-term objectives, or who had been favorably employed immediately after discharge, had a high rate of discontinuance. Among the disabilities tabulated, those with psychiatric disorders showed the highest incidence of noncompletion.

Other participation statistics.—Certain medical and educational statistics give an indication of the extent to which rehabilitation services have been given to veterans. The services cited do not include all that have been and are available. However, they represent some of those that are most significant for rehabilitating veterans requiring special services to achieve economic and social adequacy.

In the 8 years, fiscal year 1948 through fiscal year 1955: 56,000 hearing aids were fitted for disabled veterans, 50,000 artificial legs were supplied, 7,700 artificial arms were supplied, 58,500 pairs of orthopedic shoes were supplied, 9,500 wheel chairs were furnished.

During the year ending May 31, 1955, there were 205,000 veterans with service-connected disabilities for whom the Veterans' Administration serviced prostheses of various types.

As of January 31, 1956, the Veterans' Administration had made contributions up to $10,000 each to build 6,049 houses specially designed for veterans whose disabilities prevented their efficient use of houses of traditional design.

To the end of fiscal year 1954, the Veterans' Administration had contributed $1,600 toward the purchase of each of 41,091 automobiles for veterans with certain types of disabilities.

Costs.—To April 1955, the Public Laws 16 and 894 program had cost a total of $1,287,000,000 for subsistence. It is estimated that the amount will be $33,000,000 during fiscal year 1956. To April 1955, $288,000,000 had been paid out for tuition and $48,500,000 had been paid for equipment and supplies. It is estimated that for fiscal year 1956 these two items will cost $8,755,000 and $1,270,000, respectively.

Counseling is a service that has been available to both the disabled and the nondisabled veteran. Much of this counseling has been offered on a contract or fee basis. To April 1955, fees for counseling have totaled $33,000,000. For fiscal year 1956, it is estimated that the fees will reach $1,298,000.

It has not been possible to isolate the costs in the Department of Medicine and Surgery that could properly be charged against "rehabilitation" activities. Nor has it been feasible to isolate the administrative costs chargeable to Public Laws 16 and 894 in the Department of Veterans Benefits.

General.—The programs of rehabilitation administered by the Veterans' Administration have had many limitations as well as strengths that have had a bearing on the general mission. It is difficult to fix the value of a program of this type in terms of dollar costs.

Even if the accounting methods were such that all of the costs could be isolated and identified there would still be many unknown values to be considered.

It is not possible to evaluate in accurate monetary terms the desirability of disabled persons in the society being capable of maintaining themselves and making a contribution to the economic well-being of the country. Some estimates show that the amount invested in rehabilitating a person will be repaid to the community by the resulting increased productivity of the person rehabilitated. It has been estimated that in about 4 years the tax dollars required to rehabilitate a disabled person will have been repaid to the Treasury through the income taxes paid by the rehabilitated individual. These are satisfying data. However, it is not considered that it would be wise, as a matter of national policy, to insist that there shall be no investment made in the rehabilitating of disabled persons unless it can be shown that this investment is sound from a purely monetary point of view. The values of rehabilitation are measured in many different ways. More significant than the money aspects are those which can be expressed in terms of strengthening the general social, political, and defense posture of the country. Although less tangible, these values resulting from the successful rehabilitation of millions of disabled persons in the population may be more meaningful.

VETERANS APPLYING FOR REHABILITATION UNDER THE STATE-FEDERAL PROGRAM

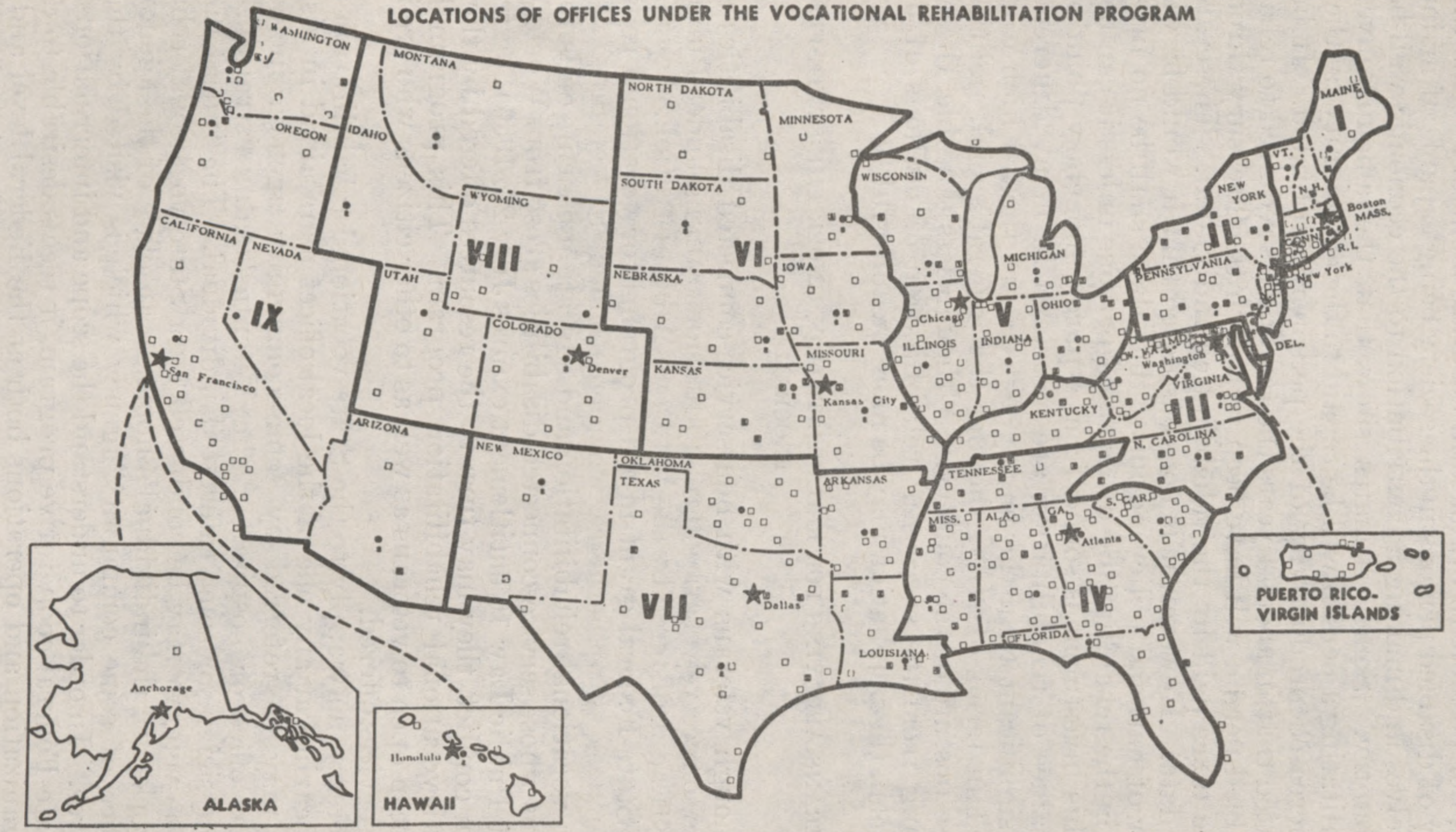
Although veterans with non-service-connected disabilities are not eligible to receive vocational rehabilitation training under Public Laws 16 or 894 administered by the Veterans' Administration, they may look to the State-Federal grant-in-aid programs for vocational rehabilitation services. Furthermore, when entitlement to Veterans' Administration vocational rehabilitation and education benefits ends for those veterans whose service-connected disabilities arose from World War II (under Public Law 16 entitlement expires July 25, 1956), or from the Korean conflict, they may turn to the resources offered by the State-Federal vocational rehabilitation program. This program has always been open to veterans as well as to other citizens who are in need of the services offered.

A veteran may apply to the State vocational rehabilitation agency by appearing at any one of the local offices maintained in his State; or he may be referred by some community agency, including a regional office or hospital of the Veterans' Administration, by his own physician, or some interested individual. The initial interview with the veteran may be conducted by a State vocational rehabilitation worker in the individual's home, in an office of the agency, or in the office of some community agency which is visited by the State employee. In order to understand the scope and interrelationships of the State-Federal cooperative program, it seems desirable to describe its organization and operations both at the Federal level and in the local communities where veterans live. A map showing the distribution of local offices of the 22 State agencies is included herein. See Exhibit H.

78811—56——20

EXHIBIT H

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
Office of Vocational Rehabilitation
LOCATIONS OF OFFICES UNDER THE VOCATIONAL REHABILITATION PROGRAM



1/ District Office – Territory of Alaska

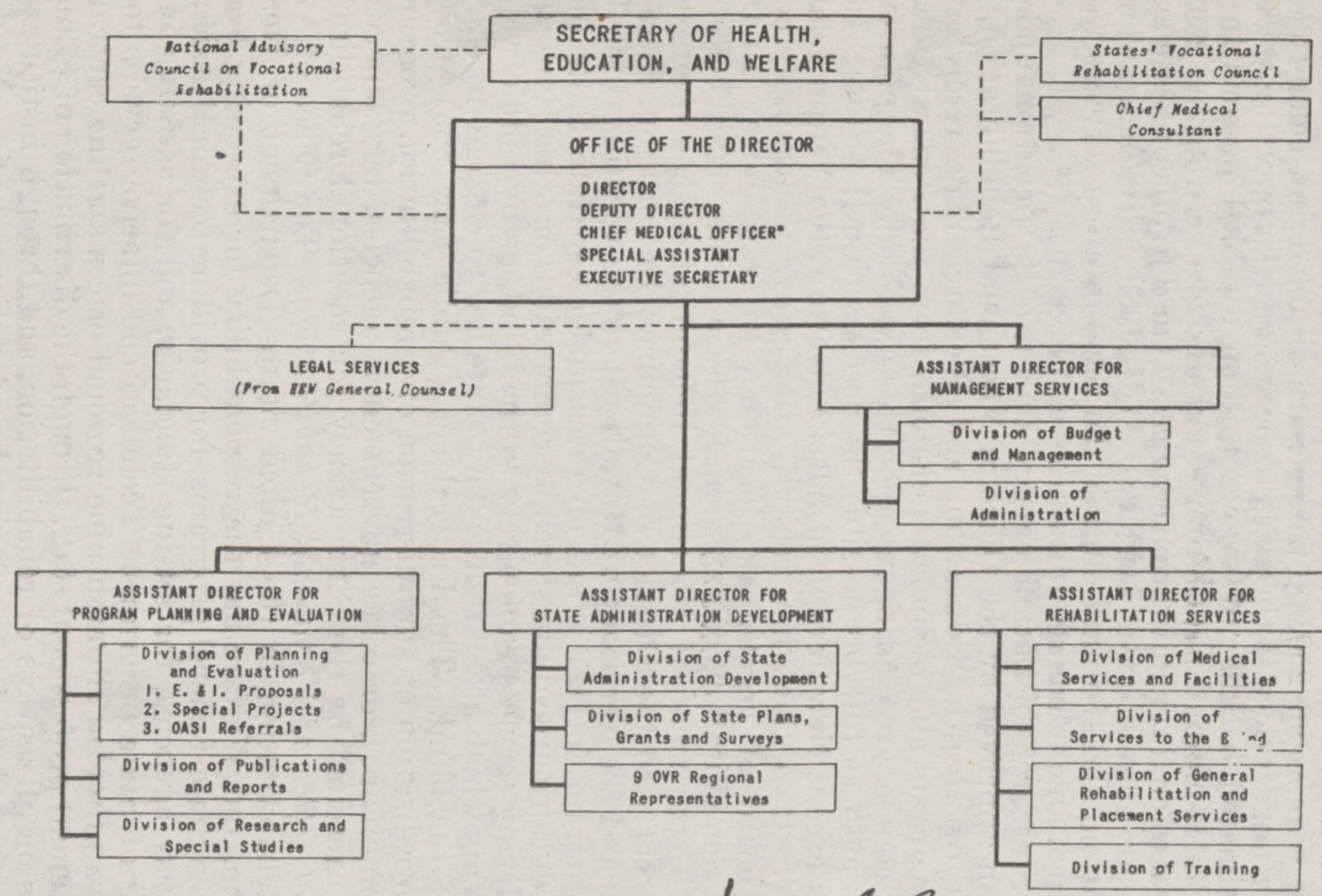
Organization of the State-Federal Program

The State-Federal system of vocational rehabilitation is a grant-in-aid program conducted cooperatively by the Federal Government and 88 State and Territorial agencies. The objective of the program is to assist individuals disabled by accident, illness, or congenital defects to overcome the limitations imposed by their disabilities so that they may engage in remunerative employment. It is estimated that each year about 250,000 persons are disabled and come to need rehabilitation services if they are to become self-supporting. There is an estimated backlog of over 2 million disabled persons in the United States civilian population today who are needing but not receiving vocational rehabilitation services. On the rolls of State agencies there are at any time at least 100,000 disabled individuals awaiting investigation, and if found eligible the rehabilitation services would render them able to engage in suitable employment.

Each State rehabilitation agency operates its program under a State plan approved by the Office of Vocational Rehabilitation, Department of Health, Education, and Welfare. The receiving of monetary grants and technical assistance from the Federal Government, of course, are contingent upon this approval. The plan is designed to meet as fully as possible the needs within the State. In all 48 States except New Jersey, in Alaska, Hawaii, the Virgin Islands, and Puerto Rico, there is a rehabilitation program administered by a State board of vocational education. In New Jersey an independent rehabilitation commission is the administering body. A separate Department of Vocational Rehabilitation has been established recently in the District of Columbia. In addition, there are 36 States and the Territory of Hawaii where the vocational rehabilitation program for the blind operates under separate State plans. These programs are administered by commissions or other State agencies rendering services exclusively to the blind, or by public welfare departments which are authorized by State law to engage in rehabilitation of the blind. The Federal act (Public Law 565) provides for decentralization of administration of a rehabilitation program to county, municipal, or other governmental agencies, but supervision must be exercised by the State agency for vocational rehabilitation.

Federal Office of Vocational Rehabilitation.—The Office of Vocational Rehabilitation in the United States Department of Health, Education, and Welfare has the responsibility for exercising leadership of the State-Federal programs, for providing technical assistance to the State agencies, for setting standards, and for assisting in the financing of State programs. Technical consultative services to the States are provided through nine regional offices and the central office by a small professional staff, through the distribution of technical materials on all aspects of rehabilitation, and through institutes and workshops conducted on a regional and national basis. No direct services to individuals are provided by the Federal agency. An organization chart is attached. (See chart II.)

CHART II



*Also serves as Chief, Division of Medical Services and Facilities.

OFFICE OF VOCATIONAL REHABILITATION

Mary E. Switzer

DIRECTOR OF VOCATIONAL REHABILITATION

November 22, 1954

DATE

The act authorizes three types of grants to the States: (1) basic support for the vocational rehabilitation program; (2) extension and improvement grants to undertake organized activities to extend and improve services to disabled persons; and (3) during the fiscal years 1955 and 1956, grants for planning, preparing for, and initiating a substantial expansion of the vocational rehabilitation of the program in the State. In the latter, the grant may be made directly to a nonprofit agency or organization for projects or activities developed in cooperation with the State rehabilitation agency.

In addition to the above, grants may be made to a State rehabilitation agency and public and nonprofit organizations to pay part of the cost of research or demonstration projects which hold promise of making a substantial contribution to the solution of vocational rehabilitation problems common to all or several States. All applications for such grants are reviewed by the National Advisory Council on Vocational Rehabilitation. Grants may also be made to colleges, universities, and other organizations to pay part of the cost of training rehabilitation personnel. Traineeship awards may be made to individuals undergoing professional training.

The following estimate of Federal funds available for grants in fiscal year 1956, and State funds certified as available, or which may be required for matching Federal funds, shows the size of the program:

Type of grants	Federal funds available	State matching funds
Basic support grants (to 88 State agencies)	$30,000,000	$18,308,443 (certified by States).
Extension and improvement grants (89 grants made to 38 States by Feb. 1, 1956).	1,500,000	500,000.[1]
Expansion grants	1,250,000	625,000.[2]
Special projects of national significance (17 grants made up to Dec. 1, 1955).	1,000,000	(3).
Teaching and training grants (105 teaching grants to 91 institutions; 695 traineeships to individuals).	2,075,000	(3).

[1] State funds required to match the Federal appropriation available for approved projects.
[2] Funds required from project sponsors, either State agencies, or other public or nonprofit agencies, to draw the Federal funds.
[3] Sponsors of projects must show financial participation in special projects, and training institutions are expected to pay part of the cost of teaching grants, but there is no percentage of funds required by law or regulation.

The Federal agency conducts studies and investigations of State agency operations. It might make surveys and reports on various rehabilitation programs which concentrate on special disabilities or special groups, such as the tuberculous, special techniques in rural and industrial placement of the blind, rehabilitation of disabled miners, rehabilitation of the homebound and of the industrially injured. Through a special provision of Public Law 565, the Office of Vocational Rehabilitation, assisted by a National Advisory Council, has approved in fiscal years 1955 and 1956 48 research and demonstration projects requiring more than $1 million. The projects are under the sponsorship of nonprofit and public agencies, including a few State rehabilitation agencies. These are unique special projects to discover new approaches to rehabilitation of special disability groups—such as the mentally retarded, blind and sighted shut-ins, speech, hard of hearing and deaf, cerebral palsied adults, and mentally ill. They also in-

clude research in improved methods of locating and serving certain groups of disabled—such as workmen's compensation cases, the chronically ill, nursing home patients, and others.

Federal grants may be made for the training of personnel who are greatly needed in the rehabilitation field and fields closely allied to rehabilitation. During the first 5 months of fiscal year 1956, some 105 grants were made to 91 educational institutions for training rehabilitation counselors, social workers, occupational therapists, physical therapists, nurses, and physiatrists. Such grants should aid greatly in staffing the expanded State programs within the next 5 years, and should result in raising the quality of services rendered to handicapped individuals.

The State Rehabilitation Council, composed of State directors of the 88 State agencies receiving Federal grants, is used continuously by the Federal director as an advisory group for planning purposes, for exchange and dissemination of information and experiences, and for discussion of the impact of policy pronouncements or changes on State programs prior to their actual promulgation by the Federal office. The director meets with this body at least once each year, and more frequently with its executive committee. The executive committee is made up of representatives selected by the directors of the various State agencies. In addition, the Federal office works with special committees established from time to time by the council, such as committees on administration of State agencies; staff development in State programs; vending stand programs for the blind; committees on relationships with other public agencies, such as public assistance, workmen's compensation, schools for the blind, and the Federal Bureau of Old-Age and Survivors Insurance.

As required by the Vocational Rehabilitation Amendments of 1954, the Secretary of Labor and the Secretary of Health, Education, and Welfare cooperate in developing and in recommending to the appropriate State agencies, polices and procedures which will facilitate the job placement of disabled persons. Together with the Chairman of the President's Committee on Employment of the Physically Handicapped, they also develop and recommend methods which will assure maximum use of the Committee and cooperating State and local committees, in promoting job opportunities for the handicapped.

Special emphasis has been placed on stimulating responsibility at State and local levels for increasing employer acceptance of the handicapped. In fiscal year 1955, the three Federal agencies combined their efforts toward the holding of regional meetings for promoting better working relationships of all agencies concerned with the handicapped. Coordinated publicity and educational projects on employment of the handicapped have been conducted each year. The Federal agencies have obtained the participation of their program counterparts at the State level, and in turn, cooperation has been forthcoming from the local offices of these agencies. Two national art contests of handicapped amateur artists, annual essay contests on employment of the handicapped, radio and television publicity, poster campaigns, and other educational projects have been sponsored.

Efforts toward securing maximum utilization of State employment services in the placement of individuals served by State rehabilitation agencies are continuously under way. There has been a national agreement between the Office of Vocational Rehabilitation and the Bureau of Employment Security for many years. Agreements between the States and their respective employment agencies are required by both the Federal Rehabilitation and Wagner-Peyser Acts. Increased appropriations under Public Law 565 make possible designation of at least one employment counselor in each local office of the State employment service. This should improve greatly the end results of this working relationship at State and local levels of operation.

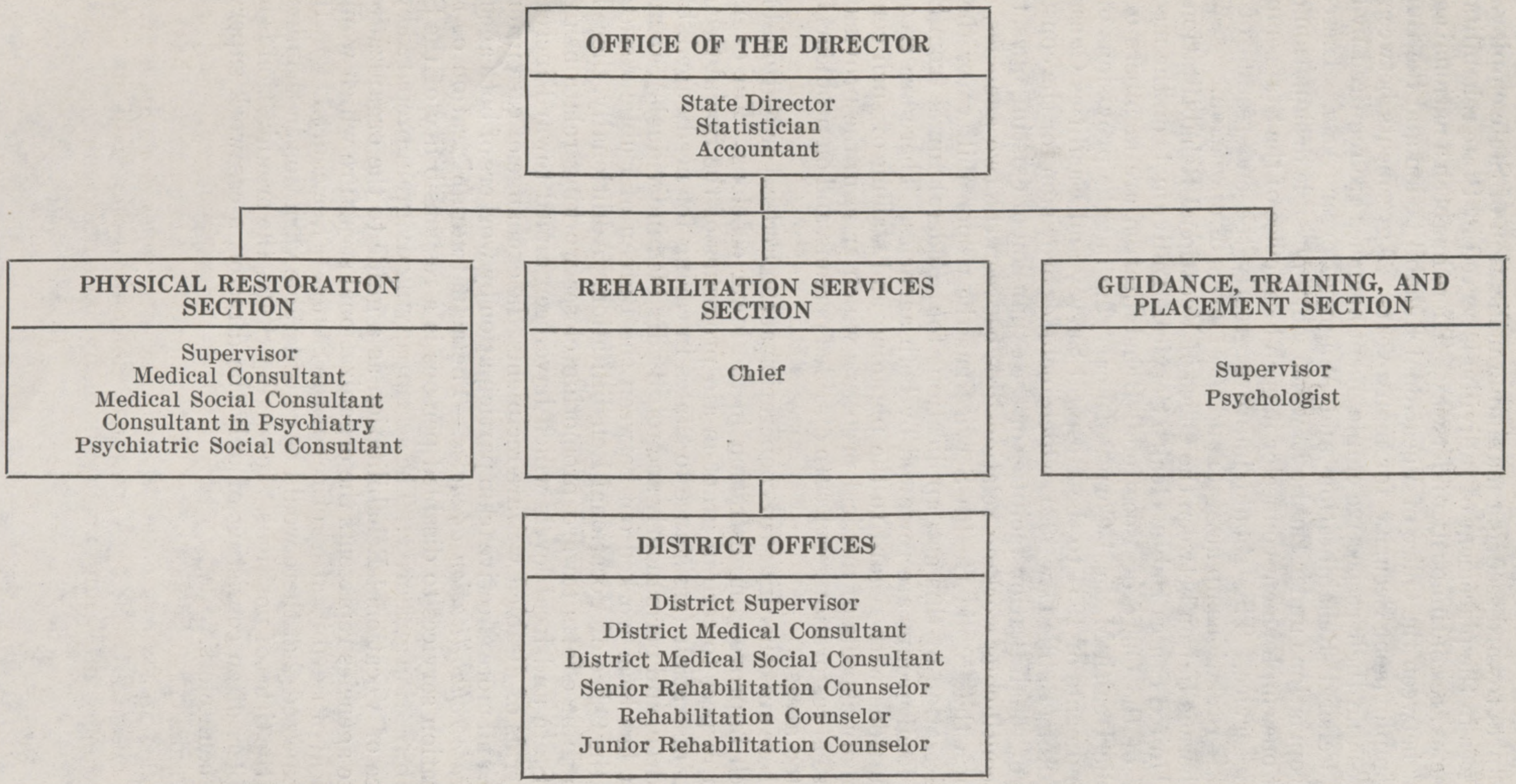
There is liaison between the Office of Vocational Rehabilitation and the United States Public Health Service. Individuals on the medical staff of the Office of Vocational Rehabilitation are members of the Public Health Medical Corps. In carrying out the provisions of the amendments of 1954 to the Hospital Survey and Facilities Construction Act (Public Law 482), which includes provision for the construction of rehabilitation facilities or the expansion of existing ones, there are continuous working relationships between the two agencies. Although the Public Health Service has the responsibility for the administration of this act, applications for Federal funds from State and local groups are reviewed by both agencies. There are frequent discussions with regard to the planning and staffing of such centers, on many aspects of medical problems which arise in the provision of physical restoration services to disabled persons, and on problems from related areas.

There are other kinds of cooperation at the Federal or National level which improve administration in the lower echelons. For example, with respect to certain grant-in-aid programs of the Social Security Administration (assistance to States in caring for needy aged, blind, children, and permanently and totally disabled individuals), an agreement has been worked out between the Bureau of Public Assistance and the Office of Vocational Rehabilitation. Additionally, there have been joint efforts toward promoting closer working relationships at the State and local levels which have been aimed toward increasing referrals of disabled welfare recipients, the exchange of case information, and more effective team participation by workers of both agencies.

State rehabilitation agencies.—The actual administration of rehabilitation services to disabled persons is a responsibility of the State rehabilitation authority. The accompanying diagram prepared by the Office of Vocational Rehabilitation as a guide to the organization of State agencies represents the organizational structure which would be typical of rehabilitation offices of the States. (See chart III.) It can be expected that there would be considerable variation in the numbers and the titles of positions. In smaller States the organization is much simpler, often consisting of only the director, a casework supervisor and counselors.

CHART III

POSITION CHART—STATE REHABILITATION AGENCY



NOTE.—1. Clerical positions are not listed. 2. When there are no district offices, counselors work under immediate supervision of section chief.

In every State agency there is a State director or supervisor of the program who reports to the State board of vocational education, or, in the case of the blind, to some other board or commission having responsibility for the program. In 59 of the 88 State rehabilitation agencies, civil service or joint merit system agencies conduct the initial examination or do the rating of applicants for positions. All 36 agencies serving the blind are governed by merit system procedures.

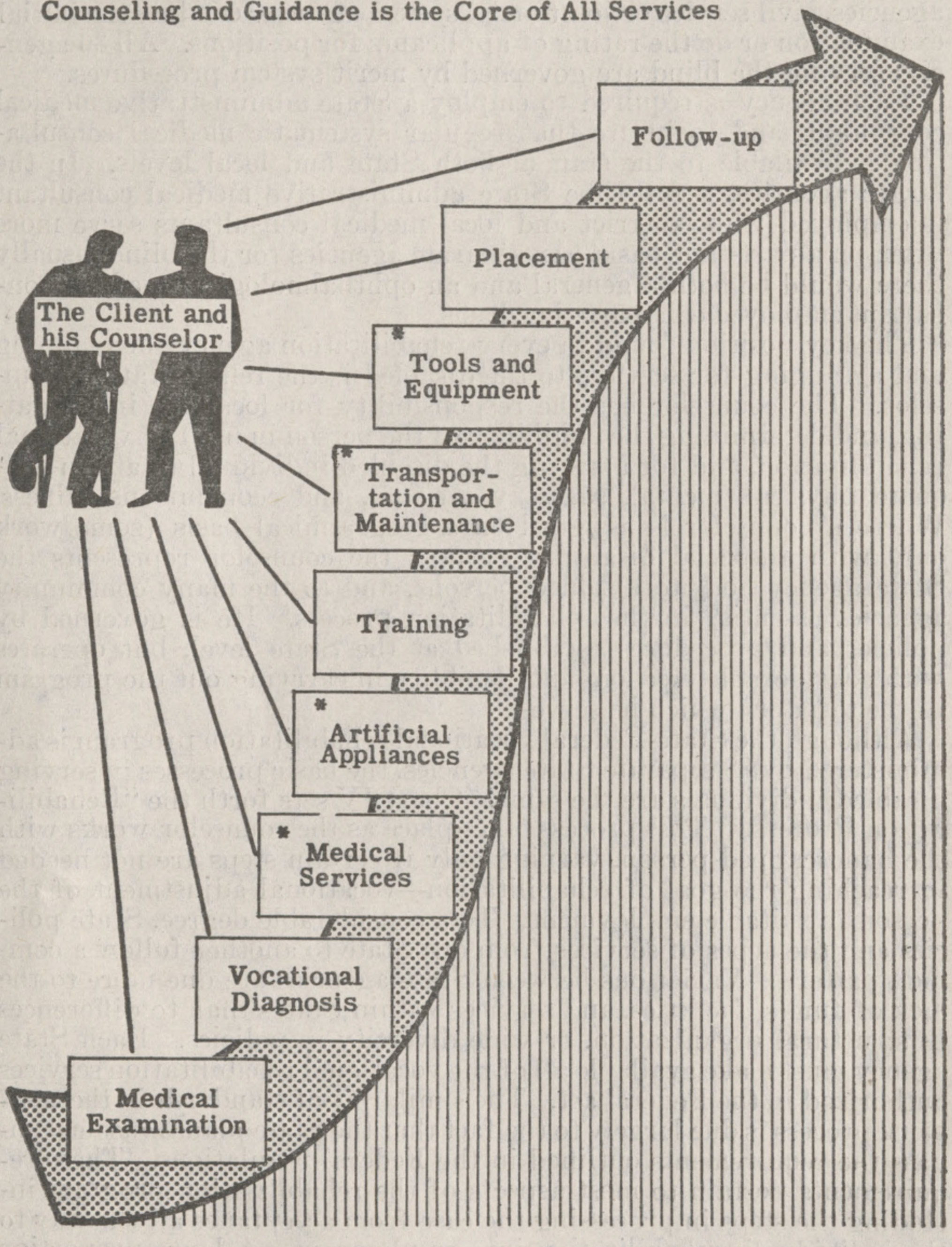
Each agency is required to employ a State administrative medical consultant, and to insure that regular systematic medical consultation is available to the staff at both State and local levels. In the larger agencies, a full-time State administrative medical consultant is employed while district and local medical consultants serve more often on a part-time basis. In separate agencies for the blind, usually there would be both a general and an ophthalmological medical consultant employed on a part-time basis.

The key position found in every rehabilitation agency for planning and arranging for services to the disabled is the rehabilitation counselor. The counselor has the responsibility for locating, investigating, and determining the eligibility of the person in need of vocational rehabilitation, and for assisting the disabled individual to attain adequate physical, mental, social, vocational, and economic usefulness. Where a counselor is assigned on a geographical basis (some work only with a special disability group), the counselor represents the State agency both to disabled persons, and to the many community agencies essential in the rehabilitation process. He is governed by policies and procedures established at the State level, but operates with considerable freedom and flexiblity in carrying out the program in the territory which he serves.

Although the State-Federal vocational rehabilitation program is administered by 88 separate State agencies, the basic processes in serving disabled individuals are the same. Chart IV sets forth the "Rehabilitation Process." This process takes place as the counselor works with the handicapped person, varying only if certain steps are not needed in reaching the goal of rehabilitation—vocational adjustment of the person in suitable employment. To a considerable degree, State policies and the types of services from one State to another follow a common pattern. Variations between State agencies are due more to the lack of funds, facilities, and services within States than to differences in structural organization, or wide diversity in policies. Each State agency must make available all of the vocational rehabilitation services authorized in the Federal act. The similarity of standards in the casework process is due largely to the fact that the State plans must encompass the requirements outlined in the Federal regulations. These requirements pertain to most aspects of the rehabilitation program including the steps in processing the case from acceptance all the way to the individual's rehabilitation into employment. A large proportion of the leadership at the administrative and supervisory levels, as well as a nucleus of counselors in the majority of the agencies, have been enrolled in staff orientation institutes and workshops sponsored by the Federal Office of Vocational Rehabilitation. This has helped to promote uniformity among the many State programs.

CHART IV

THE REHABILITATION PROCESS
Counseling and Guidance is the Core of All Services



*Paid from public funds to extent the disabled is unable to pay for them from his own funds.

Source: Department of Health,
Education and Welfare

Case Finding: Referrals and Acceptance of Cases

Nature of referrals.—As pointed out earlier, the disabled veteran is potentially a candidate for services from the vocational rehabilitation program of the State in which he resides. There has been a long-standing agreement between the Office of Vocational Rehabilitation and the Veterans' Administration pertaining to the referral of veterans, and exchange of information between the two agencies. When a veteran of World War II or the Korean conflict applies to a State agency for services, it is common practice for the counselor to ascertain whether he has applied for training benefits under laws administered by the Veterans' Administration. If training is a needed service for the rehabilitation of the veteran, and he has not exhausted his entitlement to benefits administered by the Veterans' Administration, he is urged to apply to the appropriate Veterans' Administration regional office for these benefits. In some instances where the person has exhaused his entitlement to training under the veterans' legislation, he has been accepted by the State agency and provided with the additional training necessary to complete the planned course. If a veteran indicates that he prefers to be rehabilitated by the State agency, he might receive all needed services from this agency. It is recognized, of course, that he may face more stringent eligibility requirements, also a longer waiting period before the services would commence.

There follows below a description of the various methods of case-finding, and the types of sources from which referrals are made to State rehabilitation agencies. Every State agency is required to provide in its State plan that "it will establish and maintain cooperative working relationships with the workmen's compensation agency, the Bureau of Employee's Compensation of the Department of Labor, the State agency administering the State's public assistance program, the Bureau of Old-Age and Survivors Insurance of the Department of Health, Education, and Welfare, and the State system of public employment offices." [13] Both the Federal law for the State-Federal vocational rehabilitation program and the law establishing the nationwide system of public employment offices require that each State must develop a written agreement which shall provide, among other things, for reciprocal referral services, exchange of reports of service, joint-service programs, continuous liaison and maximum utilization of the services of the public employment offices.[14]

In addition, the State rehabilitation agency in its plan agrees to establish and maintain working relationships with other public and private agencies such as: tuberculosis sanatoriums, crippled children's agencies, Veterans' Administration facilities, hospitals, State and local health departments, and voluntary social and health agencies providing services that relate to vocational rehabilitation. Written agreements, together with specific procedures for referrals, have been developed between State rehabilitation offices and workmen's compensation agencies, State welfare departments, and certain other public

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[13] Regulations pursuant to Public Law 565, sec. 401.13.
[14] Ibid., sec. 5 (a) (1).

agencies. There are often agreements with private rehabilitation facilities from which services are purchased by State agencies. These agreements include provision for reciprocal referral of clients by one agency to the other.

Commission's study of Relationships of Veterans' Administration Hospitals with other agencies.—Referrals are generally on a regular automatic basis with tuberculosis sanatoriums, and certain other specialized hospitals in many States. A questionnaire was mailed by the Commission to 18 (approximately 10 percent) of the Veterans' Administration hospitals and domiciliaries, requesting information about working relationships with outside agencies. Only 2 of the 18 facilities reported that no relationships had been established with State vocational rehabilitation agencies. Of the 16, 4 reported that a representative of the State agency visited the hospital regularly, 2 reported irregular visits, and 10 stated that a representative responded upon request. Eleven of the 16 were satisfied that the arrangements which had been developed between the hospital and the State agency were adequate to meet the needs of their patients; 5 others wanted more frequent contacts by the representative of the State agency. A total of 558 veterans had been referred by these Veterans' Administration hospitals to State rehabilitation agencies in fiscal year 1955. Of these cases, 10 percent were service-connected. In Veterans' Administration hospitals the State-agency representative is likely to participate with the Medical Rehabilitation Board in discussions of cases, and may be provided, both orally and in written summaries, a considerable amount of medical data and counselling information. He may give and be given assistance in planning the program for the individual veteran.

Extent and importance of referrals.—Valuable as agreements and established procedures are for insuring coordination, practice has shown that the keys to good working relationships are the attitudes of the leadership at the supervisory levels and of the counselor at the operating level. The counselor is expected, as a part of his assigned duties, to maintain a schedule of regular contacts with welfare and employment offices, secondary schools and colleges, and with other agencies to whom disabled persons are known. He may have desk space in the offices of some agencies, and may be invited to attend staff meetings to present the rehabilitation program.

The counselor uses many community resources in obtaining services for his clients, such as physicians, clinics, welfare agencies, rehabilitation centers and other special facilities. The disabled veteran in his home community may be brought to the attention of the local rehabilitation counselor through a very great variety of ways. (See Table 2.)

TABLE 2.—*Number of persons rehabilitated, by source of referral, fiscal years ended June 30, 1945 and 1954*

Source of referral	1945		1954	
	Number	Percent	Number	Percent
Total	41,925	100.0	55,825	100.0
Educational, total	4,084	9.8	5,853	10.5
Business college	514	1.2	408	.7
Private school	741	1.8	328	.6
Public school	2,521	6.1	4,537	8.2
School for handicapped	308	.7	580	1.0
Health, total	4,816	11.5	18,455	33.1
Crippled Children's Agency	1,089	2.6	1,019	1.8
State mental hospital	50	.1	465	.8
Tuberculosis sanatorium or association	1,251	3.0	4,494	8.1
Marine hospital or relief station	182	.4	43	.1
Other hospital or clinic	837	2.0	2,879	5.2
Other health agency	787	1.9	2,101	3.8
Physician	620	1.5	7,454	13.3
Insurance, total	2,072	5.0	1,303	2.3
Insurance company	10	(1)	67	.1
Bureau of OASI	5	(1)	0	0
State Workmen's Compensation Agency	1,684	4.1	1,180	2.1
United States Employees Compensation Commission	373	.9	56	.1
Welfare, total	4,242	10.1	9,171	16.5
American Red Cross	1,367	3.3	204	.4
Public welfare agency	2,340	5.5	7,857	14.1
Private welfare agency	535	1.3	928	1.7
Community advisory center	(1)	(1)	182	.3
Other Government agencies, total	15,591	37.3	6,048	10.9
Selective Service System	3,172	7.6	78	.1
State vocational rehabilitation agency	1,205	2.9	850	1.5
State employment service	9,092	21.7	3,742	6.9
Veterans' Administration	746	1.8	585	1.0
Maritime Commission	40	.1	4	(2)
Public official	1,336	3.2	322	.6
United States Civil Service Commission	(1)	(1)	6	(2)
Other Government agency	(1)	(1)	461	.8
Miscellaneous, total	11,014	26.3	14,898	26.7
Artificial appliance company	772	1.8	1,747	3.1
Employer	1,014	2.4	489	.9
Labor union	25	.1	438	.8
News item, publicity, etc	605	1.4	553	1.0
Other individual	3,606	8.6	5,389	9.7
Self-referred	4,362	10.5	5,930	10.6
Other	630	1.5	352	.6
Not reported	106	(3)	97	(3)

[1] Not available.
[2] Less than 0.05 percent.
[3] Excluded from distribution.

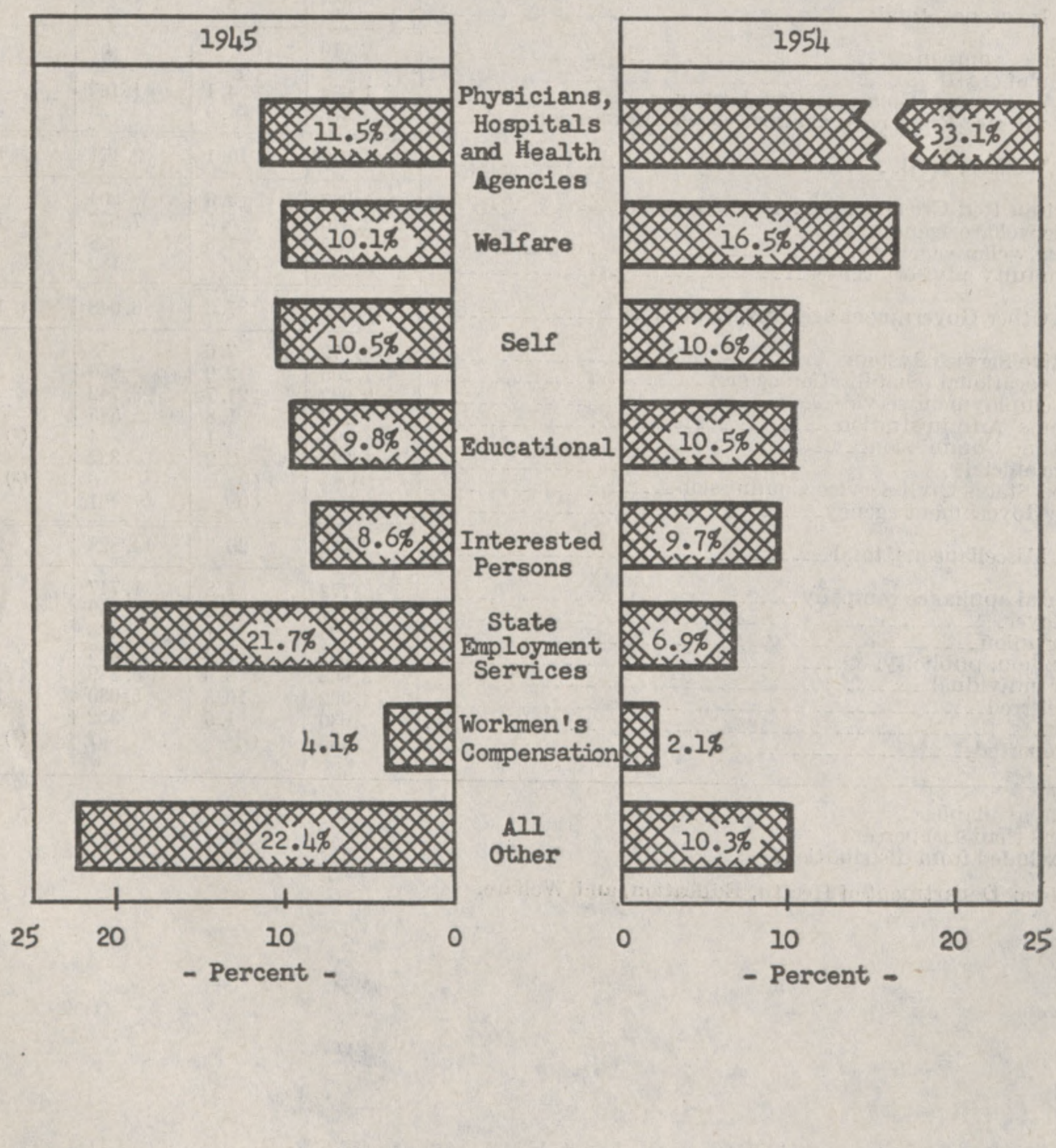
Source: Department of Health, Education, and Welfare.

Chart V shows a comparison of referrals by sources for 1945 and 1954. It is important to note that the largest percentage of referrals in 1954 came from health agencies and physicians, with the next largest group coming from welfare agencies. This is in contrast with the 1945 situation when governmental agencies were referring the largest numbers of handicapped persons. Medical sources are considered primary sources of referrals, since the disabled individual becomes known to these agencies and to physicians early in the period of his disablement. The better the working relationships that have been established with community agencies, the less reliance has to be

CHART V

PERSONS REHABILITATED IN 1945 AND 1954
BY MAJOR SOURCES OF REFERRAL

By Percentage Distribution of Total Number



Source: Department of Health, Education, and Welfare

placed on referrals from miscellaneous sources, some of which have limited knowledge of the program.

It is well to point out that in several States arrangements have been made with the workmen's compensation agency to pay the costs of training and other services essential in the rehabilitation of injured workmen. Among these referrals, of course, would be veterans—since they constitute nearly one-third of the labor force. Where the Federal-State cooperative program in Aid to the Permanently and Totally Disabled has been established (in 41 States, 3 territories, and the District of Columbia),[15] vocational rehabilitation counselors usually participate on State and local teams rendering decisions on eligibility for this program. Where such arrangements have been made, there is a large number of referrals from welfare departments to State agencies.

Time of acceptance of cases as related to onset of disability.—It is a maxim in rehabilitation that the sooner the rehabilitation process begins with a disabled person, the greater the likelihood that it will culminate in success. Many factors cause time lags in making the original referral, and in the period between referral and acceptance for rehabilitation. Among those factors causing delays in referrals to the State agency are: Lack of awareness among handicapped persons of the program and its significance for them; lack of awareness among agencies and professional personnel who come in early contact with the disabled; inadequate Federal and State funds for staff and for the purchase of essential case services; lack of understanding of the potentialities of rehabilitation by medical personnel and others in related fields (often because of no recognition in the training programs of such professions); and an erroneous concept by many individuals and agencies that the State rehabilitation agency is primarily a training program for the disabled. This latter concept became outmoded in 1943, yet there are still many cooperating agencies, as well as a few State rehabilitation agencies, which tend to take this narrow view of rehabilitation.

The present Federal vocational rehabilitation statute, Public Law 565, provided for a greatly expanded State-Federal program when it was passed in August 1954. At that time, State agencies had a backlog of over 81,000 cases which they had not been able to investigate. State legislatures had already made their current appropriations with the result that in many instances there were insufficient State funds to match the Federal funds available. State appropriations for fiscal years 1956 and 1957 are showing considerable increase. However, there are not only large backlogs of cases referred for rehabilitation, but these numbers are continuously increasing. This results, in part, from stepped-up programs of publicity, inauguration of permanent and total disability assistance programs by welfare departments for meeting the subsistence needs of indigent handicapped persons, and more recently the "freeze provisions" for disabled workers which constituted an amendment to the old-age and survivors insurance provisions of the Social Security Act.

In spite of the backlogs of cases, there is evidence that handicapped persons are being brought to the attention of State rehabilitation agencies earlier in their period of disablement than they were 10 years

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[15] Bureau of Public Assistance, Social Security Administration, Department of Health, Education, and Welfare.

ago, or even in more recent years. This decrease in time is due in large measure to the steadily climbing proportion of referrals coming from physicians, hospitals, nurses, clinics and other health agencies. These are the sources which usually are first to know whether persons have residual disabilities which interfere with their potential employability. Table 2 shows the numbers and percentages of the total group of rehabilitants as related to sources of original referral in 1945 and in 1954. Whereas only 11.5 percent of the cases rehabilitated in 1945 came from health agencies and physicians, 10 years later 33.1 percent came from these referral sources. That the family doctor is becoming increasingly aware of the program is amply demonstrated by the fact that this source accounts for 13.3 percent of the rehabilitants as compared with 1.5 percent of the total in 1945.

Table 3 relates the age-groups of rehabilitants between 15–49 to age at onset of disability, distributed by 5-year intervals. It is noted that 37.8 percent of the persons rehabilitated, who incurred their disabilities between ages 15 to 19, were accepted within the first 5 years of their period of disablement. The percentage of the total persons rehabilitated within each 5-year group at onset of disability increases until 50 percent of the persons between 40–44 were rehabilitated from 1 to 5 years or less following the incurrence of the disability. This increases to 53.5 percent of the 45–49 year age-group being rehabilitated at some time within the first 5 years of their disablement. Although table 3 is only for the year 1954, comparisons made with similar studies 5 and 10 years previously, show that State agencies are increasingly reaching disabled persons closer to the date the disability occurs.

TABLE 3.—*Number of persons rehabilitated, by age at disablement and by age at acceptance, fiscal year ended June 30, 1954*

Age at disablement (years)	All ages	Age at acceptance for rehabilitation						
		15–19	20–24	25–29	30–34	35–39	40–44	45–49
Total	55,825	9,800	7,650	5,951	5,787	6,294	6,019	5,147
Congenital	7,289	3,247	1,593	762	483	409	304	220
Under 5	3,213	1,352	613	311	236	221	209	120
5–9	3,042	1,283	637	309	236	194	140	113
10–14	3,626	1,621	699	359	230	211	170	143
15–19	5,924	2,328	1,822	595	388	287	220	119
20–24	5,664	0	2,255	1,518	697	428	304	200
25–29	5,060	0	0	2,066	1,472	675	356	221
30–34	4,937	0	0	0	2,005	1,610	700	307
35–39	4,678	0	0	0	0	2,227	1,496	547
40–44	4,118	0	0	0	0	0	2,093	1,343
45–49	3,346	0	0	0	0	0	0	1,788

Source: Department of Health, Education, and Welfare.

Determination of eligibility

Generally, the counselor has some information from the referral source about the disabled person in addition to name, address, age and disability. In many instances, particularly when the person is referred from a medical source, a summary of case information (including a considerable amount of medical data) is available in appropriate cases. Regulations applicable to Veterans' Administration hospitals require these facilities to foward summaries of both medical

and counseling information to the State agency upon consent of the individual. The medical examination report essential to determine certification of the disabled person as totally and permanently disabled under the "freeze" provisions of the Social Security Act, is made available on these referrals if the State rehabilitation agency has been designated to perform the certification function. Fifty-one rehabilitation agencies in 43 States, 3 territories, and the District of Columbia have been designated to carry this responsibility.[16]

In some instances the rehabilitation worker may prepare for his conference with the handicapped persons by contacting the referral source and requesting certain types of information from them. He often has access to the complete case-record of the referring agency. There are strict requirements, of course, which protect the confidentiality of the information.

Initial interview.—This may take place in the office of the agency, at one of the many itinerant offices of the State welfare department or of the employment service which the counselor contacts regularly, or it may be by appointment in the home of the individual. For a veteran who has been hospitalized, the interview would, preferably, take place in the hospital prior to discharge.

It is during the first interview that any specific State requirement for eligibility, such as a State residence requirement, would be considered. In all but four State agencies, the State plans make the bona fide intention of the individual to reside in the State the primary basis for establishment of residence. California and Wisconsin have a 1-year residence requirement, but in Idaho if the injury is incurred in the State the requirement is waived. New Mexico requires 90 days of residence, provided the person is not in the State for temporary purposes. If a State has set a time period as one of the elements in establishing residence, this is necessarily not a serious obstacle for the person seeking services, because the counselor may proceed with necessary case investigation and planning with the person in the period before residence is established.

During the first interview, the counselor explains the program objectives of the agency, how it functions with respect to the individual, and what is expected of him in achieving his rehabilitation. The sources for pertinent information are determined and the written consent obtained from the individual for release of such information. The amount of information elicited from the client in this interview depends upon his expressed needs, the likelihood that the person will qualify for acceptance, the necessity of having medical appraisal before discussing a plan, and to some degree the accessibility of the person to the local office and to the services he may need.

Often an extensive survey interview is conducted at the time of initial contact. In this would be collected such data as: Age; marital status; size of family; number of dependents and family relationships; employment status and educational background of family members and of the applicant; vocational history—including jobs held, wages, duration and reason for termination of employment; vocational adjustment to the disability, if any; current status of the disability and treatment; and previous medical history of hospitalizations and

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[16] The State Welfare Department has been designated in 5 States.

treatment. There is considerable exploration of the client's attitude toward adjustment to his disability—especially as related to motivation toward employment. There is generally some assessment of the social and economic situation to determine whether he can participate in the cost of purchased services.

In some instances during the initial interview the counselor can determine that the major services required by the individual are those best provided by other agencies, or that his greatest need is assistance toward placement in a field of work for which he is already qualified. In such cases appropriate referral would be made to other agencies.

If the counselor believes that the person's needs come within the proper scope of the agency, arrangements are made for obtaining diagnostic information from sources to which the person has been known. Referral would be made to the physician chosen by the individual for examination to establish physical and health status. This examination may be a general medical appraisal, or it may be a special medical evaluation; or both types of examinations may be undertaken early in case processing. The counselor often communicates with the physician by letter or telephone, setting forth questions which must be answered in order to determine eligibility, and to plan on a sound basis with the handicapped person. Agency policies may be set forth in a casework manual which serves as a guide to the counselor in making arrangements for medical evaluation. In some agencies specialty examinations would always be obtained for certain disabilities, while in others the medical consultant would determine the necessity for such examinations. With visually handicapped persons, often the ophthalmological examination has been done and the report is available from the original source, or from the welfare department if a determination has been made with respect to eligibility for blind assistance.

The counselor must have a good understanding of the medical diagnosis in order to determine whether the disability constitutes a substantial handicap to employment, and whether physical-restoration services should be provided to remove or reduce the disability. If there are questions about eligibility, whether physical-restoration services are needed, or assistance is needed in planning a program which recognizes fully the impact of the disability, the counselor would usually consult his supervisor and the medical consultant. A psychological examination is required in any case where the disability is mental retardation, and a psychiatric evaluation is usual procedure for emotionally disturbed individuals. The counselor, his supervisor, and the medical consultant share responsibility for insuring that the case record contains adequate medical appraisal for decisions on eligibility, for planning physical restoration and other needed services.

In the case-investigation process, information from schools attended by the disabled person might be relevant if such attendance was recent and if the information is significant for case planning. If he is in need of formal training to supply a lack of skills, a transcript of credits might be obtained. However, if the primary need is surgery and medical treatment, there might be little exploration of the school background. Reports of previous psychological examinations, if recent, are often requested. Arrangements to purchase psychological services may be made by the counselor where such information will assist toward sound planning. In some cases where the disabled per-

son would find it difficult, if not impossible, to travel in order to be examined by a psychologist, the counselor may give the necessary tests. In some States the employment service will administer its general-aptitude tests.

The counselor explores the family and social situation of the client in a number of ways, including interviews with and observations of the client and family members, reports from other agencies who have known the person and the family, and the use of a social worker on the agency staff or in another agency to interview the client. The spouse, or parents in the case of a minor, would often be interviewed and their cooperation solicited in the planning of the individual rehabilitation program. A home visit is made to evaluate the social-economic circumstances of the client and family.

There is need for a careful evaluation of the vocational background of disabled persons in order to determine eligibility and to gather information on work skills and adjustment to employment. Visits to employers are useful for this purpose, as well as to locate suitable work opportunities.

Case diagnosis.—Essential to the determination of eligibility and to sound rehabilitation planning is case diagnosis. In this process—as far as possible—are identified the problems to be solved and the needs to be met in terms of their significance for employment. The counselor must take the following steps in determining whether a disabled individual is eligible:

> (1) Establish the presence of a disability and the resulting functional limitations, or limitations in activities;
>
> (2) establish the presence of a substantial handicap to employment caused by the limitations resulting from such disability; and
>
> (3) determine whether there is a reasonable expectation that vocational rehabilitation services may render the individual fit to engage in a remunerative occupation.[17]

The amount of case investigation, and the timing of the decision of eligibility, vary from case to case. In some cases it is obvious at the time of referral, or early in the initial interview, that the client has a disability which prevents his engaging in his former field of work, or any other for which he is qualified. In other cases, extensive medical appraisal describing the functional limitations (or limitations in activities) is necessary to establish existence of a substantial employment handicap. The term "substantial handicap to employment"—as defined in the Federal regulations—

> means that the functional limitations (or limitations in activities) resulting from a disability materially impede an individual's occupational performance by preventing his obtaining or retaining employment consistent with his capacities and abilities.

It becomes necessary, therefore, to obtain essential medical diagnostic information which sets forth the physical and mental capacities and limitations, together with appropriate vocational data which can be analyzed to determine the meaning of the physical or mental disability for the particular individual with respect to his employment situation. A serious disabling condition for one person may not affect his ability to carry on his work; for another, the same condition—

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[17] Regulations, Public Law 565, sec. 401.14 (b).

coupled with personal, social, and vocational factors—may represent an insurmountable obstacle to his rehabilitation.

In some cases where there are severe personality and maladjustment problems, it may take weeks or even months to complete the third step of eligibility. It may even mean the initiation of services to remove some of the "blocks to rehabilitation" before the agency can render a sound decision on whether the case can be rehabilitated. The coordinated team approach, the use of a rehabilitation center, psychiatric treatment, or a trial period in a sheltered work situation, may have to be tried before the agency can decide to accept or reject the case.

Of the 55,825 persons rehabilitated in 1954, 76 percent were unemployed at the time of acceptance, of whom 12 percent had never worked, and 24 percent had had only part-time or very intermittent employment. In practice, there is always more strict application of the term "presence of a substantial handicap to employment" with persons who have jobs than with those who have been unsuccessfully seeking work. If an employed person is to be accepted the disbility must be endangering to his retention in the job, or the employment may be aggravating the disability, or he has only part-time or unsuitable work not commensurate with his abilities. Most of the 24 percent of those working at the time of acceptance were unemployed while undergoing their rehabilitation; some of these, following physical restoration or other services, were able to return to the same employer.

The question of "reasonable expectation of rehabilitation", often referred to as "feasibility", depends upon the available facilities, personnel and services, quite as much as the severity of the disability. Although out-of-State facilities are used, difficulties of transportation, unwillingness of the client to leave home, and lack of cooperation on the part of his physician frequently present insurmountable rehabilitation problems. The lack of a motivating spirit within the individual, and the lack of cooperation of his family, often prove far greater obstacles to planning than the severity of the disability. In achieving a successful rehabilitation there is no substitute for the individual's wholehearted cooperation in the planned program.

Counseling and Planning

This function, begun at the outset, is one of the major services performed by the State agency, and is inherent in the total rehabilitation process. Usually, however, counseling with respect to the employment objective and the planning of services must await the accumulation of medical, vocational, and other case data. Where personal, social, and family problems are involved, the counselor may endeavor to advise on them, or he may request assistance from others on the agency staff, or enlist the services of another agency which specializes in such problems. If the disabled person shows a reluctance to accept medical services—such as surgery, or the wearing of an appliance—the counselor may arrange for a conference in which the supervisor of physical restoration, the medical consultant, and the client participate. The makeup of this rehabilitation team varies with the problem and the circumstances surrounding it.

If subsistence is needed for the client and his family, generally the counselor will refer the person to the welfare office—enlisting the cooperation of a social worker in carrying out this part of the rehabilita-

tion program. The Vocational Rehabilitation Act provides for Federal reimbursement to State agencies only for expenditures for the handicapped person. If there are family needs to be met during the rehabilitation process the State would generally arrange for the public welfare agency or some other welfare service to meet the situation. The needs of the client's family can and often do condition the type and duration of the program that can be planned.

The counselor enlists the assistance of medical and social service personnel in advising on complicated socio-health problems, often utilizing the family physician, or arranging for consultation with medical and psychiatric social workers employed by the referral agency or by the facility from which medical services are purchased.

Development of the rehabilitation plan.—Each State agency must provide in its State plan that—

> an individual plan of vocational rehabilitation will be formulated for each eligible client * * * The individual plan (1) shall be based upon data secured in the diagnostic study; (2) shall specify the vocational rehabilitation objective (or tentative objective * * *) and the services necessary to accomplish the client's vocational rehabilitation, and the plan for providing * * * such necessary services; and (3) shall be formulated with the client's participation.[18]

There are other provisions required in the client's plan concerning the carrying of services to their completion insofar as possible, terminating or revising the plan when it is evident that the client's vocational rehabilitation cannot be achieved by the program, or the services cannot be completed, or the client's needs have changed. The plan outlines specifically the scope of the individual program. To a considerable extent the soundness of the program determines whether the person will or will not be rehabilitated into suitable employment.

The counselor, in performing this important function, should have extensive knowledge of the client, of occupations and vocational fields which can most effectively utilize or accommodate his abilities and limitations. He must know the community and his State, and what is available to meet the great variety of needs of handicapped persons. Each plan must be "tailormade" for the individual. The steps in developing the plan and putting it into operation are discussed below.

Selection of the employment objective.—This process obviously varies from case to case. In some instances, the step is a fairly simple one because early in the development of the case it is indicated that, following the provision of medical services, the person can return to his last job, or to a former employer, or at least to the same type of work in which he had engaged prior to the disability. In others, where extended physical restoration services are considered necessary, and where the outcome of these may not be forecast, the counselor may be able to discuss the vocational objective only in very broad and tentative terms until the individual has completed the medical aspect of the program. Where the person has never worked, or a decidedly new field of work must be considered, the selection of the employment objective is a longer process. Where there is a conflict between the person's interests and ambitions, as well as his abilities and physical limitations, the counselor must find ways of bringing the handicapped person to a realistic appraisal of himself and of employment possibilities.

[18] Ibid., sec. 401.16.

Problems and unmet needs requiring solution must be discussed frankly if the program planned is to be carried forward to successful completion. Where long-term training is indicated, and there are dependents, the counselor must be certain that the needs of the family can be taken care of during the training period, or the program must be revised until it is on a solid basis. Where the disability may be aggravated by employment, or there is any question of the suitability of the employment objective for the person from the standpoint of his physical or mental condition, the counselor would discuss the individual plan with his supervisor—and often with the medical consultant. In some States every plan is reviewed by the supervisor of physical restoration and the medical consultant before services are initiated.

Where the cooperation of another agency (such as the welfare department or the workmen's compensation agency) may be necessary for the successful completion of a client's program, there must be assurances that it will participate until the final goal is reached. The counselor must be satisfied that the client is ready not only to accept the total program, but to put forth his best efforts in working toward its completion.

Selection of services and facilities.—State rehabilitation agencies use a very great variety of facilities and services to meet the needs of those they serve. They are continuously searching for new potential resources for the disabled. For diagnostic and treatment purposes, the facilities used would include every recognized medical facility, and all licensed professional personnel that are available—including physicians of all types, hospitals and clinics, rehabilitation centers, and personnel in allied professional fields such as physical and occupational therapists. The medical advisory committee of the State agency is utilized in determining the standards for the selection of medical personnel, and where new facilities have been established, in evaluating the suitability for the agency's program. Both public and private accredited training institutions at the secondary and college level are used. Also, public vocational schools serving adults, workshops, personal adjustment centers, on-the-job training through employers, and technical schools known to offer sound training programs.

The agency's State plan is required to show that "working relationships will be established and maintained with other public and private agencies * * * to assure maximum utilization on a coordinated basis of the services which all agencies in the State have to offer for the vocational rehabilitation of handicapped persons."[19] The State agency also agrees "to establish and maintain standards for the various types of facilities and professional personnel utilized in providing services to eligible individuals, and shall describe the bases on which they were developed."[20] The State agency must also develop fee schedules for diagnostic services, also for training and physical restoration services, to be purchased for clients.[21] Therefore, the counselor is required to set forth in the plan for the individual, the services and facilities to be used in preparing the person for employment. Although the framework within which services are provided allows for considerable flexibility, and recognizes community participation in the

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[19] Ibid., sec. 401.13 (b).
[20] Ibid., sec. 401.24.
[21] Ibid., sec. 401.25.

rehabilitation of handicapped persons, the negotiations and arrangements for the services with the client and with facilities, takes considerable skill and time.

Provision is made to give the client as much latitude as possible in selecting the physician and the facility to be used. The agency may maintain a panel of specialists from which the client may make his choice for physical restoration services. Often the family physician, or the specialist who did the examining and made the recommendations, are a determining factor in the selection of the facility to be used for physical restoration services.

Training facilities within the State are generally selected, unless the required courses of study are not readily available, or there is reason to believe an out-of-State facility would be more suitable for the individual. The counselor discusses with the client the various facilities which offer the training, the advantages or disadvantages of each in the particular case, and explains agency policy if this is a factor in the selection. If a new school is considered, the counselor in the area where it is located would make the investigation and report to the State office on the equipment, teaching staff and other conditions, and the cost of the training. The report is then made available to all operating personnel. If an out-of-State school is considered and has not been used by the State agency for any clients, the rehabilitation director of the State in which the facility is located would be asked for an evaluation of the training offered.

Approximately 36 percent of the 1954 rehabilitants received training. In many instances the type of training appropriate for the individual was available only through a single source, such as a workshop, a personal adjustment center, or in a local business or industrial establishment, or in a hospital, clinic, or some other medical facility. It is not infrequent that an employer who knows the disabled person is persuaded to try him in several different jobs, to pay him a minimum wage during this period and then determine the occupation in which it becomes evident he has the most to offer without aggravation of the disability. This type of service would not be reported as training, because of no cost to the agency.

A type of case where the counselor gives a great amount of time to planning, the selection of services, and to counseling about a large number of matters, is that of the severely disabled person who is rehabilitated into self-employment. These cases may or may not involve physical restoration and training; they often require the purchase of suitable tools and equipment, selection and rental of space, advertising, and a study of the best methods for marketing the product or the services of the handicapped person.

Establishment of Need for Certain Services

A State agency in its "plan" may make the establishment of economic need a condition for the provision of rehabilitation services to a disabled person. Listed below are the various services provided by State agencies. Those with an asterisk are the services for which Federal financial participation is available, only

if the expenditures have been made for services to eligible handicapped individuals found by objective standards uniformly applied in accordance with the State plan to be in economic need.[22]

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[22] Ibid., sec. 401.20, sec. 401.41.

(*a*) Medical diagnostic services to learn about the disability and to help determine eligibility for services.

(*b*) Individual counsel and guidance, including psychological testing.

*(*c*) Physical restoration services.

(*d*) Training (except that 2 States require the establishment of need for this service; i. e., a means test).

*(*e*) Books and training materials.

*(*f*) Tools, equipment and initial stocks (including livestock) and supplies; equipment and initial stocks and supplies for vending stands; and necessary shelters in connection with foregoing items.

*(*g*) Maintenance, with certain limitations after placement (expenditures for short periods of medical care for acute conditions, which if not cared for, would constitute a hazard to achievement of the vocational objective).

*(*h*) Transportation (economic need not required if in connection with diagnosis).

*(*i*) Occupational licenses.

*(*j*) Other goods and services (such as business licenses, reader and attendant services), necessary to render a handicapped person fit to engage in a remunerative occupation, and not contraindicated by the act.

(*k*) Placement in a suitable job.

(*l*) Followup to insure successful employment adjustment.

If the State agency desires Federal reimbursement for expenditures for services conditioned on need, it must meet certain specific requirements set forth in the Federal regulations.[23] For instance, the State plan must set forth—

the policies and standards for objectively measuring the individual's ability to procure services conditioned on economic need, and for determining the amount of agency supplementation required to procure the necessary services.

The State is required to take into account all consequential resources available to the individual, including pensions, compensation, insurance, and current income as well as remuneration in kind and from on-the-job training, or any other source. The State may provide for the exemption of specified capital assets, such as property, cash, liquid assets not constituting income, which may be deducted from available resources, but such amounts must be stated in the plan, and must be reasonable.

The regulations require the State to establish a "normal living requirement" which is used as the yardstick in assessing how much each client needs for his own living expenses. The amount allowed in the normal living requirement, together with certain amounts for specified obligations, can be deducted from the client's available resources, before determining whether he has any resources to meet the costs of essential rehabilitation services conditioned on need. In a study of 50 State general agencies made in 1954 by the Office of Vocational Rehabilitation (which included Puerto Rico and the District of Columbia programs), the median dollar value of this basic standard when shelter was included was $105 per month. The range was from $41 for Puerto Rico to $173 for Florida and $175 for Minnesota. Mod-

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[23] Ibid.

ifications for special conditions, such as special diets, or unusual requirements of a severely disabled person, are provided for in about one-half of the agencies.

The Federal agency allows resources of the client to be used for such obligations as: (*a*) legal dependents and others living in the home for which he has accepted responsibility; (*b*) obligations he is required by legal process to meet; (*c*) others that would be a substantial obstacle to his rehabilitation if not recognized. Most States recognize these obligations and under the latter item (*c*) may specify certain types of debts, taxes on property included in the exemption of capital assets, sales and income taxes, insurance premiums within certain limits, and similar items. Among the assets exempt are a specified amount of real property, which often is restricted to the home in which the client resides provided it does not exceed a stated maximum value. Because this maximum is expressed in some States by assessed valuation and in others by market value of property, it is difficult to describe this type of exemption. In the study mentioned, the range of this exemption was from $2,500 to $10,000, but some of these are expressed in assessed values and others in what the property would bring if put on the market. The States generally aim at exempting the residence of the client unless it is more than a moderately priced home. The exemption takes into account indebtedness on the property.

The amount of liquid assets exempt from resources to be considered available for rehabilitation varied from $50 to $600, the most common amount being $500 in 10 States, and $300 in 9 others. Six other States combine liquid assets with personal property and allow amounts ranging from $500 to $1,000. Quite generally exempt are personal belongings, household furnishings, and handtools which would be an asset to the individual.

The State is required to develop methods for assuring uniform interpretation and application by all staff members of its "needs" standard in cases where determination of need is necessary. In any State, if the client is found able to pay for only a portion of the cost of services conditioned on need, he is required to use his resources for this purpose. The counselor in the planning process discusses with the disabled person his responsibility and that of the agency in meeting the costs of rehabilitation. In a number of States the client is required to sign not only the "determination of need statement," indicating the authenticity of the data furnished by him, but also the statement setting forth his and the agency's responsibility for meeting the costs of services.

"Maintenance" is one of the services provided and paid for by the agency, only if the client is not able to take care of the cost himself. According to Federal regulations, "maintenance" may be provided if necessary at any time in connection with vocational rehabilitation services from diagnosis to a reasonable period following placement. However, States generally limit the provision of maintenance to periods during which the individual is receiving physical restoration, training, or following placement prior to receipt of the first paycheck. States faced continuously over the years with inadequate funds to meet the needs of handicapped persons have been reluctant to pay maintenance for long periods of training, and have endeavored to

find other ways of meeting this need. Now that funds are becoming available in larger amounts, States are changing their restrictive policies.

Arranging for, Authorizing Purchase of, and Initiating Services

As soon as the plan has been formally written and approved by the supervisor, the counselor makes the necessary arrangements for all services, completes and issues written authorizations for services to be purchased, and arranges for encumbrance of funds. The authorization sets forth both the nature and scope of the services and the fee that will be paid. In some States it is standard practice for the medical social worker, or a supervisor of physical restoration, or some other designated person in the agency to make all arrangements for medical services with all physicians, hospitals, and other medical facilities.

Relationships with other agencies.—Some States require counselors to report to agencies when services are initiated for persons they have referred; others may report only when the person is initially interviewed, found eligible or ineligible, and at the time the case is closed. The frequency of contacts with workers of other agencies often determines the amount of reporting that takes place on referrals. Where written agreements concerning procedures have been developed between two agencies, there is likely to be more systematic reporting by both agencies. Where another agency is involved in the individual program, the counselor is expected to keep the cooperating agency fully informed, and the same cooperation should be received from the other agency concerned with the outcome of the case.

Most State agencies have developed methods for obtaining training reports regularly from educational facilities, and medical reports when physical-restoration services are provided. Since the counselor must approve all bills for services, he has an obligation to ascertain that the service has been properly rendered. With respect to medical services, frequently the medical consultant or a medical social worker may contact the physician or the medical facility to determine the results of the surgery or other treatment.

In a number of States there are agreements between the rehabilitation agency and the workmen's compensation commission, where the latter agency pays the costs of services rendered to its clients. In such arrangements there is necessarily provided regular reporting on referrals and actions taken with respect to them.

In an increasing number of States, working-team relationships have been developed between welfare departments and rehabilitation agencies, both in connection with aid to the permanently and totally disabled as well as other assistance programs, especially the aid-to-dependent-children and aid-to-the-blind programs.

Supervision of preparatory services.—The counselor has a responsibility to maintain continuous contact with the client during the period he is receiving services and to assist him in the solution of problems which might arise during this period. Numerous methods are used in carrying out this responsibility, such as requiring the client to report in person or by letter to the counselor, reports at intervals by schools and other agencies providing services, and visits by the counselor to the agency providing the service, or to the establishment which is providing employment training.

Where there is good supervision of the rehabilitation case-work program, counselors are expected to review their caseloads monthly, or at least quarterly, and to do the necessary follow-up both on cases in service, as well as those in other stages of development. Authorizing services for individuals for short periods of time requires the counselor to maintain close contact with his clients so that there will be extension of such authorization as needed.

Job-Finding and Placement

In the State-Federal program no disabled person is considered rehabilitated until he is placed in a suitable job. Section 401.30 of the Federal regulations requires the State agency in its State plan to indicate that it "will assume responsibility for placement of individuals accepted for service * * *" This does not imply that because the agency has the responsibility, it must actually perform the placement function. In fact, another section of the regulations—section 401.13—requires the State agency to make maximum use of the placement and employment counseling services and other services and facilities of the public employment service.

Similar to the individual plan, the plan for finding employment for the disabled person must be made with full cognizance of all the circumstances, and to prevent delays it should be developed before the conclusion of the preparatory services. The counselor discusses with the client his responsibility for finding his own job, again helping the person to understand his limitations and his abilities, suggesting places where the person might apply, and the methods he should use in seeking employment. During this period the client is referred formally to the appropriate office of the State employment service, with pertinent information on physical limitations and capacities, the employment objective, and information about training, being furnished to that agency. There is a considerable proportion of the active cases who do not register with the employment service because they prefer to seek their own jobs they wish to apply to a former employer and may be hired by him, or they know before their preparatory services are concluded that they have a job through some other source. From the following statistics on how persons rehabilitated in 1954 found their jobs, it will be observed that one-third located their own employment.

Job finding by persons rehabilitated in 1954	Number	Percent
Returned to or retained on former job	13,367	24.0
Placed by counselor	8,400	15.1
Placed by State employment service	2,094	3.8
Placed or employed by trainer	3,595	6.4
Self-employed persons	7,118	12.8
Client located own job	18,038	32.3
Other method	3,142	5.6
Not reported	71	(1)
Total	55,825	[1] 100.0

[1] The number not reported are excluded in the percentage item.

Followup and closure of case as rehabilitated.—The State agency is required in its State plan to—

set forth the standards established for determining if the client is suitably employed, and shall provide for a reasonable period of followup after placement

to assure that the vocational rehabilitation of the client has been successfully achieved.[24]

During the period of followup the counselor determines from the employer and from the client whether the job is satisfactory for the person in terms of his physical disability, his capacities, and his training or other preparatory services, the remuneration is appropriate for the work performed, and in accordance with wages of other workers doing the same or similar work, whether other services are needed, and if there are any problems needing the attention of the counselor. Often it is essential that the counselor be available outside of the regular workday so that the handicapped person can discuss with him problems which have arisen and any fears he may be experiencing about holding his job.

The case record is required to show the reason and justification for closing the case, including the employment status of the client. If the case is closed as "employed", the record must show the basis on which the employment was determined to be suitable. Each agency must establish its criteria for closing a case as rehabilitated, but in the majority of States the standards set forth by the Office of Vocational Rehabilitation in the Manual for State Operations are adopted. The manual states that—

> Rehabilitation employment is considered suitable when, after a reasonable period of followup (a recommended minimum of 30 days), it has been established that the following minimum conditions have been met:
>
> 1. The work performed is consistent with the client's physical and mental capacities, interests, and personal characteristics.
> 2. The client possesses or has acquired necessary skills to perform the work successfully.
> 3. The employment and working conditions will not aggravate the client's disability nor jeopardize the health or safety of others.
> 4. The wage and the working conditions conform to State and Federal statutory requirements.
> 5. The client and employer are satisfied.
> 6. The employment is regular and reasonably permanent and the client receives a wage commensurate with that paid other workers for similar work. If not employed full time, the employment is consistent with the client's capacity to work and produce, such limitation of capacity having been recognized insofar as possible when the rehabilitation plan was formulated.[25]

There may be certain situations where, even though all the criteria are not met, the case would be closed. For example, the client may accept and decide to remain on a job which, in the opinion of the counselor, is not compatible with his physical capacities or his mental and educational abilities, or is not sufficently permanent to assure his continued self-support. The client must always be free to make his own choice, but the counselor has a responsibility for seeing that the individual understands the full import of the choice.

Other types of closures.—Cases that have been found eligible but not rehabilitated into employment may be eliminated from the caseload by three methods, namely: (1) Closed with services, not employed; (2) closed for other reasons; and (3) transferred to other agencies. In category (1) the plan has been developed and the person

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[24] Ibid., sec. 401.30.
[25] The Vocational Rehabilitation Manual, ch. 24, sec. 2 : Standards for Terminating Cases.

has begun services. In the second category, the case was closed before the planned program was started. Among these two groups are the following types of situations, and many others: Women who marry before the program is completed; persons who begin a program, but stop for family reasons, change of residence to another State, increased activity of the disease or aggravation of the disability; persons who die; persons who withdraw from the program and cannot be persuaded to consider rehabilitation; persons who during the rehabilitation process show their inability to pursue any program of services until employed; or the counselor finds it impossible to develop a program for the individual.

The ratio of closures of cases not rehabilitated into employment from the agency's caseload to those successfully rehabilitated will vary greatly among the States. A considerable part of the variation can be traced to different policies and practices by agencies in the acceptance of cases. Some States delay the determination of eligibility in cases presenting difficulties until a planned program can be worked out, but if the counselor is unsuccessful in making a plan, he is expected to drop the case from further consideration. Some States eliminate the questionable cases from agency statistics entirely by screening very carefully the referrals before they are recorded as potential cases for investigation.

A COMPARISON OF THE VETERANS' ADMINISTRATION AND THE STATE-FEDERAL PROGRAMS OF REHABILITATION

INTRODUCTION

An attempt is made here to describe the various facets of the Veterans' Administration and the State-Federal programs of rehabilitation under common headings and to compare those characteristics that are susceptible of comparison.

In many respects direct comparison is not feasible, mainly because the comparable basic information is not available. Many of the VA statistics are based on data pertaining to veterans provided training, while only about 40 percent of the clients rehabilitated through the State-Federal program received training. Furthermore, the characteristics of the clientele in the two programs are quite different. About 90 percent of the VA clientele are males between the ages of 20 and 40, with an average age of less than 27. Eligibilities for many of the services or benefits administered by the VA and that have "rehabilitation" significance, are established by the fact of previous military service and a "rating" as to disability for compensation purposes. The rehabilitants of the State-Federal program are composed of 37 percent females and 63 percent males between the ages of 16 and 70 with an average of about 34. Client eligibility is established by evaluation of the individual's situation and in keeping with State law.

Another factor that makes comparison difficult is the nature of the financing of the two programs. The VA program is financed entirely by Federal appropriation while the State-Federal program is financed jointly by the States and the National Government. Various rehabilitating services or programs in the VA are administered in organizationally separated echelons of the agency. Financing is provided under individual appropriation. In reports and in statistical treatment the various programs are not related to each other or to a single concept of "rehabilitation."

VETERANS' ADMINISTRATION

I. HISTORICAL BACKGROUND

A. Prior to 1918

The readjustment of servicemen returning to civilian life after fighting a war has always been an important problem. As early as 1862 in this country there was evidence that some people were thinking of vocational rehabilitation as we know it today. However, little of significance was done to ease the problems of disabled veterans, beyond awarding small pensions, until the demobilization following World War I.

B. 1918–28

Public Law 178, 65th Congress (approved June 27, 1918), provided for the vocation rehabilitation (primarily vocational training) of veterans honorably discharged and occupationally handicapped by their service-connected disabilities. Direction of the program was made the responsibility of the Federal Board for Vocational Education. This Board was made up of the Secretaries of Commerce, Labor, Agriculture, and the Commissioner of Education—all ex officio members—and three Presidential appointees representing commercial, agricultural, and labor interests. (In 1921 the 67th Cong. established the U. S. Veterans' Bureau and transferred the responsibilities of the Board to that Bureau.) Placement of trained veterans in jobs was to be by the Department of Labor "insofar as practicable." Other laws provided medical care and treatment of disabled veterans and provided for special services for the severely disabled.

Coordination with the War and Navy Departments was made mandatory to effect a continuous process of vocational training. It was emphasized that those departments would have exclusive responsibility for functional and mental restoration prior to discharge of the serviceman.

The directing agency was given broad authority "to do all things necessary to insure vocational rehabilitation" of its clients and to

STATE-FEDERAL

I. HISTORICAL BACKGROUND

A. Prior to 1920

Prior to 1916 the need for the rehabilitation of the disabled had been recognized chiefly by charitable and nonprofit agenices, special hospitals and special schools. By 1916 workmen's compensation agencies began showing an active interest in rehabilitation of injured workers. In 1917 they supported legislation for disabled exservicemen, and were among those who requested a national program for the civilian disabled.

In 1917 the Federal Board of Vocational Education initiated a research project in vocational rehabilitation, and soon became one of the governmental agencies pressing for a program of rehabilitation of veterans to be conducted by a civilian agency and not by military authorities.

Twelve States enacted laws for civilian disabled with six programs in operation before 1920. Four of the State laws were comprehensive, covering most categories of disabled, and defining rehabilitation broadly as "the rendering of a disabled person fit to engage in remunerative employment." Physical restoration, prosthetic appliances, maintenance during training, and training, were all included. The other laws were largely vocational training acts for disabled. Much opposition was expressed to a law providing training primarily, when Federal legislation was before Congress.

B. 1920–43

In 1920 the national Vocational Rehabilitation Act was enacted, providing for allotment of funds to States on the basis of population, with a 50–50 matching ratio of Federal-State funds; administration to be by the Federal Board of Vocational Education, and the respective State boards. Congress gave to the Federal Board and to the States a charter for the development of a program of broad scope.

I. HISTORICAL BACKGROUND

place them in employment. This included providing education and training through established facilities so far as they could be utilized in furnishing the necessary services. Monthly compensation was provided that ranged from $80 to $120 a month for the client and his dependents while he was in training.

Participation in the program was much greater than had been anticipated. About 675,000 veterans made application for rehabilitation, and 330,000 were found eligible and in need of rehabilitation training. About 180,000 entered training and about 129,000 were declared "rehabilitated" or "completed." There were 5 million training months supplied. The total cost was $645,007,450.62, or about $125 for each training month—cost of monthly compensation or training allowance included.

The educational backgrounds of the clientele ranged from "no education" to "college graduate." The median educational level was about 7th grade. They were trained to many occupations and skills in about 6,500 institutions and establishments and on about 5,000 farms. The Board or Bureau itself operated several schools to teach illiterates to read and write, and provided some special centers to condition severely disabled veterans to acceptable work tolerances.

About 98 percent of the rehabilitated were placed in employment. Average annual incomes were increased from $1,125 before training to about $1,375 after rehabilitation.

This program ended June 30, 1928. The law apparently accomplished what Congress had intended. The concept of rehabilitation received great impetus during the years of program's operations, as reflected in other programs for the disabled not confined to veterans.

I. HISTORICAL BACKGROUND

The national act was a permanent law, except for the section authorizing appropriations. This required amendments on three occasions (1924, 1930, 1932) before a permanent authorization of Federal funds for the program was made in the Social Security Act of 1935. This title also provided for an increase of funds for States and for Federal administration.

Although the national act gave broad authority to the Federal agency to plan a comprehensive program with the States for rehabilitation of the disabled, for nearly 20 years Federal matching funds were made available primarily for vocational training, vocational counseling, placement, and, under certain conditions, prosthetic appliances. Matching of State expenditures for maintenance and for physical restoration were forbidden. By 1940, because of pressures from the States to amend the act, and interpretations by Congress, the Federal agency began liberalizing its policies on matching State expenditures, so that services other than training could be provided. However, until new legislation was enacted in 1943, the program was largely confined to vocational counseling training and placement.[1]

From 1921–1943 the program remained small. Approximately 200,000 were rehabilitated in the 23 years, or an average of 9,000 per year. This was far below the number of persons disabled annually and who were in need of services. By 1943 expenditures by the Federal Government had reached nearly $3 million dollars with State and local expenditures in excess of the Federal contribution. Approximately 400 professional persons were employed by State agencies.

[1] Mary E. MacDonald. Federal Grants for Vocational Rehabilitation. University of Chicago Press, pp. 236–244.

I. Comment: Historical background

Wartime casualties have always made the public aware of the need for rehabilitation programs for veterans, and have also given impetus to planning for the civilian disabled. In 1918 recognition of the needs of veterans by enact-

ment of Public Law 178, heightened the interest in a program for disabled civilians, and resulted in enactment of the Federal Vocational Rehabilitation Act in 1920. This act provided for a Federal-State grant-in-aid program. Public Law 178 for veterans was administered primarily as a training program, with provision for medical services from facilities of the War and Navy Departments. Although the 1920 law for civilian disabled was as broad in its definition of the terms "disabled" and "rehabilitation" as current legislation, the Federal Board of Vocational Education in its administration denied Federal matching funds for physical restoration and for maintenance during training. The termination of the servicemen's rehabilitation law in 1928 ended that program. The civilian program though continuous was not established on a permanent basis until Federal financing was provided for in a title of the Social Security Act. During the period 1920–43 all of the States and Territories became eligible for Federal grants for rehabilitation of civilian disabled, but the program remained small, with vocational training counseling, placement, and prosthetic appliances the primary services provided.

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VETERANS' ADMINISTRATION

II. DESCRIPTION OF PRESENT VOCATIONAL REHABILITATION PROGRAM OF THE VA

A. Legislative basis

The 78th Congress passed Public Law 16 (Mar. 24, 1943) to provide some of the basic requirements for the vocational rehabilitation of veterans disabled during World War II service. The provisions of Public Law 16, as amended, were extended to apply for veterans of the Korean conflict, by Public Law 894, 81st Congress.

Although the law obviously emphasizes training as a means to vocational rehabilitation, there is provision made for a wide range of services that the Administrator of Veterans' Affairs might find necessary to achieve the vocational rehabilitation of disabled veterans. The medical and other services of the VA are available as resources for the rehabilitation mission. Authority is given the Administrator to utilize all public and private agencies and facilities that he deems necessary to vocational rehabilitation.

One resource for rehabilitation, especially physical restoration, was the veterans' hospitals which had been built and operated by the VA between World War I and World War II. During and

STATE-FEDERAL

II. DESCRIPTION OF STATE-FEDERAL VOCATIONAL REHABILITATION PROGRAM

A. Legislative basis

In 1943 Congress enacted Public Law 113, which provided for a comprehensive program of rehabilitation services. The law specifically mentioned the blind, and the term "disabled" was interpreted to include both physically and mentally disabled. Federal financial participation was provided to States for a wide range of services, including the costs of physical restoration and maintenance during training. The act provided for matching of State expenditures for case services on a 50–50 basis; and 100 percent of costs of administration, including personnel costs, were provided from Federal funds.

During the next 10-year period the scope of services especially in the area of medical services, broadened very greatly. Federal funds to States increased by 830 percent and State and local financing of the program increased over 400 percent. Professional personnel employed quadrupled.

Public Law 565 was enacted in 1954 to provide further expansion to increase the number rehabilitated. This is done through: (1) Greatly increased financing by the Federal Government and the

after World War II the number was greatly increased. Public Law 293, 79th Congress (1945–46) set up a separate Department of Medicine and Surgery in the VA and broadened the range and quality of services that could be given veteran patients. Other benefits provided for veterans under other Federal laws could also often be used to facilitate vocational rehabilitation.

Public Law 346 for veterans of World War II and Public Law 550 for veterans of the Korean conflict provide education and training for eligible veterans, whether they are disabled or not. Disabled veterans have had the option of taking training under these less closely supervised programs if they did not wish to accept the indications resulting from counseling for rehabilitation, and many have done so.

States; (2) provisions for support of projects for extension and improvement of State program operation, and for special projects for research and for demonstrations; (3) grants for training professional personnel and for traineeships; (4) financial assistance toward the establishment of public and other nonprofit rehabilitation facilities and workshops, and the establishment of small-business enterprises for the severely handicapped; and (5) additional items in the list of services for which the Federal Government assumes its proportionate share of the costs. State agencies were required to utilize the services of State assistance agencies, State employment offices, the Bureau of Old Age and Survivors Insurance, and other public agencies providing services related to rehabilitation.

II–A. Comment: Legislative basis

Public Law 16, enacted in 1943, provided for a federally operated vocational rehabilitation program for service-connected disabled veterans of World War II, under the administration of the Adminisrator of Veterans Affairs. Public Law 113, enacted the same year to provide a more comprehensive program for disabled civilians than had existed the previous 23 years, continued to provide for this to be a Federal-State grant-in-air program, with State and Territorial agencies operating the program of services.

Although Public Law 16 emphasizes training as the service to be provided, along with subsistence during training, training equipment and supplies, and emergency interest-free loans, provision is made for medical services to be obtained through VA medical facilities. In the civilian disabled legislation all vocational rehabilitation services are to be provided by the same agency within the framework of a program of services all directed toward rendering the person fit to engage in remunerative employment. The State agency is free to obtain these services from any source. Public Law 113 included in the comprehensive list of services customary placement tools and equipment, making it possible to assist a disabled person toward establishing a small business.

Public Law 894 was similar to Public Law 16, providing services to service-connected veterans of the Korean conflict. Public Law 565, passed in 1954 for the civilian disabled, is similar to Public Law 113, but provides for a greatly expanded Federal-State program through increased Federal and State financing, additions to the list of services for

the disabled, for assisting public and nonprofit agencies in establishing rehabilitation facilities and workshops, and for support of research and demonstration projects.

Public Law 346 and Public Law 550, laws providing training benefits for all veterans and utilized by disabled veterans even more than Public Laws 16 and 894, have some advantages over the laws for disabled veterans or disabled civilians. Under these the veteran can delay determination of the vocational objective until he has taken some training, and unlike under Public Law 16 he can supplement his income during training by part-time employment. Many disabled veterans elected Public Law 346 or Public Law 550 training.

Public Law 293, 79th Congress, defines the functions of the VA Department of Medicine and Surgery. This Department supplies many services, available to disabled veterans, that are significant to rehabilitation.

VETERANS' ADMINISTRATION

B. Administrative organization and financing

(1) *Central office.*—The line organization of the Veterans' Administration is presently composed of three departments—Veterans' Benefits, Medicine and Surgery, Insurance. Policy is developed for the field activities of vocational rehabilitation and education by the Office of the Director of the Vocational Rehabilitation and Education Service in the Department of Veterans' Benefits. Hospitals and medical services, often used in the rehabilitation process, are directed by the central office, Department of Medicine and Surgery. Supervision is provided through 5 area supervision offices of the Department of Veterans' Benefits and 7 area medical offices of the Department of Medicine and Surgery.

The Office of the Director of Vocational Rehabilitation and Education is organized into four specialty echelons: Benefits and facilities, counseling, education and training, and research and evaluation. The Office of the Assistant Director for Benefits and Facilities specializes in problems of eligibility, awards, contracts, and compliance. The Office of the Assistant Director for Counseling furnishes policy determinations and technical direction on all aspects of the counseling function. The Office of the Assistant Director for Education and Training is concerned with policies related to training, program planning, trainee supervision, etc. The Research and Evaluation Office appraises program attainment and actual benefits accruing to veterans as a result of training. The Director of Vocational Rehabilitation and Education is advised by an advisory committee of civilian educators.

STATE-FEDERAL

B. Administrative organization and financing

(1) *General.*—The Federal-State program is a grant-in-aid program administered by the Federal Office of Vocational Rehabilitation and 88 State rehabilitation agencies. Thirty-six of the State programs serve only the blind and are administered by commissions for the blind, State welfare departments, or other agencies legally authorized to rehabilitate the blind.

Fifty of the programs which serve all disabled, or all except the blind, are administered by State boards of vocational education. In New Jersey there is an independent commission which serves all except the blind, and the District of Columbia has a special Department of Rehabilitation which serves all disabled.

(2) *Federal office.*—The Office of Vocational Rehabilitation, the Federal agency, is a constituent of the Department of Health, Education, and Welfare. The Office has a Director, who is assisted in administration by a Deputy Director, Chief Medical Officer, and four Assistant Directors. The four Assistant Directors are in charge of: Program planning and evaluation; State administration development; rehabilitation services; and management services. There are 9 regional field offices; each staffed with 2 or 3 professional consultants. The Federal office through the units under the Assistant Directors makes grants to State agencies, and under some conditions to nonprofit agencies for approved projects; provides technical consultation to regional offices and to States; conducts surveys and special studies; and establishes policies and standards for State program operations. There is a national

(2) *Regional offices.*—Each of the 66 regional offices of the VA has a Vocational Rehabilitation and Education Division. This Division administers the rehabilitation and education program at the operating level. The three sections of the Vocational Rehabilitation and Education Division: Benefits and facilities, counseling, education and training—carry the operations that their respective offices of Assistant Director are concerned with at the central office level.

Under the supervision of the Department of Medicine and Surgery there are outpatient clinics operated at regional offices to which applicants for vocational rehabilitation can be referred for treatment of physical or psychological disabilities. Veterans living or training at a distance from the regional offices may be supplied medical services by contract with local hospitals and physicians. VA hospitals and special treatment centers are available for referral of rehabilitation candidates. Medical consultants are furnished to the Veterans Rehabilitation and Education Division of the regional office.

Under the VA organization the various rehabilitation services are not unified under a single direction or supervision. A counselor may find with his client that various services are indicated but he loses contact with him as he proceeds to receive these services. If a counselor does not have contact with the veteran, either at the hospital or in the Veterans Rehabilitation and Education Division of a regional office, many benefits may be claimed by the veteran without vocational rehabilitation impact resulting from these benefits.

(3) *Financing.*—The program of rehabilitation, as provided by Public Laws 16 and 894, is financed by Federal appropriations. While limitations on VA employment of specialists to operate the program might be imposed by limited appropriations, no limitation has been placed on veteran participation in the program. Supplemental appropriations have been made when needed to cover veteran participation.

advisory committee which reviews requests for special projects of a research and demonstration nature. There is a special training unit which makes grants to educational institutions for training rehabilitation workers, and personnel in allied fields.

(3) *State agency.*—Each State agency has a director, one or more medical consultants, casework supervisory personnel, rehabilitation counselors, and frequently specialized technical consultants. The rehabilitation counselor is the key person who interviews the disabled person, determines whether he is eligible, plans with him and provides for all needed services. Counselors, and often district supervisory personnel are located in local offices. There are approximately 700 offices in local communities, with a larger number of itinerant contact points where the disabled are scheduled for interviews. The counselor utilizes various professional consultants, and obtains assistance and services from a wide range of facilities and community agencies in evaluating the needs of and planning with the disabled person. He utilizes the Employment Service and all other available methods for locating and placing individuals in jobs, and does followup until assured the person is rehabilitated into suitable employment.

(4) *Financing.*—Federal funds are allotted to States by a formula contained in the Federal act, which uses as a basis both population and per capita income of States, together with certain other factors. There are also some special funds allotted to States for extension and improvement activities and for grants to public and nonprofit agencies, expansion, demonstration and research, and for aiding in establishing workshops and other rehabilitation facilities. State agencies obtain Federal funds on a matching basis set forth in the act.

II–B. Comment: Administrative organization and financing

The organization of the VA is such that there is lack of unity in control of the various rehabilitation services for veterans. Direction of certain services comes through the Department of Medicine and Surgery and direction of others is through the Department of Veterans' Benefits. The claims program which provides disability compensation does not stress rehabilitation. The State-Federal program is operated in the States, but with considerable direction set forth in Federal regulations and manuals from the Office of Vocational Rehabilitation. The division of work in the VA among the various specialty echelons results in there being no one person assisting the veteran through the various phases of his rehabilitation. However, a judgment or decision by one worker in one VA regional office is normally binding on all other workers in all other offices, and this makes for uniformity of benefits and program quality.

The State-Federal program is carried out at the community level, with maximum utilization of local resources for evaluation, planning, preparing, and finding suitable employment for the disabled individual. The State-Federal program can be more flexible and adaptable to meet the individual's needs. However, a federally-administered program directed from one central point has some overall administrative advantages compared to one administered through a combination of a Federal agency and 88 State agencies, even when the Federal agency establishes requirements that the States must meet. The State-Federal program necessarily results in variations in the provision of services, some of which are to the benefit of the individual while others may be to his disadvantage. The possibility of policy variations from State to State could result in the setting of priorities or in practices and in failure to serve adequately some clientele groups.

In the State-Federal program where the individual is served through one key individual, the rehabilitation counselor, there is a coordinated, continued, and unified approach to assessment of needs, development of a program of services, and placement of the disabled person. In the veterans' rehabilitation program, there is a separation in the administration of medical services from the counseling, training and auxiliary services, and placement responsibility rests with another agency, the State employment service. The final test of success of the individual rehabilitation program is readily discernible in the civilian program—a remunerative job—in the veterans' program with the closure of the case following training, it is not possible to measure as easily whether planning and preparatory services have been on a sound and realistic basis.

The VA program is federally financed with funds continuously made available to pay the costs of the services to veterans. Although Federal appropriations have been steadily increased for grants to States for the civilian disabled, they have never been sufficient to meet all the needs. State funds must be available to match Federal funds; there are some lags between Federal funds made available and State matching money.

VETERANS' ADMINISTRATION

C. Potential clientele

(1) *Sources of cases.*—Public Laws 16 and 894 provide that any veteran who incurred a service-connected injury during the period of September 16, 1940, to July 25, 1947, or the period June 27, 1950, to February 1, 1955, for which he is entitled to compensation (or would be but for receipt of retirement pay), is eligible to receive vocational rehabilitation services if needed to restore his employability lost by virtue of the service-incurred injury.

A veteran cannot receive rehabilitation services under these laws beyond 9 years after termination of the war or emergency (World War II, July 27, 1947; Korean emergency, February 1, 1955). He may have up to 13 years if prevented from meeting the 9-year limit by (*a*) medical infeasibility, (*b*) improper discharge, later amended, (*c*) failure to establish the compensability of his injury, timely.

As of September 30, 1955, there were 1,779,149 veterans of World War II and the Korean conflict with running awards. It is not known how many of these veterans are in need of vocational rehabilitation services. Many, of course, have already been rehabilitated. It is not possible to make the determination of need except after collection of data and the application of counseling procedures in individual cases. The compensation laws do not provide for referral to rehabilitation.

Based on a number of factors, including past experience, the average numbers of veterans who will be in training under the two laws are estimated as follows: Fiscal year 1956, 24,000; fiscal year 1960, 11,000; fiscal year 1965, 4,000. Normally, about 60 percent of these who apply for rehabilitation enter training. It is difficult to estimate the number of veterans who will apply for other services available through the VA that are significant for rehabilitation. Such service will include physical restoration, prosthetic appliances, psychotherapy, small business loans.

(2) *Methods of acquiring clientele under Public Law 16 and Public Law 894.*—The Veterans' Administration follows a policy of

STATE-FEDERAL

C. Potential clientele

It is estimated that there are 2 million disabled persons of employable age in need of vocational rehabilitation. This includes about 190,000 in mental or tuberculosis hospitals, homes, or schools for the handicapped and other homes and hospitals, in need of services. It also includes about 100,000 persons over 65 with chronic conditions in need of vocational rehabilitation. Annually 250,000—because of disease, accidents, or congenital conditions—come to need vocational rehabilitation services if they are to become self-supporting. There was a total of 221,000 persons on the State agency rolls at the end of fiscal year 1955. To determine how many can be rehabilitated requires the collection of necessary information and application of eligibility policies and counseling procedures.

(1) *Sources of cases.*—Disabled persons come to the attention of State agencies usually through their local offices or contact points which are visited regularly. They are referred by a very great number of sources, such as physicians, clinics, welfare offices, employment service, schools of all kinds, various community agencies, individuals, and through a variety of publicity media.

The 1954 Social Security Amendments provide for OASI coverage of 90 percent of total labor force. All persons who become disabled and apply for preservation of insured benefits are brought to the attention of State rehabilitation agencies early after onset of disability.

Working relationships and referral procedures are established with the State employment service, State welfare department, with social-security offices (OASI), with workmen's compensation agencies, tuberculosis and mental hospitals, schools for the handicapped, VA facilities, and with other agencies and organizations to whom disabled are known.

(2) *Aggressive approach to locating cases.*—State agencies follow a policy of bringing the program to the attention of the public

rigidly avoiding any activity that might be interpreted as soliciting a claim against the Government. A veteran desiring vocational rehabilitation must file an application. He is given assistance in completing the application if he is in a hospital or clinic or calls at any VA office. When he receives from the VA a notice that his disability claim has been favorably considered there is enclosed an application form for rehabilitation (VA–7–1900), with directions for completing it. Much radio and newspaper information has been released by the VA concerning rehabilitation services. The veterans' organizations work very closely with the VA regional offices and are aggressive in acquainting veterans with the benefits for which they may apply.

continuously, seeking out the disabled in need of services even though the agency has numbers of persons not yet served. Through this approach they keep alive the interest of all community groups who should be concerned with the rehabilitation of the handicapped. The earliest possible referral after disablement is sought to enhance opportunities for successful rehabilitation.

II–C. Comment: Potential clientele

With an increase in the time lapse since World War II and the Korean conflict, there is a decrease in the veterans applying for training under the training benefit legislation. For the most part, benefits (training) for World War II veterans will terminate in July 1956. The number of service-connected disabled veterans in training in 1956 is 24,000—but this will decrease until not over 11,000 will be enrolled by 1960. Currently there are about 1,800,000 veterans of World War II and the Korean conflict with running awards. But among these are a large number not in need of rehabilitation services. It is estimated that there are at any time 2 million civilian, including service-connected and non-service-connected veterans, of employable age in need of vocational rehabilitation, with an annual increment of 250,000 persons coming to need rehabilitation. Therefore, there are large numbers of persons, including veterans, who need rehabilitation services as defined in the civilian rehabilitation program. The number on the rolls of the State-Federal program is increasing.

The traditional policy of the VA of refraining from any activity that might be interpreted as "soliciting a claim against the Government" has probably been a disservice to many disabled veterans. It is possible that all veterans receiving disability compensation should receive some definite encouragement to have their rehabilitation needs diagnosed and met. The Federal-State agencies carry on an extensive program for informing the disabled and all sources in contact with such persons so there will be early referral for services. Informing and referring veterans is done very extensively by veterans' organizations. The VA is staffed to give services to all eligible veterans who make application. Large backlogs have often developed in the State-Federal program—suggesting understaffing or overproduction.

VETERANS' ADMINISTRATION

D. Nature and scope of services

There are many benefits and services available to disabled veterans under the various public laws that can have rehabilitation significance. They are not organized under the single organizational unit in the VA. This tends to dissipate their usefulness as rehabilitation factors in a great many cases. Furthermore, many veterans accept these benefits without a felt need of them to assist in readjustment or rehabilitation. However, the rehabilitation counselor takes into account all the benefits that might be requisitioned for his client when he considers his needs and the plan to meet those needs. A veteran who does not enter the vocational rehabilitation program of the VA, as such, might find many of the various benefits for which he is eligible helpful to him in rehabilitating or readjusting himself. Following is a list of the major benefits:

(*a*) Vocational counseling, including testing.
(*b*) Personal adjustment counseling.
(*c*) Physical and psychiatric examination and evaluation.
(*d*) Physical restoration and indicated therapies.
(*e*) Prosthetic appliances, hearing aids, etc.
(*f*) Psychotherapy.
(*g*) Specialized restorative training.
(*h*) Vocational training (school, on-the-job, on-the-farm), generally with a 48-month limitation.
(*i*) Regular supervision of training.
(*j*) Tuition, books, tools, supplies as required for training.
(*k*) Reader service for blinded students.
(*l*) Transportation: Travel to and from a distant point for rehabilitation training (beginning and end of school terms); to and from medical treatments or personal counseling services; to and from licensing examinations; pay and travel of an attendant, if required, when traveling.
(*m*) Hospitalization as required.
(*n*) Training allowances ranging from $75 a month to over $200 a month, depending on the degree of disablement and the number of dependents.

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D. Nature and scope of services

Vocational rehabilitation services available to disabled persons are broadly defined within the following categories:

(*a*) Medical diagnostic services—including all types of medical evaluation necessary to establish the diagnosis, determine the extent to which the disability limits, or is likely to limit, the individual's daily living and work activities, and to appraise the need for and results of physical restoration services.
(*b*) Individual personal and vocational counsel and guidance, including psychological tests, for development of a plan, and for carrying it forward to successful completion.
(*c*) Training: prevocational; personal adjustment; vocational, and any other rehabilitation training.
(*d*) Physical restoration services—including medical or surgical treatment, psychiatric treatment, hospitalization, nursing services, dentistry, convalescent care, drugs and supplies, prosthetic devices essential to obtaining or retaining employment, physical, occupational, speech and other therapies, physical medicine services, and other medical or medically related rehabilitation services.
(*e*) Books and training materials.
(*f*) Tools, equipment and initial stocks (including livestock) and supplies; equipment and initial stocks and supplies for vending stands; and necessary shelters in connection with the foregoing items.
(*g*) Maintenance during rehabilitation, with certain limitations following placement (including medical care for short periods for acute conditions, which would constitute a hazard to achieving the vocational objective).
(*h*) Occupational licenses.
(*i*) Other goods and services (such as business licenses, reader and attendant services) necessary to the rehabilitation of the individual and not otherwise contra-indicated by the act.
(*j*) Transportation and related costs for obtaining diagnostic services, or incidental to the provision of other rehabilitation services, for disabled persons and attendants, or escorts, where such may be needed.

(*o*) Leaves of absence, with allowances continued, up to 30 days a year.

(*p*) Adjudication of injury or death suffered while in rehabilitation training as if the event had occurred in wartime-service.

(*q*) Small (up to $100), interest-free, emergency loans while in training.

(*r*) Job placement, in coordination with the public employment agencies.

(*s*) Guaranteed home, farm, or business loans; $1,600 toward an automobile for those with special disabilities; special homes for paraplegics.

(*k*) Placement in a suitable job.

(*l*) Followup to insure successful employment adjustment.

Federal participation in the costs of items (*d*) to (*i*) is available to State agencies, only if the State has determined by objective methods that the individual cannot pay for the services. Item (*j*) does not require establishment of need for transportation in connection with diagnosis, or placement but does with other services. Most of the above services are obtained from sources outside of the State agency. Item (*b*) "individual counsel and guidance" is provided by the rehabilitation counselor; he may administer tests or secure the service from another source. Item (*k*) may be performed by the counselor, or done by some other method.

II–D. Comment: Nature and scope of services

Over 50 percent of service-connected disabled veterans enrolled in training have had extensive medical services, including periods of hospitalization, either from military personnel and facilities or the Veterans' Administration, or from both sources prior to applying for training benefits. This is a higher percentage than would be the case with persons served by the civilian rehabilitation program. If a veteran is in need of medical services at time of or following application for training, he would be referred to the Department of Medicine and Surgery, by the staff of the Division of Vocational Rehabilitation and Education, Department of Veterans' Benefits. The medical service rendered may be essential for the trainee to reach his training objective, or it may be a general medical service. In the civilian program medical service as well as any other service is planned by the counselor as a part of a total program of services, and must be essential for meeting the rehabilitation objective. Medical services are always purchased from sources outside of the rehabilitation agency, and are paid for by the agency only to the extent the disabled individual cannot obtain them for himself.

Subsistence (called maintenance in the civilian program) during training is provided in every training case by the VA. This service is provided to disabled civilians only if essential during the provision of other rehabilitation services, including training, and the person is unable to pay for it himself. A standard amount is paid to the veteran depending largely upon degree of disablement and whether single or with dependents. In the civilian program maintenance paid depends upon a State standard, and also upon the individual needs of the disabled person. While the veteran may receive a loan up to $100 to meet emergencies, there is no loan provision in the civilian program. However, maintenance when needed may be paid in the civilian program from the beginning of rehabilitation services, including diagnostic services, until a reasonable period after placement.

II–D. Comment: Nature and scope of services—Continued

Tools, equipment, and initial stocks (including livestock) and supplies, vending stand equipment and initial stocks and necessary shelters, as part of establishing disabled persons in small business enterprises, are available in the civilian program to the disabled person not able to pay for them. These are not available, usually, in the veterans' rehabilitation program, but the loan guaranty program might assist the veteran in borrowing money to purchase such items, if a lending agency would consider making such a loan. In certain cases of very severely disabled veterans, equipment is furnished by the VA in connection with home business training.

In the civilian program the above-mentioned services are available to disabled persons only if the State determines by its standards that these persons cannot pay for the services in whole or in part. In the veterans' rehabilitation program determination of need (financial) is not a condition for any service.

VETERANS' ADMINISTRATION

III. THE REHABILITATION PROCESS

A. Determination of eligibility

If a veteran's disability was incurred between the dates of September 16, 1940, and July 25, 1947, or June 27, 1950, and February 1, 1955, and it has been determined to be service-connected, and if his discharge is other than dishonorable, he is eligible for rehabilitation training under Public Law 16 or 894, and for all the services available in the VA medical and other programs necessary to restore his physical or mental health—including supplying prosthetic devices.

He may not be afforded vocational rehabilitation training, however, if, in the course of counseling, any one of these four conditions is found: (1) He is already suitably employed; (2) he is employable in a suitable occupation; (3) his disability does not limit the types of employment which he might hold—even though failure to attain employability is due to lack of training or experience; and (4) loss of employability in a suitable occupation, initially engaged in after separation from the armed services, is due to causes other than the service-connected disability.

If need for vocational rehabilitation training is not established, the counselor explores other alternatives with the veteran, such as employment, that will result in his rehabilitation. If the veteran

STATE-FEDERAL

III. THE REHABILITATION PROCESS

A. Determination of eligibility

Prior to determining whether the person is eligible for rehabilitation, the counselor obtains information in such areas as: medical diagnosis—including an evaluation of the effects of the disability on physical and mental capacities; personal; educational; socioeconomic data; and employment background in order to assess the significance of the disability to the person vocationally. He identifies the needs and the problems to be met in the rehabilitation of the individual.

The determination of eligibility requires the agency, usually through the action of the counselor, to: (1) Establish the presence of a disability, including its functional limitations; (2) establish that the limitations imposed by the disability result in a substantial handicap to securing or retaining suitable employment; and (3) that there is a reasonable expectation that the individual, through receiving rehabilitation services, may be rendered fit to engage in a remunerative occupation. The counselor often utilizes the medical consultant, and others, to assist in making this determination, since he must have a thorough understanding of the medical findings, the limitations imposed by the disability, and whether the disability can be reduced or removed through medical

is not satisfied with the decision as to his eligibility for rehabilitation services he may appeal to the Central Office Board of Veterans' Appeals, where his case will be reviewed and a final decision made on his claim.

or surgical treatment. He must understand job requirements; he must know the individual, his interests, motivation, and he must appraise the educational and employment background. He must be able to relate all the information in order to determine whether the disability the person has constitutes for him a substantial employment handicap, and whether he can benefit sufficiently from services to be rehabilitated into remunerative employment.

If the State has any special requirements, such as a time period for residence, the counselor must determine whether the requirement is satisfied.

III–A. Comment: Determination of eligibility

In both the VA and the Federal-State programs there must be a disability that is vocationally handicapping if the client is to be found eligible for rehabilitation services. Both, therefore, require that there be a need for vocational rehabilitation. In addition, the VA requires that the disability be service connected for eligibility under Public Law 16 or 894, and that he have a discharge from the service other than dishonorable. Rehabilitation services may be provided through or under the auspices of a VA hospital, even though the disability is not service connected. In the civilian program the disability may arise from any cause. In both programs eligibility is based on whether the disability prevents the person from obtaining or retaining suitable employment. In the State-Federal program two States require the person to reside in the State for 1 year, but in one this requirement is waived if the disability was acquired in the State. Two other States have a 6-month and 90-day residence requirement respectively. Each State agency is required to establish an appeals procedure with respect to eligibility or provision of services. In the civilian program Federal matching funds are available for expenditures for certain services only if provided to individuals who are found to be unable to pay for them. These cases are provided other services without reference to need, and assistance in arranging for the needed service is given to the disabled person whether he pays all costs, or part, or nothing. Training is provided without reference to need in all but 2 of the 88 State agencies. Financial need is not a condition for the providing of any service to a service-connected case under veterans' benefit laws. The VA provides an appeal procedure for those veterans protesting an unfavorable decision on eligibility in the local regional offices.

III–A. Comment: Determination of eligibility—Continued

VETERANS' ADMINISTRATION

B. Development of the individual plan

Vocational counseling is available in VA hospitals, and in the Vocational Rehabilitation and Education Divisions of VA regional offices. The counselor collects medical information from VA files and medical examinations; educational information from the veteran and the schools he has attended; occupational, family, and social information from the VA social worker, referring agency, and from the veteran; personal information through tests and interviews with the veteran. This information is synthesized and its implications discussed with the veteran. His needs and the resources and services available to meet these needs are explored. If he is in need of additional information concerning occupational fields and opportunities, the counselor supplies it. He is assisted in the selection of a course of action that is appropriate and acceptable to him and to the VA.

If the medical information reveals that the veteran is physically or psychologically not able to undertake a program of vocational rehabilitation training he is found "medically not feasible." He is then advised of the actions he should take to establish feasibility. Required therapies are provided through the VA medical services. Often it is arranged that two or more courses of action are pursued concurrently, e. g., training and psychotherapy.

Veterans eligible under Public Law 16, 894, 346, or 550 can be counseled in the facilities administered by the Vocational Rehabilitation and Education Divisions of regional offices. Others will have VA vocational counseling available at the hospital if they are hospitalized by the VA.

A training officer located in the community where the veteran is to train develops the details of the training plan after the veteran and the counselor have selected a goal. Community resources are

STATE-FEDERAL

B. Development of the individual plan

Counseling and planning for the disabled individual is one of the major functions of the State agency, and although continuous throughout case processing, it assumes major importance in the development of the plan—including the selection of the employment objective, and the services needed to reach that goal. The counselor discusses the information collected with the individual, interprets its significance with respect to requirements of vocational fields, and specific occupations in these, and the nature of services required. If physical restoration is needed this is considered together with the vocational implications of removing or reducing the effects of the disability. All services are provided for the purpose of reaching the employment objective, so to the extent possible the objective is selected prior to initiation of services. Where extensive medical services are planned, or the outcome of these may not be foreseen, it may be necessary to postpone the final determination of the specific objective until the results are known.

In planning the program, consideration must be given to such factors as responsibility for dependents, absence of the person from the family during the period of services, cooperation available from the spouse, or parent, or family members, and from other agencies expected to participate in the program, the duration of the services, and the source of funds to pay for all purchased services.

If the client is in need of services and is unable to purchase them (see item II, "Nature and scope of services"), the counselor must make a determination of financial need. This requires the obtaining of information on all resources (including capital assets; current income of all kinds; any benefits—such as pension, compensation, insurance payments), and the amount required for normal living needs. If, after the person's needs and his obligations are met, there are any resources available, these are applied toward services conditioned on need. Policies and standards for deter-

mobilized and utilized as needed to meet the requirements for reaching the veteran's objective.

mining need are established by each State agency, within the framework of general requirements set forth in regulations issued under Public Law 565, the Vocational Rehabilitation Act, as amended. Standards for establishing need in the rehabilitation program do not require the individual to be indigent before he can be provided with the services which are conditioned on need.

III–B. Comment: Development of the individual plan

Adequate counseling for establishing a rehabilitation goal has a standard approach. Full information about the client, his family, his background, his capabilities and deficiencies, his needs and motivations, his resources and economic liabilities are assessed. This information is weighed against the rehabilitation services available, and the client is assisted in the selection of a goal and a plan for reaching that goal. Thus, there are no basic differences between the counseling as practiced in the VA and as practiced in the State-Federal program. Variations will be introduced by the extent and nature of the services available, and to some degree by the kind of emphases being felt felt in the respective programs. An unusually large percentage of veterans have been counseled into some type of rehabilitation training. This might in large degree be due to availability of training for practically all the VA clientele through Public Laws 346 and 550. Applicants for rehabilitation with the VA usually were motivated by a desire to take some type of training.

Medical services are provided in the VA program by specialists in the Department of Medicine and Surgery. In the civilian program the counselor interprets to the individual the recommendations of outside specialists and the agency medical consultant, and frequently develops the plan for obtaining these services from sources outside of the agency. Job counseling is provided in both programs, furthermore the important function of followup after placement involves a considerable amount of counseling. Where services are obtained from other cooperating agencies, as is common in the civilian program, there is a considerable amount of personal and family counseling. In the VA, personal counseling is provided by well-trained specialists in that field. Family contacts and counseling are usually provided through training officers of the VA or social workers cooperating in the case.

VETERANS' ADMINISTRATION

C. Provision of services

(1) *Selection of services and facilities.*—A veteran who is to enter vocational training will have had the collaboration of a VA training officer in the selection of his goal and course. The training

STATE-FEDERAL

C. Provision of services

(1) *Selection of services and facilities.*—Selection of services and facilities is made by the counselor in cooperation with the disabled person. It frequently involves searching for appropri-

III–B. Comment: Development of the individual plan—Continued

VETERANS' ADMINISTRATION—Continued

officer finds a suitable training facility that is equipped and manned to develop the skills and knowledge required for the veteran to reach his goal. An agreement is made with the training facility that lists the services to be given and the contributions to be made by the VA. If training is in an on-the-job situation, some assurance is asked that the employer-trainer will keep the trainee as an employee after completion of training.

The veteran is ordinarily expected to devote his full time to his training program. However, provision can be made for short working days if the veteran's work tolerance is low.

Tuition, books, individual training equipment and training supplies are furnished by the VA. If it develops that the veteran needs medical treatment, personal counseling or other services to keep him effectively in training these are furnished. If a special tutor is needed, one is supplied. Limited assistance can be given to the training establishment in making modifications in its facilities to accommodate the trainee's physical disability.

A veteran who does not require training may be given medical treatment, fitted with a prosthetic appliance, referred to the State Employment Service, referred for a VA-guaranteed loan, etc., as needs require.

(2) *Supervision.*—The supervising training officer makes visits to the trainee every 30 to 60 days to observe his progress in his training program and to assist him with personal problems that might interfere with his progress.

If it becomes apparent that the veteran will not succeed in the selected program the training officer will refer him for reevaluation by the Counseling Section. A revised goal and program might be agreed upon. If lack of success in the training program is due to the veteran's own willful misconduct, he may be dropped from training. The training officer determines when the veteran can be considered as having completed his program and can be rehabilitated.

STATE-FEDERAL—Continued

ate resources. The counselor presents to the individual the various alternative choices, and counsels with regard to the advantages of each. He coordinates the services into a total program which will result in attainment of the employment objective without loss of time.

(2) *Arrangements for services.*—The counselor determines the dates when services can be initiated, makes the detailed arrangements, sends written authorizations to the vendors, setting forth the fees to be paid and the duration of each service, and informs all persons concerned of the plan. Where another agency is providing a service without cost to the rehabilitation agency, the counselor confirms the plan to the client and to the agency to insure complete understanding.

(3) *Supervision.*—The counselor is responsible for continuous supervision of the program until its completion. He utilizes a variety of methods to insure that each service is according to the plan and meets the needs of the client. He revises the plan when changes become necessary. If problems arise, such as acute medical conditions, or difficulties encountered are interfering with the success of the program, the counselor investigates and takes appropriate action, amending the plan when necessary.

III–C. Comment: Provision of services

In the State-Federal program the counselor carries responsibility for the case from determination of eligibility to "closed, rehabilitated into remunerative employment." In the VA program of vocational rehabilitation the counselor does not usually work with the individual after the training objective has been established and the broad outline of services has been included in the plan. The training officer assists the veteran in selection of the training facility, and does follow up until the training program has been completed, or is terminated. If reevaluation becomes necessary, the individual is referred back to the Counseling Section. The training officer determines when the training has been completed, and the case can be closed as "rehabilitated."

VETERANS' ADMINISTRATION

IV. PLACEMENT AND FOLLOWUP

A. Coordination with public employment services

The laws administered by the VA require that the employment services of the States and the United States Employment Service will be used by the VA in finding employment for a veteran who has been rehabilitated and needs job placement. The employment services have employment officers who specialize in placing veterans referred to them. The principles of cooperation between the USES and the VA have been described in a joint statement issued by the two agencies. Under that statement the VA will (1) refer to the Employment Service veterans needing employment; (2) release to the Employment Service data on veterans' physical capacities (recorded on a USES form) if the VA has recent (under 1 year) data; (3) report to the Employment Service any job openings found while searching for training opportunities; (4) make a direct effort, in coordination with the Employment Service, to locate jobs for the severely disabled veterans; (5) refer to the Employment Service a veteran who applies for on-the-job training under Public Laws 346 and 550 and needs help in locating a training opportunity.

The Employment Service will: (1) Accept referrals of veterans from the VA; (2) report to the VA on placements; if not placed in the specialty recommended, explanation will be furnished to the VA; (3) supply VA with data collected on veteran clients during employment counseling; (4) refer veterans needing or requesting

STATE-FEDERAL

IV. PLACEMENT AND FOLLOWUP

A. Placement

Prior to the termination of training, or physical restoration or other preparatory services, the counselor discusses with the individual methods for finding employment, unless it has already been determined that the person will return to work for his former employer. In some instances, the counselor has an important role in persuading the employer to use the former worker in a new capacity. This may involve the removal of prejudice toward hiring a person who has had tuberculosis, or a history of mental illness, or with a residual disability such as blindness, or it may be assisting the firm to find a suitable place for the worker. Twenty-four percent of the 1954 rehabilitants returned to work for former employers.

Provisions for maximum use of the placement facilities of the USES in the placement of disabled civilians is set forth in a formal cooperative agreement between the USES and OVR. Similar agreements are in effect between each of the 88 State agencies and the State Employment Service.

VETERANS' ADMINISTRATION—Continued

IV. PLACEMENT AND FOLLOWUP—continued

rehabilitation; (5) notify the VA of on-the-job-training opportunities; (6) advise the VA if a veteran takes a job while he is in training under VA auspices; (7) furnish the VA with local occupational and labor-market information; (8) assist VA hospital counselors in placing a veteran as a trainee-employee if he cannot or does not use VA training benefits.

B. Followup

After a veteran has been rehabilitated and has been placed in employment the VA does not regularly perform any followup service related to his vocational adjustment. Occasional research projects will require postrehabilitation contact with the veteran. The adjudication activity of the regional office is required to review periodically the appropriateness of continuing the disability ratings of veterans with certain types of disabilities. If the need for further medical care is revealed by these reexaminations the veteran is referred to a VA hospital or clinic.

STATE-FEDERAL—Continued

IV. PLACEMENT AND FOLLOWUP—continued

Public Law 565 also requires the Secretary of Labor, the Secretary of HEW, together with the Chairman of the President's Committee on Employment of the Physically Handicapped to develop and recommend methods to promote job opportunities for the handicapped.

Where a job opportunity must be found, the person is formally referred to the Employment Service, and pertinent information provided that agency. The client is also counseled in methods of finding his own job. In 1954, 33 percent of the group rehabilitated found their own employment. Where special conditions are required for vocational adjustment, as well as in other cases, the counselor is very likely to seek for suitable opportunities. In 1954 the counselor placed 39 percent of the total group in jobs, or in self-employment.

B. Followup

Followup after placement is an essential service to determine whether the person is making a successful vocational adjustment. The counselor determines from the employer and the client whether the job is satisfactory in terms of the person's physical or mental limitations, his capacities and his training or other preparatory services, and whether the remuneration is appropriate for the work performed, and with what is paid to others doing the same or similar work. If additional services are needed, the counselor makes provision to meet these needs.

C. Closure of the case as rehabilitated

For a State agency to take credit for a rehabilitation the case record is required to show the reason and justification for closing the case, including the employment status of the client, with the name of the employer, the wage received, and the basis on which the employment is determined to be suitable for the disabled individual. Each State agency is required to submit individual reports on its rehabilitation closures, to the Federal agency. These reports require the completion of 26 basic items.

If a rehabilitated veteran wishes to have his status reviewed and to pursue further training, such review will be made upon his application. He can be reentered into training if the review reveals that he was improperly rehabilitated or if his service-connected condition has worsened and he can no longer perform effectively in the occupation in which rehabilitated.

A veteran who has received physical restoration services may return for VA medical services as often as such services are indicated.

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Although each agency is required to establish its criteria for closing a case as rehabilitated, the standards recommended in the Federal Vocational Rehabilitation Manual are those generally adopted. These are:

1. The work performed is consistent with the client's physical and mental capacities, interests, and personal characteristics.
2. The client possesses or has acquired necessary skills to perform the work successfully.
3. The employment and working conditions will not aggravate the client's disability nor jeopardize the health or safety of others.
4. The wage and the working conditions conform to State and Federal statutory requirements.
5. The client and employer are satisfied.
6. The employment is regular and reasonably permanent and the client receives a wage commensurate with that paid other workers for similar work. If not employed full time, the employment is consistent with the client's capacity to work and produce, such limitations of capacity having been recognized insofar as possible when the rehabilitation plan was formulated.

IV. Comment: Placement and followup

A. Placement

The State agencies are required to assume responsibility for placement of individuals accepted for service, whereas the VA in carrying out its vocational rehabilitation program does not engage in direct placement activities (except in the severely disabled cases), but utilizes the public employment service to perform the function. The State agency is required to enter into a cooperative agreement with the public employment service for maximum utilization of all of its services, and does refer individuals needing placement assistance regularly to this agency. However, this does not relieve the State rehabilitation agency of its placement responsibility. The VA has found it necessary to seek suitable employment opportunities for the severely disabled trainees, in cooperation with the Employment Service. With both agencies disabled persons trained on-the-job often remain with the firm which provided the training. Both agencies do considerable to show former employers of disabled persons how to utilize these individuals in new capacities following preparatory services.

IV. Comment: Placement and followup–continued

B. Followup and closed rehabilitated

Followup after placement or establishment of the individual in his own business is a service provided in every rehabilitated case in the civilian program. The counselor determines from both the employer and the client whether the employment is suitable and the worker satisfactory, and whether any additional services may be needed. The State rehabilitation agency cannot consider a disabled person rehabilitated until certain determinations are made about the suitability of the job for the individual. In the VA rehabilitation program followup service is not provided. The VA closes a case as rehabilitated when the training is completed. A rehabilitated veteran may request and receive reconsideration of his needs. But such review is not initiated by the VA, except that those veterans on compensation rolls are reexamined on a regular schedule for possible rerating, but rehabilitation is not stressed in the claims program. If upon such reexamination, additional needs are recognized, the veteran is referred to the appropriate service. If at any time the State-Federal rehabilitated individual has difficulties in his job or with aggravation of his disability he may reapply to the State agency and have his case reopened for needed services.

VETERANS' ADMINISTRATION

V. OPERATING STATISTICS (SOURCE: VETERANS' ADMINISTRATION) [26]

A. Participation statistics

Certain medical and education statistics give an indication of the extent to which rehabilitation services have been given to

STATE-FEDERAL

V. OPERATING STATISTICS (SOURCE: OFFICE OF VOCATIONAL REHABILITATION)

A. Participation statistics

In fiscal year 1954 there were 55,825 disabled persons rehabilitated through the State-Federal rehabilitation programs. The following services were given with the frequency shown:

[26] For additional data see Record and Evaluation of the Vocational Rehabilitation Program for Service-Connected Disabled Veterans, House Veterans' Affairs Committee Print No. 109, 84th Cong., 1st sess.

veterans. The services cited do not include all that have been and are available. However, they represent some of those that are most significant for rehabilitating veterans requiring special services to achieve economic and social adequacy.

In the 8 years, fiscal year 1948 through fiscal year 1955:

Hearing aids were fitted for disabled veterans	56,000
Artificial legs were supplied	50,000
Artificial arms were supplied	7,700
Pairs of orthopedic shoes were supplied	58,500
Wheelchairs were furnished	9,500

During the year ending May 31, 1955, there were 205,000 veterans with service-connected disabilities for whom the VA serviced prostheses of various types.

As of January 31, 1956, the VA had made contributions up to $10,000 each to build 6,049 houses specially designed for veterans whose disabilities prevented their efficient use of houses of traditional design.

To the end of fiscal year 1954 the VA had contributed $1,600 toward the purchase of each of 41,091 automobiles for veterans with certain types of disabilities.

Available statistics do not reveal how many of these disabled veterans also took rehabilitation training or how many applied for the benefits listed above as the result of vocational counseling.

As of December 31, 1955, 1,234,164 veterans of World War II had applied for rehabilitation training under Public Law 16; of these 610,460 had entered training; 372,688 had been rehabilitated; 7,260 were still in training. As of the same date 79,287 veterans of the Korean conflict had applied for rehabilitation training under Public Law 894; 35,686 had entered training; 6,351 had been rehabilitated; 17,668 were still in training.

About 670,000 disabled veterans of World War II had taken training under Public Law 346. About 280,000 had trained under both Public Law 16 and 346.

About 27 percent who might have been eligible for rehabilitation training under Public Law 16 did take some training under that law.

The more severely disabled veterans (40 percent or higher rating) tended to elect rehabilitation training under Public Law

Number of persons rehabilitated by State-Federal program by type of service, during fiscal year 1954

Type of service	Number	Percent
Guidance, counseling and placement with—		
Examinations only	8,323	14.9
Physical restoration only	23,531	42.2
Training only	16,139	28.9
Placement equipment and occupational licenses	658	1.2
Physical restoration and training	4,746	8.5
Physical restoration, placement equipment, and occupational licenses	312	.6
Physical restoration, training, placement equipment, and occupational licenses	641	1.1
Training, placement equipment, and occupational licenses	1,194	2.1
Other	73	.1
No other service	208	.4
Total	55,825	100.0

Number of rehabilitated persons who received services, by type and cost of such services, fiscal year 1954 [1]

Type of service	At no cost	With cost
Examinations, medical and psychiatric	9,682	45,277
Examinations, psychological	2,526	4,271
Transportation for diagnostic services	761	2,430
Surgery and treatment	2,766	16,255
Prosthetic appliances	1,032	13,366
Hospital and convalescent care	1,482	12,370
Training and training materials	2,759	19,961
Maintenance and transportation	952	11,568
Occupational tools, equipment and licenses	134	2,525
Equipment for business enterprise programs	39	139
Other services	150	1,052
Total	22,283	129,214

[1] Many individuals received more than 1 service.

VETERANS' ADMINISTRATION—Continued

V. OPERATING STATISTICS (SOURCE: VETERANS' ADMINISTRATION)—continued

16. Those veterans with disability ratings who elected training under Public Law 346 were generally those with the lower ratings.

About 3,200,000 World War II and Korean veterans have been given vocational counseling by the VA or under contract with the VA.

STATE-FEDERAL—Continued

V. OPERATING STATISTICS (SOURCE: OFFICE OF VOCATIONAL REHABILITATION)—continued

Comment

The above data on individuals participating in the VA or the State-Federal rehabilitation programs are not directly comparable. Those for the VA show what services have been given to disabled veterans over a period of time. Those for the State-Federal program show the services given in the fiscal year 1954 and only to those clients who were rehabilitated. Those individuals served by the State-Federal agencies were actually under programs of vocational rehabilitation, planned through counseling, and supervised to insure compliance with the plans. Many of the VA services were given as the result of the veterans' own application for the service and were furnished because a statutory eligibility and/or a need was found to exist. That these services did contribute toward the readjustment and rehabilitation of the individual veterans can be assumed.

Other statistical information which follows compares VA trainees with 35,272 male rehabilitants of the State-Federal program reveals somewhat better bases for comparison of the two programs. However, many of the tables must be evaluated with recognition given to certain limitations. Many of these limitations are mentioned in the comments following each set of tables presented.

TABLE 4–A.—*Participation in the VA rehabilitation training program, Public Laws 16 and 894, 1946 through 1945*

Fiscal year	Applications received	Entered training	Rehabilitated	Average number in training
1946	344,130	98,234	1,895	115,701
1947	315,159	200,599	9,517	225,545
1948	173,923	110,679	31,537	226,525
1949	133,005	75,181	75,885	185,848
1950	82,116	48,579	84,433	124,296
1951 [1]	38,323	23,198	68,252	66,840
1952	29,858	13,790	48,889	37,717
1953	30,273	12,746	28,272	22,350
1954	36,019	15,905	13,806	23,754
1955	33,707	16,482	11,063	24,067

[1] Public Law 894 cases included from 1951 through 1955.

TABLE 4–B.—*Participation in the State-Federal program, from 1946 through 1955*

Fiscal year	New referrals	Cases accepted	Cases in process	Cases rehabilitated	Number rehabilitants trained [1]	Percent rehabilitants trained
1946	112,792	80,380	101,451	36,106	13,115	36.3
1947	145,876	68,692	102,706	43,880	14,391	32.8
1948	157,604	88,357	117,795	53,131	16,266	30.6
1949	158,364	99,202	133,715	58,020	17,604	30.3
1950	154,819	92,009	140,941	59,597	19,391	32.5
1951	153,291	90,603	139,559	66,193	23,673	35.8
1952	154,470	88,922	137,450	63,632	23,691	37.2
1953	153,969	84,398	133,177	61,308	23,674	38.6
1954	145,289	78,045	126,770	55,825	22,720	40.7
1955	176,067	82,269	127,573	57,981	(2)	(2)

[1] These persons also received other services. In 1954, 5,387 also received physical restoration services; 1,835 were furnished occupational placement tools and equipment, and occupational licenses. Only 28.9 percent received training without these other services.
[2] Not available.

Comment

The peak of participation by World War II disabled veterans in the rehabilitation training program provided by Public Law 16 occurred in 1947–48, when over 200,000 entered and the average in-training load was over 225,000. Effects of Public Law 894, which extended the program of rehabilitation training to veterans of the Korean conflict, are noted in the slight rise in participation after 1953. These data do not reflect the numbers of disabled veterans entering training under Public Laws 346 and 550. The total of these disabled trainees is greater than the total entering under Public Laws 16 and 894.

VA estimates indicate that the number of participants under Public Laws 16 and 894 will begin to decline after fiscal year 1957, to 11,000 in training in 1960, and 4,000 in 1965. After July 1956, there will be practically no World War II veterans in Public Law 16 training.

Veterans rehabilitated through services other than Public Laws 16 and 894 training are not reflected in the data in table 4A.

Comment—continued

The State-Federal program has been placing greater emphasis on serving the severely disabled and has introduced screening teams more widely in its cooperative relationships with other agencies such as welfare departments and mental and tuberculosis hospitals. This results in a decrease in the number entered as referrals, but the individuals have greater potential for rehabilitation than unscreened referrals. Emphasis on services to the more severely disabled has tended to lower the number of rehabilitants for the current period. The trend is now reversed in all the categories. The results from program expansion under the 1954 legislation (Public Law 565), with considerable increase in Federal and State funds is beginning to make itself felt. Goals are set for a steady expansion annually until at least 200,000 persons are rehabilitated into employment each year. In table 4B, although training cases are shown separately in column 6, it should be noted that many of these cases receive other basic services, and that the largest percentage of the State-Federal agency rehabilitants are rehabilitated through services other than training (in 1954, 64.4 percent of the total).

VETERANS' ADMINISTRATION

TABLE 5–A.—*Percentage distribution of veterans entering training under Public Laws 16 and 894, by age*

	Public Law 16 [1]	Public Law 894 [2]
Total	100.0	100.0
Under 20	2.1	1.3
20 to 24	39.6	60.6
25 to 29	33.2	27.8
30 to 34	14.7	5.2
35 to 39	7.1	2.6
40 to 44	2.3	1.5
45 and up	1.0	1.0

[1] Public Law 16 data to March 1952.
[2] Public Law 894 data to December 1954.

NOTE.—Median age for Public Law 16 trainees, 26.3 years. Median age for Public Law 894 trainees, 23.9 years.

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TABLE 5–B.—*Percentage distribution of all rehabilitants, and of males only, of the State-Federal programs in fiscal year 1954, by age*

	Total rehabilitants	Total males
Total	100.0	100.0
Under 20	17.6	16.8
20 to 24	13.7	13.5
25 to 29	10.7	9.9
30 to 34	10.4	9.3
35 to 39	11.3	10.8
40 to 44	10.8	11.0
45 to 49	9.2	9.8
50 to 54	7.1	8.0
55 to 59	4.6	5.3
60 and up	4.6	5.6

NOTE.—Median age of all rehabilitants, and of males only, is 34 years.

TABLE 5–C.—*Percentage distribution of veterans entering training under Public Laws 16 and 894, by educational level*

Number of years of school completed	Public Law 16 [1]	Public Law 894 [2]
Total	100.0	100.0
None	0.2	0.6
1 to 8	25.8	16.8
9 to 12	60.5	67.8
Above high school	13.5	14.8

[1] Public Law 16 data to March 1952.
[2] Public Law 894 data to December 1954.

NOTE.—Median educational level for Public Law 16 trainees, 11.6 years. Median education level for Public Law 894 trainees, 12.0 years.

TABLE 5–D.—*Percentage distribution of male rehabilitants of the State-Federal program in fiscal year 1954 by educational level at acceptance*

Number of years of school completed	*Percent*
Total	100.0
None	3.7
1 to 8	48.1
9 to 12	41.6
Above high school	6.6

NOTE.—Median educational level, about 7th grade.

Comment

Almost 75 percent of the Public Law 16 trainees, and 89.7 percent of the disabled veterans of the Korean conflict taking training under Public Law 894, were under 30 years of age when they entered training (table 5–A). This is in contrast to the 40.2 percent of the males rehabilitated by the State-Federal program who were in this age group (table 5–B). Between three-fifths and two-thirds of the disabled veterans entering vocational rehabilitation training had some secondary schooling (table 5–C). In the State-Federal program more than 50 percent had 8 grades or less of schooling (table 5–D).

In planning training programs, amount of previous schooling is a significant factor. Although not shown in these tables, it is known that of the veterans taking training under Public Law 16, there were 27.2 percent who attended institutions of higher learning under the program, while for the Korean veterans, 37 percent who entered training under Public Law 894 attended college. Of the total group of men trained in fiscal year 1954 in the State-Federal program, only 25.6 percent took college or university training. It should be observed that considerably less than 50 percent would have been able to meet college entrance requirements.

VETERANS' ADMINISTRATION

TABLE 6–A.—*Percentage distribution of veterans by type of employment prior to entering Public Law 16 training, to March 1952*

Employment:	Percent of total
Total	100.0
None	30.5
Professional and managerial	5.3
Clerical and sales	12.7
Service	3.6
Agricultural, forestry, fishing and kindred	9.5
Trade and industrial	38.4

TABLE 6–C.—*Percentage distribution of veterans by type of employment prior to entering military service*

Employment:	Percent of total
Total	100.0
None	17.8
Professional and managerial	4.4
Clerical and sales	11.7
Service	4.0
Agricultural, forestry, fishing, and kindred	15.1
Trade and industrial	47.0

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TABLE 6–B.—*Percentage distribution of State-Federal males rehabilitated in fiscal year 1954 by source of support at acceptance*

Source of support:	Percent of total
Total	100.0
Wage earnings	20.9
Relief, public and private	13.5
Family support	41.6
Isurance, unemployment compensation	2.4
Insurance, workmen's compensation	3.4
Insurance, other	2.1
Other, including savings	16.1

TABLE 6–D.—*Employment history of State-Federal male rehabilitants, fiscal year 1954, when accepted*

Employment:	Percent of total
Total	100.0
Never worked	12.7
Unsubstantial employment	42.8
Substantial	44.5

Comment

Tables 6–A and 6–C above reveal that veterans employed after World War II military service and prior to Public Law 16 training, were employed at about the same skill levels represented by their prewar jobs. More were unemployed in the months between discharge and start of rehabilitation training than were unemployed prior to entering service (30.5 percent against 17.8 percent).

Among the veterans, 69.5 percent were employed just prior to training under Public Law 16. In contrast (table 6–B), only 20.9 percent of the clients of the State-Federal rehabilitation programs were classified as wage earners at the time they were accepted. About 87 percent of the civilian clients had a history of previous employment (table 6–D).

However, about one-half of these had had "unsubstantial" employment. Among the veterans, at least 82 percent had had some employment experience (i. e., prior to entering military service; table 6–C). From these observations it would appear that the veterans represented somewhat more promising clientele for successful vocational rehabilitation than those who were candidates of the State-Federal program.

TABLE 7.—*Distribtuion of disabilities among the 595,304 veterans entering Public Law 16 training to December 1952, and among the 55,825 individuals rehabilitated by the State-Federal program in fiscal year 1954*

Disabilities	Veterans, percent	State-Federal, percent
Total	100.0	100.0
Orthopedic	36.7	40.6
Multiple amputations, or loss of use of upper extremities, and muscle injuries to upper extremities	7.8	10.0
Amputation or loss of use of lower extremities, and muscle injuries to lower extremities	16.3	22.5
Impairments to spine, chest, neck, head, torso, skull	4.6	8.1
Other	8.0	----------
Total and partial blindness	.1	5.9
Other visual	2.0	5.8
Impairment of hearing	3.1	6.2
Pulmonary tuberculosis	2.8	11.2
Cardiac	2.7	4.2
Epileptic	.8	1.9
Mental or nervous system diseases, except epilepsy	24.0	4.9
Hernia	.4	4.7
Other	27.4	14.6

Comment

Table 7 compares the distribution of disabilities among the veterans who entered the Public Law 16 program prior to December 1952, with the distribution among the rehabilitants (both sexes) of the State-Federal programs for fiscal year 1954. (It should be emphasized that diagnostic or disability classifications alone do not accurately describe the extent of the handicaps or the difficulties to be overcome in rehabilitating the individuals with these disabilities.)

The category with the highest percentage among the veterans group was the neuropsychiatric classification—24 percent, including 5.1 percent neuropathological. The State-Federal clients in this category represented 4.9 percent

Comment—continued

of the total. The percentages in the orthopedic groups were about the same—VA, 36.7 percent; State-Federal, 40.6 percent. Wide differences in percentages are apparent in the blind and in the tuberculosis classifications. In each case the State-Federal percentage was substantially higher than the percentage of the veterans disabled by blindness or tuberculosis.

The "Other" category includes those for whom no diagnostic or disability classification had been given in the available statistical reports and those categories in the two programs that could not be directly compared.

TABLE 8–A.—*Percentages of trainees enrolled in major types of training establishments—Public Laws 16 and 894, and State-Federal program*

Type of training	Public Law 16, average percentage, 1947–52	Public Law 894, average percentage, 1954	State-Federal percentage, 1954 [1]
Total	100.0	100.0	100.0
Institutions of higher learning	27.2	37.0	25.6
Schools below college level	16.1	31.5	59.6
Institutional on-farm	22.5	8.7	
On-the-job and apprentice	34.2	22.8	14.8

[1] For breakdown, see table 8–B.

TABLE 8–B.—*Percentage distribution of males rehabilitated through State-Federal programs in fiscal year 1954, by type of training agency* [1]

Type of training agency:	*Percentage of total rehabilitated*
Total	100.0
Institutions of higher learning	25.6
On-the-job in business establishment	14.8
Business college	11.8
Private trade school	14.1
Public vocational school	12.1
Sheltered workshop	4.7
Tutor, correspondence school, other	16.9

[1] This is a more detailed breakdown than is provided in table 8–A.

Comment

Table 8A reveals that the World War II veterans training under Public Law 16 attended institutions of higher learning in a significantly lesser ratio than the veterans of the Korean conflict under Public Law 894, through 1954. The World War II veterans chose on-the-job training more often than did the veterans of the Korean conflict.

In the State-Federal program, when training was utilized, schools below college level were used extensively. The proportion trained in institutions of higher learning was about the same as for World War II veterans.

VETERANS' ADMINISTRATION

TABLE 9–A.—*Employed veterans by post-training occupations by major occupation group* [1]

Major occupational group:	Percent
Total	100.0
Professional and semiprofessional	15.4
Managerial and official	6.3
Clerical and kindred	10.0
Sales and kindred	8.4
Service	4.2
Agricultural	7.1
Skilled	25.8
Semiskilled	11.3
Unskilled	4.4
None	3.8
Not stated	3.3

[1] Based on sample study of Public Law 16, trainees, 1952.

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TABLE 9–B.—*Male rehabilitants by major occupational group, closed as employed, fiscal year 1954* [1]

Major occupational group:	Percent
Total	100.0
Professional and semiprofessional	8.4
Managerial	3.7
Clerical and kindred	10.9
Sales and kindred	5.1
Service	12.4
Agricultural and family workers	14.0
Skilled	18.3
Semiskilled	18.8
Unskilled	8.4
Homemakers	(2)

[1] 64.4 percent of the total male rehabilitants did not receive training; 35.6 percent were given training.
[2] Excluded—not in the labor force.

TABLE 9–C.—*Percentage distribution of males in the labor force by occupational groups, fiscal year 1954*

Major occupational group:	Labor force (percent)
Total	100.0
Professional and semiprofessional	8.3
Managerial and official	12.3
Clerical and kindred	6.6
Sales and kindred	5.7
Service	6.2
Agricultural	12.4
Skilled	19.2
Semiskilled	21.0
Unskilled	8.3

TABLE 9–D.—*Comparison of annual income before and after rehabilitation of Public Law 16 veterans and State-Federal male rehabilitants, fiscal year 1954*

Category	Estimated annual average income at application	Average annual income after rehabilitation
Veterans	[1] $1,950	[2] $3,600
State-Federal	[3] 1,540	[4] 2,183

[1] 69.5 percent applicants were employed.
[2] Based on special study of rehabilitated Public Law 16 cases through 1952.
[3] Based on 20.9 percent of males employed at time of acceptance.
[4] Based on all male rehabilitants—79.1 percent were unemployed at acceptance; only 35.6 percent were provided training.

Comment

The information relative to occupational and economic conditions of the clientele of the VA rehabilitation program and of the State-Federal program is not directly comparable. About 69.5 percent of the veterans were employed when they applied, while 79 percent of the male civilian rehabilitants in 1954 were unemployed. Some 55 percent of the State-Federal group were on welfare rolls or were supported by their families. It might reasonably be supposed that the "unemployed" status of the civilian group resulted partially, at least, from their disabilities. Many of the

veterans among the 20.5 percent unemployed were possibly not working because of their recent discharge from service.

There is a considerable difference in the average amount of schooling of the veteran and the nonveteran groups prior to application for rehabilitation as well as after rehabilitation. (See tables 5C and 5D.) Educational level and age are important factors affecting the types of jobs available to the men in each group. More than 28 percent of the civilian males were 45 years or older when they were seeking jobs following services. About 3 percent of the veterans were in this upper-age group.

Tables 9–A, 9–B, and 9–C show the percentage distribution by occupational groups of (1) veterans employed in 1952 who had had training under Public Law 16; (2) male civilians rehabilitated into employment by Federal-State agency in fiscal year 1954 by job at closure; and (3) percentage distribution of males in the labor force.

The veterans, all of whom had received training, show a greater percentage at the higher skill levels (professional, semiprofessional, and skilled labor) than is found in the labor force or among the State-Federal program rehabilitants. These may be accounted for by several factors: Training of all the veterans; only 35.6 percent of the State-Federal group were trained; veterans were at optimuum age for acceptance by employers; in the State-Federal group one-half were above 34 years of age; the veterans' group were a select group by virtue of screening by the Armed Forces prior to entering service; military experience itself helps develop some persons to a capacity for technical leadership.

Fifty-five percent of the State-Federal group were living on grants from welfare agencies or were supported by their families when they applied for rehabilitation. Lack of education (see table 5–D), and more maturity with family responsibilities made it more difficult to consider training for a large number of the State-Federal rehabilitants.

Training for the young group of World War II disabled veterans apparently raised their level of occupational skill above workers in the general labor force. For this disabled group training would seem to have been a good rehabilitation technique.

In evaluating the annual income data as shown in table 9–D it should be noted that the $1,950, estimated annual average income of veterans at application, is based on 69.5 percent of the Public Law 16 group through 1952 who were employed at that time. The $1,540 average income for the State-Federal group is based on 20.9 percent of the group who were employed when they applied. All the veterans were trained. Although training is considered in practically every civilian rehabilitation case, only 35.6 percent received training. The income of $3,600 for veterans after rehabilitation represents an average of earnings of veterans who had, in many cases, been working several years after they had completed their training. The State-Federal item of $2,183, postrehabilitation wages received by males, is based on the beginning wage at closure of the case. Seventy-nine percent of the group who had no earnings, and 20.9 percent who were working at time of application, are represented in the $2,183 average income at closure figure.

Comment—continued

The earnings of this entire group went from $10,788,550 per annum before rehabilitation to $76,983,475 per annum after rehabilitation.

TABLE 10.—*Cost of rehabilitation training by selected items, VA 1943 to April 1955, and the Federal-State rehabilitation program in fiscal year 1954*

Cost item	VA training (Public Laws 16 and 894)			State-Federal program		
	Expenditures, VA program	Number rehabilitated with training	Average cost per case	Expenditures	Number rehabilitated with training	Average cost per case
Total	$1, 520, 349, 025	371, 688	$4, 090	$9, 643, 130	19, 961	$483
Tuition, books and supplies	261, 052, 664	371, 688	702	5 933, 941	[1] 19, 961	297
Subsistence and travel	1, 259, 296, 361	371, 688	3, 388	3, 709, 189	11, 568	321

[1] Only a portion of these were provided books and supplies at cost to the State agency.

Comment

The above table represents only two categories of costs of training disabled persons in rehabilitating them. It is not possible to make comparisons on other items such as medical care provided by the VA and by the State-Federal program. Furthermore, there are difficulties in making comparisons between administrative costs of a federally operated program and a State-operated program.

Tuition is paid by the VA for all veterans trained under Public Laws 16 and 894, and subsistence is provided to all veteran trainees. Most trainees were provided books, tools, and supplies.

In the State programs in 1954, the year covered by the above data, 35.6 percent of all rehabilitants (or 22,720 persons) received training. Of these, 2,759 received training without cost to the State agency (public vocational school training, free scholarships to disabled persons, etc.). For the 19,961 persons for whom tuition was paid, and for a lesser number who were provided with books and supplies, the average cost was $297. (Books and supplies are provided only if the person cannot afford to buy them himself.) The purchase of books and supplies in every case from State funds would have raised the average cost for the category by $50–$75 per case. The average cost for the 371,688 persons who completed training under VA auspices was $702 for these items.

Subsistence was paid in all the VA cases, but to only 11,568 (or 58 percent) of the 19,961 State-Federal trainees. Either the service was not needed for the remainder of these trainees, or the person himself or another agency (welfare department, workmen's compensation commission, etc.) met the cost. This item is a large one in the costs of training veterans, averaging $3,388 per case. The average was $321 in the State-Federal cases. This amount also includes some maintenance and travel costs for these persons during the provision of physical restoration services and following placement prior to receipt of the first paycheck (5,387 of the total group of trainees were provided with medical services). The average length of the training courses offered to the State-Federal trainee is not known. The average length for the VA trainees was about 28 months. The subsistence cost alone was about $100 per trainee-month.

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