

Certification of Disability in Social Insurance

RUTH E. STOCKING, M. D.*

TODAY, UNDER THE SOCIAL SECURITY ACT, the programs of unemployment compensation and old-age and survivors insurance are providing protection to workers who are forced to withdraw from the labor market, either temporarily because of unemployment or permanently because of the handicaps of age; under the latter program, dependents of workers are also assured an income if the wage earner is removed by death. On the other hand, if the wage earner is forced from the labor market before age 65 because of illness or injury, neither he nor his dependents have at present any protection under the social security program against loss of income resulting from disability. Yet the loss of income for a worker and his family, when he is forced to leave gainful employment for a long time or permanently, is an actuality whether his retirement is caused by old age or disablement; and the risk, for the worker who is temporarily unable to earn, is the same whether the interruption of earnings results from economic dislocation or physical incapacity.

The Social Security Board has already expressed its interest in a program offering protection for the disabled worker and has recommended that consideration be given to measures for insurance against both temporary and permanent disability. The Chairman of the Board has pointed out¹ the extent to which benefit provisions of old-age and survivors insurance are applicable to a system of disability insurance and has indicated some of the new provisions that would need to be added and some of the changes that would have to be made if disability benefits are incorporated in old-age and survivors insurance.

Estimates of the volume of both temporary and permanent disability have been made.² The

*Bureau of Research and Statistics, Division of Health and Disability Studies. This article deals primarily with specific problems in certifying disability under illustrative social insurance systems. The description of the procedures in Great Britain and Germany relate to procedures followed prior to September 1939. The cooperation of the U. S. Employees' Compensation Commission and the Railroad Retirement Board in furnishing data for incorporation in this article is gratefully acknowledged. Other systems may be covered in a later paper.

¹ Altmyer, A. J., "Social Insurance for Permanently Disabled Workers," *Social Security Bulletin*, Vol. 4, No. 3 (March 1941), pp. 3-10.

² Falk, I. S., and Sanders, B. S., "The Prevalence of Disability in the United States With Special Reference to Disability Insurance," *Social Security Bulletin*, Vol. 4, No. 1 (January 1941), pp. 2-8.

magnitude of these estimates indicates that disability is one of the serious risks threatening the economic security of American families.

One problem that presents itself in contemplating the extension of either old-age or unemployment insurance to cover the risk of disability relates to the determination whether a worker otherwise qualified for benefits is disabled, under the definition adopted for that term, and is thereby entitled to receive disability benefits. This problem is essentially that of certification of disability. In practice there are many problems involved in determining that disability exists; these include medical and legal problems, labor-market relations, medical-service provisions. The number and complexity of the problems are closely related to the definition or concept of disability expressed or implied in the law.

Concepts of Disability

Three fundamental concepts have been expressed in national legislation: physical disability, occupational disability, and general disability for work. All three have a physical connotation; the second and third have an economic implication as well.

The concept of physical disability is based on the idea of the impairment of physical fitness resulting from injury or disease. This impairment or loss of physical fitness is evaluated by reference to the strength and fitness of a normal, able-bodied, and healthy person. No direct account is taken of the economic or occupational consequences of injuries or disease. The questions which arise in evaluating physical disability are mainly medical; they can be standardized to such an extent that schedules are frequently used in evaluating the degree of disability. This concept of disability is more applicable to workmen's compensation than to disability or invalidity insurance.

Occupational disability indicates incapacity for a limited field of activity or disability for a specific occupation. When the concept of occupational disability is adopted, the incapacity resulting from a disease or accident is evaluated by reference to a given employment or group of employments.

For example, chronic heart disease in a watchmaker may not be a disabling affliction, but it may definitely incapacitate a manual laborer.

The concept of general disability for work or loss of earning capacity in the general labor market is based on the possibility of the disabled individual's obtaining any employment. The consequences of the worker's incapacity are not measured with reference to a specific occupation but rather with respect to the opportunities for earning which still remain open to him in view of the nature and gravity of his disease, his previous occupation, age, and all other factors on which his continuation in or reabsorption into industry depends. Reabsorption may involve a change of occupation or trade, though in disability insurance practice it has not been permitted to entail an excessive lowering of the worker's occupational status.

In evaluating general disability for work, regard must be given to the physiological consequences of the worker's illness and the difficulties he is likely to encounter in finding employment, and not merely to his actual earnings after he returns to the labor market. The questions which arise must be answered jointly by the labor-market expert and the physician.

In a large number of national invalidity or disability insurance systems the definition of the risk covered is based on the concept of general incapacity for work.³ General disability for work is recognized as dependent on the prospects of employment. During times of industrial prosperity many individuals who are partially disabled and some who are by definition totally disabled may actually be employed in substantially remunerative employment. Similarly disabled individuals, during less prosperous periods, may be unable to find any employment because of their disability.

Temporary and Permanent Disability

The majority of the national insurance systems

³ This concept is embodied in the national invalidity insurance systems of the following countries; the groups affected are indicated in parentheses: Austria (workers), Bulgaria (workers), Czechoslovakia (workers), Denmark, France (employed persons and minors), Germany (workers), Great Britain (employed persons, permanent disablement), Greece (tobacco workers), Hungary (workers and miners), Irish Free State (employed persons, permanent disablement), Italy (employed persons), Luxemburg (workers), Netherlands (employed persons), Poland (workers), Rumania (employed persons and craftsmen), Sweden, U. S. S. R. (employed persons). International Labour Office, *The Evaluation of Permanent Incapacity for Work in Social Insurance*, Studies and Reports, Series M (Social Insurance) No. 14, Geneva, 1937, p. 25.

make a clear distinction between incapacity that is temporary or of short duration and that which is permanent or long-continued; they delimit the risks involved in each type of disability and generally provide different types of benefits. Even in the systems which do not expressly separate sickness from invalidity insurance, two types of benefits are generally provided.

The problem of certification would be simplified somewhat if temporary disability were defined as the physical condition of the disabled person during and immediately following the illness or injury responsible for disablement, and if permanent disability were defined as the remaining damage or impairment after all reasonable and available medical and surgical measures have been carried out and sufficient time has elapsed to allow nature to repair the ordinary consequences of trauma. Definitions based on such purely clinical concepts of disability are impractical, however, in that they oversimplify the complex problems involved.

Disability for which temporary disability benefits are provided is, in general terms, total disability for the usual employment of the beneficiary. The general principle followed is that the beneficiary should not be expected to change his occupation as long as there is likelihood of his being able to resume his ordinary occupation in the near future. In practice, the social insurance systems associate the existence of temporary disability with the need of curative treatment. It is expected that the disabled beneficiary will not engage in any kind of work which may endanger the success of the treatment.

Permanent disability benefits are provided, in general, for some degree of disability for any employment which the beneficiary may reasonably be expected to take up, and which has reached a stage of relative stability so that no substantial change is likely in the near future. Treatment has presumably done all that it can toward restoring the individual to a state of employability. The beneficiary is left with only a limited, if any, earning capacity. The existence of permanent disability is decided by determining whether the beneficiary has some earning capacity in any employment which he may reasonably be expected to accept.

Three different definitions have been adopted in national legislation for determining permanent disability or disability which extends beyond tem-

porary disability. Under one definition, permanent disability begins when treatment ceases to effect improvement; under another, it begins at the expiration of a given period; the third definition combines both these concepts and determines that disability is permanent when it has either become stabilized or has lasted through a given period.

The laws of some countries fix the starting point of permanent disability benefits at the date when treatment ceases to effect improvement, that is, when disability has become permanent or persistent.⁴ In theory this solution seems equitable; it enables permanent disability benefits to be paid only when the extent of the economic loss resulting from the disability can be measured on a reliable basis. To determine economic loss requires consideration of physical condition, functional readjustment and habituation to disability, and occupational retraining and change of employment.

There are certain difficulties inherent in this solution. The time during which disability reaches a permanent or relatively stable condition varies widely according to the nature of the disease or injury and the age, occupation, and other personal characteristics of the individual. Among cases of substantially similar injury or disease, the stabilization of the disability may require from several months to several years. Throughout this period the beneficiary and the insurer are left in doubt concerning the outcome. Moreover, this solution leaves discontinuities if the system is operated in connection with a temporary disability system paying benefits for a stated period—the first 26 weeks or 1 year at most. Some cases will not have become stabilized by the end of this period.

The laws of certain countries provide that permanent disability benefits shall start at the expiration of a fixed period.⁵ When this period ends, permanent disability benefits become payable, even when the disability is probably or certainly not permanent. This solution has the merit of simplicity, so far as primary certification is concerned. The distinction between temporary and permanent disability is one of time only. The fixed period is a compromise between medico-social

considerations and practical administrative requirements. It implies, however, that temporary disability benefits shall be paid for the period of 6 months or 1 year, in all cases of prolonged disability, even when after 2 or 3 months or less it appears probable or even certain that the incapacity will be permanent and when stability of the condition is established before the end of 6 months or a year. The use of the fixed period is to be recommended for administrative and practical reasons, however, provided that arrangements are made for periodic review of the incapacity.

Under national legislation of the third type, i. e., combining the two definitions first described, permanent disability benefits start when the need for treatment has ceased or when the beneficiary's condition is definitive, but not later than the expiration of a fixed period of disability. Thus, the expiration of a fixed period is an alternative condition, operative only if the primary requirement of relative stability in the beneficiary's condition is not attained before the expiration of a fixed period.⁶ In this provision, attempt is made to give due weight to all relevant factors. It is possible to award permanent disability benefits before the expiration of the fixed period when the condition of the disabled person justifies it, and the disadvantages of awarding temporary disability benefits over a long period are avoided.

This solution, however, leads to the award of permanent disability benefits to persons whose condition is not necessarily permanent, and in certain cases to persons whose disability is almost certainly temporary, though disability has extended beyond a fixed period. To meet this difficulty, nearly all laws provide for the review of so-called permanent disability in order to take account of subsequent condition of the beneficiary.

As important as the specific concept of incapacity to be applied is the necessity for specifying in national legislation the minimum degree of incapacity required for the payment of benefits. For administrative purposes some definition must be given of the degree of incapacity which is considered sufficiently substantial to necessitate the intervention of the insurance benefits. In most national systems the minimum is clearly and definitely fixed by law.

⁴ Among these countries are Obile, Italy, and Sweden; *ibid.*, pp. 104-105.

⁵ The invalidity insurance laws of France, Germany, Great Britain, and the Irish Free State make this provision; *ibid.*, pp. 107-109.

⁶ Examples of invalidity insurance laws of this type are found in Bulgaria, Czechoslovakia, Denmark, Greece, Hungary, Netherlands, and Rumania; *ibid.*, pp. 172-173.

Under many insurance codes no cash benefit is payable for the first few days of illness. This waiting period eliminates payment to a large number of workers who are incapacitated for only short periods of time.

Although disability under most systems of insurance which provide sickness or invalidity benefits is not defined in purely clinical terms, but is measured by loss of earning capacity, it should be clear from this brief review that the administration of either cash or medical benefits depends in part on services of the medical profession. In a system which provides cash benefits, the system is dependent upon the physician for the certification of disability; one which provides medical benefits depends upon the practitioner of medicine for medical service.

A review of the specific measures adopted in two foreign systems with long years of experience and wide coverage, and in two systems in this country which provide cash payments during disability, may serve to illustrate different procedures followed in certification.

Medical Certification Under the British System

It is difficult to comprehend clearly the procedure of certification under the British national health insurance system without understanding the relationship between the approved societies, which administer cash benefits, and the insurance doctors, who provide medical care and certify for cash benefits.⁷ Under some European systems, one organization administers both cash and medical benefits; in Great Britain the two administrative organizations are separate, though their responsibilities are closely related through the certification procedures.

Cash benefits for both short-time and long-continued incapacity are administered by the approved societies. Sickness benefits are weekly cash payments intended primarily for short-time incapacity, that is, they are payable for not more than 26 weeks. Disablement benefits are weekly cash payments paid for disablement which continues after the 26-week period has elapsed.

The approved societies decide in every case whether cash benefits will be paid an insured member. These societies are the mutual-benefit or-

⁷ For a brief discussion of medical services under British and other European systems, see Falk, I. S., "Medical Services Under Health Insurance Abroad," *Social Security Bulletin*, Vol. 3, No. 12 (December 1940), pp. 11-20.

ganizations which were already operating voluntary sickness insurance and other societies or insurance organizations which entered the sickness insurance field at the time or after the National Health Insurance Act became law in 1911. They are affiliated with trade-unions, friendly societies, large corporations, or industrial insurance companies, and most of them are commonly organized on a national basis. A society with headquarters in London may have members scattered throughout the whole of England. Subject to the general supervision of the Minister of Health, the societies are nevertheless "self-governing" associations of insured workers.

The local insurance committees, which administer medical benefits, are composed of representatives of the workers, the doctors, and the public. Unlike the approved societies, the committees are organized on a territorial basis; there is one in each county or county borough. The committees prepare and publish lists of doctors and pharmacists who have agreed to participate in the system, and are responsible for the medical and pharmaceutical services in their respective areas.

Customarily a worker on entering the insurance system joins an approved society. Membership in a society is not obligatory nor are the societies obliged to admit all applicants to membership; insured persons who do not join societies pay their contributions to a deposit contributors' fund. The approved society notifies the local insurance committee of the member's title to medical benefit. The insurance committee sends the insured worker a medical card. The member then chooses a doctor by presenting his card to a practitioner whose name is on the county panel, i. e., the list of medical doctors who have agreed to participate on the terms offered under the health insurance act. If the doctor accepts the worker, as is usually the case, he signs the card and returns it to the insurance committee, which then puts the worker's name on the doctor's list and sends the medical card back to the worker. He has only to present this card to his physician when he is in need of medical service. The physician is paid by the committee out of insurance funds.

One of the obligations accepted by the health insurance doctor is that of certifying for cash benefits in case of disablement. Although the

approved society has the responsibility of deciding that cash benefits are to be paid, the basis of the decision is in general the doctor's signed certification that the member is incapable of work.

The law does not define incapacity for work. In administering sickness benefits, the approved societies take the position that an insured person may properly be considered incapable of work when he is in such a condition that any attempt

to work would be seriously prejudicial to his health. Work is generally understood to mean the occupation in which the insured person is ordinarily engaged. The concept underlying cash benefits is, at the outset, that of occupational incapacity; however, the concept of general incapacity for work may be applied at any time it becomes apparent that the beneficiary will be unable to resume his ordinary work within a reasonable time.

Sickness benefits are payable after a 3-day waiting period, for 26 weeks only, during any year. If, however, the insured worker is judged still incapable of work after he has received benefits for 26 weeks, he is entitled to a disablement benefit. The latter is practically a continuance of sickness benefit at a reduced rate and is equivalent to the invalidity pensions provided by the continental invalidity insurance systems. The cash benefits are payable until the insured person's incapacity for work is terminated by recovery or death, or until attainment of age 65 (or age 60 in the case of women). If the insured person meets the qualifying-period requirement of old-age insurance, he receives an old-age pension for the rest of his life.

Since officials of approved societies have to deal daily with medical certificates from widely separated parts of the country, regulations controlling certification had to be standardized and procedures made applicable throughout the country.

In certifying for disability, i. e., temporary or continued incapacity for work, the forms most frequently used are: first certificate of incapacity for work, intermediate certificate, and final certificate (see accompanying forms). Other official forms are the special intermediate certificate, intermediate convalescent certificate, and voluntary certificate.

The doctor is under no obligation to issue a first certificate unless the worker asks for it. If the worker makes such a request and the doctor is satisfied that his patient has become incapable of work because of some "specific disease or bodily or mental disablement," the doctor must issue a first certificate at the time of the examination or within 24 hours thereafter. If the insured worker fails to ask for a first certificate within 24 hours of the examination, the doctor is not permitted to issue a first certificate in connection with that examination. He may, at his discretion, issue a

Great Britain: Forms of first and intermediate certificates of incapacity for work

<p>FIRST CERTIFICATE OF INCAPACITY FOR WORK</p> <p>To.....</p> <p>I hereby certify that I have examined you on the undermentioned date, and that in my opinion you were at the time of examination incapable of work by reason of*.....</p> <p>†You should come to see me again on.....day next.</p> <p>Doctor's signature.....</p> <p>‡Date of examination.....</p> <p>‡Date of signing.....</p> <p>Any other remarks by doctor.....</p> <hr/> <p>INTERMEDIATE CERTIFICATE</p> <p>To.....</p> <p>I hereby certify that I have examined you on the undermentioned date, and that in my opinion you have remained incapable of work up to and including that date by reason of*.....</p> <p>†You should come to see me again on.....day next.</p> <p>Doctor's signature.....</p> <p>‡Date of examination.....</p> <p>‡Date of signing.....</p> <p>Any other remarks by doctor.....</p> <p>*Here insert the name of the specific disease or bodily or mental disablement which renders the insured person incapable of work. †To be filled up at doctor's discretion, where not obligatory under rules. ‡These dates should ordinarily coincide, and both lines may in that case be bracketed together and the one date inserted.</p>

Source: National Health Insurance, *Approved Societies Handbook*... London, 1933, p. 313.

Great Britain: Form of final certificate of incapacity for work

FINAL CERTIFICATE

To.....

I hereby certify that I have examined you on the undermentioned date, and that in my opinion you have remained incapable of work up to and including that date by reason of:—

*

and that in my opinion you will be fit to resume work { tomorrow
on.....day (see Note).

‡Date of examination.....

‡Date of signing.....

Doctor's signature.....

Any other remarks by doctor.....

NOTE.—The date here inserted must not in ordinary cases be later than the second day after the date of this certificate and not later than the third day in the case of insured persons who reside at a distance of more than two miles from the practitioner's residence in a rural area, *e. g.*, if the certificate is given on October 2nd, this form of certificate must not be issued unless the practitioner expects the insured person to resume work at latest on the 4th in ordinary cases and on the 5th in rural cases. In any other case he should see the insured person again before giving a final certificate.

*Here insert the name of the specific disease or bodily or mental disablement which renders the insured person incapable of work.
‡These dates should ordinarily coincide, and both lines may in that case be bracketed together and the one date inserted.

Source: National Health Insurance, *Approved Societies Handbook*... London, 1933, p. 313.

voluntary certificate or a private certificate, or he may issue no certificate at all.

Accompanying the first certificate is a notice of sickness, to be completed by the insured worker and sent by him to his approved society. This notice provides a convenient method of informing the society of the incapacity. The insured person may give notice in other ways, however; in fact, alternate methods are necessary on occasion. For example, a written statement from any responsible officer of a hospital that the insured person is an inmate of the institution is acceptable to the societies as establishing the fact of incapacity.

The doctor must give a second certificate—either intermediate, if the patient asks for it, or final, as the case may require—not later than the seventh day after the date of the first certificate. If at any time within the 7 days the doctor, upon examining the patient, is of the opinion that he will be fit to resume work within 2 days (or on the

third day if the insured person lives in a rural area more than 2 miles from the doctor's office), he issues a final certificate to that effect. If he is convinced that the insured person will remain incapable of work for a longer period, he issues, if the patient requests it, an intermediate certificate.

In general, an intermediate certificate must be given weekly by the doctor as long as incapacity continues, if cash payments are to be made to the insured person. If, however, the physician decides that the patient's condition is such that there will be no substantial change or need of additional treatment for a longer period of time, the doctor may, with the society's approval, issue a special intermediate certificate not less often than every 4 weeks.

An intermediate convalescent certificate is used in cases in which the practitioner is of the opinion that a period of absence from home is necessary for the patient's recovery. This certificate may be used only when the insured person has been continuously incapable of work during the preceding 28 days, and the period covered by the certificate may not exceed 14 days. The certificate instructs the insured person to visit his doctor immediately upon his return home; if he remains absent more than 14 days, he must obtain certificates at the place where he is temporarily staying. He is also instructed to apply for his society's consent before leaving home.

A final certificate must be given by the practitioner, whether requested by the insured person or not, if at any time the physician finds, upon examination, that the insured person is fit to resume work immediately after the examination. If the practitioner is of the opinion that the patient, though not fit to resume work on the day following his examination, will be able to return to work on the second day (or the third day for rural cases), the terms of the final certificate must be adapted accordingly.

Ordinarily, the practitioner is required to specify on the certificates the cause of incapacity as precisely as his knowledge of the patient's condition permits. When the disabling condition is diagnosed as a specific disease, the diagnosis must in most cases be clearly stated.

More difficult decisions are involved when an insured person becomes permanently incapable of resuming his previous occupation. In this situation a different criterion of disability is applied,

and the doctor is instructed not to certify the patient as incapable of work, unless in the practitioner's judgment the patient is physically unable to perform any other suitable kind of remunerative work, whether at once or after a short course of training. If it is clear that the insured person may take up some other employment, his approved society is responsible for determining how long the benefits should continue in order to allow the member a reasonable time to qualify for a new occupation. If, on the other hand, the patient is certified as incapable of any work, reexamination and certification by his doctor must be made at least every 4 weeks until the recipient reaches the age of 65 (or age 60 in the case of women), when old-age pensions begin for those who meet the qualifying-period requirement, or until death intervenes.

In many of the cases involving disablement benefits, a second medical opinion may be desired as to existence or continuance of disability. These cases are referred to members of the regional medical staff, employed by the Ministry of Health. The regional medical officers are full-time, salaried physicians, all of whom have had experience in the general practice of medicine; they serve principally as "medical referees." They are required to examine insured persons at the request of the approved societies, or on the invitation of the attending physician, and to render opinions concerning either the question of incapacity or the diagnosis and treatment. When a case is referred by the society, the insured person and his doctor are notified by the medical officer of the time and place of examination; the patient's doctor is free to attend.

The responsibility of the medical officer is to advise societies and practitioners. The society is not relieved of its responsibility for deciding whether or not a referred member is entitled to benefit, nor is the practitioner relieved of any responsibility for treating his patient or for exercising his professional judgment on the question of incapacity. Even so, it is to be expected that the society will ordinarily accept the opinion expressed by the regional medical officer.

Medical Certification in Germany

In Germany, in contradistinction to Great Britain, there is a definite separation in the administration of sickness and invalidity insurance.

Sickness benefits, that is, cash payments for incapacity for work ordinarily not extending beyond 26 weeks, are administered by sickness insurance funds (*Krankenkassen*), parts of the system of sickness insurance; invalidity benefits, for permanent or long-continued incapacity, are administered by state or regional institutions, parts of the old-age, invalidity, and survivors insurance system.

Sickness insurance.—A person is considered unable to work if he cannot continue to follow his former occupation or can do so only at the risk of aggravating his condition. The incapacity is considered to exist even if the sick person might earn his living by undertaking other work and even though the new work would be in accordance with his strength and skill and might reasonably be asked of him in view of his previous training and occupation.

The insured worker has in general free choice of doctor from among those engaged in insurance practice. When a worker becomes ill, however, he does not ordinarily go directly to his physician, as the worker does in Great Britain, but applies to his local insurance office or to his employer for a sickness certificate, for which he pays a small fee. This certificate, issued for a calendar quarter, identifies the worker and is proof to the physician that the worker is entitled to medical treatment.

If, on examination, the doctor finds the insured incapacitated for work, the fact must be entered on the sickness certificate. This fact provides the local office a basis for a decision whether or not the worker is incapacitated. Proof of incapacity for work may also be established by other means—as, for example, by the statement of a reliable person who knows the incapacitated insured person. In such cases, the burden of proof falls on the individual claiming benefit.

The sickness certificate consists of three attached sections, approximately 5 x 8 inches in size and identified by the same number. Section A is divided down the center. The left side is filled in by the local insurance office and provides information concerning the right of the insured to receive wages during disability, his name, residence, occupation, and whether or not illness is due to an accident. A space is provided for affixing a stamp, which serves as a receipt to the worker for the payment of his fee. This part of

the certificate is signed by an official of the local insurance office.

The worker then takes the certificate to his physician, who fills in the right side of Section A. This part provides information on when treatment began, when incapacity for work set in, the designation and cause of the illness, and the date the patient is dismissed. The physician returns the completed form to the local sickness insurance office, which then decides, on the doctor's evidence, whether or not to pay weekly cash benefits.

Section B serves as a record of the physician's services and is used by him in submitting his bill to the Association of Sickness Insurance Physicians. It contains spaces for listing all types of services rendered and for the amount of remuneration which the physician is to receive for them. Section C serves to identify the worker when he presents himself for further treatment.

If the illness continues beyond the end of the calendar quarter for which the original certificate was issued, the insurance office issues a certificate of extension to the worker. This certificate also has three parts. In Section A the physician certifies to the local insurance office that continued treatment is required. Sections B and C are essentially the same as the corresponding sections of the original sickness certificate. In addition to the sickness certificate, in the event of incapacity for work, the doctor gives the patient either (1) a cash-benefit certificate each week or (2) a cash-benefit certificate at the end of the incapacity for the entire period. One or the other of these certificates must be presented to the insurance office when a claim is made for cash benefits.

As in England, cash benefits are payable on the fourth day after incapacity begins. The weekly cash-benefit certificate must contain the following information filled in by the doctor: name of the fund, number of the benefit book of the fund, name of the insured, date of birth, date when patient visited the doctor or was visited by the doctor, period of incapacity, final diagnosis, signature of physician. The insurance office fills in information about the individual's wages and benefit.

The cash-benefit certificate for the duration of the incapacity contains similar information; it

also notes when the patient may be away from home and when he must be seen by the doctor.

If the sickness insurance fund desires a second medical opinion on the question of incapacity for work, it refers the case to medical referees (*Vertrauensärzte*), whose functions are in part similar to the regional medical officers in Great Britain. In contrast to the situation in England, however, where the regional medical officers act only in an advisory capacity, the judgment of the *Vertrauensarzt* concerning the insured person's capacity for work is binding on the insurance fund.

When it becomes evident that a worker receiving sickness benefits may avoid invalidity if proper preventive measures are inaugurated, it is the responsibility of the insurance doctor to report such cases to the local insurance office in order that appropriate measures may be instituted. This function is a significant part of the responsibility of the insurance practitioner.

Invalidity insurance.—When an individual has exhausted his sickness benefits, or when it is evident that he is permanently disabled, he may become eligible for invalidity benefits.

Invalidity insurance covers the risk of general loss of earning capacity. While a definition of sickness is not included in the law, the law does define what is meant by invalidity. An insured person receives an invalidity pension if he (1) is permanently invalidated or (2) is temporarily invalidated—that is, if invalidity has lasted uninterruptedly for 26 weeks or still lasts after the cessation of sickness cash benefits.

Invalidity is deemed to exist if the insured person cannot earn, in any employment suited to his strength and ability which can reasonably be assigned to him in view of his training and previous occupation, one-third of the sum usually earned by a physically and mentally sound person with similar training and ability in the same district. The definition thus embodies the concept of general disability for work or loss of earning capacity in the general labor market.

Establishment of invalidity.—Although invalidity benefits under the German system are comparable with disablement benefits under the British system, the establishment of invalidity in Germany is a more formal and somewhat more elaborate procedure than the British certification for disablement. This difference arises in part from the more definite connotation of permanent

impairment of earning capacity under the German concept of invalidity than attaches to the British conception of disablement.

Claims for invalidity benefits may be directed either to the local insurance office or to the insurance institution of the district. The state or regional invalidity insurance institution has the responsibility of examining the application for invalidity benefits and collecting necessary evidence to enable it to decide whether the application is well-founded; it may in every case call for further expert advice, either on its own initiative or at the request of the insured person. Medical examination and pertinent medical records may form a part of the proof. If the insured person requests it, the opinion of his physician must be obtained; in this case the applicant must pay the cost involved but is reimbursed if the pension is granted.

When a medical examination is required for approval of an invalidity pension, the form used for the medical report is a four-page document covering the physician's report of the complete history of the case, a statement of the present complaint, and a history of the patient's capacity for work; a complete record of the objective findings of the medical examination; the diagnosis; and an evaluation of the capacity to work, with an opinion regarding the permanency of the condition, the possibility of restoration through medical treatment, and other information.

Once an applicant is accepted for invalidity pension in Germany, he is reexamined only when the invalidity insurance institution considers it necessary to verify the continued existence of the circumstances in respect of which the pension was granted. In England, in contrast, disablement requires recertification at least every 4 weeks.

Medical Certification Under the Railroad Retirement Act

In the United States, the definition of disability established under the Railroad Retirement Act of 1935 embodied the concept of occupational disability; an otherwise qualified railroad worker could qualify for a disability annuity if it could be shown that he had been "retired by the carrier on account of mental or physical disability." In other words, a person could be disabled for a specific railroad occupation but not necessarily for other work. The 1937 act defines disability

in more stringent terms. A worker is not eligible for disability under that act unless it can be established that he is "totally and permanently disabled for regular employment for hire." This definition of disability, like the German definition of invalidity, embodies the concept of loss of earning capacity in the general labor market.

The Railroad Retirement Act also requires that a person must have reached the age of 60 or have rendered 30 years of service to a covered employer before he can be eligible for a disability annuity. The act provides only for cash benefits.

A decision that permanent and total disability exists is made by the Disability Rating Board in Washington. This Board is composed of two physicians and an attorney. The basis for their decision is the report of the medical examination.

Application for a disability annuity is initiated by the employee. He may file application if he is retired by a carrier for disability or if he deems himself unable to work. Arrangements for physical examinations of applicants for annuities are made by the Railroad Retirement Board. If the railroad system employs a surgeon, he is responsible for the physical examination and medical data required by the Board; in about two-thirds of the cases examined for annuities, the railroads themselves arrange for the medical examination. If the carrier indicates that medical data are not available, the Board arranges for the examination of the applicant by a designated physician, usually one who has had experience in the examination of veterans who apply for compensation or benefits. He may be connected with the local Veterans Administration. Physicians designated by the Board receive a fee of \$5 for their services. Examinations are ordinarily conducted in or near the town in which the applicant resides.

In reporting physical examinations, a prescribed four-page form is used by the carrier surgeon or a physician selected by the surgeon. This form provides a complete report, including the applicant's medical and industrial history, and the results of the physical examination, laboratory work, X-ray, and other diagnostic tests. A Veterans Administration examiner reports on the regular eight-page form of the Veterans Administration, which supplies substantially the same information as the four-page form.

On completion, the reports are sent to the Railroad Retirement Board in Washington. The

examining physician is not asked to express a judgment or opinion as to the extent of disability of the applicant; this decision is the responsibility of the Rating Board. The report of the physical examination goes to one of the physicians on the Rating Board. He may make a decision from the evidence at hand, if he finds it adequate, or he may request additional information and, in some cases, an examination by a second physician. The complete record is then sent on to a second member of the Rating Board, who approves or disapproves the decision. It is then passed on to the third member for his decision. A unanimous decision is necessary for granting an annuity. The decision of the Rating Board as to whether the claim should be granted or denied, and the reasons therefor, are made a part of the record.

If the members of the Rating Board disagree as to the existence of total and permanent disability, as defined, they discuss the case further; a unanimous decision is generally reached. If a claim is denied, the claimant has the right of appeal to an appeals board.

Experience so far has indicated that, in about 50 percent of the claims granted, provision is made for reexamination of the annuitant at the end of a year to obtain proof of the continuance of total disability. In the other 50 percent there is either no question as to the continuance of total disability or the applicant will attain 65 years of age within the year and thus automatically become eligible for retirement instead of disability benefits. The provision for reexamination is the responsibility of the Railroad Retirement Board and is generally made in the same manner as the original examination.

If on reexamination an annuitant is found to have recovered from his disability, his annuity ceases. As of June 30, 1940,³ 36 disability annuities out of a total of approximately 24,000 initially granted since 1936 had been discontinued because the annuitant had recovered.

Certification Under the United States Employees' Compensation Act

The United States Employees' Compensation Act, covering civil employees of the Federal Government, provides for monthly cash payments during disability of an employee resulting

³ *Annual Report of the Railroad Retirement Board for the Fiscal Year Ended June 30, 1940*, pp. 102, 104.

from injury sustained in the performance of duty.⁴ Total disability, and partial disability which affects the wage-earning capacity of the worker, are compensated. The act also provides for medical services for any injury sustained by an employee in the performance of duty whether or not disability has arisen. Such services are furnished either by United States medical officers and hospitals or, when this procedure is not practicable, by private physicians and hospitals designated or approved by the Employees' Compensation Commission, which administers the act.

Neither the act nor the regulations governing its administration define disability. Since, however, compensation is specified as a percentage of the monthly pay or wage-earning capacity of the disabled employee, the connotation is clearly that of occupational disability. The Commission decides in all cases whether compensation shall be paid. To be eligible for compensation, an employee is required to notify his immediate superior in writing of the injury within 48 hours after it occurs, unless reasonable cause can be shown for delay, in which case the Commission may allow compensation if notice is filed within a year. This notice states the name and address of the employee, the year, month, day, and hour when and the particular locality where the injury occurred, and the cause and nature of the injury. The superior official provides the injured worker with a request for treatment, which he presents to the doctor. Two forms are used, one when there is no doubt that the injury occurred in performance of duty and one when the cause of injury is in doubt. Both forms give the name, age, sex, and race of the employee, the name and address of the office where he is employed; the first gives the date and nature of the injury; the second, the date and nature of the alleged injury.

The attending physician is required to make a report of the medical examination on a form issued by the Commission. Included in the report are the history of the employee's accident, the exact description, nature, location, and extent of the injury; X-ray findings if X-ray examination has been made, the nature of the treatment, the degree of disability (described in terms of function), diagnoses, prognosis (including probable perma-

⁴ The act has been extended by amendments to include persons employed under Federal emergency work programs. The procedures discussed are fully applicable only to regular civil employees; variant procedures apply to persons on emergency work programs.

ment effect), and recommendations. In cases in which there is doubt as to the cause of the injury a supplementary statement is required, giving a medical opinion why the condition is or is not the result of injury. The completed medical report is sent to the Commission in Washington.

If an injury in the performance of duty results in disability with loss of pay for more than 3 days, the employee's superior officer advises him of his right to benefits and provides him with a form for claiming compensation. The form is filed with the superior officer upon the termination of disability if the duration is less than 18 days, or at the expiration of 18 days from the date pay stops if disability continues beyond that date. The superior officer sends the report immediately to the Commission.

The Commission's trained examiners review the medical reports and other information necessary to establish the employee's eligibility to benefits. The examiner who first reviews the data may recommend that payment be made; the record then goes to a second examiner and, if he concurs, the Commission may decide to pay benefits. When the decision is more difficult because of the medical evidence, or lack of it, the record is sent to a physician who is a member of the Commission's advisory medical staff for his opinion; or, if the case presents especial difficulty, the report or the claimant may be referred to the medical director, or by the director to a specialist of the United States Public Health Service, or to a private physician. When a medical opinion or opinions have been obtained, the file goes to members of the Commission for consideration; two of the three members must concur in a decision.

The certification of the attending physician as to further disability must be obtained semi-monthly if disability is continuous, unless such frequent medical evidence is unnecessary. In long-continued cases such evidence of continuance of disability must be submitted as required by the Commission. An injured employee is required to submit to examination by a physician approved by the Commission as frequently and at such times and places as the Commission may require; if he refuses or in any way obstructs an examination his right to compensation is suspended.

When an injured employee is discharged, the attending physician must mail a discharge report to the Commission. When the employee is able

to return to work, his superior officer must immediately report this fact to the Commission.

Summary

Only two of the four systems for which certification has been described define by law the terms used to indicate incapacity for work. The German act defines invalidity; the Railroad Retirement Act defines disability. Under all four systems, however, as in most disability insurance systems, the concept of disability, whether defined by law or determined by regulation, is not a purely medical concept; it is related rather to the economic loss suffered by the disabled worker.

In Great Britain the concept of occupational disability is applied at the outset in determining eligibility for sickness benefit; that is, the insured individual is certified as unable to work if an attempt to resume his ordinary occupation might be seriously prejudicial to his health. There is a shift in the concept from occupational to general incapacity for work at any time that it becomes apparent that the beneficiary will be unable to resume his ordinary work within a reasonable time. In Germany the concept applied in certifying for sickness benefits is that of occupational disability; for invalidity benefits it is general incapacity for work. The concept of general incapacity for work is applied in certifying disablement for which benefits are paid under the Railroad Retirement Act. The provision for disablement benefits under the Employees' Compensation Act is more limited and applies only to workers injured in performance of duty; the concept employed is, in general, injury which prevents a worker from performing his accustomed duties.

Most national insurance systems make a clear distinction between disability which is temporary and that which is more or less permanent; generally two types of benefit are provided, even in systems which do not expressly separate sickness and invalidity insurance. This distinction is found in both the British and the German systems. Three of the four systems studied in this article provide cash benefits for both short and long-term incapacity for work; the Railroad Retirement Act alone provides only for permanent or long-term disability.

The three systems which provide for short-term disability make provisions for medical benefits or care during such disability. Most national sys-

tems associate, in practice, need for curative treatment with temporary disability. Certification for permanent disability benefits, on the other hand, more often predicates disability which has reached a stage of relative stability; treatment has presumably done all that it can toward restoring the individual to a state of employability. The German plan provides for preventive treatment for workers in receipt of invalidity pension only if there is a likelihood of restoring the worker to

employability. The British plan provides medical care during long-time incapacity; under the United States employees' compensation system, medical care is furnished for any condition which is the result of injury, whether resulting in long-time or short-time disability. All four systems make provision for reexamination to determine fitness for work while the individual is receiving cash benefit, whether for short-term or long-continued disability.