Domestic Politics and International Expertise in the History of American Disability Policy

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COMPARATIVE LITERATURE ON THE WELFARE STATE looks for reasons why America has "lagged" behind western Europe in the development of national social insurance programs, such as national health insurance. By prejudging what should have happened instead of trying to understand what did, in fact, happen, some analysts allow themselves to become "dispensers of moral judgments," in Herbert Butterfield's phrase, "dividing the world into the friends and enemies of progress" (Ashford 1989). Although this approach makes for spirited history, it also obscures the unique ways in which different countries have attempted to solve common social problems (Fox 1986).

This essay uses rehabilitation and disability policy—relatively unfamiliar areas of social welfare policy—to compare the United States with the earliest German social insurance programs and with Great Britain, the Netherlands, and Sweden. It seeks historically informed answers to two questions. What is distinctive about the American approach? Do nations learn from one another, or do cultural differences overwhelm efforts to transplant social policy from one nation to another?

Guiding Assumptions and Initial Cautions

The answers must of necessity be tentative. In part, this condition reflects my ability to read the sources. I use the relatively abundant

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sources on the American experience and the far more fragmentary secondary sources on foreign disability policy to compare America with other nations. The simple fact is that I know more about America than I do about Great Britain, Germany, Sweden, or Holland. In part, also, this condition has to do with the broad scope of time covered by this essay. Generalizations about comparative social policy in the late nineteenth century may not apply to social policy after World War II. I find an extreme divergence between America and Great Britain and America and Sweden in the post-World War II era, rather than before.

For all the care that must be taken with making broad generalizations, nations do emulate one another in conceptualizing and sometimes implementing social policies. For example, American social insurance experts, anxious to make their proposals appear legitimate, have copied notions, such as the very idea of social insurance, and specific programs, such as workers' compensation, from their foreign counterparts. American advocates for the handicapped have taken proposals, such as quotas in hiring, directly from western European models.

American experts have attempted to learn from foreign experience as well as from foreign ideas. Because American programs have followed upon the adoption of similar programs in Europe, American experts have drawn on a tangible body of foreign administrative experience, rather than borrowing theoretical constructs alone. These experts have also tried to modify foreign programs in an effort to improve, rather than merely transplant, them.

Lessons learned from an international community of experts and advocates have acquired a particularly American cast as a result of domestic politics. More than experts and advocates are involved in the policy process, after all. Others with a legitimate claim on the policy-making process, such as legislators, have modified foreign proposals.

Disability policy, in other words, is largely the result of the same historical and structural forces that have shaped American social policy more generally. This is not the place to define those forces, yet certain factors carry particular weight in explaining the differences between American and European disability policy. It mattered, for example, that America, unlike most other countries, tried to institute a social

insurance program in the Depression, rather than in a more prosperous era.

Significant American structural forces, not present to the same degree in the other countries considered here, included the tradition of relying on states and courts, rather than the federal government, to design and carry out social policies. In part, that practice stemmed from conscious constitutional design, but in part it reflected a more general vision of government as an agent resolving disputes between private parties. Also, democratic pressures cancelling out opposing views and a lack of administrative capacity have created a void that the courts have filled (Skowronek 1982). Not surprisingly, then, much of our disability policy has flowed from the courts, rather than from Congress.

A final dimension of politics needs to be mentioned. Our politics is inevitably bureaucratic, and at any given time there is no *one* version of the American state, but rather a series of departments and other bureaucratic entities, each with its own aspirations (Quadagno 1988). Although I recognize that bureaucratic politics is universal, I choose to emphasize American bureaucratic politics within the executive branch of the federal government. That reflects my use of international comparison as a means of illuminating American, rather than foreign, disability policy.

The First Programs: Partial Emulation of Great Britain and Germany

"The very notion of disability," writes Deborah Stone (1984), "is fundamental to the architecture of the welfare state; it is something like a keystone that allows the other supporting structures of the welfare system and, in some sense, the economy at large to remain in place." Disability, according to Stone and many other social scientists such as Saad Nagi (1979), represents a social and politically determined concept that serves to link injuries, diseases, or other forms of deterioration in health conditions with a less clearly defined concept usually described as an "inability to work." Disability, although important, is, therefore, a vague concept, and, perhaps for that reason, disability has always been something of an afterthought.

Whatever the reason, disability has never been the primary risk covered by a major social insurance program. Instead, it has functioned as an appendage of other programs. If modern social policy can be said to date from the establishment of national social insurance laws in Germany between 1883 and 1889, then the notion of disability as a secondary risk goes back to the very beginnings of the modern era (Heclo 1974).

The earliest commentators on social insurance in America noted that disability always stemmed from another social welfare problem, such as the aging process or the progress of a specific disease or injury. Isaac Rubinow, the Russian immigrant generally considered to be America's greatest authority on social insurance in its early years, wrote that a person could take three routes to disability. He could be born with a disability. He could also take what might be described as the "pre-old" route, such as by doing heavy labor and breaking down, or he could take the "sickness" route, getting a disease that left him incapacitated. Rubinow specifically cited European social insurance experts who pointed out that "permanent impairment" could come from the "after effects of sickness or accidents" or from "advanced age" (Rubinow 1916). It followed, then, that disability was not a distinctive social risk but could instead be handled through extension of the social provisions for education, health insurance, work accidents, and old age.

When Germany passed the first national social insurance laws in the 1880s, that country institutionalized the notion of disability as a secondary risk. There were two important links between the social insurance system and disability. Health insurance, best thought of as temporary sickness insurance because of its emphasis on the payment of cash benefits, included a short-term cash grant to cover income lost during illness. After twenty-six weeks, this grant could be converted to a *temporary* "sickness pension." The technical definition of this pension mentioned people who were "not confirmed invalids" but who were "unfit for work during an entire year" (section 10 of the 1889 "Act for Insurance Against Old Age and Invalidity," quoted in Brooks [1895, 168]). Old age insurance also contained an "invalidity" clause that allowed a person to take what we would now call early retirement if he could not earn one-third of his previous wages (Falk 1936).

From the beginning the Germans were able to isolate candidates

for rehabilitation, primarily among people receiving the "sickness pensions". The authorities recognized that a medical or vocational intervention could prevent a sick person from crossing over the line from temporary to permanent disability and thus save the German Friendly Societies and "Kassen" money. The intervention took the form of what Rubinow translated as "invalidity insurance institutions." By 1908 these institutions, apparently heavily medical rather than vocational in nature, included 36 sanatoria for lung disease and 29 other institutions of various types that treated 87,000 persons (Rubinow 1916). In addition, some German employers, such as Krupp, took steps to keep injured workers employed after an industrial accident through the provision of "invalid workshops," in which jobs were matched with what American disability administrators would call the "residual functional capacities" of the employees (Brooks 1895).

Significantly, these institutions focused on younger workers making the transition from temporary to total disability, rather than older workers nearing retirement. The Germans understood that rehabilitation functioned more effectively among the young rather than the old. In the old-age insurance program, for example, the disability emphasis was on retirement. A person could get regular old-age benefits at the age of 70, but benefits were payable to younger people on the basis of "invalidity," or a reduction in earning capacity. By 1908, in fact, the overwhelming number of people on the rolls got there on the basis of invalidity rather than old age. Of 140,000 pensions granted in the German system in 1908, only 11,000 were for normal old age; 117,000 were for permanent invalidity and 12,000 for sickness (Rubinow 1916, 358).

When the British Parliament passed Lloyd George's act in 1911 covering unemployment and health insurance, it followed the German example and united payment for health services and cash benefits within one program. The British system, like the German system, emphasized the payment of cash benefits rather than the provision of medical care. In the British scheme, a worker could receive cash sickness benefits for 26 weeks, after which he became eligible for a "disablement" benefit (Gilbert 1970; Gregg 1967). Apparently, however, the British showed less interest in establishing a rehabilitation link in their social insurance system.

Many state legislatures in America passed social insurance laws at

the same time that the British created an unemployment, health, and sickness insurance program. Unemployment insurance, begun in 1911 in Britain, would not arrive in America until 1932 (and then only in Wisconsin). Governmentally supplied national health insurance never became part of America's social policy; it took until 1942 for Rhode Island to create the first American state sickness insurance program. Still, "progressive" American reformers, as historians use that term to designate middle-class professional men and women interested in the passage of such laws as minimum wages and workers' compensation, followed German and particularly British developments with interest. Inspired in part by the passage of German and British laws, these reformers played major roles in the creation of state workers' compensation laws.

Both the domestic and international contexts mattered in the development of American workers' compensation programs, which grew into one of the world's largest social insurance systems. Workers' compensation owed its origins to a complex political discussion over the costs of industrial accidents. This discussion concerned the efficiency of America's legal system in handling work accident cases. Significantly, the discussion bridged the Atlantic since Britain and the United States shared a common legal heritage: The state of Illinois, for example, formally accepted the British common law in one of the first acts of its state legislature. The American institutional context was crucial in explaining such matters as why workers' compensation was more acceptable to business than other forms of social legislation and in determining why the measure emerged when it did; the British had passed a workers' compensation law in 1897 for selected occupations and extended it to cover most occupations in 1906 (Beveridge 1942). The American context was less influential in the specific design of workers' compensation programs. Here, what a political scientist has called the "international context of communication and policy development" became important (Heclo 1974, 68–69).

In particular, American legislators accepted the British practice of combining benefits for temporary and permanent disability and for uniting health service and income maintenance benefits within one social insurance program. The Americans also used somewhat similar institutions to administer their laws. Where the British depended on friendly societies and industrial life insurance companies, the Americans utilized property and casualty insurance companies.

By 1920, American workers' compensation programs, although they operated on the state level, covered most of the nation's workers. Most states began only with monetary benefits, but by 1935, 23 states had legislated unlimited medical care for injured workmen. Limited to work-related injuries, the American workers' compensation laws nonetheless generated 77 million dollars in medical expenses by the 1930s (Falk 1936, 291, 298). To put this amount in the international context of social insurance, the Americans spent about as much on medical care of injured workers as the British spent on medical care in their health insurance system.

In the workers' compensation system, the Americans created partial links between income maintenance and rehabilitation measures, just as the Germans had in their social insurance system. Many factors, such as the uncertain costs of rehabilitation, mitigated against its universal adoption within American workers' compensation programs. Yet, in New Jersey the governor and the labor commissioner, impressed with the work in medical rehabilitation being done in Germany, helped to establish a rehabilitation clinic as part of the state's workers' compensation program in April 1918. The clinic, an early example of what would later be called a rehabilitation center, contained facilities for orthopedic surgery, physical therapy, and occupational therapy (Kessler 1968).

Few states followed New Jersey's example. Instead, they continued practices that had begun in the legal system, such as rewarding an injured worker with a lump sum as a form of recompense for the impairment he had sustained (Berkowitz and Burton 1987). Workers' compensation was a form of legal "settlement" rather than a source of rehabilitation. The two goals were, in fact, antithetical to one another: the more a rehabilitated worker reduced his impairment, the less he could expect as a settlement of his workers' compensation claim. Furthermore, insurance executives, mindful of the variance in rehabilitation's cost from case to case, continued to regard rehabilitation with suspicion (Berkowitz 1989). Despite constant pleas on behalf of rehabilitation and frequent rediscoveries of the lack of rehabilitation within the compensation system, rehabilitation never became a central feature of workers' compensation (Somers and Somers 1954).

The New Deal, Depression Politics, and American Social Insurance

During the New Deal, America added old-age insurance and unemployment insurance to its array of social insurance programs. In time, American policy makers augmented each of these programs by giving them disability features: a disability pension in the old-age insurance program (1956) and, in at least five states, a sickness benefit in the unemployment insurance program (except, in New York, which linked the sickness benefit with its workers' compensation program). In creating social insurance programs in the New Deal period and in extending those programs to cover disability, American officials learned from both their own experience with workers' compensation and the considerable experience that had developed in the British unemployment insurance and health insurance programs.

In planning what became the 1935 Social Security Act, the members of the Committee on Economic Security, appointed by President Roosevelt in June 1934, and the committee's staff began with the notion of a national social insurance program. An important aspect of this policy would consist of a contributory program designed to provide an annuity to retired workers. This contributory annuity would provide the base on which a disability pension would eventually be built. The committee's staff soon discovered the difficulties of starting such a program during a depression. Plans to create a system that was self-financing were overshadowed by noncontributory programs in aid of groups, such as the elderly, considered worthy of immediate federal financial assistance.

In 1935, as Congress prepared to consider the Social Security Act, workers' compensation illustrated what could go wrong, rather than what was right, with social insurance programs. The notion of workers' compensation as a failed program became a matter of faith among the public health technicians, actuaries, pension experts, and academics who advised the government on the Social Security program. After 1935, many of these same people became mid-level government bureaucrats who designed amendments to the Social Security program. Their critique of workers' compensation centered on its failure to end litigation and on the political way in which its benefits were awarded.

Analysts, the public health experts and lawyers who were not immediately affected by changes in compensation costs and therefore

considered themselves to be impartial in their assessment, regarded state workers' compensation programs as too political. Employers had obvious reasons to understate the extent of a worker's disability and to provide the employee with shoddy medical care. Incompetent or corrupt administrators allowed the employers to get away with it. "In the choice of doctors many or most of the companies have been far more interested in the cheapness of the professional work than in its quality or effectiveness from the point of view of the injured employee," wrote public health expert I.S. Falk (1936, 307). In the state of Illinois, the officials appointed to hear disputed compensation cases spent most of their time "keeping their political fences intact," noted legal expert Walter Dodd (1936). For these analysts, then, the flexibility and local discretion built into workers' compensation were sources of despair. They vowed not to repeat those mistakes in the Social Security program.

By 1935, as well, Americans could draw lessons from foreign social insurance programs. Whether the same congressmen who could not keep the details of the American social insurance program straight in their minds—"the congressmen have a very confused idea what this whole program is about," wrote one exasperated staffer—understood much about European programs is unclear (Cohen 1935). It is, however, a matter of historical record that the advisory staff for the legislation spent the bulk of its time drafting reports on foreign social insurance programs. These were the logical precedents for their proposals (U.S. Committee on Economic Security 1937).

To an American student of social insurance, the foreign experience contained a cautionary note that was not unlike the lesson that could be learned from workers' compensation. What started as a limited and controlled program of unemployment insurance in Britain soon mushroomed into an uncontrollable and widely dispersed dole. Politicians, faced with unrest among the unemployed, could not resist extending coverage and benefits and permitting the government, rather than the employers or employees, to assume the increased costs. (The experience with American Civil War pensions could be read in somewhat the same way.) Further, people responded rationally to the incentives built into the social insurance programs. If the benefits were higher on unemployment than on sickness benefits, as they were in the British system after 1921, a disabled person might well prefer to switch to the more liberal system. Even the less generous sickness

benefit system was subject to charges that its rolls contained malingerers. "Malingering clearly grew as unemployment grew worse," for reasons that had to do, in part, with the administrative design of the sickness benefit program (Gilbert 1970). The moral of this tale was clear: much attention needed to be lavished on administrative design of a social insurance program, particularly the parts of it concerned with disability.

The designers of the Social Security Act matched their wits against those of the members of Congress. It was easy for each side to see the other as a stumbling block toward effective legislation. Congressmen, the planners believed, diminished society's welfare by distributing social benefits according to the political loyalties of the recipients. If the planners required proof of this proposition, they had only to listen to the tales of disgruntled politicians who felt *their* partisans were being excluded. "Out in Minnesota where we have a radical administration in power now," one congressman told Edwin Witte, a Wisconsin professor serving as executive director of the Committee on Economic Security, "it is almost impossible for indigent Democrats and Republicans to qualify for relief, and the result is that they are all joining up with this radical party in order to get relief" (Knutson, 1935, 130).

Planners, the congressmen believed, placed abstract theory above social necessity. Politicians regarded the attempt to begin self-financed social insurance programs during a deep depression as a perfect example. Congressman Ernest Lundeen, the author of a radical alternative to the Social Security Act, could ridicule the social planners in the Roosevelt administration by pointing out that the legislation emphasized eventual, rather than immediate benefits. Lundeen portrayed the administration's position as follows: "We will not do anything for the aged now. We will not permit you to help the aged today or tomorrow or this year or next year. We will think about doing something for them several years from now. I say to the Members of the House that you will face the voters in 1936, and these aged people will rise up in your audiences and demand from you, 'What did you do to bring us adequate, genuine old-age pensions in the Seventy-fourth Congress?' " (*Congressional Record* 1935, 5962).

The planners hoped to create a system that would, in effect, defeat what they regarded as the politicians' worst instincts. The planners' strategy included proposals for nonpartisan administration through a

social insurance board containing representatives of both parties, for federal supervision of local social welfare programs and complete federal control of old-age insurance, for the creation of a self-financed old-age insurance program that would not depend on politically sensitive and easily manipulated general revenues, and for a system of financial accounting in which the future liabilities of the system were always visible to current policy makers. The hopes were, therefore, for administrative competence and financial prudence.

In the minds of the experts who considered themselves removed from the pressures of partisan politics, the congressional debate over the Social Security Act confirmed the need to remove the American social welfare program from political or popular forces. As expected, Congress paid almost no attention to old-age insurance. Instead, legislative debate reflected the strong desire on the part of the states and localities for fiscal relief from the crushing burden of caring for the unemployed and the elderly during the Depression. Particularly in the House of Representatives, congressmen simply dismissed the old-age insurance sections of the legislation, which as part of the planners' prudent strategy would not pay regular benefits until 1942. They concentrated instead on the administration's proposal to fund one-half of the cost of state-administered pensions for the elderly. Congress, in other words, clearly favored the dole over social insurance, noncontributory over contributory pensions. This response reflected its emphasis on immediate, tangible benefits, as contrasted with the planners' emphasis on orderly social procedures.

Not a central feature of the 1935 debate, disability nonetheless figured into the discussion, since one of the amendments inserted by Congress and opposed by the Committee on Economic Security staff concerned disability. Federal planners, mindful of the British experience, had scrupulously avoided recommending the creation of a disability program on the theory that the government lacked the administrative capacity to implement such a program. Ignoring this advice, Congress hastened to add a special program for the blind and allowed the blind to receive federally subsidized but locally administered pensions. Predictably, Congress chose noncontributory pensions, funded from general revenues and payable immediately, over social insurance.

Asked about including the blind in the Social Security Act by a congressional committee, Edwin Witte argued that no special leg-

islation was necessary. He said that the blind fared better than any other group of impaired individuals, because they had already made an effective appeal to the "sympathies of the public." Although Witte (1935, 114) did not rule out federal aid to the blind, he urged that others affected by the Depression come first.

The blind's special standing in American policy accounted both for Witte's argument that the blind were relatively well off and for Congress's special attention to the blind. The lack of stigma associated with blindness, the relative ease with which people could imagine and hence fear the state of blindness, and the long history of blindness all contributed to that special standing. So did the very fact that blindness was less disabling than other impairments (Berkowitz 1987).

Members of the Ways and Means Committee agreed with Witte, and they managed to defeat a special amendment on behalf of the blind offered by Republican Congressman T.A. Jenkins on the House floor. His rhetoric reflected the characteristic paternalism of the era: "With the rich man flying by in his limousine, with the athlete skipping by in the full flower of health, with the grand lady in her rustling silks passing by with her vain superiority complex, with the happy care-free children . . . there sits the poor blind with his little tin cup extended. Are you going to leave him on the street or will you assist me to put him upon his feet?" (*Congressional Record* 1935, 6043–44).

Defeated in the House, the advocates for the blind tried the Senate. The Senate Finance Committee inserted grants to the blind in the bill. Senator Pat Harrison (D-Mississippi), the committee chairman, noted that the sight of several old blind men being led into the committee hearing room by their dogs "moved" the committee (*Congressional Record* 1935, 9269). The committee reported to the Senate that only 15 percent of the blind were employed and argued that the need for financial assistance outweighed the blind's need for rehabilitation. "Social work among the blind is important, but their greatest need, particularly among those in the older age groups, is actual financial assistance," the committee stated (U.S. Senate Finance Committee 1935, 22).

The measure passed the Senate with no opposition, and the House concurred in the conference committee. When the congressman who had pressed the case for the blind in the House returned from the conference committee, he told his fellow representatives in partisan

political language aimed at the Democrats that the "brain trusters" had tried to push aside the blind but had failed. The congressmen thanked the conferees on "behalf of the thousand of poor blind who must grope their way through a dark world" (*Congressional Record* 1935, 11327). In this way, aid to the blind became an established part of American social policy.

Great Britain, it might be added, had similar legislation on behalf of the blind. The Blind Persons Act of 1920 provided for a register of blind people, a welfare grant to blind people over the age of 40, and a loose program of local assistance to the blind that included sheltered workshops and training centers. Although no evidence suggests that the countries copied one another, the blind became a special class of citizen in both countries, entitled to aid from the state (Beveridge 1942). In both countries, social planners complained of this practice but to little avail.

Divergence after the New Deal

In the period after 1935, the American and European experience with disability policy diverged significantly. In the first place, the British took steps to integrate their health insurance, unemployment, and old-age insurance programs and to expand coverage and benefits. In the second place, some of the European countries, such as Holland and Sweden, developed manpower programs designed to minimize structural unemployment and aid in the creation of a full-employment economy.

Federal employees tried to interest Congress in emulating the British and the Swedes. The Social Security Administration advocated integrating short-term and long-term disability laws. The Department of Labor initiated manpower programs in aid of the handicapped and, immediately after World War II, endorsed the passage of quota laws on behalf of the handicapped. Because of the existence of a legislature with a strong ability to respond to outside interests such as the blind, a pervasive tradition of federalism that reasserted itself after World War II, active bureaucratic competition in the federal government, and continuing mistrust of Congress and local government by federal planners, the effort to initiate an British, Dutch, or Swedish disability

policy failed. This outcome strengthened the American reliance on the courts and private employers to implement social policies.

Great Britain passed the most famous version of the postwar welfare state by creating a national system of social insurance that was universal—it covered everyone—and comprehensive—it provided a full range of benefits to cover such economic risks as old age, disability, ill health, and unemployment (McCrostie and Peacock 1984). During the 1940s, Great Britain passed laws and declarations calling for full employment, introducing family allowances, liberalizing the old age and workers' compensation laws, and creating a national health service (Johnson 1986).

In 1943 American Social Security administrators proposed a plan that faintly echoed the 1942 Beveridge plan in England. Resting on the notion of coordination of social insurance at the federal level, the plan called for a system of contributory social insurance that included unemployment compensation, temporary disability, permanent disability, old-age insurance, and health insurance. In practice, implementation of the plan would have meant the federalization of the unemployment program and the creation of health and disability programs.

Congress reacted with indifference. Old-age insurance, or Social Security as it would be called, was far from the popular program that it would later become. Distracted by the war, Congress also showed little interest in challenging private service providers such as doctors.

The British, by way of contrast, reacted differently to the war, as their enthusiastic reaction to the Beveridge Report revealed. The report contained stirring rhetoric calling the war "a revolutionary moment in the world's history," which was sure to abolish "landmarks of every kind" and create a "free field." Wartime sacrifice required that the government be "ready in time with plans for [a] better world." After issuing the report, Beveridge became a celebrity. Over half a million copies of the report were sold. As his biographer notes, "pictures of Beveridge, looking prophetically white-haired and benign, were flashed by Pathe News into every cinema in the country" (Harris 1977, 426).

Little in the Beveridge Report could either have surprised or alarmed American Social Security administrators. For all of Beveridge's graceful prose and his rhetorical theme of a revolution in social relations, his report featured the same sorts of criticism of British social policy as

American administrators were making of American social policy. In particular, Beveridge attacked the lack of bureaucratic coordination in British social policy and devoted much of the report to a condemnation of British workers' compensation that Americans, such as Walter Dodd and I.S. Falk, could easily have written. Beveridge criticized the level of litigation, the adequacy of benefits, the impossibility of separating occupational from nonoccupational disability, and the high costs of administration. Furthermore, Beveridge's notion of social insurance was, with the exception of his notion of a flat benefit, compatible with the American system. He wanted contributory benefits and careful monitoring of disability claims.

The British moved in Beveridge's direction after the war, and the Americans veered away from the centralized, coordinated welfare state that he and his American counterparts, such as Arthur Altmeyer of the Social Security Board, advocated. One consequence was a new British workers' compensation law in 1946, in which, for the first time, the central government, rather than private insurance companies, took charge of the payment of benefits. The law did not do away with the distinctions between industrial injuries and other forms of disability as Beveridge had wanted, but it did permit a broadening of workers' compensation financing to include contributions from workers as well as employers. In America, by way of contrast, efforts to pass a national disability law that would supercede the state workers' compensation law failed to find acceptance. If anything, the state workers' compensation administrators gained power, as the case of temporary disability revealed.

The politics of temporary disability in America were entangled with the efforts by Social Security administrators to pass the Wagner-Murray-Dingell bill during and after the war. Although this federal social insurance plan, first introduced in 1943, never came close to passage, it contained an important piece of disability policy that reflected lessons American planners had learned from British health insurance programs. The Americans believed that, by combining health insurance and cash disability benefits, the British had made a mistake: Doctors who both treated patients and certified disability exaggerated the severity of sickness and the duration of disability. In this manner, they encouraged malingering and raised the costs of the program. As a result, American planners concluded that cash benefits should be separated from the provision of medical care. In America,

unlike Britain, the same doctor would not be allowed both to treat a patient's illness and certify his eligibility for cash benefits.

Because of the American planners' reading of the British experience, they wanted to separate health insurance and disability insurance and to link disability with other forms of income maintenance. They decided to include temporary disability benefits as part of unemployment compensation and permanent disability benefits as part of old-age insurance. Unemployment and temporary disability paid temporary benefits; old-age insurance and permanent disability insurance paid permanent benefits. Unemployment was a state program; old-age insurance was a federal program.

Those decisions added to the consequences of failing to pass the Wagner-Murray-Dingell bill in the 1940s. By linking temporary disability and unemployment compensation and failing to get a federal unemployment compensation law through Congress, federal planners relegated the provision of temporary disability to the state level of government. During the 1940s, five states passed temporary disability laws; the United States never passed a federal temporary disability law that applied to all of the states (Berkowitz 1987). Indeed, by 1949 the notion of a federal temporary disability law mustered nearly no political support. In that year, Mary Donlon, the New York state workers' compensation administrator who had been put in charge of that state's new temporary disability law, lectured Congress on the "disturbing tendency in the field of industrial relations to favor the substitution of stateism, through political action, for the process of collective bargaining." Donlon (1949, 2253) asserted that such an approach led to the "eventual liquidation of labor organizations" and that the New York State approach which permitted private parties "the widest latitude" was superior.

This reliance on localities and private parties to cover the risk of temporary disability—so divergent from what happened in postwar Britain—related to the American approach toward the rehabilitation of the disabled. Simply put, other countries, such as Holland, maintained better bridges between temporary and permanent disability. In Holland's more integrated system, one that was influenced by the Beveridge report (Emanuel, Halberstadt, and Peterson 1984), trade associations administered both temporary and permanent disability benefits. At the end of a year of sickness benefits, the beneficiary's trade association automatically prepared an application for permanent

disability benefits (DeJong 1984). The Dutch system allowed the government to identify candidates for rehabilitation far more easily than did the administratively fragmented American system.

In America, by way of contrast, Social Security officials simply abandoned the effort at rehabilitation. Bureaucratic rivalry at the federal government contributed to the decision. Some federal bureaucrats, such as the administrators of vocational rehabilitation, opposed the Wagner-Murray-Dingell bill. They believed that the heavy reliance on the federal government would sap local initiative and that the reliance on income maintenance and social insurance would inhibit creative alternatives. They criticized officials of the Social Security Administration for following an inflexible script that called for the constant expansion of the old-age and survivors' insurance program. Hence, one federal ally of the vocational rehabilitation program commented in 1942 that, "the social security people are incapable of nonbureaucratic decisions and objective planning" (Switzer 1942).

Faced with this sort of criticism, the Social Security officials beat a tactical retreat from programs that emphasized employment, social services, or rehabilitation and concentrated instead on income maintenance and retirement. Although many of these officials, such as Arthur Altmeyer, had begun their careers in state government, they grew increasingly distrustful of the states' motives and competence. In 1940, when the first disability plans were being put together, federal planners stated that one of the major purposes of a social insurance program against disability was to supply occupational retraining to persons with chronic impairments. Legislation prepared by the Social Security Board in 1940 (but not passed) included a $400,0000 appropriation for "medical, surgical, rehabilitation, and other services to disabled beneficiaries." "Rehabilitation," claimed the Social Security Board, "is in the interest not only of the worker but also of the insurance system" (Falk 1940). As it became clearer that the federal government would administer only a program for the permanently and totally disabled, with few ties to the widely dispersed state programs for temporary disability, and with active hostility from other federal officials running manpower programs, Social Security officials lost interest in the notion of rehabilitation.

In time, the Social Security Administration wanted nothing to do with any form of manpower program designed to eliminate or forestall unemployment. When, for example, the idea of combining manpower

and income maintenance programs resurfaced in the 1960s, Social Security officials insisted on a strict separation of cash benefits and services. After Congress passed a law that emphasized the rehabilitation of welfare beneficiaries in 1962, Social Security officials supported the creation of a separate "Welfare Administration" to administer the service end of the law. The resulting lack of cooperation placed considerable strain on efforts to link income maintenance and rehabilitation (Winston 1963).

Bureaucratic competition extended beyond the program and agency level to reach the departmental level. The Department of Labor and the Federal Security Agency, the forerunner of the Department of Health, Education, and Welfare, fought over a wide range of issues in the 1940s, including disability policy. The Department of Labor, created in 1913, saw itself as the primary federal agency for manpower policy; the Federal Security Agency (FSA), created in 1939, viewed its mission as the maintenance of economic security through health services and income supports. In the American style, the division of responsibility between the two departments was never clearly articulated and consequently involved a constant process of political negotiation. As an example, the old-age insurance program, developed under the supervision of Department of Labor officials, eventually became part of the Federal Security Agency. The unemployment compensation program shuttled between the two departments as officials of both departments tried to convince Congress and the President that it belonged in Labor or the FSA. Labor Department officials emphasized the job-placement features of unemployment compensation; the Federal Security Agency officials highlighted the income-maintenance features of the program. Matters of bureaucratic coordination often became matters of congressional politics as well.

Each department maintained a disability agenda. The Federal Security Agency, and its constituent Social Security Board, wanted to pass a permanent disability social insurance program. The Department of Labor wanted to strengthen employment services for the handicapped and even, at one point, to implement a quota system on behalf of the handicapped.

Since both sides sought data to develop its arguments, both agencies asked Congress for permission to collect disability statistics. The Office of Vocational Rehabilitation, the Public Health Service, and the Social Security Administration, all members of the Federal Security Agency,

buried their considerable differences over the design of health and disability programs and joined forces to persuade the Census Bureau to include a question on disability in the 1950 census. The Federal Security Agency wanted to know the number of disabled people of working age, the duration of their disability, their age and sex, and their employment history. Contending with yet a different form of bureaucratic politics, census officials replied that disability questions made people uncomfortable, "which not only results in inadequate information being given on this subject, but also hinders the obtaining of complete answers to other questions already on the schedule" (quoted in Berkowitz 1980a). Instead of the census, the Federal Security Agency settled for a question in the Current Population Survey, a much smaller sample. Meanwhile, the Department of Labor asked the census to include a question on the number, age, and location of the physically handicapped—a question that reflected the department's interest in finding jobs for the physically impaired—and received the same negative reply. The Federal Security Agency even refused to share the results from the Current Population Survey with the Department of Labor.

The Department of Labor then took the confrontation a step further and prepared a bill calling for a survey of physically handicapped people, which was introduced in 1948 and 1949. When the Federal Security Agency heard about this bill, it prepared unfavorable comments, but these comments came too late to throttle the Department of Labor bill. The Federal Security Agency decided to introduce its own bill. Where the Department of Labor emphasized the economic characteristics of disabled people, the Federal Security Agency showed the most interest in the diseases of disabled people. The Federal Security Agency convinced Senators Pepper and Murray, two supporters of President Truman's health legislation, to support the bill. The Department of Labor bill went to the Post Office and Civil Service Committee; the Federal Security Agency bill went to the Committee on Labor and Public Welfare. Neither bill became law, in part because each department succeeded in killing the other's initiatives.

This incident, a small matter in the development of American social policy, nonetheless demonstrated the difficulty of coordinating manpower and income-maintenance policies in postwar America. Such incidents, multiplied many times over, illustrated how bureaucratic politics as expressed at the departmental level by differences between

the Department of Labor and the Federal Security Agency forced income-maintenance and manpower programs to develop along completely different tracks.

European Manpower Programs

The Dutch and the Swedes proved far more tolerant of a mix of income maintenance and manpower programs. Where the Americans tended to set the two types of programs in opposition to one another, the Europeans saw no conflict. Income-maintenance programs could, for example, be used to subsidize handicapped individuals engaged in rehabilitation. In America, manpower programs tended to be viewed as interventions that would lessen a person's dependence on income supports. In Europe, manpower programs could themselves function as welfare programs.

The Social Employment Program illustrated the Dutch approach. The program formed part of the nation's postwar commitment to a "full employment" policy. The Dutch, as Robert Haveman has put it, took "seriously" the "right to work" mandate of the United Nations Declaration of Human Rights. The United States, one might add, placed much less emphasis on the government's obligation to provide jobs to insure full employment. In 1950 two Dutch ministerial decrees—one for manual workers and the other for white-collar workers (a distinction never made so overtly in American public programs)—established a formal employment program for the handicapped. The program operated under national government auspices and with national government funds (although the local municipalities ran sheltered workshops and supervised such jobs as maintaining parks or working in libraries). Two years later, the employees in these program workshops received full entitlement to sickness and other benefits and also received a wage that approximated that of regular workers (Haveman 1979).

In 1969 the Social Employment Act combined the older programs for manual and white-collar workers into one consolidated, complex, and heavily regulated program. By 1976 this program maintained 64,000 workers (1.5 percent of total Dutch employment) (Haveman 1979). Even as economists calculated that due to the large costs and low productivity of such a program it represented a net social cost

to Dutch society, the program endured (Emanuel, Halberstadt, and Peterson 1984).

In the United States, a low benefit-to-cost ratio would have seriously undermined political support for such a program. In fact, American economist Robert Haveman concluded his account of the Dutch program with some lessons from the Dutch experience that contained many cautionary notes about "unknown but very large costs" should such a program be adopted in America (Haveman 1979, 132). Haveman's findings caused a "stir" in the Netherlands, according to an American observer. This observer nonetheless concluded that Dutch voices critical of the program were "few," since, "the position of the Dutch on the issue reflects their belief that work is valuable in itself and, as such, a matter of entitlement" (Noble 1982).

Sweden has gone the farthest of any European country with this manpower, employment-oriented approach to disability policy. As in Holland, public works formed an important tradition in Swedish public policy, even before the Second World War. The country approached income-maintenance programs gingerly, not subsidizing "unemployment benefit societies," for example, until 1934 and even then enforcing such stringent conditions that most of the societies preferred to go without such assistance. Disability pensions remained small, income-tested, and difficult to obtain. Even though social policy changed after World War II, the emphasis on the work principle remained (Wadensjo 1984). For the young, work programs and the provision of rehabilitation reached the point where, in one authority's words, "income maintenance is regarded as temporary remedy, until a return to work has been achieved" (Burkhauser 1986).

Beyond formal rehabilitation programs and government jobs, the English and the Dutch also attempted the rehabilitation of the handicapped by forcing employers to hire the handicapped. Wartime and postwar proposals for handicapped quotas reflected an international exchange of policy ideas. England passed the Disabled Persons Employment Act in 1944. A comprehensive measure, the act included vocational rehabilitation, cash stipends during training periods, and job counselling for the handicapped. The handicapped were expected voluntarily to register with the employment service, and an employer with more than 20 workers was expected to fill 3 percent of his vacancies from the register (Scotch 1987). The 1944 act also "designated" certain types of employment for the handicapped, such as

electric passenger lift attendant and car park attendant (McCrostie and Peacock 1984). After World War II, the Dutch passed an "Act to Place Less Able Workers" that required every employer of 20 or more workers to hire 2 percent of his employees from a public register of handicapped workers (Emanuel, Halberstadt, and Peterson 1984).

The Failure of the Manpower Approach in America

This approach received only a cursory trial in America and never became national policy, yet such things as designated employment were not alien to America. Like the British, we had designated certain forms of employment for the handicapped. In 1936, for example, Congress approved a program that reserved employment in news and lunch stands in federal buildings for the blind (U.S. Department of Education 1988). The separation of the blind from other impaired groups was typical of social legislation in both Britain and America. In characteristically American fashion, the law applied to federal, rather than private, activities. Yet, it illustrated that the coercive approach to disability policy did have a place in American social policy.

Despite this partial precedent, the quota notion failed of passage in postwar America. It was discussed and rejected. Beginning in 1946, the Department of Labor sponsored a series of proposals for European-style disability programs that emphasized the employment of the handicapped and included the quota idea. It managed to pass some of the proposals but not others. Those that did pass, such as National Employ the Handicapped Week, posed little threat either to the traditions of local and private initiative or to the federally oriented social insurance proposals of the Federal Security Agency (Berkowitz 1980b).

In October 1945, America, preoccupied with the problems of post-war adjustment, held the first National Employ the Handicapped Week. Soon an elaborate structure developed, one that was closely tied to local luminaries and activities, and by 1949 Congress had authorized an annual appropriation for the President's Committee on National Employ the Handicapped Week, which in time became the President's Committee for the Employment of Disabled Persons.

This committee held meetings, told inspirational stories of people

who had overcome their handicaps, and inspired local businessmen to recognize that hiring the handicapped was good business, but it did not compel local employers to do anything, nor did it lobby on behalf of increased income supports for the handicapped. It represented a style of social welfare, popular at the time, that sought to energize local communities and encourage them to apply their resources toward the solution of national programs. Nothing about this program challenged existing institutions (unlike the provisions in the Wagner-Murray-Dingell bill), enabling it to emerge from Congress relatively unscathed.

In addition to the week devoted to the employment of the handicapped, self-proclaimed advocates of the handicapped wanted to create a comprehensive program of handicapped benefits. Representative John Sparkman (D-Alabama) introduced a bill in 1946 that called for the creation of a federal Commission for the Physically Handicapped. This commission would administer a quota system: Handicapped people would be placed on a register from which employers would hire 2 percent of their employees. It was a direct translation of the British and Dutch proposals. To permit the handicapped access to the jobs, federal safety engineers would devise ways of eliminating architectural barriers. In addition, the handicapped would be eligible for low-interest loans and, if attempts at rehabilitation failed, to cash grants. To make sure that employment of the handicapped was taken seriously, the vocational rehabilitation program would be removed from the Federal Security Agency and put with the other employment programs in the Department of Labor (Berkowitz 1980b).

Bureaucratic reaction was predictable. The Department of Labor supported the proposal, and the Federal Security Agency vigorously opposed it. Social Security Administration officials saw the special-interest nature of the bill as its greatest defect. To them, the pensions for the handicapped resembled the aid to the blind program—a program that would be at the mercy of Congress, be subject to constant pressures for liberalization and other political manipulations, and would consequently hinder orderly social planning. Vocational rehabilitation officials saw no advantage in being moved to the Department of Labor. The handicapped, argued these officials, should not become a special interest and attempt to push their way into the labor market interest through quotas and other coercive devices. Instead, they needed a wide array of social and medical services that

would facilitate their integration into the labor force. Far better, the officials believed, to use federal funds to construct rehabilitation centers, linked to hospitals, and "research and adjustment centers" than to spend federal money protecting the handicapped as a special interest (Kingsley 1949).

The ultimate defeat of Sparkman's bill, due largely to bureaucratic sniping within the Truman administration (Berkowitz 1980b) left postwar America without a quota law. The defeat of the Wagner-Murray-Dingell bill left America without a Beveridge-style social insurance law covering temporary and permanent disability. In the past, America had adopted approaches to disability that were not incompatible with European models, such as workers' compensation laws and designated employment for the blind; after 1946, the American approach diverged significantly from that of Britain, Holland, and Sweden.

Postwar America: A Distinctive American Approach

In the absence of extensive social insurance and manpower programs, the American political system produced practical alternatives to Europe's heavy emphasis on the state to promote the employment of the handicapped. These alternatives relied on voluntaryism, private initiative, and the courts. In addition, they depended on complicated linkages between the public and private sectors in which the federal government set minimum standards and allowed private companies considerable freedom in meeting them.

In the postwar era, the divergence between American and foreign practice no longer generated much criticism, even among social planners in the Social Security Administration who, by becoming more flexible and sophisticated in their approach to politics, gained many of the items on their long-term agenda, including disability insurance. The new flexibility and sophistication were themselves functions of the agency's success. In particular, the adoption of the 1950 Social Security amendments, that extended coverage and raised Social Security benefit levels above those paid by state welfare agencies, enabled the Social Security Administration to operate with greater political confidence. Postwar prosperity, furthermore, had the effect of softening trade-offs between different approaches to policy. Both voca-

tional rehabilitation and permanent disability insurance could be lavishly funded.

The Social Security administrators, who had so enthusiastically greeted the 1942 Beveridge Report and treated Beveridge like a hero when he visited America in 1943 (Altmeyer 1966), downplayed the connections between their policies and those of the English in the postwar years. In part, this had to do with the red scare, which reached into Social Security politics. In 1949 Marjorie Shearon, a former Social Security Board employee who "recanted," told Congress that the Wagner-Murray-Dingell proposals and their successors were really the products of the International Labor Organization. In rhetoric that meshed neatly with other political exposés of the era, Shearon (1949) said, "Long before the members of this committee consider social security proposals, the principles of the bills are mapped out by representatives of foreign countries whose ideologies are repugnant to us. As one studies these alien suggestions, one is reminded again and again that the stage had already been set . . . when in 1934 this country entered the ILO in the role of a novice among a group of experienced left-wing actors."

Even disability insurance, when it arrived in 1956, differed significantly from the earlier Wagner-Murray-Dingell proposals. It now contained a large dose of state administration (Berkowitz 1987), featured no links with the state temporary disability insurance programs, and showed only cursory interest in rehabilitation. As I have detailed at length elsewhere (Berkowitz 1987, 1988) efforts of the Office of the Vocational Rehabilitation to create a rehabilitation program for disability applicants failed.

This failure of the disability insurance program to effect rehabilitation should not be surprising; in Britain and Holland, after all, few of the permanently disabled went back to work. In those countries, however, other routes toward disability, in particular the health insurance system, increased the usefulness of employment and rehabilitation measures. In Sweden and Holland, also, the government tolerated costly subsidized employment programs. The state was, in other words, willing to pay for the employment of the handicapped. In America, by way of contrast, work-fare programs gained proponents not only because of the presumed psychic benefits of work but also because these programs promised to save money in the long run.

In the postwar era, the private sector remained important in Amer-

ican disability policy. One-quarter of America's welfare expenditures in the 1970s were made by nonpublic institutions. Although health care constituted the primary private expenditure, private employers also paid for sick leave and temporary disability programs. Private pensions even supplemented the income of nearly one-half of the recipients of public disability benefits (Stevens 1988).

The costs of these private endeavors motivated social action. As the costs of short-term disability rose to between 2 and 4 percent of payroll, the same business coalitions that were created to help private employers with the management of health care costs took an interest in controlling disability costs. With the aid of these coalitions, employers initiated programs known as "disability management at the workplace." Components of these programs included a grab bag of health care, psychological counselling, management planning, and ergonomic techniques too diverse to characterize. Disability management could include early identification of job-related disability problems, planned management of disability-related costs, the willingness to modify jobs, and development of personnel policies to facilitate work return and job retention for the injured, disabled, or chronically ill worker (Carbine and Schwartz, 1987).

The concept implied a coordinated disability policy, with many of the same linkages that characterized the European system and, no doubt, with many of the same bureaucratic problems. Most American companies, for example, have not designated a "disability benefits manager" nor created a cohesive structure to unite workers' compensation benefits, health care coverage, and work-place modification (Carbine and Schwartz 1987).

At the same time, disability management reflects American rather than European traditions. Corporate officials involved in disability management speak the language of human capital investment, a language that goes back at least as far as the welfare capitalism of the 1920s. As an officer of 3M puts it, "Just as we strive to maximize our return on our material resources, it is also our policy to maximize the contribution of our human resources" (Carbine and Schwartz 1987; Berkowitz and McQuaid 1988). Some unions react to this sort of rhetoric with the same sort of caution that characterized labor's reaction to scientific management and welfare capitalism. The object, after all, is to reduce the cost of fringe benefits through such devices as modifying seniority rules and permitting handicapped individuals to work.

Even disability management at the workplace, for all of its reliance on private initiative, depends on crucial linkages between the public and private sectors. To cite just one example, a worker cannot retire on a private, permanent disability pension unless he also applies for a Social Security disability benefit. That means that the private sector uses the public sector to preserve a strict definition of disability and to pay part of the cost of permanent disability pensions.

These sorts of private/public links also apply to the other weapons in the American arsenal for the employment of the handicapped. The courts have played a far more vital role in American public policy than they have in the development of European policy. Courts have defined a wide body of rights that apply to disabled persons, such as the right of an institutionalized retarded citizen to treatment and services that "maximize the developmental potential of the person and are provided in the setting that is least restrictive of the person's personal liberty" (U.S. Commission on Civil Rights 1983). This body of rights creates the possibility of using legal action as a means of securing a job for the handicapped person; for, as the courts have ruled and the Congress has noted, the right to discriminate against a handicapped person is carefully circumscribed. In particular, an employer receiving federal funds cannot discriminate against an "otherwise qualified handicapped individual . . . solely by reason of his handicap."[1]

These familiar words from Section 504 of the Rehabilitation Act of 1973 nicely illustrate the American approach. They stem from a legislative action that was preceded first by court rulings and then by the passage of similar legislation on behalf of blacks (1964) and women (1972). The strategy, then, is to handle handicapped grievances as an extension of civil rights law. In the American style, a person who feels himself the victim of discrimination must pursue a legal remedy, one that relies on individual dispute resolution far more than on mass social action. Further, just like the earlier laws reserving jobs for the blind, the Rehabilitation Act of 1973 relies on federal authority over the consequences of federal funds (Berkowitz 1987). If a company wishes to receive federal funds, it must agree to a series of labor standards, including the pledge not to discriminate against the handicapped. This sort of agreement constitutes another important

[1] 29 U.S. Code 794 (supp. 5), 1981.

American linkage between the public and private sectors. It is our answer to the development of formal quotas or formal manpower programs, one that uses the coercive power of the federal government and still permits a degree of private discretion.

Although this American approach has its drawbacks, it may be superior to the European quota approach. Disability management, it is true, does nothing for people outside the labor force, but the record of formal quotas is not encouraging. The British, like the Dutch, have never pursued the enforcement of their quota law, allowing the maximum penalty to remain at 100 pounds and bringing only nine prosecutions since 1947. Between 1950 and 1980, the number of people registered fell by nearly one-half, perhaps because people with potentially disabling impairments realized that identifying themselves as handicapped would hinder, rather than help, their job search. Over 60 percent of the firms failed to fill their quotas in 1978, but then again, there were not enough handicapped people registered to fill all the positions "reserved" for the handicapped (McCrostie and Peacock 1984).

Conclusion: The Consequences

This essay has demonstrated the emergence of distinctive American institutions, such as disability management at the workplace, even in the face of Heclo's "international context of communication and policy development" that has brought such ideas as quotas or a national system of social insurance across the Atlantic. If one avoids the temptation to become a "dispenser of moral judgments," one still cannot escape the fact that history has consequences, as the following hypothetical comparison of a thirty-year-old Swedish worker and an American worker who become disabled reveals.

What happens to these workers as a consequence of the institutions that have developed over time? First, the Swedish worker receives cash sickness benefits, and social assistance (if his income is low enough), along with medical care. Later, the authorities give the worker a more permanent assignment or classification. Although the severely disabled get permanent disability pensions, the expectation for many people, particularly young people, is that the disability will be only temporary in duration. For these people, such as the thirty-

year-old worker, the country makes available a wide variety of training programs, public works projects, subsidized jobs, and sheltered workshops. "It is official government policy that impaired people of working age should be rehabilitated both medically and vocationally" (Haveman 1984).

If a thirty-year-old worker were to get disabled in Illinois, he would not receive a public cash "sickness" benefit, nor would the state or federal government necessarily pay for his medical care. That would be true in at least 45 other states as well. Nor has the situation changed substantially since 1965. The range of retraining options would also be more limited, and the worker would not be guaranteed a program of rehabilitation. If the worker were to receive a public benefit, it would probably be Social Security disability insurance, unless, of course, the disability originated in the course of employment.

The outcome of the American worker's case would depend upon the policies of the worker's employer. The worker's boss might very well value the employee enough to invest in a disability management program on his behalf (particularly if he were a long-term employee with a great deal of firm-specific training), and the worker's company would, in all probability, allow the employee to receive sick pay and, later, long-term disability benefits. The outcome would also depend upon the creativity of the worker's lawyer, who might very well discover a means of recovering damages from a "deep pocket."

In short, the Swedish worker would be more likely to depend on the state, the American worker on the employer and the court. Furthermore, that has been the case at least since 1946 and is independent of the workers' relative marital statuses and even work histories. On average, the American worker would be less likely to re-enter the labor force than would his Swedish counterpart. The American worker's chances of receiving monetary benefits conditioned on the worker's withdrawal from the labor force would be better than his chances of receiving retraining or rehabilitation. That would not be the case for the Swedish worker.

The case study reflects the burden of the comparative history that has been developed in this essay. Unlike Great Britain, Sweden, and Holland, the United States has not developed a national temporary disability system, except for the state-run programs that compensate industrial injuries. By not developing the sickness route to disability

in the public sector, we have insured that our public disability caseload consists mainly of the "pre-old" who suffer from invalidity and that the task of coordinating disability benefits and providing employment to the handicapped falls mainly to the courts and private employers. This outcome makes us neither a friend or enemy of progress, to revert to the language at the beginning of the essay, but it does reveal a distinctively American approach to disability policy that has asserted itself in the postwar era.

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